Boardworks 2.0

CMHSP's
Why us?

- There are 46 CMHSP's serving Michigan's 83 counties
- Michigan constitution requires Legislature to pass laws for protection and promotion of public health.
- CMHSP's, together with their County, have had a 50 year + partnership with the State of Michigan to care for, and share expenses for, vulnerable populations needing our services.

MHC – requirements of CMHSPs

- Provide comprehensive array of services appropriate for individuals regardless of ability to pay
- Provide services to individuals who have a serious mental illness, serious emotional disturbance or intellectual disability.

Federal Government Involvement

- Federal government is responsible for Medicaid and Medicare.
- State and federal government cost share for valid expenditures for Medicaid. Medicare has no State responsibility. As Medicare covers primary medical, State's will pay the premiums for those with Medicaid. This is known as the Medicare buy in.
- States often use waivers as a vehicle of service delivery. E.g. 1915, 1115 – Waivers waive a section of the Social Security Act.

Waivers - continued

- Since 1998 we have operated under several waivers, including a1915(b), 1915(i) and 1915 (c) waiver – the C waiver is for habilitation supports, Children's Waiver and SED Waiver. We are currently under an 1115 waiver for most of our funding.
- There have been several changes to the Waiver, including the development of the PIHP systems, and changes to funding methodologies.

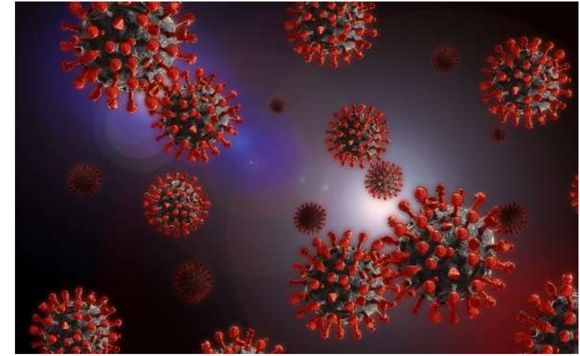
Waiver's – why change?

- The State applied for, and was granted, an 1115 waiver for all services except HSW, Children's Waiver and SED Waiver
- Current waiver expires 9/30/2024
- Michigan is transitioning the current 1915(b)(3) waiver for some services to the 1115 waiver.
- This is a big change for the CMH system.

- Persons receiving certain services (cls, supported employment, residential, respite) will now have to be enrolled in the State system called the WPS, which monitors and tracks clients eligibility for services.
- Evaluations for services for these clients will have to take place annually
- Other services were rolled into the State Plan so it would not be necessary to enroll everyone in the WPS system.
- There is a tremendous administrative burden on the CMHSP system to comply.

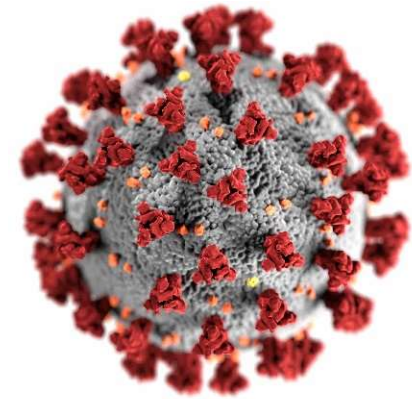
- No one “lost” Medicaid during the PHE. There are 700,000 more people on Medicaid now than pre-pandemic
- Historically few services could be done via telehealth
- Right after COVID started, most services were authorized to be completed via telehealth. Most of these authorizations are still in place.
- Nurses can now administer injections without a physician present for Medicare individuals.

COVID changes



- Authorizations could be verbal – this has now been rescinded
- Site reviews and audits are now largely virtual
- Some of these changes have been made permanent
- As of March 31, 2023, Medicaid eligibility is not tied to the Public Health Emergency.
- DHHS could take a year or longer to review every individual’s Medicaid eligibility
- This may ultimately reduce CMH revenue as we are paid per Medicaid eligible.

Financial changes



- Spenddowns were suspended
- Individuals have not lost Medicaid due to financial reasons – Numbers of people on Medicaid are at an all time high. This will change in FY23.
- Many PIHP's/CMHSP's have had extra Medicaid funding in excess of what is allowed by contract for risk and carryforward. This also will likely change.

Cause and Effect

- For some CMHSP's, there is an excess of General funds as no spenddowns are occurring, and many programs that GF pays for are more limited.
- General funds also were moved between CMHSP's to have funding be more equitable amongst them. It takes time to develop programs that balance Medicaid and General funds. There are some expense that are either all Medicaid or all GF, but largely every dollar of expense is split between the two.
- This has caused an anomaly of extra funding within the system – it is temporary

So…..how does a CMH get their money?????????

Michigan Medicaid

- Open-ended entitlement for enrolled beneficiaries
- PIHPs are paid per eligible per month (PEPM)
- Rates will vary by person dependent on why they have Medicaid (TANF vs. DAB), age, sex, etc.
- Some programs also pay a case rate.
- All of the Medicaid money gets combined into one "pot" by the CMHSP.
- It is broken back out and reported by funding stream to the State. One funding stream can pay for overruns by another, e.g. Medicaid can cover Healthy Michigan, or vice-versa

- Procurement laws
- No payments directly to beneficiaries
- Medicaid does not pay for room and board (substance use disorder residential excluded).
- Medicaid does not pay for food for consumers in residential
- Medicaid does not pay for Alcohol (under any circumstances)
- Medicaid does not pay for services to incarcerated individuals – jail services are all general fund.
- Medicaid does not pay for services without a valid contract
- Medicaid does not pay for extravagant or unnecessary services
- Medicaid does not pay for services that are not medically necessary
- You can not give retro-active contract increases (Michigan constitution)

- Medicaid does not pay for services not properly documented
- Medicaid does not pay for rent in excess of fair market value or cost (depending on circumstances) – for providers – it doesn't pay rent at all for clients.
- Medicaid does not pay for car repairs for clients
- Medicaid does not pay for transportation that is the requirement of another agency, or not related to programs
- Medicaid does not pay for long term housing costs for clients
- Medicaid does not buy people cars, housing, or businesses

If not allowable by Medicaid, then what?

- Some expenses may be covered by General Funds (excess room and board costs, spend-downs, etc.)
- Some expenses are not allowable by either (excessive costs, alcohol, etc.)
- For GF, not allowable is referred to as "unmatchable" expense – can not use general funds to cover it.
- Then must use local funds to cover – must receive "fair consideration" for local expenditures – can not give "something for nothing". Thus, we can not make donations, etc. to causes, fund raising, etc. with any funding source – simply not allowable.

Children's Waiver

- Closed end entitlement – limited slots available
- Children are enrolled in the waiver until the age of 18
- Children's Waiver is now part of the capitated payment
- Serves medically fragile or behaviorally challenged children with high needs

- Most kids do not have Medicaid other than for this waiver. They have private insurance.
- State determines who gets the available slots based on a needs based system
- Slot based system will continue.
- After age 18 they are generally transitioned to the HSW

SED Waiver

- Also now part of the capitation payment
- DHHS is providing this match to draw down federal funds
- Targets children served in multiple systems (court, DHHS, CMH, etc.)
- Now required to be provided by all CMHSP’s
- If a family isn’t eligible for Medicaid, the SED waiver will make the child eligible. (for CMH services only – not other medical services)

Earned contracts

- Usually a contract with another CMHSP, (COFR), local court, DHHS etc. or a grant for Mental Health type services e.g . Court services, County contracts etc.
- CMHSP is generally required to charge its full costs, including administration. (Can’t subsidize, if it isn’t a mental health benefit.)

Block grants

- MDHHS awards Mental Health block grants
- Federally funded – no match required
- Both PIHP's and CMHSP's apply for block grants
- Categorical funds- not an entitlement, and non-risk based
- Funding amount fixed annually, but may be changed with legislative or administrative actions
- Generally a two year grant

Local funds –

- Local funds are those funds which we use to match the State expenditures
- Local contribution is required for general fund net matchable expenditures (10% per MHC)
- Also required for State inpatient match
- Required for local match draw down (now in process of elimination… ☺)
- Limited sources of local – County contribution, interest, some client fees and donations
- Excess local = Total local revenues less amount required for match

Local funds - continued

- Excess local funds are placed into a CMH fund balance as part of the unrestricted fund balance – no restrictions on its use. *It is the only source of funds for the unrestricted fund balance*
- Fund balance can have restricted, reserved and unrestricted funds in it
- Local funds cover general fund overruns
- If you have a negative fund balance then you must complete a treasury plan of correction.
- A “safe” fund balance is at least 15 percent of annual budget. Many look for anywhere from 30-35% as a goal.

State General Fund

- Formula Funding share of state appropriated funds.
- General funds serve the “priority population”, which includes people Severe Mental Illness, Children with SED and persons with IDD who meet State determined service criteria but do not have Medicaid
- Mental Health code requires that GF funds serve the priority population, priority needs and core CMH functions (recipient rights, 24 hour emergency services, etc.)
- You can carry-forward up to 5% of your total general fund if you don’t spend it all. It must be spent in the following year.

General funds also cover…

- Prevention programs
- Community benefit programs e.g. Jail diversion and jail services, education/school programs, Multi-purpose collaborative body, etc.
- Psychiatric inpatient for non-Medicaid consumers is the responsibility of the CMHSP
- Spend down expense
- MARA workers (DHHS employees)

General funds

- You can use GF for other programs after you have met your Mental Health Code obligations
- GF funds are annually fixed but may be reduced or increased by the state
- In 2018, MDHHS issued a new funding formula plan to have funding be more equitable between CMHSP's
- This equitable funding is now completed

State Hospitalizations

- As of October 1, 2015, CMSHP's are no longer fully financially responsible for persons admitted to a State Facility.
- This is primarily due to the large reduction of general funds in 2014, and the lack of funds to pay for additional admissions to State Facilities.
- CMHSP's are still responsible for the local share of costs.
- CMHSP's are also responsible for admissions and discharge planning.

- There is limited/no availability to admit a client to a State Hospital.
- The State is reducing the number of persons in State Hospital beds for a number of reasons, one being lack of staffing.
- The State is assisting with discharges through a program called MCTP, where the State pays for a residential placement for 90 days, then it is transitioned to the CMH responsibility.
- There is a long waiting list for people to be seen at the Forensic Center as well.
- The CMH system is struggling with treating some clients in the community who need a higher level of care.

- Several years ago MDHHS expressed a need to know why costs varied greatly between CMH’s for similar services.
- Formed a workgroup to try to standardize how costs are allocated.
- The purpose of the group expanded and evolved over time.

SCA Allocation Goals

- Cost Centers
- Staff Allocation Methods
- Fringe Benefit Allocations
- Building Allocations
- Other non-program allocations

- Many CMHSPs & PIHP’s believe the SCA violates basic accounting principals as well as Federal costing requirements. The State disagrees.
- The SCA moves costs that have been historically service related, and moves them to administrative. This will make administrative costs artificially high.
- It is REALLY complex and adds a lot of time and money to the accounting and cost settlement process.
- It takes functions that the CMH’s have done for years (credentialing, claims processing, etc.) and considers them managed care administration. These are functions CMH’s have to do regardless of who pays them.
- Many CMH’s have to totally revamp their accounting systems to comply with the SCA.

Encounter Quality Initiative (EQI)

- Replaced MUNC and Sub-element Reports
- Another method to help describe cost variations within the system
- Breaks out costing of Encounter Units between direct/contracted services
- Is the primary way the actuary determines CMHSP system funding

WHAT ARE THEY AND HOW DO THEY AFFECT US???

Dual eligibles – who are they?

- Dual eligibles are individuals who qualify for both Medicaid and Medicare – also known as “duals”.
- Significant numbers of CMH consumers are “duals” Due to their disabilities, it is a large portion of our funding. (HSW, residential, etc)
- 52% of Medicare consumers in Michigan also have Medicaid

Dual eligibles

- In general, Medicare covers acute care services
- Medicaid covers Medicare premiums and long term care
- Tend to be poor and have lower health status than other beneficiaries
- We also refer to this population as “unenrolled”, although they not all of the unenrolled population. This indicates they are generally not enrolled with a health plan, i.e. – fee for service

Dual eligibles

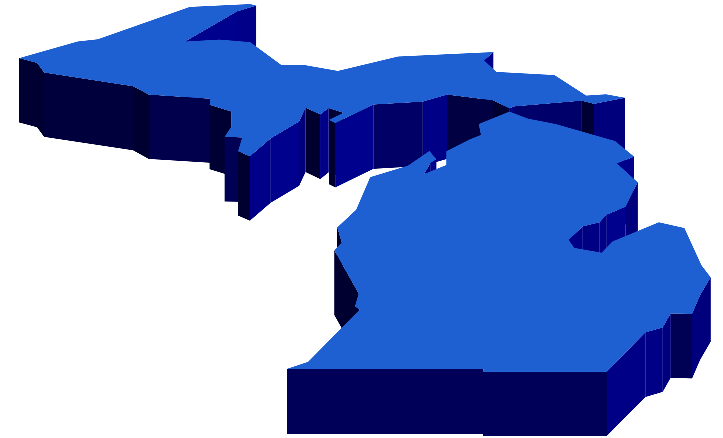
- Medicare costs are covered by federal government
- State pays their share (varies) of Medicaid costs
- State largely spends its Medicaid money on long term care (nursing homes), behavioral health, and Medicare cost sharing (Medicaid covers Medicare premiums and copays)

Dual eligibles

- Problem of coordinating benefits
- Medicare is the primary insurer – Medicaid is secondary
- Medicare and Medicaid have separate payment systems that lead to numerous perverse incentives
- Current system does not coordinate care

- Controlling Medicare & Medicaid cost is critical in controlling future health care costs
- If dual costs can come under control, it is easier to solve other problems and issues
- The "dual issue" is somewhat separate from the Affordable Care Act, although related as service delivery systems are set up

The Michigan Plan



- Michigan as a current pilot testing integration between the Health Plans and the Behavioral Health system.
- Integrated Care Organizations (ICOs) cover physical health and long term care – essentially same as Health Plans
- PIHPs cover behavioral health and habilitative services, including services for the mild and moderate
- Officially called “MI Health Link”

- Duals project eligibles is around 100,314, about ½ of the dual recipients statewide
- Currently there are 44,573 persons enrolled.
- Many individuals have opted out of the demonstration

Physical Health

Demographics
Assigned Primary Care Provider
Physical Health Diagnosis
Medications
ER Visits
Office Visits
Lab Work
Health/Wellness Indicators
Case Management

Behavioral Health

Demographics
Guardianship
Living Arrangement
Natural Supports/Transportation
Behavioral Health Diagnosis
Behavioral Health Visits
Medications
Crisis ER Visits
SUD History/Prevalence

MI Health Link

- 4 regions were originally part of this
  - Region 1 – Entire UP
  - Region 4 – Southwest Michigan (SWMBA)
  - Region 7 – Macomb County
  - Region 9 – Wayne County

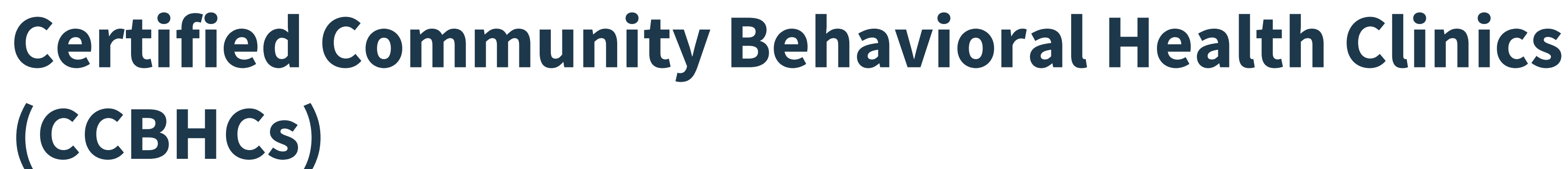
  - Southwest Michigan has recently removed itself from the project

Duals in Michigan

- In Michigan, there are approximately 294,000 dual eligible representing 10% of total Medicaid enrollees
- The State is considering rolling the dual eligible population into “managed care” in their next waiver application.
- The acronym is D-SNP… Duel Eligible Special Needs Plans
- CMS would like Medicaid and Medicare to be more integrated as well as coordinated.
- It has not been determined how Michigan will set up its D-SNP program but this may profound impact the CMHSP system funding and clients served.

Privatization Threats

- The on-going threats of privatization of the Michigan BH system
- SB 597/598 2022
- D-SNP waiver, although Michigan could elect for a type that allows for behavioral health to be carved-out of the required health plan integration.
- The CMHSP/PIHP system needs to continue to advocate for preservation of the delivery system.



Certified Community Behavioral Health Clinics (CCBHCs)

- A Certified Community Behavioral Health Clinic model is designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth.
- 11 CMHSP’s are currently operating or developing a CCBHC. 7 other providers are also developing a CCBHC for a total of 18.

Behavioral Health Home

- Behavioral Health Home receives reimbursement for providing the following federally mandated core services:
  - Comprehensive Care Management
  - Care Coordination
  - Health Promotion
  - Comprehensive Transitional Care
  - Individual and Family Support
  - Referral to Community and Social Services
- Currently several regions operate BHH’s. This is expanding every year.
- BHH’s are paid via case rate – per person, per month

Contact info:

Carol Mills, CEO Newaygo CMH
cmills@newaygocmh.org

Jeff Labun, COO Newaygo CMH
jlabun@newaygocmh.org