HEALTH MANAGEMENT ASSOCIATES

Special Edition: Michigan Budget and More - June 2017

The Michigan Update

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General Michigan Budget Issues

Historically, after the May consensus revenue conference, the Governor and legislative leaders reach a consensus spending target for each budget for the coming fiscal year (FY). This year Governor Rick Snyder did not participate in target setting because of a disagreement over teacher pensions described below. Instead, House and Senate leadership developed their own targets and moved forward on budgets for FY 2017-2018, which begins October 1, 2017. As of June 8th, members of the Michigan House and Senate Appropriations Committees had met as Conference Committees on every budget for FY 2017-18 and all bills were approved by those committees. In many cases the votes were along party lines with Republicans supporting the conference agreements and Democrats in opposition.

Tentative Framework on Teacher Pensions

As of June 8th, the Governor and legislative leaders agreed to a tentative framework for the structure of the Michigan Public School Employees Retirement System (MPSERS) for new teachers. While the Governor supports continuation of the current hybrid program (with both a 401k component and a defined benefit pension component), the legislature proposed offering only a 401k plan to new teachers. Gongwer News Service indicates that the new framework agreement would set the 401k plan as the default plan. However, new teachers could opt out of the 401k plan and instead be enrolled in a new plan which would include both a 401k and a pension component, but would differ from the current hybrid plan.

Other Spending Target Issues

The Governor has indicated that some of the budgets approved by the conference committees need change but has not indicated what changes are needed. One likely area is Corrections. The budget for the Department of Corrections (MDOC) reduces funding for prison operations

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by $10 million. According to the Gongwer News Service, MDOC officials claim that this funding reduction could jeopardize safety in Michigan's prisons. On June 8th, the Gongwer News Service reported that the School Aid budget and funding for roads and infrastructure were also among areas that might be changed. Legislative leaders have indicated willingness to postpone final votes on the budget for a week to allow time to negotiate possible changes.

Michigan Department of Health and Human Services (MDHHS) Budget

The conference agreement on the MDHHS budget includes an increase of $473.3 million in total funding for the Department from current year appropriations, but a decrease of $75.4 million General Fund/General Purpose (GF/GP) revenues. This represents a significant reduction from the funding recommended by the Governor ($179.2 million gross and $144.4 million GF/GP). However, a large portion of the reduction relates to consensus reductions in caseload estimates.

Behavioral Health Integration

The integration of behavioral health and physical health care has been the most contentious issue for the MDHHS budget for FY 2017-2018. As we have reported in past issues of *The Michigan Update*, section 298 of the FY 2016-2017 enacted budget required establishment of a workgroup and a report to the legislature including recommendations regarding future policy on integration of care.

PIHP Consolidation

Section 298 of the 2017-2018 conference agreement requires the Department to reduce the number of Prepaid Inpatient Health Plans (PIHPs) from the current 10 plans to only 4 plans, beginning by October 1, 2017. The existing metro region PIHPs (Detroit-Wayne, Oakland and Macomb) will remain as is. The remaining seven PIHPs will be merged into one PIHP covering the remainder of the state. It is unclear whether this is scheduled for completion by March 1, 2018. *"The department shall begin to implement the pilot projects and demonstration models described in subsections (2), (3), and (4) by no later than October 1, 2017 and shall implement the pilot projects and demonstration models described in subsections (2), (3) and (4) by no later than March 1, 2018."* It is notable that this includes subsection 3 which is the consolidation of the PIHPs, which would imply that the PIHP consolidation is

included as part of the March 1st deadline, but it is not a pilot project or demonstration model.

Integration Pilots
Beginning by October 1, 2017 with implementation no later than March 1, 2018, up to four pilots will be created to better integrate physical and behavioral health in Michigan. One pilot will be based in Kent County and is likely to be between Network180 (the Community Mental Health Services Program or CMHSP) and willing Medicaid Health Plans (MHPs) in Kent County. Currently there are six MHPs that serve Kent County: Blue Cross Complete, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Priority Health Choice and UnitedHealthcare Community Plan.

Up to three other pilots can be selected in the state; the legislation states that there shall be a single contract between the state and each MHP in the pilot area. The pilots must allow the CMHSP to be a provider of behavioral health supports and services, but there is no indication that the CMHSP would be the sole provider of these services. Also, it is not explicitly stated what role, if any, the PIHPs will play in these pilots, nor is it explicitly stated what method will be used to select the three pilots.

Summary of Section 298
The Senate Fiscal Agency and House Fiscal Agency staff prepared a document that summarized the major changes in the bill. Their summary of Section 298 reads as follows:

"Conference replaces current language with:
(1) Requirement to contract with a project facilitator to establish performance outcome metrics, finalize implementation milestones, provide guidance and conflict resolution, and other necessary oversight;
(2) Requirement to work with a willing CMHSP in Kent County to pilot a full physical and behavioral health integrated service model;
(3) Requirement to reduce the number of PIHPs from 10 to 4;
(4) Requirement to pilot 3 fully financially integrated physical and behavioral health services using single contracts with Medicaid health plans in a manner that allows the CMHSP in the pilot area to be a provider of behavioral health services;
(5) Requirement for DHHS to being implementation by October 1 and for implementation by March 1;
(6) Requirement for any and all realized benefits and cost savings from integrating physical and behavioral health services, for the duration of the pilots and demonstrations, be reinvested into behavioral health services and supports;

(7) States intent that the primary purpose of the pilots and demonstrations to test how the state can improve health outcomes and maximize efficiencies;
(8) Requirement to contract with a state research university to evaluate the pilots and demonstrations, evaluate their replicability, and compare to other state outcomes;
(9) Requirement for DHHS to report on time frame for implementation, barriers, and remedies to the barriers to implementation;
(10) Requirement for managing entities of the pilots and demonstrations to report on outcomes.

The full text of Section 298 is included at the end of this document. (Section 234 of the Senate bill, which was related to Section 298, was not retained. Section 234 set a goal of full integration of physical and behavioral health services by September 30, 2020).

Other Policy Changes to Medicaid and Behavioral Health

Direct Care Wage Increase: The compromise agreement increases the wages of direct care workers by $0.25 per hour effective October 1, 2017. There is an additional $0.25 per hour increase effective June 1, 2018 for those receiving less than $10.90 per hour.

Autism Services: The conference agreement reduces funding for Autism Services by $5.0 million ($1.8 million GF/GP).

Special Hospital Payments: The Governor's Executive Budget Recommendation had proposed a $217.6 million reduction in Quality Assurance Assessment (QAAP)-funded payments to hospitals (Medicaid Access to Care Initiative or MACI, and Hospital Rate Adjustment or HRA). The House and Senate agreed with the Executive recommendation. However, the numbers were revised to reflect the May caseload consensus. The conference agreement decreases these payments by $168.1 million, of which $20.0 million is state general funds.

Medicaid Non-Emergency Medical Transportation (NEMT) Expansion: The Governor had proposed a $12.0 million increase to expand the NEMT broker program into additional counties. The conference agreement does not concur with this expansion and instead provides an increase of $1.4 million gross ($0.5 million GF/GP) to expand the use of local public transportation.

Ambulance QAAP: The Executive budget included $10.3

million gross ($0.0 million GF/GP) to add QAAP-funded supplemental Healthy Michigan Plan ambulance payments. The legislature agreed with the Executive. (Section 1790 of the bill provides additional instructions.)

New Nursing Facility Quality Pool: The budget for FY 2018 establishes a new Nursing Facility Quality Pool of $73.0 million, funded with $47.3 in federal funds and nearly $34.0 million in revenues from an increased nursing facility assessment, resulting in a net savings of more than $8.2 million to the General Fund. The payments from this pool are to be based on CMS star quality ratings, licensed beds, and Medicaid utilization.

Program of All-inclusive Care for the Elderly (PACE) Expansion: The Executive added $20.0 million to support a 2.5% rate increase, increased enrollment at existing PACE sites and to fund two new PACE sites in Newaygo County and in central Michigan. (There is no net cost to the state for PACE expansions since long-term care funding is reduced by the same amount.) The legislature reduced the funding by $1.6 million to support a per member per month increase of 1.0% rather than 2.5%.

Medicaid Direct Primary Care Pilot: The legislature added $5.7 million ($2.0 million GF/GP) on a one-time basis to support a Medicaid direct primary care pilot. Boilerplate in Section 1913 provides significant detail on this initiative.

Other Medical Services Program Reductions: The Executive proposed $10.4 million in reductions by eliminating Graduate Medical Education (GME) payments for Authority Health (formerly the Detroit Wayne County Health Authority); eliminating the dental rate increase for pregnant Medicaid beneficiaries, funding for the University of Detroit dental clinic, and the Medicaid Health Plan immunization grant; and by reducing funding for the Wayne State Psychiatric residency. The conference agreement only eliminates GME payments for Authority Health ($2.8 million gross, $1.3 million GF/GP).

Economic Issues in the MDHHS Conference Agreement

The following are the largest economic changes from the current year budget.

Caseloads: A significant component of the MDHHS budget reduction is revisions to caseload estimates, to which all parties agreed at the May revenue estimating conference.

While Human Services caseload-related costs were estimated to be slightly higher than the Executive recommendation for FY 2017-18, Medicaid GF/GP expenditures are estimated to fall $109.2 million below FY 2016-17 appropriated levels and $69.5 million below the FY 2017-18 Executive recommendation.

Federal Matching Funds: Michigan's Medicaid federal matching funds rate will decrease from 65.15% to 64.78% for the new fiscal year. There is a parallel decrease in the CHIP matching funds rate. In addition, the state share of Healthy Michigan Plan costs increases from 5% to 6% on January 1, 2018. In the aggregate, these three items reduce federal funding by $117.5 million, and increase State GF/GP costs by $99.3 million. (Some of the federal reduction is offset by increases in local and restricted funds.)

Actuarially Sound Rates: All parties have agreed to a 1% actuarial soundness adjustment to rates for three programs: Medicaid Health Plans, Prepaid Inpatient Health Plans, and Healthy Kids Dental. One large item of difference is assumptions about the Accountable Care Act Insurer Fee. The Governor's budget had included $167.0 million to cover reinstatement of this fee. The conference agreement excludes this cost.

Health Insurer Claims Assessment (HICA): The Executive, House, Senate and Conference all agree that the amount of HICA revenue can be increased by $129.9 million from the current year appropriation, resulting in GF/GP savings of the same amount.

Key Boilerplate Changes

In addition to Section 298 on integration of physical and behavioral health, several other sections of boilerplate that are new or revised for FY 2017-2018 are noteworthy.

Section 1806 - Common Formulary for Medicaid Health Plans: The Executive budget had deleted this section. The conference bill requires MDHHS to monitor progress on implementation of the common formulary and report to the legislature. The language also requires a public process for input on changes to the common formulary.

Section 1859 - Medicaid Research Activities: This new section was added by the legislature and requires MDHHS to partner with the Michigan Association of Health Plans (MAHP) and the Medicaid Health Plans on research activities to improve health, increase quality of care, and

reduce the cost of care. MDHHS would make data, including Medicaid behavioral health data, available to MAHP or an approved vendor.

Section 1893 - Healthy Kids Dental Procurement: Conference added language which states that the RFP for the Healthy Kids Dental program must require that a vendor, upon being awarded a contract, must pass a readiness review not less than 60 days before the effective date of the contract. This section also prohibits the RFP from requiring the respondents to submit contracts, letters of intent, or letters of application during the RFP process.

We would note that Senate included Section 1852 which would have created a managed long-term services and supports pilot in the counties that are part of MI Health Link, the financial alignment demonstration for Medicaid/Medicare dual eligibles. Section 1852 was not included in the conference agreement.

Section 298 Language in the Conference Agreement

(1) Before implementing the pilot projects and demonstration models described in subsections (2), (3), and (4), the department shall contract with an independent project facilitator with at least 10 years of project management experience to establish performance outcome metrics of the pilot projects and demonstration models, finalize each pilot project's or demonstration model's implementation milestones, determine and manage the critical path to the pilot project's or demonstration model's completion, provide independent guidance on resolving conflicts between parties, and perform other necessary oversight and implementation functions as determined by the department. These performance metrics shall evaluate how the pilot projects and demonstration models impact, at a minimum, each of the following categories:

a. Improvement of the coordination between behavioral health and physical health.
b. Improvement of services available to individuals with mental illness, intellectual or developmental disabilities, or substance use disorders.
c. Benefits associated with full access to community-based services and supports.
d. Customer health status.
e. Customer satisfaction.
f. Provider network stability.
g. Treatment and service efficacies.
h. Financial efficiencies.
i. Any other relevant categories.

(2) The department shall work with a willing CMHSP in Kent County and all willing Medicaid health plans in the county to pilot a full physical and behavioral health integrated service demonstration model. The department shall ensure that the pilot project described in this subsection is implemented in a manner that ensures at least the following:

a. That each willing Medicaid health plan is contractually required to utilize the CMHSP in Kent County as the provider of behavioral health specialty supports and services.
b. That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot project described in this subsection must only be in effect for the duration of the pilot project described in this subsection.
c. That the project is consistent with the stated core values as identified in the final report of the workgroup established in section 298 of article X of 2016 PA 268.
d. That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(3) The department shall reduce the number of PIHPs providing Medicaid behavioral health managed care services to 4.

a. The department shall maintain single-county PIHPs in each county that had a population greater than 800,000 according to the most recent decennial census.
b. The department shall create a single PIHP for those counties not included in the PIHPs described in subdivision (a).
c. The PIHPs described in this section shall operate in a manner consistent with the core values stated by the workgroup described in subsection (2).

(4) In addition to the pilot project described in subsection (2), the department shall implement up to 3 pilot projects to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models. These demonstration models shall use single contracts between the state and each licensed Medicaid health plan that is currently contracted to provide Medicaid services in the geographic area of the pilot project. The department shall ensure that the pilot projects described in this subsection are implemented in a manner that ensures at least the following:

a. That allows the CMHSP in the geographic area of the pilot project to be a provider of behavioral health supports and services.
b. That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot projects described in this subsection must only be in effect for the duration of the pilot projects described in this subsection.
c. That the project is consistent with the stated core values as identified in the final report of the workgroup described in subsection (2).
d. That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(5) The department shall begin to implement the pilot projects and demonstration models described in subsections (2), (3), and (4) by no later than October 1, 2017 and shall implement the pilot projects and demonstration models described in subsections (2), (3) and (4) by no later than March 1, 2018. Each pilot project shall be designed to last at least 2 years.

(6) For the duration of any pilot projects and demonstration models, any and all realized benefits and cost savings of integrating the physical health and behavioral health systems shall be reinvested in services and supports for individuals having or at risk of having a mental illness, an intellectual or developmental disability, or a substance use disorder.

(7) It is the intent of the legislature that the primary purpose of the pilot projects and demonstration models is to test how the state may better integrate behavioral and physical health delivery systems to improve behavioral and physical health outcomes, maximize efficiencies, minimize unnecessary costs, and achieve material increases in behavioral health services without increases in overall Medicaid spending.

(8) The department shall contract with 1 of the state's research universities at least 6 months before the completion of each pilot project or demonstration model to evaluate the pilot project or demonstration model. The evaluation shall include information on the pilot project's or demonstration model's success in meeting the performance metrics developed in subsection (1) and information on whether the pilot project could be replicated into other geographic areas with similar performance metric outcomes. The evaluation shall also include a comparison of Michigan model outcomes with similar model outcomes in other states. The evaluation

shall be completed within 6 months of the end of the pilot project or demonstration model and shall be provided to the department, the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office.

(9) By October 1 of the current fiscal year, the department shall report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on progress, a time frame for implementation, and any identified barriers to implementation, and the remedies to address any identified barriers of the items described in subsections (2), (3), and (4). The report shall also include information on policy changes and any other efforts made to improve the coordination of supports and services for individuals having or at risk of having a mental illness, an intellectual or developmental disability, a substance use disorder, or a physical health need.

(10) Upon completion of any pilot projects or demonstration models advanced under this section, the managing entity of the pilot project or demonstration model shall submit a report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office within 30 days of the completion of that pilot project or demonstration model detailing their experience, lessons learned efficiencies and savings revealed, increases in investment on behavioral health services, and recommendations for extending pilot projects to full implementation or discontinuation.