

CMH FINANCING HISTORY
SUMMARY OF 20 YEARS OF THE STATE FINANCING STRATEGY
FOR CMH

IT IS NOT ABOUT MEDICAID FUNDING
IT IS ALL AND ALWAYS HAS BEEN ABOUT
STATE FUNDING
AND STATE SUPPORT
FOR PUBLIC MENTAL HEALTH SERVICES

PREMISE:

By moving to community-based services, the CMH system has
saved the State hundreds of millions of dollars
and improved quality of services
over the past 20 years

HOWEVER

Savings created by this movement
were not retained in the CMH system to support consumers in the community

Contents:

Funding Strategy Highlights from past 20 Years (page 2)
CMH Funding – Base Funding Reductions outweigh increases (page 4)
State GF/GF for CMH – Economic Increases – Chart
CMH Funding – GF & Medicaid in FY99 (page 6)
Medicaid History – Highlights (page 8)
Michigan's Medicaid Health Plans – Observations (page 13)
GAO/CMS Reports of concern (page 14)
CMH State Funding Distribution (page 15)
CMH Financing History – Detailed (page 17)

*This document was prepared by Judith Taylor on behalf of the Michigan Association of
Community Mental Health Boards*

FUNDING STRATEGY HIGHLIGHTS FROM THE PAST 20 YEARS

- The state financing strategy for CMH for 20 years is based on a poor economic premise.
 - CMH system has been expected to provide services with no state fund increases for unavoidable cost increases
 - CMH system has been required to serve more needy customers with flat state funding
- The Advent of Medicaid federal funding for CMH services in 1983 allowed the CMH system to increase resources/services by expanding Medicaid, with the same or lower state funding
- In the 1980s the additional federal funds earned by CMHBs were used in the state appropriation to finance additional categorical services for targeted consumers thus limiting the resources for serving its priority community population
- Over 20 years the CMH funding base has received very few cost increases to support continuation of services
- Over 20 years the CMH state funding base has been eroded by state financing strategies
- Since 1983, DMB funding strategy has been to maximize federal funds and reduce or keep flat state funding
- CMHBs have been in partnership with the state in pursuit of other funds and being good managers of limited state resources, thereby saving the state hundreds of million in state funds. In the mid-late 1990s these options began to dry up for many CMHSPs as they had maximized Medicaid billing and maximized full management.
- Medicaid fee screens saw limited increases for cost increases in the 1980s, and in late 1980s the fee screens were frozen, even though the CMH system had the state match needed to cover the Medicaid cost. Thus, CMH used GF to cover these additional cost increases.
- In 1993, DMB instituted an annual fee screen adjuster for CMH Medicaid, which allowed some of the costs above fee screen to be billed to Medicaid, with the state keeping 80% of the additional federal funding. As of FY98, this was \$35 million per year.

- Funds follow the individual as they exit from state facilities, but once the funding is in the CMH base it is eroded due to the lack of economics
- Up to 1996, state financing recognized that there were overlapping costs as individuals were placed from state facilities. As of 1996, full management was required to be cost neutral in the same year that placements occurred. As the state facility census dropped this makes little economic sense as the remaining residents are more needy/costly
- When the state moved all of the Medicaid to managed care it removed one of the financing tools used by CMHSPs to finance cost increases, namely increased Medicaid billing.
- As of FY99, with the Medicaid now capped, the state financing strategy for the past 16 years should have changed – it did not.
- The waiver included and HCFA approved rate increases of 3-5% per year to address cost increases
- The Medicaid specialty services waiver called for a) increased access, b) increased flexibility, and c) slow growth in rates. The first 2 occurred, the last did not.
- It was expected that CMH Managed Care would receive rate increases (just like other state supported services), but this did not happen.
- CMH Non-Medicaid GF continues to be redirected (eg ABW) to maximize federal funding and create savings for the state, not for increase in services to non-Medicaid consumers
- CMH Non-Medicaid GF is more vulnerable to reductions than Medicaid
- CMH got no funding benefits from the 1990s economic recovery (but it did experience cuts) – but since FY01 it did share in reductions as the economy slowed and as taxes were reduced.

**CMH FUNDING:
Base Cost Increases = Funding Needed to Continue Services Each Year**

BASE FUNDING REDUCTIONS OUTWEIGH INCREASES:

20 year average: Increase of 1.0% per year
 Decrease of 1.2% per year

10-year average thru FY00 Increase of 0.8% per year
 Decrease of 1.1% per year

Years with appropriated cost increases for CMH:

FY85	2.0%
FY86	2.0% (in part funded by Medicaid FFP)
FY87	2.5%
FY88	2.8%
FY89	0.4%
FY90	1.0%
FY91	Residential increase of 2%
FY98	Direct care wage pass through (in part funded by FFP)
FY99	Direct care wage pass through - appropriated as all GF, later DMB substituted FFP
FY04	Medicaid rate increase 1.6% funded by CMH GF redirection

Years with reductions for CMH base funding:

FY88	0.5% reduction, 0.75% reduction
FY88	\$6.5m redirection due to FFP gains
FY89	CMH GF reduction to fund OBRA (gross \$38.4, GF loss \$17m)
FY89	0.5% reduction
FY91	0.75% reduction
FY91	Approximately 2.5% reduction
FY92	Approximately 2.2% reduction
FY97	\$15m reduction, approx 2%
FY99	\$35m reduction in CMH GF (DMB fee adjuster share)
FY99	Under-funded Medicaid hospital budget transfer, CMH GF redirection approx \$28m
FY00	Reduction in CMH-GF \$3.5m for Medicaid pharmacy
FY00	Reduction in CMH-GF \$0.6m (SA eligibles)
FY01	Executive budget added pharmacy to CMH Medicaid at \$26m, final appropriation removed to MSA at \$42.4m, ie GF loss at \$7.1m
FY01	Elimination of spend-downs, GF loss at \$16m, Medicaid loss of \$34.5m (3%)

FY02	Reduction in multicultural and prevention funds \$1.7m
FY03	CMH Non-Medicaid GF reduction of 2.5%
FY03	CMH Medicaid rates reduced by 1.1%
FY03	Reduction in SED Respite by \$3.3m (\$1m restored in FY04 by legislators)
FY04	Reduction in CMH GF by \$40m for ABW (Net loss of GF \$17.6m)

CMH FUNDING: General Funds and Medicaid as of FY99

MEDICAID FUNDING BASE 10/1/98:

Based on FY96 fee-for-service base, trended forward for CMH continued increase in Medicaid to maximize federal revenues, along with transfers into CMH base (community inpatient and partial hospitalization, state residential services, state facility placements).

DD	\$733.4m
MIA/SED	\$367.7m
CMH Medicaid total	\$1,100m
State share (approx)	\$ 598m
SA	\$24m

DD was 67% of the total due to the national efforts in the 1980s to expand the Medicaid benefit for persons with developmental disabilities. This included community supported living arrangements, Alternative Institution Services (AIS), and Home and Community Habilitation waiver.

Even though MH was 37% of the total, Michigan enjoyed one of the broadest array of Medicaid state plan services compared to other states. Michigan had actively pursued the Rehabilitation Option that allowed many MIA/SED services to be Medicaid covered.

The MIA/SED base:

Community based CMH services	\$226.4m
Community inpatient, partial hospital and related services	\$141.3m

Under the new program, CMHSPs shifted from earning federal Medicaid through fee for service (FFS) billing, and were instead paid a pre-payment each month. Under the combined 1915b/c waiver, HCFA required the Managed care program to use a payment methodology based on Medicaid eligibles. The state actuary set up a rate cell structure and computed the rates. The DCH financing strategy for distribution of the prepayments to the 50 CMHSPs was to keep payments close to what they would have been under FFS. The exception to this was a movement of 10% towards the state average for MIA/SED geographic factors/rates. In large part this was due to the uneven distribution of the community hospital benefit.

CMH Non-MEDICAID FUNDING BASE FY99

CMH GF/GP funding base from FY98 (projected forward to full year) was \$924.6m. This includes community and state facility funding. After the removal of state match needed for Medicaid, and reduction for DMB share of fee adjuster (\$34.8m), the funding available for non-Medicaid was \$411.4m (of which \$109.4m was for state facility purchase of services and \$302m for community).

This \$411.4m was distributed to the 50 CMHSPs using a 10% movement to state average on 4 factors, a distribution of \$5.7m from the top end CMHSPs (15) to the other 35 CMHSPs.

At that time, DCH estimated that the community GF was used:

- 10% for persons with developmental disabilities (\$30m)
- 15% for children with serious emotional disturbance (approx \$45m)
- 75% for adults with mental illness (approx \$227m)

Estimates for purchase of service funding:

- DD \$21m (19%)
- SED \$10m (9%)
- MIA \$78m (72%)

ESTIMATE OF FUNDING SPLITS IN FY99

DD	\$784.4m	(52%)
MIA/SED	\$727.7m	(48%)

MEDICAID HISTORY – HIGHLIGHTS

In 1980, the only DMH Medicaid funded mental health services were DD Centers, ICF-MR Residential (AIS homes), and State Psychiatric hospitals (under 22 and over 65).

There were additional Medicaid coverages through the then DSS for psychiatric inpatient and partial hospitalization services and physician/psychiatrist services. Michigan had elected to cover persons under age 22 for psychiatric hospitalization (a federal optional service)

In 1980 Medicaid Personal Care for persons in licensed foster care and group homes was added to the Medicaid state plan.

Implementation of Section 116 (full management) as well as pressures on state budget resulted in community based services being covered by Medicaid through a 2-year 1915b waiver implemented in 1983. In addition there was expansion of the AIS (DD) system of services.

Under the 1915b waiver CMHBs could bill for a limited set of services that had been 100% GF services. The initial set of services was the traditional Medicaid services: therapy and clinical services. DMH was also able to get certain day programs covered.

In 1985 the 1915b waiver turned into a Medicaid State Plan coverage through the Clinic Services option

The CMHBs billed for the cost of the service through the fee-for-service system. They were paid at the fee screen for the service, and at the same time the state deducted the state share from their GF. The net gain to the CMHB was the federal share only.

It was this gain in federal funding by CMHBs that promoted the state financing policy of Maximizing Medicaid, as well as the state policy to not fund increases in CMH GF, a practice that escalated in the 1990s.

In the mid-late 1980s and throughout the 1990s, CMHBs had three funding options to offset the lack of state funding for cost increases: Maximize Medicaid billing, place persons from state facilities, and/or cut back services to persons who were non-Medicaid.

In the late 1980s, DMB imposed a freeze on Medicaid fee screens for all Medicaid services. This meant that CMHBs had to use GF to subsidize the cost of Medicaid services. In 1993, DMB implemented an annual fee screen adjuster on CMH costs above fee screen. This drew down additional federal funds, 80% of which DMB retained.

DMH also obtained a 1915c Home and Community Habilitation waiver for persons with developmental disabilities. This provided a more flexible array of services than that covered by the 1915b waiver. This waiver picked up the CSLA persons when that option ended. This waiver also picked up persons in AIS homes that were decertified as well as providing a funding base for persons exiting state DD Centers. This has grown to 8000 individuals as of 2004.

Starting in FY87, the state plan was expanded significantly due to federal options for Medicaid state plans. Targeted Case Management was added in 1987.

Additional expansion occurred through the Medicaid Rehabilitation Option in 1991. This added services to the coverage, including:

- Assertive Community Treatment
- Psycho-Social Rehabilitation services (Clubhouses)
- Home-Based services

In 1995, the state plan was expanded to cover Crisis Residential and Intensive Crisis Stabilization services. This was done in conjunction with the DSS-DMH joint plan whereby CMHSPs managed admissions and authorizations for Medicaid hospital based services.

The federal government also opened up a program called Community Supported Living Arrangements. This was targeted to persons with developmental disabilities living at home or in their own residence.

In 1996 the Mental Health Code was amended to include person-centered planning.

In 1995, Governor Engler asked the directors of DSS and DMH to each develop a statewide plan for health care using managed care as the foundation. The plans were to cover: basic health services, long term care (nursing homes, services to the aged), children's special health care, and behavioral health (MH/SA). A 5th component for DD was added later. In 1996, DCH was created as the combination of Medical Services Administration, Public Health, and Mental Health. The DMH Director was appointed DCH Director.

Mental Health and Substance Abuse divisions/bureaus begin to lose staff within DCH structure (a continuing trend to present). Responsibilities for CMH funding, policy and contracts get dispersed within Department.

The managed care plans recognized the importance of carving out certain specialized services, including: nursing homes, services to the aged; children with special health care needs; specialty services for persons with developmental disabilities, specialty services for persons with mental illness including children

with serious emotional disturbance, and limited services for persons with addictive disorders.

Basic health services had been provided through fee-for-service, through an optional primary care manager model, as well as through optional capitated HMOs. In 1997 enrollment in a Qualified Health Plan became mandatory for about 75% of the Medicaid population. Exemptions: Medicare-Medicaid eligibles, spend-downs, retro-eligibles, children in foster care. It should be noted that persons who are exempt from mandatory enrollment are in general the high users of health services.

QHPs were responsible for the basic mental health needs of their enrollees (20 outpatient visits) as well as psychiatric inpatient. In July 1997 the inpatient responsibilities were removed from their scope. In January 1998, substance abuse services were removed from their scope. Payment reductions were not consistent with the reduction in responsibilities – in general QHPs lost the responsibility but not the funding.

Initial planning, as directed by Governor Engler, had called for one plan for MH/SA and one for DD. These were combined into a single 1915b waiver in late 1997.

This waiver was one of a kind nationally as it was a combination of a 1915b and 1915c waiver. This was needed to create a single blended comprehensive system including the then 7000 persons on the Home and Community Habilitation waiver. In addition, this was the only waiver that covered the whole state and all the Medicaid eligibles (ie no fee-for-service for specialty services remained)

The goals of this original waiver were:

- **Slow growth – HCFA approved 3-5% per year increases in rates**
- **Flexibility in service provision and how CMHSPs can use Medicaid funds**
- **Improved access for all Medicaid eligibles – no waiting list for access**
- **No savings in Medicaid – spend at the Upper Payment Level, no efficiencies for managed care taken off the top by the state**
- **Carved out all Medicaid specialty services**
- **Blends Medicaid and GF at the local level**

The waiver built upon the Code required Person centered planning. Both waivers (1915b and 1915c) allowed for Medicaid funds to be used to provide a flexible array of alternative services.

The waiver built upon the public accountability and stewardship of the Michigan public mental health system, This also allowed for flexibility between GF and Medicaid needed for persons who move in/out of Medicaid eligibility due to their illness.

The waiver was truly comprehensive. No fee for service remained (except for the Children DD waiver). It covered all Medicaid eligibles, including spend-downs and retro-eligibility.

This waiver was recognized nationally as a break-through waiver, although the state administration never acknowledged that or used this to recognize Michigan's efforts.

While the waiver provided opportunities for a more flexible use of Medicaid funding, it did require CMHSPs to manage access and plans of services differently. In the past they could manage demand that exceeded resources through the creation of waiting lists. Medicaid as an entitlement does not permit waiting lists for needed services.

Under managed care, the annual appropriation financing strategy should have been simple:

- Rate changes – are increases needed to cover increased costs to provide the coverage as required?
- Are their changes in eligibles (ie covered lives)?
- Are their changes in policy with respect to the benefit package?

- Rate Changes for 6 years:
 - NO increases FY00 through FY03 from state funding
 - In FY02 CMHSPs agreed to use local funds (\$25m) for a rate increase (draw-down federal funds, increase of \$31m, 2.6%)
 - Reduction of 1.1% in FY03
 - Increase of 1.6% in FY04
 - Approximately 2% proposed in FY05.

Note as of FY05 rate increases based on assumptions of increased cost for services are required by BBA for actuarial soundness

- No increase budgeted in appropriation FY00 to FY02 for eligibles trends although payments did increase; FY03 budgeted increase was way low compared to what actually happened in FY03; FY04 base was seriously under budgeted for eligibility increase (other Medicaid lines increased through supplemental) – by at least \$30m; FY05 budgeted for 0.5% increase – actuary trended it higher than that.

- DMB removed various eligible groups from payments in FY01, primarily spend-downs. CMHSPs still required to cover these persons. Loss of revenues to CMHSPs at \$34m
- Funding does support policy with respect to persons exiting state DD Centers. This was not implemented until FY01, as DMB would not support increasing federal share of payments.
Note: There is no MIA equivalent mechanism as there is very limited federal fee-for-service funding for state psychiatric hospitals, unlike DD Centers, which qualify under ICF-MR rules
- Attempts to change policy and funding for children has not been successful
- Attempts to transfer in under-funded pharmacy benefit was also rebuffed by the legislators

Medicaid funding for MH/DD has grown from \$1.1 billion as of 10/1/98 to \$1.272 billion in FY04 (which was about \$35m less than should have been budgeted for eligible trend and DD placements). This growth of approximately 2% per year was almost solely due to eligible growth (ie increased demand on the service system) at \$30m the first few years and \$50m in FY03. Some of the increase was funds following individuals exiting from state DD Centers. The FY04 rate increase (1.6%) was \$23m. The FY03 rate decrease was \$13.4m. The loss of eligibles in FY01 was a reduction of \$34m.

The BBA of 1997 required changes to all Medicaid managed care waivers. These changes went into effect in FY04:

- Alternative services are provided under 1915 B(3)
- Rates must comply with BBA requirements
- Rates were re-based using FY98 FFS
- Rate structure changed to include c-waiver payments through enrollment not Medicaid covered lives
- Rates for FY04 were reduced by 5% for MH/DD and 9% for SA by the actuary in order that the new rates were under the FY04 appropriation.
- Medicaid payment distribution across PIHPs changed due to FY98 FFS base. Variance from FY03 payments: Gain of 16% to loss of 3.5%. DCH partially offset Medicaid losses by redistribution of \$7.2m GF as of 1/1/04

Rates for FY04 included 4% for administration costs of the c-waiver, and 8% for the 1915b services. (Rates for Michigan's Health Plans received 12-14% for administration)

The BBA requires annual rate increases (actuarial soundness). If the state complies, then the third element of the initial (Fy99-00) CMHSP based specialty waiver will be met (ie slow growth)

Michigan's Medicaid Health Plans: Some Observations

- The Health Plans appear to have more influence on their funding
- Health Plans have threatened withdrawal from Medicaid
- Responsibilities (scope) have been reduced without equivalent offsetting rate reduction. In some instances the state asked the Health Plans to identify how much they were spending on the benefit to be removed.
 - Elimination of Medicaid psychiatric inpatient and hospitalization services in July 1997
 - Elimination of Substance Abuse benefit in January 1998
 - Reduction in responsibilities for psycho-pharmacology (FY00) for all their Medicaid enrollees, not just those in CMH
- In the late 1990s, Health Plan Medicaid rates were reduced as DMB set the ceiling on rates based on the lowest bid
- Medicaid Health Plans have received rate increases through the appropriation process since 2000.
- Health Plans provide very little basic mental health outpatient services (as reported from their encounter data)
- Some Health Plans default on their 20 Mental health Outpatient benefit, with CMHSPs having to pick up these services
- Health Plans have dropped out of the Medicaid program, leaving some counties with only one plan and no fee-for-service alternative. MSA has not pursued adequate capacity, so CMHSPs have picked up these services.
- Some Health Plans have long waiting lists/times
- The state actuary uses a 12-14% factor for Health Plan administration

General Accounting Office Reports

The GAO and CMS have cited concerns with several of Michigan's Medicaid Programs over the past 5 years. Notably missing is CMH services.

Special Financing, particularly through use of intergovernmental transfers

School-based Services

Quality Assurance Provider Tax

MiChoice Waiver Renewal

Health Plans

ABW Implemented prior to federal approval

- **CMH State Funding Distribution**

Funding distribution across the 46 CMHSPs is based primarily on each CMHSP history on key factors, along with several redistribution efforts.

CMHSP Non-Medicaid funding is the combination of Community Funds and State Facility funds (Purchase of Service).

Each CMHSP funding is based on:

- How well they fared under expansion funding in the 1980s. This was in part driven by the availability of local match
- The use of state facilities at the time they became full management – the later the better for funding base as the state facility rates increased but community base stayed flat
- Where DCH developed community-based services as placements for persons exiting state facilities. This is primarily a DD funding factor (both AIS and CLF).

There are no reliable measures for determining need, which should be the foundation of funding.

There have been several redistributions of state general funds:

- While some base reductions (primarily due to tradeoff problem) in the late 1980s and early 1990s were made across-the-board, there were attempts by DMH to target reductions to those viewed as higher funded.
- In FY97 a base reduction of \$15 million was required, again due to tradeoff problems. This was accomplished using a funding factor strategy developed by Citizens Research Council that used: number of all Medicaid eligibles, estimate for uninsured, estimate for adults with serious mental disorder. In addition, \$1.1m was redirected to the 4 lowest CMHSPs. The \$16.1m was reduced from 14 CMHSPs (out of 52).
- In FY99 a modified funding formula was applied to the non-Medicaid GF. This used: population (10% factor), poverty under age 18 (15%), poverty over age 18 (35%) and estimate of serious mental disorder (40%). This was applied across all CMHSPs, shifting each CMHSP 10% towards state average. This resulted in distributing \$5.7m from 15 CMHSPs above the average to those 34 CMHSPs below the average.
- Note: In FY99, Medicaid MH was also subjected to a 10% shift towards state average

- In FY02, as part of the local funded Medicaid draw-down, 7 CMHSPs (all at the high end of funding factors) gave up \$5.9m in GF to provide increased funding to 20 CMHSPs at the low end.
- As of January 2004, an additional \$7.2m is being redistributed to offset the state share of the Medicaid funding decreases. 7 CMHSPs gave up GF funding, and 28 gained GF funding.
- The ABW deduct has also impacted CMH-GF distribution. At \$40m, this was an 8.9% reduction in CMHSP community and POS GF funding. The range of loss was 3.3% (from one of the CMHSPs above average on funding factors) to 14.3% (from one of the low end CMHSPs)

1990's

- FY91 appropriated increase for residential services at 2%
- State economic recession. FY91 budgets cut by 9.2%. CMH state funding cut approximately 5%. Various state facilities closed – placements to CMH funded in year of placement (but no economics the following year).
- Medicaid State Plan expanded through Rehabilitation Option
- Medicaid fee screens frozen. State provides no increase to fee screens for Medicaid services. CMH covers the cost above fee screen through their GF/GP
- 1993 DMB implements fee screen adjuster for CMHSPs through intergovernmental transfer mechanism. State computes what fee screen should have been; computes the difference between what paid at fee screen and what should have paid. Bills Medicaid for the difference and draws additional FFP. CMHs earned 20% of additional FFP. State keeps the rest.
- Economy recovers
- No base increases for CMH state funding FY93 through FY97
- Tradeoffs from state facilities were under calculated. FY97 reduction in CMH GF by \$15 million (approximately 2%) taken from approximately 15 CMHSPs with funding above the state average (CRC study).
- FY98 appropriated increase for residential direct care staff wages (\$0.72/hr) with FFP funding about 40% of the cost (approx \$28m total). Legislative intent was a 3% increase for all CMH services but was insufficient funding for increase to any other CMH services.
- CMH financing strategy in 1990s: given no increase in state funding CMHSPs needed to maximize Medicaid FFP, increase in c-waiver participation, increase in state facility placements, maximize billing.
- August 1995, CMHSPs assume management of Medicaid hospital based services. Medicaid retains payment responsibility.
- FY96 fee screen adjuster – rebased rates used, increases total from \$40m to \$75m per year. Increased FFP by \$20m/year; state share increased by \$16m (ie doubled)

- FY99 Implementation of Medicaid 1915b/c waiver:

Intent of Managed Care program in 1998 waiver submission:

- Slow growth – HCFA approved 3-5% per year increases in rates
- Flexibility in service provision and how CMHSPs can use Medicaid funds
- Improved access to service system
- No savings in Medicaid – spend at the Upper Payment Level, no efficiencies for managed care taken off the top by the state
- Carved out all Medicaid specialty services
- Blends Medicaid and GF at the local level

Financing:

- CMH Medicaid funding at \$1,100 million; Substance abuse at \$24m
 - DMB transferred \$67.2 million for hospital related services – base computed by actuary was \$133m in FY98. CMH GF used to finance the state share of \$65.8m (approx \$28m)
 - Fee adjuster was included at \$80million for costs previously covered by GF. CMH GF reduced by \$35m for State share of the IGT.
 - All state funding required as state match (approx 45%) came from CMH GF base, except for under-funded hospital transfer from Medicaid budget.
- FY99 appropriation included a second wage pass through (\$.50/hr) for residential and paraprofessional day program staff. Originally all funded as GF (ie annual about \$26m). Later was added to Medicaid program at \$20m, which created approximately \$11m in GF savings that was removed from CMH funding
- FY00
 - No rate increase for Medicaid specialty managed care.
 - Medicaid eligibles increase – impact of \$30 million
 - No increase in CMH GF base, other than state facility tradeoffs
 - \$3.5m transferred out from CMH GF for pharmacy in MSA budget
 - Economy still doing well; other Medicaid lines get rate increases
 - FY01
 - No rate increase for Medicaid specialty managed care
 - \$16.4m loss of Medicaid appropriation due to funding for pharmacy
 - Eligibility trend continuing at \$30m (approximately 2.7%)

- January 2001, DMB eliminates payments for spend-downs. Loss of \$34m in revenues annually for CMHSPs
- April 2001, DMB attempted to remove payments for retro-eligible months, potential loss of \$50m in revenues. Legislators intervene. Months removed but rates increased to off-set
- Economy still doing well but impact of tax cuts being felt; other Medicaid lines get rate increases

- FY02
 - No rate increase for Medicaid appropriated
 - Executive Order reductions in multi-cultural and prevention
 - CMHSPs volunteer to provide local funds to finance Medicaid rate increase
 - Impact of tax cuts being felt

- FY03
 - No rate increase for Medicaid appropriated
 - Appropriated increase for eligibles
 - Executive Order: Reduction in Medicaid rates by 1.1% (all Medicaid managed care received this cut)
 - Elimination of certain Medicaid eligible groups
 - Reduction in CMH GF by 2.5%
 - Elimination of SED respite (tobacco tax)

- FY04
 - Medicaid rate increase of 1.6%, with state share from redirected CMH GF (\$10m)
 - Appropriated increase for eligibles understated by at least \$30m due to 2003 trend. (Note other lines received a supplemental in Fall 2003)
 - CMH GF reduced by \$40m in the appropriation to finance the ABW.
 - ABW uses 70% FFP, so \$40m created \$28m in savings in state funds.
 - ABW implemented before federal approval, so no FFP for 3.5 months. CMH GF used to cover this loss. (Other ABW components covered by state funding or other federal funds).
 - State facility budgets are short by \$10m, even with supplemental transferring \$17.1m from CMH GF.

- DCH submits waiver renewal in Fall 2003. Medicaid rates required to comply with BBA. This requires the actuary to apply a cost increase each year.

- FY04 new Medicaid rates implemented in January 2004. Due to appropriation understating the eligibility trend, the actuary applies a 5% managed care savings (reduction) to MH rates and 9% to SA rates.

- FY05 As Proposed
 - Medicaid rate increase at 2.08% for MH/DD and 2.8% for SA.
 - Eligibility trend does not cover the loss in 2004 (\$30m for MH/DD and \$2.5m for SA), and projects only 0.5% increases.
 - ABW proposed at same \$40m. Actually running at \$49.6m. Assume CMH GF will be reduced by \$9.6m, though only need state funds of \$2.9m to finance the increase.
 - State facility budgets are still short \$10m