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Senate Bill 1152 (S-1, Draft 1 as reported)
Committee: Appropriations

Throughout this document Senate means Subcommittee.

FY 2009-10 Year-to-Date Gross Appropriation	\$13,093,816,100
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Changes from FY 2009-10 Year-to-Date:

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| <p>1. Medicaid Base Funding. The Senate bill included base adjustments for Medicaid, Community Mental Health (CMH) Medicaid services, and other Medicaid programs. These adjustments would increase GF/GP costs by \$57,486,800.</p> | 141,157,300 |
| <p>2. Actuarially Sound Rates. The Senate provided an adjustment in Medicaid managed care capitation rates and CMH Medicaid rates of 3.0% to meet Federal requirements that capitation rates be actuarially sound, at a cost of \$45,557,500 GF/GP.</p> | 133,170,300 |
| <p>3. Special Medicaid Payments and Quality Assurance Assessment Program (QAAP) Adjustments. The budget reflected the anticipated Federal revenue available for various special financing mechanisms, expanded other special payments to providers, and made adjustments to maximize use of QAAP revenue.</p> | 242,441,100 |
| <p>4. Fund Source Adjustments. The Senate included adjustments reflecting a \$4,000,000 loss of revenue from the Medicaid Benefits Trust Fund, a \$126,320,600 increase in Merit Award Trust Fund revenue, and a one-time retroactive FMAP payment of \$160,000,000, resulting in a GF/GP cost decrease of \$282,320,600.</p> | 0 |
| <p>5. Medicaid Match Rate Adjustments. The Senate assumed savings of \$223,504,100 GF/GP from the increase in the base Medicaid match rate from 63.19% to 65.79%. The budget assumed that the American Recovery and Reinvestment Act (ARRA) stimulus funding would be available for nine months in FY 2010-11 and also included ARRA match rate funding related to Medicare Part D, resulting in a net increase in GF/GP costs of \$120,160,300 compared to FY 2009-10.</p> | 0 |
| <p>6. Restoration of Hospital and Nursing Home Payment Reductions. Senate used an increase of hospital and nursing home QAAPs to help restore the 8.0% provider rate reduction implemented in FY 2009-10.</p> | 101,498,500 |
| <p>7. Cost Reduction Measures. The Senate budget reflected administrative reductions, a enrollment freeze for the HAB C and Adult Benefits Waiver programs, and implementation of Medicaid revenue recovery and Medicaid Inspector General programs. The budget included numerous program cuts, including a 20.0% reduction to CMH non-Medicaid services (\$57.5 million) and a 4.0% reduction to some physician payment rates and cuts to substance abuse, the Healthy Michigan Fund, caretaker relatives and 19 and 20 year olds, local public health, lab services, human growth hormone therapy for the Children's Special Health Care Services program, and aging services programs. Total GF/GP savings were \$107,474,900. The Senate rejected the Governor's proposal for a Physician QAAP.</p> | (215,536,300) |
| <p>8. Program Restorations. The Senate budget restored the "second" Disproportionate Share Hospital pool, certain Medicaid optical services, and Medicaid adult dental and podiatric services. The total GF/GP cost of these initiatives was \$9,545,000.</p> | 32,787,000 |
| <p>9. Economic Adjustments. The Senate bill did not include funding for the 3.0% civil service pay increase. Total GF/GP costs of these adjustments were \$7,654,100.</p> | 25,556,300 |
| <p>10. Other Changes. Other changes resulted in a minor increase in funding.</p> | 11,076,100 |
| <p>11. Comparison to Governor's Recommendation. The Senate is \$830,964,600 Gross and \$96,040,400 GF/GP below the Governor.</p> | |

FY 2010-11 Senate Appropriations Subcommittee Gross Appropriation	13,565,966,400
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Changes from FY 2009-10 Year to Date:

1. **Deletions.** The Senate bill eliminated numerous boilerplate sections, including but not limited to: Salvation Army Harbor Light's contract (412), a Healthy Michigan 2010 report by the State Surgeon General (651), report on nursing home case mix reimbursement (1695), Adult Benefit Waiver enrollment consistency (1716), Medicaid eligibility errors (1725), a required study of the current nursing home occupancy ceiling (1789), a required examination of strategies of IT changes to promote the sharing of medical records (1796), expansion of the beneficiary monitoring program (1826), and language requiring the creation of a physician QAAP and mandating GF/GP reductions if the QAAP is not implemented. (1830)
2. **Consolidation of Coordinating Agencies.** Current law boilerplate was modified to require reimbursement for substance abuse services be made through Pre-Paid Inpatient Health Plans by April 1. (Sec. 407)
3. **CMH Funding Adjustments.** New boilerplate required the DCH to continue to utilize the funding formula mandated for the distribution of CMH Non-Medicaid funds in FY 2009-10. The language expressed legislative intent to remove geographic factors from rate setting for the next re-bid of CMH Medicaid services. (Sec. 462)
4. **Mental Health/Substance Abuse Subcontractor Standards.** New boilerplate required the DCH to establish a workgroup to develop a plan to establish uniformity in the standards required of providers contracting with PIHPs, CMHSPs and substance abuse coordinating agencies. (Sec. 490)
5. **Food and Custodial Contracting for Facilities.** New boilerplate required the DCH to contract with private entities for the provision of food and custodial services at state hospitals where contracting for these services has been determined to be cost effective. (Sec. 608)
6. **Medical Marihuana Contract.** Current law boilerplate was replaced with new language requiring the DCH to implement a bid process to identify a private or public entity to manage the State's medical marihuana program. (Sec. 727)
7. **Genetic Diagnostic and Counseling Services for the Children's Special Health Care Services (CSHCS) Program.** The Substitute deleted language allowing the Department to provide such services to CSHCS clients, reflecting a dollar decision. (Sec. 1202)
8. **CSHCS and Medicaid Managed Care.** Current law boilerplate was adjusted to require the DCH and Medicaid health plans to identify a method of reimbursing health plans for CSHCS services. Language further required recipients enrolled in CSHCS and Medicaid, without an established physician relationship, to enroll in a Medicaid health plan. (Sec. 1204)
9. **Medicaid Cost Sharing.** Current law boilerplate was modified in the Senate bill to reflect an increase in the required Medicaid cost share for the first day of inpatient hospitalization from \$50 to \$100. (Sec. 1631)
10. **Ambulatory Surgery Centers.** The Substitute added additional language setting guidelines for the reimbursement of ambulatory surgery centers using Medicaid funds. (Sec. 1642)
11. **Medicaid Emergency Room Physician Reimbursement Methodology.** The Substitute removed specific requirements on emergency room reimbursement changes, including the requirement that payments not exceed 70% of Medicare payment rates. (Sec. 1711)
12. **Low-Day Medicaid Hospital Reimbursement.** New boilerplate required the Department to reimburse hospitals for Medicaid admissions of 24 hours or less as outpatient observation stays. (Sec. 1786)
13. **Special Medicaid Physician Payments.** New language limited physician reimbursement for specialty network access fees and physician adjustor payments to 90% of Medicare rates. (Sec. 1831)
14. **Nursing Home Quality Incentives.** New language required the DCH to create a workgroup to examine the creation of budget-neutral quality incentive payments for Medicaid nursing home services. (Sec. 1838)
15. **Adult Benefits Waiver (ABW) Workgroup.** New language required the DCH to create a workgroup to explore modifications in the ABW program that would focus physical and mental health services to single low-income adults with serious mental illness. (Sec. 1839)

Date Completed: 3-12-10

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