AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
FINANCE COMMITTEE MEETING

Wednesday, March 13, 2024 at 5:00 pm

William B. Cammin Clinic, Bay Room, 1010 N. Madison Avenue, Bay City, MI 48708

Committee Members:	Present	Excused	Absent		Present	Excused	Absent	Others Present:
Ernie Krygier, Ch				Patrick McFarland				BABH: Marci Rozek, Chris Pinter, and Sara McRae
Sally Mrozinski, V Ch				Robert Pawlak, Ex Off				
Tim Banaszak				Colleen Maillette, Ex Off				
Jerome Crete				Richard Byrne, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
Robert Luce								

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Investment Earning Reports for Period Ending February 29, 2024		3) Consideration of motion to refer the investment earnings reports for period ending February 29, 2024 to the full Board for information
4.	Contracts 4.1) Finance March 2024 Contract List		4.1) Consideration of motion to refer the Finance March 2024 contract list to the full Board for approval
5.	Unfinished Business 5.1) None		
6.	New Business 6.1) Current 2024 Medicaid Enrollment Trends 6.2) Medicaid Inpatient Tiered Rate Proposal		6.1) No action necessary 6.2) No action necessary

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7.	Adjournment	M -	S -	pm	MA

Bay-Arenac Behavioral Health Authority
Estimated Cash and Investment Balances February 29, 2024

Balance February 1, 2024	7,011,099.61
Balance February 29, 2024	3,615,485.24
Average Daily Balance	5,708,043.25
Estimated Actual/Accrued Interest February 2024	18,877.47
Effective Rate of Interest Earning February 2024	3.97%
Estimated Actual/Accrued Interest Fiscal Year to Date	107,624.99
Effective Rate of Interest Earning Fiscal Year to Date	4.17%

Note: The Cash and Investment Balances exclude Payroll and AP related Cash Accounts.

Cash Available - Operating Fund

	Rate	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Beg. Balance Operating Funds - Cash, Cash equivalents, Investments		5,531,567	4,929,028	4,145,850	3,560,754	2,822,426	3,940,689	3,431,903	4,022,437	3,285,926	8,549,839	7,456,274	7,733,635
Cash in		5,799,795	6,405,791	7,365,485	6,140,991	9,939,499	6,328,711	12,694,585	11,257,050	21,945,755	11,552,037	11,480,507	4,835,627
Cash out		(6,402,334)	(7,188,968)	(7,950,581)	(6,879,319)	(8,821,236)	(6,837,497)	(12,104,052)	(11,993,562)	(16,681,841)	(12,645,602)	(11,203,146)	(9,401,946)
Ending Balance Operating Fund		4,929,028	4,145,850	3,560,754	2,822,426	3,940,689	3,431,903	4,022,437	3,285,926	8,549,839	7,456,274	7,733,635	3,167,316
Investments													
Money Markets		4,929,028	4,145,850	3,560,754	2,822,426	3,940,689	3,431,903	4,022,437	3,285,926	8,549,839	7,456,274	7,733,635	3,167,316
90.00													
180.00													
180.00													
270.00													
270.00													
Total Operating Cash, Cash equivalents, Invested		4,929,028	4,145,850	3,560,754	2,822,426	3,940,689	3,431,903	4,022,437	3,285,926	8,549,839	7,456,274	7,733,635	3,167,316
Average Rate of Return General Funds		2.03%	2.14%	2.25%	2.41%	2.51%	2.60%	2.69%	3.82%	3.96%	4.01%	4.04%	4.05%
		2.50%	2.81%	3.01%	3.66%	3.46%	3.51%	3.71%	3.82%	4.09%	4.13%	4.11%	4.10%
average		5,963,080	5,703,476	5,435,635	5,145,279	5,024,820	4,880,009	4,808,545	3,285,926	5,917,883	6,430,680	6,756,419	6,038,598

Cash Available - Other Restricted Funds

	Rate	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Beg. Balance-Other Restricted Funds - Cash, Cash equivalents, Investments		427,405	428,924	430,428	432,047	433,645	435,308	437,156	438,953	440,817	442,629	444,508	446,396
Cash in		1,519	1,504	1,619	1,598	1,663	1,849	1,797	1,864	1,812	1,880	1,888	1,773
Cash out													
Ending Balance Other Restricted Funds		428,924	430,428	432,047	433,645	435,308	437,156	438,953	440,817	442,629	444,508	446,396	448,169
Investments													
Money Market		428,924	430,428	432,047	433,645	435,308	437,156	438,953	440,817	442,629	444,508	446,396	448,169
91.00	0.70%												
91.00	1.10%												
91.00	1.15%												
91.00	1.35%												
90.00	1.70%												
91.00	2.05%												
90.00	2.15%	-	-	-	-	-	-	-	-	-	-	-	-
365.00	80.00%												
Total Other Restricted Funds		428,924	430,428	432,047	433,645	435,308	437,156	438,953	440,817	442,629	444,508	446,396	448,169
Average Rate of Return Other Restricted Funds		3.32%	3.47%	3.58%	3.68%	3.76%	3.88%	3.97%	5.00%	5.00%	5.00%	5.00%	5.00%
		4.00%	4.35%	4.35%	4.50%	4.50%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
average		425,556	426,252	426,976	427,717	428,476	429,265	430,073	440,817	441,723	442,651	443,587	444,504
Total - Bal excludes payroll related cash accounts		5,357,952	4,576,278	3,992,801	3,256,071	4,375,997	3,869,059	4,461,390	3,726,743	8,992,468	7,900,782	8,180,031	3,615,485
Total Average Rate of Return		2.09%	2.17%	2.25%	2.34%	2.41%	2.51%	2.58%	4.04%	4.08%	4.20%	4.21%	4.17%

Bay-Arenac Behavioral Health
Finance Council Board Meeting
Summary of Proposed Contracts
March 13, 2024

			Old Rate	New Rate	Term	Out Clause?	Performance Issues? (Y/N) Risk Assessment Rating (Poor/Fair/Good/Excellent)
SECTION I. SERVICES PROVIDED BY OUTSIDE AGENCIES							
Clinical Services							
1	M	**Michigan Community Services, Inc.** Beechwood Home to become a 6 bed home vs. 5 bed home	$1,031.49	Same	2/19/24 - 9/30/24	Y	N
2	M	**Game Changer Pediatric Therapy Services** Case Specific Agreement for CLS services for 1 BABHA individual	$0	CLS & In-Home Respite: $10/unit	2/11/24 - 5/11/24	Y	N
3	M	**Bay Human Services** Union Home - Extension until HNSE is able to take over the home	$1,444.02/day	Same	3/1/24 - 3/19/24	Y	N
Admin/Other Services							
4	R	**DocuSign** eSignature module *Business Pro Addition - up to 5 users* *Premier support*	 $1,822/year $273/year	 $1,913/year $287/year	4/20/24-4/19/25	Y	N
5	D	**Pitney Bowes** Mail machine rental - Parish Road	$147.59/month	$140.36/month	6/30/24-6/29/29	Y	N
6	N	**Professional Insurance Consultants** Billing & coding training for BABHA employees	N/A	$1,000	5/30/2024	N/A	N
SECTION II. SERVICES PROVIDED BY THE BOARD (REVENUE CONTRACTS)							
SECTION III. STATE OF MICHIGAN GRANT CONTRACTS							
SECTION IV. MISC PURCHASES REQUIRING BOARD APPROVAL							

R = Renewal with rate increase since previous contract
D = Renewal with rate decrease since previous contract
S = Renewal with same rate as previous contract
ES = Extension
M = Modification
N = New Contract/Provider
NC = New Consumer
T = Termination

Footnotes:

Impacts of Medicaid Redetermination

on Michigan's Public Mental Health System

Medicaid disenrollment patterns deeper and steeper than predicted

Medicaid redetermination presents a fundamental financing issue for the Community Mental Health Association of Michigan and its members that provide public mental health services throughout Michigan. During the COVID-19 public health emergency, Medicaid redetermination was frozen – resulting in an increase in Medicaid recipients throughout the state. With the redetermination process reinstated in 2023, it is anticipated that hundreds of thousands of recipients will lose their Medicaid coverage, causing a ripple effect on the public mental health system through decreased funding to providers.

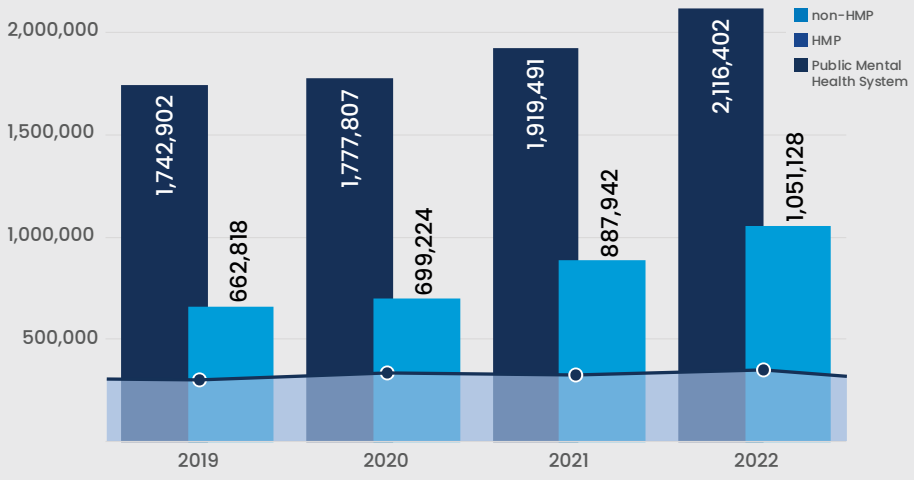
How CMH/PIHPs are paid

Public mental health providers receive payment through capitation payments. **Capitation payments** are fixed monthly allocation provided to a medical provider through a state or private health plan – simply put, the more people enrolled means more overall financial support being allocated to the mental health services. **These payments are paid monthly to providers for each member enrolled in the health care plan no matter how many times the member utilizes services.** Increased enrollment in the Medicaid system throughout the public health emergency boosted budgets allowing for increased services and better mental health support throughout the state.

Public mental health system usage

The number of persons served by Michigan's public mental health system does not fluctuate as overall Medicaid enrollment goes up or down. The vast majority of consumption within our public mental health system is by two groups – the serious and persistently mentally ill population as well as the intellectually developmentally disabled population. Overall, the public mental health system consistently serves 300,000-350,000 persons annually.

Average Medicaid and Healthy Michigan Plan (HMP) Enrollment



Medicaid Rate Variable Issues

1

Due to the expected drop in Medicaid enrollees, public mental health funding is anticipated to drop significantly throughout the state. Current trends indicate that the drop-off is happening at an even faster rate than originally projected.

2

Medicaid rates have not kept up with inflation. The adjusted consumer price index has gone up nearly 19% over the past three years which has greatly outpaced any increases in overall Medicaid rates during that time. Additionally, FY24 rates did not reflect increased wages required to close workforce gaps (increased wages, signing bonuses and provider costs that were required in FY23, but are still needed to recruit and retain staff in the future).

3

Incorrect Medicaid bucket slotting will cause additional stress on the mental health system. During the redetermination process, enrollees are assigned into a Medicaid bucket that determines their funding allocation. Currently the state's PIHPs and CMSHPs are experiencing ineffective re-enrollment determination patterns causing many enrollees to be incorrectly assigned.

4

The financial impact of incorrect slotting is detrimental. Using the example above, reimbursement rates of the different buckets provide a snapshot into the impact of incorrect slotting at redetermination:

1. **Disable Aged Blind (DAB)** $378.32/per person per month
2. **Temporary Assistance for Needy Families (TANF)** $34.58/per person per month
3. **Health MI (HMP)** $42.46/per person per month

Our members conducted a study that showed nearly 42,000 individuals in FY16 & FY17 categorized as Disabled, Aged, and Blind (DAB) moved to Healthy Michigan Plan (HMP) & Temporary Assistance for Needy Families (TANF) programs during the Medicaid redetermination process. This change in enrollment has resulted in nearly $100 million in lost revenue to our PIHP/CMH system.

Our Asks

> Adjust Medicaid rates to offset disenrollment patterns and to accurately account for the necessary staffing adjustments and provider costs increases.

> Ensure that enrollees are slotted into the correct Medicaid bucket to properly empower providers to deliver needed services.

CMHA Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.

CMHAM.org /CMHAMich @CMHAMich

Public Notice

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

Michigan § 1115 Behavioral Health Demonstration Waiver Renewal Application

In accordance with 42 CFR § 431.408, the Michigan Department of Health and Human Services (MDHHS) is providing public notice of its intent to submit an application to the Centers for Medicare and Medicaid Services (CMS) under § 1115 of the Social Security Act seeking a five-year extension of the Michigan § 1115 Behavioral Health Demonstration. The current Demonstration is authorized through September 30, 2024. Additionally, MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with substance use disorder (SUD). The complete application and applicable attachments are available at www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Adult Behavioral Health & Developmental Disability >> BH Recovery & Substance Use. Additionally, paper copies are available at the Bureau of Specialty Behavioral Health Services located in the Capitol Commons Center, 400 South Pine Street, Lansing, MI 48909.

Demonstration Description & Goals
The Demonstration supports a comprehensive continuum of care for Medicaid-enrolled individuals with an opioid use disorder (OUD) or other SUD. MDHHS is requesting continued authority to provide residential treatment services for individuals who are receiving treatment and withdrawal management for SUD and are short-term residents in facilities that meet the definition of an institution for mental disease (IMD). Through this extension, the State also intends to continue operation of its prepaid inpatient health plan (PIHP) delivery system to manage specialty mental health and SUD treatment benefits.

Through the Demonstration, Michigan seeks to improve health outcomes and sustained recovery for beneficiaries with SUD/OUD by:

- Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.
- Enhancing provider competency related to the use of American Society of Addiction Medicine (ASAM) criteria or other nationally recognized, SUD-specific program standards, for patient assessment and treatment.
- Expanding the treatment continuum of residential care including medically necessary use of qualified residential treatment facilities, withdrawal management programming, and medication assisted treatment (MAT).
- Expanding the use of recovery coach-delivered support services.
- Establishing coordination of care models between SUD providers, primary care, and other behavioral health providers.

Additionally, MDHHS is seeking new authority to provide CM as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. CM is an evidence-based behavioral health treatment in which individuals living with a SUD can earn motivational incentives in the form of small, non-cash rewards when they avoid the use of specified substances or otherwise take steps to engage in recovery. The State intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an OUD, but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. Beneficiaries who qualify for and participate in the Recovery Incentives (RI) Pilot, will be eligible to receive an annual maximum of $599 in incentives in the form of low denomination gift cards. Eligible beneficiaries may earn these incentives for desired behaviors as evidenced by specific activities such as negative drug screens and engagement with CM services. MDHHS is seeking a two-year approval of this component of the Demonstration, from October 1, 2024, through September 30, 2026.

The goals of the RI Pilot are to improve health outcomes for beneficiaries living with StimUD and/or OUD. This includes:

- Reducing the number of emergency department (ED) visits
- Reducing the rate of repeated ED visits
- Reducing adverse health outcomes (e.g., death, overdoses)
- Increasing engagement and retention in treatment

Eligibility
Under the Demonstration extension there is no change to Medicaid eligibility requirements. Pending CMS approval, Michigan Medicaid members will be eligible for CM services if they meet the service-specific criteria listed below.

- Diagnosed with a StimUD and/or OUD for which the CM benefit is medically appropriate. The presence of additional SUDs and/or diagnoses will not disqualify an individual from receiving the CM benefit.
- Enrolled in a PIHP that elects and is approved by MDHHS to provide the CM benefit.
- Receive services from a non-residential provider that offers the CM benefit in accordance with MDHHS policies and procedures.

Native American/American Indian beneficiaries not enrolled in a PIHP are also eligible to receive CM services through participating Tribal Health Centers (THCs) and tribal providers.

Enrollment & Fiscal Projections
Budget neutrality is a comparison of without-waiver expenditures (WOW) to with-waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per capita method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for this behavioral health 1115 waiver, which was developed using CMS budget neutrality requirements, will be demonstrated using the per capita method. Attachment 2 provides the completed 1115 Waiver Budget Neutrality Template worksheets (Template) for this extension.

It should be noted that the budget neutrality section of this report is intended for public comment only. The accuracy and completeness of this budget neutrality illustration is limited because of, but not limited to, the considerations below. It is certain that values within the document and accompanying budget neutrality template will change prior to its final filing with CMS, and it is possible that those changes may be material.

- ***Several policy decisions related to key programmatic considerations for SFY 2024, SFY 2025, and future years remain outstanding.***
- ***Recent historical experience from SFY 2023, which will be used in the development of SFY 2025 capitation rates and valuation of program changes, is not fully complete nor reconciled to financial reports.***
- ***The data stratification and analysis that is required to value policy decisions which have been more recently decided cannot be effectively completed within the timeframe for release of the document for public comment.***
- ***The impact of eligibility redetermination following the COVID-19 PHE is still emerging and is expected to have a material impact on the average acuity for members who retain eligibility.***

Figure 1 describes each of the Medicaid Eligibility Groups (MEGs) which are covered under MDHHS' Behavioral Health 1115 Waiver:

FIGURE 1: MEDICAID ELIGIBILITY GROUP DESCRIPTIONS

MEG NAME	MEG DESCRIPTION
DAB	Includes non-dual and dual eligible members who are enrolled in the disabled, aged, or blind (DAB) eligibility categories.
TANF	Includes non-dual and dual eligible members who are enrolled in the Temporary Assistance for Needy Families (TANF) eligibility categories.
HMP	Includes non-dual and dual eligible members who are enrolled in the Healthy Michigan Plan (HMP) eligibility categories.
HSW	Includes members who are enrolled in the 1915(c) Habilitation Supports Waiver (HSW) program.
SED	Includes members who are enrolled in the 1915(c) Serious Emotional Disturbances (SED) Waiver program.
CWP	Includes members who are enrolled in the 1915(c) Children's Waiver Program (CWP).

SUD-IMD-DAB	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the DAB eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD-IMD-HMP	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the HMP eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD-IMD-TANF	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, 1115 Behavioral Health Demonstration Approval Period: April 5, 2019 through September 30, 2024 Page 28 of 132. Amended on September 27, 2019 provided to individuals in the TANF eligibility category during a month in which the individual is a short-term resident in an IMD.

Historical data and projected expenditures have been stratified as follows:

- Actual historical data: demonstration year (DY) 1 through DY 4 (October 1, 2019 through September 30, 2023)
- Base year: Capitation rates for DY 5 (October 1, 2023 through September 30, 2024)
- Projected expenditures: DY 6 through DY 10 (October 1, 2024 through September 30, 2029)

In addition to requesting continued authority corresponding to the existing 1115 Waiver approval, MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The state initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval of this component of the demonstration, from October 1, 2024, through September 30, 2026. This service has been reflected as hypothetical expenditures under the DAB, TANF, and HMP MEGs with identical costs included in both the WOW and WW projections.

B. Without Waiver Projections for Historical Medicaid Populations

i. Base year (DY 5) for DAB, TANF, HMP, HSW, SED, and CWP

The SFY 2024 (October 2023 through September 2024) capitation rates from the *State Fiscal Year 2024 Behavioral Health Capitation Rate Certification* dated September 19, 2023 (current SFY 2024 PMPMs) are the starting point for development of DY 5 PMPM costs. Those capitation rates are expected to be amended during quarter 3 (Q3) of SFY 2024 in consideration of known program changes retroactively effective to October 1, 2023 resulting in amended SFY 2024 PMPMs. The amended SFY 2024 PMPMs and corresponding estimated enrollment are illustrated in figure 2 below and represent the base year (DY5) values documented in the WOW sheet of the template. The applicable program changes are described below.

FIGURE 2: DY 5 BASE PMPM

	SFY 2024 CAPITATION RATES		SFY 2024 WITH AMENDMENT PROGRAM CHANGES			
MEDICAID POPULATIONS	ELIGIBLE MEMBER MONTHS	PMPM COST	ELIGIBLE MEMBER MONTHS	ENROLLMENT ACUITY	DCW OVERTIME	PMPM COST
DAB	6,292,038	$ 378.32	6,013,780	4.6%	0.4%	$397.59
TANF	16,421,393	34.58	15,606,942	5.2%	0.1%	36.43
HMP	10,284,690	42.46	9,458,519	8.7%	0.1%	46.22
HSW	89,482	7,102.89	89,482	0.0%	0.8%	7,157.05
CWP	5,852	3,304.46	5,852	0.0%	0.8%	3,330.25
SED	5,411	1,962.26	5,411	0.0%	0.2%	1,966.34

a. Enrollment/acuity adjustments related to COVID-19 public health emergency (PHE)

This adjustment recognizes the impact of unwinding COVID-19 PHE-related enrollment growth and the resumption of redeterminations and discontinuation of Medicaid coverage associated with the continuous eligibility expiration during SFY 2024. Additional funding was included in the September 19, 2023 rate certification for acuity changes due to the anticipation that lower acuity members will be disenrolled from the program, leaving a higher level of average acuity for remaining members than reflected in the base period for capitation rate development. Development of the current SFY 2024 PMPMs assumed that 70% of the enrollment increase from pre-COVID levels would be disenrolled over the course of 12 months following the end of the PHE using the distribution of member redetermination dates. Emerging enrollment data indicates that approximately 90% of additional enrollment growth during the PHE will not meet redetermination requirements. Thus, additional acuity adjustments have been reflected in the development of the base year (DY 5) PMPM costs.

b. Direct Care Worker (DCW) overtime adjustment

Effective October 1, 2024, MDHHS increased DCW services by $3.60 per hour ($3.20, including an additional 12% for employer related expenses) over hourly pay effective prior to the COVID-19 Pandemic. The planned SFY 2024 amendment reflects a further increase in DCW reimbursement to $4.80 per hour for overtime hours, which were assumed to comprise 10% of overall DCW hours.

ii. Base year (DY 5) for SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF

SFY 2024 (DY 5) PMPMs for the SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF MEGs have been projected from SFY 2023 (DY 4) experience using simplified adjustments of 5% PMPM cost trend and no enrollment trend. Determination of estimated impacts related to the separate program changes between SFY 2023 and SFY 2024 will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

iii. SFY 2025 Program Changes and Trend

Figure 3 illustrates the estimated combined impact of known program changes and trend assumptions underlying the development of SFY 2025 (DY 6) PMPMs and enrollment for each of the MEGs except SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF. Similar to the projection of SFY 2024 (DY 5) expenditures for those MEGS, adjustments between SFY 2024 (DY 5) and SFY 2025 (DY 6) are limited to a 5% PMPM cost trend and no enrollment trend. Determination of the impact of separate program changes will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

FIGURE 3: SFY (2025) DY 6 DEVELOPMENT

MEDICAID POPULATIONS	DAB	TANF	HMP	HSW	CWP	SED
SFY 2024						
Eligible Member Months	6,013,780	15,606,942	9,458,519	89,482	5,852	5,411
PMPM Cost	$ 397.59	$ 36.43	$ 46.22	$ 7,157.05	$ 3,330.25	$ 1,966.34
SFY 2025						
Eligible Member Months	5,786,068	14,763,272	8,159,031	89,482	5,852	5,411
Enrollment Acuity	3.9%	5.7%	15.9%	0.0%	0.0%	0.0%
Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Contingency Management - Incentive	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%
Contingency Management - Utilization	0.0%	0.1%	0.3%	0.0%	0.0%	0.0%
Other Program Changes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PMPM Cost	$ 434.02	$ 40.50	$ 56.62	$ 7,514.90	$ 3,496.76	$ 2,064.65
Composite PMPM Adjustment	**9.2%**	**11.2%**	**22.5%**	**5.0%**	**5.0%**	**5.0%**

a. Enrollment/acuity adjustments related to COVID-19 public health emergency (PHE)

Enrollment is expected to remain flat following the end of the PHE unwinding. However, as illustrated in Appendix C a further acuity adjustment is necessary to annualize the impact of the PHE unwinding on the acuity assumptions underlying the SFY 2025 (DY 6) expenditures.

b. Contingency management

MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The state initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval for this component of the 1115 Waiver, from October 1, 2024, through September 30, 2026 (i.e., DY 6 and DY 7).

As illustrated in Appendix C, the estimated cost impact for addition of CM has been separated into two categories: (1) cost of the member incentives, and (2) projected costs associated with increased service utilization associated with increased testing because of the program. Since these services are included as hypothetical expenditures, identical costs have been included in the WOW and WW projections. The enclosed estimates should generally be considered placeholders given the broad array of outstanding policy decisions related to the service. We have preliminarily assumed 3,000 participants in DY 6 and 12,000 participants in DY 7, with fiscal impact estimates of $4.3M and $19.4M respectively based on data provided by MDHHS. The cost assumptions for CM will be further refined and detailed in the final budget neutrality documentation for the 1115 Behavioral Health Demonstration extension filing.

c. SFY 2025 program changes

A list of programmatic changes that may become effective with the SFY 2025 behavioral health capitation rates is listed below. However, due to the limitations highlighted in Section I. Background, the financial impact of those changes cannot be calculated for this distribution of the budget neutrality documentation. Each of these items will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

- DCW wage increases.
- Inpatient psych tiered rates.
- MICAS service array.
- Waskul lawsuit.
- Others.

d. SFY 2025 Trend Assumptions

Expenditures in the template assume an annual PMPM trend of 5%, which reflects the unit cost trend assumed in the SFY 2024 capitation rate certification.

iv. Projections, PMPM costs, and Member Months

Expenditures in the template assume an annual PMPM trend of 5% consistent with the unit cost trend assumed in the SFY 2024 capitation rate certification. Enrollment has been projected to be flat following the end of the PHE reenrollment period.

C. With-Waiver Projections, PMPM Cost, and Member Months

The With-Waiver PMPM cost and member month projections are fully consistent with the Without-Waiver projections.

FIGURE 4: 1115 BUDGET NEUTRALITY EXPENDITURE PROJECTIONS BY GROUPING

MEG	DY 06	DY 07	DY 08	DY 09	DY 10
DAB	$ 2,511.3	$ 2,639.8	$ 2,771.8	$ 2,910.4	$ 3,055.9
TANF	$ 597.9	$ 631.4	$ 663.0	$ 696.2	$ 731.1
HMP	$ 462.0	$ 497.9	$ 522.7	$ 548.9	$ 576.3
HSW	$ 672.4	$ 706.1	$ 741.4	$ 778.4	$ 817.4

CWP	$ 20.5	$ 21.5	$ 22.6	$ 23.7	$ 24.9
SED	$ 11.2	$ 11.7	$ 12.3	$ 12.9	$ 13.6
SUD IMD DAB	$ 12.9	$ 13.5	$ 14.2	$ 14.9	$ 15.7
SUD IMD TANF	$ 5.7	$ 6.0	$ 6.3	$ 6.7	$ 7.0
SUD IMD HMP	$ 32.7	$ 34.4	$ 36.1	$ 37.9	$ 39.8

Notes:

1. Values reflect state and federal expenditures, illustrated in millions of dollars.
2. DY 06 - DY 10 represent the waiver demonstration period of October 1, 2024 through September 30, 2029.

Benefits, Cost Sharing & Delivery System

Benefits

Michigan Medicaid enrollees will continue to have access to a comprehensive package of evidence-based OUD/SUD treatment and withdrawal management services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective community-based settings. Through the Demonstration extension, enrollees will continue to have access to treatment in an IMD setting.

Additionally, this Demonstration will add CM as a benefit to Michigan's current array of treatment services for people living with a SUD. CM consists of small motivational incentives for meeting treatment goals, such as negative urine drug tests or participating in clinical interventions when a urine drug test is positive. Under the Demonstration, incentives will be disbursed to eligible beneficiaries at the point of testing and in the form of low denomination gift cards; beneficiaries will be able to earn up to $599 annually. The benefit will be available only in outpatient settings to Medicaid beneficiaries who meet the benefit criteria for CM.

Cost Sharing

This Demonstration extension will not modify current cost sharing arrangements. Similar to other outpatient SUD treatments in Michigan, CM will be exempt from cost sharing.

Delivery System

This Demonstration extension will not modify current fee-for-service (FFS) and managed care delivery system arrangements. All Medicaid populations except Native American/American Indian beneficiaries will continue to be mandatorily and passively enrolled into a PIHP.

Native American/American Indian beneficiaries may continue to elect to obtain Medicaid mental health and SUD services directly from Medicaid enrolled Indian Health Services (IHS) facilities and Tribal Health Centers (THCs). For mental health and SUD services provided to Native American beneficiaries, the IHS facilities and THCs will be reimbursed directly for those services by MDHHS under the memorandum of agreement as specified in the Michigan Medicaid Provider Manual. Any Native American/American Indian beneficiary who needs specialty mental health, developmental disability, or SUD services may also elect to receive such care under the Demonstration through the PIHP.

The CM benefit will be delivered through PIHPs and their provider networks. Participation in the pilot will be optional for PIHPs. All PIHPs that MDHHS determines can meet the criteria for participation will be approved. THCs and tribal providers who participate in the RI Pilot will provide CM services to Medicaid beneficiaries. THCs and

tribal providers may bill their contracted PIHP for CM services or they may bill MDHHS directly on a FFS basis.

Hypotheses & Evaluation

MDHHS does not propose any changes to the currently approved Evaluation Design for the IMD portion of the Demonstration. Continuation of the current plan will permit additional study of outcomes over an extended period of time. Table 1 outlines the hypotheses, research questions, and analytic approach that will continue to be studied during the extension.

Table 1: IMD Waiver Evaluation Components

Hypotheses	Primary Research Question	Analytic Approach
Implementation of Michigan's Behavioral Health Demonstration Waiver will increase utilization of evidence-based standards for patient assessment and treatment placement.	Does the proportion of beneficiaries assessed and recommended for placement using evidence-based standards increase over the demonstration period?	• Descriptive comparison over time • Qualitative analysis
Implementation of Michigan's Behavioral Health Demonstration will expand availability of critical levels of SUD/OUD treatment, including residential treatment, withdrawal management, and MAT.	Does the number of qualified SUD providers increase over the demonstration period?	• Descriptive comparison over time • Qualitative analysis
Implementation of Michigan's Behavioral Health Demonstration will increase utilization of SUD treatment.	Does utilization of SUD treatment increase over the demonstration period?	• Interrupted time series; multivariable logistic regression models • Descriptive comparison over time • Qualitative analysis • Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)
Implementation of Michigan's Behavioral Health Demonstration will improve care coordination and transitions in care for beneficiaries with SUD/OUD.	Does care coordination for beneficiaries with SUD increase over the demonstration period?	• Interrupted time series; multivariable logistic regression models • Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression) • Descriptive comparison over time • Qualitative analysis

Hypotheses	Primary Research Question	Analytic Approach
Implementation of strategies to improve care coordination and transitions in care will result in increased duration of SUD/OUD treatment.	Does the duration of SUD/OUD treatment increase over the demonstration period?	• Interrupted time series; multivariable logistic regression models • Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable regression)
Implementation of care coordination strategies will increase the receipt of primary care services during or after SUD/OUD treatment.	Does the proportion of beneficiaries with SUD/OUD who receive primary care services increase over the demonstration period?	• Descriptive comparison over time • Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)
Implementation of high-risk management strategies will result in decreased number of opioid fills among beneficiaries with OUD.	Does the average number of opioid fills among beneficiaries with OUD decrease over the demonstration period?	• Descriptive comparison over time • Qualitative analysis
Implementation of the demonstration will improve the health and well-being of beneficiaries with SUD/OUD.	Do beneficiaries with SUD/OUD report improved health and well-being over the demonstration period?	• Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable regression) • Descriptive comparison over time

The impact of CM will be measured through an evaluation that will be conducted over the course of the pilot. The hypotheses under consideration for the new authorities requested for this Demonstration for the RI Pilot are outlined in Table 2.

Table 2: Contingency Management Evaluation Components

Hypotheses	Evaluation Approach	Data Sources
The number of ED visits with StimUD and OUD as the primary reason will decrease.	Examine the number of ED visits with StimUD and OUD as the primary cause compared to number prior to launch of the Recovery Incentives Pilot	• Claims data
The number of repeat ED visits will decrease among beneficiaries living with StimUD and OUD if participating in the Recovery Incentives Pilot.	Examine rates of ED visits for beneficiaries participating in the Recovery Incentives Piot compared with rates prior to the Pilot	• Claims data
The number of adverse outcomes (e.g., deaths, overdoses) among beneficiaries living with StimUD	Examine the number of deaths and rates of overdoses among beneficiaries living with StimUD	• Claims data

Hypotheses	Evaluation Approach	Data Sources
and OUD will be lower relative to what they would have been in the absence of the Recovery Incentives Pilot.	and OUD who have participated in the Recovery Incentives Pilot and those who have not	• Death data from the MDHHS
SUD treatment retention rates will increase among beneficiaries living with StimUD and OUD who receive incentives.	Examine usage of SUD treatment services among beneficiaries participating in the Recovery Incentives Pilot	• Claims data • Patient-reported outcomes survey
The percentage of beneficiaries living with StimUD and OUD who participate in the Recovery Incentives Pilot will increase during the Demonstration period.	Examine participation in the Recovery Incentives Pilot for beneficiaries living with StimUD and OUD (contingent on benefit implementation and establishment of billing codes)	• Claims data
The rate of negative drug screens (stimulant-free biological tests) will increase among beneficiaries living with StimUD and OUD who participate in the Recovery Incentives Pilot.	Examine rates of positive and negative drug screens among beneficiaries living with StimUD and OUD, and who are participating in the Pilot.	• Data from CM vendor

Waiver & Expenditure Authority

MDHHS is requesting continued waiver and expenditure authority as approved in the current Demonstration. Additionally, new waiver and expenditure authorities are requested to operate the RI Pilot. Table 3 outlines the waiver authorities to be requested and Table 4 outlines the expenditure authorities to be requested.

Table 3: Demonstration Waiver Authorities

Waiver Authority	Use for Waiver	Currently Approved Waiver?
§ 1902(a)(1) Statewideness	To enable the State to provide contingency management as a pilot and on a geographically limited basis. Authority is requested through September 30, 2026.	No
§ 1902(a)(10)(B) and **§ 1902(a)(17)** Amount, Duration, and Scope and Comparability	To enable the State to provide contingency management services that are otherwise not available to all beneficiaries in the same eligibility group. Authority is requested through September 30, 2026.	No

Table 4: Demonstration Expenditure Authorities

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
Expenditures related to RI Pilot	Expenditure authority to provide CM through small incentives via gift cards to beneficiaries with qualifying StimUD or OUD. Authority is requested through September 30, 2026.	No
Residential Treatment for Individuals with SUD	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.	Yes
PIHP Services	Expenditures for all PIHP services, including case management and health education services that are not available to other Medicaid beneficiaries to the extent that not all services for categorically needy individuals will be equal in amount, duration, and scope. The State will ensure that all beneficiaries use a specific regional PIHP and will restrict disenrollment from them. The State is also granted the authority to restrict freedom of choice of provider for the Demonstration eligible population.	Yes

Public Hearings

MDHHS will host two hearings at which the public may provide comments.

	Public Hearing #1	Public Hearing #2
Date	Wednesday, February 28, 2024	Friday, March 1, 2024
Time	1 p.m. – 3:30 p.m.	12 p.m. – 1:30 p.m.
Venue	Virtual/Teleconference: Phone only option: (248) 509-0316 ID: 822 584 861#	Library of Michigan & Historical Center 1st Floor Forum 702 W. Kalamazoo Street Lansing, MI 48933 Link to online access available upon registration.

Hearing Link	https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting?rtc=1 Meeting ID: 287 623 829 036 Passcode: AXgGGs	https://us06web.zoom.us/meeting/register/tZ0ufu-rqDMpHtWX5dhM3n1-V-zt0T0Az98V Meeting ID: 893 9636 8341

Written Public Comments

MDHHS will also accept written public comments until 5:00 p.m. EST on March 20, 2024. Written comments may be sent via email to: mdhhs-bhdda@michigan.gov. Please include “Behavioral Health 1115 Demonstration Extension” in the subject line. Additionally, comments may be mailed to MDHHS/Behavioral and Physical Health and Aging Services Administration, Program Policy Division, PO Box 30479, Lansing MI 48909-7979.

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March 6, 2024

Keith White, Director
Actuarial Division
Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health and Human Services

RE: 1815 Inpatient Psychiatric Tiered Rate Proposal

Mr. White:

Bay-Arenac Behavioral Health Authority (BABHA) is a community mental health services program (CMHSP) that provides services to nearly 5,000 residents a year from Bay and Arenac Counties. BABHA is part of the Mid State Health Network (MSHN) Prepaid Inpatient Health Plan (PIHP) region comprising 12 CMHSPs and 21 counties.

The Michigan Department of Health and Human Services (MDHHS) Behavioral and Physical Health and Aging Services Administration convened a Stakeholder Group to operationalize Section 1815 of the current year Appropriation Act which reads in part as follows:

> *"From the funds appropriated in part 1 for health plan services, Healthy Michigan plan, and hospital services and therapy, the department shall allocate $20,000,000.00 in general fund/general purpose revenue and any associated federal match to increase Medicaid reimbursement rates.* ***The rates shall be increased in both of the following areas: (a) $8,000,000.00 in general fund/general purpose revenue and any associated federal match to increase inpatient psychiatric base rates.*** *(b) $12,000,000.00 in general fund/general purpose revenue and any associated federal match to increase Medicaid reimbursement rates paid to level I and level II designated trauma facilities to recognize increased cost in maintaining level I or level II trauma status."*

Please also note that the goal as subsequently defined by the 1815 Stakeholder Group itself is much more detailed than a straightforward increase of inpatient psychiatric rates within a capitated payment methodology and would actually require significant changes as to how all public inpatient services are currently negotiated and reimbursed:

> ***"Use of a tiered rate methodology to provide a standardized approach to payment increases that incentivize provision of inpatient psychiatric care with enhanced staffing levels and improve access to care"***

BABHA appreciates the commitment of MDHHS to provide important leadership to this process and improve the access to psychiatric inpatient care in our communities, similar to the implementation of the inpatient bed registry several years ago. The inclusion of representatives from inpatient hospitals in this stakeholder process is also a very important component of identifying any tangible long term solutions.

In addition BABHA also recognizes the intention of MDHHS to implement these proposals within the existing PIHP and CMHSP contractual and statutory requirements.

It is also clear from the MDHHS 1815 proposals released as of February 2024 that many strategies and options have been considered during these deliberations. Moreover, the expanded goals of incentivizing both the provision and access to inpatient care is commendable. Unfortunately, the proposals in their current form are unlikely to accomplish these objectives because they fail to address the core problem currently faced in Michigan: limited supply of inpatient hospital beds and expanding public demand for these services.

BABHA has negotiated increases in inpatient hospital rates for several years due to community demand AND difficulty recruiting hospital professional staff. Although overall psychiatric hospitalization was reduced during the 2020-2022 Pandemic years, we have experienced a tremendous amount of post-COVID service rebound since the beginning of FY2023. This has dramatically increased our inpatient hospitalization expenses nearly 37% since October 2022 and has yet to plateau. Much of this is related to the fact that more persons than ever have mental health commercial benefits but are unable to access their network providers in the area due to professional staffing shortages. This is compounded by the historically non-competitive rates commercial health plans often pay for mental health care. These persons ultimately are unable to access mental health services until becoming eligible for the CMHSP urgent or emergent care through a subsequent inpatient hospital admission.

As BABHA has responded to these market conditions and increased hospital reimbursement rates, another consideration further complicates this issue: inpatient psychiatric hospitals as health care providers do not have the same inherent public safety obligations to their communities as a CMHSP under the law. The hospital may always default to a simple cost-benefit analysis (assuming they have available direct care staff in the first place) that it may actually be more financially advantageous for the hospital to leave the bed open or accept someone with lesser needs than admitting a challenging public patient.

BABHA has experienced this result even when significant rate adjustments are offered to compensate the hospital's increased risk. The tiered rate concept does NOT change that basic calculation. The hospital will still have the negotiating leverage of supply and demand. This is likely to increase PIHP and CMHSP expenses for higher acuity cases without actually improving access to inpatient services, ultimately defeating one of the primary goals in the workgroup's stated purpose.

Recommendations for Consideration

1. The establishment of a "minimum" rate for each tier will not increase access to inpatient services. Many CMHSPs already reimburse hospitals far above the proposed minimums discussed by the workgroup. In addition, I am unaware of any incidence in Bay or Arenac Counties that an inpatient hospital denied admission to a public patient because BABHA would

not reimburse at a sufficient rate. In fact, quite the opposite has occurred: local hospitals have refused to admit CMHSP consumers regardless of how much we have offered to compensate them for the care.

2. The establishment of a tiered rate structure in of in itself does not go far enough in improving access to inpatient care. Although formally recognizing different levels of inpatient care based on acuity is a positive direction, it will have minimal impact on actual access to inpatient services without two additional corollaries: **a) a fixed state-wide tier schedule that ALL CMHSPs and hospitals have to honor (similar to the autism rates) and b) requiring hospitals to admit public patients authorized by the CMHSP if a bed is available.** This will justify the increased hospital rates in the long term, reduce the number of public patients boarded in Emergency Departments and improve public safety.

3. As MDHHS has already defined the purpose of the workgroup beyond simply increasing the base capitation rates in areas of the state demonstrating more significant inpatient utilization issues, why is the Hospital Rate Adjuster (HRA) payment not being included in this proposed methodology? The HRA specifically shares the same objective of the workgroup: increasing access to mental health services in hospitals for Medicaid patients. A proposal that links inpatient hospitals to embracing both the tiered rate structure and future HRA payments force multiplies their incentive to serve our most complex public patients.

4. The implementation of the tiered rate schedule on a state-wide basis in the middle of an existing contract year seems premature without more comprehensive historical inpatient utilization data. A trend analysis over a longer period of time such as 2016-2023 would more likely account for both overall market and COVID variables in the data set. MDHHS is also encouraged to implement the final proposals to correlate with the state fiscal year to avoid overlap with non-comparable annual periods for future program evaluation. In addition, MDHHS might consider piloting the tiered rate schedule and related changes initially on a more limited geographic basis in order to determine if the anticipated inpatient outcomes are reflected in actual practice.

Thank you for the opportunity to comment on these important matters. We absolutely support the MDHHS effort to increase access to local inpatient psychiatric hospital care and are willing to assist in any way possible. If you have any questions regarding this correspondence, please contact me at (989) 895-2347.

Sincerely,

Christopher Pinter
Chief Executive Officer

cc: Joe Sedlock, CEO, MSHN
Robert Sheehan, CEO, Community Mental Health Association of Michigan