AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
FINANCE COMMITTEE MEETING

Wednesday, February 12, 2025 at 5:00 pm

Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

	Committee Members:	Present	Excused	Absent		Present	Excused	Absent	Others Present:
	Tim Banaszak, Ch				Pam Schumacher				BABH: Marci Rozek, Jennifer Lasecki, Chris Pinter, and Sara McRae
	Sally Mrozinski, V Ch				Pat McFarland, Ex Off				
	Jerome Crete				Robert Pawlak, Ex Off				
	Christopher Girard				Richard Byrne, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
	Kathy Niemiec								

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Investment earnings reports for period ending January 31, 2025 4.2) Bay Human Services 2024 Contract Cost Settlement 4.3) Finance February 2025 contract list 4.4) Earned Sick Time Act (ESTA) Implementation		4.1) Consideration of motion to refer the investment earnings reports for period ending January 31, 2025 to the full Board for information 4.2) No action necessary 4.3) Consideration of motion to refer the Finance February 2025 contract list to the full Board for approval 4.4) Consideration of motion to refer the Employee Handbook revisions regarding the ESTA to the full Board for approval

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	4.5) Fiscal Year (FY) 2025 Service, Revenue, & Expense Trends 4.6) FY 2026 Executive Budget Recommendation 4.7) Medicaid Guidelines for Protected Asset Limits		4.5) No action necessary 4.6) No action necessary 4.7) No action necessary
5.	Adjournment	M - S - pm	MA

Bay-Arenac Behavioral Health Authority
Estimated Cash and Investment Balances January 31, 2025

Balance January 1, 2025	8,251,674.27
Balance January 31, 2025	6,245,818.15
Average Daily Balance	5,885,708.31
Estimated Actual/Accrued Interest January 2025	16,822.04
Effective Rate of Interest Earning January 2025	3.43%
Estimated Actual/Accrued Interest Fiscal Year to Date	72,844.41
Effective Rate of Interest Earning Fiscal Year to Date	3.58%

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

Cash Available - Operating Fund

	Rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Beg. Balance Operating Funds - Cash,													
Cash equivalents, Investments		7,733,635	3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099
Cash in		4,835,627	19,658,739	13,131,069	13,733,115	3,521,802	21,031,319	18,649,095	11,484,363	12,579,941	20,255,107	13,201,840	11,895,758
Cash out		(9,401,946)	(16,716,214)	(13,094,320)	(14,391,408)	(7,959,163)	(17,914,080)	(16,135,454)	(12,277,820)	(13,159,621)	(16,962,838)	(14,017,688)	(13,903,259)
Ending Balance Operating Fund		3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099	5,777,598
Investments													
Money Markets		3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099	5,777,598
90.00													
180.00													
180.00													
270.00													
270.00													
Total Operating Cash, Cash equivalents, Invested		3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099	5,777,598
Average Rate of Return General Funds		4.05%	4.08%	4.08%	4.08%	4.08%	4.08%	4.08%	4.05%	3.70%	3.61%	3.57%	3.50%
		4.10%	4.24%	4.08%	4.05%	4.08%	4.05%	4.08%	3.72%	3.70%	3.52%	3.48%	3.30%
average		6,038,598	6,050,472	6,064,203	5,992,215	5,443,183	5,315,682	5,439,876	5,477,250	5,308,678	6,954,812	7,231,574	6,868,080

Cash Available - Other Restricted Funds

	Rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Beg. Balance-Other Restricted Funds -													
Cash, Cash equivalents, Investments		446,396	448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575
Cash in		1,773	1,903	1,850	1,919	1,865	1,935	1,943	1,828	1,803	1,675	1,684	1,645
Cash out													
Ending Balance Other Restricted Funds		448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575	468,220
Investments													
Money Market		448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575	468,220
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		448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575	468,220
Average Rate of Return Other Restricted Funds		5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	4.99%	4.84%	4.84%	4.84%	4.84%
		5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	4.84%	4.84%	4.84%	4.84%	4.84%
average		444,504	445,432	446,359	447,294	448,229	449,170	450,117	451,058	463,216	464,054	464,894	465,725
Total - Bal excludes payroll related cash accounts		3,615,485	6,559,912	6,598,512	5,942,137	1,506,641	4,625,816	7,141,400	6,349,771	5,771,894	9,065,837	8,251,674	6,245,818
Total Average Rate of Return		4.17%	4.20%	4.19%	4.19%	4.18%	4.19%	4.19%	4.17%	3.84%	3.71%	3.63%	3.58%

Bay-Arenac Behavioral Health
Finance Council Board Meeting
Summary of Proposed Contracts
February 12, 2025

			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	ES	**DBT Institute of Michigan** Extension of the Single Case Agreement for one BABHA individual	$1,200/day	Same	1/20/25-1/22/25	Y	N
2	N	**7CLingo** ASL Interpretation Services	$0	$125/hour + flat mileage fees depending on the distance	2/21/25 - ongoing	Y	N
3	N	**Maxim Healthcare Services, Inc.** Staffing for PDN services for one BABHA individual	$0	RN - $72.32/hour LPN - $61.44/hour	2/21/25 - 2/21/26 (auto-renews)	Y	New Provider
4	N	**Mercy Plus Healthcare Services** Staffing for PDN services for one BABHA individual	$0	RN - $72.32/hour LPN - $61.44/hour	2/21/25 - 9/30/25	Y	N
5	M	**Bay Human Services, Inc.** Increase the FY24 CLS Contract Maximum	$782,000	$846,265	10/1/23 - 9/30/24	Y	N
6	M	**Rose Hill Center, Inc.** Second BABHA individual moving into Kelly Community Center	$718.28	Same	2/12/25 - 9/30/25	Y	N
SECTION II. SERVICES PROVIDED BY THE BOARD (REVENUE CONTRACTS)							
7	N	**Mid-State Health Network** MOU for Clubhouse Spenddown Project. Funds available to address consumers' spenddown obligations	$0	$20,000	10/1/24 - 9/30/25	Y	N
SECTION III. STATE OF MICHIGAN GRANT CONTRACTS							
SECTION IV. MISC PURCHASES REQUIRING BOARD APPROVAL							
8	S	**Calm, Inc.** Access to mental healht wellness/mindfulness website 175 users	$5,460/year $2.60/user/month	Same	3/3/25-3/2/27	N/A	N
9	D	**The Doctors Company** Professional liability insurance, Dr. Roderick Smith	$5,021	$4,322	2/1/25-2/1/26	N/A	N

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:

EARNED TIME OFF

22.1 Earned Time Off (ETO)

Earned Time Off (ETO) is provided to all eligible full-time employees of BABHA. ETO is a combined paid leave benefit to be utilized for vacation, ~~sick (including up to 40 cumulative hours for qualifying leave events under the Michigan Paid Medical Leave Act)~~ and personal leave. (Please refer to the Section 22.11 Earned Sick Time Act for paid sick time.) Planned use of ETO is encouraged to assist employees with balancing work and home life. ETO is to be ~~——~~pre-approved by the supervisor whenever possible. The excessive use of unplanned ETO may impact an employee's ability to schedule vacations or take other planned time off.

22.2 Rate of Accrual

Full-time employees currently accrue Earned Time Off (ETO) at the following rate, provided, however, the employee's combination of hours worked and used banked ETO result in at least all scheduled hours being covered. Regular full-time employees working less than forty-(40) hours per week accrue ETO on a pro-rated basis provided, the employee's combination of hours worked and used banked ETO result in at least a pro-rated amount of paid days similar to that of a 40 hour a week employee. Eligible employees who were previously, but no longer, subject to a negotiated CBA shall accrue ETO at the following rate effective January 1, 2020 based on eligible years of service with BABH, as approved by the BABH Board of Directors.

Employees may be eligible to accrue ETO as follows:

First Year	160 hours (20 days)
Years 2-9	232 hours (29 days)
10 or more Years	264 hours (33 days)

22.3 Accumulation of ETO

Accumulation of ETO is limited; that is, the amount carried forward may not exceed eight hundred forty (840) hours. Hours above this amount will be forfeited and are not compensable.

When an employee's continuous length of service reaches a point entitling him/her to the next higher rate of ETO accrual, earning at the new ETO rate will begin with the payroll period that includes his/her date of employment.

Employees shall receive ETO on the basis of their normal work week and at the rate of pay prevailing at the time the ETO is taken.

The amount of ETO available for use ~~will be reflected on the employee's most recent pay stub~~ is available to view in the time and attendance system.

22.4 Probationary Period

Probationary employees shall accrue ETO as outlined in "Rate of Accrual" above.

22.5 Temporary

Temporary employees shall not be entitled to ETO.

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22.6 Separation

Currently, upon retirement, death, layoff, or voluntary resignation, eligible employees shall be compensated for any accrued ETO hours at the rate prevailing on the employee's last working day. Effective October 1, 2018, eligible employees will receive payout of 50% of accrued ETO at voluntary separation (non-retirement) as long as 30 day written notice of resignation is received. Eligible employees retiring under the terms and conditions of Bay-Arenac Behavioral Health and the Bay County Employees' Retirement System, layoff or death will receive 100% payout of accrued ETO. Payment of ETO upon voluntary resignation or retirement is further contingent upon the employee's return of all agency property issued to, or in the possession of the employee, including, but not limited to, keys, ID badge, computer equipment, cell phone, etc. ETO is not authorized once notice of resignation is made unless pre-approved prior to notice of resignation and/or the employee provides verification of incapacity to perform work from a physician**.** Employees who are discharged are not eligible for payout of accrued ETO. Terminal ETO shall not be added to an employee's length of service.

Failure to return all agency issued property at the time of separation will be considered theft and will be reported to the local police department.

22.7 Holiday

If an observed holiday falls within an employee's ETO, it shall not be counted as an ETO day unless the employee was scheduled to work on a holiday.

22.8 Leave of Absence

ETO shall not accrue during periods of leave of absence.

22.9 ETO Schedules

ETO schedules for employees shall be developed and approved by his/her Supervisor. Each supervisor shall schedule ETO over as wide a period as possible in order to maintain required services. Employees are to seek written pre-approval from their immediate supervisor prior to scheduling time off. ETO may be taken in increments of one-quarter (1/4) hour with advance approval of the supervisor. (Banked ETO must be utilized prior to requesting leave without pay.) ETO requests are not guaranteed and may be denied based on program need and/or outstanding work assignments.

Employees who request leave without pay must submit their request, including reasons for the request, through the chain of command to the Chief Executive Officer for approval. Denial of the request and/or the use of leave without pay due to poor attendance will subject the employee to disciplinary action as referenced within this handbook.

22.10 Verification of Illness

a) Eligible employees may ~~Utilization of~~ utilize ETO due to illness if the employee has exhausted ESTA hours or does not have accrued ESTA available~~ may require verification from a physician as determined by the Employer~~.

~~b) An employee who is unable to work more than five (5) consecutive scheduled workdays must present a physician's release to return to his/her regular job duties.~~

~~c)~~b) In the absence of available ESTA, ~~-~~ETO may be used for injury or illness of an employee or a member of his/her immediate family that necessitates his/her absence from work. Immediate family is defined in the ESTA and FMLA sections of the Employee Handbook. ~~as the employee's spouse, parents, children, or other current family members for whom the~~

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~~employee is principally responsible for their financial/physical care.~~ ETO may also be utilized for appointments with doctors, dentists, or other recognized practitioners to the extent of time required to complete such appointments in the absence of available ESTA.

~~d)~~c) Employees returning to work from an illness or leave of absence of more than three (3) days may be required by his/her department head to submit a statement from his/her physician qualifying his/her ability to work or to verify the illness.

~~e) Personnel taking ETO on their last scheduled day of work before a holiday and/or ETO, on their first scheduled day after a holiday or ETO, may be required to submit a statement from their physician verifying the illness. It shall be the employee's responsibility to check with his/her department head when calling in to determine if the statement is necessary.~~

~~f)~~d) ~~In the event of a dispute involving an employee's physical or mental ability to perform his/her job or to return to work after a leave of absence of any kind and the Employer is not satisfied with the determination of the employee's doctor, the Employer may require a report from a medical doctor of the Employer's choosing at the Employer's expense if not covered by the employee's insurance. If the dispute still exists, the Employer's doctor and the employee's doctor shall agree on a third doctor to submit a report to the Employer and the employee. Any expense of the third doctor shall be borne equally by the Employer and the employee, if not covered by the employee's health insurance~~.

~~22.11 Paid Medical Leave Act Leave~~

~~Eligible Employees as defined under the Michigan Paid Medical Leave Act, 2018 PA 369 (the "MPML Act"), who are not eligible for ETO under this Policy may be eligible to receive paid medical leave as provided and required by the MPML Act. Posters from the Department of Licensing and Regulatory Affairs have been posted by the BABHA, setting forth the eligibility requirements, medical leave rights and remedies under the MPML Act. This may currently include certain regular part-time BABHA employees who work twenty-five (25) hours per week on average, but are who are not eligible for ETO as defined in this Policy. In addition, the following parameters apply to MPML Act paid medical leave:~~

~~a. MPML Act paid medical leave may only be taken by eligible employees for the reasons set forth in the MPML Act. BABHA employees eligible to participate in ETO are not eligible for additional MPML Act paid medical leave, even if ETO leave has been exhausted by the employee;~~

~~b. Eligible Employees shall accrue MPML Act paid medical leave at the rate of one (1) hour for every thirty-five (35) hours worked for a maximum cumulative accrual of one (1) hour per week and forty (40) hours during the benefit year. Accumulation of MPML Act paid medical leave is limited; that is, the amount carried forward may not exceed forty (40) hours. Hours above this amount will be forfeited and are not compensable. MPML Act paid medical leave is not compensable upon separation of employment;~~

~~c. Newly hired Eligible Employees may utilize accrued MPML Act paid medical leave as it is reflected on the employee's most recent pay stub.~~

~~d. MPML Act paid medical leave must be used in fifteen minute increments; and,~~

~~e. Eligible Employees who request MPML Act paid medical leave must submit a request to their immediate supervisor or designee, including reasons for the request.~~

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~~Utilization of MPML Act paid medical leave due to qualifying illness may require verification from a physician as determined by BABHA and is subject to the provisions of Sections 22.10(a) (b), (d) and/or (e) of this Policy. Eligible Employees will be provided no less than three days to provide such documentation.~~

22.11 Earned Sick Time Act (ESTA)

Effective February 21, 2025 all employees, including full-time, part-time, seasonal, and temporary workers are eligible to accrue paid sick time. Employees will accrue one (1) hour of paid sick, time for every 30 hours worked. Current employees may begin using their accrued paid sick time as it accrues. Employees hired after February 21, 2025 may not begin using their accrued sick time until the ninetieth (90) calendar day after commencing their employment with BABH.

a. Employees who are exempt from the overtime pay requirements of the Fair Labor Standards Act, 29 USC 213(a)(1), are assumed to work forty (40) hours per week unless the employee's normal work week is less than forty (40) hours, in which case earned sick leave time accrues based upon that normal work week.

b. When requesting the use of sick time, employees should provide sufficient information for the employer to determine whether the leave meets the eligible uses of the ESTA.

c. Employees can use earned sick time for any of the following reasons:

1. The employee's mental or physical illness, injury or health condition; medical diagnosis, care or treatment of the employee's mental or physical illness, injury, or health condition; or preventative medical care for the employee.

2. For the employee's family member's mental or physical illness, injury, or health condition; medical diagnosis, care or treatment of the employee's family members' mental or physical illness, injury or health condition; or preventive medical care for a family member of the employee.

3. If the employee or the employee's family member is a victim of domestic violence or sexual assault, for medical care or psychological or other counseling for physical or psychological injury or disability; to obtain services from a victim services organization; to relocate due to domestic violence or sexual assault; to obtain legal services; or to participate in any civil or criminal proceedings related to or resulting from the domestic violence or sexual assault.

4. For meetings at a child's school or place of care related to the child's health or disability, or the effects of domestic violence or sexual assault on the child; or

5. For the closure of the employee's place of business by order of a public official due to a public health emergency; for an employee's need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency; or when it has been determined by the health authorities having jurisdiction or by a health care provider that the employee's or employee's family member's presence in the community would jeopardize the health of others because of the employee's or family member's exposure to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease.

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d. For the purposes of this policy, "family member" includes all the following:

1. Biological, adopted or foster child, stepchild, or legal ward, a child of a domestic partner, or a child to whom the employee stands in loco parentis.

2. Biological parent, foster parent, stepparent, or adoptive parent or a legal guardian of an employee or an employee's spouse or domestic partner or a person who stood in loco parentis when the employee was a minor child.

3. A person to whom the employee is legally married under the laws of any state or a domestic partner.

4. A grand parent.

5. A grandchild.

6. A biological, foster or adopted sibling.

7. Any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

e. For earned sick leave of more than three consecutive days, the employer may require reasonable documentation that the earned sick leave has been used for a permissible purpose. Upon request, the employee must provide this documentation in a timely manner.

1. Employer required documentation should not include a description of the illness or details of the violence.

a. Documentation signed by a health care professional indicating that earned sick time is necessary is reasonable documentation for purposes of this subsection. Documentation providing details of the nature of the illness is not required.

b. In cases of domestic violence or sexual assault, one of the following types of documentation selected by the employee shall be considered reasonable documentation:

i. a police report indicating that the employee or the employee's family member was a victim of domestic violence or sexual assault;

ii. a signed statement from a victim and witness advocate affirming that the employee or employee's family member is receiving services from a victim services organization; or

iii. a court document indicating that the employee or employee's family member is involved in legal action related to domestic violence or sexual assault.

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2. If the employer requires documentation, the employer is responsible for paying all out-of-pocket expenses the employee incurs in obtaining the documentation.

3. Commencement of use of sick time will not be delayed while awaiting documentation.

e. Unused, accrued paid sick time will be carried over into the next benefit year without a maximum. However, only a maximum of 72 hours of accrued sick time can be used in a calendar year (January 1st – December 31st). Sick time will be paid at the employee's regular rate of pay. If any employee is paid for sick leave which is subsequently denied, the overpayment may, as permitted by law, be deducted from the employee's next paycheck and/or future paychecks.

f. All unused, accrued sick time will be forfeited at the time of separation (unless the employee is reinstated within 6 months).

g. The use of paid sick leave must be approved by the employee's supervisor. Employees are asked to provide notice no more than 7 days in advance but no less than one hour before your scheduled start time, if they are aware of the need to use sick time if the absence is foreseeable. If the need for sick time is not foreseeable, notification should occur as soon as reasonably practicable. If the employee's absence due to illness or injury exceeds the amount of accrued paid sick leave, the employee must seek and obtain approval for other leave such as Family Medical Leave or ETO.

h. Employees will not be penalized or retaliated against in any way for requesting or using accrued paid sick time for the purposes designated above. Retaliatory actions against an employee for requesting or using paid sick leave time is prohibited. If an employee believes that the Employer has violated this Policy, that employee may bring a civil action or file a complaint with the Michigan Department of Licensing and Regulatory Affairs.

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Additional Sections requiring revision due to the Earned Sick Time Act:

CONTINUOUS LENGTH OF SERVICE

9.1 Definition

Continuous length of service for a Bay-Arenac Behavioral Health employee is that period of employment with the agency that is continuous and unbroken. However, length of service may be defined differently by action of the Board of Directors, or applicable benefit plan document, or as required or approved as to eligibility for wages or fringe benefit programs.

Continuous service is not recognized until the employee attains the status of a regular employee, at which time his/her length of service shall include the period of his/her probationary period.

Regular part-time employees are given half credit for continuous length of service if it immediately precedes regular full-time employment regardless of the number of hours actually worked. Regular full-time service is given full credit towards regular part-time service.

Time spent on approved paid leaves of absence shall be included in continuous length of service.

Continuous length of service for layoff purposes does not continue to accrue if the employee is on workers' compensation, Family and Medical Leave, disability leave [Short-Term Disability (STD) and Long-Term Disability (LTD)] or any unpaid leave. Earned Sick Time (ESTA) and Earned Time Off (ETO) will not accrue during such leaves.

9.2 Resignation

To be eligible for payment of accrued ETO, employees who intend to resign must provide their supervisor with at least thirty (30) calendar days written notice of their intention to resign. Resigning employees must provide the required thirty (30) calendar days written notice and must return all agency property issued to them or in their possession, including keys, ID badge, computer equipment, cell phone, etc., to be entitled to any payment of accrued ETO. Effective October 1, 2018, eligible employees voluntarily separating (non-retirement) will receive payment of 50% of accrued ETO as long as required thirty (30) calendar days written notice of resignation is received and all agency issued property is returned. ETO is not authorized once notice of resignation is made unless pre-approved prior to notice of resignation and/or the employee provides verification of incapacity to perform work from a physician**.** The Chief Executive Officer may waive the thirty (30) day notice requirement. All unused, accrued Earned Sick Time (ESTA) will not be paid out at the time of separation.

16.17 Overtime

Non-exempt employees of Bay-Arenac Behavioral Health that are subject to the overtime provisions of the Fair Labor Standards Act ("FLSA") shall be paid overtime compensation at the rate of time and one-half (1-1/2) of regular rate of pay for all hours actually worked in excess of forty (40) hours worked in a work week. (Workweek is defined as seven (7) consecutive twenty-four hour periods from Monday through Sunday). If ETO, ESTA, or paid holidays are included in the payroll week during which overtime is worked, ETO and/or ESTA will be adjusted and may be banked. Overtime pay is only authorized for hours **actually** worked in excess of forty (40) per week. Overtime work must receive prior authorization by the appropriate

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supervisor/CEO. Employees that are exempt from the overtime provisions of the ("FLSA") are not eligible for, and will not receive, overtime pay as defined here.
All overtime work must receive prior authorization by the appropriate supervisor. All emergencies or unforeseen problems resulting in overtime must be reported to the appropriate supervisor and CEO for approval on the following workday.

Salary exempt employees are not entitled to overtime pay.

16.22 Agency Closure

In the event that BABH closes due to inclement weather or other unforeseen circumstances, employees who are actively working will be compensated through the end of their regularly scheduled shift. This time will be recorded as "weather" on the time sheet.

Employees in 24/7 operations who are required to work regardless of whether the agency closes will be compensated for actual hours worked. Such employees will bank earned time off (ETO) for the time worked through the duration of the weather closure.

Employees who are on approved ETO or ESTA on a day that the agency closes will be paid ETO or ESTA hours as scheduled.

If it is pre-announced that Bay-Arenac Behavioral Health is closed and staff are instructed not to report to work, employees will receive compensation for their full scheduled shift. This time is recorded under "weather" on the time sheet.

18.5 Time Worked

All agency personnel are required to begin work at their scheduled starting time and continue to their scheduled quitting time. For FLSA non-exempt employees, time late or the time involved in the case of early quit (except for sickness or other supervisor approved leave) shall not be paid as hours worked or by any other benefit. Tardiness or absenteeism will not be tolerated. The use of planned and unplanned leave will be monitored by the supervisor. Planned leave is defined as leave requested and approved with at least twenty-four (24) hours of advance notice. Excessive use of unplanned leave will result in disciplinary action, up to and including discharge from employment.

Employees classified as an exempt salaried employee will receive a salary which is intended to compensate the employee for all hours worked for BABH. This salary will be established at the time of hire or when the employee becomes classified as an exempt employee. While it may be subject to review and modification from time to time, such as during salary review times, the salary will be a predetermined amount that will not be subject to deductions based on the quantity or quality of the work performed.

Under federal and state law, an employee's salary is subject to certain deductions. Deductions may be taken from an exempt employee's salary as permitted or required by law. This would include, but is not limited to, the employee portion of health, vision, dental or life insurance premiums; state, federal or local taxes; social security; Bay County Employees' Retirement System; legal garnishments; and voluntary contributions to a retirement plan.

In addition, unless state law requires otherwise, an employee's salary can be reduced for the following reasons:

- When an exempt employee is absent from work for one or more full days for personal

DRAFT

reasons other than sickness or disability;

- When an exempt employee is absent for one or more full days due to sickness or disability if the deduction is made in accordance with a bona fide plan, policy or practice of providing compensation for salary lost due to illness (ETO/ESTA);
- When an exempt employee does not perform any work during a workweek;
- For unpaid disciplinary suspensions of one or more full days imposed in good faith for workplace conduct rule infractions of major significance;
- For penalties imposed in good faith for infractions of safety rules of major significance;
- For weeks in which an exempt employee takes unpaid leave under the Family and Medical Leave Act; and
- An employer is not required to pay the full salary in the initial or terminal week of employment. In these circumstances, either partial day or full day deductions may be made.

If an exempt employee believes he/she has been subject to any improper deductions, he/she should immediately report the matter to Human Resources. Reports of improper deductions will be promptly investigated. If it is determined that an improper deduction has occurred, the employee will be promptly reimbursed for any improper deduction made.

20.9 Workers' Compensation

BABH provides workers' compensation coverage as provided by Michigan State statute. FMLA runs concurrently with an employee's Workers Compensation time off the job. The affected employee must report all on-the-job injuries on the appropriate form by the end of the workday of the alleged injury. Failure to properly report an injury may disqualify an employee for benefits. The injured employee's supervisor shall forward the accident report to the Human Resources Director with a copy to the respective designated manager or department head immediately upon receipt. The supervisor is responsible for assuring that all witnesses receive and complete the accident investigation report.

Examination: If the injured employee requires or requests medical attention, the supervisor shall contact Human Resources to make immediate arrangements for the employee to be evaluated and treated, if necessary, by the medical authority designated by the Board.

Pay Status: An employee who is injured during the course of his/her employment shall be paid for all hours scheduled to work on the date of the injury. If the employee is unable to work, workers' compensation shall begin on the eighth calendar day from the date of injury/illness. The first seven (7) calendar days, or five (5) workdays, subsequent to the date of the injury shall be subject to Earned Time Off or Earned Sick Time (ESTA), if requested by the employee.

If the injured employee is unable to work for fourteen (14) calendar days following his/her accident, workers' compensation shall be made retroactive to the first full day of absence. If such occurs and the employee received pay for any of the five (5) working days subsequent to the date of injury, his/her leave time will be reinstated to be utilized at a later date and his/her paycheck will be reduced accordingly.

The employee shall remain in communication with the employer concerning the nature of the disability and expected date of return. The employee will not be permitted to return to work without medical evidence of his/her ability to do so.

DRAFT

Health insurance shall continue for one (1) year for non-probationary employees and three (3) months for probationary employees when they are receiving workers' compensation benefits. During this time, the Employer portion of premium may continue at agency expense. The employee continues to be responsible for their employee share of monthly premium. No other benefits, including ETO and ESTA, shall accrue or continue.

LEAVE OF ABSENCE

24.1 Procedure

All leaves of absence shall be without pay unless otherwise provided herein. Employees shall submit requests for leaves of absence to the department head who shall have disapproval authority. If the department head desires to secure approval of the request, it shall be forwarded to the Chief Executive Officer (CEO) for consideration.

24.2 Approval

All leaves of absence must be requested from and approved by the CEO.

24.3 Family and Medical Leave

It is intended that the Employer's policy concerning leaves of absence will comply with the Family and Medical Leave Act of 1993 (FMLA).

1. FMLA Leave. An eligible employee who has completed twelve (12) months of employment and worked at least 1250 hours in the past twelve (12) months may request an unpaid leave of absence for a period not to exceed twelve (12) weeks in any twelve (12) month period measured forward from the date the employee's first FMLA leave begins. The Employer reserves the right to place an employee on FMLA leave for absence related to the conditions set forth below. Unless leave is taken for the employee's own serious health condition, the total leave taken by spouses both employed by the Employer is limited to twelve (12) weeks. Employees are required to complete FMLA paperwork for any leave (paid or unpaid) related to the reasons below.

   The request must be in writing, must give the reason for the request and must give the expected duration of the leave. The leave may be taken for the following reasons:

   a. A serious health condition that makes the employee unable to perform the functions of his/her position;

   b. In order to care for the employee's spouse, child or parent if the person being cared for has a serious health condition;

   c. Because of the birth of a child of the employee and in order to care for the child within twelve (12) months of the child's birth;

   d. Because of the placement of a child with the employee for adoption or foster care and in order to care for the child within twelve (12) months of the child's placement;

   e. For any "qualifying exigency" (as defined by the Secretary of Labor)

DRAFT

arising out of the fact that the spouse, son, daughter or parent of any employee is on active duty (or has been notified of an impending call order to active duty) in the Armed Forces in support of a contingency operation.

f. To care for a covered family member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grade, rank or rating.

2. Qualified employees may request a single leave of up to a total of 26 weeks of Family and Medical Leave for the following reason:

   If the employee is a spouse, son, daughter, parent or next of kin of a covered service member and requires leave to care for a "covered service member" who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

   a. A "covered service member" is a member of the Armed Forces, including the National Guard and Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for an injury or illness incurred by the member in the line of duty <u>on active duty</u> that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

   b. "Next of kin" is defined as the closest blood relative of the injured or recovering service member. "Next of kin" may include (1) un-remarried surviving spouses; (2) natural and adopted children; (3) parents; (4) remarried surviving spouses (except those who obtained a divorce from the service member or who remarried before a finding of death by the military); (5) blood or adoptive relatives who have been granted legal custody of the service member by court decree or statutory provisions; (6) brothers or sisters; (7) grandparents; (8) other relatives of legal age in order of relationship to the individual according to the civil laws; or (9) persons standing in loco parentis to the service member.

   c. The leave provided under this provision is combined with that set forth above, for a combined total of 26 weeks of FMLA leave during a single 12-month period. This means that if an employee also has some other FMLA-qualifying even in that 12-month period (for example, birth of a child, or the employee's own serious health condition), his or her total amount of FMLA leave during that 12-month period is still limited to 26 weeks. This also means that even if the service member's recovery lasts longer than the initial 12 months, the 26 weeks of service member FMLA cannot be "renewed", and the employee would not be eligible for an additional 26 weeks of service member FMLA in the following 12-month period.

   BABH may require a certification by the service member's health care provider.

3. Intermittent Leave. Unless the Employer agrees, leave for the birth or placement of the employee's child, or to care for the child within twelve (12) months of the child's birth or

DRAFT

placement, may not be taken intermittently or on a reduced leave schedule. If medically necessary, leave for the employee's serious health condition or to care for a seriously ill spouse, child or parent may be taken intermittently or on a reduced leave schedule.

4. Substitution of Paid Leave. Prior to taking unpaid leave, employees must use Earned Sickt Time (ESTA) or Earned Time Off (ETO) for leave taken for the employee's serious health condition or to care for a seriously ill spouse, child or parent. Prior to taking unpaid leave, an employee must use ESTA or ETO for leave taken for the birth or placement of the employee's child, or to care for the child within twelve (12) months of the child's birth or placement. The use of paid leave will not extend an employee's FMLA entitlement. When an employee is eligible to and is approved to receive paid disability leave the employee may not be required to substitute paid leave in accordance with disability policy statements.

5. Scheduling and Notice by Employees. When leave is taken for the birth or placement of the employee's child or to care for the child within twelve (12) months of the child's birth or placement, and the leave is foreseeable based on the expected birth or placement, the employee must provide not less than thirty (30) days' notice before the date the leave is to begin. If the date of the birth or placement requires the leave to begin in less than thirty-(30) days, the employee must provide such notice as is practicable.

   When leave is taken for the employee's serious health condition, or to care for a seriously-ill spouse, child or parent, and the leave is foreseeable based on planned medical treatment, the employee must make a reasonable effort to schedule the treatment so as not to unduly disrupt the employer's operations. The employee must provide not less than thirty (30) days' notice before the date the leave is to begin. If the date of treatment requires leave to begin in less than thirty-(30) days, the employee must provide such notice as is practicable.

6. Medical Certification. When leave is taken for the employee's serious health condition, or to care for a seriously-ill spouse, child or parent, the Employer will require certification issued by the health care provider of the employee or of the spouse, child or parent of the employee, as appropriate. This certification must include the date the condition began, its probable duration, appropriate medical facts within the knowledge of the health care provider regarding the condition, and a statement that the employee is unable to perform his/her job function or is needed to care for a sick family member for a specified time.

   For leave taken intermittently or on a reduced leave schedule, further certification requirements are as follows:

   a. When there is planned medical treatment, the certification must include the dates on which treatment is expected and its duration.

   b. When leave is taken for the employee's serious health condition, the certification must include a statement of the medical treatment necessary for such leave and its expected duration.

   c. When leave is taken to care for a seriously ill family member, the certification must include a statement that such leave is necessary for the care of the family

DRAFT

member who has a serious health condition or will assist in his/her recovery, and the expected duration and schedule of the leave.

7. Second and Third Opinions; Recertification. The Employer may require, at its own expense if not covered by insurance, a second medical opinion from a health care provider designated by the Employer, but not employed on a regular basis by the Employer. In the event of a dispute concerning the second certification, the Employer may require, at its own expense if not covered by insurance, a third opinion from a health care provider. The employee and Employer must agree on the selection of the third health care provider whose opinion is binding on both parties. The Employer may require that the employee obtain subsequent recertification on a reasonable basis.

8. Benefits During Leave. The Employer will continue to pay the Employer's portion of an employee's health insurance premiums for an eligible employee during the period the employee is on leave for any of the reasons under Subsections 1(a)-1(f) above. The employee shall be responsible to pay his/her portion, if applicable, of health insurance premiums during the period the employee is on leave for any of the reasons under FMLA Subsections a-f above. If an employee's health insurance premium payment is more than 30 days late, the Employer upon 15 days' notice to the employee may cease to continue the employee's health insurance coverage if the employee does not pay his/her portion of health insurance premium prior to the specific time. The employee will not accumulate ETO, nor be paid for holidays that may fall during the period of unpaid leave. If the employee fails to return after the leave has expired due to circumstances within the employee's control, the Employer may recover from the employee any premiums that the Employer paid to maintain medical coverage during the leave.

9. Return Rights. Upon return from a leave taken for a reason listed under Subsection 1(a)-1(e) above, the employee will be returned to his/her former position or to a position equivalent in pay, benefits, and other terms and conditions of employment. In all other circumstances, the employee is not guaranteed that he/she will be restored to his/her former position or to an equivalent position. The decision will be at the discretion of the Employer.

24.4 Military Leave

The agency shall observe the provisions of the federal and state law regarding re-employment rights and leaves of absence in accordance with federal and state statutes.

24.5 Bereavement Leave

In the event of a death in the employee's immediate family (spouse, significant other, child, step-child, parent, step-parent, parent-in-law, grandparent, grandchild, son-in-law, daughter-in-law, brother or sister) an employee shall be allowed three (3) days off, one of which should be the day of the service, if scheduled on a normal work day, without loss of pay.

The Chief Executive Officer may authorize up to two (2) additional days of leave with pay if circumstances such as extensive travel require the employee to be absent. Extensive travel is defined as any distance over 300 miles one-way.

Bereavement leave is authorized for full-time and part-time employees

DRAFT

24.6 Jury/Witness Leave

A regular full-time and regular part-time employee who is summoned for jury duty, or who is subpoenaed as a witness to testify as to matters directly related to the employee's work for the agency, are eligible for jury/witness leave. Employees on jury/witness leave shall receive their regular scheduled pay and shall surrender the proceeds of their remuneration from the Court, except travel reimbursement, for those scheduled days of work.

To be eligible for jury/witness leave pay, the employee must give their supervisor, service director, and CEO advance written notice that he/she has been summoned or subpoenaed. After the trial, must provide the CEO with a written statement from the appropriate public official listing the dates the employee was required to serve on jury duty, or as a witness, and the amount of pay received for such service at those times. If a partial day is served, the employee must report to work for the remainder of the day.

24.7 Administrative Leave

An employee may be granted administrative leave not covered by the FMLA or other leave sections noted hereunder, at the Chief Executive Officer's sole discretion, for a period of up to one (1) year without pay and benefits (including health insurance). An eligible regular employee who has been granted a leave may not request a subsequent leave during the same calendar year and/or until 365 days after expiration of the expiration of the previously granted administrative leave.

All such leaves shall be specific in their duration and purpose.

Employees may not engage in gainful employment during an administrative leave, or any other authorized leave of absence granted by the agency, without prior written approval of the Chief Executive Officer.

Employees engaged in gainful employment during leaves of absence, without prior written approval of the Chief Executive Officer, will be considered voluntarily resigned.

24.8 Benefits

All personal leaves of absence shall be without pay and benefits. Employees may continue insurance coverage at their own expense during a personal leave of absence. An employee will not accumulate ETO, nor will be paid for holidays which may fall during the leave period.

24.9 Return from Leave of Absence

When granted a leave of absence, the employee commits himself/herself to returning to work immediately at the end of the leave. If an employee fails to return to work immediately at the expiration of a leave of absence or extension thereof, the failure to return shall be considered a resignation from agency employment.

DRAFT

Medicaid, Healthy Michigan, and Autism
Revenue and Expenditure Trends
FY 2024

PEPM Funding	Estimated FY25	FY 24	FY 23	FY 22	FY 21
Medicaid	48,116,068.04	48,505,584	45,008,334	45,509,427	45,227,598
HMP	3,855,421.12	3,991,865	6,216,452	5,848,365	5,599,888
Autism	7,041,375.24	5,978,518	4,739,058	4,299,855	4,798,051
SUD 24/7/365	210,000.00	210,000	210,000	210,000	210,000
Total Revenue	59,222,864	58,685,967	56,173,844	55,867,647	55,835,537
PEPM Increase from prior year	***0.9%***	***4.5%***	***0.5%***	***0.1%***	
4 year Increase	***6.1%***				

Expenditures	FY25 Estimated Expenses	FY24 Actual Expenses	***FY23 Actual Expenses	***FY22 Actual Expenses	FY21 Actual Expenses
Medicaid	48,954,796	50,652,241	47,148,496	44,738,032	42,895,542
HMP	7,739,627	6,491,168	6,361,799	5,033,474	5,093,168
Autism	12,315,047	11,633,429	9,744,027	7,812,056	6,648,895
	69,009,470	68,776,838	63,254,322	57,583,562	54,637,605
Expense Increase from prior year	***0.3%***	***8.7%***	***9.8%***	***5.4%***	
3 year Increase	***26.3%***				
Expenditures above/(below) PEPM	9,786,606	10,090,871	7,080,478	1,715,915	(1,197,932)

NOTES:

***Excludes staffing crisis stabilization funding that was paid out (FY23 $1.3M, FY22 $1.5M)

Community Mental Health Association of Michigan - Comparison of Actuarial Projected Funding versus Actual Funding Advances FY25

As of: 1/8/25

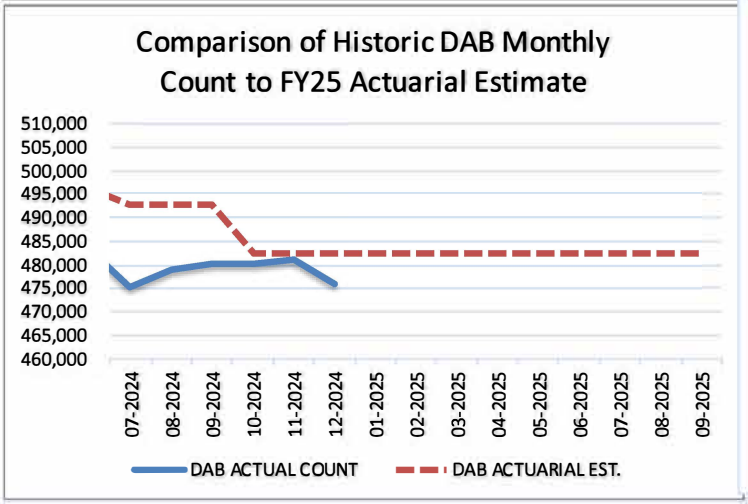
Funding per Date Comparison *	Actual Advanced on A YTD Basis	Actual Advanced on A YTD Basis	Number of Months of Advances	Year to Date Over+ & (Under -)	Percentage Advanced
DAB Capitation Behavioral Health	$ 535,900,000	$ 514,586,343	3	($21,313,657)	96.0%
DAB Capitation Substance Use Disorder	$ 10,775,000	$ 10,580,777	3	($194,223)	98.2%
TANF Capitation Behavioral Health	$ 98,050,000	$ 96,578,250	3	($1,471,750)	98.5%
TANF Capitation Substance Use Disorder	$ 11,600,000	$ 11,211,741	3	($388,259)	96.7%
HSW,CWP, & SED Payments	$ 171,750,000	$ 167,469,398	3	($4,280,602)	97.5%
HMP Capitation Behavioral Health	$ 78,750,000	$ 77,432,024	3	($1,317,976)	98.3%
HMP Capitation Substance Use Disorder	$ 37,325,000	$ 36,270,233	3	($1,054,767)	97.2%
Autism all Populations	$ 98,875,000	$ 98,206,750	3	($668,250)	99.3%
Total:	**$ 1,043,025,000**	**$ 1,012,335,516**	3	**($30,689,484)**	**97.1%**

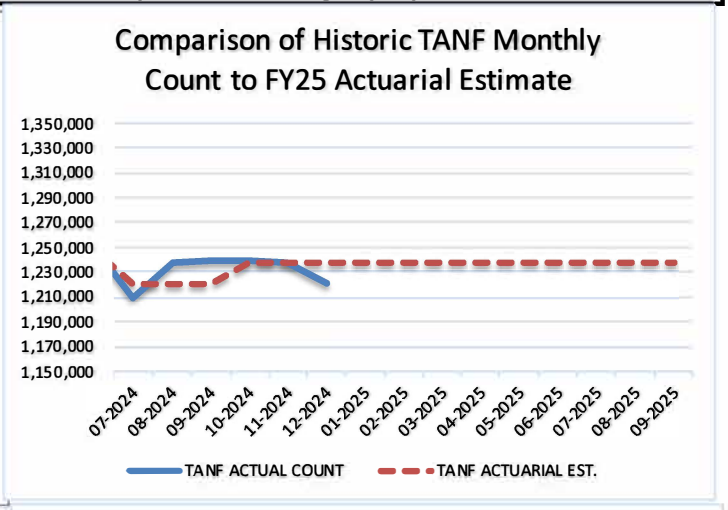
Capitation Populations	*Projected Per Certification Document	Actual Paid Census	Difference	As a Percentage	Aproximate Difference due to Population Counts
DAB Average Population per month	482,397	466,339	(16,058)	96.7%	($18,197,304)
TANF Average Population per month	1,237,340	1,232,198	(5,142)	99.6%	($455,701)
HMP Average Population per month	710,394	701,119	(9,275)	98.7%	($1,515,545)
HSW Average paid per month	7,322	7,205	(117)	98.4%	($2,744,435)

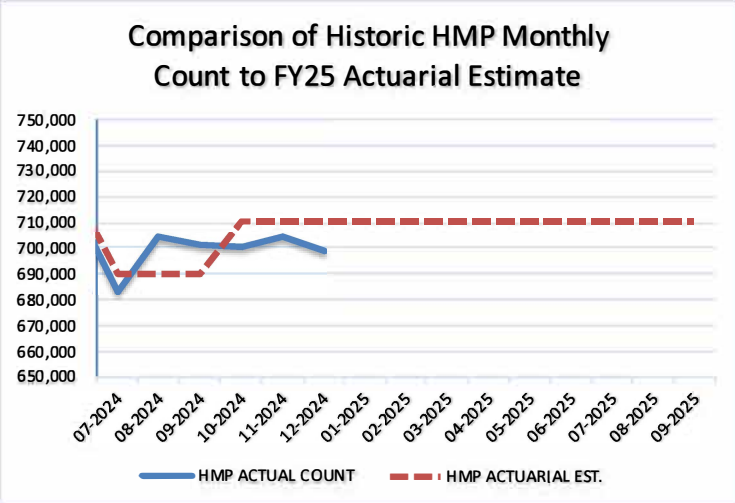
** Population projection is from appendix 5 of Capitation Rate Certfication Document*

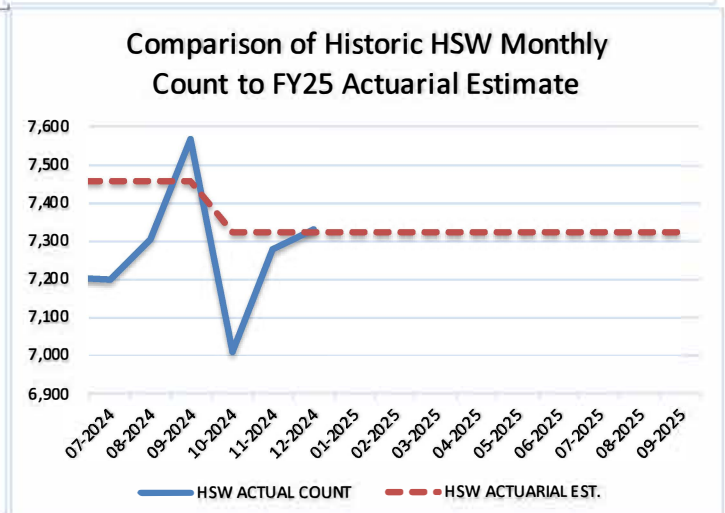
Capitation Population Average Rate per Month	Average Certification PM/PM Rate:	Average Rate Paid Per Member Month	Difference in Expected versus Actual	Percentage Paid rate is to Certification Rate:	Aproximate Funding Difference due to Rates
DAB Population:	$ 377.75	$ 375.38	($2.37)	99.4%	($3,310,576)
TANF Population:	$ 29.54	$ 29.16	($0.38)	98.7%	($1,404,308)
HMP Population:	$ 54.47	$ 54.06	($0.41)	99.3%	($857,198)
HSW Population:	$ 7,818.90	$ 7,747.83	($71.07)	99.1%	($1,536,167)

Charts begin with July 2024 which is the first month with no public health emergency impact









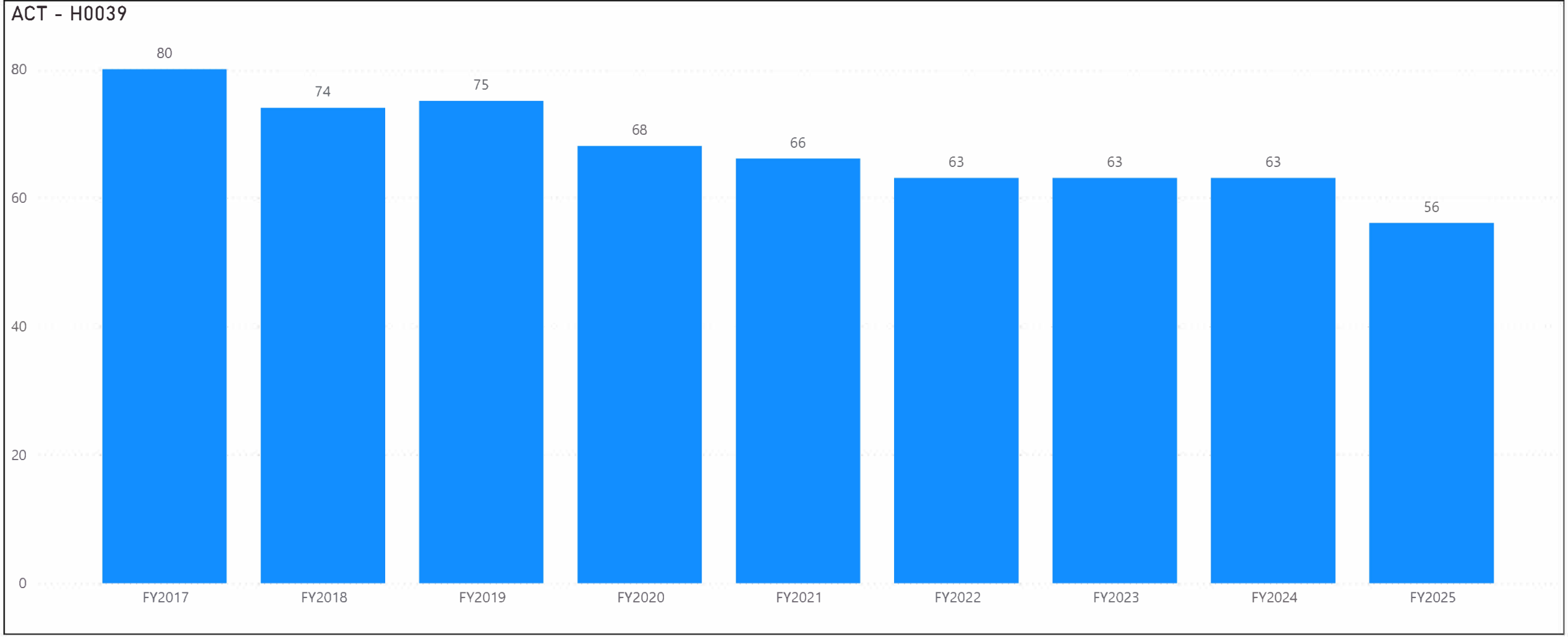
Microsoft | Power BI

Program Counts - By Fiscal Year

View in Power BI

Last data refresh:
2/4/2025 11:41:26 AM UTC

Downloaded at:
2/4/2025 9:42:19 PM UTC

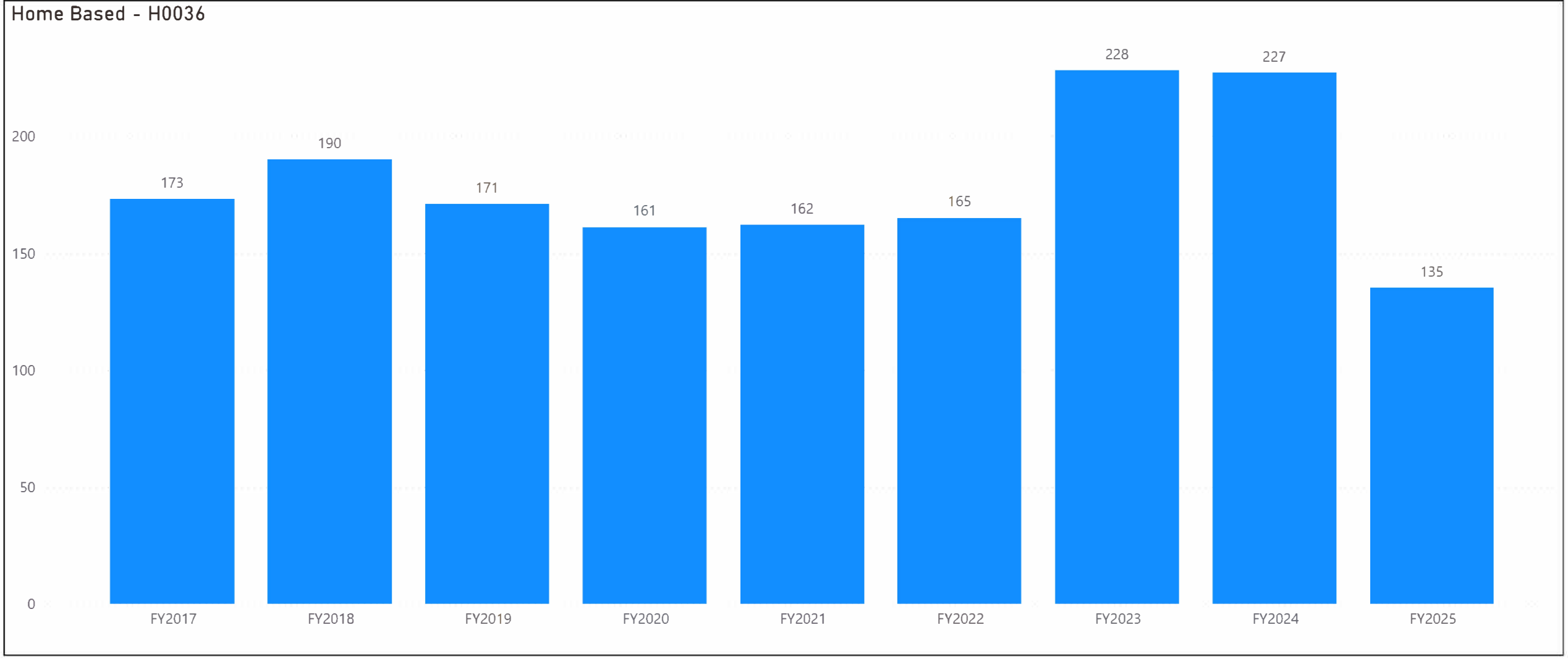


Procedure Code	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	**Total**
⊞ H0039	80	74	75	68	66	63	63	63	56	**146**
Total	**80**	**74**	**75**	**68**	**66**	**63**	**63**	**63**	**56**	**146**

The information above includes:
- All billable/(sent) encounters.
- Includes procedure code: H0039

REMOVED - Organization type is "Direct Program"

Home Based - H0036

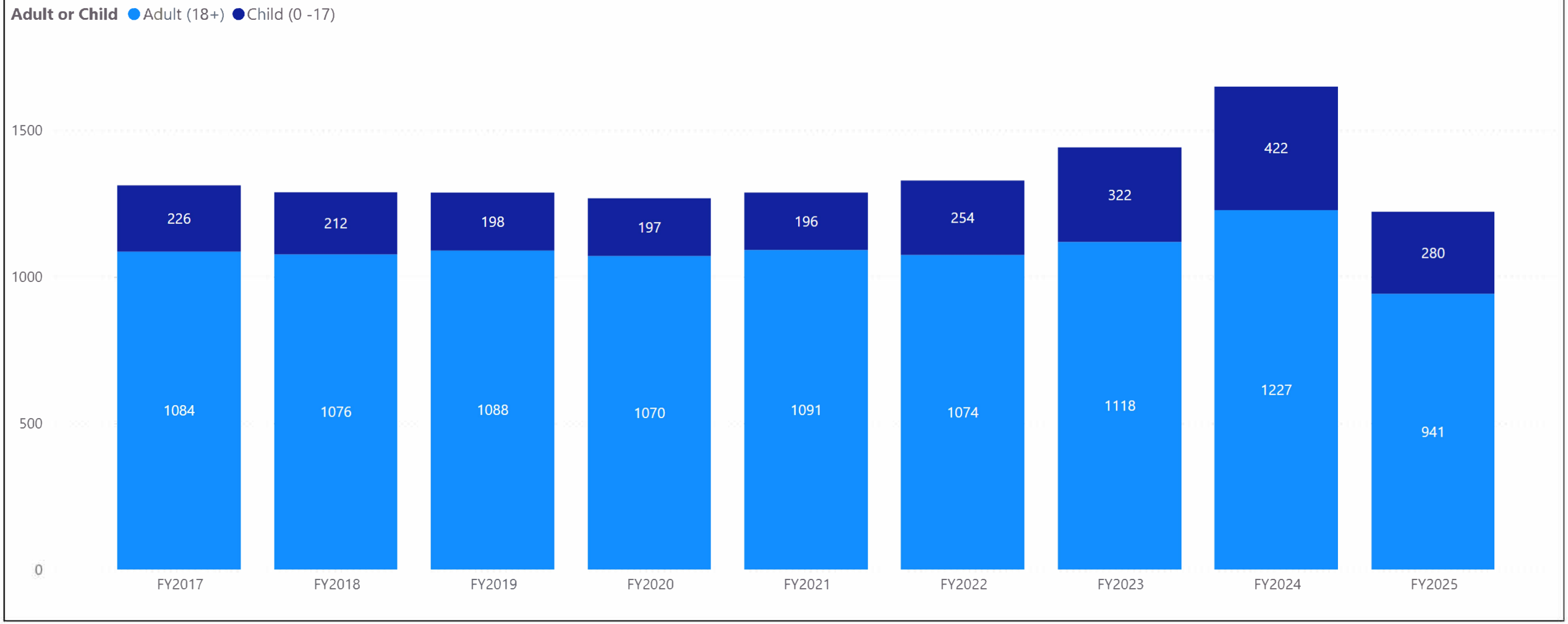


Procedure Code	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	**Total**
⊞ H0036	173	190	171	161	162	165	228	227	135	**732**
Total	**173**	**190**	**171**	**161**	**162**	**165**	**228**	**227**	**135**	**732**

The information above includes:

- All billable/(sent) encounters.
- Includes procedure code: H0036

Case Managment Services

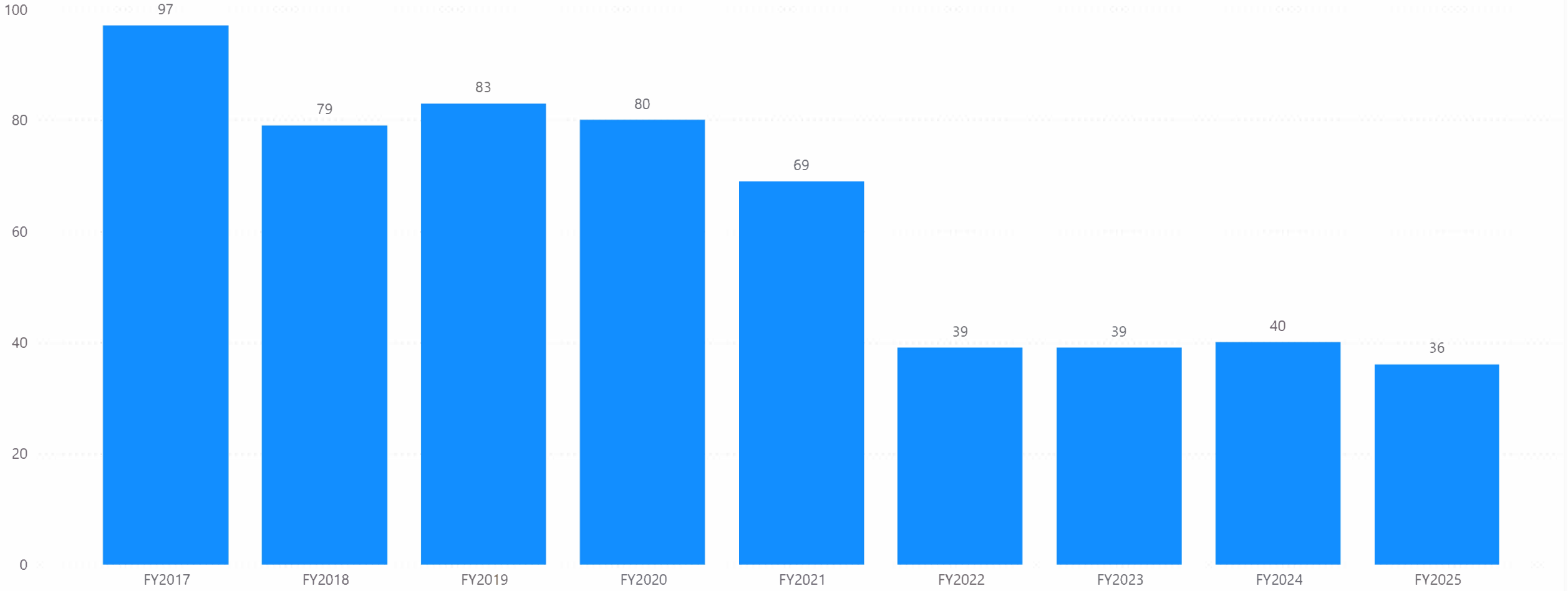


Procedure Code	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	**Total**
⊞ T1016	768	748	747	752	734					**1135**
⊞ T1017	593	596	589	578	621	1320	1430	1639	1221	**3387**
Total	**1303**	**1282**	**1277**	**1259**	**1278**	**1320**	**1430**	**1639**	**1221**	**3680**

The information above includes:
- All billable/(sent) encounters.
- Includes procedure codes: T1016, T1017
- Organization Type is "**Direct Program**"

REMOVED
- **Place of contact is: CLF/AFC Home, Community, Home, Office, Other, School. Telehealth. Walk In Clinic. Hospital Inpatient**

Community Integration: Community Supports Services

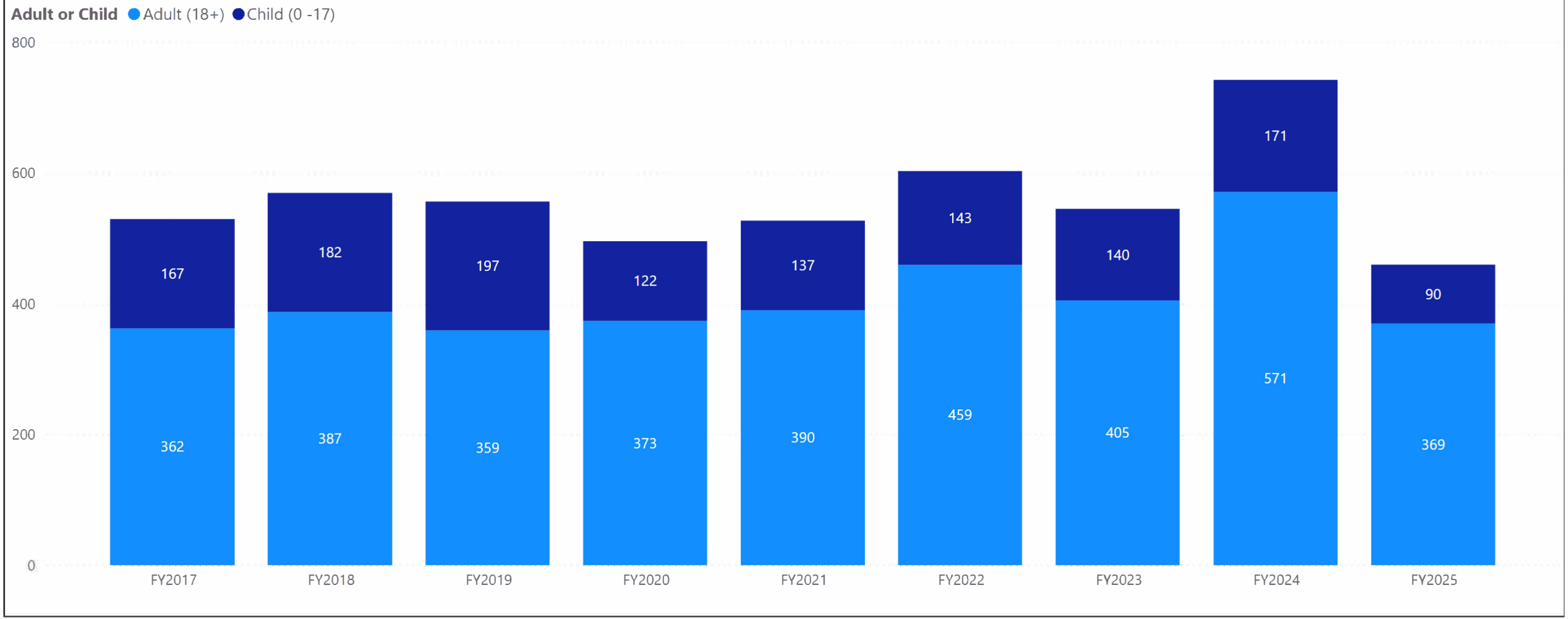


Procedure Code	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	**Total**
97001	6									**6**
97003	8									**8**
H0032	69	21	26	56	56	23	23	3		**103**
H0043				1						**1**
H2000			1							**1**
H2014	1									**1**
Total	**97**	**79**	**83**	**80**	**69**	**39**	**39**	**40**	**36**	**132**

The information above includes:
- All billable/(sent) encounters.
- Provider Name: North Bay

REMOVED - Includes procedure code: H2014, H2015
ADDED - North Bay provider only

Outpatient Treatment



Outpatient Treatment

Adult or Child	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	**Total**
⊞ Adult (18+)	362	387	359	373	390	459	405	571	369	**1484**
⊞ Child (0 -17)	167	182	197	122	137	143	140	171	90	**672**
Total	**528**	**566**	**549**	**490**	**523**	**595**	**539**	**733**	**457**	**2084**

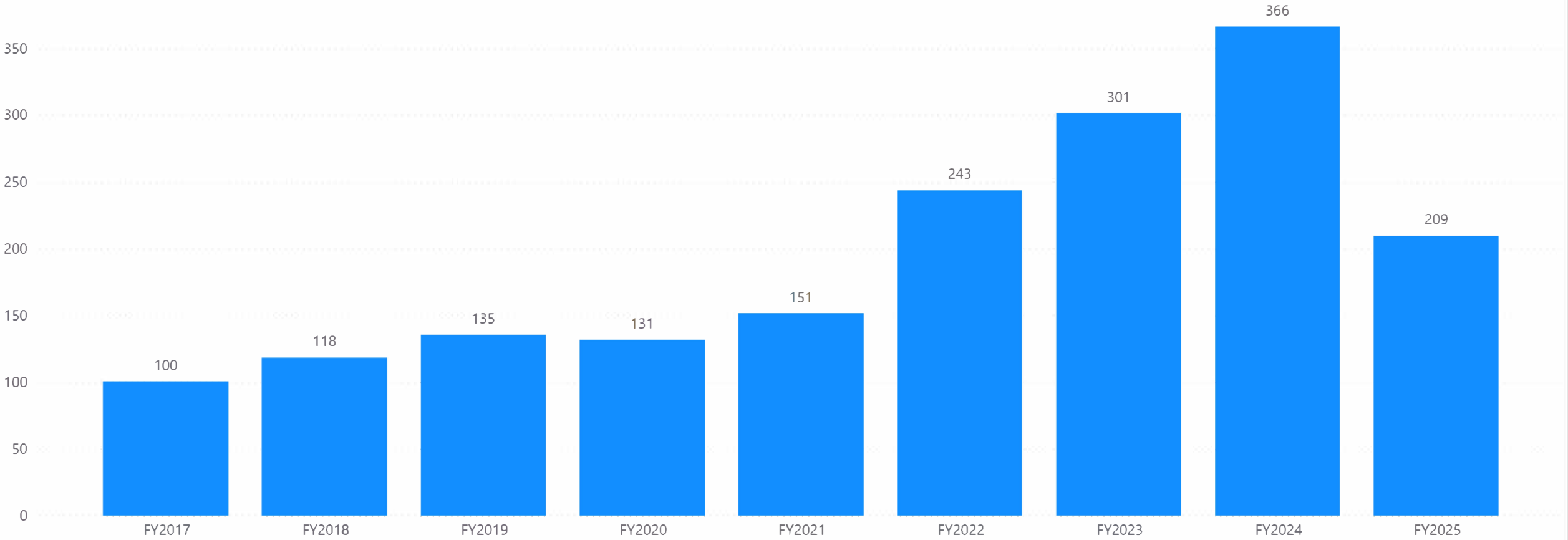
The information above includes:

- All billable/(sent) encounters.
- Organization type is "Direct Program"
- Includes procedure codes:

90832,90834,90837,90846,90847,90785,90849,90853

REMOVED - Place of contact is: Office, Home, Nursing Home

Applied Behavioral Analysis

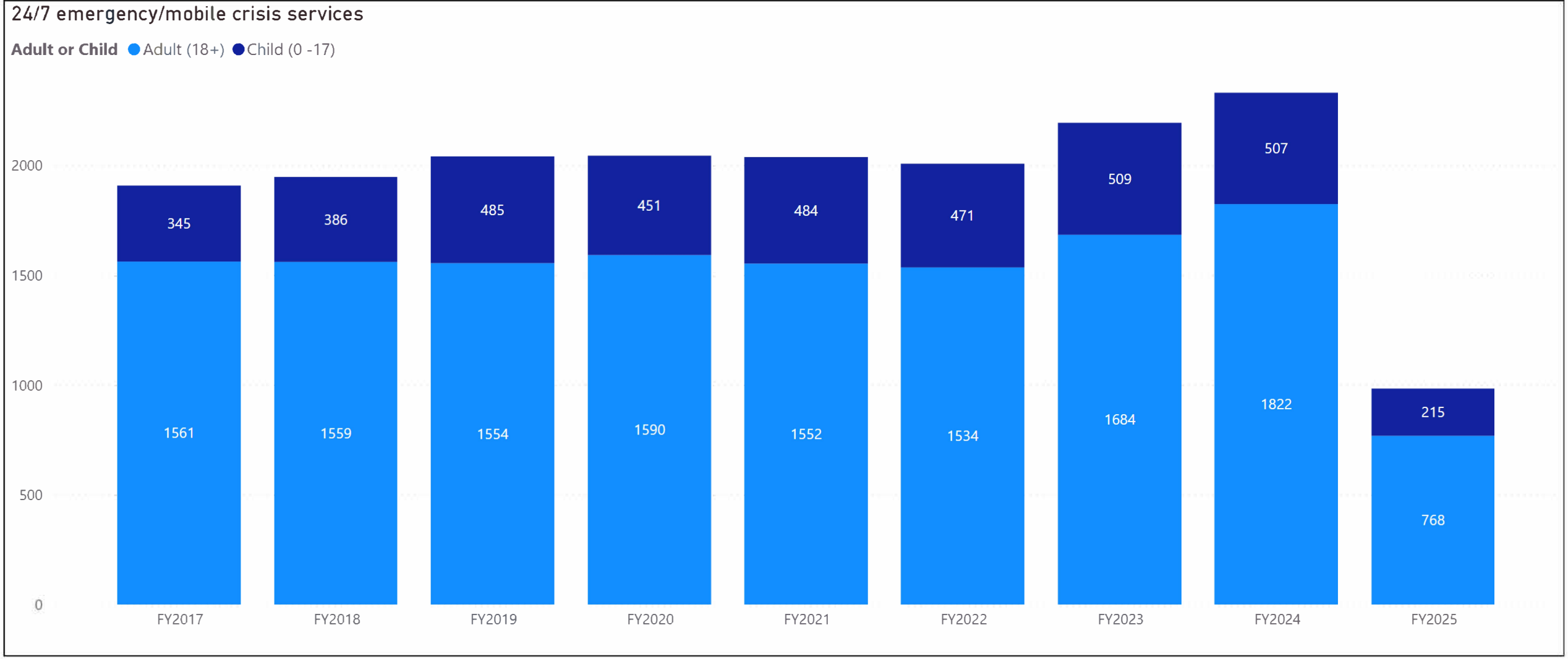


Procedure Type	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	**Total**
ABA Assessment	79	102	129	110	144	222	281	351	105	**716**
ABA Treatment	85	105	116	113	136	147	185	224	168	**428**
ABA Clinical Observation	86	105	118	112	140	153	189	232	172	**427**
ABA Family Guidance	49	83	111	102	121	141	176	216	161	**397**
ABA 2:1 Staffing	5	5	3	5	8	8	12	12	8	**24**
Total	**100**	**118**	**135**	**131**	**151**	**243**	**301**	**366**	**209**	**730**

The information above includes:
- All billable/(sent) encounters.

REMOVED - Includes the following services a U5 modifiers
ADDED: ABA codes

24/7 emergency/mobile crisis services



24/7 emergency/mobile crisis services

Document Name	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	**Total**
⊞ Crisis Contact	1669	1661	1790	1840	1893	1856	2044	2213	917	**10111**
⊞ Mobile Crisis Screening						73	157	210	102	**453**
⊞ Pre-Admission Screening	1052	1036	1031	991	977	982	1134	1065	410	**6014**
Total	**1902**	**1943**	**2036**	**2037**	**2028**	**2003**	**2191**	**2325**	**982**	**10770**

Contains Crisis Contact, Pre-Admission screening. and **Mobile Crisis Contact**

Health Spending

How does medical inflation compare to inflation in the rest of the economy?

By Shameek Rakshit, Emma Wager, Paul Hughes-Cromwick, Cynthia Cox, and Krutika Amin *KFF*

August 2, 2024

Note: This analysis was updated on August 2, 2024 to include new data.

Medical care prices and overall health spending typically outpace growth in the rest of the economy. Health costs represent a growing share of gross domestic product and many American families have seen the **costs** of health services and premiums grow faster than their wages.

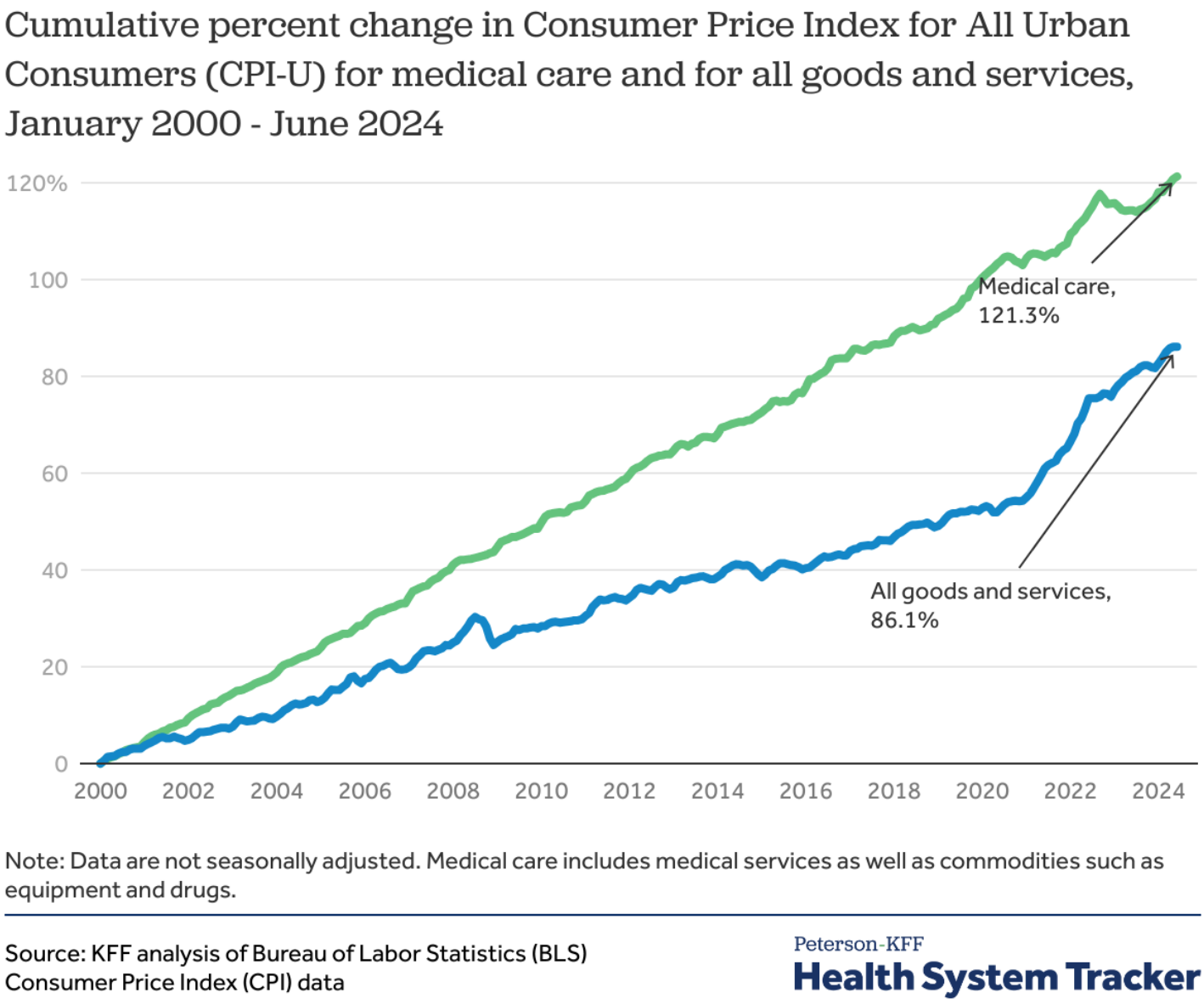
This brief analyzes prices for medical care compared to other goods and services using consumer price index (CPI) and producer price index (PPI) data from the Bureau of Labor Statistics (BLS) and personal consumption expenditures (PCE) price index data from the Bureau of Economic Analysis (BEA).

Using the CPI, overall prices grew by 3.0% in June 2024 from the previous year, while prices for medical care increased by 3.3%. Overall prices excluding medical care grew by 2.9%. This marks the first month since early 2021 that prices for medical care had grown faster than overall inflation.

In June 2024, medical prices grew by 3.3% from the previous year, higher than the 3.0% overall annual inflation rate.

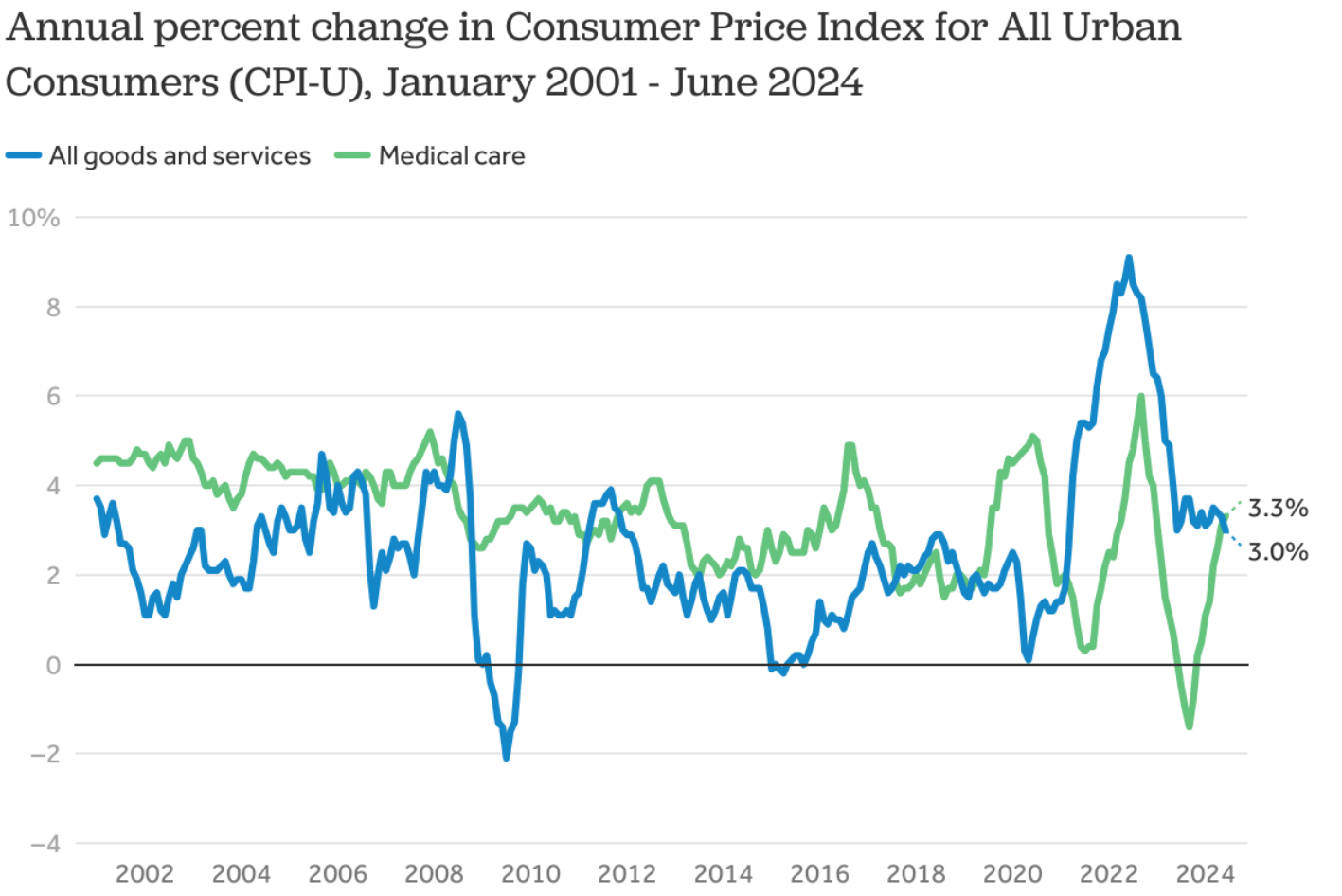
SHARE ON X

Medical care prices have generally grown faster than overall consumer prices



Since 2000, the price of medical care, **including** services provided as well as insurance, drugs, and medical equipment, has increased by 121.3%. In contrast, prices for all consumer goods and services rose by 86.1% in the same period.

In June 2024, prices rose 3.0% across the economy from the previous year, compared to 3.3% for medical care



Note: Data are not seasonally adjusted. Medical care includes medical services as well as commodities such as equipment and drugs.

Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data

Peterson-KFF Health System Tracker

Medical care prices typically outpace growth of prices in the rest of the economy. However, starting in 2021, prices for many non-medical goods and services began increasing rapidly, outpacing the growth in medical prices. As general economic inflation has begun to cool more recently, though, medical prices are once again outpacing growth in other prices. Using the CPI, overall prices grew by 3.0% in June 2024 from the previous year, while prices for medical care increased by 3.3%. Overall prices excluding medical care grew by 2.9%.

As general economic inflation pushes wages upward, health worker **wage increases** also put upward pressure on medical prices, unless hospitals and other providers can find ways to operate with fewer staff or cut other expenses. However, many health prices are set in advance, administratively or via private insurance contracting, so there is a delay in observable price increases. Public payer prices are set by the federal and state governments annually. Medicare uses indexing measures to update payment rates

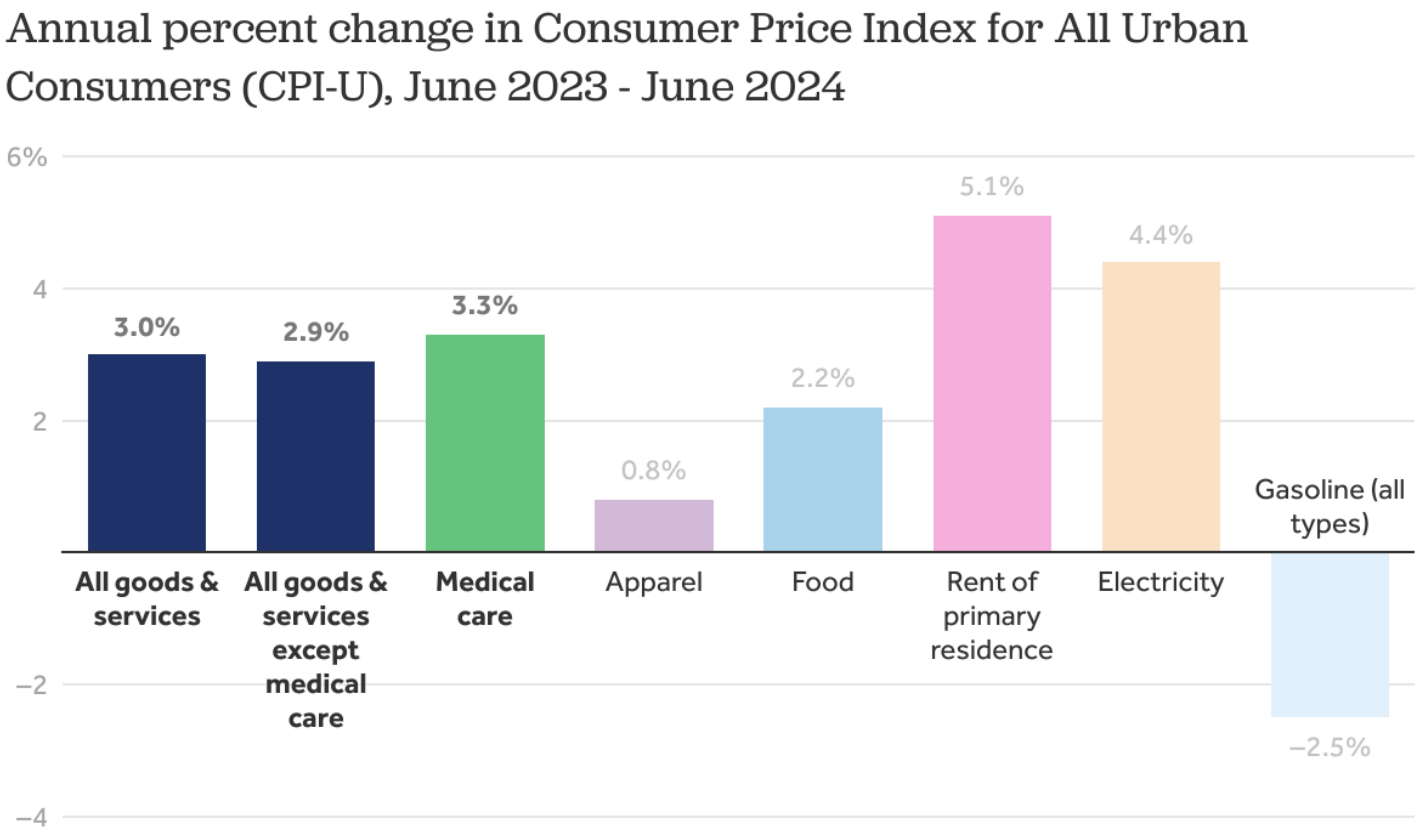
annually, reflecting increases in operating costs and wage growth, among other factors. Some commercial rates are negotiated throughout the year, but most are tied to the plan or calendar year.

The Consumer Price Index (CPI)

*The consumer price index for all urban consumers (CPI-U) measures the U.S city average change in prices consumers pay for goods and services. For medical care, CPI measures total price changes, including both the costs consumers pay out-of-pocket and those insurers (public and private payers) pay to providers and pharmacies. While CPI measures total price changes, the index weights spending to match consumers' out-of-pocket costs, including consumers' spending at the point of care and on health insurance premiums. For example, physician and hospital services are **47%** of the medical care index.*

*BLS used **new expenditure weights** to calculate the CPI starting from January 2023 and will continue to update the weights annually. Previously, BLS updated CPI weights once every two years using two consecutive years of consumer spending data. CPI weights will now be calculated each year using one year of spending data for greater accuracy.*

Medical care prices increased somewhat faster than prices for other consumer goods and services in the past year



Note: Data are not seasonally adjusted. Medical care includes medical services as well as commodities such as equipment and drugs.

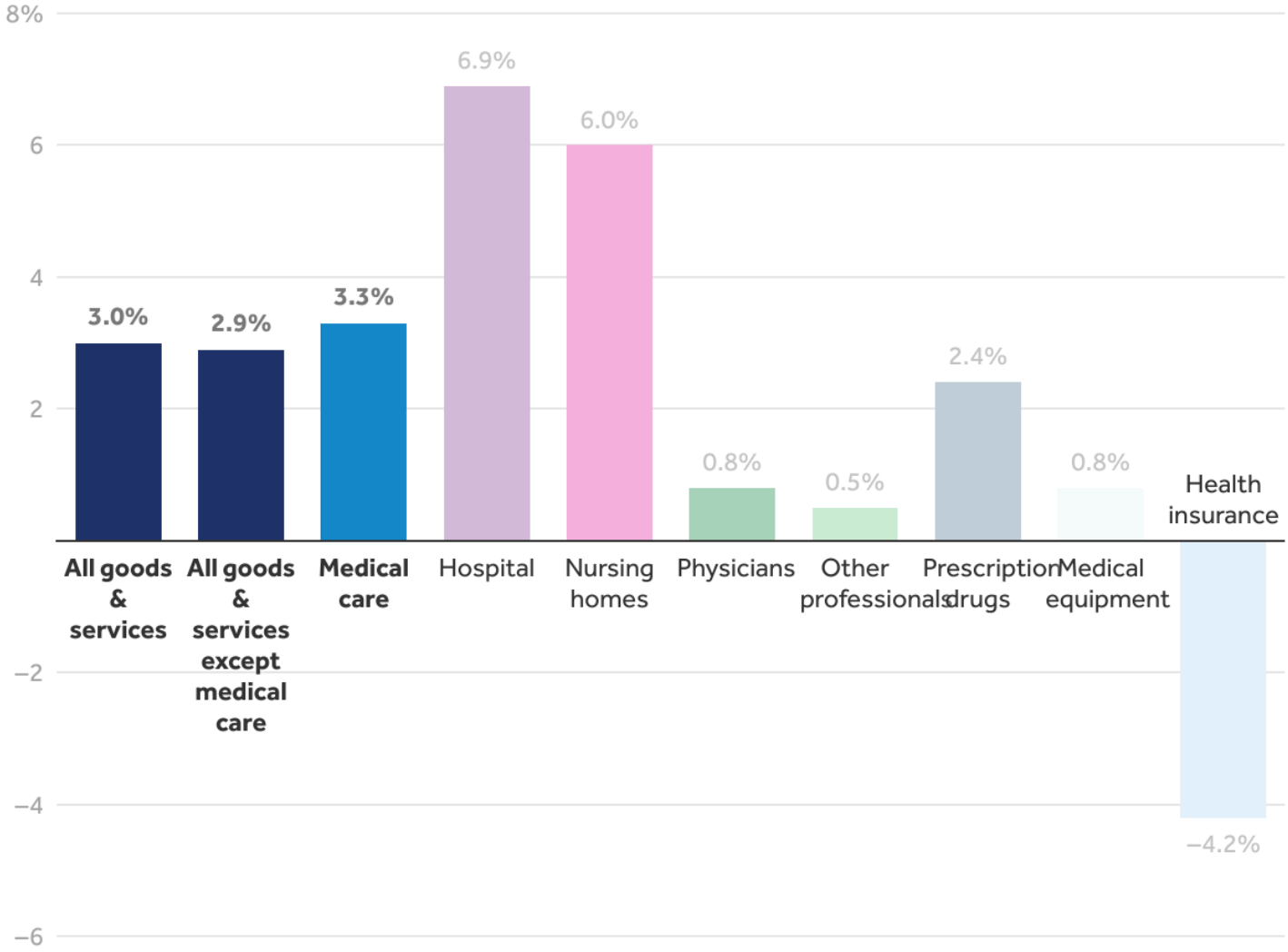
Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data

Peterson-KFF Health System Tracker

While the annual growth in medical prices is once again outpacing the growth in non-medical prices (3.3% vs. 2.9% in June) on average, some non-medical goods and services saw larger increases. Residential rents grew by 5.1% and electricity costs grew by 4.4%. Other household budget items, such as food and apparel, have seen smaller price increases in the past year than medical care. Gasoline was the fastest-growing essential household expense in 2022, reaching a peak inflation rate of 59.9% in June 2022. More recently, as of June 2023, gasoline prices have declined by -2.5% from the same month last year.

Some health prices increased faster than others in the past year

Annual percent change in Consumer Price Index for All Urban Consumers (CPI-U) for medical care, by category, June 2023 - June 2024



Note: Data are not seasonally adjusted. "All medical care" includes medical services as well as commodities such as equipment and drugs. CPI for medical care is generally lagged farther than other categories. Health insurance CPI represents health administration costs and profits; this measure is at least one-year lagged.

Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data

Peterson-KFF Health System Tracker

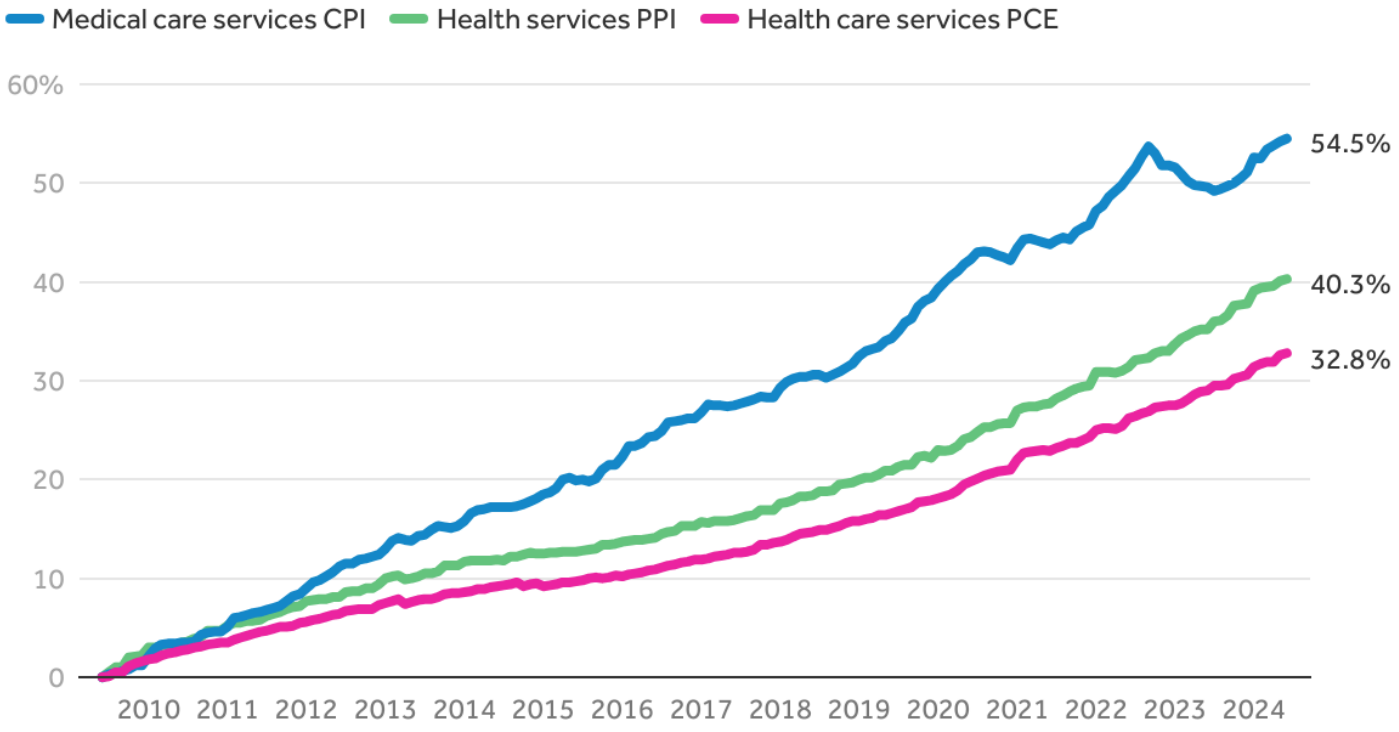
Prices for hospital services (6.9%) as well as for nursing homes (6.0%) rose faster than for prescription drugs and physicians' services (2.4% and 0.8%, respectively). The medical CPI is generally based on lagged data even more so than other CPI categories. For example, the prescription drug CPI does not immediately reflect the introduction of new, high-priced drugs.

The medical care CPI also includes a price index for health insurance. This index measures **retained earnings** of health insurers – it is not a reflection of the premiums they set. The health insurance CPI fell from an annual increase of 28.2% in September 2022 (the all-time high) to a decrease of -4.2% in June 2024. However, the health insurance CPI presents data that is almost one-year lagged, so it is not representative of current price changes. In fact, the health insurance CPI through September 2022 reflects **insurers' margins** in 2020, as they paid lower medical claims than in a typical year. Nevertheless, insurers likely saw lower **margins**, on average, in 2021 and 2022 than they had been in the first year of the pandemic due to returning utilization.

Regardless, with a 9% weight of the total medical consumer price index, health insurance brought the overall medical CPI up during most of 2022 and is now exerting downward pressure.

Different measures of medical inflation produce different estimates of price growth

Cumulative percent change in selected health care price indices, June 2009 - June 2024



Note: CPI and PPI data are not seasonally adjusted. Producer Price Index (PPI) data measures health care services as a commodity for all payers. Consumer Price Index for All Urban Consumers (CPI-U) data measures medical care services only, including hospital and other health facility services (excluding drugs and equipment). Personal consumption expenditures (PCE) data measure total personal health care expenses.

Source: KFF analysis of Bureau of Labor Statistics (BLS) and Bureau of Economic Analysis (BEA) data

Peterson-KFF Health System Tracker

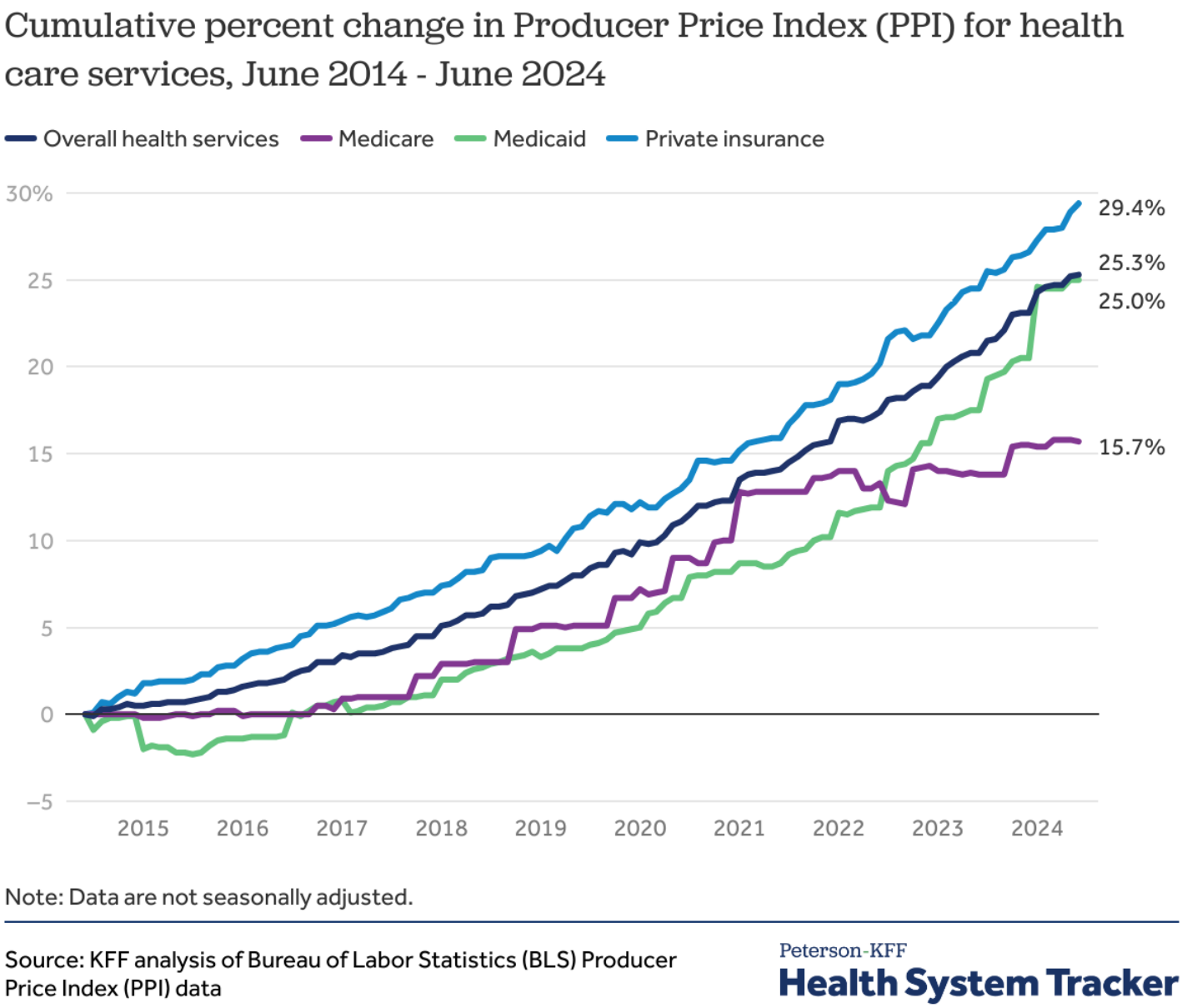
While the CPI covers inflation in prices paid directly by consumers, another measure of inflation, the personal consumption expenditures (PCE) price index, also tracks changes in prices paid on behalf of consumers. For example, the health care services PCE price index covers payments by employers, private insurers, and government programs to providers in addition to premiums and out-of-pocket expenses paid by consumers. The PCE price index also accounts for shifts in consumer spending patterns in response to price changes. CPI, by contrast, assumes consumers buy a similar bundle of goods and services and does not account for trade-offs consumers may be making in response to price changes.

A third measure of inflation, the producer price index (PPI), represents inflation from the producers' perspective in both the public and private sector. The PPI for health services includes medical services (provided by physicians or other care providers) paid for by third parties, such as employers or the federal

government. Unlike the CPI, the PPI considers changes in industry output costs with a focus on the actual transaction prices.

Since June 2009, the CPI-U for medical care services has risen by 54.5%, while the PPI for health care services has increased by 40.3% and the PCE price index for health care services has increased by 32.8%. Services included in this chart include hospital, physician, and other professional and facility care prices. While drugs and medical equipment are included in previous CPI-U charts in this analysis, this chart measures CPI-U of medical care services specifically and excludes drugs and medical equipment in both PPI and CPI-U measures.

Prices paid by private insurance generally outpace those paid by public programs



Generally, prices paid by private insurance are higher and rise more quickly than prices paid by public payers. Prices for private insurers are the result of negotiations between health systems and the insurance companies, while public payer prices are set administratively. In 2024, healthcare prices paid for by private insurance and Medicaid are rising faster than those paid for by Medicare. The private insurance health services PPI has risen by 29.4% since June of 2014, compared to 15.7% for Medicare and 25.0% for Medicaid in the same period. The overall health services PPI increased by 25.3% since June 2014.

During the public health emergency, Medicare provider reimbursement for COVID-19 treatment was boosted by 20.0%, which explains part of the reason for the increase in the Medicare PPI in 2020.

About this site

The Peterson Center on Healthcare and KFF are partnering to monitor how well the U.S. healthcare system is performing in terms of quality and cost.

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Sara McRae

Subject: FW: FY26 Executive Budget Proposal

WARNING: This message has originated from an **External Source**, please use caution when opening attachments or clicking links.

From: Alan Bolter <ABolter@cmham.org>
Sent: Thursday, February 6, 2025 1:35 PM
To: CMHA Board of Directors, CMH & PIHP Directors, Provider Alliance, SUD Directors, and Legislation & Policy Committee
Cc: Robert Sheehan <RSheehan@cmham.org>
Subject: FY26 Executive Budget Proposal

All,

Yesterday, Governor Gretchen Whitmer and Michigan State Budget Director Jen Flood and Deputy Director Kyle Guerrant presented Governor Whitmer's Fiscal Year (FY) 2025 - 2026 Executive Budget Recommendations before a joint meeting of the Michigan Senate and House Appropriations Committees. This presentation jumpstarts what is known as budget season in Lansing, where both the House and Senate use the Governor's recommendation as a guide to negotiate their respective budget proposals and ultimately present a unified budget to the Governor before the statutory deadline of July 1st.

It is important to note that this budget recommendation serves as a jumping off point to get the negotiations with the House and Senate started. Many priorities the Governor announced will be replaced with those of legislative leaders. More likely than not, we expect negotiations to continue throughout the summer, past the July 1st statutory deadline into September, with a final FY 26 budget being presented to the Governor days before the October 1st fiscal year start date.

The much-anticipated budget recommendation, which amounts to the largest state budget in Michigan history, was released amidst the January Consensus Revenue Estimating Conference report that indicated the state's general fund was $1.2 billion higher than expected.

This year's presentation offers a $83.5 billion budget recommendation that includes a general fund total of $15.3 billion and a School Aid Fund total of $21.2 billion. The Governor highlighted the following priorities for strategic investment:

- Lowering costs for Michiganders
- Creating Jobs
- Getting Smart on Education
- Supporting Seniors
- Protecting and Defending Michiganders
- Making Government Work Better

More specifically, here are the items of significance to the public mental health system (I am in the process of reviewing of boilerplate sections and will send out an updated document once I have completed that review):

Links to budget documents Executive Budget and Associated Documents
Links to budget bill (DHHS begins on page 114): FY26-General-Omnibus.pdf

Specific Mental Health/Substance Abuse Services Line items

	FY'24 (Final)	FY'25 (Final)	FY'26(Exec Rec)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$3,160,958,400	$3,387,066,600	$3,422,415,900
-Medicaid Substance Abuse services	$95,264,000	$95,650,100	$98,752,100
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,599,700	$79,626,200	$80,207,900
-Health Homes Program	$53,400,100	$53,418,500	$53,239,800
-Autism services	$279,257,100	$329,620,000	$458,715,500
-Healthy MI Plan (Behavioral health)	$590,860,800	$527,784,600	$535,508,300
-CCBHC	$386,381,700	$525,913,900	$916,062,700
-Total Local Dollars	$10,190,500	$10,190,500	$9,943,600

Other Highlights of the FY26 Executive Budget:

Proposed FY26 Investments The FY26 Executive Budget provides $62 million ($15.2 million general fund) in new supports to address the opioid epidemic and provide behavioral health services for those in need. Proposed funding includes:

- $15.2 million to begin operating the new state psychiatric hospital in Northville, bringing 264 new beds online and increasing capacity by 54 beds (32 adult beds and 22 pediatric beds). This investment includes operational support and hiring staff to provide services at the new facility.

- $46.8 million of Michigan Opioid Healing and Recovery Fund dollars for prevention, treatment, harm reduction, recovery, and data collection for those affected by the opioid epidemic. This additional allocation will expand services to reduce the number of opioid users and overdoses.

- $15 million one-time to invest in new programs to reduce opioid usage and overdoses.
- $31.8 million ongoing to continue existing, successful programs, including efforts to address the racial disparities in overdose deaths statewide. This brings the total annual ongoing funding to $55 million per year, supported by incoming settlement dollars.
- The department's three-year plan will drive the use of these resources. The plan represents a comprehensive, multifaceted, data-driven approach intended to strategically leverage available resources and take full advantage of this generational opportunity in the most impactful yet sustainable way possible. The plan includes:

    - Increasing the age of first opioid use though new and expanded programs. The department will partner with nonprofits, youth engagement organizations, and existing partners to expand prevention programing in schools. They will also conduct public awareness campaigns.
    - Reducing overdose deaths and addressing racial and geographical disparities. Those disparities are demonstrated in the chart below. DHHS will use resources to award multi-year grants to organizations working in underserved or under resourced communities. DHHS will also provide annual grants or contracts with organizations addressing racial disparities in opioid deaths and continue distributing naloxone in areas that need it most.
    - Growing the behavioral health workforce through scholarships to prospective students, paid internships, and loan repayment.
    - Prioritizing work to increase recovery beds and access to affordable housing. This will include reimbursing the cost of stay of residents and expansion of recovery housing. It also includes permanent affordable housing and investing in wraparound support programs like transportation and employment that enable people to stay in stable housing.
    - Investing in administrative infrastructure to gather data to track success and provide technical assistance to local governments. This ensures these funds are being utilized for maximum impact and allows the department to partner with local governments to collaborate on ways to address opioid usage

- $96.4 million to expand Medicaid eligibility ($33.1 million general fund) with a new income disregard that will allow more people to gain access to coverage.
    - Currently Medicaid requires elderly and disabled enrollees with income above 100% of federal poverty limits (FPL) to spend the majority of their income on health care costs each month – until their remaining income is less than 40% FPL – to access Medicaid. This proposal would shift this level to 100% FPL, broadening access to Medicaid supports and preventing excessive spend down to help keep more seniors in their homes and prevent individuals from spending down into poverty.

- $400,000 to explore the feasibility of expanding Medicaid eligibility for children aged 0 - 6 years ($200,000 general fund).
    - This will allow DHHS to prepare a feasibility study to determine long-term costs, benefits, potential barriers and any associated nuances of implementing continuous eligibility for Medicaid beneficiaries aged 0-6.

- $40 million for the community reentry of incarcerated individuals ($20 million general fund) to provide coverage starting 90 days before an individual's scheduled release.

    - This will allow for health screenings and other services prior to reentry to identify key health needs and social determinants to facilitate a successful transition. Investing in these transition services will help improve health outcomes and access to community services, all of which will reduce recidivism.

- $2.5 million for access to mental health services (general fund, one-time) to support behavioral health resources for first responders and public safety staff.

- $258 million to support the mental and emotional wellbeing of 1.4 million students through continuation of mental health and safety grants to school districts.

- $5 million to support the MiABLE program expansion.

Alan Bolter
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: January 16, 2025

FROM: Daniel Tsai, Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: 2025 Federal Poverty Level Standards

As required by Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)), the Department of Health and Human Services (HHS) updates the poverty guidelines at least annually and by law these updates are applied to eligibility criteria for programs such as Medicaid and the Children's Health Insurance Program (CHIP). These annual updates account for the increase in the Census Bureau's current official poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U).

The 2025 guidelines reflect the 2.9 percent price increase between calendar years 2023 and 2024. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family and household sizes. For a family or household of 4 persons living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2025 is $32,150. Separate poverty guideline figures are developed for Alaska and Hawaii, and different guidelines may apply to the Territories. The guidelines can be found at https://www.federalregister.gov/public-inspection/2025-01377/annual-update-of-poverty-guidelines. To determine eligibility for Medicaid and CHIP, states generally use a percentage multiple of the guidelines (for example, 133 percent or 185 percent of the guidelines).

Included with this informational bulletin is the *2025 Dual Eligible Standards* chart that displays the new standards for the Medicare Savings Program categories. These standards are also available on Medicaid.gov at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. The asset limits are not derived from the poverty guidelines but are instead based on a statutory formula described in section 1905(p)(1)(C) of the Social Security Act (the Act).[1] Please note that the income figures for the Qualified Disabled Working Individual (QDWI) program identified in the chart incorporate earned income disregards, in addition to the $20 general income disregard. Please update your standards in accordance with this information.

For additional information about this CIB, please contact Marc Steinberg, Acting Director of the Division of Medicaid Eligibility Policy, at 410-786-3508 or marc.steinberg@cms.hhs.gov. States may also submit questions by contacting their Medicaid state lead or CHIP project officer.

Attachment:

[1] For more information on this formula, please see the CMCS Informational Bulletin "2025 SSI, Spousal Impoverishment, and Medicare Savings Program Resources Standards," available here: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11152024.pdf.

2025 Dual Eligible Standards

(Based on Percentage of Federal Poverty Level)

Qualified Medicare Beneficiary (QMB):

Monthly Income Limits: (100% FPL + $20)*

QMB	Individual	Couple
All States and DC (Except Alaska & Hawaii):	$ 1,325.00	$ 1,783.00
Alaska:	$ 1,650.00	$ 2,223.00
Hawaii:	$ 1,520.00	$ 2,047.00
Asset Limits:	$ 9,660.00	$ 14,470.00

Specified Low-Income Medicare Beneficiary (SLMB):

Monthly Income Limits: (120% FPL + $20)*

SLMB	Individual	Couple
All States and DC (Except Alaska & Hawaii):	$ 1,585.00	$ 2,135.00
Alaska:	$ 1,975.00	$ 2,663.00
Hawaii:	$ 1,819.00	$ 2,452.00
Asset Limits:	$ 9,660.00	$ 14,470.00

Qualifying Individual (QI):

Monthly Income Limits: (135% FPL + $20)*

QI	Individual	Couple
All States and DC (Except Alaska & Hawaii):	$ 1,781.00	$ 2,400.00
Alaska:	$ 2,220.00	$ 2,994.00
Hawaii:	$ 2,044.00	$ 2,756.00
Asset Limits:	$ 9,660.00	$ 14,470.00

Qualified Disabled Working Individual (QDWI):

Monthly Income Limits: (200% FPL + $20)*

(Figures include additional earned income disregards)

QDWI	Individual	Couple
All States and DC (Except Alaska & Hawaii):	$ 5,302.00	$ 7,135.00
Alaska:	$ 6,602.00	$ 8,895.00
Hawaii:	$ 6,082.00	$ 8,192.00
Asset Limits:	$ 4,000.00	$ 6,000.00

*$20 = Amount of the Monthly SSI Income Disregard