Bradley P. Casemore Testimony before the Michigan House Subcommittee on MDHHS Appropriations

The Honorable Representative Christine Morse, Chair

April 10, 2024

Madame Chair Morse and esteemed Subcommittee Members thank you for permitting me to testify today. I am Bradley Casemore CEO of Southwest Michigan Behavioral Health (SWMBH) representing the ten Prepaid Inpatient Health Plans (PIHP) serving 290,000 of Michigan's most vulnerable citizens living with intellectual and developmental disorders, severe mental illness, serious emotional disturbance, autism spectrum disorders and substance use disorders.

Collectively through our valued Community Mental Health Service Programs (CMHSP) and other providers PIHPs administer $4.2 billion in Medicaid, Healthy Michigan, federal Block Grant and PA 2 funds annually. Seven PIHPs are multi-CMHSP PIHPs and three are standalone CMHSP PIHPs.

I appear today to discuss troubling PIHP Medicaid financial estimates for fiscal years 2024 and 2025 absent adequate Medicaid and Healthy Michigan rate setting and appropriations for fiscal year 2025.

This financial jeopardy is widespread, structural and not a result of poor management. See below and today's CMHAM testimony material for information on the drivers of Medicaid revenue shortfalls and expense increases not the least of which is inflationary and workforce supply shortages placing pressure on wages and salaries across the public behavioral health system.

Multiple access expansion and quality initiatives in youth services, criminal justice diversion and jail services, opioid epidemic prevention and treatment, Demonstrations such as Community Behavioral Health Clinic (CCBHC), Opioid Health Homes (OHH), Behavioral Health Homes (BHH) and others expanded the breadth of services, increased the number of persons served and added expense. These new program expansions must be recognized in Medicaid rates and appropriations based on projected utilization not prior years' activity which is minimal or non-existent.

For risk management purposes PIHPs are permitted to retain 5% of Medicaid and Healthy Michigan Plan revenue savings annually into the following year and to maintain an actuarially sound Internal Service Fund (ISF). PIHPs are in a financial risk sharing arrangement with the state and once PIHP ISFs are depleted the state is at financial risk. Note that Medicaid Health Plans receive twice the financial risk reserve allowance percentage than the PIHPs.

PIHPs and CMHSPs welcomed the recent fiscal year 2024 Medicaid $116 million statewide rate increase, *though this is $94 million less than the fiscal year 2024 appropriation*.

Be aware that the financial projections below are under refinement and subject to changes in assumptions and facts as fiscal year 2025 Medicaid and Healthy Michigan Plan rates and appropriations are finalized. We do not have information on specific PIHPs today.

Fiscal year 2024 projections show four PIHPs with negative margins of $7 million, $15 million, $6.5 million and $23 million. Another PIHP is at breakeven with no savings into fiscal year 2025 and other PIHPs having reduced savings going into fiscal year 2025. **Distribution of the remaining $94 million already appropriated for fiscal year 2024 will improve these circumstances.**

Fiscal year 2025 financial projections worsen based on assumptions of system wide expense increases of 5%, a 3% increase in Medicaid funds redirection to Certified Community Behavioral Health Clinics (CCBHC) and revenues at fiscal year 2024 levels. Five PIHPs will have negative margins of $14.5 million, $21.5 million, $11 million, $31 million, and $4.6 million with three PIHPs at breakeven and two others with significantly reduced Medicaid savings. Two PIHPs are projected to enter into the risk corridor with DHHS and two others will have depleted ISFs.

Since inception of the PIHPs, margins, Medicaid Savings, ISF uses and balances have varied widely and will continue to do so as multiple Demonstrations and service expansions attract more persons served and higher expenses. Medicaid rate increases take several years to materialize into the system. Fiscal year 2025 rates must not be based on prior year diminished service encounters due to the pandemic.

Medicaid services are entitlements which cannot and must not be reduced, suspended or terminated when medically necessary. Actuarially sound capitation rates are intended to provide for all reasonable appropriate and attainable costs that are required under the terms of the PIHP/MDHHS Agreement for the time period and eligible populations. Public behavioral health expense pressures are widely known chief among them increased treatment need and demand for persons with Autism Spectrum Disorders and persons requiring community inpatient psychiatric hospitalization as well as inflationary pressures on salaries for clinical and support staff and provider rate increases.

Revenue pressures stem from cessation of federal Public Health Emergency Medicaid infusions of funds into the healthcare system, lapse of federal economic stimulus packages and notably high disenrollments from Medicaid and Healthy Michigan Plan as a result of the federal requirement to reinstate Medicaid and Healthy Michigan Plan eligibility redeterminations after a period of several years where Medicaid and Healthy Michigan Plan eligibility redeterminations were suspended due to the Public Health Emergency.

A rational person could say "Medicaid enrollments are down therefore demand for services is down thus costs are down." Unlike other types of Health Plans the public behavioral health system is designed to embrace risk rather than avoid risk and serves any person eligible for services. The PIHP and CMHSP system serves Michigan's most clinically and financially troubled citizens. Our mandated and priority populations have intense and complex life circumstances and for many life-long or episodic costly supports and services. Thus this group of citizens does not and should not leave treatment services regardless of payment coverage.

Our message to you and the rest of the legislature is to support and appropriate fiscal year 2025 Medicaid, Healthy Michigan, Certified Community Behavioral Health Clinic (CCBHC) and mental health General Fund funds necessary to protect Medicaid and non-Medicaid community behavioral health service recipients and to insulate public behavioral health system clientele and the state from a jarring financial blow in January 2026. MDHHS and the state's actuary Milliman are aware of these facts and are making best efforts to project, plan and perform.

A recommendation regarding state and municipal opioid settlement funds reminds you that PIHPs are state designated *Community Mental Health Entities* (CMHE) already under contract to MDHHS and are the only statutorily empowered regional agencies for substance use disorder prevention and treatment planning, policy, programs and performance. CMHEs have a decade of data demonstrating success and favorable outcomes, unparalleled subject matter expertise and mature communication channels in every area of the state. I provided the specific statutory references to the Committee staff. **Please consider the CMHEs as named administrative vehicles for state and/or municipal opioid settlement funds as you deliberate effective and efficient deployment of the $1.5 billion state and municipal opioid settlement funds in fiscal year 2025 and over the next fifteen years.**

Respectfully,

Bradley P. Casemore MHSA, LMSW, FACHE

brad.casemore@swmbh.org

Member, Michigan Opioids Task Force

Member, Michigan Mental Health Diversion Council

Former Member, Michigan Opioid Advisory Commission

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

330.1210 Community mental health services program; election to establish; coordination of services.

Sec. 210. (1) Any single county or any combination of adjoining counties may elect to establish a community mental health services program by a majority vote of each county board of commissioners.

(2) A department-designated community mental health entity shall coordinate the provision of substance use disorder services in its region and shall ensure services are available for individuals with substance use disorder.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 2012, Act 500, Imd. Eff. Dec. 28, 2012.

330.1269 Department-designated community mental health entity and community mental health services program provider network; ability to contract for and spend funds; purposes.

Sec. 269. The department-designated community mental health entity and its community mental health services program provider network may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder. A department-designated community mental health entity and other community mental health services program may make contracts with the governing bodies of other department-designated community mental health entities and other community mental health services programs and other persons for these purposes.

History: Add. 2012, Act 500, Imd. Eff. Dec. 28, 2012.

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

330.1274 Duty of department-designated community mental health entity to assume responsibility for providing services for county or multicounty region.

Sec. 274. A department-designated community mental health entity designated by the director to assume responsibility for providing substance use disorder services for a county or multicounty region, with assistance from its community mental health services program provider network, shall do all of the following:

(a) Develop comprehensive plans for substance use disorder treatment and rehabilitation services and substance use disorder prevention services consistent with guidelines established by the department.

(b) Review and comment to the department of licensing and regulatory affairs on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations.

(c) Provide technical assistance for local substance use disorder service programs.

(d) Collect and transfer data and financial information from local programs to the department of licensing and regulatory affairs.

(e) Submit an annual budget request to the department for use of state administered funds for its substance use disorder treatment and rehabilitation services and substance use disorder prevention services in accordance with guidelines established by the department.

(f) Make contracts necessary and incidental to the performance of the department-designated community mental health entity's and community mental health services program's functions. The contracts may be made with public or private agencies, organizations, associations, and individuals to provide for substance use disorder treatment and rehabilitation services and substance use disorder prevention services.

(g) Annually evaluate and assess substance use disorder services in the department-designated community mental health entity in accordance with guidelines established by the department.

History: Add. 2012, Act 500, Imd. Eff. Dec. 28, 2012.

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

330.1287 Department-designated community mental health entity; composition of board; use of funds; contracts; allocation formula; establishment of substance use disorder oversight policy board; report on redistricting of regions; administrative and reporting requirements; entities as coordinating agencies.

Sec. 287. (1) The composition of the department-designated community mental health entity board shall consist of representatives of mental health, developmental or intellectual disabilities, and substance use disorder services.

(2) The department-designated community mental health entity shall ensure that funding dedicated to substance use disorder services shall be retained for substance use disorder services and not diverted to fund services that are not for substance use disorders.

(3) A department-designated community mental health entity designated by the director to assume the responsibilities of providing substance use disorder services for a county or region shall retain the existing providers who are under contract to provide substance use disorder treatment and prevention services for a period of 2 years after the effective date of the amendatory act that added this section. Unless another plan is approved by the county board of commissioners, counties or regions that have local public health departments that contract with substance use disorder providers on the effective date of the amendatory act that added this section shall continue to allow the local public health department to carry out that function for 2 years after the effective date of the amendatory act that added this section.

(4) The department and the department-designated community mental health entity shall continue to use the allocation formula based on federal and state data sources to allocate and distribute nonmedical assistance substance use disorder services funds.

(5) A department-designated community mental health entity shall establish a substance use disorder oversight policy board through a contractual agreement between the department-designated community mental health entity and each of the counties served by the community mental health services program under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536, or other appropriate state law. The substance use disorder oversight policy board shall include the members called for in the establishing agreement, but shall have at least 1 board member appointed by the county board of commissioners for each county served by the department-designated community mental health entity. The substance use disorder oversight policy board shall perform the functions and responsibilities assigned to it through the establishing agreement, which shall include at least the following responsibilities:

(a) Approval of any department-designated community mental health entity budget containing local funds for treatment or prevention of substance use disorders.

(b) Advice and recommendations regarding department-designated community mental health entities' budgets for substance use disorder treatment or prevention using other nonlocal funding sources.

(c) Advice and recommendations regarding contracts with substance use disorder treatment or prevention providers.

(d) Any other terms as agreed to by the participating parties consistent with the authorizing legislation.

(6) The department shall report to the house of representatives and the senate appropriations subcommittee on community health on the redistricting of regions not later than 30 days before implementation of the plan.

(7) The department shall work with department-designated community mental health entities and community mental health services programs to simplify the administrative and reporting requirements for mental health services and substance use disorder services.

(8) Beginning not later than October 1, 2014, or at the time the implementation of the changes in this chapter are complete, whichever is sooner, department-designated community mental health entities are coordinating agencies for purposes of receiving any funds statutorily required to be distributed to coordinating agencies.

History: Add. 2012, Act 500, Imd. Eff. Dec. 28, 2012.