



Milwaukee County
Department of Health Services
Behavioral Health Division

Analysis of Funding Alternatives in
Alignment with Wisconsin Act 203

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Executive Summary

Introduction

Section 51.42 (8) of Act 203 requires the Milwaukee County Mental Health Board (MCHB) to arrange for a study of alternate funding sources for mental health services and programs, including fee-for-service models and managed care models that integrate mental health services into managed care and other provider contracts. The Milwaukee County Department of Health and Human Services Behavioral Health Division (BHD) engaged Deloitte Consulting to perform this study focused on inpatient services. Our results demonstrate the financial impact on BHD over the next three years as a result of potential changes in the payer environment and other external factors. In addition, opportunities to improve revenue at BHD are included.

Approach

Deloitte analyzed BHD revenue and costs using three approaches described in the report as “elements”:

1. **Element 1:** Summarizes the analysis of the historical business of BHD from 2013-2015. This includes a review of the Gross Billed, Net Revenue, Utilization, and Cost trends over this experience period.
2. **Element 2:** Examines the financial impact of potential changes to the payer mix, reduction in costs, and other potential policy changes over a three-year period (2016-2018), assuming costs and revenue remain consistent with 2015 experience.
3. **Element 3:** Examines alternative funding opportunities that may be explored by BHD.

Findings

Historically, BHD has experienced annual increases in Gross Billed and Net Revenue, as well as Costs. As Net Revenue grew at a faster rate than Costs, BHD experienced improvements in its gross margin. Yet, there are significant non-recoverable and self-pay dollars—about one-fourth of Total Gross Billed in 2014—that have a low Net Revenue as a percentage of Cost.

However, many opportunities exist to limit non-recoverables, increase revenue, improve gross margins, and provide a more sustainable business model. This report analyzes payment policies and models multiple financial scenarios to demonstrate the opportunities that exist and what potential financial impacts these could have on BHD over the next three years. In addition, we

Analysis of Funding Alternatives for Milwaukee County Department of Health Services Behavioral Health Division
 SUMMARY OF FINDINGS

provide several findings that will assist BHD and the MCMHB in development of a strategy to assure financial stability, including exploring partnerships and/or contracts for the provision of behavioral health services.

The summary table below highlights, at a high level, how potential shifts in payer mix and other funding opportunities could impact BHD Final Revenue and Gross Margin. The estimated impact of each opportunity shown in the table below is independent of the other.

Calendar Year	Final Revenue (in millions)	Gross Margin
2014 Actual	\$22.50	-134.4%
Adjusted 2015	\$26.62	-104.0%
Scenario	2018 ¹ Revenue Impact (in millions)	Increase to 2018 ¹ Gross Margin
1. 25% per year reduction of Non-Recoverable and Self-Pay Moves 75% of Non-Recoverable and Self-Pay revenue and cost to all the other financial classes by 2018	\$5.62	35.4%
2. Increase Medicaid MCO revenue Renegotiate rates with Medicaid MCO's from 63% to 85% of cost	\$2.91	20.1%
3. \$1M state share increase in Supplemental Payments Increase state share of supplemental payments by \$1 million (\$2.41M all funds)	\$2.41	16.9%
4. Shift \$1M of IMD excluded claims to being covered Shifts \$1M of IMD claims from being excluded to being included in revenue	\$1.00	7.4%
5. 25% per year Shift in Medicaid FFS to MCO Shifts 75% of Medicaid FFS claims to Medicaid Managed Care by 2018	\$0.62	4.3%
6. 10% per year increase in commercial business Increases commercial by 10% each year from 2016 to 2018, 30% by 2018.	\$0.59	2.6%

¹ For purposes of this report, 2018 Revenue and Gross Margin are based on 2015 adjusted amounts without trend. Therefore, the 2018 estimates are only modified for the scenarios analyzed.

Introduction and Project Background

Introduction

In 2013, the Wisconsin legislature passed Act 203 that, in part, required the Wisconsin Department of Health Services (DHS) to conduct an operational and programmatic audit of the Milwaukee County Mental Health system. The objective of the audit was to evaluate the effectiveness of the Milwaukee County Mental Health system and make recommendations for transition of oversight and operations among the Behavioral Health Division of the Milwaukee County Department of Health and Human Services, the psychiatric hospital of the Milwaukee County Mental Health Complex, and related community-based behavioral health programs. Deloitte Consulting was engaged by the Wisconsin Department of Health Services to perform the assessment¹ and provide insights into areas of best practices and areas for improvement.

Within that report, BHD was recognized for its efforts to reduce costs and improve quality for behavioral health consumers in Milwaukee County. For example, BHD downsized inpatient psychiatric capacity from nearly 100 beds in 2006 to 60 by 2013. The reduction in beds is accompanied by BHD building partnerships with private systems to identify and transfer less acute individuals to other hospitals.

Another critical requirement of Act 203 is Section 51.42 (8). This section mandates the Milwaukee County Mental Health Board (MCHB) to arrange for a study of alternate funding sources for mental health services and programs, including fee-for-service (FFS) models and managed care models that integrate mental health services into managed care and other provider contracts.

Equally important to BHD and the MCHB's pursuit of alternative funding sources is the consideration of a new delivery system model in which BHD may turn over the operation of inpatient psychiatric services to a partner or vendor. This paradigm shift in service delivery requires an understanding of aspects of the current financial standing, as well as analysis of alternative operational and management scenarios.

¹ Wisconsin Department of Health Services: Assessment of the Milwaukee County Behavioral Health System - SUMMARY OF FINDINGS WORKING PAPER: <https://www.dhs.wisconsin.gov/library/milwaukee-county-behavioral-health-final.htm>

Study Purpose and Scope

In January 2016, BHD and the MCBH engaged Deloitte Consulting to help satisfy the requirements of Section 51.42 (8) and to provide insight into opportunities BHD has to realize additional revenue in the context of delivery system and payment policy transformation.

The goal of Deloitte’s assessment is to provide analysis and insights to BHD focused on:

- Understanding the current cost per unit provided by BHD by type of service and the current reimbursement environment (i.e. payer mix and Gross Billed per unit);
- Analyzing the impact of impending policy changes on the future reimbursement environment for care provided at the inpatient psychiatric hospital (i.e., FFS and capitated Medicaid rates for behavioral health services, IMD exclusion, etc.); and
- Describing the potential future payer and/or patient mix for BHD, its impact on BHD financial projections, and whether BHD should target new populations and services to provide alternative funding sources.

The scope of this project includes analysis of three “elements” covering both financial and policy considerations.

- **Element 1:** Analyzes baseline cost of care for Inpatient, Day Treatment, Observation and Psychiatric Emergency Room (PCS) services using three years of historical claims; compares current payment to estimated costs; identifies population and services to include in analysis. This section also analyzes the historical trends for Gross Billed, Net Revenue and Cost for 2013-2015.
- **Element 2:** Details payer mix using multiple models (FFS and managed care) in the context of the current market, the BHD evolving operating model, population and service profile; assesses current mix of payers and estimates three years ahead to account for impending changes in the market, other payment methodologies and policy changes.
- **Element 3:** Identifies potential payment methods, changes in services, populations and models, and related impacts; identifies funding sources and requirements to meet those funding opportunities; and estimates impact on fiscal revenue streams.

The intent of the analysis is to provide additional perspectives to inform BHD and the MCMHB to support development of strategies to assure financial stability, including finding partners and/or subcontractors to manage and provide inpatient and emergency department psychiatric services.

Analysis Approach

Data Inputs

To conduct the analysis, Deloitte used a number of financial data components and reports received from both BHD and the State of Wisconsin Department of Health Services Division of Health Care Access and Accountability, as well as researched funding opportunities from Federal agencies, behavioral health advocates, and non-profit grant organizations. The data received included claims data, cost reports and unit cost by service category, supplemental payments, revenue reports, reimbursement methodologies, and utilization methodologies.

A detailed listing of all information received is in Appendix 1. In summary:

- The primary source of financial detail came from the fee-for-service (FFS) and encounter data from 1/1/2013 through 11/30/2015 for services provided at the inpatient psychiatric hospital (Psychiatric Emergency Room (PCS), Inpatient, Observation, Day Treatment services). The data included amounts paid by each financial class/payer for services provided, amounts written off or otherwise unrecognized as revenue, dates of service, admit and discharge dates, lengths of stay, service type, and other identifiers. Financial Classes/Payers included: Medicare FFS and Medicare managed care; Medicaid FFS and Medicaid managed care; Commercial (Commercial managed care and Commercial non-managed care); Affordable Care Act/Marketplace Exchange Plan, Military, Family Care, Non-Recoverable, Self-Pay and Collections. The dollars associated with each of the components may be found in Appendix 1.
- Claims data was provided separately for 2013, 2014 and 2015. De-identified data was provided in order to identify distinct members. Age was also provided for each member. Service codes, along with the corresponding summarized service category, were provided for each claim line. The estimated cost to provide each service, as well as claim line level paid amounts, were provided. Payment codes and descriptions were included. Finally, information related to the duration of each service was included in the claims. This included length of stay, admit and discharge date, as well as dates of service.
- The data included service detail on the four inpatient units (Intensive Treatment Unit, Adult Acute Unit, Women's Treatment Unit, and the Child and Adolescent Unit) PCS, Day Treatment (Dialectical Behavior Therapy and Recovery Teams), and Observation.

- Estimated cost information was provided for calendar years 2013-2015 by category of service (i.e. Inpatient Adult, Inpatient Child, Emergency Room 1, etc.) and by the number of units.
- Supplemental payments (i.e. UPL/Certified Public Expenditures, Disproportionate Share Hospital, Pay for Performance) received from the State were provided by both the State and BHD for calendar years 2013-2015.

In addition to reviewing existing reports, members of the project team had multiple conversations with BHD financial staff. Finally, the Deloitte team reviewed several sources of healthcare policy, pending payment policy regulations, and grant funding opportunities. These sources are reflected in footnotes throughout the report.

Methodology

Deloitte based the analysis on data provided by BHD and DHS. We reviewed the data provided for reasonableness and consistency during the course of our work; however, Deloitte did not audit any of the data received from BHD or DHS. Absent an audit, all data and information provided was assumed to be complete and accurate. If the underlying data or information provided was inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

The claims data was compared to financial reports to check for reasonableness and completeness of the data. For example, “Gross Billed” amounts and “Net Revenue” were calculated from the claims and supported by BHD financial reports. The estimated cost to provide each service, as well as claim line level paid amounts, were used to calculate the various components of revenue. Payment codes and descriptions were included and used to identify specific components of Net Revenue.

Financial Class/Payer Adjustments

Gross Billed, Net Revenue and Cost information was summarized by Financial Class/Payer level. In cases where claims were paid by multiple payers, the claim was assigned to the Financial Class/Payer with largest Gross Billed amount. This approach was used in order to understand the trends at the Financial Class/Payer level, as well as to make payer-specific observations. When summarizing data by Financial Class/Payer, the report methodology categorizes members who had both Medicare and Medicaid FFS or Medicare and Medicaid managed care coverage (Dual Eligibles) as “Dual FFS” and “Dual Managed Care”, respectively. Additionally, the Affordable Care Act/Marketplace Exchange Plan, Military, Family Care, and Collections members were grouped as

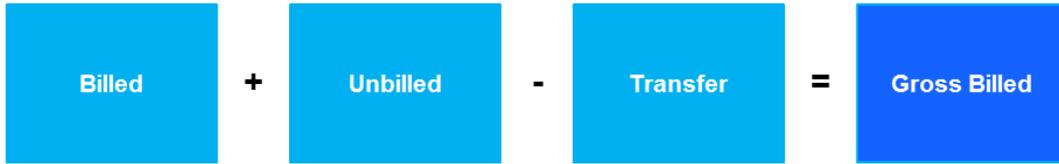
“Other” and are referred to as such throughout the report. Self-pay and non-recoverable Financial Classes were analyzed separately. They are defined by BHD as follows:

- **Self-Pay:** Consists of all consumers lacking third-party payer coverage for some or all services who are full cost or who have been determined to have some ability to pay for services they receive from BHD. Ability to pay, as per state regulation, is determined by income and household size using a state provided sliding fee scale. Consumers who do not cooperate with a financial investigation are made full cost.
- **Non-Recoverable:** A function of the BHD current electronic medical record and billing system, used to separate out claims that will not be paid during the billing process as a result of the consumer being verified as indigent, if the consumer is classified under the Federal IMD exclusion, or because the consumer’s Medicare inpatient mental health bed days have expired. Approximately half of the non-recoverable claims are classified as “IMD” or “exhausted Medicare bed days.” Billing in the BHD EMR system is required to be closed for each month, which occurs about 4 months after the date of service. At this time all non-recoverable claims are written off to charity by the system.

Gross Billed

Total Gross Billed is the sum of all billable services multiplied by the amount billed for providing these services for any given time period. Gross Billed at the Financial Class/Payer level is calculated by adding Billed and Unbilled amounts within each Financial Class/Payer level and removing any payments that are transferred to a different Financial Class/Payer. Billed amounts indicate that a claim was sent to a payer or a statement was sent to a consumer. If the claim does not have a valid claim ID, then this amount is categorized as an Unbilled amount. Claims, at times, saw a transfer of payments, meaning the Gross Billed for a particular Financial Class/Payer was reduced because that service was transferred to another Financial Class/Payer. The Total Gross Billed is the amount that we will refer to in order to reference what BHD is billing for services it is providing.

Chart 1: Methodology to Calculate Gross Billed Amount



Net Revenue

The claims data also included various components of the BHD revenue recognition process, in addition to the Gross Billed components mentioned previously. Other revenue recognition financial components included write-offs, bad debt, recoupment, and bankruptcy losses. These components are defined below. Each of these components, with exception to recoupment, are financial debits that reduce BHD overall revenue. To determine the Net Revenue, the Gross Billed Amount was reduced by write-offs, bad debt, and bankruptcy and the recoupment amounts that were credited to the amount received. It is important to note that this does not include the costs to provide care or any supplemental payments BHD receives; is referred to as Net Revenue to be consistent with BHD business processes. Note that the Net Revenue was calculated at the claim level using claims data through November 2015. The amounts included in this report for 2013 and 2014 will have additional months of runout and transfer payments than would likely have been captured in the BHD general ledger each year. The adjusted 2015 Net Revenue was estimated using 11 months of claims without runout and represents an estimated net revenue for the full year.

The components of Net Revenue are demonstrated in the chart; a description of the elements that compose Net Revenue are described below. The definitions below were provided by BHD.

Chart 2: Methodology to Calculate Net Revenue



- Charity Write-Off: Write-off resulting from free or reduced fee care established by a consumer’s income and household size. DHS charity care includes write-off amounts for Medicaid beneficiaries classified as under the IMD exclusion.
- Contractual Write-Off: Write-off resulting from care that is discounted under a billing agreement with a third-party payer or established contract rate with DHS (Medicaid) and Medicare.

- Admin Write-Off: Write-off due to a provider action or lack of action such as timely filing, lack of medical necessity, non-credentialed providers, lack of authorization, or a clinical decision that a client's uncovered care should continue (i.e. an insurance company has determined that medical necessity is no longer met but the clinician feels care must continue).
- Bad Debt: Uncollectible Medicare debt derived from deductible and co-insurance. Much of the BHD Medicare Bad Debt occurs as a result of Dual Eligibles who meet the IMD exclusion.
- Recoupment: Money taken back by any Financial Class/Payer for a payment they feel was made in error.
- Bankruptcy: Uncollected payments due to bankruptcy.

Utilization

The final piece of information estimated using the claims data is utilization, which is summarized below for the different Service Categories.

- For both Inpatient and Observation, the number of days was calculated by taking the length of stay (LOS) based on the admission and discharge date on each claim.
- For PCS, the number of visits/services was determined by the count of unique consumer visits or services provided to each consumer.
- For Day Treatment, the number of treatments was determined by the number of unique days of treatment each consumer had.

If a service spanned across multiple calendar years, utilization was attributed to the calendar year in which a service was provided.

Table 1: Service Category and Utilization Summary

Utilization		
Detailed Service Category	Combined Service Category	Utilization
43A Intensive Treatment Unit	Inpatient Adult	Number of Days
43B Adult Acute Unit		
43C Women's Treatment Unit		
53B Children and Adolescent Treatment Unit	Inpatient Child	
Crisis Professional Services	Psychiatric Emergency Room (PCS)	Number of Visits/Services
PCS Room and Board		
Dialectic Behavior Therapy (DBT) Team	Day Treatment	Number of Treatments
Recovery Team		
Observation	Observation	Number of Days

Data Limitations

Data provided contained claims incurred and paid through 11/30/2015. One month of data (December) was missing in 2015, as were several the write-offs that do not occur throughout the year. Therefore, Deloitte needed to use adjustment factors to estimate the complete 2015 Utilization, Gross Billed, and Net Revenue. In order to analyze a full year of data for 2015, adjustment factors were used, and are explained in detail in Appendix 2. Additionally, service units were not provided in the data, i.e., length of an Observation stay or a Day Treatment session. As a result, Utilization for Day Treatment was summarized on a per treatment basis, while Observation stays were summarized on a per diem basis. Detail surrounding this may be found in the next section.

Healthcare Policy Impacts

BHD plays an important role as a safety-net provider for highly complex consumers in Milwaukee County with behavioral health diagnoses, histories, socioeconomic factors, and/or care coordination needs that may currently make treatment in a private hospital inaccessible or less conducive to their care plan and/or recovery. In 2014, nearly 70% of the BHD patient population was covered by government-sponsored insurance (Medicaid or Medicare), while 7% was covered by commercial insurance and 10% was uninsured (self-pay). This is demonstrated in Graph 1, in the Baseline Financial Analysis section. Because of this mix of payers, BHD is unique compared to other behavioral health providers in the County.

There are a few key Federal and State healthcare financing policies anticipated to change that have the potential to impact the BHD revenue model. As part of the Deloitte analysis, we studied the policy and financial implications of the Federal exclusion for payment to Institutes for Mental Disease (IMD) and inclusion of behavioral health benefits into Wisconsin Medicaid managed care program through waivers. A brief background on these policies is below; the financial impact of these policies is demonstrated in detail in Elements 1-3.

Exclusion for Institutes for Mental Disease (IMD)

Section 1905(c) of the Social Security act prohibits any state Medicaid agency from paying for services provided to certain Medicaid beneficiaries—those age 21 and over and younger than 65—while in a public mental health facility or private psychiatric inpatient treatment facility that has more than 16 beds. These facilities are categorized as Institutes for Mental Disease (IMD). BHD operates four 24-bed units for short-term inpatient psychiatric stabilization, classifying it as an IMD. Because payment for Medicaid beneficiaries who meet the age criteria for the IMD exclusion is not covered costs incurred are placed in the BHD non-recoverable financial class. According to BHD, the IMD exclusion represented a loss of around \$3 million in potential revenue (nearly 13%) due to IMD excluded members still in Medicaid FFS in 2015.

However, there are evolving State and Federal policies that are anticipated to lessen the impact of the IMD exclusion on Medicaid payment for inpatient psychiatric services in Milwaukee County. These changes may include waivers allowing Medicaid to pay for acute treatment and recovery services for Substance Use Disorder for which states historically have not received Federal match. This becomes critical as BHD considers partnering with private systems (two of which, Rogers Memorial and Aurora Psychiatric, are subject to IMD exclusion) to provide inpatient psychiatric care.

In addition, CMS’s proposed managed care rules contain a provision allowing states to include inpatient stays less than 15 days in their capitation payments and create longer stays by aligning stays over two consecutive months (14 days in one month and 14 in the next). A discussion of these policy options and modeling of financial impacts is included in Element 3 of this report.

Integration of Behavioral Health Benefit into Medicaid Managed Care

Wisconsin Act 55 requires DHS to propose changes to the Family Care and IRIS programs that will integrate behavioral health, long-term, acute, and primary care services through regional, integrated health agencies (IHAs) available in every county across the State². A policy paper³ was released in March 2016 that details plans to integrate the benefits, divide the State into three regions, and contract with three IHAs in each region.

Through this new model, BHD may have opportunity to serve a broader population of Family Care beneficiaries with inpatient and outpatient services, day treatment services, crisis intervention, Community Support Program (CSP), Comprehensive Community Services (CCS), and Community Recovery Services (CRS). Dual Eligible members who qualify for Family Care benefits will have the choice of selecting an IHA or receiving benefits (including behavioral health) through a FFS structure.

Once DHS receives public comment on the policy paper, it will seek Legislative approval and then begin development on a waiver, likely in 2016.

Baseline Financial Analysis

In the section below, Deloitte provides a “baseline” perspective of certain aspects of BHD current financials. These aspects include: Utilization, Cost, Gross Billed, Net Revenue, and Supplemental Payments.

² <https://www.dhs.wisconsin.gov/familycareiris2/dhs-publichearing-092015.pdf>

³ <https://www.dhs.wisconsin.gov/familycareiris2/familycare-irisconceptpaper.pdf>

Approach to Baseline Analysis

The analysis used data from 2013, 2014 and 2015 as a basis for estimates and projections detailed in Elements 1 through 3. Data from 2013 and 2014 was assumed by Deloitte to be complete and required no adjustments; data received for 2015 contained services through November 30, 2015. As such, adjustment factors were used to estimate December 2015 experience in order to estimate a full year of data in 2015 that could then be compared to the potential scenarios in 2016-2018 shown in Element 2.

Utilization

The information in Table 3 demonstrates the utilization of different categories of service in additional detail. For the purposes of this analysis, utilization is defined differently for each service category:

- **Days** - the total number of days consumers received Inpatient, Observation and Day Treatment services at the BHD Inpatient psychiatric hospital
- **Services** – the total number of services provided in Psychiatric Emergency Room (PCS) and is separated into PCS Room and Board and Crisis Professional Services at the request of BHD.
- **Bed Days** - the total number of days for all consumers provided Inpatient and Observation
- **Average Census**—the percentage of bed days used each year, divided by available beds (based on 102 beds each day of the year)
- **Average Length of Stay**—the average number of days spent in inpatient psychiatric hospital, based on admission and discharge (total number of bed days divided by total consumers)

Table 3* below details utilization of BHD services at the psychiatric hospital. Unadjusted 2015 utilization is based on 11 months of data provided; Adjusted 2015 shows estimated 2015 utilization using adjustment factors. There was a slight increase in use of child inpatient services from 2013 to 2015, while other services remained fairly flat or decreased slightly, likely due to the strategic reduction in inpatient beds by BHD.

Table 2: Utilization Summary

Analysis of Funding Alternatives for Milwaukee County Department of Health Services Behavioral Health Division
SUMMARY OF FINDINGS

Service Category	Unit Type	2013	2014	Unadjusted 2015	Adjusted 2015
Inpatient Adult	Days	20,617	20,631	18,626	20,726
Inpatient Child	Days	2,692	3,505	3,398	3,462
Crisis Professional Services	Services	9,404	8,767	7,836	8,077
PCS Room and Board	Services	10,446	9,702	8,698	9,013
Observation	Days	2,347	2,759	1,757	1,815
Day Treatment	Days	2,365	2,926	2,312	2,424
Total		47,871	48,290	42,627	45,517

****Utilization of the Psychiatric Emergency Room (PCS) is separated into PCS Room and Board and Crisis Professional Services at the request of BHD.***

Table 3 shows the total Bed Days and Census by Financial Class/Payer for 2013-2015. Bed Days are calculated by totaling adult and child inpatient and observation services and are represented below by Financial Class/Payer. Overall, the number of Bed Days and the Average Census has remained steady across the three year historical experience data.

Table 3: Bed Days and Census Information

Financial Class/Payer	Bed Days			
	2013	2014	Unadjusted 2015	Adjusted 2015
Medicare FFS	1,988	1,641	1,934	1,557
Medicare MCO	801	968	1,547	1,311
Medicaid FFS	2,759	2,692	1,675	1,706
Medicaid MCO	4,072	4,718	6,226	6,445
Commercial	626	747	817	616
Other	542	576	101	157
Non-Recoverable	8,690	9,576	4,491	6,971
Self-Pay	1,785	1,707	2,100	3,259
Dual FFS	3,600	3,119	3,867	3,114
Dual MCO	793	1,151	1,023	867
Total	25,656	26,895	23,781	26,003

Total Available Bed Days	37,230	37,230	37,230	37,230
Average Census	69%	72%	70%	70%

Table 4 below shows the Average Length of Stay for Inpatient visits for children and adults. Average Length of Stay for Inpatient services varies for each Financial Class/Payer; consumers in the Dual MCO financial class/payer group had the longest length of stay.

Table 4: Average Inpatient Length of Stay

Financial Class/Payer	Average Inpatient Child LOS			Average Inpatient Adult LOS		
	2013	2014	2015	2013	2014	2015
Medicare FFS				15.8	18.2	21.5
Medicare MCO				14.5	19.1	20.2
Medicaid FFS	3.5	3.5	4.1	12.5	11.4	9.7
Medicaid MCO	3.2	3.5	4.1	10.7	11.8	14.9
Commercial	3.6	2.8	3.0	9.6	8.4	7.5
Non-Recoverable	2.6	2.7	3.5	14.0	19.5	19.5
Self-Pay	3.1	3.0	3.3	11.1	15.3	27.8
Other	4.3	4.5	3.0	9.0	15.4	9.8
Dual FFS				17.2	19.1	28.6
Dual MCO				18.0	24.1	30.1

Note: LOS was calculated by taking the number of days divided by the number of admissions

Unit Cost

The Unit Cost (cost per unit) was provided by BHD at the service category level. The costs used throughout this report are based on this cost per unit calculation and do not completely reflect the total operational costs for BHD.

Based on discussions with BHD, it is our understanding that the cost per unit is consistent across Financial Classes/Payers. To achieve the estimated total cost for each claim, Utilization was multiplied by the Unit Cost. The following list includes additional information regarding the Unit Cost information received:

- Cost is differentiated between adult and child-related Inpatient services.
- PCS costs are split among five differentiated ER levels and PCS Room and Board services.
- Day Treatment services are assumed to be billed at cost, as service units were not provided in the data.
- Costs related to Observation services are the same as those for adult Inpatient services each year.

Table 5 shows Unit Cost, Utilization, and Total Cost for 2013-2015. It shows that the average Unit Cost increased over 9% each year from 2013-2015.

Table 5: Estimate of costs over the three year experience period (based on cost per unit provided by BHD)

Service Category	2013 Cost			2014 Cost			2015 Adjusted Cost		
	Unit Cost	Utilization	Total Cost	Unit Cost	Utilization	Total Cost	Unit Cost	Utilization	Total Cost
Inpatient Adult	\$1,389	20,617	\$ 28,637,013	\$1,483	20,631	\$ 30,595,773	\$1,694	20,726	\$ 35,109,322
Inpatient Child	\$2,672	2,692	\$ 7,193,024	\$2,400	3,505	\$ 8,412,000	\$2,215	3,462	\$ 7,668,574
Crisis Prof. Services ER Level 1	\$56	3,141	\$ 175,896	\$56	1,837	\$ 102,872	\$56	1,634	\$ 91,527
Crisis Prof. Services ER Level 2	\$84	2,708	\$ 227,472	\$84	2,885	\$ 242,340	\$84	2,486	\$ 208,785
Crisis Prof. Services ER Level 3	\$151	3,184	\$ 480,784	\$151	2,993	\$ 451,943	\$151	2,397	\$ 361,959
Crisis Prof. Services ER Level 4	\$232	319	\$ 74,008	\$232	758	\$ 175,856	\$232	1,102	\$ 255,750
Crisis Prof. Services ER Level 5	\$364	52	\$ 18,928	\$364	294	\$ 107,016	\$364	456	\$ 166,145
PCS Room and Board	\$590	10,446	\$ 6,163,140	\$699	9,702	\$ 6,781,698	\$639	9,011	\$ 5,758,078
Observation	\$1,389	2,347	\$ 3,259,983	\$1,483	2,759	\$ 4,091,597	\$1,694	1,815	\$ 3,074,305
Day Treatment	\$624	2,365	\$ 1,474,930	\$607	2,926	\$ 1,776,891	\$668	2,424	\$ 1,618,450
Total	\$997	47,871	\$ 47,705,178	\$1,092	48,290	\$ 52,737,986	\$1,193	45,517	\$ 54,312,895

Gross Billed and Net Revenue

Each year, Inpatient services provided at the BHD acute psychiatric facility account for about 75% of all Gross Billed amounts and slightly higher percentages each year in Net Revenue. As seen in Table 6 below, the distribution of Gross Billed among different aggregated service categories remained about the same from 2013 to 2015. The distribution of Net Revenue has changed since 2013, driven by increases in Inpatient Net Revenue and decreases in Net Revenue for PCS.

Table 6: Gross Billed and Net Revenue by Service Category⁴

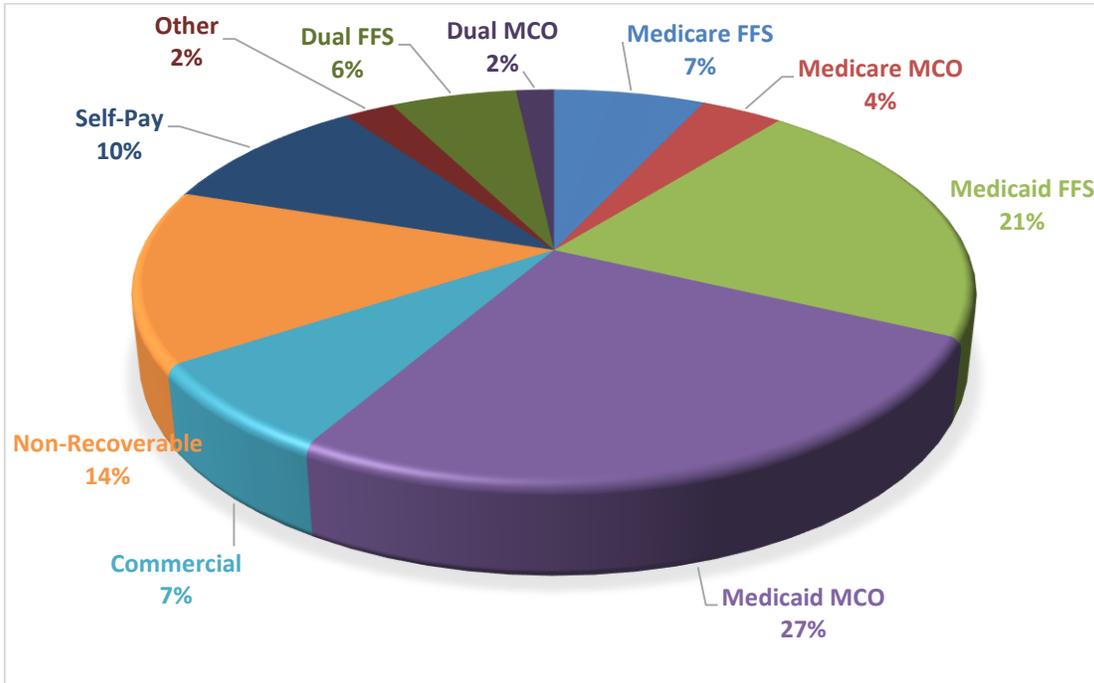
Services Summary	2013		2014		2015 Adjusted	
	Dollars	% of Total	Dollars	% of Total	Dollars	% of Total
Gross Billed	\$47,985,185	100%	\$49,895,177	100%	\$52,122,784	100%
<i>Inpatient</i>	\$35,738,190	74%	\$37,147,445	74%	\$40,047,963	77%
<i>Psychiatric Emergency Room (PCS)</i>	\$7,322,089	15%	\$6,881,784	14%	\$6,899,908	13%
<i>Observation</i>	\$3,449,976	7%	\$4,089,057	8%	\$3,519,177	7%
<i>Day Treatment</i>	\$1,474,930	3%	\$1,776,891	4%	\$1,655,736	3%
Net Revenue	\$17,313,803	100%	\$20,486,539	100%	\$24,014,720	100%
<i>Inpatient</i>	\$13,545,976	78%	\$17,070,241	83%	\$20,017,320	83%
<i>Psychiatric Emergency Room (PCS)</i>	\$2,924,712	17%	\$2,302,993	11%	\$2,625,570	11%
<i>Observation</i>	\$859,303	5%	\$949,183	5%	\$1,021,521	4%
<i>Day Treatment</i>	-\$16,188	0%	\$164,123	1%	\$350,309	1%

⁴ 2015 data was based on 11 months of data with a singular month of runout

Consumers of Inpatient Services by Financial Class/Payer

To further understand the distribution of BHD business by Financial Class/Payer, we analyzed consumers served by Financial Class/Payer. As seen in the following graph, the highest percentage of consumers served by BHD in 2014 were covered by Medicaid MCO.

Graph 1: 2014 Distribution of Consumers Receiving Services by Financial Class/Payer



The distribution of number of consumers by Financial Class/Payer has changed fairly significantly over the past three years. The payer mix (as measured by the number of consumers) has shifted towards Medicaid MCO managed care. In 2013, about 40% of all Gross Billed Amounts was attributed to Self-Pay, Non-Recoverables, and “Other” Financial Classes/Payers. A majority of these fell under Non-Recoverable and Self-Pay, driven by IMD exclusion, Medicare expired bed days, and inability for indigent consumers to pay. As shown in Table 7 below, this trend decline over the past two years as the market shifted from Medicaid FFS towards Medicaid managed care, and BHD realized revenue previously lost due to the IMD exclusion.

Table 7: Consumer and Gross Biller per Consumer by Financial Class/Payer (2013 – 2015)

Financial Class/Payer	Consumer				Gross Billed Per Consumer			
	2013	2014	2015	2013 - 2015 Annualized Trend	2013	2014	2015	2013 - 2015 Annualized Trend
Medicare FFS	776	509	318	-36%	\$4,143	\$4,836	\$9,036	48%
Medicare MCO	227	276	209	-4%	\$6,053	\$7,306	\$11,517	38%
Medicaid FFS	1,248	1,549	1,147	-4%	\$5,294	\$4,440	\$5,072	-2%
Medicaid MCO	1,748	1,926	2,260	14%	\$5,004	\$5,510	\$7,039	19%
Commercial	558	538	445	-11%	\$2,697	\$3,811	\$5,170	38%
Non-Recoverable	1,924	1,042	401	-54%	\$7,752	\$14,456	\$14,974	39%
Self-Pay	974	732	753	-12%	\$3,630	\$4,310	\$3,182	-6%
Other	299	168	96	-43%	\$3,553	\$5,420	\$4,665	15%
Dual FFS	460	425	424	-4%	\$12,541	\$12,066	\$12,091	-2%
Dual MCO	135	128	115	-8%	\$9,303	\$12,664	\$11,059	9%

Supplemental Payments

Deloitte was provided with supplemental payments made to BHD for 2013-2015. Payments listed below are those BHD received from 2013-2015. According to BHD, supplemental payments account for all additional payments received outside of the claims derived revenue/data.

Supplemental payments are not included in Gross Billed Amounts or Net Revenue, but are added to Net Revenue to create the Final Revenue. Table 8 outlines all supplemental payments received.

Table 8: Supplemental Payments

Supplemental Payment	2013	2014	2015
UPL/CPE	No Payment Received	\$319,000	\$957,000
P4P	No Payment Received	No Payment Received	\$81,085
DSH	No Payment Received	\$1,169,655	\$1,103,421
WIMCR Day Treatment	\$473,604	\$149,305	\$237,923
Medicare Bad Debt	\$56,128	\$51,677	\$64,690
GME	\$213,001	\$219,890	\$76,586
Inpatient Cost Report	\$134,489	\$104,939	\$89,432
Total	\$877,222	\$2,014,466	\$2,610,137

Financial Summary

As seen in the Table 9, in 2014, Cost exceeded Final Revenue by \$30M in 2014. While Cost is currently higher than Gross Billed, the primary driver of the negative Gross Margin is due to the large amount charity care and contractual write-offs.

Financial Classes/Payers with the highest Net Revenue as a percentage of cost—in other words, the largest return on cost—in 2014 were Commercial, Medicare MCO, and managed care for Medicaid-Medicare Dual Eligibles (Dual MCO). The managed care Financial Classes/Payers have a higher Net Revenue as a percentage of cost than FFS Medicaid, Medicare, and Duals.

Table 9: 2014 Financial Summary (in millions)

Financial Summary	2014
A. Gross Billed	\$49.90
B. Charity Write-Offs	(\$14.27)
C. Contractual Write-Offs	(\$13.72)
D. Other Write-Offs	(\$1.42)
E. Net Revenue (A-B-C-D)	\$20.49
F. Supplemental Payments	\$2.01
G. Final Revenue (E+F)	\$22.50
H. Cost	\$52.74
I. Gross Payment (G-H)	(\$30.24)
J. Gross Margin (I / G)	-134.4%

Table 10 below summarizes the 2014 Detailed Financial Summary by Financial Class/Payer. Charity write-offs were not allocated at the payer level, but were allocated to the total net revenue.

Table 10 – 2014 Detailed Financial Summary (in millions)

2014 Financial Summary				
Financial Class/Payer	Gross Billed	Net Revenue*	Cost	NR as a % of Cost
Medicare FFS	\$2.46	\$1.22	\$2.66	46%
Medicare MCO	\$2.02	\$1.00	\$1.79	56%
Medicaid FFS	\$6.88	\$2.15	\$7.77	28%
Medicaid MCO	\$10.61	\$6.09	\$11.48	53%
Commercial	\$2.05	\$1.76	\$2.07	85%
Other	\$0.91	\$0.85	\$1.09	78%
Non-Recoverable	\$15.06	\$15.09	\$15.40	98%
Self-Pay	\$3.15	\$3.00	\$3.29	91%
Dual FFS	\$5.13	\$2.56	\$5.33	48%
Dual MCO	\$1.62	\$1.04	\$1.85	57%
Charity Write-Offs		(\$14.27)		
Total	\$49.90	\$20.49	\$52.74	39%

* Net Revenue includes contract write-offs, admin write-offs, bad debt, recoupment, and bankruptcy

**Charity write-offs that were allocated to specific payers are included in Total Revenue only and not Net Revenue by Financial Class/Payer

Analysis of Funding Alternatives for Milwaukee County Department of Health Services Behavioral Health Division
SUMMARY OF FINDINGS

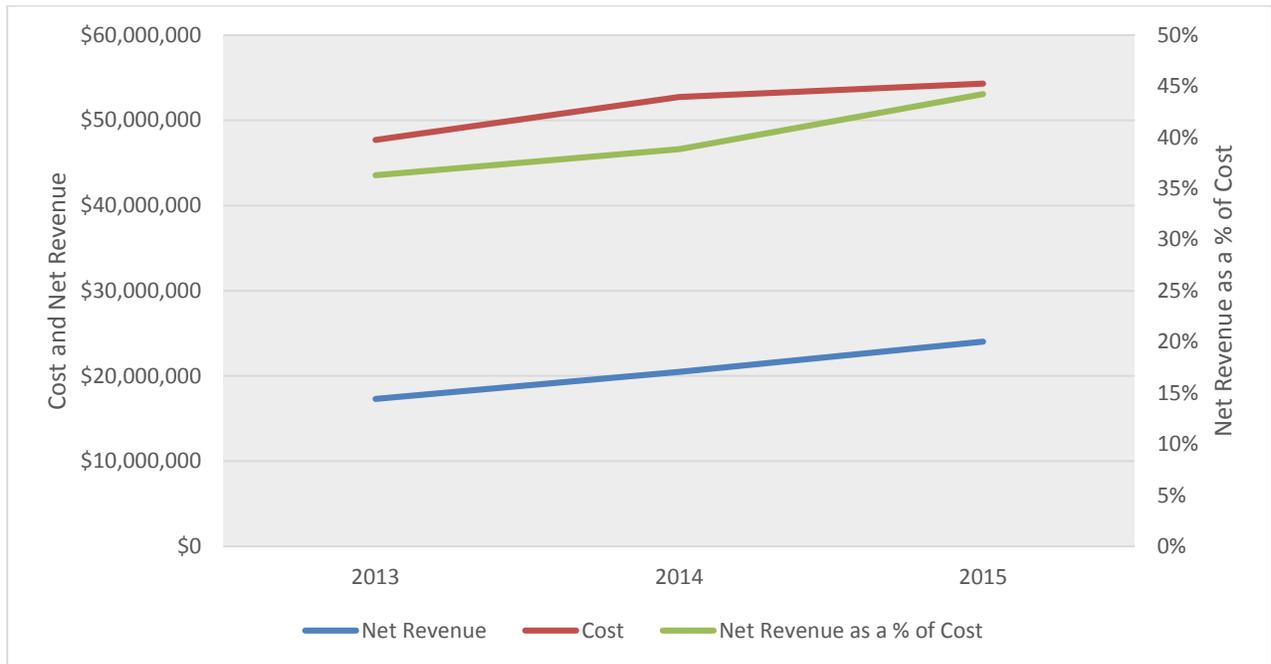
Table 11 and Graph 2 below provide a snapshot of BHD financials based on historical information from 2013-2015. The snapshot reflects assumptions outlined throughout this section.

Gross Payments represent the profit realized by BHD after taking into account costs and supplemental payments each year. Because many BHD services are billed at or below cost and there are large write-offs and other expenses, there is a large negative margin each year. However, the margin has improved each year as Net Revenue has increased at a faster rate than Cost.

Table 11 – Current Financial Snapshot with Adjusted 2015 Data

Services Summary	2013		2014		2015 Adjusted	
	Dollars	% of Total	Dollars	% of Total	Dollars	% of Total
Gross Billed	\$47,985,185	100%	\$49,895,177	100%	\$52,122,784	100%
<i>Inpatient</i>	\$35,738,190	74%	\$37,147,445	74%	\$40,047,963	77%
<i>Psychiatric Emergency Room (PCS)</i>	\$7,322,089	15%	\$6,881,784	14%	\$6,899,908	13%
<i>Observation</i>	\$3,449,976	7%	\$4,089,057	8%	\$3,519,177	7%
<i>Day Treatment</i>	\$1,474,930	3%	\$1,776,891	4%	\$1,655,736	3%
Net Revenue	\$17,313,803	100%	\$20,486,539	100%	\$24,014,720	100%
<i>Inpatient</i>	\$13,545,976	78%	\$17,070,241	83%	\$20,017,320	83%
<i>Psychiatric Emergency Room (PCS)</i>	\$2,924,712	17%	\$2,302,993	11%	\$2,625,570	11%
<i>Observation</i>	\$859,303	5%	\$949,183	5%	\$1,021,521	4%
<i>Day Treatment</i>	-\$16,188	0%	\$164,123	1%	\$350,309	1%
Cost	\$47,705,178	100%	\$52,737,986	100%	\$54,312,895	100%
<i>Inpatient</i>	\$35,830,037	75%	\$39,007,773	74%	\$42,777,896	79%
<i>Psychiatric Emergency Room (PCS)</i>	\$7,140,228	15%	\$7,861,725	15%	\$6,842,244	13%
<i>Observation</i>	\$3,259,983	7%	\$4,091,597	8%	\$3,074,305	6%
<i>Day Treatment</i>	\$1,474,930	3%	\$1,776,891	3%	\$1,618,450	3%
Supplemental Payments	\$877,222	100%	\$2,014,466	100%	\$2,610,137	100%
<i>UPL/CPE</i>	\$0	0%	\$319,000	16%	\$957,000	37%
<i>P4P</i>	\$0	0%	\$0	0%	\$81,085	3%
<i>DSH</i>	\$0	0%	\$1,169,655	58%	\$1,103,421	42%
<i>WIMCR Day Treatment</i>	\$473,604	54%	\$149,305	7%	\$237,923	9%
<i>Medicare Bad Debt</i>	\$56,128	6%	\$51,677	3%	\$64,690	2%
<i>GME</i>	\$213,001	24%	\$219,890	11%	\$76,586	3%
<i>Inpatient Cost Report</i>	\$134,489	15%	\$104,939	5%	\$89,432	3%
Gross Payment	(\$29,514,153)		(\$30,236,980)		(\$27,688,038)	
Gross Margin	-162%		-134%		-104%	

Graph 2: Current Financial Snapshot



Funding Alternatives Available to Behavioral Health Division

Element 1

Element 1 is an analysis of the current business, analyzing historical Gross Billed, Final Revenue, Cost, and Utilization.

Below are key findings from our analysis in Element 1:

Key Findings
<ul style="list-style-type: none">• Net Revenue as a percent of Cost is increasing. In 2013, Net Revenue as a percentage of Cost was 36%. In 2015, Net Revenue as a percentage of Cost was estimated to be 44%.• The historical cost from 2013-2015 is trending at a higher rate than Gross Billed. Cost is trending at 6.7% while Gross Billed is trending at 4.2% from 2013-2015. This is causing the difference between Cost and Gross Billed, where Cost is now higher in 2015, to continue to increase.• Net Revenue as a percentage of Gross Billed is increasing. The gap between Gross Billed and Net Revenue (i.e. amount of Non-Recoverables, Write-Offs, etc.) has decreased over the past three years. Therefore, the amount of Net Revenue as a percent of Gross Billed has increased and has improved the financial performance over the past few years.• Profitability by Financial Class/Payer varies significantly. Medicaid and Medicare FFS have the lowest Net Revenue as a percentage of cost across all Financial Classes/Payers. On the other end, Commercial is one of the smallest payers based on Gross Billed for BHD, but has the highest Net Revenue as a percentage of cost excluding the “Other”, Self-Pay and Non-Recoverable Financial Classes, which include the majority of charity write-offs.• Shift from FFS to managed care has occurred from 2013-2015. The BHD Medicare and Medicaid business has shifted from services provided under FFS arrangements to

Key Findings

managed care. It is our understanding that this shift has been largely driven by expansion of BadgerCare to include childless adults who, as of April 2014, are enrolled in Medicaid MCOs.

- **The level of charity care is historically reducing Net Revenue by over 40%.** In 2014, charity care accounted for over \$14,000,000 in lost revenue. BHD estimates that \$3,000,000 is lost due to the IMD exclusion. The impact of recognizing revenue on these dollars is analyzed in Element 2.
- **Commercial business has been the most profitable.** While commercial business is a small percentage of the BHD overall book of business based on Gross Billed, the profitability of that business is the highest amongst all payer categories.
- **Inpatient, Observations and Day Treatment utilization has been stable while the Utilization of the other services has decreased.** From 2013-2015, Inpatient, Observations and Day treatment utilization increased 0.7% annually. While utilization of these services has been flat, there was a decrease of 7% annually in the utilization of other services (i.e., PCS Room and Board and Crisis Professional Services).

Historical 2013-2015

The table below demonstrates historical Gross Billed, Cost and Net Revenue and calculation of the annualized trend for each. Although Cost has increased at a faster rate than Gross Billed each year, Net Revenue has increased at a faster rate than both. This creates a decreasing gap between Gross Billed and Net Revenue seen below, causing an improvement in Gross Margin each year.

Table 12 – Gross Billed, Cost, and Net Revenue by year (in millions)

Financial Type	2013	2014	2015	Annualized Trend
Gross Billed (in millions)	\$47.99	\$49.90	\$52.12	4.2%
Cost (in millions)	\$47.71	\$52.74	\$54.31	6.7%
Gap GB to NR	\$30.67	\$29.41	\$28.11	-4.3%
Net Revenue (in millions)	\$17.31	\$20.49	\$24.01	17.8%
Ratio (NR/GB)	0.36	0.41	0.46	

Table 13 below provides a snapshot of financial data provided. As Final Revenue increases at a faster rate than Cost each year, and additional supplemental payments are received, Gross Margin improves each year analyzed. BHD staff reported to Deloitte that four factors were primarily responsible for this trend in Gross Margin

These adjustments include, but are not limited to:

1. Enrollment of the previously uninsured childless adult population into Medicaid MCOs beginning in April 2014, thus increasing net revenue.
2. The BHD strategy to encourage enrollment of SSI beneficiaries covered under FFS Medicaid into SSI managed care plans, thus increasing net revenue.
3. A reduction of overhead by approximately \$1 million in 2015, thus reducing cost.

BHD indicates that because these were one-time efforts or included time-limited factors, the trend observed from 2013-2015 is expected to carry forward.

Table 13: Financial Snapshot for Experience Period (2013-2015)

Services Summary	2013	2014	2015
A. Gross Billed	\$47.99	\$49.90	\$52.12
B. Write-Offs	(\$30.67)	(\$29.41)	(\$28.11)
C. Net Revenue (A-B)	\$17.31	\$20.49	\$24.01
D. Supplemental Payments	\$0.88	\$2.01	\$2.61
E. Final Revenue (C+D)	\$18.19	\$22.50	\$26.62
F. Cost	\$47.71	\$52.74	\$54.31
G. Gross Payment (E-F)	(\$29.51)	(\$30.24)	(\$27.69)
H. Gross Margin (G / E)	-162.2%	-134.4%	-104.0%

Graph 3: Estimated Financial Snapshot for Experience Period (2013-2015)

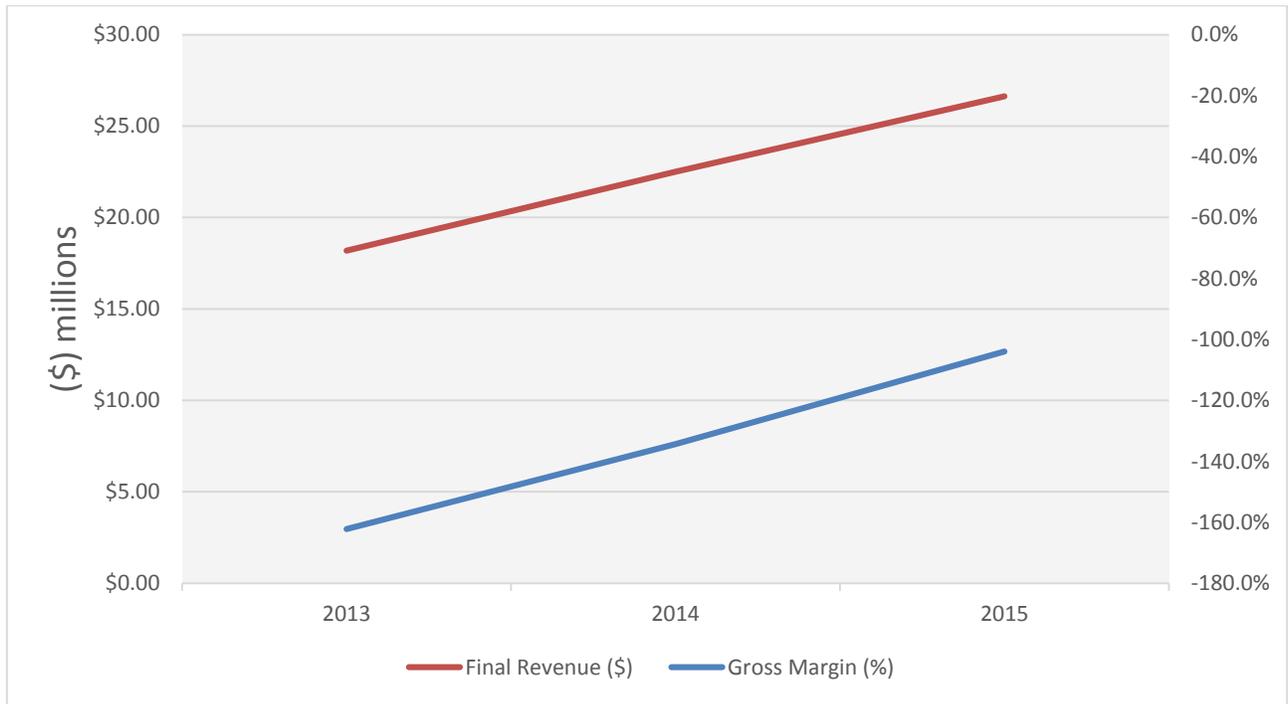


Table 14 below shows the Medicaid managed care net revenue estimates for Inpatient children and (age < 18) adults, as well as the other categories of service that made up a small percentage of net revenue in 2014.

Table 14: Medicaid MCO Net Revenue by Service Category

Service Category	2014		
	Net Revenue (\$ Millions)	% of Medicaid MCO	Unit Net Revenue
Inpatient Adult	\$2.66	44%	\$1,054
Inpatient Child	\$2.38	39%	\$1,299
Crisis Professional Services	\$0.05	1%	\$21
PCS Room and Board	\$0.79	13%	\$279
Observation	\$0.04	1%	\$116
Day Treatment	\$0.17	3%	\$235

Appendix 3 contains more detail on the trends observed for Gross Billed, Net Revenue, Utilization and Cost for 2013-2015. Further shifts in payer mix as the result of policy changes and other external factors are described in Element 2.

Element 2

This section analyzes scenarios that could impact BHD financials such as changes in the payer mix and reduction in cost. Element 2 models these potential impacts on the 2015 adjusted experience to Gross Billed, Net Revenue, Utilization and Cost. The estimated impact through 2018 assumes that costs and revenue remain consistent with 2015 experience. Therefore, no trend was applied to the 2015 adjusted financial data.

Potential market changes and shifts are analyzed in five separate scenarios as described below. Specific cases were chosen for each of the five scenarios to analyze the market impact and give a range of the potential financial impacts within each scenario. The five scenarios we explore are:

1. Shift in business from Medicaid FFS to Medicaid managed care
2. Increase in Commercial Non-MCO and Commercial MCO business
3. Decrease in Unit Costs for all services
4. Total coverage of IMD excluded members
5. Shift of Non-Recoverable and Self-Pay Financial Classes/Payers to other Financial Classes/Payers

From 2013 to 2015, BHD experienced annual increases in Gross Billed, Net Revenue, and Costs. As Net Revenue increased at a faster rate than Cost, BHD experienced improvements in Gross

Margin. Still, revenue is negatively impacted each year by the large amount of write-offs associated with non-recoverable self-pay clients. BHD Commercial payer business, which is the most profitable, only comprises about 5% of the business.

However, there are opportunities to grow Net Revenue, improve Gross Margin, and provide a more sustainable business revenue model. The scenarios analyzed within this section outline some of the opportunities that exist, and what potential financial impacts they could have on BHD over the next three years.

The key findings from analysis of the scenarios described above are highlighted in the following table.

Key Findings
<ul style="list-style-type: none">• Medicaid Institutions for Mental Diseases (IMD) opportunity. BHD estimated a loss of approximately \$3,000,000 in potential revenue due to IMD excluded members in 2015. If BHD is able to make efforts to continue to encourage enrollment of Medicaid SSI beneficiaries into Medicaid MCOs or there are DHS policy changes that result in mandatory MCO enrollment, BHD Gross Margin could increase up to 21 percentage points each year.• Cost reduction opportunities. Through discussions with BHD it is our understanding that some of the costs (e.g. facility rent) may be higher than the market standard. We would recommend a further assessment of current costs for each category (i.e. staff, facility, meals, security, etc.) and compare to behavioral health providers in the Wisconsin and Milwaukee County area. For example, a 5% reduction in cost each year would improve the gross margin by 30 percentage points by 2018.• Increased revenue opportunities. With the cost beginning to exceed most payer gross billed amounts in 2015, there may be opportunity to increase fee schedules or contracted rates under a managed care program. There are dependencies that would need to be addressed in order to increase rates, such as, Wisconsin DHS payment policy for Medicaid including actuarial soundness requirements, availability of State and/or local matching Medicaid funds, BHD/County resources to negotiate managed care rates, etc. Each percentage increase in total revenue is a direct percentage increase in gross margin.

Table 15 demonstrates the additional revenue opportunity of increasing Medicaid managed care net revenue (i.e. gross billed and write-offs) to 85% and 100% of the associated cost. Medicaid managed care business is the largest payer, making up more than 35% of estimated 2015 net

revenue across all payers. The table below summarizes the opportunity to bring revenue closer to cost through increasing Medicaid managed care rates, which would require additional state funding. Additional opportunities to increase revenue, as well as opportunities to reduce costs and improve the overall profitability of BHD, were examined in the five scenarios detailed later in this section.

Table 15: Medicaid Managed Care Estimated 2015 Financial Scenarios

Scenario	Adjusted 2015 (in millions)				
	% of Total Net Revenue	Net Revenue	Cost	Ratio of NR to Cost	State share needed
Adjusted 2015	35.3%	\$8.22	\$13.09	0.628	
Increase to 85% of Cost	42.4%	\$11.13	\$13.09	0.850	\$1.21
Increase to 100% of Cost	46.4%	\$13.09	\$13.09	1.000	\$2.02

Scenario 1

Overview

This scenario explores the impact of the market shifting from Medicaid FFS to Medicaid managed care. We analyze the financial impact of accelerated shifts in the BHD Medicaid payer mix using two models.

- **Scenario 1.1:** 10% of the Medicaid FFS business shifts to Medicaid managed care in 2016, 20% of the Medicaid FFS business shifts to Medicaid MCOs in 2017, and 30% of the Medicaid FFS business shifts to Medicaid MCOs in 2018.
- **Scenario 1.2:** 25% of the Medicaid FFS business shifts to Medicaid managed care in 2016, 50% of the Medicaid FFS business shifts to Medicaid MCOs in 2017, and 75% of the Medicaid FFS business shifts to Medicaid MCOs in 2018.

Assumptions

Modeling in Scenario 1 used the adjusted 2015 experience without trend applied to the 2016 to 2018 estimates. The impacts were applied to the utilization of Medicaid FFS and Medicaid managed care days and services. Unit cost and Gross Billed per unit were assumed to remain constant within Medicaid FFS and Medicaid managed care. No additional adjustments were made and no revenue was realized as a result of IMD excluded members shifting from Medicaid FFS to Medicaid MCOs. For purposes of estimating this scenario impact, supplemental payments in 2016-2018 were assumed to be equal to those received in 2015.

The graph and table below demonstrates the impact in Gross Billed and other financial indicators when Scenarios 1.1 and 1.2 were applied.

Graph 4: Gross Billed Comparison

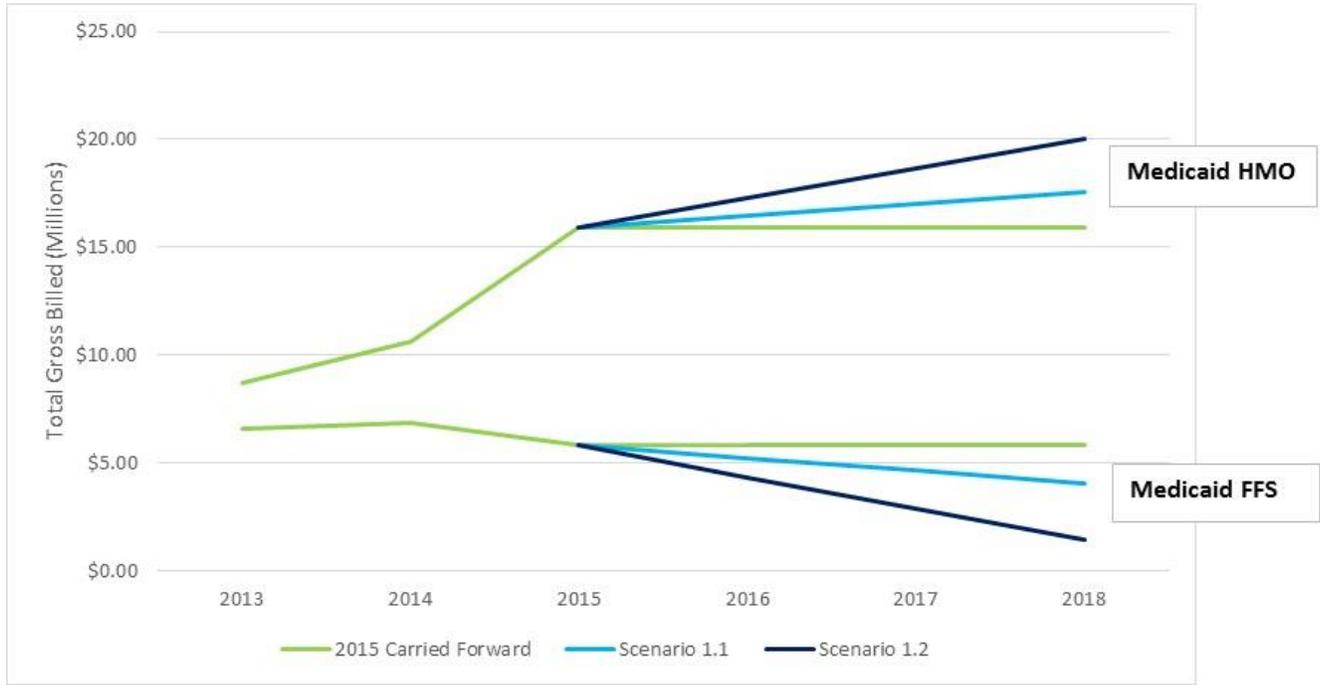


Table 16: Scenario 1 Financial Snapshot¹

		2016	2017	2018
Adjusted 2015 (No Trend Applied to 2016-2018)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$54.31	\$54.31	\$54.31
	Gross Payments	-\$27.69	-\$27.69	-\$27.69
	Gross Margin	-104.0%	-104.0%	-104.0%
Scenario 1.1 (FFS to MCO 10% shift each year)	Revenue	\$26.71	\$26.79	\$26.87
	Cost	\$54.32	\$54.34	\$54.35
	Gross Payments	-\$27.62	-\$27.55	-\$27.47
	Gross Margin	-103.4%	-102.8%	-102.2%
Scenario 1.2 (FFS to MCO 25% shift each year)	Revenue	\$26.83	\$27.04	\$27.25
	Cost	\$54.34	\$54.37	\$54.40
	Gross Payment	-\$27.51	-\$27.33	-\$27.15
	Gross Margin	-102.5%	-101.1%	-99.6%

¹Revenue refers to Total Revenue (Net Revenue + Supplemental Payments)

Additional Findings

- Under both scenarios, there is a small impact to the Gross Margin, which improves 2016-2018.
- While the modeling does not show a significant impact on Gross Revenue, Cost, or Gross Margin, there are other factors that could impact the BHD Medicaid FFS and managed care payer mix. For example, the cost of care and utilization of consumers covered by managed care plans may be less compared to those in FFS.
- Since Cost has grown at a quicker rate than Net Revenue, there would be a positive impact on the Gross Margin.

Additional information regarding the managed care rate setting process for both Medicaid and Medicare may be found in Appendix Element 4.

Scenario 2

Overview

This scenario assesses the impact of growing BHD Commercial Non-MCO and Commercial MCO businesses. While the total Commercial business makes up about 5% of the total business, it is the most profitable. If BHD is able to increase this revenue category, there is a potential to improve the overall margin.

This scenario looks at the estimated financial impacts associated with growing Commercial Non-MCO and Commercial MCO businesses using two models:

- ***Scenario 2.1:*** Commercial and Commercial MCO businesses increase by 5% in 2016, 10% in 2017, and 15% in 2018.
- ***Scenario 2.2:*** Commercial and Commercial MCO businesses increase by 10% in 2016, 20% in 2017, and 30% in 2018.

Assumptions

Modeling in Scenario 2 is applied to the adjusted 2015 experience without trend applied to the 2016 to 2018 estimates. Increases in Commercial business were applied by increasing the utilization estimates. Unit Cost and Gross Billed per unit were assumed to remain constant within the respective Commercial businesses (i.e. Non-MCO and MCO). No additional adjustments were made. For purposes of estimating impact, supplemental payments in 2016-2018 were assumed to be equal to those received in 2015.

Graph 5 and Table 17 below show impacts on BHD Commercial business based on Scenarios 2.1 and 2.1.

Graph 5: Gross Billed Comparison

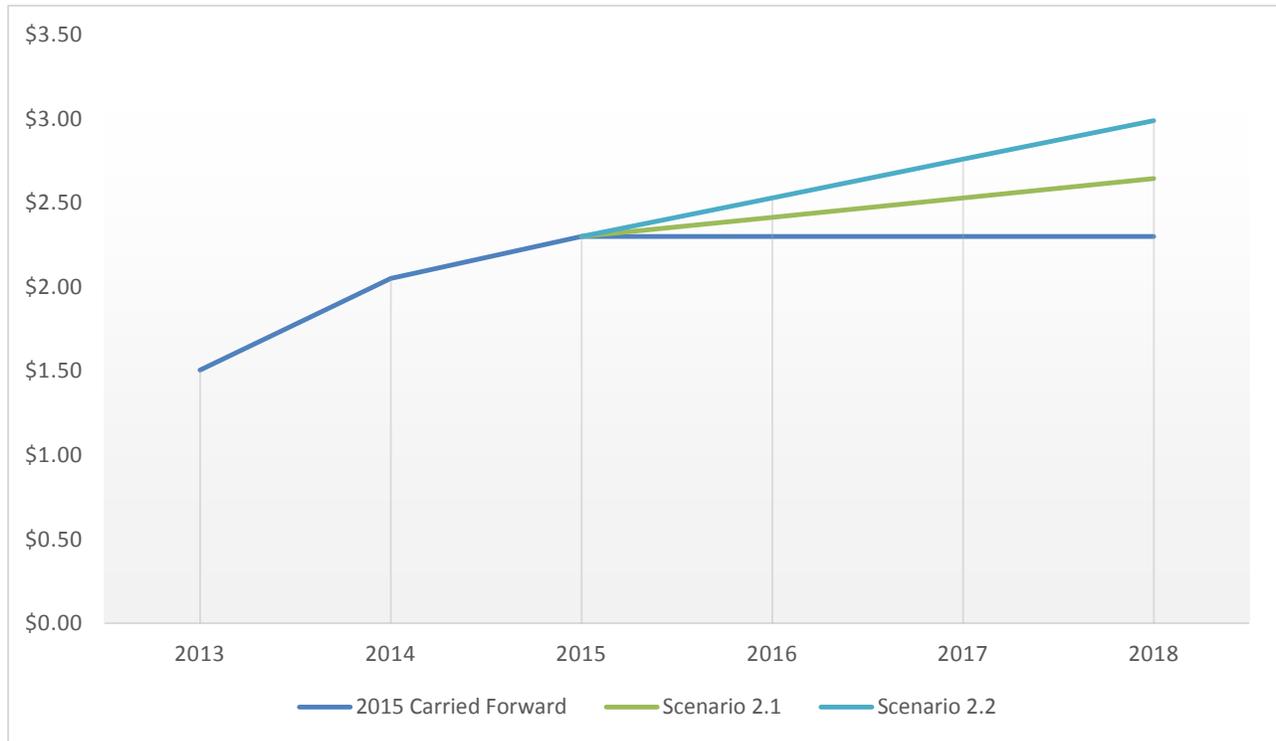


Table 17: Scenario 2 Financial Snapshot¹

		2016	2017	2018
Adjusted 2015 (No Trend Applied to 2016-2018)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$54.31	\$54.31	\$54.31
	Gross Payment	-\$27.69	-\$27.69	-\$27.69
	Gross Margin	-104.0%	-104.0%	-104.0%
Scenario 2.1 (5% Commercial Increase each year)	Revenue	\$26.72	\$26.82	\$26.92
	Cost	\$54.40	\$54.48	\$54.56
	Gross	-\$27.67	-\$27.66	-\$27.64
	Gross Margin	-103.6%	-103.1%	-102.7%
Scenario 2.2 (10% Commercial Increase each year)	Revenue	\$26.82	\$27.02	\$27.21
	Cost	\$54.48	\$54.64	\$54.81
	Gross Payment	-\$27.66	-\$27.63	-\$27.59
	Gross Margin	-103.1%	-102.2%	-101.4%

¹Revenue refers to Total Revenue (Net Revenue + Supplemental Payments)

Additional Findings

- Since the Commercial business is not a significant portion of the total Net Revenue, an increase in the number of consumers covered by Commercial insurers would be necessary to see material improvement in the overall profit margin.
- When assuming a 5% increase in Commercial business, there was an improvement in margin but it was minimal. Even with a 25% increase in Commercial business, the margin only improved approximately three percentage points by 2018.

Scenario 3

Overview

This scenario analyzes the impact of reducing the Cost per unit across the BHD book of business. The majority of services are Inpatient services (~77% in 2015). BHD Cost include salaries and wages, building costs, prescription costs, meal costs, security costs, transportation and other services, information technology, and fiscal and admin costs. BHD noted that the building costs, such as rent, are higher compared to other facilities in the Milwaukee market.

To understand the potential impact of reducing direct and indirect costs, this scenario tests the impact of a reduction of 5-30%. The two sub-scenarios listed below were analyzed in order to get this range of potential financial impact.

- ***Scenario 3.1:*** Unit Costs across all businesses decreases by 5% in 2016, 10% in 2017, and 15% in 2018.
- ***Scenario 3.2:*** Unit Costs across all businesses decreases by 10% in 2016, 20% in 2017, and 30% in 2018.

Assumptions

Modeling in Scenario 3 is applied to the adjusted 2015 experience without trend applied to the 2016 to 2018 estimates. Decreases in costs were applied by reducing the Cost per unit across all Financial Classes/Payers. Utilization and Gross Billed per unit were assumed to remain constant within the respective payers. No additional adjustments were made. For purposes of estimating impact, supplemental payments in 2016-2018 were assumed to be equal to those received in 2015.

The graph and table below demonstrate the impact of reducing Cost.

Graph 6: Total Cost Comparison

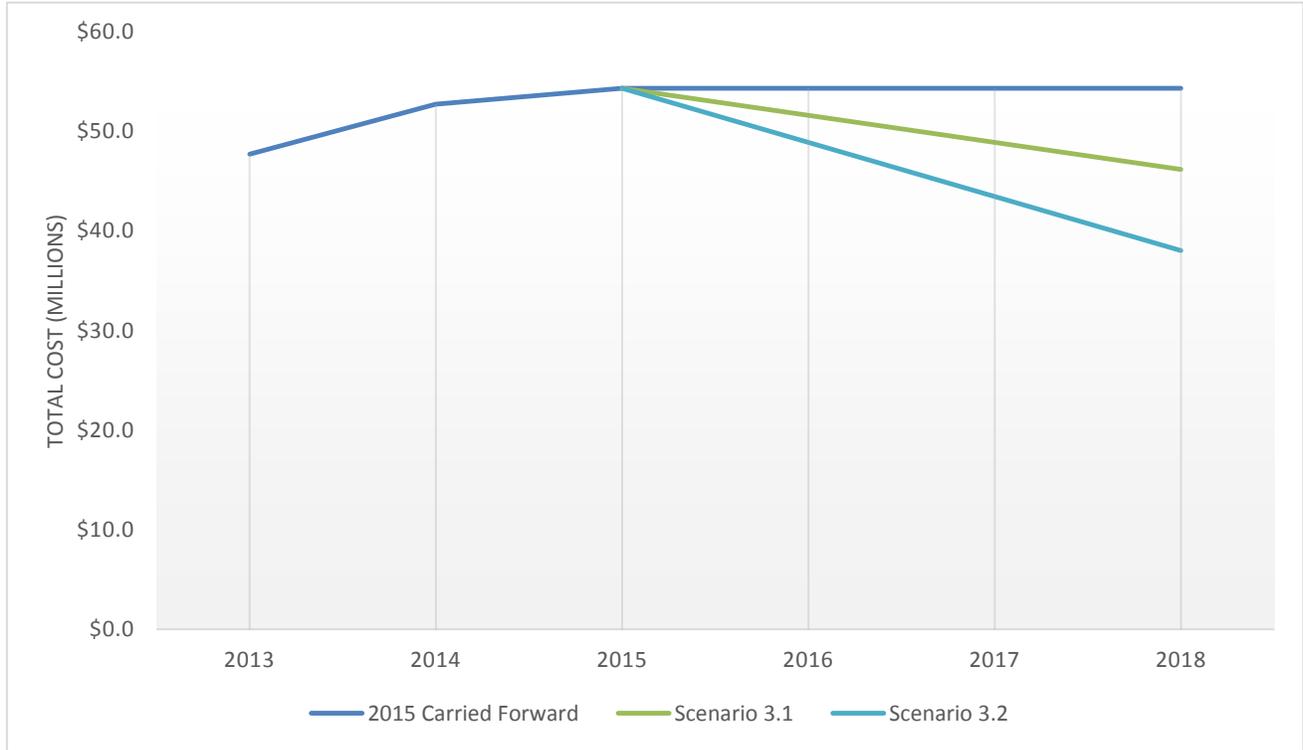


Table 18: Scenario 3 Financial Snapshot¹

		2016	2017	2018
Adjusted 2015 (No Trend Applied to 2016-2018)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$54.31	\$54.31	\$54.31
	Gross Payment	-\$27.69	-\$27.69	-\$27.69
	Gross Margin	-104.0%	-104.0%	-104.0%
Scenario 3.1 (5% Decrease in Unit Costs each year)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$51.60	\$48.88	\$46.17
	Gross Payment	-\$24.97	-\$22.26	-\$19.54
	Gross Margin	-93.8%	-83.6%	-73.4%
Scenario 3.2 (25% Decrease in Unit Costs each year)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$48.88	\$43.45	\$38.02
	Gross Payment	-\$22.26	-\$16.83	-\$11.39
	Gross Margin	-83.6%	-63.2%	-42.8%

¹Revenue refers to Total Revenue (Net Revenue + Supplemental Payments)

Additional Findings

- A reduction in Cost has a significant impact on the profit margin. For every percentage point reduction in Cost there is nearly a two percentage point improvement in Gross Margin.
- The ability to mitigate the increasing costs will have a significant impact on the profit margin over the next several years.
- While the scenarios show a simplistic view of reducing costs, further assessment is required to understand what is driving costs to increase at the current pace.
- We understand BHD performed assessment of indirect costs (i.e. building/facility costs/rent, etc.) that indicates opportunities to significantly reduce these costs. BHD may also consider new opportunities to reduce direct costs through new or modified operating models.

Scenario 4

Overview

This scenario assesses the impact of changes related to the IMD exclusion. As described earlier in this report, section 1905(a)(b) of the Social Security Act prohibits Medicaid agencies to pay for care or services for Medicaid FFS beneficiaries 21 and older and younger than 65 while they are hospitalized in an IMD facility, such as the BHD inpatient psychiatric hospital. BHD estimated a loss of approximately \$3,000,000 in revenue in 2015 due to this exclusion. Coverage for these members has steadily increased due to the market shift from Medicaid FFS to Medicaid managed care, where these services are generally reimbursed.

This scenario looks at the estimated financial impacts associated with BHD ability to obtain full coverage for currently IMD excluded members.

- ***Scenario 4.1:*** \$1 million in revenue lost due to IMD exclusion is recognized in 2016, \$2 million in 2017, and \$3 million in 2018.

Assumptions

Modeling in this scenario used adjusted 2015 experience without trend and applied that to 2016 to 2018 estimates. It was assumed that the additional revenue captured would directly impact Net Revenue. It's our understanding that the Gross Billed amount and Utilization currently include the services and amounts for this population. No additional adjustments were made. For purposes of

estimating impact, supplemental payments in 2016-2018 were assumed to be equal to those received in 2015.

The graph and table below demonstrate the impact of capturing revenue previously lost due to the IMD exclusion.

Graph 7: Total Revenue Comparison

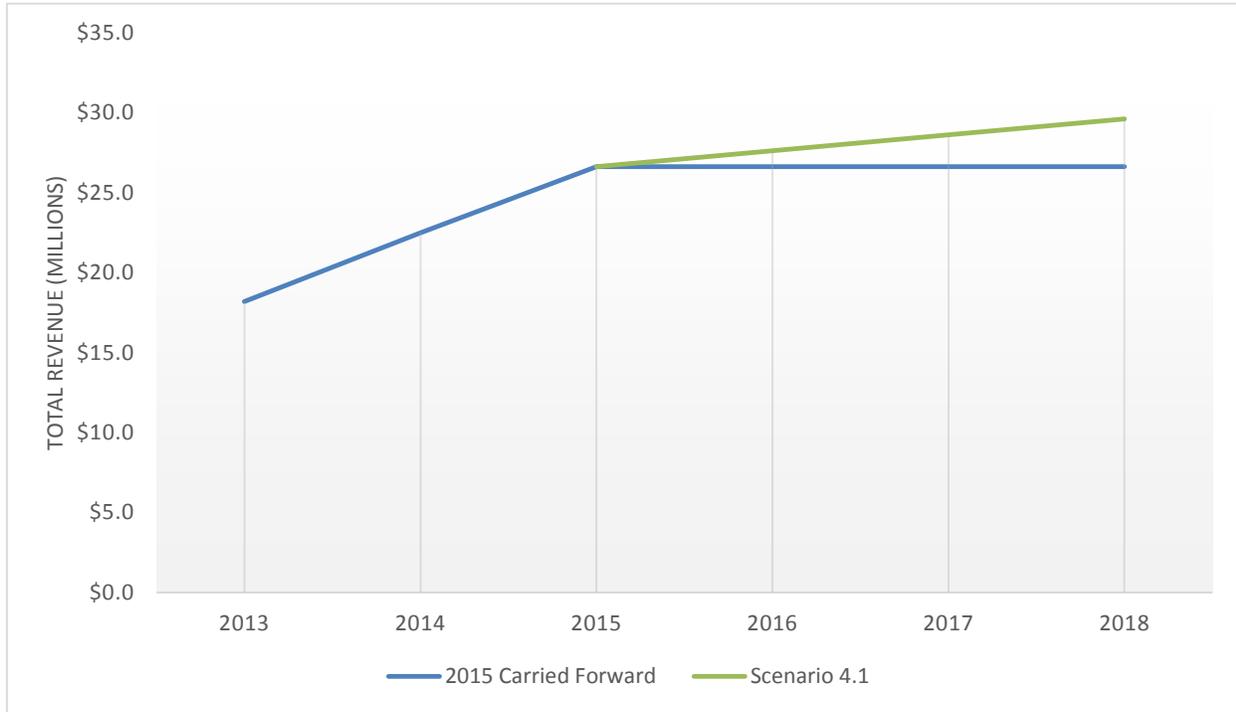


Table 19: Scenario 4 Financial Snapshot¹

		2016	2017	2018
Adjusted 2015 (No Trend Applied to 2016-2018)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$54.31	\$54.31	\$54.31
	Gross Payment	-\$27.69	-\$27.69	-\$27.69
	Gross Margin	-104.0%	-104.0%	-104.0%
Scenario 4.1 (\$1 Million Dollar Removal of IMD Exclusion per year)	Revenue	\$27.62	\$28.62	\$29.62
	Cost	\$54.31	\$54.31	\$54.31
	Gross Payment	-\$26.69	-\$25.69	-\$24.69
	Gross Margin	-96.6%	-89.7%	-83.3%

¹Revenue refers to Total Revenue (Net Revenue + Supplemental Payments)

Additional Findings

- The additional revenue, assuming the IMD population is reimbursable, has the potential to improve the Gross Margin approximately 20 percentage points by 2018.
- The results would be most representative of a policy shift or some other external factor that removes the IMD exclusion.
- It is estimated that BHD Gross Margins will range from -104.0% and -83.3% as shown in Table 19 as more revenue is realized.

Scenario 5

Overview

This scenario assesses the impact of reducing Non-Recoverable and Self-Pay revenue. Because the self-pay population is primarily uninsured, indigent consumers, and as previously explained operates under the IMD exclusion for many Medicaid beneficiaries, BHD writes off nearly all Non-Recoverable and Self-Pay revenue. Through various means, including Medicaid targeted payments, waivers, grants or additional funding sources, there may exist opportunities to shift some of this to a reimbursable Financial Classes/Payers.

To understand the impact of shifting Non-Recoverable and Self-Pay revenue to other Financial Classes/Payers, we modeled two scenario, listed below, to understand the range of potential financial impact.

- ***Scenario 5.1:*** 10% of Self-Pay and Non-Recoverable revenue moved to other Financial Classes/Payers in 2016, 20% in 2017, and 30% in 2018
- ***Scenario 5.2:*** 25% of Self-Pay and Non-Recoverable revenue moved to other Financial Classes/Payers in 2016, 50% in 2017, and 75% in 2018

Assumptions

Modeling used adjusted 2015 experience without trend applied to the 2016 to 2018 estimates. To estimate the impact of reducing these amounts and moving them to a reimbursable financial class, the shift impacts were applied to the Utilization of the different Financial Classes/Payers.

Utilization of Self-Pay and Non-Recoverables was reduced by Scenario 5.1 and 5.2 assumption (e.g. 10% in 2016 for Scenario 5.1) and distributed proportionately to the other Financial Classes/Payers. The Unit Cost and Gross Billed per unit by Financial Class/Payer were assumed to remain constant. For purposes of estimating this scenario impact, supplemental payments in 2016-2018 were assumed to be equal to those received in 2015.

The graph and table below demonstrate the impact of shifting Non-Recoverable and Self-Pay revenue.

Graph 8: Total Revenue Comparison

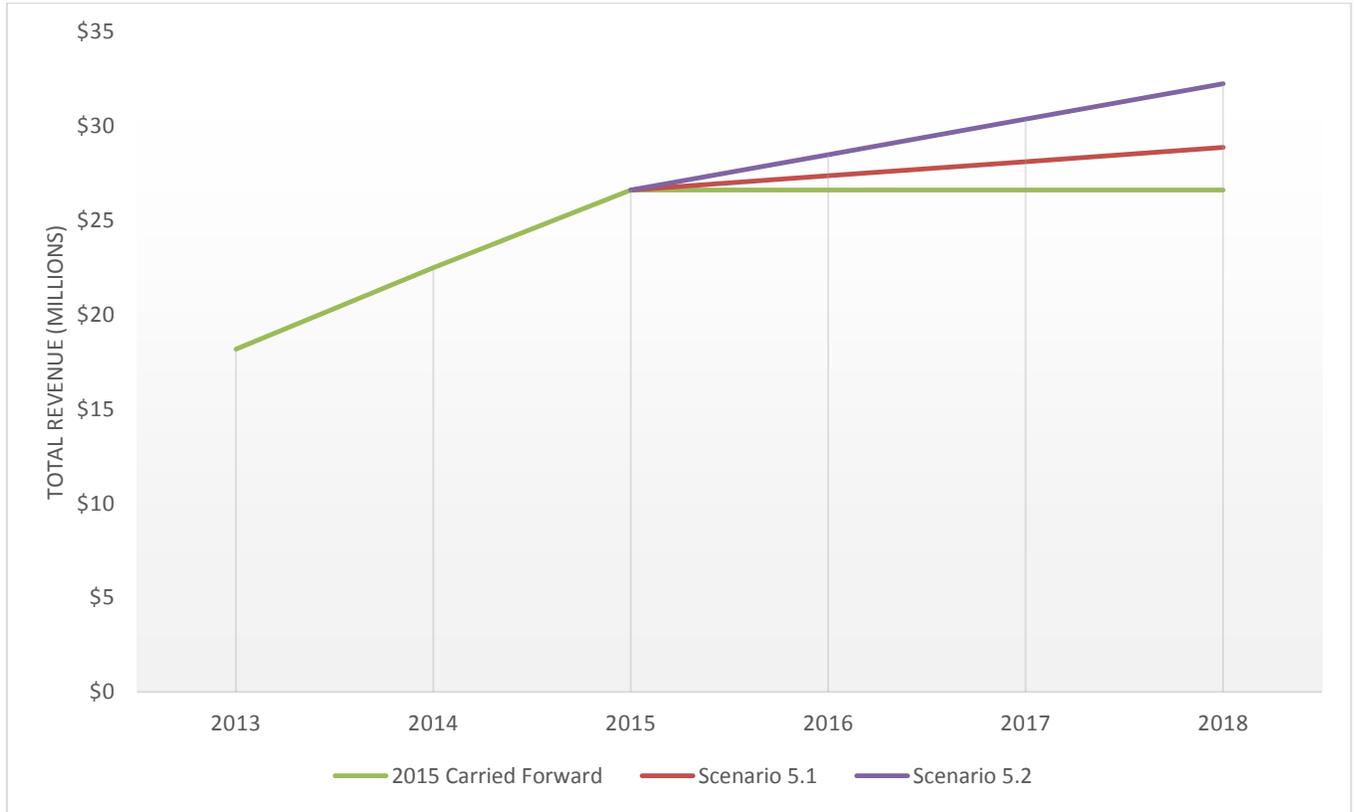


Table 20: Scenario 5 Financial Snapshot¹

		2016	2017	2018
Adjusted 2015 (No Trend Applied to 2016-2018)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$54.31	\$54.31	\$54.31
	Gross Payment	-\$27.69	-\$27.69	-\$27.69
	Gross Margin	-104.0%	-104.0%	-104.0%
Scenario 5.1 (10% Decrease in Non-Recoverables and Self-Pay each year)	Revenue	\$27.37	\$28.12	\$28.87
	Cost	\$54.32	\$54.33	\$54.33
	Gross Payment	-\$26.95	-\$26.20	-\$25.46
	Gross Margin	-98.4%	-93.2%	-88.2%
Scenario 5.2 (25% Decrease in Non-Recoverables and Self-Pay each year)	Revenue	\$28.50	\$30.37	\$32.25
	Cost	\$54.33	\$54.35	\$54.37
	Gross Payment	-\$25.83	-\$23.98	-\$22.12
	Gross Margin	-90.6%	-78.9%	-68.6%

¹Revenue refers to Total Revenue (Net Revenue + Supplemental Payments)

Additional Findings

- Table 20 illustrates Gross Margin is significantly improved by shifting Non-Recoverable and Self-Pay revenue to a reimbursable Financial Class/Payer.
- Since Non-Recoverable and Self-Pay Financial Classes typically contribute little to no revenue, the shift has a direct impact on the revenue received.
- While policy changes will be the biggest driver behind the shift modeled in this scenario, there may continue to be opportunities for BHD to assist in the eligibility and enrollment process for coverage through Medicaid, Medicare and the Exchange/Marketplace plans.

Element 3

This section examines revenue and funding opportunities potentially available to BHD in context of an evolving payer and policy environment in the State and County. The increasing gap between BHD cost and gross billed was discussed in Elements 1 and 2. While the limitations of the BHD current payer mix—such as the Federal IMD exclusion and a steadily declining FFS population and associated supplemental payment allotment—are one cause of the gap, the analysis indicates opportunities in which BHD may be able to increase revenue. Deloitte’s financial and policy analysis discussed earlier in the report provide the basis for the following discussion relating to enhanced funding for BHD.

Funding Opportunity
Policy changes to the IMD exclusion at the Federal level, potential inclusion of Medicaid Institutions for Mental Diseases (IMD) opportunity.

The Federally-mandated IMD exclusion is a critical variable in the payment of behavioral health services for Medicaid beneficiaries. BHD estimated a loss of approximately \$3,000,000 in potential revenue due to IMD excluded members in 2015. However, given the changes in coverage of inpatient behavioral managed care and the opportunity to encourage enrollment in Medicaid SSI MCOs that provide integrated physical and behavioral health services, the impact on the County and its partners is shifting.

Opportunities to recognize additional revenue exist through shifts in State and Federal policy are discussed below:

- **CMS anticipates revision to the current restrictions on Medicaid financing for inpatient psychiatric stays, specifically those 14 days or fewer.** Proponents believe the change will help address shortages in short-term inpatient mental health and substance use disorder treatment through better financing options. Covered stays would be limited to fewer than 15 days in any month, with flexibility to create longer stays by aligning stays over two consecutive months (i.e., 14 days in one month and 14 in the next). Currently, approximately 58% of total Medicaid FFS Inpatient bed days for 21-64 year olds are spent in the first 14 days of an individual visit based on 2013-2015 claims data. Assuming these days would be covered under the loosening of restrictions by CMS, it is estimated that approximately \$1.75 million dollars in revenue could be realized each year.
- **In Wisconsin, it appears that IMD facilities contract with the Medicaid MCOs for the payment of psychiatric hospitalizations for members' age 21-64 that would have normally been uncompensated due to the IMD exclusion.** The annualized growth trend from 2013-2015 for Medicaid MCOs was 14% while Medicaid FFS was -4%. The Gross Billed per consumer for Medicaid MCOs was nearly 40% higher than that of Medicaid FFS, indicating that managed care is a growing market with improved reimbursement levels for BHD and thus BHD may further invest in efforts to continue to contract with its partner MCOs.
- **Support SSI member enrollment in Medicaid MCOs providing integrated physical and behavioral health services.** Beneficiaries between the ages of 21-64 eligible for Medicaid due to age, blindness or a disability, whose benefits are reimbursed through FFS payments, remain subject to the IMD exclusion. However if individuals in Southeast Wisconsin elect to participate in an SSI MCO, BHD has the opportunity to receive a capitated payment for these individuals. Therefore, BHD should continue to support efforts to enroll eligible SSI members (currently covered under FFS Medicaid) into SSI managed care plans. Additionally, if DHS supports policies to increase enrollment of SSI beneficiaries into managed care plans across Wisconsin, there is greater potential for capitated revenue and enhanced coordination of inpatient and outpatient behavioral health services.

The additional revenue, assuming 100% of the IMD population becomes reimbursable, has the potential to improve the Gross Margin approximately 21 percentage points by 2018. It is

estimated that the BHD Gross Margin will range from -104.0% and -83.3% as fewer consumers are excluded on the IMD basis and BHD is able to recoup payment.

Funding Opportunity

BHD should explore opportunities to negotiate improved rates with Medicaid MCOs.

As Cost exceeds most payer Gross billed amounts in 2015, there may be opportunities to increase fee schedules or contracted rates under and Medicaid managed care program. Table 21 below depicts scenarios where BHD is paid at 85% and 100% of cost, respectively. Note that each percentage increase in Total Revenue is a direct percentage increase in Gross Margin.

Table 21: Impact of 85% and 100% cost coverage by Medicaid MCOs

Scenario	Adjusted 2015 (in millions)				
	% of Total Net Revenue	Net Revenue	Cost	Ratio of NR to Cost	State share needed
Adjusted 2015	35.3%	\$8.22	\$13.09	0.628	
Increase to 85% of Cost	42.4%	\$11.13	\$13.09	0.850	\$1.21
Increase to 100% of Cost	46.4%	\$13.09	\$13.09	1.000	\$2.02

There are dependencies that would need to be addressed in order to increase rates, such as, payment policies for Medicaid, availability of State and/or local matching funds, BHD/County resources to negotiate managed care rates, etc.

In addition, in order for Wisconsin DHS to consider increased capitation payments to MCOs for provision of behavioral health services under the Federal ‘actuarial soundness requirement’, BHD may need to further analyze its current cost structure as well as conduct a comparable service and cost analysis in the Milwaukee County market. Further, in order to increase net revenue to approximately 85% of the cost by 2018, we estimate that net revenue must increase by approximately \$2.91 million dollars, of which \$1.21 million would need to come from state or local funding in order to leverage additional federal Medicaid funds for increased payments for psychiatric inpatient services provided by BHD.

Funding Opportunity
BHD may consider County intergovernmental transfer of funds as potential source of State share which would generate new Federal matching funds to support new or increased supplemental payments and/or targeted managed care rates increases for critical IP and OP psychiatric safety net services.

Based on the Medicare upper payment limit (MUPL) calculations from the State, both BHD and the peer group (non-state public providers) appear to be paid at the calculated UPL cap. However, there is currently a gap between the allocated amount of UPL and the actual supplemental payments for the private acute care hospital peer group. An acute care hospital (potentially contracted to operate inpatient psychiatric beds in a unit) could in theory use the room under the acute UPL to justify additional UPL payments. Additionally, it’s our understanding that there may be a gap between the disproportionate share hospital (DSH) limit, total current DSH payments statewide, and the DSH payment to BHD. Through intergovernmental transfers (IGT)⁵ BHD may be able to increase the federal payments for these programs, similar to payment methodologies previously utilized to support the former Milwaukee County General Assistance Medical Program (GAMP).

Table 22: Federal Funding at FY 2017 FMAP

The tables below illustrates how each \$1M in State matching generates Federal funding at current WI FMAP.

FMAP	Enhanced FMAP	Enhanced FMAP w/ ACA 23 pt Increase
58.51%	70.96%	93.96%

State Share	Federal Match at 58.51% FMAP	Generated All Funds
\$1,000,000	\$1,410,219	\$2,410,219
\$10,000,000	\$14,102,193	\$24,102,193

⁵ IGTs require statutory authority, as well as State Medicaid and CMS approval

Funding Opportunity

Support Legislative efforts and partner with DHS in development of new CMS section 1115 demonstration waiver.

Over the last three years, BHD has experienced the shift from in the payer landscape from FFS to managed care payments for Medicare and Medicaid beneficiaries. Additionally, because of changes to BadgerCare, BHD provided services to more individuals, who were previously uninsured/self-pay. There may exist addition opportunities within the Wisconsin managed care delivery systems for the Department of Health Services to consider additional changes to populations covered, targeted payments and benefits offered by MCOs. We assume such changes would be required to be “budget neutral” under Federal expenditure guidelines.

In addition, we anticipate these policy changes may occur through the integration of behavioral and physical benefits for individuals receiving long-term-care benefits within the Family Care or Medicaid SSI program. Note, DHS may continue to support managed care coverage for most Medicaid populations throughout Wisconsin, which includes SSI beneficiaries in Southeast Wisconsin who, for those age 21-64, are currently included in the IMD exclusion criteria.

Finally in 2015, CMS launched an effort to test new delivery system, benefit, and payment designs in order to better coordinate care and reduce the impact of Substance Use Disorder (SUD). CMS is offering state Medicaid agencies an opportunity to use Section 1115 waiver authority to design service delivery systems that may cover services such as short-term acute treatment, including detoxification, intensive outpatient programs, residential treatment service, screening and intervention services in a broad range of settings, integration with primary care, medication assisted treatment and recovery supports services such as peer recovery supports and recovery coaches. Coverage and behavioral health benefits (including inpatient and outpatient services) for individuals that may not have access currently could provide BHD additional revenue as well as allow BHD to participate in innovative quality/value-based purchasing models if DHS were to develop a waiver program. Additional sources of State/Local funds would be required to implement such a waiver.

Element 2 models the impact of increasing managed care coverage on Gross Margin against the decline in Medicaid FFS funding. The estimated financial results are shown below in Table 23 and additional detail regarding this scenario may be found in Scenario 1 of Element 2.

Table 23: Scenario 1 Financial Snapshot¹

		2016	2017	2018
Adjusted 2015 (No Trend Applied to 2016-2018)	Revenue	\$26.62	\$26.62	\$26.62
	Cost	\$54.31	\$54.31	\$54.31
	Gross Payments	-\$27.69	-\$27.69	-\$27.69
	Gross Margin	-104.0%	-104.0%	-104.0%
Scenario 1.1 (FFS to MCO 10% shift each year)	Revenue	\$26.71	\$26.79	\$26.87
	Cost	\$54.32	\$54.34	\$54.35
	Gross Payments	-\$27.62	-\$27.55	-\$27.47
	Gross Margin	-103.4%	-102.8%	-102.2%
Scenario 1.2 (FFS to MCO 25% shift each year)	Revenue	\$26.83	\$27.04	\$27.25
	Cost	\$54.34	\$54.37	\$54.40
	Gross Payment	-\$27.51	-\$27.33	-\$27.15
	Gross Margin	-102.5%	-101.1%	-99.6%

¹Revenue refers to Total Revenue (Net Revenue + Supplemental Payments)

Funding Opportunity

Grant opportunities to support county behavioral health operations and programs—even with a broader service offering—are few and far between. However, BHD should monitor funding through organizations such as SAMSHA to assess opportunities and willingness to make investment of staff time in completed applications.

In addition to inpatient psychiatric care, BHD provides community-based services directly and through contracts with community-based service providers. The services that are currently provided include Community Support Program, Targeted Case Management, Community Residential Treatment, Outpatient Treatment, Comprehensive Community Services (CCS), and Day Treatment Program. BHD also provides a large network of crisis services including PCS, a crisis observation unit, toll-free crisis line, and mobile crisis teams, a Crisis Assessment Response Team, Crisis Stabilization Houses, and Crisis Resource Centers.

It is understood that BHD will continue to provide and contract these services and that there may be grant opportunities provided through the Federal government, advocacy groups, philanthropic organizations, as well as local philanthropic organization found through a web-based grant locating site.

Deloitte queried the following organizations for grant opportunities:

- Federal government (SAMSHA, CMS, gov.org, Office of Health and Human Services, National Institute of Health and National Institute of Mental Health)
- Advocacy groups (National Association for Mental Illness, National Council, American Psychiatric Association, American Psychological Association, National Association for State Mental Health Directors, and National Association for States United for Aging and Disabilities)
- Philanthropic organizations (Bill and Melinda Gates Foundation, McCormick Foundation, Buffett Foundation, Exxon Foundation); and
- Local philanthropic organization found through a web-based grant locating site

Our analysis of revealed that SAMSHA and CMS are the largest sources for funding; however, many philanthropic organizations will not grant to governmental agencies and many government funding sites such as NIH and NIMH will fund research but not operations.

In summary, the grants for which BHD could be eligible expired in February. Furthermore, there is not significant volume of grant opportunities available to governmental behavioral health entities. However, BHD should monitor organizations, specifically SAMSHA, to assess opportunities and its willingness to make investment of staff time to complete applications.

Acknowledgement

The Deloitte project team would like to thank the Milwaukee County BHD Finance Office and Wisconsin DHS Division of Health Care Access and Accountability for their cooperation, guidance and assistance in gathering and analyzing the significant amount of financial and policy data required for this report.

Appendices

Appendix 1: Data Sources

The following table summarizes all the data received by Deloitte from BHD.

Data Received	Description of Data	Provided by	Date Received
<i>Background Files from Milwaukee County</i>	Additional files including Inpatient and Outpatient Rates, State Plan Amendment information and Supplemental Payment information	Sue Moeser	12/7/2015-12/9/2015
<i>QryServices2013_Deloitte.xlsx</i> <i>QryServices2014_Deloitte.xlsx</i> <i>QryServices2015_Deloitte.xlsx</i>	Raw claims data from 2013 to 2015 for Milwaukee County BHD. These files included service category and financial class fields. Claims were provided at individual payment per payer level.	Zubair Dhala	12/29/2015
<i>2013_Summary_Deloitte.xlsx</i> <i>2014_Summary_Deloitte.xlsx</i> <i>2015_Summary_Deloitte.xlsx</i>	Three control totals files provided to tie out claims data files.	Zubair Dhala	12/29/2015
<i>2016Data.xlsx</i> <i>Copy of perdiem-sum-2.xlsx</i>	Two files that highlighted the unit costs for different service categories and service codes in Milwaukee County	Sue Moeser	1/8/2016
<i>BHD RFP what we pay for 6-26-15.xlsx</i>	Specific inpatient cost break downs and other data summaries	Jeanne Dorff	1/28/2016
<i>BOC 324 Deliverable.xlsx</i>	Medicaid claims data from the State of Wisconsin for 2013-2015	Kevin Moore	1/29/2016
<i>Supplemental Payments by Calendar Year (via E-mail)</i>	All payments received regarding supplemental payments for calendar years 2013-2015, and estimated payments for 2016-2018.	Sue Moeser	2/24/2016

The following table summarizes all the 2014 Gross Billed amounts by the payers in the Milwaukee County data. The amounts shown in the table below are based on a report provided by BHD in the *2014_Summary_Deloitte.xlsx* file. The first column shows how the data was aggregated by Deloitte. Amounts shown below do not match exactly to data shown throughout report due to how Financial Classes/Payers are assigned. This is explained in more detail in the Financial Class/Payer Adjustments section of the report.

Analysis of Funding Alternatives for Milwaukee County Department of Health Services Behavioral Health Division
 SUMMARY OF FINDINGS

Deloitte Assigned Aggregated Financial Class	Milwaukee County Financial Class	2014 Gross Billed total (\$)	% of 2014 Gross Billed amount
Medicare FFS	Medicare A	\$6,838,233	13.7%
	Medicare B	\$631,618	1.3%
Medicare MCO	HMO T18	\$3,049,668	6.1%
Medicaid FFS	Medicaid	\$7,464,759	14.9%
Medicaid MCO	HMO T19	\$10,889,524	21.8%
Commercial	Commercial	\$1,707,645	3.4%
	HMO	\$128,671	0.3%
Non-Recoverable	Non-Recoverable	\$3,632,793	7.3%
Self-Pay	Self Pay	\$14,785,419	29.5%
Other	Affordable Care Act	\$194,484	0.4%
	Family Care	\$3,585	0.0%
	Military	\$171,079	0.3%
	Collections	\$542,929	1.1%

Appendix 2: Adjustment Factors

The adjustment factors for gross billed, utilization, and cost were developed by taking the average of the 2013 and 2014 December gross billed, utilization, and cost as a percentage of the total year. Additionally, further adjustments needed to be made for the transfer amounts. Based on 2013 and 2014, a large portion of transfer payments came through towards the end of the year. In order to estimate the transfer amount for 2015, we developed adjustment factors at the Financial Class/Payer level based on 2014 data to account for the transfer of gross billed.

Finally, because a large portion of write-offs and other components of net revenue do not happen until the end of the year, in order to adjust the net revenue for 2015, we looked at gross billed as a percentage of net revenue in 2014 and applied that to the adjusted gross billed amount in 2015 for each individual Financial Class/Payer. Table A below shows the adjustment factors applied to estimate 2015 data.

Table A: Adjustment Factors

2015 Adjustment Factors	
Gross Billed	1.089
Cost	1.064
Utilization	1.064

Financial Class/Payer	Gross Billed Transfer Adjustment Factor
Medicare FFS	0.76
Medicare MCO	0.80
Medicaid FFS	0.96
Medicaid MCO	0.97
Commercial	0.71
Other	1.46
Non-Recoverable	1.46
Self-Pay	1.46
Dual FFS	0.76
Dual MCO	0.80

Appendix 3: Detailed Trending Analysis for Element 1

The below provides further explanation of the utilization and per unit trends developed and analyzed in the Element 1 analysis.

Financial Class/Payer and Service Trends (Utilization and per Unit)

To further analyze the trend impact by category of service and financial class we looked at the trend by Financial Class/Payer and service category.

- Utilization Trend:** The utilization trend was calculated using 2013-2015 experience data aggregated to the Financial Class/Payer and service type level (i.e., based on how utilization is counted, number of days or number of services). The following table shows the annualized utilization trend by service category and utilization type over the three-year experience period.

Table A: Historical (2013-2015) Utilization and Annualized Trend

Financial Class	Utilization Counting Method	2013	2014	2015	Annualized Trend
Medicare FFS	Days	2,006	1,733	1,672	-9%
Medicare MCO	Days	801	968	1,311	28%
Medicaid FFS	Days	3,638	3,527	2,298	-21%
Medicaid MCO	Days	4,470	5,458	7,505	30%
Commercial	Days	754	1,220	823	4%
Other	Days	574	673	202	-41%
Non-Recoverable	Days	9,517	10,153	7,256	-13%
Self-Pay	Days	1,868	1,819	3,379	34%
Dual FFS	Days	3,600	3,119	3,114	-7%
Dual MCO	Days	793	1,151	867	5%
Medicare FFS	Services	1,391	974	714	-28%
Medicare MCO	Services	587	766	638	4%
Medicaid FFS	Services	3,883	4,900	3,662	-3%
Medicaid MCO	Services	4,660	5,357	6,627	19%
Commercial	Services	1,075	1,095	917	-8%
Other	Services	588	346	282	-31%
Non-Recoverable	Services	4,331	1,795	775	-58%
Self-Pay	Services	1,765	1,383	2,171	11%
Dual FFS	Services	1,238	1,517	1,079	-7%
Dual MCO	Services	332	336	221	-18%

- Per Unit Trend (Gross Billed and Cost):** Similarly to utilization, in order to understand the trend in cost and gross billed by category of service and financial class, we calculated the trend in these financial components per unit. This trend allows us to estimate the change

in the financial components by service category and financial class. To be consistent with the calculation of the utilization trend, the per unit trend was calculated using 2013-2015 experience data aggregated to the Financial Class/Payer and service type level (i.e., based on how utilization is counted, number of days or number of services). The following table shows the annualized per unit trend by service category and utilization type over the 3 year experience period.

Table B: Historical (2013-2015) Gross Billed and Cost per Unit and Annualized Trend

Financial Class	Utilization Type	2013		2014		2015		Annualized Trend	
		Gross Billed per Unit	Cost per Unit	Gross Billed per Unit	Cost per Unit	Gross Billed per Unit	Cost per Unit	Gross Billed per Unit	Cost per Unit
Medicare FFS	Days	1,377	1,331	1,244	1,284	1,538	1,532	6%	7%
Medicare MCO	Days	1,443	1,389	1,780	1,510	1,641	1,694	7%	10%
Medicaid FFS	Days	1,410	1,563	1,427	1,609	1,894	1,657	16%	3%
Medicaid MCO	Days	1,570	1,693	1,577	1,686	1,773	1,711	6%	1%
Commercial	Days	1,488	1,600	1,353	1,337	2,227	1,576	22%	-1%
Other	Days	1,477	1,448	1,156	1,396	1,578	1,477	3%	1%
Non-Recoverable	Days	1,394	1,345	1,415	1,440	1,554	1,661	6%	11%
Self-Pay	Days	1,534	1,389	1,435	1,477	1,045	1,674	-17%	10%
Dual FFS	Days	1,487	1,389	1,469	1,511	1,510	1,694	1%	10%
Dual MCO	Days	1,434	1,389	1,309	1,493	1,362	1,694	-3%	10%
Medicare FFS	Services	325	361	314	448	423	427	14%	9%
Medicare MCO	Services	372	365	384	433	406	400	4%	5%
Medicaid FFS	Services	380	366	376	427	400	402	3%	5%
Medicaid MCO	Services	371	359	374	426	393	400	3%	6%
Commercial	Services	358	349	365	399	510	392	19%	6%
Other	Services	365	358	383	434	462	411	13%	7%
Non-Recoverable	Services	379	364	387	434	392	397	2%	4%
Self-Pay	Services	380	367	393	439	397	407	2%	5%
Dual FFS	Services	334	323	361	409	388	378	8%	8%
Dual MCO	Services	357	352	339	386	409	382	7%	4%

- Combined Utilization and per Unit Trend:** In order to get the total trends by Financial Class/Payer and category of services, the annualized utilization and per unit trends were combined. The combined trends are compared the aggregate trends developed at the beginning of this section. An adjustment was applied to both the per unit and utilization trends so the more detailed trends in total equal the aggregate trends. The following tables show the trended per unit and utilization by Financial Class/Payer and service category.

Supplemental Payments

As noted in the Data Sources section of the report, Deloitte was provided with supplemental payments related to Upper Payment Limit/Certified Public Expenditure (UPL/CPE), Pay for Performance Payments (P4P), Disproportionate Share Hospital (DSH), WIMCR Day Treatment, Medicare Bad Debt, GME, and the Inpatient Cost Report. All supplemental payments were recorded in the calendar year in which they were paid to Milwaukee County BHD. NOTE: No DSH payments were made in 2013 and any DSH limits for 2014 will not be known until late 2017.

Table E: Supplemental Payments for 2013-2015

Supplemental Payment	2013	2014	2015
UPL/CPE	No Payment Received	\$319,000	\$957,000
P4P	No Payment Received	No Payment Received	\$81,085
DSH	No Payment Received	\$1,169,655	\$1,103,421
WIMCR Day Treatment	\$473,604	\$149,305	\$237,923
Medicare Bad Debt	\$56,128	\$51,677	\$64,690
GME	\$213,001	\$219,890	\$76,586
Inpatient Cost Report	\$134,489	\$104,939	\$89,432
Total	\$877,222	\$2,014,466	\$2,610,137

Appendix 4: Detailed Analysis for Element 2

The below provides further explanation regarding the managed care rate setting guidelines for both Medicaid and Medicare as it relates to Scenario 1.

The following highlights the managed care rate setting guidelines for both Medicaid and Medicare. As noted previously, in addition to these guidelines there are other dependencies such as Wisconsin DHS' payment policy for Medicaid, availability of State and/or local matching funds, BHD/County resources to negotiate managed care rates, etc. that would need to be addressed to increase the contractual rate under both FFS and managed care arrangements.

Medicaid rate setting guideline: *In accordance with CMS regulations (42 CFR 438.6(c)), Medicaid capitation rates must be actuarial sound and developed by a credentialed actuary appropriate for covered populations and benefit package and in accordance with generally accepted actuarial principles and practices. In setting actuarial sound rates, states must apply defined elements or explain why they are not applicable. These elements include using (i) Base utilization and cost data from the Medicaid population, (ii) adjustments made to smooth the data including medical inflation, incomplete data, administration and utilization, and (iii) rate cells specific to the enrolled population by multiple categories. Similarly, the Actuarial Standards of Practice 49, "Medicaid Managed Care Capitation Rate and Development and Certification", gave the following definition for actuarial soundness: "Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs." As indicated above, this process of developing "actuarially sound" rates usually begins using either historical FFS data, managed care data or a blend between the two if appropriate. From that baseline data, adjustments of medical trend, program changes, managed care savings, administrative assumptions and others are applied to project the data forward to the appropriate period. The data projected forward is used to create the Medicaid MCO capitation rates. If additional funds are present to the state, higher Medicaid reimbursement rates may be targeted for certain services at facilities with a high percentage of Medicaid residents assuming that the rates do not exceed cap set by the state.*

Medicare rate development guidelines: *Medicare Advantage plans are paid by Medicare on a per member per month (PMPM) capitated payment arrangement based on membership, regardless of the services provided. As of 2006, in order to offer Medicare Advantage plans, plans must submit "bids" that meet the necessary requirements determined by CMS. The bids are then compared to benchmark amounts that are set by a formula established in statute and vary by county or region. The benchmarks are the maximum amount Medicare will pay a plan in a given area. If a plan's bid*

is higher than the benchmark, enrollees pay the difference between the benchmark and the bid in the form of a monthly premium, in addition to the Medicare Part B premium. If the bid is lower than the benchmark, the plan and Medicare split the difference between the bid and the benchmark; the plan's share is known as a "rebate," which must be used to provide supplemental benefits to enrollees. Medicare payments to plans are then adjusted based on enrollees' risk profiles. These bids are then reviewed by actuaries to determine actuarial soundness before being accepted. Similar to the Medicaid actuarial soundness description, it is reasonable to assume that the revenue received for Medicare payments should cover reasonable, appropriate and attainable costs.

Appendix 5: Grant Opportunities

Grant opportunities are reflected in an Excel file that will accompany this report.

The file has three tabs. The first lists funding for state government initiatives. There were only two opportunities currently open, both to support outpatient services. The second tab lists county government initiatives (some of which could also support state initiatives). One opportunity is from a local foundation with a track record of providing small target grants to government entities as well as other non-profits. The final tab provides a few opportunities for service providers. This is not an exhaustive list but suggests that one means for the county to support a robust continuum of care is to offer technical support to service providers applying for such grants.

Behavioral Health Division 2015 Fiscal Results

Behavioral Health Division

2015 Surplus Drivers

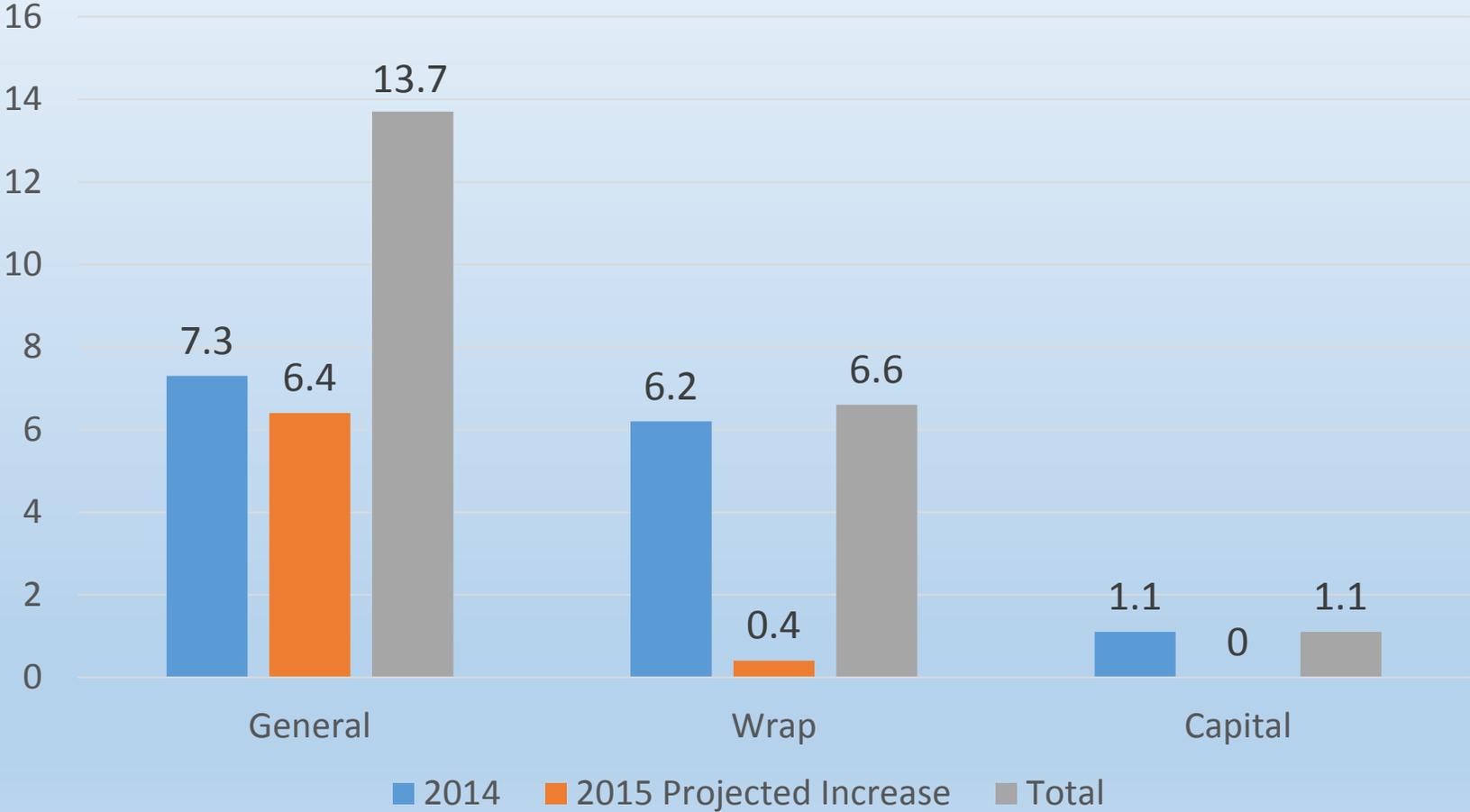
Community Services - \$0.7

- AODA
- Community MH
 - CCS
 - CRS
 - CBRF Delays
- Wrap

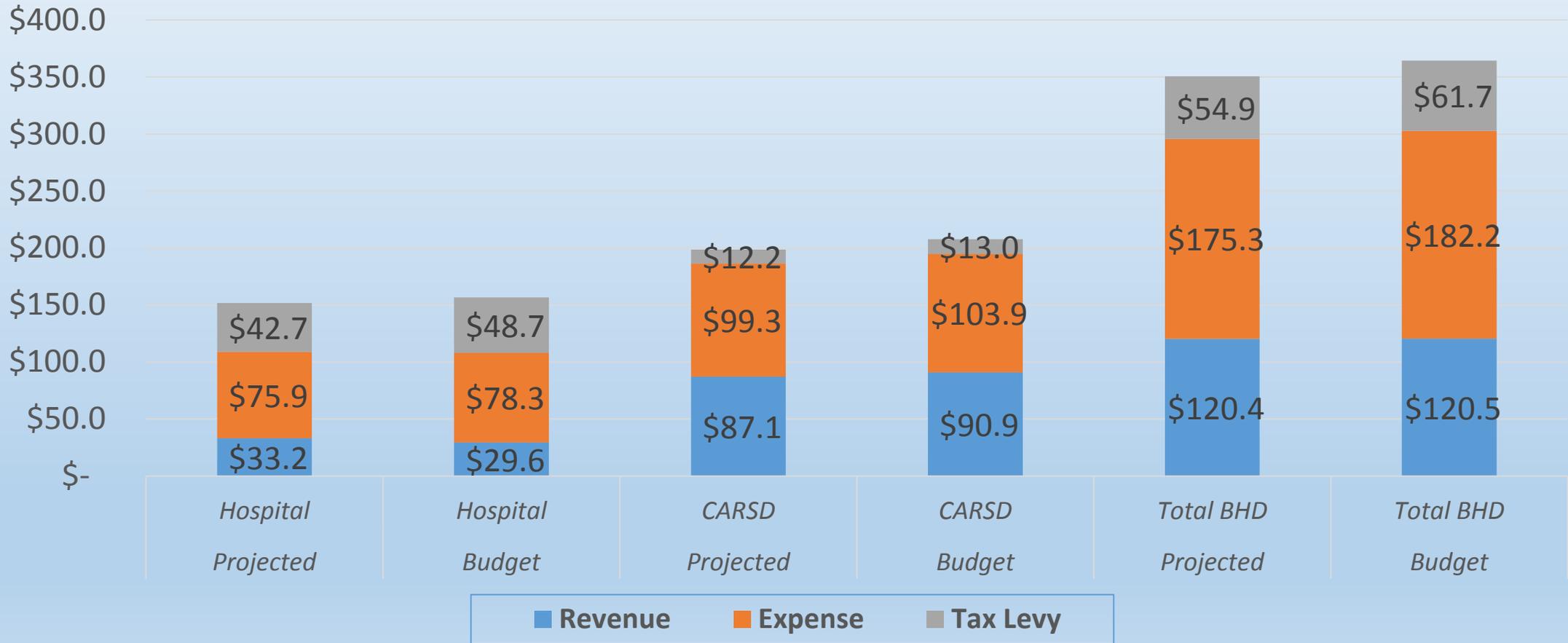
Hospital - \$6.0

- Patient Revenue
- Expenses – Personnel, Dietary, Pharmacy
- State Plan Amendment

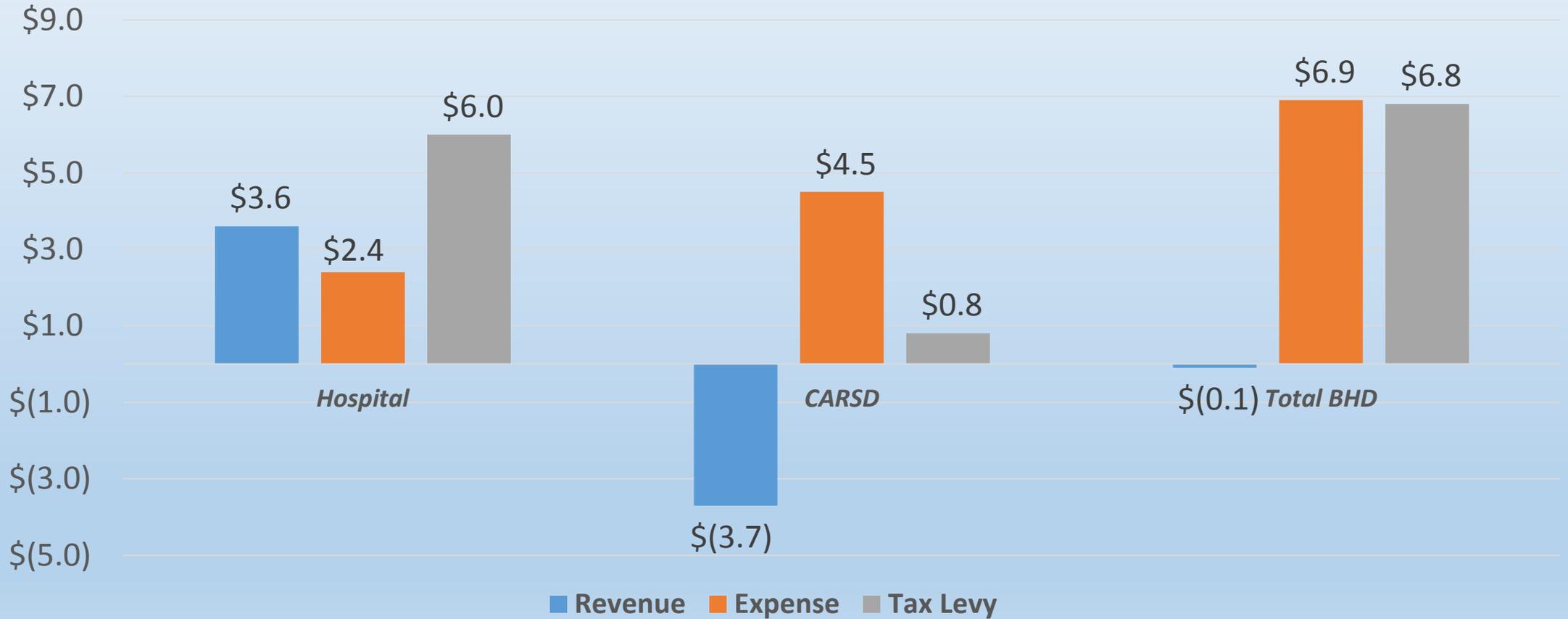
Behavioral Health Division 2015 Budget Surplus Allocation (\$millions)



Behavioral Health Division 2015 Results – Actual/Budget (\$ Millions)



Behavioral Health Division 2015 Results – Budget Variances (\$ Millions)



COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: February 24, 2016

TO: Duncan Shrout, Chairperson, Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Randy Oleszak, Chief Financial Officer, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, detailing preliminary assumptions used in building the 2017 BHD Operating Budget.**

Issue

In 2017, BHD continues to be a center of excellence for person-centered, high-quality best practice-based mental health services in collaboration with community providers. BHD fiscal staff is in the process of preparing the 2017 BHD budget.

Discussion

Below is a list of assumptions included in the preparation of the budget:

1. BHD will continue to operate a psychiatric emergency room and a child and adult psychiatric inpatient facility with census of 12 and 60, respectively.
2. BHDs' budget includes a tax levy equal or less to 2016 Adopted budget tax levy request of \$58.8M.
3. The Northside community hub will be fully operational for all of 2017
4. Southside community hub will be implemented during the 3rd Qtr. of 2017
5. Strategies to retain and recruit psychiatrists
6. Continue to expand CCS at a pace of 80 new participants per quarter for a total CCS enrollment of 800 by the end of 2017.
7. Continue support of ending chronic homelessness initiative
8. Full year of Intensive Outpatient Program
9. Implementation of 24/7 Southside Crisis Resource Center
10. Continue emphasis of providing community mental health service through a fee-for-service framework
11. Incorporation of telehealth into service array
12. Expansion of the Crisis Assessment Response Team (CART)
13. Enhanced Community Outreach and Education

The BHD Executive Team looks forward to a collaborative budgeting process with input from Mental Health Board Members.

Respectfully Submitted:



Héctor Colón, Director
Department of Health and Human Services

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: March 11, 2016

TO: Duncan Shrouf, Chairperson, Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Randy Oleszak, Chief Financial Officer, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization for Wraparound Milwaukee to amend the Master Lease with 2330 Mineral Street LLC to provide additional supportive housing for Project O-YEAH participants.**

Issue

The Director, Department of Health and Human Services (DHHS), is requesting authorization for Wraparound Milwaukee to amend a master lease with 2330 Mineral Street LLC for six additional units of supportive housing. The agreement is for \$3,646 a month in an annual lease. The lease can be mutually renewed for 15 years pending budget authority.

Background

Wraparound and the Housing Division have been working collaboratively to increase the housing options for those individuals aging out of the foster care system. In 2015, Wraparound worked with the Housing Division to begin leasing 6-units from Mineral Street LLC (c/o Journey House). After successful placements, Wraparound would like to lease six additional units from Journey House to grow the program.

The Journey House Campus Apartments are designed to assist young adults (18-25) enrolled in Wraparound who are aging out of foster care with emotional and mental health needs. Journey House Campus Apartments provide this population a place to reside while they address other needs in their transition to adulthood. Young adults face many barriers as they transition from the juvenile world and they need a specialized approach to ensure they can obtain and access the supportive services they are seeking. Project O-YEAH and Journey House, using a housing first model, provides 12 months of rent assistance to young adults whose current living situation is affecting their transition. Young adults residing in the Journey House Campus Apartments have an assigned Transitional Coordinator, as well as receive transitional services from Project O-YEAH. These services are designed to assist young adults in the areas of education, employment, daily living, mental health and overall well-being. Young adults have access to these supports and services to ensure that they have the support necessary to

successfully transition to adulthood. A Certified Peer Specialist resides in the apartments allowing additional support, as needed, to young adults living in the Journey House Campus Apartments.

Through this model young adults will gain employment, enroll in school all while creating a financial plan that will help them succeed.

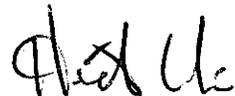
Recommendation

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to amend the Master Lease agreement with 2330 Mineral Street LLC to provide an additional six units supportive housing for Project O-Yeah participants.

Fiscal Effect

The \$43,752 amendment increases the annual cost of this lease to \$87,504. These costs will be absorbed within the Wraparound Milwaukee's budget.

Respectfully Submitted,



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Jodi Mapp, Senior Executive Assistant, BHD