Southwest Michigan
BEHAVIORAL HEALTH

**Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting**
SWMBH – Board Room
5250 Lovers Lane, Suite 200. Portage, MI, 49002
**Please join the meeting from your computer, tablet or smartphone.**
https://global.gotomeeting.com/join/455180261
**You can also dial in using your phone.**
United States: +1 (646) 749-3122
**Access Code: 455-180-261**
**Monday, November 18, 2019**
4:00 – 5:30pm

1. **Welcome and Introductions (Randall Hazelbaker)**
2. **Public Comment**
3. **Agenda Review and Adoption (Randall Hazelbaker)** (d) (pg.1)
4. **Consent Agenda (Randall Hazelbaker)**
   - September 9, 2019 Meeting Minutes (d) (pg.2)
5. **Board Education**
   a. Annual PA2 Report (Joel Smith/Anastasia Miliadi) (d) (pg.5)
   b. PA2 Utilization FY19 YTD - (Garyl Guidry) (d) (pg.9)
   c. Fiscal Year 18/19 YTD Financials (Garyl Guidry) (d) (pg.10)
   d. Approved SWMBH Fiscal Year 2020 Budget (Garyl Guidry) (d) (pg.11)
   e. Prescription Opioid Update (Achiles Malta (d) (pg.12)
   f. Safe Syringe Programs (Joel Smith) (d) (pg.15)
   g. State Opioid Response Grant Site Review (Joel Smith) (d) (pg.23)
   h. 2019 SUDOPB Attendance (Michelle Jorgboyan) (d) (pg.25)
6. **Board Actions to be Considered (Randall Hazelbaker)**
   - January 2020 Board Elections (Chair and Vice Chair)
7. **Board Action**
   - 2020 SUDOPB Meetings (Randall Hazelbaker) (d) (pg.26)
8. **Communication and Counsel**
   a. Opioid Health Homes Kalamazoo and Calhoun (Joel Smith)
   b. Legislative and Policy Updates (Brad Casemore)
      - Community Mental Health Association of Michigan (CMHAM) - How to become a successful Advocate (d) (pg.27)
      - MDHHS Director Gordon keynote to CMHAM (d) (pg.28)
      - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) Historical Data Report(d) (pg.34)
      - MDHHS announces Section 298 Pilots ending (d) (pg.37)
      - Testimony at House Health and Human Services Appropriations Sub-Committee (d) (pg.38)
9. **Adjourn**

The meeting will be held in compliance with the Open Meetings Act, 1976 PA 267, MCL 15.261 to 15.275

Southwest Michigan

BEHAVIORAL HEALTH

**Substance Use Disorder**
**Oversight Policy Board (SUDOPB) Meeting Minutes**
5250 Lovers Lane, Suite 200. Portage, MI, 49002
September 9, 2019
3:00 – 5:30 pm
Draft: 9/10/19

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**Members Present:** Randall Hazelbaker (Branch County); Richard Godfrey (Van Buren County); Daniel Doehrman (Kalamazoo County)

**Members Present via phone:** Skip Dyes (Cass County); Gary Tompkins (Calhoun County); Tara Smith (Cass County); Allen Balog (St. Joseph County); Ben Geiger (Barry County); Don Meeks (Berrien County)

**Members Absent:** Lisa White (Kalamazoo County); Paul Schincariol (Van Buren County); Kathy-Sue Vette (Calhoun County); Michael Majerek, (Berrien County)

**Staff Present:** Joel Smith, Director of SUD Services, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Garyl Guidry, Senior Financial Analyst, SWMBH; Achiles Malta, Regional Coordinator for SUD Prevention Services, SWMBH; Anastasia Miliadi, SUD Treatment Specialist, SWMBH; Justin Rolin, Gambling Disorder Prevention Specialist, SWMBH; Michelle Jorgboyan, Senior Operations Specialist and Rights Advisor, SWMBH

**Welcome and Introductions**
Randall Hazelbaker called the meeting to order at 3:00 pm. Introductions were made.

**Agenda Review and Adoption**

| | |
|---|---|
| Motion | Richard Godfrey moved to approve the agenda |
| Second | Daniel Doehrman |
| Motion carried | |

**Adjourn Board Meeting for Public Hearing**
Randall Hazelbaker adjourned the Board meeting for the Public Hearing and opened the floor for public comment. Several guests in attendance addressed the Board Members. The Board Members thanked the speakers for sharing their statements with the Board.

**SWMBH Fiscal Year 2020 Projections**
Tracy Dawson shared that there is no State budget at this time, so budget projections are complete.

**SWMBH Fiscal Year 2020 PA2 Budget Summary**
Garyl Guidry reported as documented. There were no questions from the Board members and no public comment regarding the PA2 Budgets.

**Reconvene Board Meeting**
Randall Hazelbaker reconvened the Board meeting.

**Consent Agenda**

| | |
|---|---|
| Motion | Richard Godfrey moved to approve the May 20, 2019 and July 15, 2019 Board minutes |
| Second | Ben Geiger |
| Motioned carried | |

**Board Action**
Resolution for Fiscal Year 2020 PA2 Budget

| | |
|---|---|
| Motion | Richard Godfrey moved to approve the Fiscal Year 2020 PA2 Budget as presented |
| Second | Ben Geiger |

Chairperson Randall Hazelbaker initiated a roll call vote.
The following Board Members voted in favor of the Fiscal Year 20209 PA2 Budget:

Randall Hazelbaker
Richard Godfrey
Daniel Doehrman
Allen Balog
Tara Smith
Skip Dyes
Don Meeks
Ben Geiger
Gary Tompkins

No Board Member voted against the Fiscal Year 2020 PA2 Budget. The Fiscal Year 2020 PA2 Budget was approved. The resolution reflecting the roll call vote and was signed by the Board Chair, Randall Hazelbaker

**Board Education**

**Fiscal Year 18/19 YTD Financials**
Garyl Guidry reviewed the year to date financials as documented, highlighting numbers for Medicaid, Healthy Michigan, MI Child, Block Grant, PA2, and PA2 carryforward.

**PA2 Utilization FY19 YTD**
Garyl Guidry reviewed the report as documented noting carry forward and counties that are using funds that are projected to lower their PA2 carry forward.

**Naloxone Day**
Joel Smith shared a MDHHS sponsored Naloxone Day on September 14, 2019 and reviewed the information in the packet regarding pharmacy participation and details. Discussion followed.

**Communication and Counsel**

**Public Policy Updates and Articles of Interest**
Joel Smith shared that SWMBH was recently awarded a grant from the Michigan Health Endowment Fund. SWMBH will be working with Kalamazoo Community Mental Health and Substance Abuse Services and the Family Health Center. The two-year grant will coordinate services for individuals 55+ who have Medicaid but are not enrolled in a Medicaid Health Plan and have a mental illness and one or more chronic medical conditions.
Joel Smith thanked the attendees for sharing their stories with the SUDOPB members and thanked the SWMBH staff for their hard work and collaboration in developing the PA2 budgets.

**Adjourn**

| | | |
|---|---|---|
| Motion | Daniel Doehrman moved to approve the agenda | |
| | Second | Don Meeks |
| | Motion carried | |

Meeting adjourned at 4:30pm

Southwest Michigan
BEHAVIORAL HEALTH

# End of the Year PA2 Funded Outcomes Report

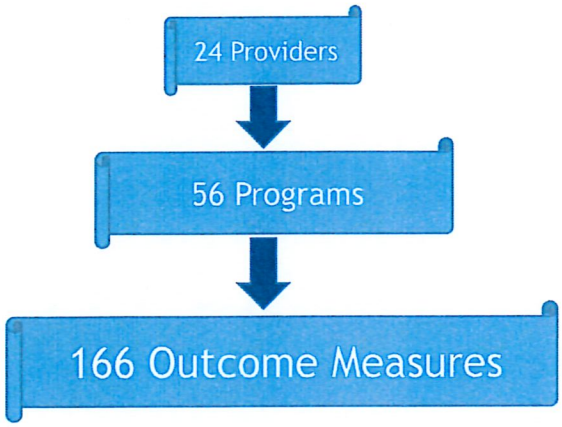
## Fiscal Year 2019

October 1, 2018 - September 30, 2019

## Brief History of PA2 Programs

- Each County determines use of local PA2 SUD dollars.
- FY2015 was the first year SWMBH utilized outcomes.
- Each provider must submit their own outcome measures - they define what they want to measure.
- SWMBH works with providers to make measures specific, measurable, attainable, and time limited.
- SWMBH works with providers to help determine the effectiveness of their programs

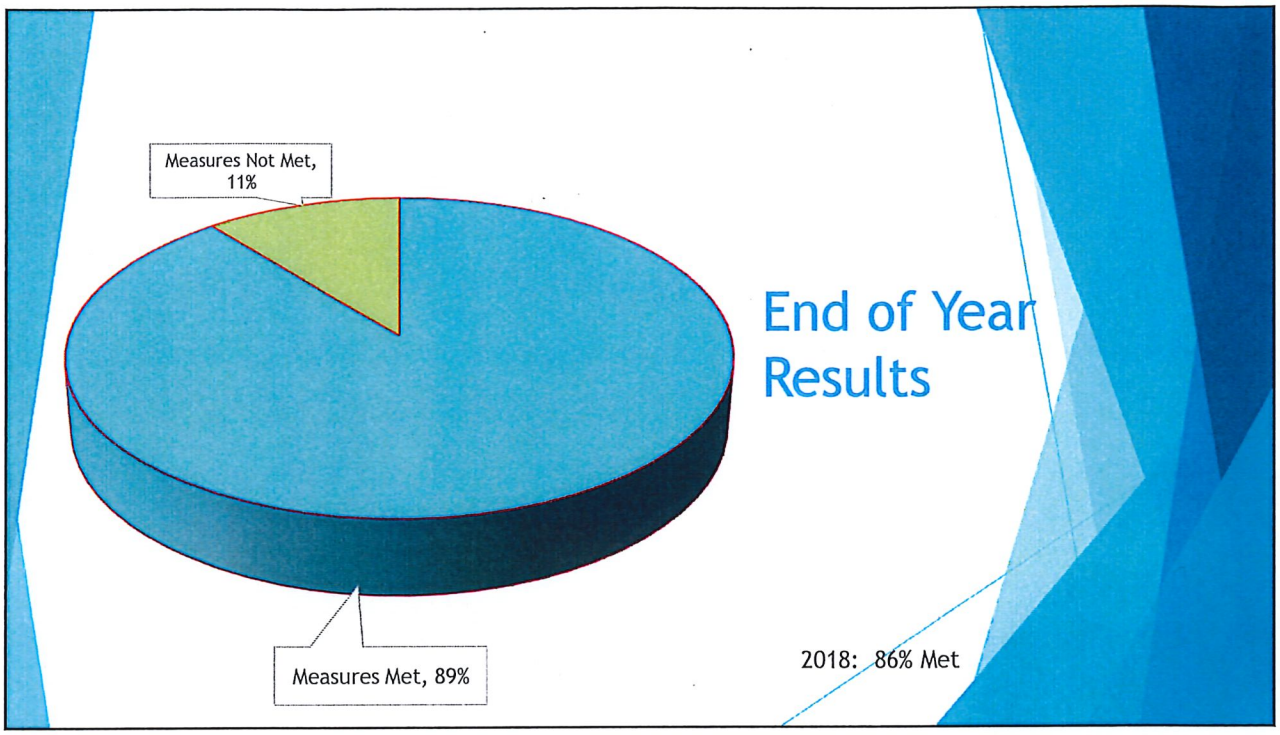
# Overview of PA2 Funded Programs: FY19




# End of the Year Measurement Definitions

Based on the Information Provided:

- **MET:** Clearly met or exceeded outcome.
- **NOT MET:** Did not meet outcome.
- **Information Not Available:** Provider did not submit any data.




- FY 19 Year End Results by County

| County | Total Outcome Measures | Met | Not Met | Percentage |
|---|---|---|---|---|
| Barry | 2 | 2 | 0 | 100% |
| Berrien | 20 | 19 | 1 | 95% |
| Branch | 12 | 9 | 3 | 75% |
| Calhoun | 26 | 25 | 1 | 96% |
| Kalamazoo | 90 | 81 | 9 | 90% |
| St Joe | 12 | 9 | 3 | 75% |
| Van Buren | 4 | 3 | 1 | 75% |
| | 166 | 148 | 18 | 89% |

# Observations

- Specialty courts (drug treatment court, sobriety court, veteran's court, etc.) continue to experience significant demand for services.
- Follow through with services after an intervention continues to be a challenge (ex: jail programming).
- When percentages are too high goals are difficult to be met (ex: 95-100% target measures).
- SWMBH will work closely with providers to create measures that are specific, measurable, timely, and simple.
- SWMBH will review utilization of the different programs.

| Program | FY19 Approved Budget | Utilization FY 19 Oct-Sep | PA2 Remaining | YTD Utilization |
|---|---|---|---|---|
| **Barry** | **66,810.00** | **34,621** | **32,189** | **52%** |
| BCCMHA - Prevention Services | 30,000 | 14,598 | 15,402 | 49% |
| BCCMHA - Outpatient Services | 36,810 | 20,023 | 16,787 | 54% |
| **Berrien** | **431,909.56** | **284,058** | **147,851** | **66%** |
| Abundant Life - Healthy Start | 68,300 | 68,300 | - | 100% |
| Berrien County - Drug Treatment Court | 15,000 | 792 | 14,208 | 5% |
| Berrien County - Trial courts | 43,919 | 20,082 | 23,837 | 46% |
| Berrien MHA - Riverwood | 6,700 | | 6,700 | 0% |
| CHC - Jail | 34,000 | 32,967 | 1,033 | 97% |
| CHC - Niles Family & Friends | 6,000 | 1,776 | 4,224 | 30% |
| CHC - Wellness Grp | 9,752 | 1,693 | 8,059 | 17% |
| CHC - Women's Recovery House | 72,117 | 47,916 | 24,201 | 66% |
| Harbortown - Juvenile and Detention Ctr | 76,122 | 10,532 | 65,590 | 14% |
| Berrien County Health Department - Prevention Ser | 100,000 | 100,000 | - | 100% |
| **Branch** | **111,850.30** | **77,267** | **34,583** | **69%** |
| Pines BHS - Jail Case Management | 72,473 | 57,862 | 14,611 | 80% |
| Pines BHS - Outpatient Treatment | 37,377 | 18,946 | 18,431 | 51% |
| Pines BHS - WSS | 2,000 | 459 | 1,541 | 23% |
| **Calhoun** | **518,421.00** | **468,756** | **49,665** | **90%** |
| Calhoun County 10th Dist Drug Sobriety Court | 160,000 | 127,014 | 32,986 | 79% |
| Calhoun County 10th Dist Veteran's Court | 6,524 | 6,500 | 24 | 100% |
| Calhoun County 37th Circuit Drug Treatment Court | 226,497 | 209,842 | 16,655 | 93% |
| Haven of Rest | 50,400 | 50,400 | - | 100% |
| Michigan Rehabilitation Services - Calhoun | 25,000 | 25,000 | - | 100% |
| Summit Pointe - Jail | 25,000 | 25,000 | - | 100% |
| Summit Pointe - Juvenile Home | 25,000 | 25,000 | - | 100% |
| **Cass** | **67,980.00** | **67,980** | **-** | **100%** |
| Woodlands - Meth Treatment and Drug Court Outp. | 67,980 | 67,980 | - | 100% |
| **Kalamazoo** | **945,734.82** | **818,685** | **127,050** | **87%** |
| 8th District Probation Court | 7,000 | 6,720 | 280 | 96% |
| 8th District Sobriety Court | 28,000 | 23,480 | 4,520 | 84% |
| 8th District Young Adult Diversion Court | 5,000 | 4,783 | 217 | 96% |
| 9th Circuit Drug Court | 60,000 | 60,000 | - | 100% |
| CHC - Adolescent Services | 21,373 | 21,373 | 0 | 100% |
| CHC - Bethany House | 57,720 | 38,970 | 18,750 | 68% |
| CHC - New Beginnings | 77,627 | 77,157 | 470 | 99% |
| CHC - Healing House | 45,000 | 15,084 | 29,916 | 34% |
| Gryphon Gatekeeper - Suicide Prevention | 20,000 | 14,640 | 5,360 | 73% |
| Gryphon Helpline/Crisis Response | 36,000 | 33,000 | 3,000 | 92% |
| Interact - IDDT | 26,600 | 20,470 | 6,130 | 77% |
| KCHCS Healthy Babies | 87,000 | 87,000 | - | 100% |
| KCMHSAS - EMH | 56,400 | 56,400 | - | 100% |
| KCMHSAS - FUSE | 25,000 | 25,000 | - | 100% |
| KCMHSAS - Mental Health Court | 65,000 | 65,000 | - | 100% |
| KCMHSAS - Oakland Drive Shelter | 34,000 | 34,000 | - | 100% |
| KPEP Social Detox | 60,000 | 18,300 | 41,700 | 31% |
| Michigan Rehabilitation Services - Kalamazoo | 17,250 | 17,250 | - | 100% |
| Prevention Works - Task Force | 50,000 | 50,000 | - | 100% |
| Recovery Institute - Recovery Coach | 60,623 | 57,210 | 3,413 | 94% |
| WMU - BHS SBIRT | 26,747 | 13,884 | 12,863 | 52% |
| WMU - BHS Text Messaging | 6,000 | 5,996 | 4 | 100% |
| WMU - Jail Groups | 73,395 | 72,969 | 426 | 99% |
| **St. Joseph** | **137,200.00** | **104,959** | **32,241** | **77%** |
| 3B District - Sobriety Courts | 8,000 | 7,775 | 225 | 97% |
| CHC - Hope House | 32,000 | 28,139 | 3,861 | 88% |
| CMH - Court Ordered Drug Testing | 43,200 | 43,192 | 8 | 100% |
| CMH Jail Program | 54,000 | 25,852 | 28,148 | 48% |
| **Van Buren** | **166,745.55** | **138,511** | **28,235** | **83%** |
| Van Buren CMHA | 141,746 | 113,511 | 28,235 | 80% |
| Van Buren County Drug Treatment Court | 25,000 | 25,000 | - | 100% |
| **Totals** | **2,446,651.23** | **1,994,838** | **451,813** | **82%** |

Southwest Michigan Behavioral Health

## Substance Use Disorders Revenue & Expense Analysis Fiscal Year 2019
### For the Fiscal YTD Period Ended 9/30/2019

| | MEDICAID | | | | Healthy MI | | | |
|---|---|---|---|---|---|---|---|---|
| | Budgeted YTD Revenue | Actual YTD Revenue | YTD Expense | Fav (Unfav) | Budgeted YTD Revenue | Actual YTD Revenue | YTD Expense | Fav (Unfav) |
| Barry | 77,328 | 153,048 | 137,888 | 15,160 | 150,647 | 255,718 | 229,941 | 25,777 |
| Berrien | 604,736 | 611,318 | 310,042 | 301,277 | 1,049,346 | 1,055,966 | 625,629 | 430,337 |
| Branch | 154,900 | 157,880 | 123,449 | 34,431 | 193,149 | 244,027 | 175,511 | 68,516 |
| Calhoun | 696,447 | 632,140 | 520,356 | 111,784 | 1,023,702 | 958,444 | 789,201 | 169,243 |
| Cass | 146,569 | 180,927 | 126,747 | 54,180 | 257,756 | 303,262 | 215,600 | 87,662 |
| Kazoo | 749,246 | 839,461 | 304,449 | 535,012 | 1,374,551 | 1,472,876 | 598,068 | 874,809 |
| St. Joe | 248,691 | 237,723 | 82,671 | 155,051 | 393,520 | 399,431 | 301,976 | 97,455 |
| Van Buren | 310,283 | 319,354 | 56,306 | 263,048 | 533,548 | 509,681 | 132,171 | 377,510 |
| DRM | 2,420,722 | 2,418,558 | 2,760,116 | (341,559) | 3,715,582 | 3,681,824 | 4,880,301 | (1,198,478) |
| **Grand Total** | **5,408,923** | **5,550,409** | **4,422,025** | **1,128,384** | **8,691,802** | **8,881,229** | **7,948,399** | **932,830** |

| | BLOCK GRANT | | | | PA2 | | | |
|---|---|---|---|---|---|---|---|---|
| | Budgeted YTD Revenue | Actual YTD Revenue | YTD Expense | Fav (Unfav) | Budgeted YTD Revenue | Actual YTD Revenue | YTD Expense | Fav (Unfav) |
| Barry | 366,088 | 366,088 | 247,218 | 118,870 | 66,810 | 73,647 | 34,621 | 39,026 |
| Berrien | 970,173 | 970,173 | 728,962 | 241,210 | 431,910 | 375,014 | 289,508 | 85,506 |
| Branch | 279,916 | 279,916 | 167,896 | 112,020 | 111,850 | 65,646 | 77,267 | (11,622) |
| Calhoun | 842,288 | 842,288 | 1,187,752 | (345,464) | 518,421 | 332,415 | 464,597 | (132,182) |
| Cass | 323,546 | 323,546 | 193,326 | 130,220 | 67,980 | 74,029 | 67,980 | 6,049 |
| Kazoo | 1,548,712 | 1,548,712 | 1,229,861 | 318,851 | 945,735 | 660,728 | 818,685 | (157,956) |
| St. Joe | 379,198 | 379,198 | 276,634 | 102,564 | 137,200 | 101,010 | 104,959 | (3,948) |
| Van Buren | 471,796 | 471,796 | 233,686 | 238,109 | 166,746 | 144,682 | 138,511 | 6,172 |
| DRM | 2,707,965 | 2,707,965 | 2,907,867 | (199,902) | | | | |
| STR | 937,098 | 937,098 | 983,748 | (46,650) | | | | |
| Gambling Prev. | 188,684 | 188,684 | 29,737 | 158,947 | | | | |
| PFS | 152,045 | 152,045 | 116,448 | 35,597 | | | | |
| SDA | 128,219 | 128,219 | 128,219 | 0 | | | | |
| Admin/Access | 238,059 | 238,059 | 418,595 | (180,536) | | | | |
| **Grand Total** | **9,533,786** | **9,533,786** | **8,849,948** | **683,838** | **2,446,651** | **1,827,172** | **1,996,129** | **(168,957)** |

| | PA2 Carryforward | | |
|---|---|---|---|
| | Current Utilization | Prior Year Balance | Projected Year End Balance |
| Barry | 39,026 | 428,430 | 467,456 |
| Berrien | 85,506 | 406,850 | 492,356 |
| Branch | (11,622) | 346,818 | 335,196 |
| Calhoun | (132,182) | 586,699 | 454,517 |
| Cass | 6,049 | 352,325 | 358,374 |
| Kazoo | (157,956) | 1,963,706 | 1,805,750 |
| St. Joe | (3,948) | 240,077 | 236,129 |
| Van Buren | 6,172 | 219,880 | 226,052 |
| **Grand Total** | **(168,957)** | **4,544,786** | **4,375,829** |

Legend
DRM - Detox, Residential, and Methadone
PFS - Partnerships for Success
SDA - State Disability Assistance

| | E | F | G | H | J | K | L | M | N | O | P | S |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | ***Southwest Michigan Behavioral Health*** | | | | *Mos in Period* | | | | | | *DRAFT* | |
| 2 | For the Fiscal YTD Period Ended 9/30/2020 | | | FY20 Budget | 12 | | | | | | | |
| 3 | *(For Internal Management Purposes Only)* | | | DRAFT | | | | | | | | |
| 4 | ***INCOME STATEMENT*** | | | TOTAL | Medicaid Contract | Healthy Michigan Contract | Autism Contract | MI Health Link | SA Block Grant Contract | SA PA2 Funds Contract | SWMBH Central | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |
| 7 | **REVENUE** | | | | | | | | | | | |
| 16 | Contract Revenue | | | 267,189,241 | 208,458,803 | 32,676,296 | 12,583,209 | 3,414,767 | 8,171,316 | 1,884,850 | - | |
| 17 | DHHS Incentive Payments | | | 650,920 | 650,920 | - | - | - | - | - | - | |
| 18 | Grants and Earned Contracts | | | 461,128 | - | - | - | - | 392,070 | - | 69,058 | |
| 19 | Interest Income - Working Capital | | | 198,574 | - | - | - | - | - | - | 198,574 | |
| 20 | Interest Income - ISF Risk Reserve | | | 48,015 | - | - | - | - | - | - | 48,015 | |
| 21 | Local Funds Contributions | | | 2,163,020 | - | - | - | - | - | - | 2,163,020 | |
| 22 | Other Local Income | | | 243,099 | - | - | - | - | - | - | 243,099 | |
| 23 | | | | | | | | | | | | |
| 24 | **TOTAL REVENUE** | | | 270,953,997 | 209,109,723 | 32,676,296 | 12,583,209 | 3,414,767 | 8,563,386 | 1,884,850 | 2,721,767 | |
| 25 | | | | | | | | | | | | |
| 26 | **EXPENSE** | | | | | | | | | | | |
| 27 | Healthcare Cost | | | | | | | | | | | |
| 28 | Provider Claims Cost | | | 22,415,051 | 3,507,021 | 5,741,644 | - | 3,719,076 | 7,592,847 | 1,854,461 | - | |
| 29 | CMHP Subcontracts, net of 1st & 3rd party | | | 218,025,411 | 180,550,408 | 19,858,280 | 15,432,201 | 1,729,255 | 455,267 | - | - | |
| 30 | Insurance Provider Assessment Withhold (IPA) | | | 2,590,858 | 2,487,625 | 103,233 | - | - | - | - | - | |
| 32 | MHL Cost in Excess of Medicare FFS Cost | | | - | 2,365,772 | - | - | (2,365,772) | - | - | - | |
| 33 | | | | | | | | | | | | |
| 34 | Total Healthcare Cost | | | 243,171,141 | 189,050,648 | 25,703,158 | 15,432,201 | 3,082,559 | 8,048,115 | 1,854,461 | - | |
| 35 | Medical Loss Ratio (HCC % of Revenue) | | | 90.8% | 90.4% | 78.7% | 122.6% | 90.3% | 98.5% | 98.4% | | |
| 36 | | | | | | | | | | | | |
| 37 | Administrative Cost | | | | | | | | | | | |
| 38 | Purchased Professional Services | | | 623,000 | - | - | - | - | - | - | 623,000 | |
| 39 | Administrative and Other Cost | | | 8,293,670 | - | - | - | - | - | - | 8,293,670 | |
| 41 | Depreciation | | | 109,640 | - | - | - | - | - | - | 109,640 | |
| 42 | Functional Cost Reclassification | | | - | - | - | - | - | 196,895 | - | (196,895) | |
| 43 | Allocated Indirect Pooled Cost | | | - | - | - | - | - | - | - | - | |
| 44 | Delegated Managed Care Admin | | | 16,835,702 | 13,993,924 | 1,532,042 | 1,176,580 | 133,156 | - | - | - | |
| 45 | Apportioned Central Mgd Care Admin | | | 0 | 6,724,479 | 935,285 | 563,811 | 199,053 | 301,229 | - | (8,723,856) | |
| 46 | | | | | | | | | | | | |
| 47 | Total Administrative Cost | | | 25,862,012 | 20,718,403 | 2,467,327 | 1,740,391 | 332,209 | 498,124 | - | 105,558 | |
| 48 | Admin Cost Ratio (MCA % of Total Cost) | | | 9.6% | 9.9% | 8.8% | 10.1% | 9.7% | 5.8% | 0.0% | 3.2% | |
| 49 | | | | | | | | | | | | |
| 50 | Local Funds Contribution | | | 2,163,020 | - | - | - | - | - | - | 2,163,020 | |
| 51 | | | | | | | | | | | | |
| 52 | **TOTAL COST after apportionment** | | | 271,196,174 | 209,769,051 | 28,170,485 | 17,172,592 | 3,414,767 | 8,546,239 | 1,854,461 | 2,268,578 | |
| 53 | | | | | | | | | | | | |
| 54 | **NET SURPLUS before settlement** | | | (242,176) | (659,328) | 4,505,811 | (4,589,383) | - | 17,147 | 30,389 | 453,189 | |
| 55 | Net Surplus (Deficit) % of Revenue | | | -0.1% | -0.3% | 13.8% | -36.5% | 0.0% | 0.2% | 1.6% | 16.7% | |
| 56 | | | | | | | | | | | | |
| 57 | Prior Year Savings | | | 735,085 | - | 735,085 | - | - | - | - | - | |
| 58 | Change in PA2 Fund Balance | | | (30,389) | - | - | - | - | - | (30,389) | - | |
| 59 | ISF Risk Reserve Abatement (Funding) | | | (48,015) | - | - | - | - | - | - | (48,015) | |
| 60 | ISF Risk Reserve Deficit (Funding) | | | 7,815 | 7,815 | - | - | - | - | - | - | |
| 61 | Settlement Receivable / (Payable) | | | (17,147) | 651,513 | (5,240,896) | 4,589,383 | - | (17,147) | - | - | |
| 62 | **NET SURPLUS (DEFICIT)** | | | 405,173 | - | - | - | - | - | - | 405,173 | |
| 63 | *HMP & Autism is settled with Medicaid* | | | | | | | | | | | |
| 64 | | | | | | | | | | | | |
| 65 | SUMMARY OF NET SURPLUS (DEFICIT) | | | | | | | | | | | |
| 67 | Current Year Savings | | | - | - | - | - | - | - | - | - | |
| 68 | Current Year Public Act 2 Fund Balance | | | - | - | - | - | - | - | - | - | |
| 69 | Local and Other Funds Surplus/(Deficit) | | | 405,173 | - | - | - | - | - | - | 405,173 | |
| 70 | | | | | | | | | | | | |
| 71 | **NET SURPLUS (DEFICIT)** | | | 405,173 | - | - | - | - | - | - | 405,173 | |
| 72 | | | | | | | | | | | | |

## SUD Prevention Priority Areas for FY 2020

Priority Areas for SUD Prevention Services (Set by OROSC, SWMBH, Local Community) based on:

a) SUD & other Health data (Prevalence of Use, Risk Behaviors & their Consequences)
b) Risk & Protective Factors/Variables
c) Community Readiness (& Other Pertinent Considerations)

SWMBH FY 2020 Priority Areas for SWMBH providers/Coalitions:

**#1: Rx Drug Abuse (emphasis on Opioid/painkiller meds)**

**#2: Underage Drinking (UAD) & Alcohol Abuse, DUI behaviors**

**#3: Youth Access to Tobacco & Vaping (ENDS)**

**#4: Trends (emerging & ongoing): Marijuana Use (focused on youth use), Meth resurgence** (in selected areas), **etc.**

1

## WHAT WAS THE CAUSE THE OPIOID EPIDEMIC?

National studies have identified some of the long standing factors & conditions in the US that have contributed to creating an opioid epidemic:

1) **Prescribing practices for treatment of acute pain**
2) **Lack of knowledge/perception of risks associated with using opioid pain relievers** (*Oklahoma law suit against J&J - 8/26/19)
3) **High household availability of "pain meds" combined with the dangerous habit of holding on to expired/unused meds**

NOTE: The high availability of opioids was the perfect catalyst to create pathways to addiction for those of us who have an increased vulnerability to addiction because of genetic, biological, environmental, & developmental factors.

*References: 1) NIDA: Topics in Brief, May/2011 (Research on "Rx Drug Abuse")
2) "Epidemics: Responding to America's Prescription Drug Abuse Crisis" (2011)

2

## (2016 thru 2018: Volume of Rx. Opioid meds per County (MAPS data)

| County | Past 3 years | Volume: # Rx Opioid Units (ex. pill) | % diff. 2017 to 2018 | # Opioid Scripts (Prescriptions) | % diff. 2017 to 2018 | # Patients w/ Opioid RX (new) | Population | % Resid. w/ at least one Opioid Rx per year |
|---|---|---|---|---|---|---|---|---|
| Barry | 2016 | 3,420,269 | | 47,428 | | | | |
| | 2017 | 2,664,591 | | 38,934 | | | | |
| | **2018** | **2,789,817** | **4.70%** | **41,259** | **5.97%** | 13,718 | 61,157 | 22% |
| Berrien | 2016 | 9,011,669 | | 136,627 | | | | |
| | 2017 | 7,651,473 | | 118,852 | | | | |
| | **2018** | **7,950,832** | **3.91%** | **121,977** | **2.63%** | 38,541 | 154,141 | 25% |
| Branch | 2016 | 2,052,643 | | 32,158 | | | | |
| | 2017 | 1,803,268 | | 28,684 | | | | |
| | **2018** | **2,115,507** | **17.32%** | **32,756** | **14.20%** | 11,868 | 43,622 | 27% |
| Calhoun | 2016 | 11,599,488 | | 158,947 | | | | |
| | 2017 | 9,662,314 | | 137,588 | | | | |
| | **2018** | **9,415,244** | **-2.56%** | **137,351** | **-0.17%** | 43,109 | 134,487 | 32% |
| Cass | 2016 | 2,072,884 | | 30,358 | | | | |
| | 2017 | 1,787,523 | | 27,618 | | | | |
| | **2018** | **1,903,337** | **6.48%** | **28,772** | **4.18%** | 9,460 | 51,653 | 18% |
| Kazoo | 2016 | 12,543,279 | | 183,762 | | | | |
| | 2017 | 10,958,342 | | 166,950 | | | | |
| | **2018** | **11,375,789** | **3.81%** | **174,411** | **4.47%** | 61,042 | 264,870 | 23% |
| St. Joseph | 2016 | 3,419,840 | | 50,516 | | | | |
| | 2017 | 2,826,495 | | 44,246 | | | | |
| | **2018** | **3,181,005** | **12.54%** | **47,703** | **7.81%** | 17,052 | 61,043 | 28% |
| Van Buren | 2016 | 5,974,642 | | 84,273 | | | | |
| | 2017 | 5,315,117 | | 76,082 | | | | |
| | **2018** | **5,226,389** | **-1.67%** | **75,412** | **-0.88%** | 22,827 | 75,448 | 30% |
| SWMBH | 2016 | 50,094,714 | | 724,069 | | | | |
| | 2017 | 42,669,124 | | 638,954 | | | | |
| | **2018** | **43,957,919** | **3.02%** | **659,641** | **3.24%** | 217,617 | 846,421 | 26% |
| State of Michigan | 2016 | 610,578,467 | | 8,756,533 | | | | |
| | 2017 | 533,616,855 | | 7,900,692 | | | | |
| | **2018** | **532,335,821** | **-0.24%** | **8,114,061** | **2.70%** | 2,570,840 | 9,995,915 | 26% |

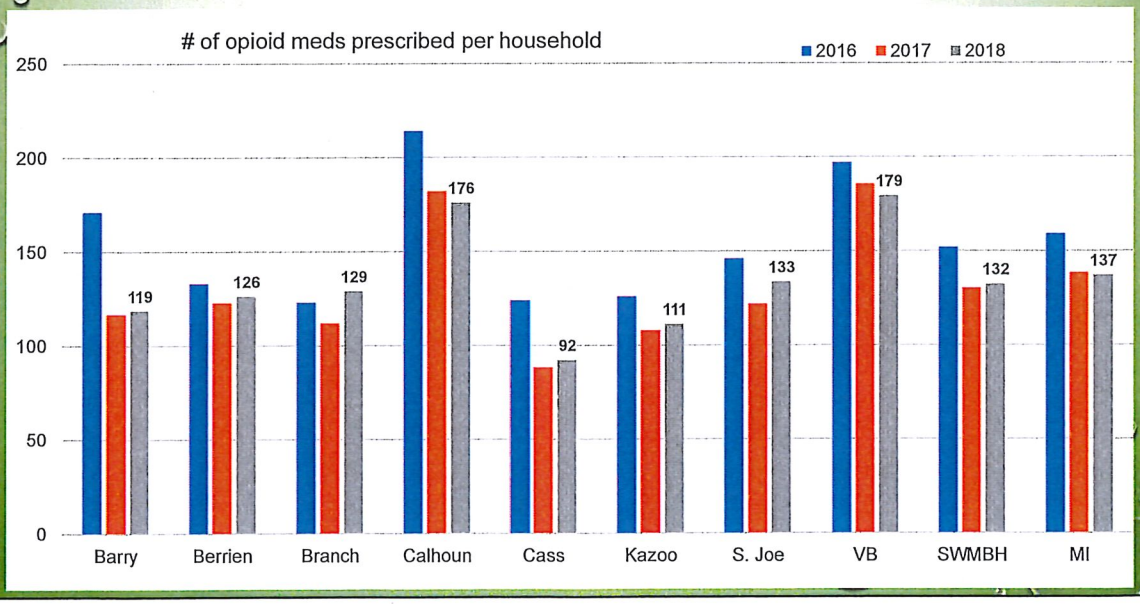
"U.S. comprises less than *5% of the world's population*, Americans consume *80% of the global opioid painkillers* and *99% of the global supply of hydrocodone . . .*"

*Edward Markey, US Senator for Massachusetts ("Overdosed: A Comprehensive Fed Strategy for addressing Americas' Rx Drug Abuse and Heroin Epidemic" - Oct/2014)*

3

## Household Availability of Opioid meds

A significant contributing factor to Rx med abuse Source: MAPS

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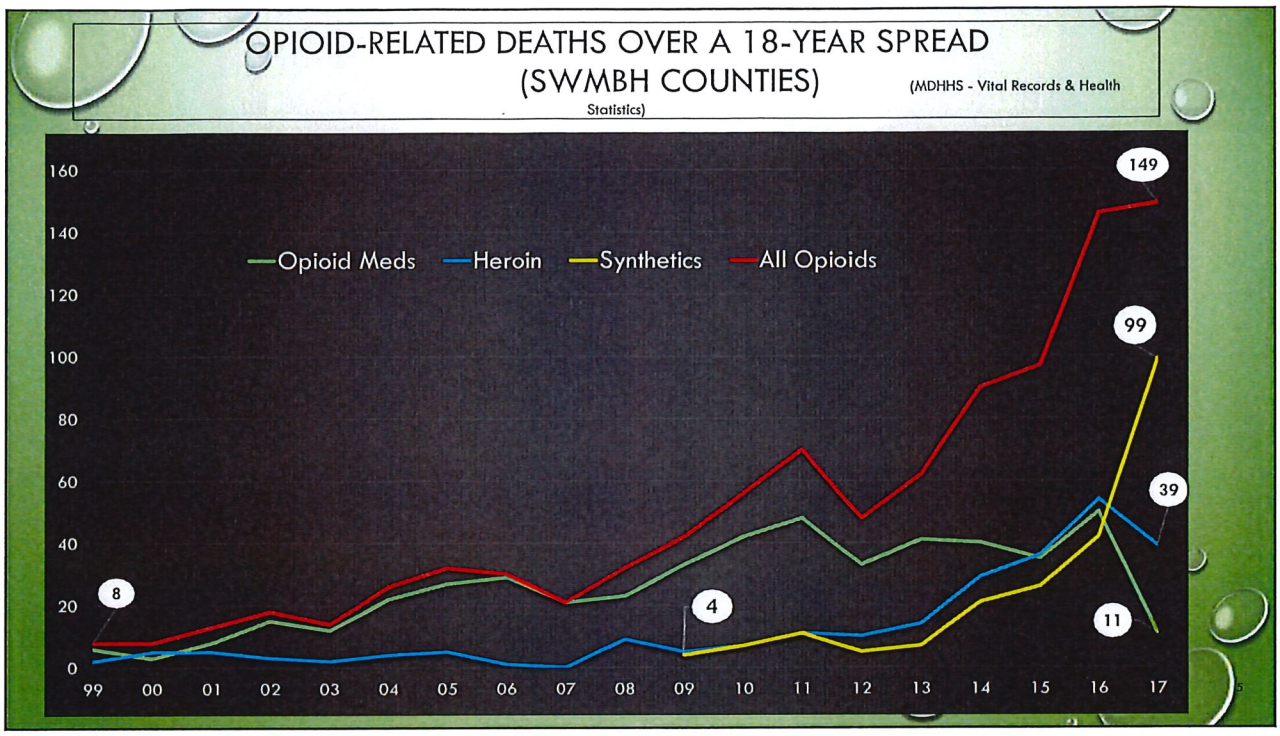
OPIOID-RELATED DEATHS OVER A 18-YEAR SPREAD
(SWMBH COUNTIES)
(MDHHS - Vital Records & Health Statistics)
Opioid Meds
Heroin
Synthetics
All Opioids
160
140
120
100
80
60
40
20
0
99
00
01
02
03
04
05
06
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14
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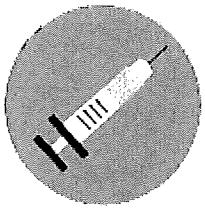
16
17
8
4
149
99
39
11

# Syringe Services Programs

## What is a Syringe Services Program (SSP)?

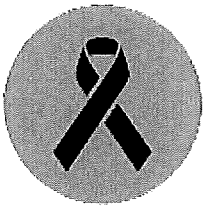
A community - based public health program that provides services to prevent drug use, HIV, and Viral Hepatitis

## SSPs provide services such as:[1,2]

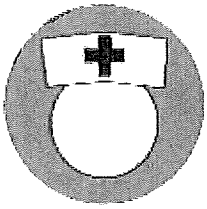


Free clean needles and syringes

Safe disposal of needles and syringes



HIV and hepatitis testing and linkage to treatment



Hepatitis A and B vaccination

**SSPs also provide:**

- Referral to substance use disorder treament
- Overdose treatment and education

## Have SSPs been successful in Michigan communities?

In 2017, Michigan SSPs directly served nearly **8,000** clients

distributing over **672,000** clean needles.

Nearly **1 in 4** Michigan SSP clients referred to substance [15]

24%

# How Do SSPs Benefit Communities and Public Safety?

1

SPs **reduce needlestick injuries** mong first responders and the ublic by providing a proper place throw out used syringes.

After the start of a SSP in Portland, Oregon, research showed

the number of syringes thrown out in an unsafe way [3]

## 2 SSPs Save Money

SSPs **save health care dollars** by preventing infections

Testing linked to hepatitis C treatment can save an estimated

**320,000 lives.** [1]

Estimated lifetime cost of treating one person living with HIV

> **$400,000** [1]

## 3 SSPs Reduce new HIV and Viral Hepatitis Infections [1]

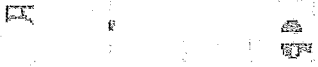
SPs **reduce new HIV and viral epatitis infections** by decreasing e sharing of syringes and other jection tools.

New HIV infections have dropped by

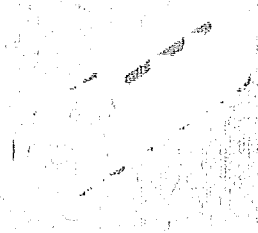
**80 percent**

among person who inject drugs nce the start of SSPs in the late 1980's [4]

## SSP clients are



more likely to enter a drug treatment program than non-clients. [5]



urces:
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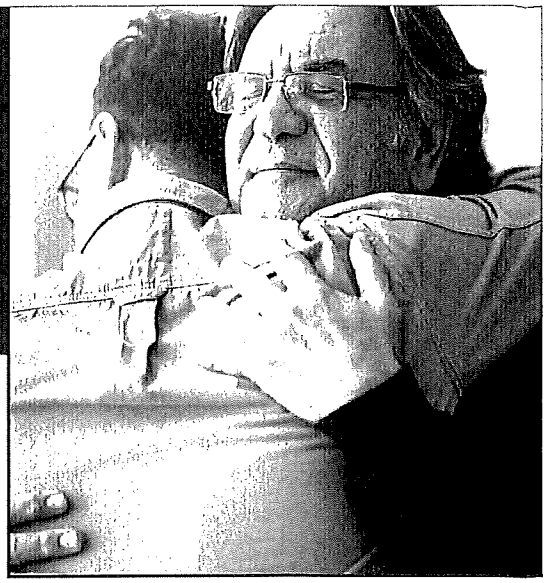
MDHHS

# Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)



## Background

The nation is currently experiencing an opioid crisis involving the misuse of prescription opioid pain relievers as well as heroin and fentanyl.[1,2] The increase in substance use has resulted in concomitant increases in injection drug use across the country.[3] This has caused not only large increases in overdose deaths,[4] but also tens of thousands of viral hepatitis infections annually[5] and is threatening recent progress made in HIV prevention.[6] The most effective way for individuals who inject drugs to avoid the negative consequences of injection drug use is to stop injecting.[7,8] However, many people are unable or unwilling to do so, or they have little or no access to effective treatment. Approximately 775,000 Americans report having injected a drug in the past year.[9] In 2017, 14% of high school students reported using opioids without a prescription and 1.5% reported having ever injected drugs.[10]

Syringe services programs (SSPs) are proven and effective community-based prevention programs that can provide a range of services, including access to and disposal of sterile syringes and injection equipment, vaccination, testing, and linkage to infectious disease care and substance use treatment.[8, 11] SSPs reach people who inject drugs, an often hidden and marginalized population. Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.[11,12] Research shows that new users of SSPs are five times more likely to enter drug treatment and about three times more likely to stop using drugs than those who don't use the programs.[13] SSPs that provide naloxone also help decrease opioid overdose deaths. SSPs protect the public and first responders by facilitating the safe disposal of used needles and syringes.

Appropriations language from Congress in fiscal years 2016-2018 permits use of funds from the Department of Health and Human Services (HHS), under certain circumstances, to support SSPs with the exception that funds may not be used to purchase needles or syringes.[14] State, local, tribal, or territorial health departments must first consult with CDC and provide evidence that their jurisdiction is experiencing or at risk for significant increases in hepatitis infections or an HIV outbreak due to injection drug use.[15] CDC has developed guidance and consults with state, local, or tribal and territorial health departments on determining if they have adequately demonstrated need according to federal law. Decisions about use of SSPs to prevent disease transmission and support the health and engagement of people who inject drugs are made at the state and local level.

**U.S. Department of Health and Human Services**
Centers for Disease Control and Prevention



CS 300156-E July 19, 2019

## Prevention of Infectious Diseases

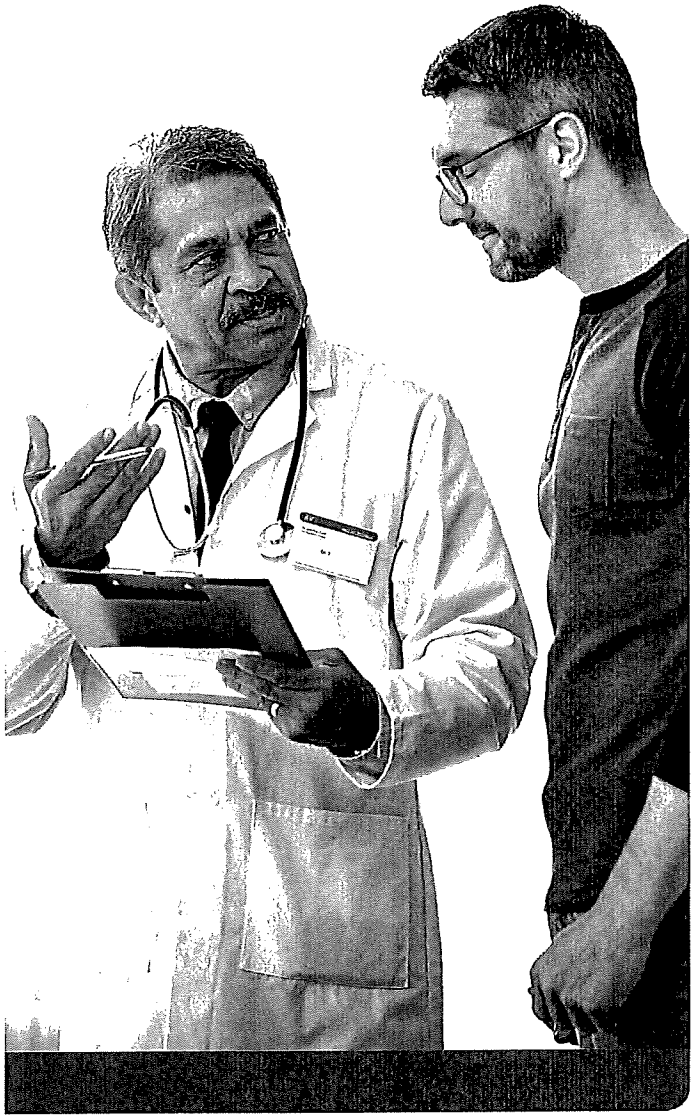

Viral hepatitis, HIV, and other blood-borne pathogens can spread through injection drug use if people use needles, syringes, or other injection materials that were previously used by someone who had one of these infections. Injecting drugs can also lead to other serious health problems, such as skin infections, abscesses and endocarditis. The best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of infection and prevent outbreaks.

During the last decade, the United States has seen an increase in injection drug use — primarily the injection of opioids. Outbreaks of hepatitis C, hepatitis B and HIV infections have been correlated with these injection patterns and trends.[16,17] The majority of new hepatitis C virus (HCV) infections are due to injection drug use, and the nation has seen a 3.5-fold increase in reported cases of HCV from 2010 to 2016, reaching a 15- year high.[5] New HCV virus infections are increasing most rapidly among young people, with the greatest incidence among individuals under 30.

Until recently, CDC had observed a steady decline since the mid-1990s in HIV diagnoses attributable to injection drug use. However, recent data show progress has stalled. Notably, new HIV infections among white people who inject drugs, the group most affected by the expanding opioid epidemic, increased 10% from 2014 to 2015.[18] The estimated lifetime cost of treating one person living with HIV is near $450,000.[19] Hospitalization in the US due to substance-use related infections alone costs over $700 million annually.[20] In the United States, the estimated cost of providing health care services for people living with chronic HCV infection is $15 billion annually.[21] SSPs can help reduce these healthcare costs by preventing viral hepatitis, HIV, endocarditis and other infections.

SSPs are a tool that can help reduce transmission of viral hepatitis, HIV, and other blood-borne infections. SSPs are associated with an approximately 50% reduction in HIV and HCV incidence.[11] When combined with medications that treat opioid dependence (also known as medication-assisted treatment) HIV and HCV transmission is reduced by more than two-thirds.[22,23]

Users of SSPs were **three times more likely** to stop injecting drugs.



## Linkage to Substance Use Treatment, Naloxone, and Other Healthcare Services

Syringe services programs serve as a bridge to other health services including, HCV and HIV diagnosis and treatment and MAT for substance use.[24] The majority of SSPs offer referrals to MAT,[25] and people who inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP.[13,26,27] SSPs facilitate entry into treatment for substance use disorders by people who inject drugs.[26,28] People who use SSPs show high readiness to reduce or stop their drug use.[29] There is also evidence that people who inject drugs who work with a nurse at an SSP or other community-based venue are more likely to access primary care than those who don't,[36] also increasing access to MAT.[30] Many comprehensive community-based SSPs offer a range of preventative services including vaccination, infectious disease testing, and linkage to healthcare services.

Syringe service programs can reduce overdose deaths by teaching people who inject drugs how to prevent and respond to a drug overdose, providing them training on how to use naloxone, a medication used to reverse overdose, and providing naloxone to them. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[31,32] SSPs have partnered with law enforcement, providing naloxone to local police departments to help them keep their communities safer.[33]

## Public Safety

Syringe services programs can benefit communities and public safety by reducing needlestick injuries and overdose deaths, without increasing illegal injection of drugs or criminal activity. Studies show that SSPs protect first responders and the public by providing safe needle disposal and reducing community presence of needles.[34–38] As many as one in every three officers may be stuck by a used needle during his or her career.[39] Needle stick injuries are among the most concerning and stressful events experienced by law officers.[40,41] A study compared the prevalence of improperly disposed of syringes and self-reported disposal practices in a city with SSPs (San Francisco) to a city without SSPs (Miami) and found eight times as many improperly disposed of syringes in Miami, the city without SSPs.[34] People who inject drugs in San Francisco also reported higher rates of safe disposal practices than those in Miami. Data from CDC's National HIV Behavioral Surveillance system in 2015 showed that the more syringes distributed at SSPs per people who inject drugs in a geographic region, the more likely people who inject drugs in that region were to report safe disposal of used syringes.[42]

Evidence demonstrates that SSPs do not increase illegal drug use or crime.[43,44] Studies in Baltimore[44] and New York City[43] have found no difference in crime rates between areas with and areas without SSPs. In Baltimore, trends in arrests were examined before and after a SSP was opened and found that there was not a significant increase in crime rates. The study in New York City assessed whether proximity to an SSP was associated with experiencing violence in an inner city neighborhood and found no association.

## SSP Implementation

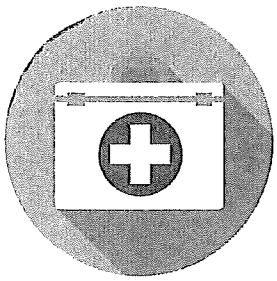
Not all SSPs are alike. Programs differ in size, scope, geographic location, and delivery venue (e.g., mobile vs. fixed sites). Community acceptance and legality also impact program success. Prior to establishing an SSP, it is important for public health agencies (or others) to assess the needs of potential clients, their families, key stakeholders, law enforcement, and the community at large.

The decision to incorporate SSPs as part of a comprehensive prevention program is made at the state and local level. Laws vary by state and can either increase or reduce access to SSPs. CDC created a guidance document to aid state and local health departments in managing HIV and hepatitis C outbreaks among people who inject drugs, which provides best practices to consider when establishing an SSP.[45] Conducting a needs assessment prior to the establishment of an SSP, developing evaluation tools, and careful planning of the operational tasks can increase the chances the SSP will be successful in a community.

HHS guidance states that SSPs should be part of a comprehensive service program that includes, as appropriate,[46]

- Provision of sterile needles, syringes, and other drug preparation equipment (purchased with non-federal funds) and disposal services.
- Education and counseling to reduce sexual, injection and overdose risks.
- Provision of condoms to reduce risk of sexual transmission of viral hepatitis, HIV or other sexually transmitted diseases.
- Provision of HIV, viral hepatitis, STD and tuberculosis screening.
- Provision of naloxone to reverse opioid overdoses.
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention, treatment, and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.
- Referral and linkage to hepatitis A virus (HAV) and hepatitis B virus vaccination.
- Referral and linkage to and provision of substance use disorder treatment, including MAT for opioid use disorder, which combines drug therapy (e.g., methadone, buprenorphine, or naltrexone) with counseling and behavioral therapy.
- Referral to medical care, mental health services, and other support services.

**SSPs save lives** by lowering the likelihood of deaths from overdose.



## Emerging Issues

In addition to the concerning increases in hepatitis and HIV rates, CDC has also identified additional emerging infectious disease risks related to injection drug use, including increases in methicillin-resistant staphylococcus aureus (MRSA) infection rates, which increased 124% between 2011 and 2016 among people who inject drugs.[47] In addition, people who inject drugs are 16 times as likely as other people to develop invasive MRSA infections.

Rates of endocarditis, a life-threatening infection of the heart valves that can occur in people who inject drugs, has also increased. For example, in North Carolina alone, the rate of hospital discharge diagnoses for endocarditis related to drug dependence increased more than 12-fold from 2010 to 2015, with unadjusted hospital costs increasing from $1.1 million in 2010 to over $22 million in 2015.[48] Identifying and responding to these emerging infectious disease threats is critical to alleviate the subsequent harms of opioid misuse and abuse. These infections have been linked to frequency of injecting and to syringe sharing.[49] SSPs may help reduce bacterial infections by providing sterile injection equipment and linkage to substance use treatment.

# Endnotes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STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ROBERT GORDON
DIRECTOR

November 1, 2019

Mr. Bradley Casemore, CEO
Southwest MI Behavioral Health – Region 4
5250 Lovers Lane Ste. 200
Portage, MI 49002

Dear Mr. Casemore:

Thank you for the cooperation extended to the *Office of Recovery Oriented Systems of Care (OROSC)* staff, during the September 9, 2019 site visit at *Southwest MI Behavioral Health.*

**PRESENT AT THE SITE VISIT**

| | |
|---|---|
| Southwest MI Behavioral Health: | Joel Smith, Director<br>Achilles Malta, Prevention Coordinator<br>Cathy Hart, SOR Coordinator<br>Garyl Guidry, Budgets<br>Anastasia Miliadi |
| OROSC: | Alicia Goodman, Project Coordinator-State Targeted Response (STR)<br>Foua Hang, Project Assistant-STR |
| Wayne State University: | Rachel Kollin, Project Manager SOR/STR<br>Danielle Hicks, Project Manager State Opioid Response (SOR) |

The purpose of the grant year two site visit was to verify that *Southwest MI Behavioral Health's State Targeted Response (STR)* grant activities and funds for opioid use disorder are in compliance with federal and state requirements to support prevention, treatment and recovery activities.

After careful consideration and review of the requirements and documentation submitted, we have determined that Southwest MI Behavior Health's activities are in compliance.

**STR REQUIREMENTS**

Prepaid Inpatient Health Plans must utilize funds within programs for individuals with opioid use disorder in order to fulfill federal and state funding requirements. STR funds are distributed to increase the availability of prevention, treatment and recovery services designed for individuals with an opioid use disorder (OUD).

The State Targeted Response grant require the following services must be included:

1. Support access to healthcare services, including services with healthcare providers to treat opioid use disorders.

2. Purchase naloxone for distribution in high need communities and train others on the use of naloxone.

3. Integrate health information technology programs to support identification of patents with an OUD and engage them in treatment.

4. Providers document and provide evidence based programs for their services.

**SITE VISIT FINDINGS**

Currently, Southwest MI Behavioral Health has all the necessary tools in place to manage, maintain and report on the STR activities and data from their provider network. Their providers will screen individuals to assess their needs and provide or make referrals for interventions as needed for individuals with an opioid use disorder.

We greatly appreciate Southwest MI Behavioral Health's preparation for the site visit and their commitment to provide our staff with the necessary documentation.

If you have any further questions, please contact Alicia Goodman, Project Coordinator-STR at 517-335-3451 or goodmana3@michigan.gov.

Sincerely,

Larry P. Scott, Director
Office of Recovery Oriented Systems of Care

LPS/ag

Enclosure (if applicable)

c: Angie Smith- Butterwick
Alicia Goodman
Joel Smith

Southwest Michigan BEHAVIORAL HEALTH

## 2019 Southwest Michigan Behavioral Health (SWMBH)
## Substance Use Disorder Oversight Policy Board (SUDOPB) Attendance

| Name | Jan | March | May | July | September | November |
|---|---|---|---|---|---|---|
| Ben Geiger (Barry) | | | | | | |
| Michael Majerek (Berrien) | | | | | | |
| Deb Panozzo (Berrien) | | | | | | |
| Don Meeks (Berrien) | | | | | | |
| Randall Hazelbaker (Branch) | | | | | | |
| Gary Tompkins (Calhoun) | | | | | | |
| Steve Frisbie (Calhoun) | | | | | | |
| Kathy-Sue Vette (Calhoun) | | | | | | |
| Tara Smith (Cass) | | | | | | |
| Skip Dyes (Cass) | | | | | | |
| Daniel Doerhman (Kalamazoo) | | | | | | |
| Lisa White (Kalamazoo) | | | | | | |
| Allen Balog (St.Joe) | | | | | | |
| Paul Schincariol (Van Buren) | | | | | | |
| Richard Godfrey (Van Buren) | | | | | | |

Green = present

Red = absent

Black = not a member

as of 9/9/19

# Southwest Michigan Behavioral Health
# Substance Use Disorder Oversight Policy Board Meetings
# (January 2020-December 2020)

January 20, 2020 4:00-5:30pm

March 16, 2020 4:00-5:30pm

May 18, 2020 4:00-5:30pm

July 20, 2020 4:00-5:30pm

**September 14, 2020 3:00-5:30pm
Public Budget Hearing

November 16, 2020 4:00-5:30pm

All scheduled meetings take place at the Principal Office, unless otherwise communicated.*

*Principal Office Located at 5250 Lovers Lane, Suite 200, Portage, MI, 49002*
*** KVCC - The Groves Center Room B1100, 7107 Elm Valley Drive, Kalamazoo, MI 49009*


Community Mental Health
Association of Michigan



# How to be a successful ADVOCATE

**Robert Gordon keynote to the Community Mental Health Association of Michigan**
**Tuesday, October 22, 2019**
**9-10 am**
***As prepared for delivery***

- On one of my first days on the job back in January, one of my first conversations was with Bob. I remember it because I was walking into the office, I didn't have a coat, and it was twenty degrees. You are blessed to have such a brilliant and passionate advocate.
- Since January I have gotten a new coat, and I have had hundreds more discussions. There is no issue I hear about more than behavioral health. I don't care if you are a Republican or a Democrat, you are from Southeast Michigan or the Western UP, you want a strong behavioral health system. That is because this work is not an abstraction. It is not somewhere else. It about improving life for our friends, our families, and our neighbors.
- Let me begin with their stories:
    - About a young man with autism, who works retail. He lives in an apartment downtown, where he gets to listen to the music he likes, pick his roommates, and decide his own schedule—all thanks to his CMH.
    - About the woman with severe depression who is doing better because she has found a psychiatrist she connects with, and because she has a case manager who connects with her if she misses appointments. Her local clubhouse supports her, and so does a great peer support specialist
    - About the boy with anxiety, ADHD, violent outbursts, and a long history of trauma, who not only receives treatment himself, but whose whole family gets the counselling, training, and respite services they need so he can live at home, attend his local middle school, and play soccer.
    - And about the mother of two who has grappled with heroin dependence for a decade. Rather than throwing her in jail, a local drug court helped her get Medication Assisted Treatment and return to her children. Now she's working toward her best life.
- Helping people lead their best lives is what all of you in this room do each and every day. The value that animates your work is one I talk about a lot at MDHHS. It is the belief that every human being has dignity and deserves respect.
- That value is rooted in every great faith. It is rooted in our country's Constitution as it has evolved through 200 years of struggle for civil rights.
- For me personally, it is rooted in the lessons of my father: an Army veteran, a Yankees fan (sad this week), and a psychiatrist. While he had a part-time private practice that allowed me to grow up with great privilege, my Dad also always worked in New York City's public system. When I was a kid, he was the therapist working with homeless individuals on the Bowery, one of the original skid rows. I remember my father naming with respect the clients he counseled, Mr. Thomas, Mr. Lopez, always Mister. I remember the deep affection he felt for his co-workers and his clients alike. He worked there for more than a decade, until the program was shut down by a Mayor named Rudolph Giuliani. After that my dad went on to work for the city's Human Resources Administration arranging services for the people we now call returning citizens. He retired from that job a year ago, at age 81. I talked to him the other day and he is trying to figure out how to go back. As for you, it was not just a job. It is a calling.

- When I was in my 20s I helped to stand up AmeriCorps, the national service program. My boss at the time, a wonderful man who died too young named Eli Segal, used to call national service a "Swiss Army knife" because it did so many different things. CMHs are like that too. You coordinate, manage, and often provide care. You train staff. You offer a 24/7 crisis system for all Michiganders. You do jail diversion and pre-admission screening. You lead innovations in integrating behavioral health and physical health. Above all, you know your community, you know your people, and you fight for them.
- Part of our success will be identifying what we need to do better. And I will get to that. But first I want to say what is already working well in Michigan today:
    - We have one of the strongest public behavioral health systems in the country;
    - We have long been a national leader in de-institutionalization;
    - We are one of the only states to codify person-centered planning in law; and
    - We have a statewide commitment to serve not only those with Medicaid, but all people in crisis, building community continuums of care on behalf of all residents.
- Many other states are trying hard to create things we already have. What people in this room have already built.
- You succeed despite challenges. Demand has grown, especially around services for opioids and autism, while resources have not kept up. Because of pay rates and a competitive job market, you struggle to attract and retain trained professionals and direct care workers. And you operate in an enormously complex landscape—PIHPs, CMHs, MHPs, LPCs, PRTFs, QRTFs, OBOTs, PIPBICs, and... well, I'll stop there.
- These complexities contribute to challenges in the lives of the people we serve. Here, too, I'll tell some stories.
    - About the man whose sister with intellectual disabilities, cerebral palsy, and epilepsy now faces a reduction in services. He worries about her going from a place she has made home, and going to... well he doesn't know if there is a place that will take the rate now on offer.
        - We must do better.
    - About the homeless single parent who desperately wants to enter treatment for SUD, but can't find a placement that will accept her and her child, and so the family is split up.
        - We must do better.
    - About the 10-year old boy with severe mental health challenges who has been to the emergency room 10 times in the last year. His mother doesn't know where else to take him, the EDs can only stabilize him briefly, and the last time he was stuck there for days waiting for a bed.
        - We must do better.
    - About the parents who have raised over a half million dollars to build a group home where their disabled son can lead a full life with other men his age. It's a heart-warming story, but how have we ended up in a place where parents are founding their own nonprofits just to make sure their children get the care they need?
        - We must do better.
- And I really mean that WE must do better. I am not here to lay these problems at your feet. At the Department I am privileged to lead, full of civil servants who share your values and your extraordinary dedication, we must do better. And we need to act in partnership—with the

Legislature, with the diverse stakeholders represented in this room, and most of all, with the people we serve.

- Michigan is no stranger to efforts to improve our behavioral health and IDD system. Moving from 55 CMHs to 46 CMHs as MCOs to 18 PIHPs to 10 PIHPs. Then HCBS waiver implementation followed by the HMP launch. (You cannot escape acronyms.)
- Most recently, for almost four years, our state has focused on one idea of how to do better. That idea – the so-called carve-in to Managed Care – proposed moving money from the PIHPs to the Medicaid Health Plans. The Section 298 pilot projects were established to test this concept.
- The aim of these pilots was laudable: to bring people together around an approach that would preserve what's best in our system, create financial savings that could be reinvested in services, and drive better outcomes for patients. Due to their incredibly hard work, the participants found a way forward on many issues.
- But after 19 months of negotiations, it is clear that there will be no consensus on fundamental issues. And as someone who has always had questions about whether the carve-in is the right solution, I do not believe it is my place to force the pilots forward.
- And so as many of you have heard, we are canceling the Section 298 pilots.
- I know this news may feel frustrating to some of you who spent so much time on that process. But that time was not wasted.
    - You built connections that had not existed before.
    - You taught us an enormous amount to inform future efforts.
    - And you created innovative partnerships between CMHs and Medicaid Health Plans. The Health Plans are critical parts of the health care infrastructure in Michigan, and very much the Department's partners alongside CMHs. Innovative partnerships with diverse entities will be critical our path forward. Given our shared goal to integrate frontline care, we will do everything we can to support collaborations born of section 298.
- I know many of you are delighted by the demise of section 298. Some of you might wish we could be done with discussions of system change. You may be skeptical of the motives for change. You may think the system works well enough. You may believe the path forward is incremental change and increased funding.
- Let me tell you one point we can agree on. The system does need more funding. When I came to town in January, your Medicaid rates for 2019 were already set. But as the year went on, we looked at the data and saw the rates were insufficient. We requested $50 million more in 2019. One of many problems we have with the budget is that it failed to fund that $50 million. I hope you and Bob will keep fighting for it.
- For 2020, our Medicaid rates reflect an estimated increase of $134 million. And that will mean relief you and your residents need and deserve.
- If I can mention one smaller item you may not know about: As part of the agreement to build a new psychiatric hospital in Caro, Governor Whitmer insisted on $5 million for community-based outpatient services, for individuals who might be placed in a state hospital, or who are in a hospital ready to be discharged and could be served nearer their loved ones. Is that money enough to get people out of emergency rooms where they do not belong? No. Is it a small but important victory? Yes.

- We need more such victories, and we'll fight for them. But there is limit to the funding we will see here in Michigan. This is a state, after all, that has not yet agreed to fix potholed roads that most of us drive each day.
- Much as money matters, pressing for it is not enough.
- Very briefly now, I want to do three things: make a case for why we need fundamental system changes; describe some of the values behind those changes; and tell you the process we envision to get them done.
- Let me start by restating strengths of our current system which we must build on:
    - a strong commitment to person-centered planning and self-determination that allows individuals to live fulfilling lives in their communities as much as possible
    - a well-developed public system that is deeply connected to local communities and plays critical safety net and crisis functions for all Michiganders, not just Medicaid beneficiaries;
    - a comprehensive benefits package, particularly with the recent addition of autism benefits;
    - and most important, thousands of stories like the ones I started with, about residents whose lives are better because of the system's work.
- Now to the challenges. I used to have a boss who joked that when you had a hard problem in public policy, what you really needed was a blue-ribbon panel. Didn't matter who was on it, but the most important thing was that the panel be blue-ribbon.
- Well, we have had a lot of blue-ribbon panels on behavioral health in Michigan, including the Section 298 workgroup, the CARES Taskforce, the Mental Health Diversion Council, the Michigan Inpatient Psychiatric Care Improvement Project, and the Altarum projects. These many workgroups are a testament to how many leaders in our state care about progress on behavioral health. And they give us a great foundation on which to build.
- Informed by their work, I want to describe the challenges we face:
    - First, individuals experience gaps in care because of our system's separate managed care entities, networks, and payment processes for physical and behavioral health. Too often, doctors don't communicate information to each other. Too often, individuals have two care managers trying to do the same job, or otherwise they have none at all. Too often, patients don't get the coordinated care they need.
    - Second, multiple payors means that when the people in this room not only improve patient outcomes but also reduce the costs of physical health care, the savings are captured by health plans, not reinvested in behavioral health care. In a system so badly stretched, you are denied resources you have earned through your success. Residents are denied behavioral health resources needed for theirs.
    - Third, many individuals cannot find the right services. Residents should have choices, but today, even experienced navigators can struggle to locate one option. If you don't like that option, your only resort is an appeal. The services people get often depend on the quality of their advocacy (and hence their resources), not the level of need.
    - Fourth, for some services, no amount of expertise or advocacy will suffice. I touched on one example earlier, intensive outpatient services that keep individuals in the community. But there are others.
        - We are short psychiatrists.

        - We are short drug treatment providers to meet demand in some areas hard hit by the opioid epidemic, like Metro Detroit and the UP
        - Michigan does not have a crisis respite system.
        - Then there are our direct care workers. These individuals do demanding and intimate work, showing love for individuals all of us love. For this they are usually paid near the minimum wage. Of course we face shortages and turnover.
    - Fifth, the challenges are especially acute when our own complex systems must coordinate with other complex systems: foster care, schools, prisons and jails. The challenges here are even greater—but so too are the opportunities.
    - Finally, I would be less than truthful if I did not speak to governance and management issues. In recent year, the state has spent millions of dollars closing the books in the behavioral health system, with $14 million more needed to close out Fiscal Years 2018 and 2019. Because these are dollars to address spending beyond budgeted rates, there is no federal match. All of us would like to do better. In truth, the state has few options to address performance problems within PIHPs, which after all face no competition within their regions. PIHPs feel they have few options to address performance problems within CMHs. CMHs feel they have few options to address performance problems among providers. And providers often feel they get too few of the dollars coming from the state while they struggle with too many differences and complexities across PIHPs and CMHs. It is not good for anyone. Inadequate accountability makes public institutions less sustainable both financially and politically. And it hurts the people we are here to serve.
- Now, considering all the challenges I've outlined, we could tackle one or another problem with one or another reform. But if we truly want to serve the whole person seamlessly; if we truly want to capture more of the dollars we're spending today for behavioral health; if we truly want to expand choice, rationalize spending, and create manageable but meaningful accountability, then we will need bold reform, including financial integration. The 298 pilot structure was not the solution, but that does not mean we should stop trying. The carve-in was not the right path to financial integration, but there are other paths—including other paths that increase choices for residents; that leverage competition to improve outcomes; and that better honor the convictions of the people in this room.
- As I have said, we will build on the best of what we already have:
    - A strong public system offering critical crisis safety net and community benefit services
    - The learning from the listening sessions and work groups of recent years
    - And our core commitments: person-centered, community-based, recovery-oriented, culturally competent care, aimed at self-determination and community inclusion.
- In the coming weeks, my team and I will announce details about our vision for a stronger, more sustainable behavioral health system. It will take careful collaboration with all of you: CMHs, PIHPs, health plans, families and individuals served, providers, advocates, and more. And we will work closely with leaders in the legislature. Republican and Democrat, every member I talk with wants the system to work better.
- We'll be laying out a framework and direction for change so that we can actually move forward this time, rather than go through another round of blue-ribbon meetings.
- But we will need all of your thoughts, input, and expertise in order to move forward effectively, so that a changed system works for our people and our state. We will let you know soon how we see this process unfolding.

- Truth be told, you are not going to agree with everything we say. Policymaking is hard, and people balancing different interests in good faith will reach different conclusions. But this I can promise with confidence: we will listen to the voices in this room, and we will find a sound path forward.
- So we look forward to finding that path with you. So our brothers with developmental disabilities can stay in the places they call home. So our sisters living with severe depression have the support to live stable and dignified lives. And so our sons and daughters stay out of the emergency room and on the soccer fields with their peers.
- The road will turn, but the individuals we serve will always be our north star. They point the way. They are the reason we work. And they are the reason we will succeed in building a system that works better for all Michiganders.

# Behavioral Health & Developmental Disabilities Administration
# Bureau of Community Based Services

## Prepaid Inpatient Health Plans

### Southwest Michigan Behavioral Health


**October 2019**

Produced by:
Program Development, Consultation & Contracts Division

## *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD and IET-CH)*

**Measure**
Percentage of beneficiaries 13 and older with a New Episode of Alcohol or Other Drug Abuse or Dependence who: (1) Initiated Treatment within 14 days, and (2) Initiated Treatment and had two or more additional services within 34 days of the initial visit.

**Standard**
N/A – Informational Only for FY 20

**Measurement Period**
January 2019 – December 2019

**Data Source**
MDHHS Data Warehouse

**Measurement Frequency**
Annually

**Summary:**
Calendar Year (CY) 2018 is displayed below as baseline data. Due to small numbers of beneficiaries in the denominator for the child measure, data from both child and adult measures were combined.

Table 1 below represents the IET-14 measure (Initiation of AOD Treatment). Numerator, Denominator and Rate columns represent beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis service.

Table 2 below represents the IET-34 measure (Engagement of AOD Treatment). Numerator, Denominator and Rate columns represent beneficiaries who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the diagnosis service.

The statewide Medicaid rates for IET-14 and IET-34 were 39.8 and 17.55 respectively. Rows showing rates by Gender and Race/Ethnicity are statewide. Your PIHP is shown in the last row of each table.

**Table 1: CY 2018, IET-14 Child and Adult Combined Total**

| Medicaid Program | Numerator | Denominator | Rate |
|---|---|---|---|
| Michigan Medicaid Total | 25,682 | 64,526 | 39.80 |
| Females | 11,109 | 28,854 | 38.50 |
| Males | 14,570 | 35,661 | 40.86 |
| African American/Black | 7,077 | 19,240 | 36.78 |
| American Indian/ Alaska Native | 389 | 1,064 | 36.56 |
| Asian American | 57 | 153 | 37.25 |
| Hispanic | 830 | 2,110 | 39.34 |
| Native Hawaiian & Other Pacific Islander | 13 | 29 | 44.83 |
| Unknown | 1,849 | 4,556 | 40.58 |
| White | 15,464 | 37,363 | 41.39 |
| Southwest Michigan Behavioral Health | 1,857 | 5,590 | 33.22 |

**Table 2: CY 2018, IET-34 Child and Adult Combined Total**

| **Medicaid Program** | **Numerator** | **Denominator** | **Rate** |
|---|---|---|---|
| Michigan Medicaid Total | 11,326 | 64,526 | 17.55 |
| Females | 4,888 | 28,854 | 16.94 |
| Males | 6,438 | 35,661 | 18.05 |
| African American/Black | 2,619 | 19,240 | 13.61 |
| American Indian/ Alaska Native | 192 | 1,064 | 18.05 |
| Asian American | 29 | 153 | 18.95 |
| Hispanic | 397 | 2,110 | 18.82 |
| Native Hawaiian & Other Pacific Islander | 7 | 29 | 24.14 |
| Unknown | 703 | 4,556 | 15.43 |
| White | 7,379 | 37,363 | 19.75 |
| Southwest Michigan Behavioral Health | 878 | 5,590 | 15.71 |

Michigan Department of Health & Human Services

MDHHS
Michigan Department of Health & Human Services

# Press Release

**FOR IMMEDIATE RELEASE**: Oct. 21, 2019

**CONTACT**: Lynn Sutfin, 517-241-2112, SutfinL1@michigan.gov

**MDHHS announces Section 298 pilots have come to an end**

LANSING, Mich. – Today, the Michigan Department of Health and Human Services (MDHHS) announced the end of the Section 298 pilots following the governor's veto and the pilot participants' inability to reach an agreement on a path forward.

"These pilots were supposed to be built on agreement among all participants," said Robert Gordon, MDHHS director. "After years of work to reach consensus, it has become clear that agreement will not be reached. We remain committed to making our behavioral health system work better for all Michiganders, and it is time to look for new ways to achieve this goal."

The Section 298 Initiative was a statewide effort to improve the integration of physical health services and specialty behavioral health services in Michigan. It was based upon Section 298 in Public Act 268 of 2016. The Michigan legislature approved a revised version of Section 298 as part of Public Act 207 of 2018.

As part of the initiative, the Michigan legislature directed MDHHS to implement up to three pilots to test the financial integration of Medicaid-funded physical health and specialty behavioral health services. The pilots were announced in March 2018 and were to be implemented by Oct. 1, 2019. Implementation was delayed to Oct. 1, 2020 to allow more time to complete design of a financial integration model.

However, the parties ultimately could not agree on two fundamental issues, the automatic statewide scaling of the model and startup costs. Despite the cancellation, Gordon said much has been learned from the Section 298 pilot design development process that will inform future redesign efforts.

"In the coming weeks, I will be sharing the department's vision for a stronger behavioral health system," he said. "Designing a system that works for all Michiganders will take careful planning and extensive collaboration with legislators, families and individuals served by the system and stakeholders. Through this process, we can chart a commonsense path that improves Michiganders' lives."

298 ended NR.pdf

MDHHS
Michigan Department of Health & Human Services

**Testimony at**

**House Health and Human Services Appropriations Sub-Committee November 6, 2019**

**The Honorable Mary Whiteford, Chair**

**Bradley P. Casemore, CEO Southwest Michigan Behavioral Health and Joe Sedlock, CEO**

**Mid-State Health Network**

## Introduction

Greetings Chairwoman Whiteford and Committee Members. I am Bradley Casemore, CEO of Southwest Michigan Behavioral Health. I am joined by Joe Sedlock, CEO of Mid-State Health Network. We represent two of the ten Michigan Prepaid Inpatient Health Plans (PIHPs) which collectively serve more than 325,000 persons with Medicaid and Healthy Michigan Plan coverage recovering from a severe mental illness (adults), serious emotional disturbance (youth), Autism Spectrum Disorder, Intellectual / Developmental Disability (one of the most vulnerable and costly populations) or Substance Use Disorder. Our scope also includes individuals in what is referred to as "fee for service" Medicaid, also known as the "Health Plan Unenrolled" population.

PIHPs are benefits managers with responsibility for Access, Quality Assurance-Performance Improvement, Program Integrity-Compliance, Customer Services, Provider Network Management, Information Systems-Information Technology, Utilization Management, Finance and Accounting, and other roles as guided by federal regulations and the 728-page MDHHS-PIHP Agreement which you see before you here.

From October 2002 through December 2013 there were 18 PIHPs. The state-mandated move from 18 to 10 PIHPs, 7 of which were required to be brand new organizations known as Regional Entities under Mental Health Code 330.1204b, was complex, expensive and caused lost momentum in PIHP and CMHSP healthcare information exchange, healthcare data analytics, and integration & quality efforts. We suggest that policy leaders avoid underestimating the costs and timeframes related to significant system change, and to recognize that the number of PIHPs in and of itself is not directly related to improved outcomes or reduced costs; the roles and responsibilities specified in the PIHP Agreement must be effectively and efficiently performed regardless of the number of PIHPs.

With the consolidation into the new PIHPs in 2014 came PIHP responsibility for the substance abuse treatment and prevention activities of many types and several hundred million dollars, previously performed by the Coordinating Agencies. PIHPs stand at the forefront of the response to Michigan's opioid crisis.

PIHPs have readily accepted all roles determined and expanded by MDHHS. Our system has successfully evolved over decades of legislative and executive branch led initiatives resulting in the design and engineering of today's system. While there is always room for

improvement hundreds of thousands of individuals every year find success in their recovery from one or more behavioral health disorders, achieve improvements in their quality of life, have their housing, food and income insecurities addressed, and enjoy full participation in their communities. These gains are a direct result of the efforts and successes of many contributors, including persons served, their loved ones and allies, and the PIHP-led Medicaid public behavioral health system. ***What matters now is well-meaning knowledgeable and dedicated people working together to improve the public specialty behavioral health system to better address the imperatives and realities of tomorrow – not of today and not of yesterday.*** We and our PIHP colleagues stand ready to continue to be constructive and productive contributors to improvement efforts in an atmosphere which focuses on achieving well-defined health and specialty behavioral health outcomes of value to the citizens of our state.

Michigan's public behavioral health system is a national leader. Elements which distinguish Michigan's public behavioral health system for the benefit of persons served and taxpayer value, include but are not limited to a. local governance and accountability; b. all savings remain in the community for services; c. lack of expensive marketing and competitive edge expenses; d. system-wide collaboration amongst PIHPs with CMHSP partners and the state to share comparative data, improve systems and implement best clinical and administrative practices; and e. active identification, engagement and provision of supports and services to our most troubled citizens.

**PIHP Contributions**

PIHPs have hit their stride working with CMHSP partners and thousands of other providers to serve the citizens of our state to improve the public behavioral health system. Examples include significant enhancements in:

- Substance use disorder provider quantity and units of service since 2015, especially expansion of Medication Assisted Treatment (MAT).
- Autism Spectrum Disorder provider quantity, quality and units of service since the benefit was introduced and expanded.
- Efficiencies and cost reductions across the system such as
    - Implementation of state-wide inpatient psychiatric hospital review/audit sharing and recognition. We will soon be adding additional levels of care to this reciprocity.
    - Development and implementation of direct care worker training standards, tracking, sharing and recognition.
    - Establishment of a web-based state-wide PIHP communications and project management tool.
    - Collective purchasing arrangements resulting in reduced overall expenses.
    - Improving uniformity of benefit. In partnership with MDHHS PIHPs are taking individual and collective steps in using common assessment tools to improve

Parity and service consistency. This approach individualizes functional status with service needs, is complementary to person-centered planning and self-determination and is readily personalized based on changes in natural supports, health status, social determinants of health, and the needs, preferences and goals of persons served. PIHPs are establishing state-wide utilization criteria for inpatient psychiatric hospital services to improve access and consistency of services. Disparities in access and service levels seen across the state are no doubt due, in part, to the multi-year reductions in CMHSP General Fund, lesser availability of providers in low density population areas, and unpredictable Medicaid/Healthy Michigan funding from year to year.

- MDHHS and PIHPs have tentatively agreed that PIHPs and their substance use disorder treatment providers will soon inherit responsibility for parolees/probationers who require substance use disorder treatment from the Michigan Department of Corrections. This action which recognizes the value of PIHPs should save the State millions of dollars in General Fund outlays once fully implemented.

**Care Integration**

Much has been said and written about care integration, both clinical and financial. Several prior Committee guests have shared views, including Mr. Betlach from Arizona. Varying financial integration models have been attempted across the nation, with mixed results. PIHPs have embraced care integration at the payer-payer, payer-provider and provider-provider levels for decades. Non-exhaustive evidence of this includes:

- Support for the many local community-based care integration initiatives, including but not limited to Certified Community Behavioral Health Clinics (CCBHC), the State Innovation Model (SIM), Opioid Health Homes (OHH), and nearly 750 other local care integration initiatives.
- Active support of shared contract language for PIHPs and Medicaid Health Plans (MHPs), including shared accountability for specifically defined population health improvements using national HEDIS measures.
- Partnership with Integrated Care Organizations (ICOs) with four PIHPs in the MI Health Link Duals (Medicare-Medicaid) federal demonstration.
- Material investment by PIHPs in healthcare information exchange with other payers and providers via national standard transactions and Michigan's Health Exchange Networks.
- Active PIHP support for the establishment, evolution and widespread use of the state data warehouse healthcare application known as Care Connect 360 (CC 360) to improve physical/behavioral healthcare coordination and health outcomes for persons served as well as to reduce avoidable healthcare services and costs.
- PIHP care coordination activities in collaborations with MHPs for persons with complex healthcare and social service needs.

- Ongoing system improvement efforts between all PIHPs and MHPs who have met frequently for several years resulting in with significant product and process improvements in healthcare status and costs.
- Numerous creative and effective PIHP, CMHSP, primary care, hospital and specialist collaboratives with multiple community partners too numerous to mention.

**Principles for Change and Change Management**

As PIHPs, legislative and executive leaders work with persons served and their allies and advocates, CMHSPs and other behavioral health and physical health experts, we endorse the following key concepts as foundational for our public behavioral health system:

- Self-Determination
- Person-Centered Planning
- Trauma-informed competencies across the health and human services provider spectrum
- Public Governance
- Effective, plentiful and appropriately compensated workforce
- Meaningful involvement of person served in governance and management
- Leverage successful foundations and public investments; do not lose the precious resource of specialty behavioral health expertise we have in Michigan.
- Adequately fund system restructuring/reforms that occurs.
- Provide adequate time and resources for transition and evaluation.
- Address the large percentage of dual eligibles (Medicare and Medicaid) and large percentage of unenrolled ("fee for service") individuals in any reform efforts of the health system.
- Ensure that all systems (e.g., law enforcement, criminal justice, education, employment, housing, etc.) especially physical health payer and providers implement best practices in addressing social determinants of health, trauma-informed care, Adverse Childhood Experiences, and specialty populations bio-psycho-social care needs.
- Recognition of and payment for the service provision contributions of person served who are trained as Peer Support Specialists, Recovery Coaches, and provide reimbursement for proven care coordination and care integration activities.
- Person-first system reform which defines the health, behavioral health and social service outcomes desired by persons served and then Policy makers.
- A period of implementation and objective evaluation, with reforms found proven to be successful against those Aims implemented.

**Policy Suggestions**

Legislative support of the following efforts and objectives via policy and funding and supporting a statutory and regulatory environment conducive to system change are:

- Create openings for unique public-private solutions.
- Assure adherence to all Mental Health Code and related Medicaid specialty populations guidelines.
- Enhance funding for MDHHS capacity and competencies in related policy and program change management tasks.
- Support establishment and use of Medicaid Care Coordination codes for PIHPs and CMHSPs.
- Continue policy and resource support for Healthcare Information Exchange (HIE) and healthcare data analytics.
- Continue policy and resource support for Specialty Courts.
- Consider revising Michigan's spend-down rules which are a barrier to access to care as well as federal funds.
- Consider revising jail status rules to reduce loss of Medicaid while incarcerated and not yet adjudicated.
- Continue Legislative support for Medicaid tele-health, direct care wage increases, healthcare professional education and training, recruitment and retention.
- Pursue fact-based reform designs. Remain attentive to the flaws and successes of other state's Medicaid reforms or privatizations and incorporate analyses of physical health status of specialty populations.
- Focus on desired outcomes, alignment of incentives, beneficiary choice, shared savings and other Alternative Payment Methods and increased accountability using current delivery system methods first. The types, amount and duration of emerging and effective care integration initiatives is very promising and should not be jeopardized.

On behalf of Michigan's PIHPs, we thank you for having us as well as for your interest in and support for the vulnerable specialty populations we serve.

Respectfully,

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