Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB)

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
Monday, May 16, 2022
4:00-5:30
Draft: 5/9/22

1. **Welcome and Introductions (Randall Hazelbaker)**
2. **Public Comment**
3. **Agenda Review and Adoption (Randall Hazelbaker)** (d) pg.1
4. **Financial Interest Disclosure and Conflict of Interest Handling (M. Todd)**
5. **Consent Agenda (Randall Hazelbaker)**
   - March 21, 2022 Meeting Minutes (d) pg.2
6. **Board Actions**
   - SWMBH SUDOPB Bylaws revisions (B. Casemore) (d) pg.7
7. **Board Education**
   a) Fiscal Year 21/22 YTD Financials (G. Guidry) (d) pg.8
   b) PA2 Utilization Fiscal Year 22 YTD (G. Guidry) (d) pg.9
   c) 2023 Overview & Budget Planning (J. Smith) (d) pg.10
   d) 2022 Mid-Year PA2 Reporting (A. Miliadi) (d) pg.15
   e) Opioid Health Home Expansion (J. Smith)
8. **Communication and Counsel**
   a) Legislative and Policy Updates (B. Casemore) (d) pg.22
   b) October 7th Healthcare Policy Forum – save the date (B. Casemore)
   c) Opioid Settlement SWMBH Role (B. Casemore) (d) pg.81
   d) MI Health Link (B. Casemore) (d) pg.96
   e) SWMBH May Board Retreat Debrief (B. Casemore)
9. **Public Comment**
10. **Adjourn**

The meeting will be held in compliance with the Michigan Open Meetings Act

Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting Minutes

March 21, 2022
4:00 – 5:30 pm
Draft: 3/22/22

Members Present: Richard Godfrey (Van Buren County); Michael Majerek (Berrien County); Jared Hoffmaster (St. Joseph County) Ben Geiger (Barry County); Joanna McAfee (Kalamazoo County); Paul Schincariol (Van Buren County); Melissa Fett (Kalamazoo County); Gary Tompkins (Calhoun County)

Members Absent: Kathy-Sue Vette (Calhoun County); Don Meeks (Berrien County); Jeremiah Jones (Cass County); Randall Hazelbaker (Branch County)

Staff and Guests Present:
Brad Casemore, Executive Officer, SWMBH; Joel Smith, Substance Use Treatment and Prevention Director, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Garyl Guidry, Senior Financial Analyst, SWMBH; Achiles Malta, Regional Coordinator for SUD Prevention Services, SWMBH; Anastasia Miliadi, SUD Treatment Specialist, SWMBH; Emily Flory, Opioid Health Homes Coordinator, SWMBH; Cathy Hart, Grants Coordinator, SWMBH; Tammy Rey, Kalamazoo County Commissioner, Megan Banning, Calhoun County Administration

Welcome and Introductions
Richard Godfrey called the meeting to order at 4:01 pm and introductions were made.

Public Comment
None

Agenda Review and Adoption

Motion	Gary Tompkins moved to approve the agenda with one change of moving the Board Actions before the Board Education.
Second	Michael Majerek
Motion Carried	

Financial Interest Disclosure Handling
Mila Todd noted she received financial interest disclosures from the following members and there is no action necessary from the Board:

- Michael Majerek
- Richard Godfrey
- Gary Tompkins
- Joanna McAfee

- Jared Hoffmaster
- Ben Geiger

Mila Todd reviewed Melissa Fett's financial disclosure and conflict of interest forms with the Board noting that Melissa Fett serves as a member of the SWMBH Substance Use Disorder Oversight Policy Board while also being employed as a Peer Recovery Coach at Integrated Services of Kalamazoo (ISK), an entity with which SWMBH has a contract to provide, among other things, SUD treatment and prevention services, for which SWMBH reimburses ISK using various SWMBH funding streams including Medicaid, Block Grant and PA2.

Motion Ben Geiger moved that a conflict exists and that:

1) The Board is not able to obtain a more advantageous arrangement with someone other than Melissa Fett;

2) The Financial Interest disclosed by Melissa Fett is not so substantial as to be likely to affect the integrity of the services that SWMBH may expect to receive; and

3) A Conflict-of-Interest Waiver should be granted. The conflict-of-interest waiver shall cover all matters Melissa Fett may undertake as part of her official duties with Southwest Michigan Behavioral Health's SUD Oversight Policy Board concerning any matters arising between Integrated Services of Kalamazoo and the Southwest Michigan Behavioral Health. Melissa Fett shall abstain from voting on financial matters that are specific to her employer, Integrated Services of Kalamazoo (ISK).

Second	Gary Tompkins
Roll Call Vote	
Richard Godfrey	yes
Paul Schincariol	yes
Ben Geiger	yes
Michael Majerek	yes
Gary Tompkins	yes
Joanna McAfee	yes
Jared Hoffmaster	yes
Motion Carried	

Consent Agenda

Motion Jared Hoffmaster moved to approve the 9/13/21 and 11/15/21 Meeting minutes as presented.
Second Gary Tompkins
Motion Carried

Board Actions to be Considered

2022 SUDOPB Meetings Calendar

Motion Gary Tompkins moved to approve the 2022 SUDOPB Meetings Calendar as presented.
Second Paul Schincariol
Motion Carried

Amendment Request: Substance Abuse Council

Garyl Guidry reported as documented. Discussion followed.

Motion	Ben Geiger moved to approve the Substance Abuse Council Amendment Request as presented.
Second	Gary Tompkins
Roll Call Vote	
Richard Godfrey	yes
Paul Schincariol	yes
Ben Geiger	yes
Michael Majerek	yes
Gary Tompkins	yes
Joanna McAfee	yes
Melissa Fett	yes
Jared Hoffmaster	yes
Motion Carried	

Amendment Request: Substance Abuse Prevention Services

Garyl Guidry reported as documented. Discussion followed.

Motion	Ben Geiger moved to approve the Substance Abuse Prevention Services Amendment Request as presented.
Second	Gary Tompkins
Roll Call Vote	
Richard Godfrey	yes
Paul Schincariol	yes
Ben Geiger	yes
Michael Majerek	yes
Gary Tompkins	yes
Joanna McAfee	yes
Melissa Fett	yes
Jared Hoffmaster	yes
Motion Carried	

New Funding Request: Integrated Services of Kalamazoo

Joel Smith reported as documented. Discussion followed.

Motion	Gary Tompkins moved to approve the new funding request from Integrated Services of Kalamazoo as presented.
Second	Ben Geiger
Richard Godfrey	yes
Paul Schincariol	yes
Ben Geiger	yes
Michael Majerek	yes
Gary Tompkins	yes
Joanna McAfee	yes
Jared Hoffmaster	yes
Motion Carried	

2022 Election of Officers

SUDOPB Members discussed Chair and Vice Chair roles and responsibilities.

Motion	Paul Schincariol moved to reappoint Randall Hazelbaker as SUDOPB Chair and Richard Godfrey as SUDOPB Vice-Chair.

Second	Ben Geiger
Richard Godfrey	yes
Paul Schincariol	yes
Ben Geiger	yes
Michael Majerek	yes
Gary Tompkins	yes
Joanna McAfee	yes
Melissa Fett	yes
Jared Hoffmaster	yes

Motion Carried

SUDOPB Bylaws
Brad Casemore reviewed the history of the SUDOPB Bylaws and issues related to obtaining a quorum. Discussion followed. No decision was made, and this topic will be discussed at the May 16, 2022 SUDOPB Meeting.

Board Education

Fiscal Year 2022 YTD Financials
Garyl Guidry reported as documented, highlighting numbers for Medicaid, Healthy Michigan, MI Child, Block Grant, and PA2.

PA2 Utilization Fiscal Year 2022 YTD
Garyl Guidry reported as documented. Discussion followed.

2021 Admission Data
Joel Smith reported as documented. Discussion followed.

2021 Prevention Outcomes
Achiles Malta reported as documented. Discussion followed.

2021 Naloxone Report
Achiles Malta reported as documented. Discussion followed.

Opioid Health Homes (OHH) Update
Emily Flory reported as documented. Discussion followed.

Communication and Counsel

Legislative Updates
Brad Casemore shared the following updates:

- Supplemental funding from Federal and State levels continues
- Representative Whiteford House Bills 4925, 4926, 4927 and 4928 were revised. The Bills have not been voted on yet.
- Senator Shirkey Senate Bills 597 & 598 were revised. The Bills have not been voted on yet.
- MDHHS reorganization as presented in the packet

Intergovernmental Contract Amendment
Brad Casemore reported as documented.

Opioid Settlement Dollars and Plans
Brad Casemore and Joel Smith reported as documented. Discussion followed.

May Board Retreat
Brad Casemore stated that the SWMBH Board Retreat is May 13, 2022 and the SUDOPB Chair and Vice-Chair are invited to attend.

Public Comment
None

Adjourn
Motion Ben Geiger to adjourn the meeting at 5:31pm
Second Unanimous voice vote
Motion Carried

3/21/2022 Proposed SUDOPB Bylaws quorum definition revision

"A quorum is achieved when there are five or more members in attendance <u>and</u> at least one representative from five or more counties. For PA 2 budget amendment Board action a representative from the county effected by the amendment must be in attendance."

Southwest Michigan Behavioral Health

Substance Use Disorders Revenue & Expense Analysis Fiscal Year 2022

For the Fiscal YTD Period Ended 3/31/2022

	MEDICAID				Healthy MI			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
Barry	682,066	113,678	11,406	102,271	171,511	249,025	28,585	220,440
Berrien	2,606,598	434,433	178,981	255,452	1,816,098	988,080	302,683	685,397
Branch	727,961	121,327	60,247	61,080	867,448	232,449	144,575	87,874
Calhoun	2,836,229	472,705	314,752	157,953	3,290,625	937,880	548,438	389,442
Cass	802,012	133,669	111,510	22,158	1,122,014	292,483	187,002	105,481
Kazoo	3,625,461	604,244	125,199	479,044	1,794,613	1,470,865	299,102	1,171,763
St. Joe	1,021,723	170,287	6,842	163,446	559,689	391,157	93,282	297,876
Van Buren	1,346,718	224,453	80,432	144,021	974,236	472,875	162,373	310,502
DRM	1,408,664	1,295,721	1,321,369	(25,647)	2,837,601	3,565,273	2,801,357	763,916
Grand Total	**15,057,432**	**3,570,516**	**2,210,738**	**1,359,777**	**13,433,837**	**8,600,088**	**4,567,397**	**4,032,691**

EGRAMS	BLOCK GRANT				BLOCK GRANT BY COUNTY			
SUD Block Grant	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
Community Grant	3,283,604	1,227,553	1,227,553	0	Barry	167,798	167,798	0
WSS	250,000	68,374	68,374	0	Berrien	149,938	149,938	0
Prevention	1,204,535	668,466	668,466	0	Branch	24,425	24,425	0
Admin/Access	80,000	80,000	80,000	0	Calhoun	208,703	208,703	0
State Disability Assistance	128,219	57,132	57,132	0	Cass	136,682	136,682	0
Gambling Prevention*	188,684	10,987	10,987	0	Kazoo	329,721	329,721	0
State's Opioid Response 2	1,365,000	420,171	420,171	0	St. Joe	74,807	74,807	0
Substance Use Disorder - Toba	4,000	0	0	0	Van Buren	87,168	87,168	0
COVID Community Grant Trea	1,474,009	276,509	276,509	0	DRM	785,149	785,149	0
COVID Prevention	848,961	332,053	332,053	0	Admin/Access	100,774	100,774	0
COVID SUD Admin	125,000	20,774	20,774	0				
COVID WSS	274,462	0	0	0				
Mental Health Block Grant								
Transitional Navigators	298,880	68,451	68,451	0				
Clubhouse Engagement*	100,000	0	0	0	Legend			
Veterans Navigator*	100,000	46,489	46,489	0	DRM - Detox, Residential, and Methadone			
Crisis Transportation	101,120	11,198	11,198	0	WSS - Women's Specailty Services			
MHBG Childrens Covid-19	1,100,000	80,865	80,865	0				
SMI Adult Covid-19	875,000	37,326	37,326	0				
Admin/Access	0	0	8,031	(8,031)				
Grand Total	**11,801,474**	**3,406,348**	**3,414,379**	**(8,031)**		**2,065,166**	**2,065,166**	**0**

	PA2				PA2 Carryforward			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)		Current Utilization	Prior Year Balance	Projected Year End Balance
Barry	39,449	40,276	8,580	31,696	Barry	31,696	569,659	601,355
Berrien	183,043	177,862	90,655	87,207	Berrien	87,207	605,319	692,526
Branch	32,647	31,551	2,911	28,639	Branch	28,639	419,798	448,437
Calhoun	336,220	333,411	183,393	150,019	Calhoun	150,019	315,826	465,845
Cass	34,489	29,361	0	29,361	Cass	29,361	427,499	456,860
Kazoo	338,920	333,512	233,526	99,986	Kazoo	99,986	1,846,148	1,946,134
St. Joe	50,805	49,512	31,653	17,859	St. Joe	17,859	308,673	326,532
Van Buren	74,931	70,829	44,564	26,265	Van Buren	26,265	339,144	365,409
Grand Total	**1,090,503**	**1,066,314**	**595,281**	**471,032**		**471,032**	**4,832,066**	**5,303,098**

* Quarterly Financial Status Reporting

Program	FY22 Approved Budget	Utilization FY 22 Oct-Mar	PA2 Remaining	YTD Utilization
Barry	**76,880.00**	**17,149**	**59,731**	**22%**
BCCMHA - Outpatient Services	76,880	17,149	59,731	22%
Berrien	**427,528.52**	**112,346**	**315,182**	**26%**
Abundant Life - Healthy Start	73,025	42,477	30,548	58%
Berrien County - Drug Treatment Court	15,000	-	15,000	0%
Berrien County - Trial courts	48,280	-	48,280	0%
Berrien MHA - Riverwood Jail Based Assessment	18,058	-	18,058	0%
CHC - Jail Group	36,421	7,136	29,285	20%
CHC - Niles Family & Friends	6,545	-	6,545	0%
CHC - Wellness Grp	11,220	-	11,220	0%
CHC - Women's Recovery House	40,000	13,310	26,690	33%
Sacred Heart - Juvenile and Detention Ctr	78,979	4,162	74,817	5%
Berrien County Health Department - Prevention Ser	100,000	45,261	54,739	45%
Branch	**80,190.00**	**4,381**	**75,809**	**5%**
Pines BHS - Outpatient Treatment	18,000	4,381	13,619	24%
Pines BHS - Jail Based Services	62,190	-	62,190	0%
Calhoun	**517,859.73**	**200,306**	**317,553**	**39%**
Calhoun County 10th Dist Drug Sobriety Court	171,582	63,842	107,740	37%
Calhoun County 10th Dist Veteran's Court	6,950	5,368	1,582	77%
Calhoun County 37th Circuit Drug Treatment Court	232,233	96,957	135,275	42%
Haven of Rest	37,095	21,639	15,456	58%
Michigan Rehabilitation Services - Calhoun	25,000	12,500	12,500	50%
Summit Pointe - Jail	20,000	-	20,000	0%
Summit Pointe - Juvenile Home	25,000	-	25,000	0%
Cass	**82,500.00**	**766**	**81,734**	**1%**
Woodlands - Meth Treatment and Drug Court Outp	82,500	766	81,734	1%
Kalamazoo	**735,176.42**	**289,827**	**445,349**	**39%**
8th District Probation Court	12,100	5,267	6,833	44%
8th District Sobriety Court	26,400	6,348	20,052	24%
9th Circuit Drug Court	60,000	26,678	33,322	44%
CHC - Adolescent Services	21,876	9,118	12,758	42%
CHC - New Beginnings	77,627	39,619	38,008	51%
Gryphon Gatekeeper - Suicide Prevention	20,000	10,200	9,800	51%
Gryphon Helpline/Crisis Response	36,000	18,000	18,000	50%
KCHCS Healthy Babies	87,000	5,466	81,534	6%
ISK - EMH	56,400	28,200	28,200	50%
ISK - FUSE	25,000	12,500	12,500	50%
ISK - Mental Health Court	65,000	32,500	32,500	50%
ISK - Oakland Drive Shelter	34,000	17,000	17,000	50%
Michigan Rehabilitation Services - Kalamazoo	17,250	8,625	8,625	50%
Prevention Works - Task Force	50,000	32,532	17,468	65%
Recovery Institute - Recovery Coach	60,623	33,533	27,090	55%
WMU - BHS Text Messaging	7,000	4,239	2,761	61%
WMU - Jail Groups	78,900	-	78,900	0%
St. Joseph	**83,040.00**	**33,919**	**49,121**	**41%**
3B District - Sobriety Courts	2,200	500	1,700	23%
3B District - Drug/Alcohol Testing	16,640	14,340	2,300	86%
CHC - Hope House	21,000	12,086	8,914	58%
CMH - Court Ordered Drug Testing	43,200	6,993	36,207	16%
Van Buren	**145,000.00**	**51,261**	**93,739**	**35%**
Van Buren CMHA	100,000	33,568	66,432	34%
Van Buren County Drug Treatment Court	45,000	17,692	27,308	39%
Totals	**2,148,175**	**709,955**	**1,438,220**	**33%**

PA2 Overview and Budget Planning

Substance Use Disorder Oversight Policy Board, May 16, 2022

Liquor Tax (PA2)

History and Overview:

- PA 2 of 1986
- Liquor Specific Tax 4% generated from each county
- 50% of the funds shall be used for substance use disorder treatment and prevention programs within the county
- The proceeds of the taxing unit shall be distributed to the coordinating agency (PIHP) designated for that county
- Convention Facility Development Fund (Cobo Hall Bond) sunset December 31, 2015
- Funding is county specific vs. regionally
- Must be used on treatment of prevention services

Liquor Tax (PA2)

SWMBH Budgeting Practice and Process:

- Prior to each fiscal year, SWMBH staff will determine/project the allocation of PA2 resources by county
- Multiple variables are taken into consideration when budgeting. These include, but are not limited to:
  - Projected PA2 revenue per county
  - County carry forward balances and projections
  - Availability of other available funding (Medicaid, Block Grant, other grants, etc.)
  - Provider program and budget submissions/prior performance
- PA2 revenue and allocations to specific providers may change from year to year based on the variables listed above
- PA2 can be carried over from year to year

Liquor Tax (PA2)

SWMBH Budgeting Practice and Process (continued):

- Carry forward reserves are monitored to assure adequate funding for current program expenditures and to assure future programming continues
- Ultimately the goal is to be fiscally responsible while providing SUD treatment and prevention services.
- SWMBH staff will meet and communicate with providers, key stake holders, and board members as needed.

Role of the Oversight Policy Board:

- Approval of any portion of SWMBH's budget that contract PA2 funds for the treatment and prevention of substance use disorders

Budget Calendar

FY23 Budget Event	Date
Initial Provider Budgets Due	Friday, June 17, 2022
SUD OPB Meeting – First Consolidated Budget	Monday, July 18, 2022
Revised Provider Budgets Due (if necessary)	Friday, July 29, 2022
Meet with SUBOPB Members – Review/Finalize	August
SWMBH Board Meeting	Friday, September 9, 2022
Final Budgets sent to SUDOPB	Monday, September 12, 2022
SUDOPB Meeting	Monday, September 12, 2022

Southwest Michigan
BEHAVIORAL HEALTH

MID-YEAR PA2 FUNDED OUTCOMES REPORT

Reporting Period 10/1/21 - 3/31/22

BRIEF HISTORY

- Each County determines use of local PA2 SUD dollars.
- Each provider must submit their own outcome measures.
- 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: MID YEAR FY22

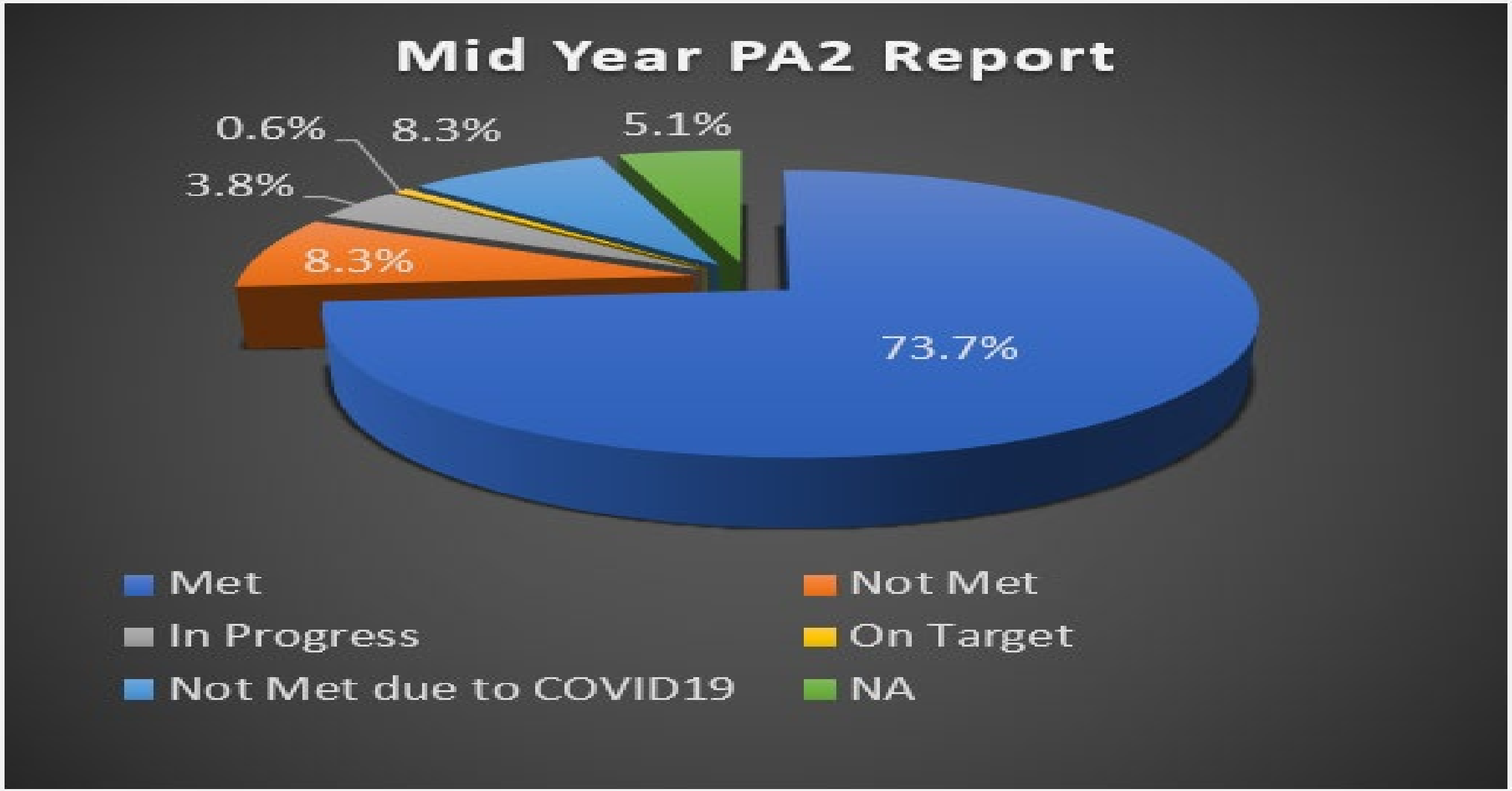
25
Providers

46
Programs

156
Outcome Measures

MID YEAR MEASUREMENT DEFINITIONS

Met: Clearly meets or exceeds outcome.
Not Met: Not meeting outcome.
Not met Due to the Pandemic: COVID-19 affected services.
On Target: Program is either very close to meeting outcome or is on target to meeting the outcome at the end of the year (e.g.: within 10%).
In Progress: Longer term projects that involve more planning, delayed implementation, or data collection.
Information Not Applicable : No data due to no consumers fitting measurement requirements.


Mid Year PA2 Report
0.6%
8.3%
5.1%
3.8%
8.3%
73.7%
Met
Not Met
In Progress
On Target
Not Met due to COVID19
NA

County	Total Outcome Measures	Met	Not Met	In progress	On target	Not Met due to COVID19	NA
Barry	6	6	0	0	0	0	0
Berrien	23	16	3	1	0	2	1
Branch	6	0	3	0	1	2	0
Cass	3	1	0	0	0	2	0
Calhoun	39	35	0	0	0	0	4
Kalamazoo	62	47	5	4	0	6	0
St Joe	8	4	1	1	0	0	2
Van Buren	9	6	1	0	0	1	1
Totals	**156**	**115**	**13**	**6**	**1**	**13**	**8**

- Delivering services in jails continues to be challenging due to COVID-19 restrictions.
- Despite the pandemic, 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.
- SWMBH continues to work closely with providers to create measures that are specific, measurable, timely, and simple and continues to review utilization of the programs.

Spring 2022 Public Policy Updates

Overview

* Budget
* Behavioral Health Restructuring
* Senate & House Redesign Proposals
* Advocacy Efforts

Budget Items

Figure 1

Budget Update

FY23 Budget Proposals

Specific Mental Health/Substance Abuse Services Line items

	FY'23 Exec Rec		FY'23 Senate		FY'23 House
-CMH Non-Medicaid services	$125,578,200		$125,578,200		$125,578,200
-Medicaid Mental Health Services	$2,975,480,500	$2,975,893,900	$2,810,590,500		
-Medicaid Substance Abuse services	$82,657,700		$82,657,700		$85,421,900
-State disability assistance program	$2,018,800		$2,018,800		$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,705,200		$78,050,700		$79,705,200
-Health Homes Program	$61,337,400	$61,337,400		$61,337,400	
-Autism services	$286,697,900		$286,697,900		$286,697,900
-Healthy MI Plan (Behavioral health)	$583,086,100		$583,086,100		$585,768,500
-CCBHC	$101,252,100		$101,252,100		$101,252,100
-Total Local Dollars	$15,285,600		$246,900		$10,190,500

Budget Update

Other Highlights of the FY23 Senate Budget:

Senate Items of Interest

- Included $101.2 million for CCBHC – concurred with executive & House
- Included $61.3 million for Health Homes – concurred with executive recommendation
- Included Opioid Settlement Fund ($16 million Gross) – concurred with executive & House
- Local match drawn down phase out – $15 million GF (eliminates all but $247,000)
- Increase CMH guardianship rates ($5 million Gross and GF)
- Families Against Narcotics ($5 million Gross and GF)
- Michigan 2-1-1 Operational Increase ($2 million Gross and GF)
- Medicaid Reimbursement for community health workers ($28.3 million Gross, $10 m GF)

Senate New One Time

- Great Lakes Recovery Centers ($250,000)
- Northern MI Crisis Stabilization unit ($5 million Gross and GF)

Budget Update

Senate Boilerplate Changes

* The Senate removed language that appropriated $500,000 for an actuarial study to create a specialty Medicaid managed care health plan for children in foster care

* The Senate modified language to direct the expansion of behavioral health homes in Prepaid Inpatient Health Plan (PIHP) regions 6 and 7 and the expansion of SUD health homes in regions 6,7, and 10. The Senate added a quarterly report on the number of individuals being served by the health homes by PIHP region by site.

* Removes a SUD Detox Pilot @ St. Mary's in Livonia

Other Notes

* The Direct Care Worker wage increase is assumed to be continued as it is built into the baseline. Boilerplate language that was slightly altered in the Exec Rec was restored in Senate: (1) Requires the department to work with PIHPs and actuaries to include state minimum wage and federal wage increases that affect direct care staff when setting Medicaid rates. (2) States legislative intent that any increased Medicaid rate resulting from a minimum wage increase shall be passed through the direct care staff.

* Many of the new investments recommended by the Governor were not included, including $25 million proposed for behavioral health provider loan repayment

* Senate budget roughly $900 million less than the Governor's recommendation.

Budget Update

Other Highlights of the FY23 House Budget:

House Items of Interest

- Included $101.2 million for CCBHC – concurred with executive & Senate
- Included $61.3 million for Health Homes to increase the number of behavioral health homes from 37 to 42 and the number of opioid health homes from 40 to 49. **But House requires** funds be used to implement intellectual or developmental disability health home ($16.8 million Gross ($2.5 million GF/GP))
- Included Opioid Settlement Fund ($16 million Gross) – concurred with executive recommendation
- 2 – 5 % actuarial soundness adjustment for prepaid inpatient health plans (PIHPs)
- Local match drawn down phase out – $5 million GF (brings to year 3 of 5-year phase out)
- $1 million to provide supports for special education system navigation and to improve educational outcomes for youth in foster care who have a disability
- Construct a new Hawthorn Center for children and adolescents ($85 million GF/GP – one-time)
- Michigan Crisis and Access Line (MiCAL) funding to continue implementation of MiCAL statewide – a behavioral health crisis intervention and support call center and also provides primary coverage in regions where a regional national suicide prevention 988 lifeline center does not provide coverage ($3 million Gross)

Budget Update

House One Time Funding

House added funding for several one-time items to increase non-state Behavioral Health Facility Capacity ($178.6 million Gross):

- Pine Rest pediatric behavioral health center ($50.0 million)
- Detroit Wayne Integrated Health Network psychiatric campus ($45.0 million)
- Establishing crisis stabilization units ($30.0 million)
- U of M Medicine children's emergency psychiatry and day program for children and adults ($11.0 million)
- Establishing psychiatric residential treatment facilities ($10.0 million)
- Team Wellness adolescent behavioral wraparound health care program ($10.0 million)
- Northern Michigan psychiatric inpatient ($5.0 million)
- Bay County pediatric psychiatric inpatient ($5.0 million)
- Kalamazoo or Berrien County pediatric psychiatric inpatient ($5.0 million)
- War Memorial psychiatric inpatient ($3.6 million)
- McLaren emergency psychiatric assessment, treatment, and healing (EmPATH) unit ($3.0 million) McLaren Greenlawn ($1.0 million)

House also includes one-time funding for the following:

- First responder mental health funding ($7.5 million SFRF)
- Easterseals - autism comprehensive care center ($2.5 million)
- Western Upper Peninsula CMHSP health professionals in schools ($1.0 million)
- Altarum substance use disorder programing ($850,000)
- Easterseals – Parent/Family stress programs ($500,000)
- Great Lakes Recovery Center ($250,000)
- Endeavor to Persevere – teen walk-in mental health ($50,000)
- Mediation services ($40,000)
- $100 placeholders for Jail Diversion Fund, Families Against Narcotics, and Salvation Army Safe Harbor ($300)

Budget Update

House Boilerplate Changes

(House budget added the following sections back into the budget – they were not included in the Governor's budget)

* Sec. 908. Uniform Community Mental Health Credentialing – States that contracts with PIHPs and CMHSPs must work toward implementing section 206b of the Mental Health Code on uniform community mental health services credentialing.

* Sec. 927. Uniform Behavioral Health Service Provider Audits – Requires DHHS to create a uniform community mental health services auditing process for CMHSPs and PIHPs, outlines auditing process requirements, and requires a report.

* Sec. 960. Autism Services Cost Containment – Requires DHHS to continue to cover all autism services that were covered on January 1, 2019; to restrain costs required DHHS to develop written guidance for standardization; and requires 3-year reevaluations, unless a clinician recommended an earlier reevaluation, and require maintenance of statewide provider trainings, limits practitioners who can perform a diagnostic evaluation and requires evaluations performed by a master's level practitioner to be reviewed by a second practitioner, provide fidelity reviews and secondary approvals, and prohibit specific providers from providing both evaluation and treatment; requires a report.

* Sec. 970. Skill Building Assistance Services – Requires DHHS to maintain skill building assistance services policies in effect on October 1, 2018, and requires DHHS to continue to seek federal matching funds for skill building assistance services.

Budget Update

Other Notes

* The Direct Care Worker wage increase is assumed to be continued as it is built into the baseline. Boilerplate language – (Sec 231) House revises to require Medicaid managed care organizations of MI Choice, MI Health Link, and PIHPs to continue the direct care wage increase and to report quarterly to DHHS on direct care salaries paid, for DHHS to perform a market rate survey, and removes references to private child caring institutions, area agencies on aging, and long-term care (which is moved to new Sec. 1644).

* Many of the new investments recommended by the Governor were not included, including $25 million proposed for behavioral health provider loan repayment

* House budget roughly $500 million less than the Governor's recommendation.

Behavioral Health Restructuring

Behavioral Health Restructuring

- **Creating the Bureau of Children's Coordinated Health Policy and Supports** to improve and build upon the coordination and oversight of children's behavioral health services and policies.
  - Lindsey McLaughlin will oversee the Bureau of Children's Coordinated Health Policy and Supports.

- Shifting the administration of Behavioral Health and Developmental Disabilities Administration to different administrations and divisions within MDHHS to improve coordination of services and leverage expertise that exists among staff in these areas.

- Renaming the MDHHS Health and Aging Services Administration to **Behavioral and Physical Health and Aging Services Administration (BPHASA)**. This administration - which already handles Medicaid and services for aging adults - will oversee community-based services for adults with intellectual and developmental disabilities, serious mental illness and substance use disorders. This will build upon the administration's existing efforts to deliver services to adults with mild to moderate mental illness.
  - Farah Hanley, Chief Deputy for Health will oversee the new Behavioral and Physical Health and Aging Services and the State Hospital Administration.

- Moving substance use and gambling disorder prevention programs to the Bureau of Health and Wellness under the Division of Chronic Disease within the Public Health Administration.

- March 21 – effective date

Behavioral Health Restructuring

SUD prevention out of behavioral health offices and to Division of Chronic Disease (Alicia Nordmann)

- Creation of Bureau of Children's Coordinated Health, Policy, and Supports and within that bureau:
  - Office of the Advocate for Children, Youth, and Families (with some of the staff of the former Children's Mental Health Services Office) (Justin Tate)
  - Contract Management and Quality Monitoring Division (with the staff of the former Children's Mental Health Services Office)
  - Service Development and Implementation Division (overseeing the Mi Kids Now initiative)
- Creation of Chief Deputy of Health with two administrations reporting to this office:
  - State Hospital Administration (note that Larry Scott, former OROSC Administrator has been moved to this administration)
  - Behavioral and Physical Health and Aging Services Administration – formerly HASA (Kate Massey)
- Movement/Creation of Bureau of Community Based Services (Jeff Wieferich) under Behavioral and Physical Health and Aging Services Administration
  - Division of Contracts and Quality Management (Jackie Sproat)
  - Division of Adult Home and Community Based Services (Belinda Hawks)
  - Creation of new Crisis Services and Stabilization Section (manager to be named)
- Movement or Creation of three Sections under Adult Home and Community Based Services
  - Federal Compliance
    - Substance Use Disorder Treatment Section (Angela Smith-Butterwick)
    - Community Based Practices and Innovations (Brenda Stoneburner)
- Creation of Bureau of Medicaid Care Management and Customer Service (Penny Rutledge) and within that Bureau:
  - Behavioral Health Customer Service Section (Kendra Binkley)
- Creation of Office of Strategic Partnerships and Medicaid Administrative Services (Erin Emerson) with three Sections within it, one of note is:
  - Service Delivery Transformation Section – which will be responsible for the state's CCBHC, BHH, a& OHH work (Amy Kanouse, Lindsay Naeyaert – both at MPHI) and Kelsey Schell)

Legislative Redesign Proposals

https://www.youtube.com/watch?v=vUi1PdYn5nk

Observations on Legislative Redesign Proposals

Overall Observations

* Senate bills are a VERY serious threat – Sen. Shirkey is planning on moving this forward
  * **Shirkey Legacy Package**
* Up hill climb so far, but still a lot of time – will continue to twist arms and cut deals
* Sen Shirkey controls what happens in MI Senate

* House proposal has more bipartisan support
* House proposal will not move in the Senate – if it passes the House

* Where is the DHHS? (legislative issue, not going to get involved at this point)
* Where is the Governor, will she veto??

Constant efforts to restructure creates instability within the system (providers, workforce and people served)

- Snyder Administration – Section 298 (2016 – 2019)
- DHHS Director Robert Gordon Proposal to create SIPs (2019 – 2020)
- Sen Shirkey health plan takeover proposal SBs 597 – 598 (2021 – present)
- Rep Whiteford ASO proposal HBs 4925 – 4928 (2021 – present)

Observations on Legislative Redesign Proposals

Where are the bills in the legislative process?

Senate Bills introduced in mid-July 2021, referred to the Senate Government Operations Committee (Chair Sen. Shirkey)

- Committee heard testimony on 9/14, 9/21 & 9/28
- Bills voted out of committee on 10/26
- Bills on Senate agenda March 2 – moved from general orders to 3rd reading of bills (S3 version)
- SB 714 – mental health supplemental - $539 million as a way to sway votes and support

House Bills introduced in late-May 2021, referred to the House Health Policy Committee

- Committee head testimony in early June of 2021 & March 17, 2022.
- Rep Whiteford did a 7 month long listening tour and received feedback and questions regarding the package.
- March 17, 2022 Health Policy committee revealed a new S-5 version of the bills to reflect feedback received. (bills have not moved out of committee)

Legislative Redesign Proposals

Comparison of Shirkey vs Whiteford proposals

Overall structure

SHIRKEY (SBs 597 & 598)

- Eliminate 10 PIHPs
- Transfers Medicaid financial control & all managed care functions to Specialty Integrated Plans (Medicaid health plan) – section 298 2.0
- State contract with DHHS (bid process for contracts)
- A minimum of 2 health plans per region (could be up to 8 in certain regions)
- Privatizes Medicaid mental health benefit

WHITEFORD (HB 4925 – 4928)

- Does not eliminate 10 PIHPS, but removes them from their current role
- Create a single statewide Administrative Services Organization (ASO) to help augment DHHS staff and assist in oversight and provision of the public mental health system.
- DOES NOT transfer money or control to Medicaid health plans
- KEEPS Medicaid mental health separate from physical health care.
- Moves mild-to-moderate benefit over to behavioral health
- State contract with DHHS to provide a number of core management functions
- Keeps Medicaid mental health benefit public – gives more control to DHHS & puts CMHs in center of care

Legislative Redesign Proposals

Timing

SHIRKEY (SB 597 & 598)

- 10 year full implementation process
  - 2 year bid/start-up, formation of SIPs
  - 8 year phased in implementation of 4 populations (2-year between each phase).
    - Phase 1 – kids
    - Phase 2 – Adults w/ serious mental illness
    - Phase 3 – substance use disorder
    - Phase 4 – intellectual & developmental disabilities
- PIHP system will be operating simultaneously during the phase in implementation process, they will continue to be responsible for the populations until they transition to health plan control.

WHITEFORD (HB 4925-4928)

- Up to 3 years for bid process and start-up of new ASO
- NO phase in approach

Legislative Redesign Proposals

Care authorization

SHIRKEY (SB 597 & 598)

* SIPS/Medicaid health plans will be responsible for authorization

WHITEFORD (HB 4925-4928)

* ASO (DHHS – would hold the risk) could be responsible for authorization, if designated by department
* Unclear what role CMH will have in authorization

Role of CMH

SHIRKEY (SB 597 & 598)

* CMHs would be just another provider – SB 598 eliminates any network control CMHs currently hold

WHITEFORD (HB 4925-4928)

* CMHs would be at the center of care and serve as a provider (and local network manager?)
* DHHS would send money directly to CMHs, including mild-to-moderate??
* CMHs would send data to ASO and interact on compliance issues
    * Unclear on delegated management/administrative functions currently done at CMH level?
* Fully fund CCBHC (Certified Community Behavioral Health Clinics) & Behavioral Health Homes / Opioid Health Homes

Legislative Redesign Proposals

Oversight / Transparency

SHIRKEY (SB 597 & 598)

- SIPS/Medicaid health plans hold a contract with DHHS
- SIPS/health plans at financial risk
- Board meetings not subject to FOIA or Open meetings act (many board meetings take place out of state)
- MSA (state Medicaid depart) would hold a much larger role over behavioral health due to health plan control
- Subject to state appropriations process and oversight

WHITEFORD (HB 4925-4928)

- Both ASO & CMHs would hold a contract with DHHS (not sure on Medicaid contract?)
- DHHS / State of Michigan at financial risk
- CMHs would manage local networks would still be accountable to local boards of county commissioners – meetings are subject to FOIA & Open Meetings Act and take place in local communities
- DHHS would assume larger oversight role than they currently hold
- Subject to state appropriations process and oversight

Legislative Redesign Proposals

Consumer interaction

SHIRKEY (SB 597 & 598)

- Creation of behavioral health ombudsman office
- Creation of an Accountability Council – various statewide representation, provide input not a governing body
  - Meetings would be public – open meetings act would apply
  - **This council goes away after the implementation process is completed.**

WHITEFORD (HB 4925-4928)

- Creation of Behavioral Health Advisory Council – provides input on both financial and operations of the behavioral health delivery system, statewide representation.
  - 1/3 of the council would be made up a consumers or family members
  - Meetings would be public – open meetings act would apply

Concepts we support in any redesign effort

We are fighting to protect what is best for individuals and families served across the state, we believe that is a PUBLIC SYSTEM:

- Has the care expertise and proven ability to develop and implement evidence-based and promising practices.
- Best understands the complex needs of the people served.
- Maximizes the amount of resources going into care for people – does not take profit off the top. We want the dollars to follow the person.
- Has a proven record of high performance.
- Has a transparent policy-making and decision-making process, ensured by the Open Meetings Act and FOIA.
- Has longstanding and deep partnerships with community organizations across a range of sectors: education, law enforcement, judiciary, housing, employment, public health, aging services, among many others

Concepts we support in any redesign effort

Public system must have:

- CMHs at the central role of care & serve as the local network managers
  - CMHs retaining risk, clinical, quality, and financial management functions in their traditional and proven role as a comprehensive specialty services network organizer
  - CMHs receive capitated or sub-capitated payment arrangement to best allow for coordination of care.
- Maintains local control, governance & local decision making tied to local elected officials
- Protects the safety net role that is tied to the community – people in need of services and community partners know who to turn to in a crisis

Potential Models & key concepts to support:

- State/Regional publicly run risk-bearing entity (PIHPs are regional risk-bearing entities)
- Public / private partnership that forms a joint entity which is jointly governed and managed.
- Publicly run system that has a private partner come along side and work collaboratively

  - Any model should fully fund CCBHC & BHH/OHH models, to ensure continuation and expansion of patient-center integration initiatives.
  - Any model must have a focus on access to care and the appropriate intensity and duration of services and supports
  - Clarity as to risk-bearing and savings retention by CMHs
  - Clarity as to how SUD services are managed and organized at the state and local levels

Why we OPPOSE SBs 597 & 598

CMHA neither supports or opposes HBs 4925-4928, however we do have a number of questions and concerns with the house package (eliminates PIHPs, removes certain CMH admin functions, changes financing model etc).

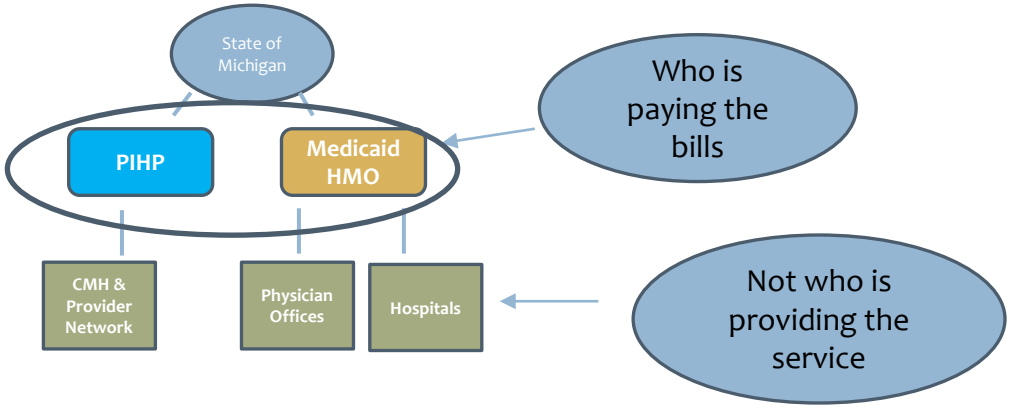
- House package does check some of the boxes of things we do support
- Rep Whiteford has shown a willingness to make changes and work with us
- **CMHA views SBs 597 & 598 as the biggest threat – it has the best chance to make it to the Governors desk.**

- Solutions MUST get at the root cause and address the areas of greatest need – access to care, increasing providers and workforce, and the lack of sufficient inpatient care.
  - SBs 597 & 598 DO NOT increase access to care
  - SBs 597 & 598 DO NOT increase providers or address workforce shortages
  - SBs 597 & 598 DO NOT address the lack of sufficient inpatient care
  - SBs 597 & 598 DO NOT improve or guarantee better outcomes.
- SBs 597 & 598 ONLY solution is to change who is paying the bills in the Medicaid program = missing the mark
- SB 597 & 598 Wrong Step at the Wrong Time
- CCGP – CARE, COST, GOVERANCE, PERFORMANCE

CARE

SBs 597 & 598 & Health plans are focused on contracts & money (not people)

* Bills only integrate funding - Integration takes place where people receive their services… **The bills do not FOCUS on CARE**

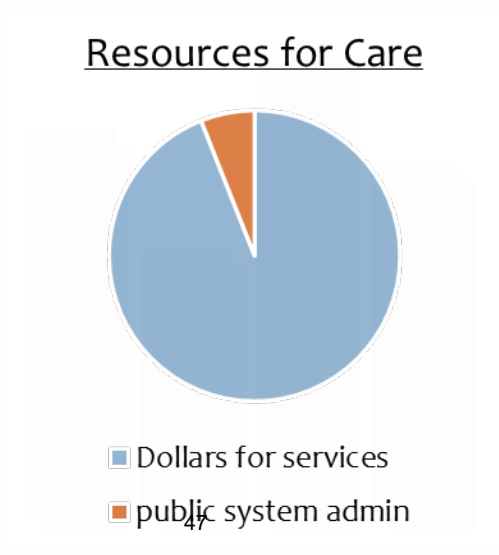


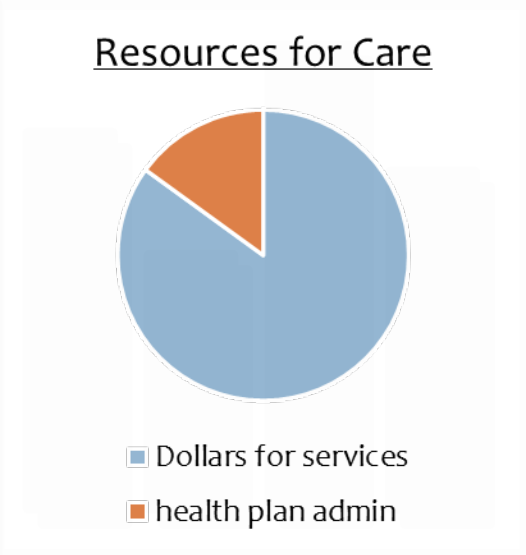
COST

* COST – Our fear is this proposal will dramatically increase costs WITHOUT an increase in services delivered or quality and will ultimately lead to an overall reduction in services – NOT an increase
  * Michigan Medicaid Health Plans showed record profits in 2020 – over $550 million in profits

* Health Plans have DOUBLE the overhead of the current public system

  * 12-15% (Health Plans) vs 6% (PIHP) admin costs = $200,000,000-$300,000,000+ MORE in costs without providing additional services or a guarantee of better quality or outcomes
    * Result = few dollars for services





GOVERANCE

The bills eliminate our local control / local decision making from our community and gives our money and mental health care decisions to out-of-state based insurance companies.

Care decisions will be made in corporate board rooms hundred or thousands miles away…

* Local County Board of Commissioners will have ZERO input with these insurance companies, who will they call during a crisis.

Large Health Plan Corporate Headquarters:

* Centene HQ – St. Louis MO
* United HQ – Minnetonka MN
* Molina HQ – Long Beach CA
* Anthem HQ – Indy IN
* Magellen HQ – Phoenix AZ

PERFORMANCE

* **Health plans do not have a good track record on behavioral health.** Currently they are responsible for the Medicaid mild/moderate benefit for mental health services

* The National Committee for Quality Assurance (NCQA) annual report card rating for Michigan's 10 private Medicaid health plans show that for the 8 key areas for treatment: Mental & Behavioral health category Michigan's health plans average less than 2.4 stars out of 5, which is a FAILING GRADE.

- July 2019, Health Endowment Fund Commissioned a report – Access to Mental Health Care in MI

  - **Showed the area of greatest unmet need for AMI (Adults with mental illness) in Michigan is mild-to-moderate conditions.**

If we REALLY want to improve people's lives

We believe these legislative proposals miss the mark, rather than focusing efforts at the PIHP level we believe the legislature should take this opportunity to address the following areas:

- Address & expand access to mental health and addiction services
  - For those individuals who are not in the current CMH system, but those on the outside looking in – MHP mild/moderate benefit and those with commercial insurance.
- Address the desperate need for more inpatient care settings for those most in need and
- Find ways to dramatically expand and increase the mental health and addiction workforce shortage
  - From front line DCWs to psychiatrists

Improving these areas would have an immediate impact on communities across this state.

- CCBHC & BHH/OHH must be part of the solution – patient-centered initiatives

Advocacy Efforts

New Advocacy Video

* As we wrap up 2021, I wanted to share an advocacy video that we developed with the help of West Michigan CMH. This video is on our CMHAM.ORG website and Facebook page, please check it out by using the link below. The video does a great job outlines our main concerns – CCGP (Care – Cost – Governance – Performance). Thank you Lisa Williams & Brooke Felger at WMCMH for their leadership and creativity on this project – please add to your social media and share with your community partners.

* Video Link: https://fb.watch/9Xo-NhPBFs/

Online Petition

* Please don't forget to sign our new online petition opposing the Shirkey bills, please join us and sign the petition by visiting:

* cmham.org/advocacy

* Our strength is our numbers, and we need to show it – please sign our petition AND please forward this message to your board members, staff, and your community partners and ask them to sign and share the petition.

Advocacy Resources Page

* CMHA has added a resources section to our advocacy page on our website. The resources section will include all of our SBs 597 & 598 opposition handouts, reference material, etc. all in one easy to find location – www.cmham.org

Advocacy Efforts

The numbers are on our side – we have many more friends than the health plans…

Well over 100+ different organizations have joined us in opposing SBs 597 & 598:

Advocacy Efforts

Disability and other Consumer Advocate Groups
•The Arc Michigan
•Association for Children's Mental Health
•Michigan's Children
•Michigan Developmental Disabilities Council
•Michigan Developmental Disabilities Institute
•Michigan Disability Rights Coalition
•Michigan United Cerebral Palsy
•National Alliance on Mental Illness

Educational Organizations
•Michigan Association of Intermediate School Administrators
•Michigan Association of School Psychologists
•Michigan Association of Superintendents & Administrators (MASA)
Human Rights Organizations
•American Civil Liberties Union
•NAACP Michigan State Conference
Judiciary
•Michigan Association for Family Court Administration
•Michigan Judges Association
•Michigan Probate Judges Association
Labor
•American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)
•American Federation of State, County, and Municipal Employees (AFSCME)
•Michigan Corrections Organization
•Service Employees International Union Local 517M (SEIU)
Law Enforcement
•Michigan Sheriffs' Association
Health & Human Services & Faith Community Associations
•Michigan Catholic Conference
•National Association of Social Workers Michigan Chapter
•Community Mental Health Association of Michigan
•Areas Agencies on Aging Association of Michigan
•Michigan League for Public Policy
•Michigan Coalition Against Homelessness
Local Government Leaders & Associations
•Michigan Association of Counties
•Antrim County Board of Commissioners
•Arenac County Board of Commissioners
•Benzie County Board of Commissioners
•Branch County Board of Commissioners
•Charlevoix County Board of Commissioners
•Cheboygan County Board of Commissioners
•Clinton County Board of Commissioners
•Eaton County Board of Commissioners
•Gladwin County Board of Commissioners
•Gratiot County Board of Commissioners
•Hillsdale County Board of Commissioners
•Huron Board of Commissioners
•Iosco County Board of Commissioners
•Isabella County Board of Commissioners
•Jackson Board of County Commissioners
•Kalamazoo County Board of Commissioners
•Lake County Board of Commissioners
•Lenawee County Board of Commissioners
•Manistee County Board of Commissioners
•Mason County Board of Commissioners
•Mecosta County Board of Commissioners
•Oakland County Board of Commissioners
•Oceana County Board of Commissioners
•Ogemaw County Board of Commissioners
•Osceola County Board of Commissioners
•Oscoda County Board of Commissioners
•Otsego County Board of Commissioners
•Saginaw County Board of Commissioners
Mental Health Services Provider & Payer Organizations
•Allegan County Community Mental Health Services
•AuSable Valley Community Mental Health Authority
•Barry County Community Mental Health Authority
•Bay-Arenac Behavioral Health Authority
•Berrien Mental Health Authority
•Centra Wellness Network
•Community Living Options
•Community Living Services, Inc.
•Community Mental Health Authority of Clinton-Eaton-Ingham Counties
•Community Mental Health for Central Michigan
•Community Mental Health of Ottawa County
•Community Mental Health Partnership of Southeast Michigan
•Community Mental Health & Substance Abuse Services of St. Joseph County
•Copper Country Community Mental Health Services
•Detroit Wayne Integrated Health Network

- Freedom Work Opportunities of Genesee County, Inc (FWOGC)
- Genesee Health System
- Gogebic Community Mental Health Authority
- Gratiot Integrated Health Network
- HealthWest
- Hiawatha Behavioral Health
- Huron Behavioral Health
- Integrated Services of Kalamazoo
- Lakeshore Regional Entity
- Lapeer County Community Mental Health Services
- Lenawee Community Mental Health Authority
- LifeWays Community Mental Health
- Livingston County Community Mental Health Authority
- Macomb County Community Mental Health Services
- Mid-State Health Network
- Monroe Community Mental Health Authority
- Montcalm Care Network
- Network180
- Newago County Mental Health Center
- NorthCare Network
- North Country Community Mental Health Authority
- Northeast Michigan Community Mental Health Authority
- Northern Lakes Community Mental Health Authority
- Northern Michigan Regional Entity
- Northpointe Behavioral Healthcare Systems
- Oakland Community Health Network
- Pathways Community Mental Health
- Pines Behavioral Health Services
- Region 10 PIHP
- Saginaw County Community Mental Health Authority
- Sanilac County Community Mental Health
- Shiawassee Health & Wellness
- Southwest Michigan Behavioral Health
- St. Clair County Community Mental Health Services
- Summit Point
- Ten16 Recovery Network
- The Right Door for Hope, Recovery and Wellness
- Training & Treatment Innovations
- Tuscola Behavioral Health Systems
- VanBuren Community Mental Health Authority
- Washtenaw County Community Mental Health
- West Michigan Community Mental Health System
- Woodlands Behavioral Healthcare Network

Factors impacting the future

What are the other factors that could play into the outcome of system redesign?

* COVID
* 2022 Campaign season (Governor, Senate and House all up)
  * Redistricting
* Economy & budget
  * Headlee issue
* Legislative priorities – horse trading
  * House could be backstop vs Shirkey bills (58-52 Republican majority)
* Lame Duck Session – late 2022

Contact Information

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Southwest Michigan Behavioral Health Board Meeting

Department of Health and Human Services Update

Farah A. Hanley, Chief Deputy for Health

Michigan Department of Health and Human Services

May 13, 2022

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Agenda

I. How the Budget Demonstrates our Values

II. Administrative Priorities

III. Policy Priorities

IV. Thinking Ahead

MDHHS
Michigan Department of Health & Human Services

Budget Demonstrates Values

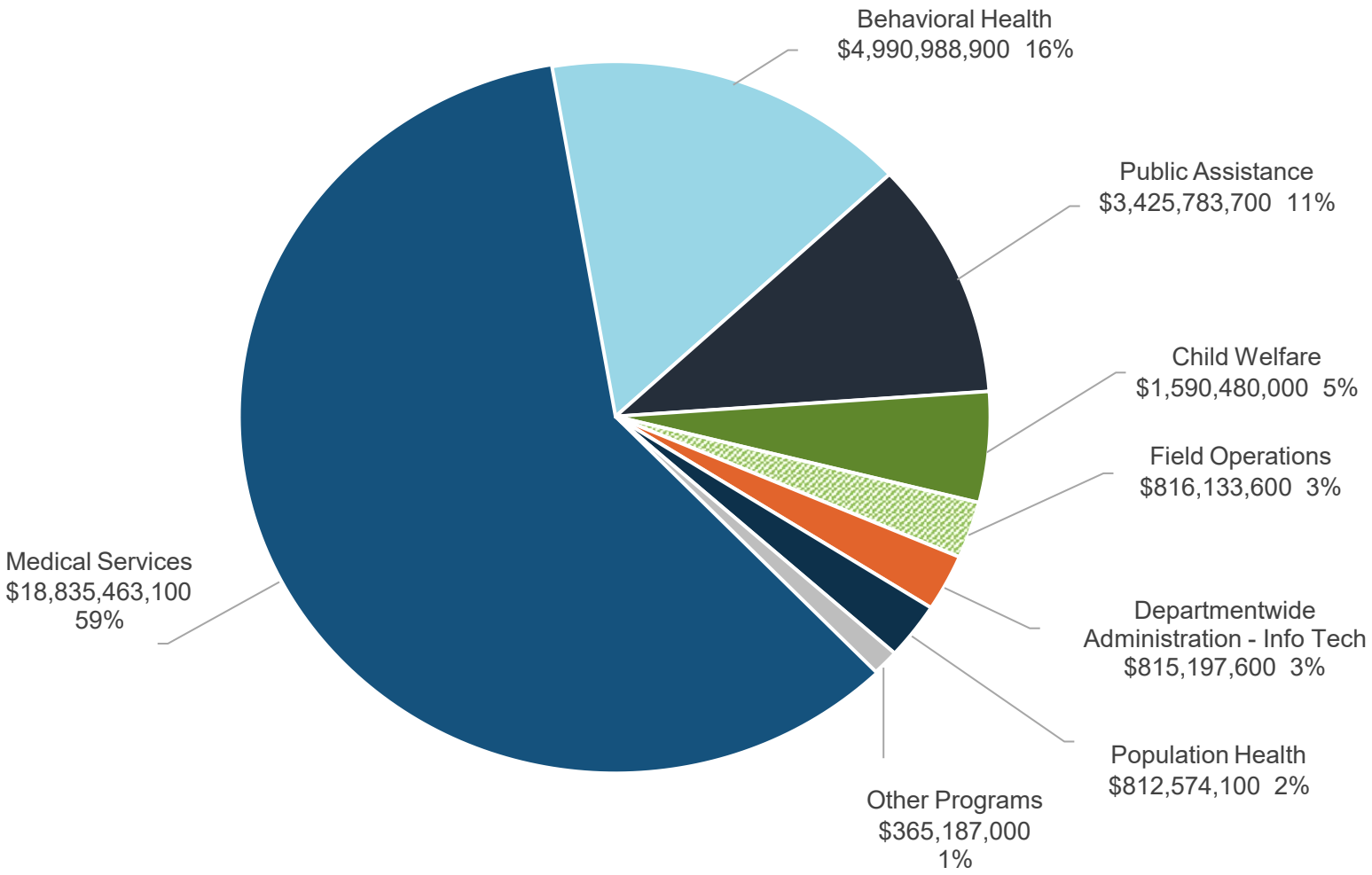
MDHHS
Michigan Department of Health & Human Services

"Don't tell me what you value. Show me your budget—and I'll tell you what you value."

– President Joe Biden

...

FY 2022 DHHS Budget by Program Areas



Three-quarters of the **$31.7 billion** DHHS budget supports **medical and behavioral health services**, most of which are provided through **Medicaid** and the **Healthy Michigan Plan**.

Source: House Fiscal Agency: December 2021 Budget Briefing

Impact in Numbers

MDHHS
Michigan Department of Health & Human Services

2021

180,000 test kits were distributed to keep families safe and kids in in-person learning through the MI Backpack Program.

Dental benefits provided to 1.1 million children.

3 million residents received health care coverage, including 1.2 million children.

1,887 children adopted and 2,575 children safely reunified with parents.

More than 6 million residents received the COVID-19 vaccine and were better protected from severe illness.

3.2 million residents received assistance to put food on the table, afford child care and keep the heat on at home.

41,239 calls, texts and chats received to connect people to behavioral health resources.

MDHHS
Michigan Department of Health & Human Services

Administrative Priorities

Department Behavioral Health Restructure

Purpose

- To reflect the prioritization of improving **behavioral and physical health services,** the department restructured its internal organization.
- MDHHS will have **one voice** related to **adult physical and behavioral health** services.
- MDHHS will improve and build upon **coordination** and **oversight** of **children's behavioral health services**.

Benefits

- Improved **coordination of services** and **leverage expertise** in these areas.
- Increased **contract oversight** and **financial management**.
- Additional investments will be made in **workforce development** and **staffing**.

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Behavioral and Physical Health and Aging Services Administration (BPHASA)

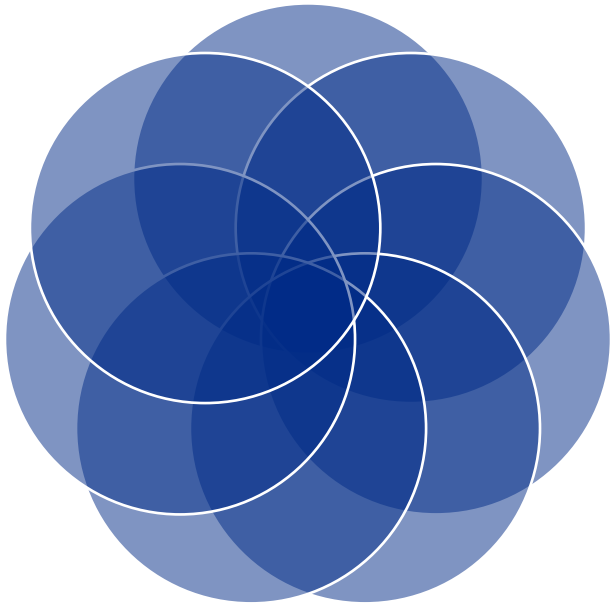
- The Health and Aging Services Administration became the **Behavioral and Physical Health and Aging Services Administration** which oversees:
  - Medicaid.
  - Aging services.
  - Community-based services for adults with **intellectual and developmental disabilities**, **serious mental illness**, and **substance use disorders**.
- Certain behavioral health operations were aligned within BPHASA to avoid duplication, including customer service, managed care contract management, site reviews and financial management.

Bureau of Children's Coordinated Health Policy and Supports

Builds upon past work to **improve coordination and oversight** of children's behavioral health services.

Works hand-in-hand with other MDHHS administrations to **maximize use of all statewide resources**.

Proactively **restructures the delivery of specialty health services** to better serve children, youth, and families.



Establishes a **clinical review team** to remove barriers and secure access to care as it's needed.

Recognizes that **services must be specific** to the needs of children, youth and families.

Ensures youth receive **appropriate services when they are needed**, rather than turning to an emergency room setting.

Emphasizes the importance of **including families** in addressing the health needs of children and youth.

MDHHS
Michigan Department of Health & Human Services

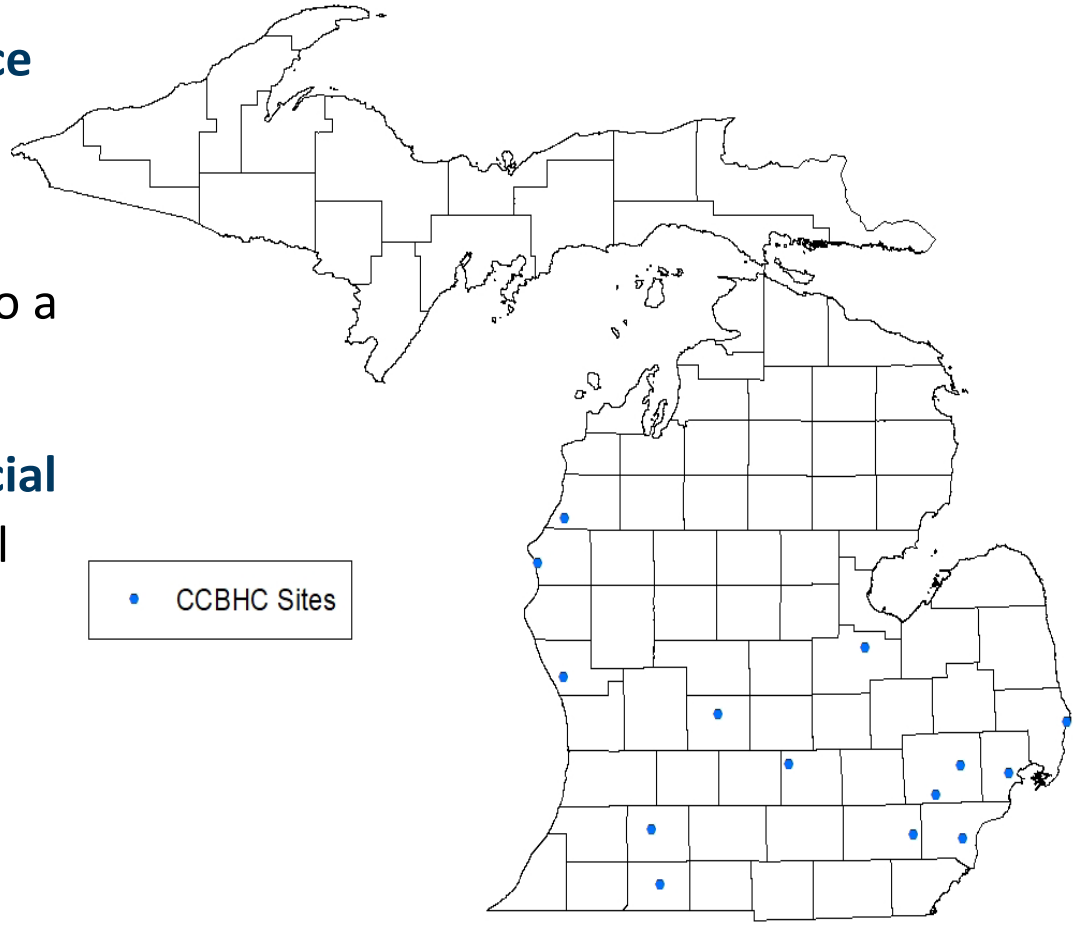
Policy Priorities

Behavioral Health:
Certified Community Behavioral Health Clinics (CCBHCs)

MDHHS Michigan Department of Health & Human Services

Michigan launched its CCBHC Demonstration on October 1, 2021.

- Serve all Michiganders with **a mental health and/or substance use disorder** regardless of severity or insurance or ability to pay.
- To expand access, over **18,000 Michiganders** were assigned to a CCBHC (over 90% are Medicaid beneficiaries).
- Provide a **comprehensive** set of **physical**, **behavioral**, and **social services** and facilitate coordination of physical and behavioral health care.
- Reimbursed at an **enhanced Medicaid prospective payment** system rate.
- Meet stringent **state-based certification** criteria.



Behavioral Health:
Overall Capacity and Access

MDHHS Michigan Department of Health & Human Services

Context

- Nearly **68%** of adults with mental disorders have another medical condition.
- **Excessive demand** and **persistent waitlists** for **inpatient psychiatric services** at state operated hospitals.
- **Long admission delays** resulting in patients waiting in emergency rooms pending placement in a state facility.

Proposed Response

The FY 2023 Executive Budget Recommendation invests **$69.3 million** to implement immediate structural improvements to:

- Expand behavioral health **inpatient community-based treatment programs**.
- Fund staff and operational costs for **two new units at the Hawthorn Center**.
- Fund staff and operational costs for a new **Center for Forensic Psychiatry** satellite facility.

Behavioral Health:
Child Welfare Day Treatment Pilot

MDHHS Michigan Department of Health & Human Services

Context

- MDHHS is diligently working to **reduce unnecessary congregate care setting placements**.
- Placement stability in family-like settings is critical to ensuring **positive outcomes** for youth in foster care.
- Day treatment programs allow youth to receive **intensive treatment** while remaining in a family-like setting.
- Youth can **practice** the **skills** learned during treatment in real-time each evening when they return home.

Proposed Response

- The FY 2023 Executive Budget Recommendation invests **$2.4 million** to implement a pilot to provide **day treatment** for youth who require more intensive support than what is available through conventional outpatient treatment programs.
- The program is designed to treat mental health issues stemming from **traumatic experiences**, such as **impulsive behavior** and **self-harm**, and will be provided to children on a year-round basis either in an after-school setting or full-time and include educational instruction.

Behavioral Health:
Strengthening the Health Care Workforce

MDHHS Michigan Department of Health & Human Services

***Proposed*: Michigan Essential Health Provider Loan Repayment Program**

The FY 2023 Executive Budget Recommendation invests $25 million to expand the Michigan Essential Health Provider Loan Repayment Program to eligible behavioral health practitioners working in federally designated health professional shortages areas (HPSA).

***Proposed*: Workforce Development Funds**

The FY 2023 Executive Budget Recommendation invests $1.3 million in workforce development funds to bolster efforts to enhance and diversify Michigan's healthcare workforce.

***Proposed*: Mental Health Care for First Responders**

The FY 2023 Executive Budget Recommendation restores $2.5 million for first responder post-traumatic stress syndrome and other mental health conditions.

Infant and Maternal Health:
Expanded Medicaid Coverage for Moms & Babies

MDHHS Michigan Department of Health & Human Services

Context

- Access to high quality health care services is a critical component of statewide efforts in addressing maternal morbidity and mortality rates in Michigan.
- As of January 2018, Michigan's Maternal Mortality Surveillance (MMMS) Committee found that approximately **50% of maternal deaths in Michigan were preventable**.
- One of the possible prevention measures identified by the MMMS committee is access to family planning and other medical health care services.
- Additionally, among pregnancy-related deaths in Michigan the committee found **persistent racial disparities**.

Response

- The Centers for Medicare and Medicaid Services (CMS) approved the state's request to **expand Medicaid coverage for a full 12-month postpartum** period to ensure the health and well-being of moms and babies across Michigan.
- Maintaining Medicaid coverage for a full year provides access to **critical health and dental services** during the first year after pregnancy, which can help to address persistent health disparities.
- The approximately $20 million budgeted for this expansion will benefit an estimated **35,000 pregnant and postpartum people in Michigan annually**.

Responding to the Direct Care Workforce Shortage

MDHHS Michigan Department of Health & Human Services

Context

- Direct care workers (DCWs) provide **essential skilled** long-term care and support to **individuals with disabilities** and **older adults**.
- **165,000** DCWs in Michigan.
- **Low Median Hourly Wage Range:** $11.85-$15.18. Well below the average starting wage at a fast-food restaurant.
- **Turnover Rate:** estimated 75.5% on average statewide.

Response

April 2020 - February 2021

- **$2 an hour premium pay increase** for skilled Nursing Facility (SNF) and Aging DCWs.

March 2021 – September 2021

- **$2.25 an hour premium pay increase** for SNF, Homes for the Aged (HFA), Adult Foster Care (AFC), and Aging DCWs.
- **$2.00 an hour premium pay increase** for Child Caring Institutions (CCI).

FY 2022

- Approved **ongoing wage increase** for direct care workers in long term care settings ($2.35) and child caring institutions ($2.00).
- ***Proposed:*** One-time bonus payment to behavioral health direct care workers.

Addressing Social Determinants of Health

MDHHS Michigan Department of Health & Human Services

THE GOAL OF MICHIGAN'S ROADMAP TO HEALTHY, RESILIENT COMMUNITIES IS TO:

Improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunity.

HEALTH EQUITY – Ensuring continuous Medicaid coverage through the Healthy Moms Healthy Babies program.

HOUSING STABILITY – Connecting MSHDA resources with MDHHS programs.

FOOD SECURITY – Closed loop referral within MIBridges.

Addressing Social Determinants of Health
Health Equity Across the Lifespan

MDHHS Michigan Department of Health & Human Services

Context

- **Health disparities** are persistent and increasing for both agricultural workers and Black and Hispanic people.
- Michigan's 2019 **infant mortality rate** of 6.3 per 1,000 live births is higher than the national average of 5.6 per 1,000 live births.
- There is a **disproportionate impact of recovering birth expenses** from Michigan's most vulnerable families.
- **Agricultural workers** face barriers to self-sufficiency due to undiagnosed and/or untreated medical conditions.

Proposed Response

The FY 23 Executive Budget Recommendation proposes an investment of **$15.5 million** to increase access to health care and reduce health care costs.

- End the state's **Medicaid birth expenses recovery program**.
- Increase access to **doula care** for high-risk families.
- Support additional community health workers to help **migrants access health care services** at the four Federally Qualified Health Centers.

Addressing Social Determinants of Health
Reducing Racial and Economic Disparities

The FY 23 Executive Budget Recommendation proposes an investment of **$20.0 million** to address **racial disparities in health care access and treatment**:

- **$4.2 million** for expansion of **Centering Pregnancy** sites across the state. Sites emphasize group prenatal care, support, and education to dramatically reduce racial disparities in preterm births.
- **$10.0 million** to create a racial disparities **Medicaid Health Plans Incentive Pool**.
- **$4.0 million** for **Michigan Area Health Education Centers** to create statewide patient-centered training and technical assistance addressing disparities in birth outcomes, particularly for adolescent mothers.

MDHHS
Michigan Department of Health & Human Services

Thinking Ahead

Opioid Settlement Update and Strategy

Opioid Settlement Update

- Michigan settled with Johnson & Johnson, McKinsey, and three opioid distributors.
- **$776 million** split between state and eligible local governments.
    - Funding will be dispersed over 18 years, though the payments will be not equal during this time.
- McKinsey will pay **$19.5 million** to the State of Michigan.
- **$407.5 million** in total **to State of Michigan over 18 years**.

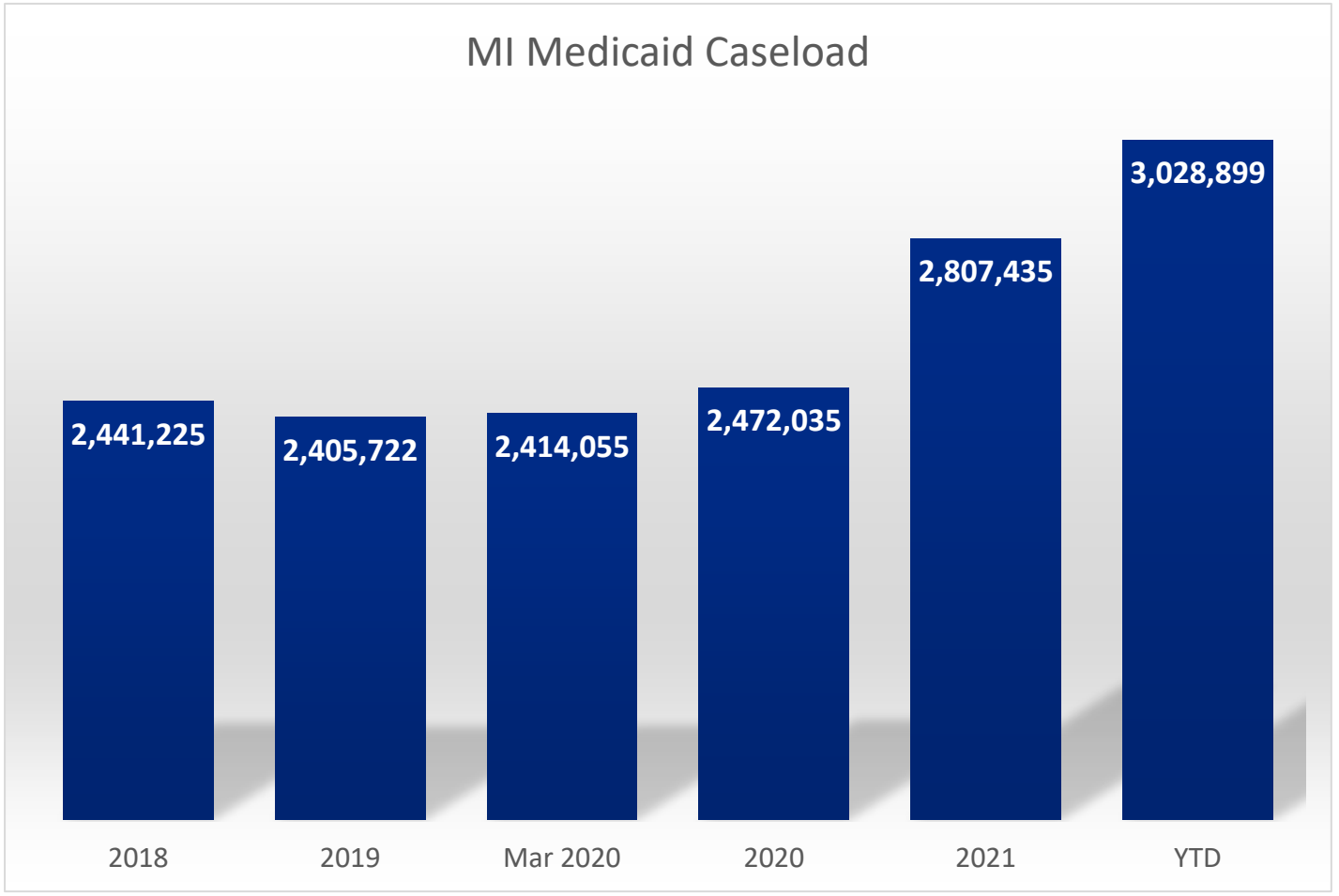
State of Michigan Opioid Strategy

- Three key considerations in settlement fund planning:
    - Align settlement funding with ongoing discussions of the opioid strategy.
    - Address **systemic barriers** to services that have no other funding.
    - Provide **equitable distribution** of funding.
- Eight Pillars of the State of Michigan Opioid Strategy:
    - **Prevention, Treatment, Recovery, Harm Reduction, Legal, Pregnant/Parenting, Data,** and **Equity.**

Medicaid and the Public Health Emergency

With the continuation of the **Public Health Emergency**, Medicaid redeterminations have been put on pause while individuals continue to receive continuous coverage.

Total **new cases** since March 2020: **648,091**



Ongoing Efforts and the Road Ahead

- Bolster **direct care workforce**.
- Optimize **behavioral health care** access.
- Improve **children's behavioral health care** services.
- Preparing for the **next public health challenge**

- Continued focus on **maternal and infant health** outcomes.
- Emphasis on improved quality of care through **long term care supports and services**
- Expand and strengthen **SDoH** efforts.
- Building on **successful whole person efforts** through CCBHCs and Health homes

MDHHS
Michigan Department of Health & Human Services

Thank you!

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

Colleagues,

After much consideration SWMBH has decided to withdraw from the MI Health Link Demonstration effective 12/31/22. This decision is in no way indicative of SWMBH agency, department, or staff flaws in implementing the MHL Demonstration. SWMBH staff have performed remarkably well with their typical focus on beneficiaries, care, and outcomes.

This complements our recent decision to cease pursuit of our NCQA MBHO Reaccreditation which expires 6/25/22, is solely related to our MHL business line, is not mandatory, carried material expense, administrative burdens and opportunity costs and did not bring the administrative relief we had expected.

SWMBH remains in MHL through 12/31/22 and all related efforts will continue. There will also be SWMBH MHL transition activity across multiple departments between now and 12/31/22 and close out activity after 1/1/23. We will commit all necessary transition resources to our MHL Enrollees and ICOs.

We did not take this decision lightly. For over a year we have analyzed the MHL Demonstration and deliberated our involvement therein. Please see the attached formal announcement suitable for circulation or publication if you so choose.

SWMBH, its Board and MHL Providers thank the Michigan Department of Health and Human Services, Meridian Health Plan and Aetna Better Health of Michigan for their diligence and collaboration during the eight-year MHL Demonstration.

Bradley P. Casemore, *MHSA, LMSW, FACHE*
Chief Executive Officer