Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB)

SWMBH – 5250 Lovers Lane, Suite 200 Portage, MI, 49002
Please join the meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/250012069
and join the conference call:
1-844-655-0022
Access Code: 738-811-844
Monday, March 15, 2021
4:00-5:30

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**
5. **Consent Agenda (Randall Hazelbaker)**
   - January 18, 2021 Meeting Minutes (d) pg.2
6. **Board Education**
   a) Fiscal Year 20/21 YTD Financials (G. Guidry) (d) pg.5
   b) PA2 Utilization Fiscal Year 21 YTD (G. Guidry) (d) pg.6
   c) Opioid Health Home (E. Flory) (d) pg.7
   d) Problem Gambling Awareness Month (J. Rolin) (d) pg.15
   e) Block Grant/PA2 Update (J. Smith)
7. **Board Actions to be Considered (Randall Hazelbaker)**
   - None
8. **Board Actions**
   - None
9. **Communication and Counsel**
   a. Legislative and Policy Updates (B. Casemore) (d) pg.22
   b. Intergovernmental Contract Amendment (B. Casemore) (d) pg.91
   c. SUDOPB Bylaws (B. Casemore) (d) pg.95
10. **Adjourn**

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

Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder
Oversight Policy Board (SUDOPB) Meeting Minutes
January 18, 2021
4:00 – 5:30 pm
Draft: 1/19/21

Members Present: Randall Hazelbaker (Branch County); Richard Godfrey (Van Buren County); Michael Majerek (Berrien County); Gary Tompkins (Calhoun County); Don Meeks, (Berrien County); Ben Geiger (Barry County); Kathy-Sue Vette (Calhoun County)

Members Absent: Daniel Doehrman (Kalamazoo County); Lisa White (Kalamazoo County); Skip Dyes (Cass County); Tara Smith (Cass County); Paul Schincariol (Van Buren 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; Justin Rolin, Gambling Disorder Prevention Specialist, SWMBH; Emily Flory, Opioid Health Homes Coordinator, SWMBH

Welcome and Introductions
Randall Hazelbaker called the meeting to order at 4:00 pm. Introductions were made.

Public Comment
None

Agenda Review and Adoption

Motion	Richard Godfrey moved to approve the agenda.
Second	Kathy-Sue Vette
Motion carried	

Financial Interest Disclosure Handling
None

Consent Agenda

Motion	Gary Tompkins moved to accept the November 16, 2020 meeting minutes as presented.
Second	Don Meeks
Motion carried	

Board Education

Fiscal Year 19/20 YTD Financials
Garyl Guidry reported as documented, highlighting numbers for Medicaid, Healthy Michigan, MI Child, Block Grant, and PA2. Discussion followed.

PA2 Utilization FY20 YTD
Garyl Guidry reported as documented.

2020 SWMBH Admission Data
Joel Smith reported as documented. Discussion followed.

2020 SWMBH Prevention Outcomes
Achiles Malta reported as documented. Discussion followed.

2020 Naloxone Reporting
Achiles Malta reported as documented. Discussion followed.

Board Actions to be Considered

PA2 Budget Amendment Requests
Woodlands Behavioral Health/Cass County – Garyl Guidry reported as documented.

Motion	Ben Geiger moved to approve the amended PA2 budget request for Woodlands Behavioral Health of Cass County as presented.
Second	Gary Tompkins
Roll Call Vote	
Randall Hazelbaker	yes
Richard Godfrey	yes
Gary Tompkins	yes
Kathy-Sue Vette	yes
Ben Geiger	yes
Michael Majerek	yes
Don Meeks	yes
Motion carried	

Barry CMHA/Barry County – Garyl Guidry reported as documented.

Motion	Richard Godfrey moved to approve the amended PA2 budget request for Barry County Community Mental Health Authority of Barry County as presented.
Second	Don Meeks
Roll Call Vote	
Randall Hazelbaker	yes
Richard Godfrey	yes
Gary Tompkins	yes
Kathy-Sue Vette	yes
Ben Geiger	yes
Michael Majerek	yes
Don Meeks	yes
Motion carried	

Prevention Works/Kalamazoo County – Garyl Guidry reported as documented.

Motion Michael Majerek moved to approve the amended PA2 budget request for Prevention Works of Kalamazoo County as presented.
Second Ben Geiger
Roll Call Vote
Randall Hazelbaker yes
Richard Godfrey yes
Gary Tompkins yes
Kathy-Sue Vette yes
Ben Geiger yes
Michael Majerek yes
Don Meeks yes
Motion carried

2021 SUDOPB Election of Officers

Randall Hazelbaker stated that both he and Richard Godfrey are willing to serve as Chair and Vice Chair unless other nominees are presented. No other nominees were presented.

Motion Kathy-Sue Vette moved to close the nominations.
Motion Don Meeks moved to approve Randall Hazelbaker as Chair and Richard Godfrey as Vice-Chair of the Southwest Michigan Behavioral Health Substance Use Disorder Oversight Policy Board for 2021.
Second Michael Majerek
Motion carried

Communication and Counsel

Legislative Updates

Brad Casemore welcomed the Board, wished them wellness for the new year and shared the following updates:

- MDHHS COVID-19 Dashboard is up and running with useful information and can be found at https://www.michigan.gov/coronavirus
- Noted the report in the packet from the University of Michigan Institute for Healthcare and Policy Innovation
- SWMBH is watching the Biden Administration plans/policies and changes
- SWMBH is waiting for release of Governor Whitmer's 2022 Budget
- Reviewed SWMBH Regional Entity Planning sessions

Intergovernmental Contact

Brad Casemore stated that the Intergovernmental Contract was signed by all eight counties in the Region and is effective January 1, 2021 through December 31, 2023.

State/Regional Reports – Grants Update

Joel Smith emphasized the importance of reviewing expenditures of block grant and other SUD grants as the State continues to reduce revenue coming from those funding sources. SWMBH remains committed to good stewardship in order to continue services.

Adjourn

Randall Hazelbaker adjourned the meeting at 5:05pm.

Southwest Michigan Behavioral Health

Substance Use Disorders Revenue & Expense Analysis Fiscal Year 2020

For the Fiscal YTD Period Ended 1/31/2021

	MEDICAID				Healthy MI			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
Barry	243,022	60,755	34,261	26,494	146,371	138,796	36,593	102,203
Berrien	955,808	238,952	115,092	123,860	1,007,949	564,406	251,987	312,419
Branch	255,943	63,986	16,910	47,076	154,498	132,394	38,624	93,770
Calhoun	1,017,868	254,467	163,051	91,416	1,705,713	516,727	426,428	90,299
Cass	292,220	73,055	65,599	7,456	832,499	164,730	208,125	(43,395)
Kazoo	1,319,271	329,818	111,099	218,719	881,593	812,387	220,398	591,989
St. Joe	371,901	92,975	56,377	36,599	522,256	215,375	130,564	84,811
Van Buren	499,406	124,852	53,627	71,225	313,165	268,400	78,291	190,109
DRM	939,109	958,434	929,993	28,442	1,891,734	1,992,105	1,860,644	131,461
Admin/Access	0	0	0	0	0	0	0	0
Grand Total	**5,894,549**	**2,197,294**	**1,546,009**	**651,285**	**7,455,779**	**4,805,321**	**3,251,655**	**1,553,666**

	BLOCK GRANT				BLOCK GRANT BY COUNTY			
EGRAMS	Budgeted	Actual	YTD	Fav	Budgeted	Actual	YTD	Fav
SUD Block Grant	YTD Revenue	YTD Revenue	Expense	(Unfav)	YTD Revenue	YTD Revenue	Expense	(Unfav)
Community Grant	3,283,604	877,996	877,996	0	Barry	72,824	72,824	0
WSS	250,000	36,558	36,558	0	Berrien	120,428	120,428	0
Prevention	1,204,535	386,725	386,725	0	Branch	40,398	40,398	0
Admin/Access	80,000	59,541	59,541	0	Calhoun	151,138	151,138	0
Partnership for Success*	126,000	0	0	0	Cass	121,904	121,904	0
Gambling Prevention*	188,684	27,926	27,926	0	Kazoo	190,669	190,669	0
State's Opioid Response NCE	1,305,000	344,245	344,245	0	St. Joe	66,795	66,795	0
State's Opioid Response 2	1,899,739	106,437	106,437	0	Van Buren	97	97	0
State Disability Assistance	128,219	20,088	20,088	0	DRM	537,027	537,027	0
					Admin/Access	59,541	59,541	0
Mental Health Block Grant								
Transitional Navigators	298,880	16,920	16,920	0				
Clubhouse Engagement*	100,000	0	0	0	Legend			
Veterans Navigator*	100,000	29,602	29,602	0	DRM - Detox, Residential, and Methadone			
Crisis Transportation	101,120	6,746	6,746	0	WSS - Women's Specailty Services			
Admin/Access	0	0	1,762	(1,762)				
Grand Total	**9,065,781**	**1,912,783**	**1,914,545**	**(1,762)**		**1,360,820**	**1,360,820**	**0**

	PA2				PA2 Carryforward			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)		Current Utilization	Prior Year Balance	Projected Year End Balance
Barry	26,299	26,299	9,130	17,169	Barry	17,169	515,148	532,317
Berrien	122,029	179,787	75,686	104,101	Berrien	104,101	503,772	607,873
Branch	21,765	21,772	0	21,772	Branch	21,772	364,424	386,196
Calhoun	22,993	22,993	120,159	(97,167)	Calhoun	(97,167)	357,654	260,487
Cass	113,146	113,146	0	113,146	Cass	113,146	385,399	498,545
Kazoo	225,947	225,947	145,062	80,885	Kazoo	80,885	1,784,112	1,864,996
St. Joe	33,870	33,870	10,395	23,475	St. Joe	23,475	267,606	291,081
Van Buren	49,954	49,954	23,991	25,963	Van Buren	25,963	290,493	316,456
Grand Total	**616,002**	**673,767**	**384,424**	**289,343**		**289,343**	**4,468,607**	**4,757,951**

* Quarterly Financial Status Reporting

Program	FY21 Approved Budget	Utilization FY 21 Oct-Jan	PA2 Remaining	YTD Utilization
Barry	**54,500.00**	**13,530**	**40,970**	**25%**
BCCMHA - Outpatient Services	54,500	13,530	40,970	25%
Berrien	**383,033.60**	**83,457**	**299,577**	**22%**
Abundant Life - Healthy Start	74,000	30,650	43,350	41%
Berrien County - Drug Treatment Court	15,000	273	14,727	2%
Berrien County - Trial courts	48,610	12,424	36,186	26%
Berrien MHA - Riverwood Jail Based Assessment	18,058	-	18,058	0%
CHC - Niles Family & Friends	5,739	-	5,739	0%
CHC - Wellness Grp	9,328	-	9,328	0%
CHC - Women's Recovery House	37,730	6,777	30,953	18%
Sacred Heart - Juvenile and Detention Ctr	74,569	-	74,569	0%
Berrien County Health Department - Prevention Ser	100,000	33,333	66,667	33%
Branch	**36,430.00**	**-**	**36,430**	**0%**
Pines BHS - Outpatient Treatment	34,430	-	34,430	0%
Pines BHS - WSS	2,000	-	2,000	0%
Calhoun	**393,699.17**	**109,390**	**284,309**	**28%**
Calhoun County 10th Dist Drug Sobriety Court	124,929	50,022	74,906	40%
Calhoun County 10th Dist Veteran's Court	6,450	1,912	4,538	30%
Calhoun County 37th Circuit Drug Treatment Court	175,225	32,322	142,904	18%
Haven of Rest	37,095	16,800	20,295	45%
Michigan Rehabilitation Services - Calhoun	25,000	8,333	16,667	33%
Summit Pointe - Juvenile Home	25,000	-	25,000	0%
Cass	**82,500.00**	**-**	**82,500**	**0%**
Woodlands - Meth Treatment and Drug Court Outp	82,500	-	82,500	0%
Kalamazoo	**799,541.50**	**181,968**	**617,573**	**23%**
8th District Probation Court	8,500	1,119	7,381	13%
8th District Sobriety Court	26,500	2,079	24,421	8%
8th District Young Adult Diversion Court	5,000	264	4,736	5%
9th Circuit Drug Court	60,000	-	60,000	0%
CHC - Adolescent Services	19,619	6,090	13,528	31%
CHC - Bethany House	27,200	-	27,200	0%
CHC - New Beginnings	77,627	25,262	52,365	33%
CHC - Healing House	19,476	-	19,476	0%
Gryphon Gatekeeper - Suicide Prevention	20,000	6,800	13,200	34%
Gryphon Helpline/Crisis Response	36,000	12,000	24,000	33%
Interact - IDDT	26,600	1,055	25,545	4%
KCHCS Healthy Babies	87,000	17,417	69,583	20%
ISK - EMH	56,400	18,800	37,600	33%
ISK - FUSE	25,000	8,333	16,667	33%
ISK - Mental Health Court	65,000	21,667	43,333	33%
ISK - Oakland Drive Shelter	34,000	11,333	22,667	33%
KPEP Social Detox	20,000	-	20,000	0%
Michigan Rehabilitation Services - Kalamazoo	17,250	5,750	11,500	33%
Prevention Works - Task Force	50,000	27,344	22,656	55%
Recovery Institute - Recovery Coach	60,623	15,268	45,355	25%
WMU - BHS SBIRT	51,747	-	51,747	0%
WMU - BHS Text Messaging	6,000	1,386	4,614	23%
St. Joseph	**83,040.00**	**14,368**	**68,672**	**17%**
3B District - Sobriety Courts	2,200		2,200	0%
3B District - Drug/Alcohol Testing	16,640	9,650	6,990	58%
CHC - Hope House	21,000	2,504	18,496	12%
CMH - Court Ordered Drug Testing	43,200	2,214	40,986	5%
Van Buren	**134,359.10**	**41,266**	**93,093**	**31%**
Van Buren CMHA	94,359	17,275	77,084	18%
Van Buren County Drug Treatment Court	40,000	23,991	16,009	60%
Totals	**1,967,103**	**443,979**	**1,523,125**	**23%**

Opioid Health Home

What is Opioid Health Home?

- Although the name suggests it is a place, it's not! It is a program designed to help coordinate and manage all the care and services clients diagnosed with an Opioid Use Disorder need.
- Opioid Health Home (OHH) consists of a care team, including:
  - A Behavioral Health Specialist
  - A Nurse Care Manager
  - A Recovery Coach, Community Health Worker, and/or Medical Assistant
  - Access to a Medical Consultant
  - Access to a Psychiatric Consultant

Who is eligible for OHH?

- Clients who live in Kalamazoo or Calhoun counties (for Region 4)
- Clients with active Medicaid or Healthy Michigan Plan (in Kalamazoo or Calhoun counties)
  - Clients with dual Medicare/Medicaid are eligible if they are not enrolled in MI Health Link
  - Clients with spend down are not eligible
  - Clients enrolled in HHBH (Behavioral Health Home), HHMICare (Health Home MI Care Team), ICO-MC (Integrated Care MI Health Link), NH (Nursing Home), or Hospice are not eligible.
- Clients who are diagnosed with an Opioid Use Disorder

What does OHH do?

- OHH provides additional support from an integrated team of providers who can:
  - Coordinate care with other doctors/specialists/providers for clients.
  - Help advocate for proper care for clients.
  - Help clients understand and manage other conditions they may have.
  - Refer clients to resources focusing on overall health.
  - Assist clients with housing, legal issues, transportation, employment, educational goals, etc.
  - Connect clients to community resources.
- OHH is an additional service. Clients continue to participate in SUD therapy and/or Medication Assisted Treatment.

Current OHH Providers:

- Victory Clinical Services in Kalamazoo
- Victory Clinical Services in Battle Creek
- Summit Pointe in Battle Creek

How do providers get paid for OHH services?

- Providers receive a case rate for all care management services provided for OHH clients each month.
- Clients must receive at least one care management service each month for providers to be paid.
- Care management services are activities previously unbillable to Medicaid, for example:
  - Care coordination with other providers
  - OHH team meetings/case consultations
  - Meetings with clients focused on one of the 6 core services
  - Coordination with community resources
  - Entering toxicology screenings
- The client does not need to be present for care management services.

OHH Goals:

MDHHS Metrics:

- Improvement in initiation and engagement in treatment for substance use disorders.
- Improvement in follow-up after Emergency Room visit for a substance-related diagnosis.
- Decreased emergency room utilization for substance-related diagnoses.

Additional Goals:

- Improve care management of clients with OUD and comorbid chronic conditions.
- Improve care coordination between physical and behavioral health care services.
- Improve care transitions between primary, specialty, and inpatient settings of care.

Additional Information

- Other regions in Michigan providing OHH services:
  - NorthCare Network (Upper Peninsula)
  - Northern Michigan Regional Entity (Upper lower Michigan)
  - Macomb County CMH
- MDHHS website: Michigan.gov/OHH
- SWMBH website: SWMBH.org/members/opioid-health-home

Southwest Michigan
BEHAVIORAL HEALTH

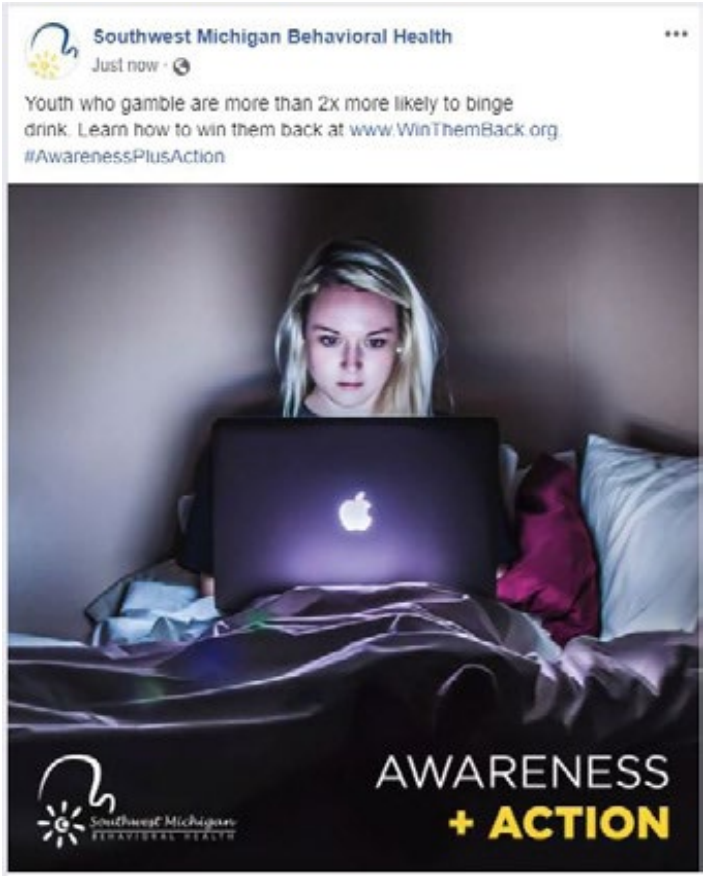
Gambling in Michigan

Date: March 15, 2021

Problem Gambling Awareness Month (PGAM)

32 Day “organic” social media campaign utilizing SWMBH Facebook page.

- Signs/Symptoms
- Statistics
- Screening
- Co-morbidity
- Reduce stigma
- Responsible gambling
- Help is available



Problem Gambling Awareness Month (PGAM)

8 Regional providers participating in National Problem Gambling Screening Day.

- Van Buren Community Mental Health
- Meridian Health Services (Waterford, MI)
- Sacred Heart/Serenity Hills (Berrien)
- Kalamazoo Probation Enhancement Program
- Pines Behavioral Health
- Barry County Community Mental Health
- InterAct of Kalamazoo
- WMU Behavioral Health Services

New Michigan Legislation

- Lawful Internet Gaming Act
- Lawful Sports Betting Act
- Fantasy Contests Consumer Protection Act

After 1-year period of regulation development, on-line gambling sites went live on January 22, 2021

Consumer Participation

Online Casinos (8)

- Generated 29.4 mm in revenue
- Broke 2013 New Jersey record of 7 mm

Sports Betting (10)

- Generated in 115 mm in “handle”
- Second place to Tennessee’s launch-month record of $131.4 million.

Evolution of Sports Betting

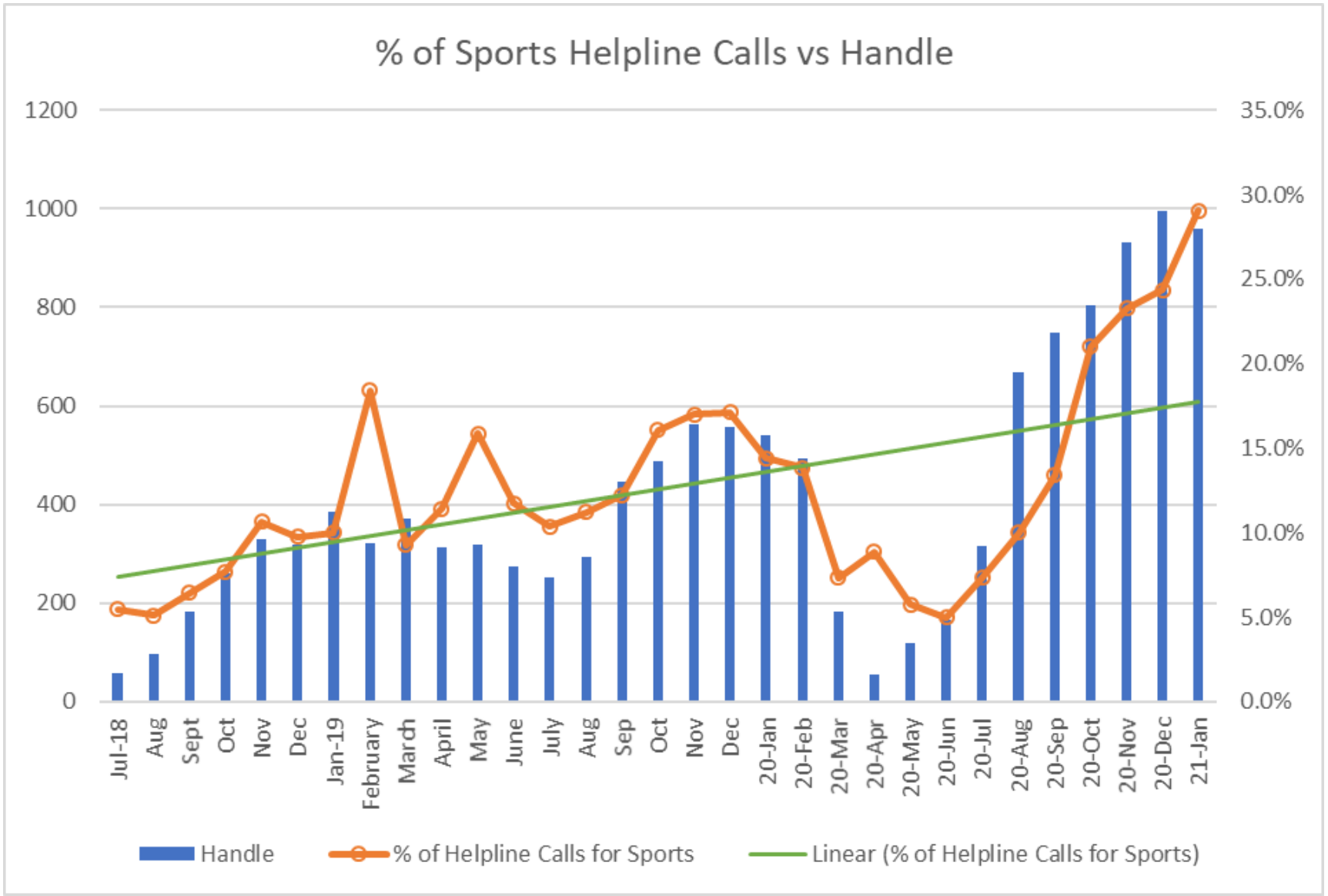
In-Play Betting

- High-speed/Continuous Reinforcement
- Lacks time component for reflection
- Immersive Activity
- Changes dynamics of the game
- Can lead to “chasing losses”
- Betting on “feelings” or “hunches”
- Fear of Missing Out

Cash-Out Feature

- Likens in-play sports gambling to stock market day trading…lock-in profits and limit losses
- Creates a feeling of control
- Can change thinking to reinforce the idea that sports betting is “skill-based”
- Increases consumer participation
- Creates continuous form of gambling

What should we expect?



MDHHS: FY22 Budget Executive Recommendation

March 9, 2021

AGENDA

- Critical COVID-19 response efforts
  - Vaccinations
  - Testing
- Current successes and new opportunities
- Investing in the future

Fiscal Year 2022 State of Michigan Budget Invests In:

- Critical COVID-19 Response Efforts
- Protecting the Most Vulnerable
- Cost-Effective Prevention Programs

VACCINE STRATEGY GUIDING PRINCIPLES

- All Michiganders have equitable access to vaccines.
- Vaccine planning and distribution is inclusive.
  - Actively engages state and local government, public and private partners; and draws upon the experience and expertise of leaders from historically marginalized populations.
- Communications are transparent, accurate, and frequent to build public trust.
- Data is used to promote equity, track progress, and guide decision-making.
- Resource stewardship, efficiency, and continuous quality improvement drive strategic implementation.

GOALS

70%

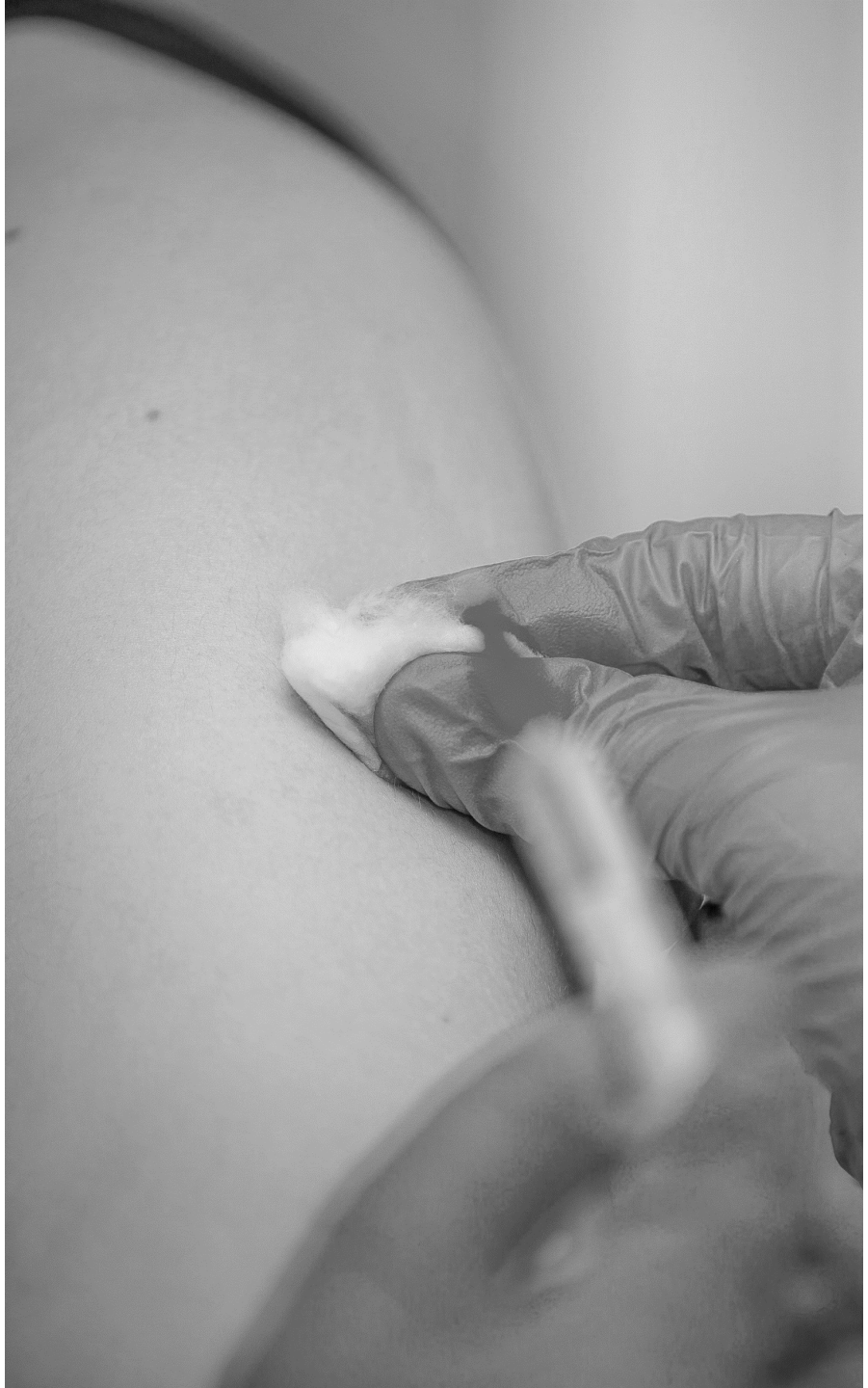
of Michiganders age 16 and up vaccinated as quickly as possible.

90%

of doses received are administered within 7 days of arrival.

95%

of people get their second dose of vaccine within the expected time frame.



MDHHS

CURRENT COVID-19 VACCINE ALLOCATION STRATEGY

Flexible Allocation to Special Populations

Flexible allocation off top for MDHHS to allocate to special populations and provide agility to vaccination efforts.

Hospital Baseline Population

- % of 2019 inpatient visits for individuals 65 years and older.
- % of the state's 2019 inpatient population for each hospital allocation.
- Can update in future based on other hospital metrics (i.e., outpatient reach).

Equitable Allocation

Equitable allocation across Hospitals and LHDs using 1B populations as the basis.

- As ongoing populations become eligible, population allocations will shift.

Social Vulnerability Index

Social Vulnerability Index used to weight LHD allocations by geography (if needed).

LHD Baseline Population

- % of the state's baseline populations for each LHD jurisdiction.
- 65 years and older, identified front line essential workers, and teachers/childcare personnel for each LHD allocation.

Vaccine Apportioned by Type

% of vaccine by type (i.e., Moderna, Pfizer) can be apportioned across hospital or LHD.

Vaccine Strategy

- **STRATEGY 1: Get more people vaccinated**
  - Work closely with local health officers to support FQHCs, mobile clinics, local health departments, school-based health centers, and other community vaccinators to specifically target vulnerable populations for vaccinations.

- **STRATEGY 2: Build robust network of vaccination sites**
  - Create mass vaccination sites working with local partners, National Guard, pharmacies, and FQHCs, targeting harder to reach rural and urban areas; leverage existing testing sites.

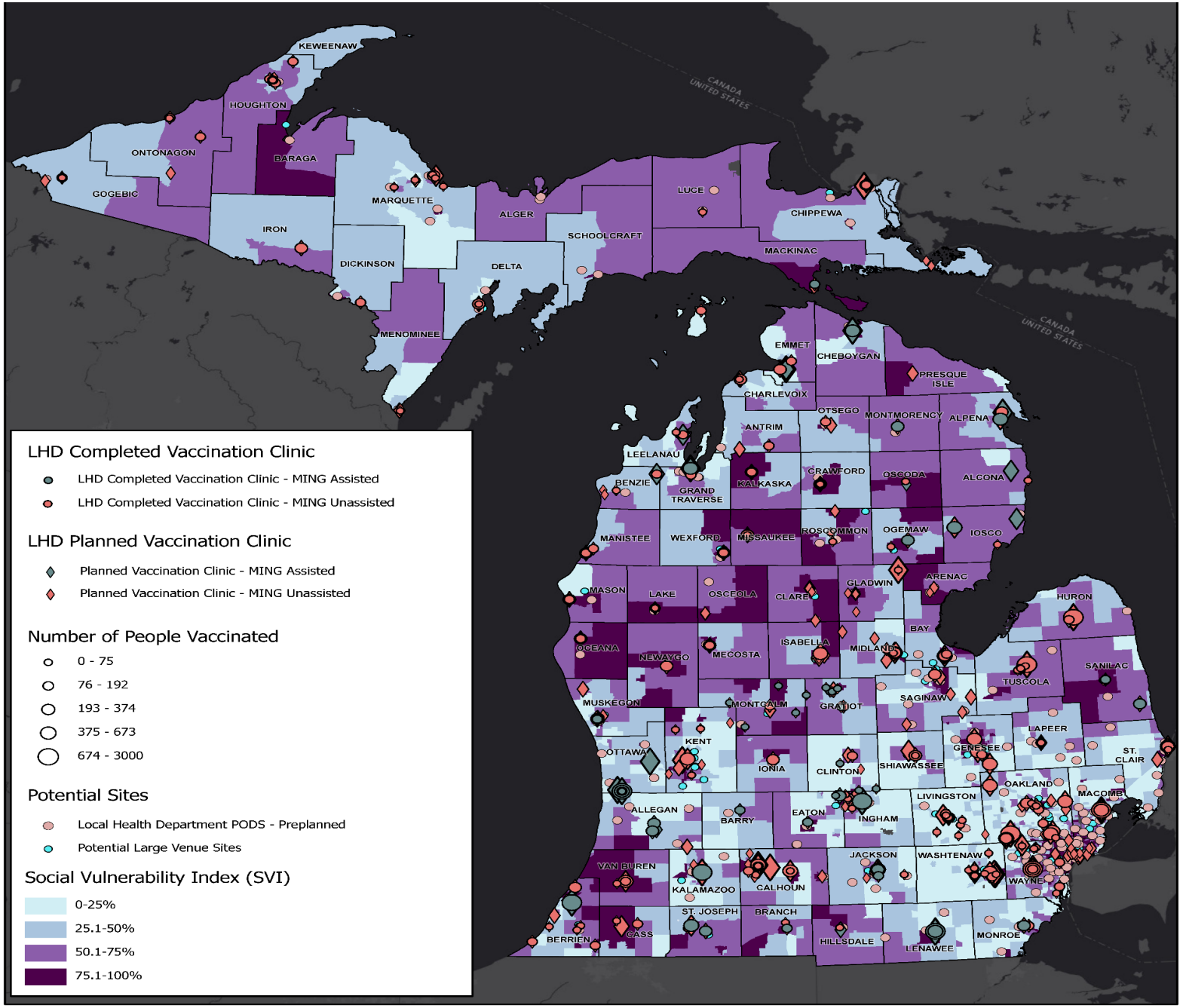
- **STRATEGY 3: Promote efficiency in vaccine delivery and administration**
  - Promote communication, mobilize public/private partnerships to enhance logistical support, and optimize distribution channels that prioritize administration to marginalized communities and efficient operational sites.

Vaccine Strategy

- **STRATEGY 4: Mobilize personnel to maximize vaccination efforts**
  - Fund additional community vaccinators, expand EMS support and other contractual workers, utilizing MI Volunteer Registry with a targeted campaign to encourage participation and clinical students to enhance vaccination efforts.

- **STRATEGY 5: Empower people with information to gain confidence to get vaccinated**
  - Build out robust earned and paid media strategy to address vaccine hesitancy and target communication efforts to those with highest vaccine hesitancy and/or where hesitancy creates highest risk.

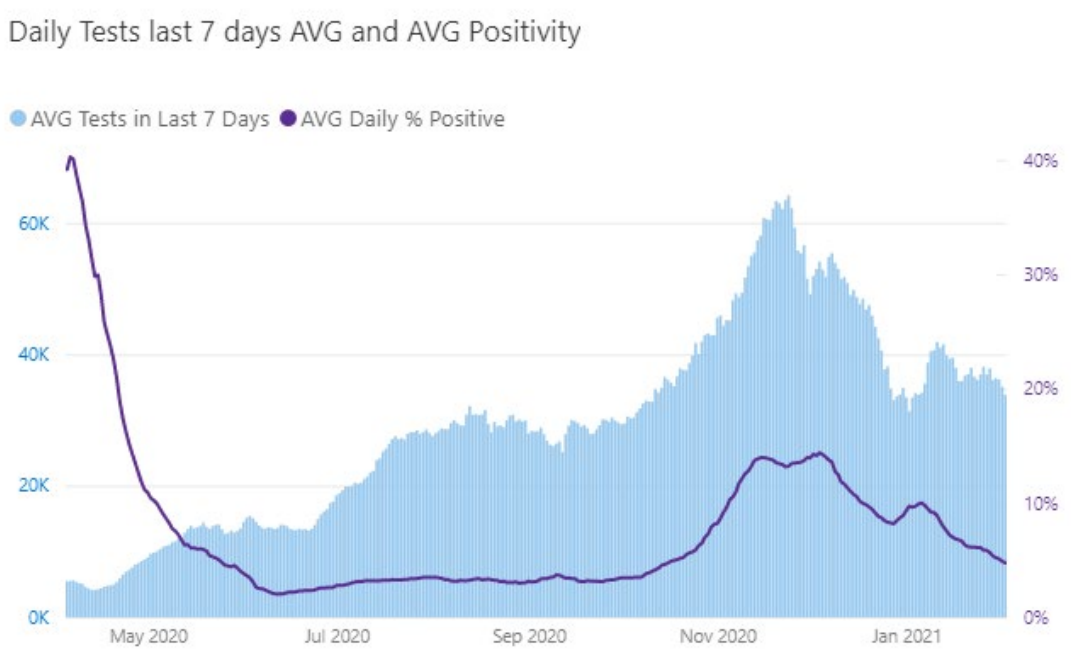
Completed and Planned Vaccination Clinics



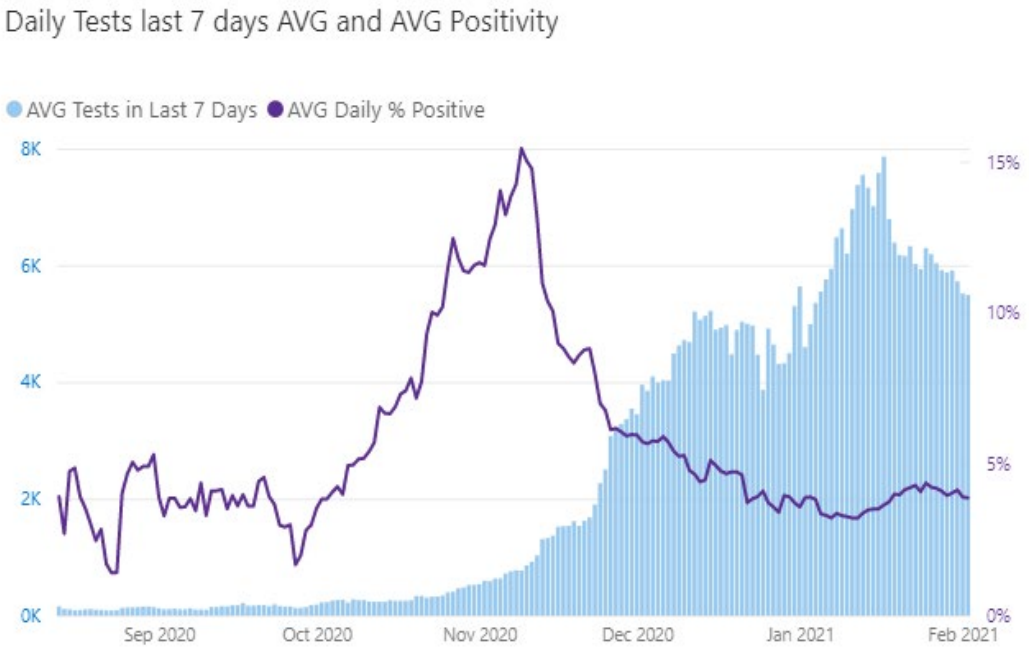
Testing Efforts Continue

Combined PCR and antigen testing growth in the last 10 months (April 2020 to February 2020) continue to improve, increasing from 423 per million to 3,400 per million.

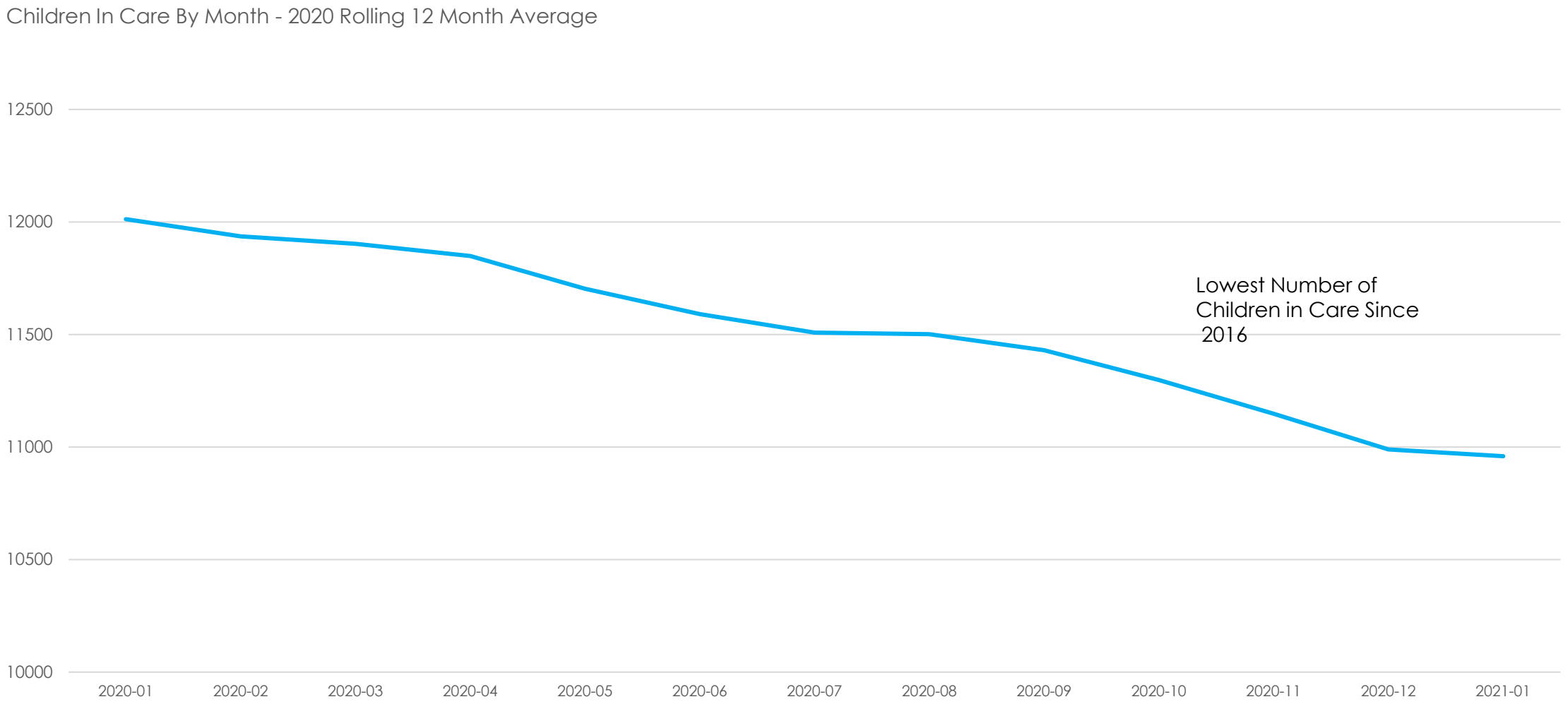
PCR testing (blue bars), positivity (purple line)



Antigen testing (blue bars), positivity (purple line)



Children in foster care

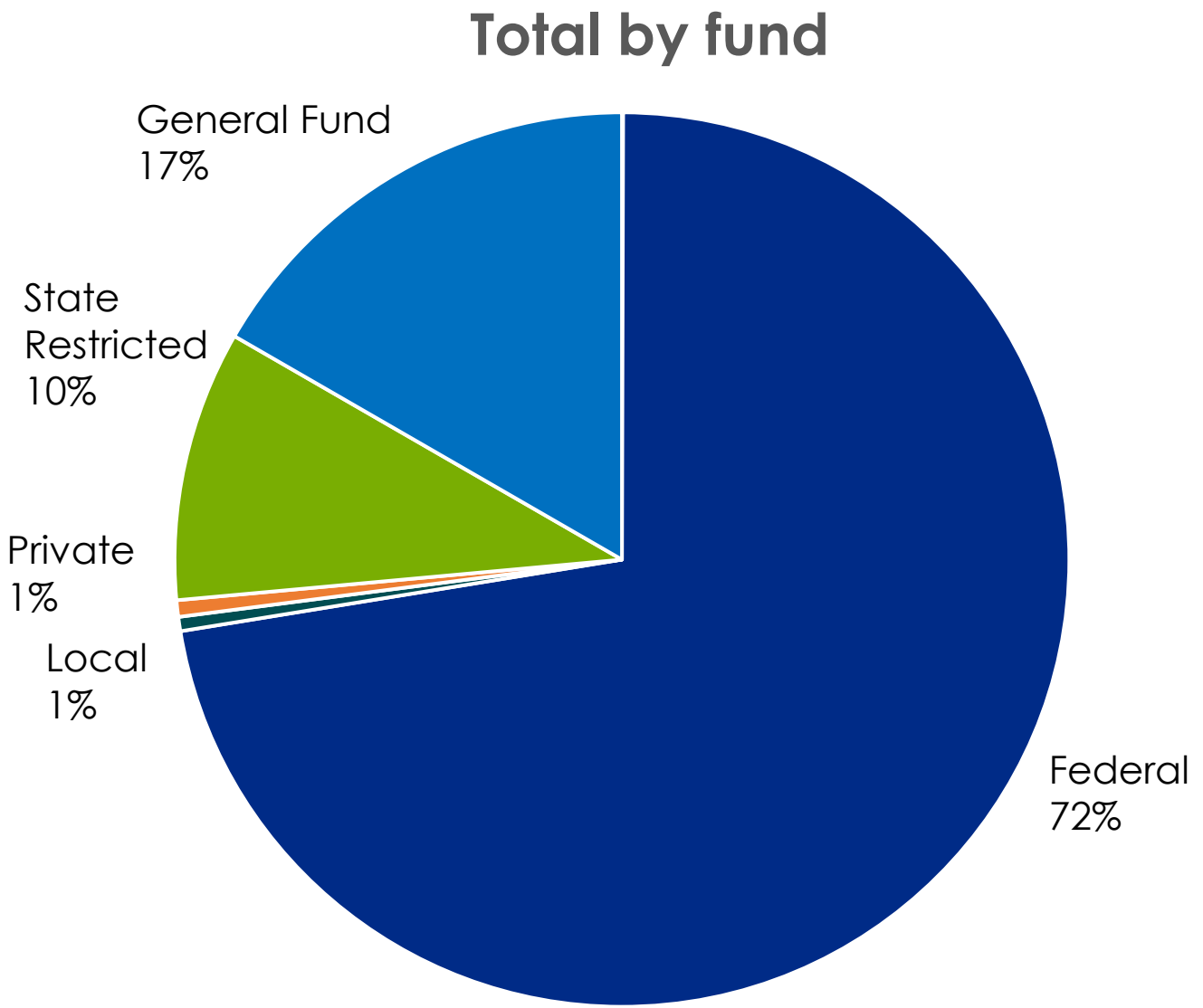


MDHHS Services Statistics

- 97% compliance for worker child visits.
- **Maltreatment of children in care rate reduced from a high of 12.58 percent in 2019 to 8.1 percent in 2020.**
- Decreased foster care congregate care by 30%.
- Served over 300,000 Michiganders through the PIHP/CMHSP public behavioral health system.
- **Increased Behavioral and Opioid "Health Home" enrollment by 156%** since beginning of FY21 (nearly 2,000 high-need beneficiaries receiving comprehensive and integrated care management as a result).
- Expanded the Children with Serious Emotional Disturbance Waiver (SEDW) statewide; augmented the Children's Waiver Program (CWP) by 100 slots.
- **Provided SUD treatment services to 24,000 pregnant/parenting women, half of which had involvement with the child welfare system.**
- Planning the development of the CMS CCBHC Demonstration, which will serve roughly 100,000 Michiganders with mental health/SUD needs.
- The *Michigan Model for Health* is implemented in five out of every six public schools, reaching at least 746,975 students each year.
- One million children are screened annually through the school-based hearing and vision program.
- **Child & Adolescent Health Centers reach approximately 44,000 youth with physical and mental health services.**
- Homes Lead Abated: 284 completed, 127 ongoing.
- Monitoring PFAS in 65 communities; sampled & assessed PFAS in drinking water from 1,291 households.
- **The Maternal Infant Health Program (MIHP) served 12,187 families and conducted 117,417 home visits (FY2020).**
- 367,320 children (out of 859,060 eligible children) who received a preventive dental visit through Medicaid, which represents 43% of the eligible population (FY2020).
- 292,135 WIC certifications (enrollments) completed from (YTD).
- Enrolled 2,400 families in evidence-based home visiting, including Nurse-Family Partnership, Healthy Families America, Early Head Start and Parents as Teachers.
- **96% of infants born in 2020 received a hearing screen under the Early Hearing Detection and Intervention (EHDI)program.**
- The Michigan Tobacco Quitline received 7,282 calls in FY20 resulting in 3,807 enrollments for the phone and online coaching programs.
- **2,933,420 individuals receive public assistance**.
- 1,284,827 residents receive and an average of $376 monthly per household in food assistance for a total monthly issuance of $209,192,142.
- 46,224 residents receive $7,446,431 of FIP benefits.
- **$750,782,697 issued in Emergency Allotment Food Assistance during the pandemic.**
- First round Pandemic EBT served 900,000 children providing $375,152,685 in food assistance.
- 832,204 children on IV-D child support cases, received $1.5B in collections.
- Issued $20,807,601.73 in water payments to 106,000 accounts across 100 municipalities.
- **838,709 bed nights in emergency shelters or motels**.
- 18,974 new referrals were investigated by Adult Protective Services in 2020.
- **1.8 million total average eligible - traditional Medicaid.**
- 1.2 million children served in Medicaid.
- 380,000 disabled adults served in Medicaid
- **700,000 individuals enrolled in Healthy Michigan Plan.**
- 1.2 million children enrolled in Healthy Kids Dental.
- Medicaid covers 46% of all births in the state and two-thirds of all nursing home beds in the state.

FY 2022 Budget

- The Governor's Recommendation for the FY 2022 DHHS Budget including ongoing funding of $31.5 billion gross, $5.2 billion general fund



FY22 General Fund Baseline Cost Increases

Current Services Baseline Adjustments of $2.7 billion, $19.0 million GF

$299.6M gross, $78.8M GF for **actuarial soundness**

<u>Legislatively mandated programs:</u>

- **Raise the Age**, $29.1 million gross, $24.2 million GF (for placing 17 year-old offenders in juvenile rather than adult corrections facilities)
- **Children's oral health screenings:** $1.8 million gross and GF

- **Anticipated caseload needs of** $1.8 billion gross, $104 million GF/GP for child welfare, public assistance, Medicaid and behavioral health
- Total GF/GP costs are **net of savings** from enhanced FMAP

Overview

	GF (M)
Reductions	($6.1)
Total ongoing investment requests	$183.5
Total one-time investment requests	$48.1

$26.5M Gross | $5M GF

Certified Community Behavioral Health Clinics

Context

- Only one-tenth of the 1.3 million Michiganders living with from behavioral health disorders are served by Michigan's public behavioral health system.
- **Over half with a mental health diagnosis and nearly 70% with a substance use disorder do not receive treatment.**

Response

- **Two-year demonstration pilot to provide integrated behavioral and physical health care services at 14 clinic sites.**

Expected impact

- **Increased access to and quality of behavioral health services.**
- **Improved patient outcomes.**
- **Cost-efficiencies for the state.**

$19.1M Gross | $6.3M GF

MI Choice Program Expansion

Context

- Through **MI Choice**, older or disabled persons who need help caring for themselves **can live independently,** while receiving nursing facility level of care.
- 70% of Michigan seniors would like to be in their homes, but only about 50% are in this setting.
- Michigan **ranks 45th** in share of long-term care expenses on home- and community-based services.
- Currently ~17,000 served through MI Choice.

Response

- **Provide funding for an additional 1,000 slots for Medicaid home- and community-based services to people who would otherwise require nursing home care.**

Expected impact

- **Improved health, welfare, and quality of life for elderly and disabled individuals.**
- **More Cost-effective.**

$3.5M Gross $2.1M Gross

Prevention of Foster Placements

Context

- Preventive investments safely **keep families intact safely** and **save money.**
- The Family First Prevention Services Act provides federal match.
- **Michigan is behind other states** on FFPSA implementation.

Response

- **Implement evidence-based services for families at risk of child removal.**

Expected impact

- **Reduced entry into foster care and group homes.**
- **Improved child & family outcomes**

$16.8M Gross | $8.7M GF

Child Welfare IT Modernization

Context

- **Aging and failing IT system, MiSACWIS.**
- **"Persistent and significant defects."**
- Caseworkers routinely describe MiSACWIS as a **critical obstacle to serving kids.**

Response

- **Completion of three additional modules to the new Comprehensive Child Welfare Information System: intake, investigation, and case management.**

Expected impact

- **Improved outcomes for kids and families.**
- **Increased caseworker satisfaction and retention.**

$6.7M Gross | $6.7M GF

Sickle Cell Disease Initiative

Context

- **Sickle Cell Disease (SCD) is the most common blood disorder in the United States, affecting an estimated 3,500 to 4,000 Michiganders.**
- **People with SCD are in desperate need of pain crisis prevention and management.**
- Timely and accurate diagnoses are imperative to initiate preventative care measures, lifelong treatment, follow-up, and education.

Response

- **Expand the CSHCS benefit to adults age 21 and older with SCD.**
- **Expand patient advocacy/outreach and referral services designed to improve quality of care.**
- **Offer additional clinics the resources to expand capacity.**

Expected impact

- **Improved access to quality specialty care for all adults with SCD enrolled in CSHCS**
- **Eligible children will have improved access to quality specialty care.**

$360M Gross | $121.4M GF

Direct Care Worker Wages

Context

- **Direct care workers** have been on the **front line of the COVID-19 public health crisis.**
- **A $2.00 hourly wage increase was approved:**
  - For April-June 2020 in 2020 PA 67
  - For July-September 2020 in 2020 PA 123
  - For October-December 2020 in 2020 PA 166
  - For January-February 2021 in 2020 PA 257

Response

- **Address longstanding challenges related to worker retention and job quality by making the $2.00 hourly rate increase permanent.**

Expected impact

- **Better attract and retain additional high-quality direct care workers.**
- **Improved health outcomes and quality of life for people served and cared for by direct care workers.**

$7.4M Gross | $6.3M GF

Infant Home Visiting

Context

- Approximately **5,607 infants were born with prenatal substance exposure in Michigan in 2018**, and only 85 percent had an Infant Plan of Safe Care
- **Less than 58% had a referral to appropriate services**.

Response

- **Support 1,000 additional home visiting slots for support to infants born with substance exposure.**
- **Provide support to hospitals and clinics to hire or retain home visiting navigators to refer families to appropriate services and programs.**

Expected impact

- **Improved family access to evidenced-based home visiting programs and better engagement with participants to address this key risk factor among infants.**

$91M Gross | $30M GF

Children's Behavioral Health Integration

Context

- **Interim settlement agreement (KB v. Lyon) requires the state to improve its delivery of behavioral health services to children with mental or behavioral disorders and developmental disabilities.**
- Required Implementation Plan (under development) must include how the state will provide an array of **intensive home and community-based services**.
- Targeted population includes children enrolled in **Medicaid** and those served through the **child welfare system**.

Response

- **Development of a plan by April 2021.**
- **Working closely with attorney's plaintiffs with support from the Attorney General's office.**

Expected impact

- **Increased access to and quality of physical, behavioral, and children's health services.**
- **Improved patient outcomes.**
- **Better alignment of service to patient needs.**

MDHHS

Other Investments

Investment	Description	Gross ($M)	GF ($M)
Nursing Home COVID Supplemental Payment	One-time supplemental increase in Medicaid payments to nursing facilities to provide support as they recover from COVID-19-influenced reductions in bed occupancy.	37.5	9.0
Medicaid Redetermination Compliance	Medicaid redeterminations have been paused during the COVID-19 pandemic. When they are resumed, funding for information technology changes and eligibility specialist worker overtime will be needed to process redeterminations in a timely and efficient manner.	23.2	11.5

Other Investments

Investment	Description	Gross ($M)	GF ($M)
Lead Poisoning Prevention Fund	Continued one-time funding supporting a public-private loan loss reserve fund to help eliminate lead poisoning in Michigan homes.	10.0	10.0
Reducing Health Disparities	Expanded use of community navigators to improve access to needed health coverage and other social supports. Funds will also improve screening and health data sharing and promote the interoperability of various health data systems operated by the Michigan Health Information Network system.	8.4	5.1

Other Investments

Investment	Description	Gross ($M)	GF ($M)
Home Health and Safety	Pilot program to promote necessary pre-weatherization construction, renovation, and repair services required to make single- and multi-family structures eligible for participation in energy efficiency or weatherization programs.	5.0	5.0
Cross-Enrollment Expansion	Efficiency improvements will allow the department to better identify and cross-enroll eligible low-income families into public and private assistance programs.	3.5	2.0

Other Investments

Investment	Description	Gross ($M)	GF ($M)
Race, Equity, Diversity and Inclusion Office	This office will support training, technical support, and data collection and analysis to promote racial equity and inclusion in DHHS-administered services.	2.1	1.7
Autism Service Navigation	Funding is maintained in the Executive Budget on an ongoing basis. Support for this program has been included in recent budgets on a one-time basis.	1.0	1.0

Reductions

Summary of all reductions

Reduction Category	GF/GP ($M)	Gross ($M)
Administrative Efficiencies/Prior Year Lapses	(2.5)	(5.6)
Policy Changes	(1.2)	(3.8)
Savings Generated from Federal or State Law Changes	(2.4)	(4.9)
Total Departmentwide FY22 Proposed Reductions	(6.1)	(14.3)

QUESTIONS & DISCUSSION

Emerging Policy Environment and Implications for Publicly-Funded Health Care

January 2021

2021 Health Care Agenda Will Be Shaped by Narrow Democrat-Controlled Government and Exogenous Factors

2020 Election Results

Presidency	Senate	House	Governors	State Houses
				
306 – 232 Joseph Biden Elected	48 – 2 – 50 Democrat control (w/ VP tiebreaker)	222 – 2 – 211 Democrat Control	Republicans will control 28 governorships; Democrats 22	Republicans control 29 legislatures; Democrats 19 (1 split and 1 non-partisan)

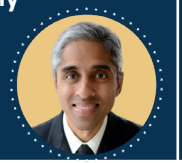
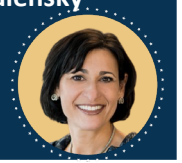
Exogenous Factors Will Shape Health Care Agenda

- COVID-19 pandemic at highest peak levels
- Economy has yet to rebound, and may be further falling
- State and local government fiscal crisis deepening
- Congressional fallout following Capitol Hill riot – timing of legislative priorities is unclear
- Supreme Court ACA actions still pending

Political Implications of Democrat Federal Government

- Elements of Biden's platform (including American Rescue Plan) and other budget related actions can pass Senate on simple majority through budget reconciliation process
  - Other elements may be stripped or could pass if bipartisan support
- Senate may become the starting point for future legislation and negotiation
- Democrat-controlled Senate should allow for Biden appointees to be confirmed quickly

Significant Pending Nominations and Appointments To Date: Health Care Team

	HHS Secretary Xavier Becerra 	General Surgeon Dr. Vivek Murthy 	Chief Medical Advisor Dr. Anthony Fauci 	COVID-19 Equity Task Force Chair Dr. Marcella Nunez-Smith 	COVID-19 Czar Jeffrey Zients 	CDC Director Dr. Rochelle Walensky 
Duties	Administer and oversee the Department of Health and Human Services' 11 agencies; Advise president on issues relating to health, welfare, and income security programs	Provide Americans with the best scientific information available on how to improve their health and reduce the risk of illness and injury; Oversee the U.S. Public Health Service (USPHS) Commissioned Corps	Advise president on public health policy	Ensure response, care, and treatment for COVID-19 is distributed equitably	Coordinate Biden administration COVID-19 response; Oversee testing, mobilization of economic aid and vaccine rollout, among other top priorities	Execute CDC's mission to protect public health and safety through the control and prevention of disease, injury, and disability in the US and internationally; Lead management of vaccine distribution across U.S., including COVID-19
Current Role	Attorney General of CA (2017-Present)	Health adviser on Biden campaign; Co-chair of President-Elect Covid-19 advisory board	Director of NIAID (1984-Present); White House COVID-19 Task Force member (Jan 2020-Present)	Associate professor of medicine and epidemiology at the Yale School of Medicine; Associate Dean for Health Equity Research	Co-chair of Biden transition team	Associate professor of medicine and epidemiology at the Yale School of Medicine; Associate Dean for Health Equity Research
Relevant Experience	Member of the House of Representatives (1993 – 2017); Served on Health Subcommittee and Social Security Subcommittee in Committee on Ways & Means as congressman	Surgeon General (2014-2017); Key leader in addressing Ebola and Zika outbreaks and Opioid crisis	Infectious disease expert, including COVID-19 and HIV/AIDS; HIV/AIDS Researcher	Founding director of the Equity Research and Innovation Center	Addressed mismanaged rollout of Healthcare.gov; Director of National Economic Council (2014-2017); Acting Director of Office of Management and Budget (2010 & 2013)	Infectious disease expert, primarily HIV/AIDS; Advisor to WHO and UNAIDS
Requires Senate Confirmation	Yes	Yes	No	No	No	No

Source: Pictures of nominees from Biden-Harris transition website

Biden Actions/Policies on COVID Response- American Rescue Plan

Biden's "American Rescue Plan": $1.9 trillion economic recovery and coronavirus plan **(L)**

1. National vaccination program: $20 billion **(L)**
2. Expanded testing: $50 billion cover the purchase of rapid tests, expand lab capacity and assist schools with testing protocols **(L)**
3. School funding: $130 billion to help schools reopen; can include modifying spaces for social distancing or improving, improving ventilation, or providing PPE **(L)**
4. Significant funding for new health care workers (100,000 community health workers) and community clinics and tribal clinics **(L)**
5. Financial support for congregate settings to deal with outbreaks **(L)**
6. Extension of 15% increase in monthly SNAP benefits and other direct relief to families **(E/L)**
7. Increase subsides for insurance to increase coverage and reduce out of pocket costs **(L)**
8. Reinstate paid leave supports and cost protections for COVID-19 infected people **(L)**

Policies to Watch:

- Future distributions and guidance of the Provider Relief Fund
- Extensions/additions of Medicaid waivers and Medicare payment flexibilities
- Federal standards that may override state vaccine distribution and response, testing, and staffing requirements
- Funding distribution and usage rules for states and local stimulus

Potential Disruptors/Influencers:

- Vaccine and vaccinator availability as well as the distribution infrastructure are already stretched, need to fill the gap. Data systems and vaccination tracking are disorganized and underfunded.
- Vaccine uptake still problematic—slowing progress towards herd immunity even if supply/distribution path is smoothed

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Actions/Policies to Restore the ACA

Biden Campaign Proposals:

1. Provide new choices of ACA coverage through a public option plan **(L)**
2. Expand tax credit eligibility and limit the cost of coverage to make ACA coverage more affordable **(L)**

Policies to Watch:

- Expansion of Marketplace enrollment, extension of open enrollment, restoration of Navigator program and renewed education and marketing, updated guidance on Section 1332 waivers
- Reversal of "market stabilization" regulations and Section 1557 (discrimination in health programs) changes that limited scope of protections
- Rescinding prior executive orders such as interstate insurance sales, short-term limited-duration health plans, and religious exceptions to coverage for LGBTQ and women's reproductive health
- Expansion of Essential Health Benefits to cover pandemic-related services, require standardized plans, limit surprise medical billing

Potential Disrupters/Influences:

- Supreme Court Outcome in April-June 2021; Senate's interest in legislative fixes after Supreme Court decision
- Roll back of Trump Administration's 2019 guidance on 1332 waivers; implementation of new paradigm for 1332 waivers
- Shift in Senate balance could open new doors for ACA policy, but unlikely dramatic changes on legislative front

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Actions/Policies for Medicaid

Biden Campaign Proposals:

1. Provide premium-free coverage through a public option for eligible individuals in states that have not expanded Medicaid coverage; provide states that have expanded Medicaid the choice to move expansion populations to the public option **(L)**
2. Ensure that people making less than 138% of federal poverty level (FPL) are automatically enrolled for coverage through public schools or by eligibility for other federal programs. **(L)**
3. Expand access to home and community bases services (HCBS) by eliminating the current waitlist and providing states with option to convert current HCBS waivers into a new state plan option with an enhanced federal match **(L)**

Policies to Watch:

- Suspension of all actions to promote or approve work requirements and implement block grants, including recent waiver approvals
- Review recent and pending regulations and promulgate changes
- Continuation of flexibilities provided to states in response to COVID
- Incentives and dollars for non-expansions states to expand coverage
- Promotion of health disparities initiatives and greater state accountability to address them
- Reform of long-term services and supports to ensure safer living environments

Potential Disrupters/Influences:

- Supreme Court Outcome in April-June 2021
- State fiscal crisis may inhibit or drive uptake of different options, including COVID flexibilities
- Response of Republican-led states receiving Trump era waivers (GA, TN, FL, etc.)

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Actions/Policies for Medicare

Biden Campaign Proposals:

1. Expand Medicare to individuals 60-65 **(L)**
   - The Biden Campaign proposed to lower Medicare eligibility to those age 60 and to permit individuals age 60-65 to "buy-into" the program on a voluntary basis. The Campaign stated that any new Medicare costs associated with the policy would be paid from sources outside of the Medicare trust fund
2. Reduce prices of pharmaceuticals (see slide 9) **(L, though additional regulatory proposals may be considered)**

Policies to Watch:

- Potential changes to Medicare Advantage payment rates
- Extensions of COVID-19 waivers and flexibilities including telehealth
- Promotion of value-based payments and Center for Medicare and Medicaid Innovation (CMMI) agenda

Potential Disruptors/Influencers:

- Medicare Trust Fund is projected to go insolvent in 2024 which may accelerate Congressional and Administration actions to reduce Medicare costs

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Actions/Policies on Commercial Market

Biden Campaign Proposals

1) Promote public option to put greater pressure on provider reimbursements and private insurance premiums **(L)**
2) Address market concentration across the health care system by implementing more aggressive anti-trust enforcement of health care mergers **(E)**
3) Create limitations on practices that drive medical debt **(can be done through E but strongest protections require L)**
4) Reduce prices of pharmaceuticals (see following slide)
5) Increase wages and benefits for low-wage direct care workers (e.g., home health workers) **(L)**
6) Double federal investment in community health centers **(L)**

Policies to Watch:

- Reinstatement of limitations on short-term health insurance; rollback of Trump administration 12 months limit to Obama-era 90 days
- Acceleration of testing and deployment of innovations that target higher quality across the health care system
- Implementation of the recent "surprise billing" prohibition passed in December

Potential Disruptors/Influencers:

- State-level commercial market reforms

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Prescription Drug Pricing Priorities

Biden Campaign Proposals

1. Lower Medicare prescription drug costs by: 1) repealing the statutory prohibition on Medicare negotiating drug prices with manufacturers **(E)**; 2) establishing an independent review board to assess the value of "specialized biotech drugs that will have little to no competition **(E)**; and 3) limiting the increase of brand, biotech and "abusively priced" generic drugs **(L)**
2. Leverage International Reference Pricing by creating a Review Board that will use International Reference Pricing to help set drug prices for newly launched specialty (Part B) drugs **(L)**
3. Allow drug reimportation **(L)**
4. Limit drug price increases to inflation, including Medicaid and Public Option (if implemented) and all brands, biologics, and some generics **(L)**
5. Eliminate the tax break for advertising drugs **(L)**

Policies to Watch:

- Biden Administration actions to repeal or modify pending Trump Administration regulations and Executive Orders to control drug prices
- Action on the Grassley-Wyden introduced legislation (S. 4199)
- Actions to further regulate pharmacy benefit managers in the post Rutledge v. PCMA decision that favors independent pharmacies
- Joint legislative and FDA policy making on removing/amending patent barriers and drug exclusivity periods to bring lower cost generics to market faster
- State waiver authority to allow states to maneuver around Section 1927 of the SSA (closed formulary provisions in TN Waiver) and pool drug purchasing

Potential Disruptors/Influencers:

- COVID-19 vaccine successes could mean manufacturers enjoy a hiatus in criticism over drug pricing, which could ameliorate Executive administrative actions
- Drug shortages for COVID-19 treatments could raise drug prices/rationing
- Supply chain issues with getting approved COVID-19 vaccines to communities quickly will continue to be a focus in the first term

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Actions/Policies to Address Behavioral Health

Biden Campaign Proposals

1. Appropriate $4 billion to SAMHSA and HRSA to expand access to mental health and substance use disorder services (L) (this funding is included in Biden's recent American Rescue Plan)
2. Provide flexible grants to states and localities for prevention, treatment, and recovery efforts **(L)**
3. Ensure that Medication Assisted Treatment (MAT) is universally available **(L** if new funding is needed**)**
4. Support development and expand coverage for alternative pain medications and treatments **(E)**
5. Enforce mental health parity laws **(E)**

Policies to Watch:

- Federal opioid settlements
- Promotion of new Medicare/Medicaid models to better integrate behavior health services
- Expansion of telehealth services

Potential Disruptors/Influencers:

- COVID-19 pandemic overshadowing opioid epidemic as priority public health crisis
- State-level settlements will differ state by state in their use and oversight models

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Trump Administration Actions Likely to be Reviewed by Biden Administration

- ACA related:
  - Length of open enrollment period (returning to 90 days)
  - "Market stabilization" rule changes that increased access to short term plans, supported grandfathered plans
  - 2019 guidance on Section 1332 waivers
  - Women's health related policies, including payment for abortion, Section 1557 (discrimination in health programs), "provider conscience" protections, exemptions to the contraceptive mandate
- Medicare/Prescription Drugs
  - Review of recent drug pricing proposals issued through rulemaking (e.g., Most Favored Nation, Rebate Rule)
  - Medicare Advantage payment rates
  - Review of/modifications to recent CMMI demonstration models (e.g., Geographic Direct Contracting)
- Medicaid
  - Approval of TN waiver: 10-year demonstration providing fixed Medicaid funding on a per-capita cap basis. Provides enhanced state discretion on services offered; and includes implementation of prescription drug formulary. The Operational Plan requires approval by TN state legislature
  - SCOTUS agrees to hear Trump admin appeal on Medicaid work requirement pilot programs in Arkansas (*Azar v. Gresham*) and New Hampshire (*Azar v. Philbrick*)
  - Managed care regulations
  - CMS guidance to help state Medicaid and CHIP programs transition back to normal operations when COVID-19 PHE ends (Addresses pending eligibility and enrollment actions developed during the COVID-19 PHE and other planning considerations, including steps needed to be taken should states make any of the temporary flexibilities permanent

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

QUESTIONS? CONTACT US

JONATHAN BLUM
VP, Federal Policy and Medicare
jblum@healthmanagement.com

MARY GODDEERIS
Senior Consultant, Chicago
mgoddeeris@healthmanagement.com

NARDA IPAKCHI
Senior Consultant, Washington DC
nipakchi@healthmanagement.com

NORA LEIBOWITZ
Principal, Portland
nleibowitz@healthmanagement.com

KATHLEEN NOLAN
Regional VP, Washington DC
knolan@healthmanagement.com

STEPHEN PALMER
Principal, Austin
spalmer@healthmanagement.com

ANNE WINTER
Managing Principal, Phoenix
awinter@healthmanagement.com

COMMUNITY MENTAL HEALTH ASSOCIATION

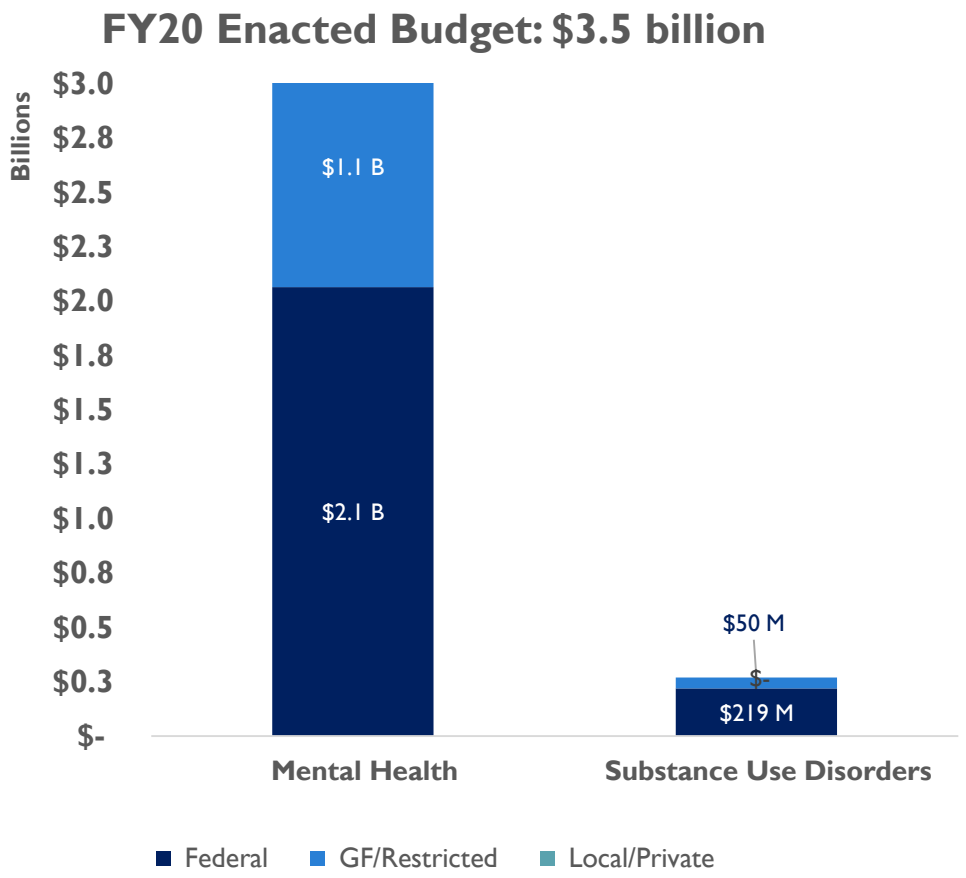
Improving Outcomes Conference

January 19, 2021

Allen Jansen, Senior Deputy Director
Behavioral Health And Developmental Disabilities Administration
Michigan Department Of Health And Human Services

MICHIGAN'S PUBLIC BEHAVIORAL HEALTH SYSTEM – COMMUNITY-BASED SERVICES

- **46 Community Mental Health Services Programs (CMHSPs)**
- **10 Medicaid Prepaid Inpatient Health Plans (PIHPs)**
- **Populations Served**
  1. People in crisis
  2. Persons with:
     a. Adults: Serious Mental Illness (SMI)
     b. Children: Serious Emotional Disturbance (SED)
     c. Intellectual/Developmental Disabilities (I/DD)
     d. Substance Use Disorders (SUD)
- **Total Served (2019): 308,738***
  - $3.2 billion for Mental Health (92%)
  - $269 million for Substance Use Disorders (8%)
  - Nearly 90% served through Medicaid; roughly 10% GF



FY20 STRATEGIC PRIORITIES AND PROGRESS

- Expand integration at the service delivery level
- Increase access to safety-net psychiatric care
- Bolster the continuum of crisis services
- Implement Michigan's 1115 Behavioral Health Demonstration
- Continue to mitigate the substance use crisis
- Optimize PIHP/CMHSP financial and operational structures
- Strengthen services to persons exiting incarceration
- Promote self-direction and community inclusion for persons with intellectual/developmental disabilities

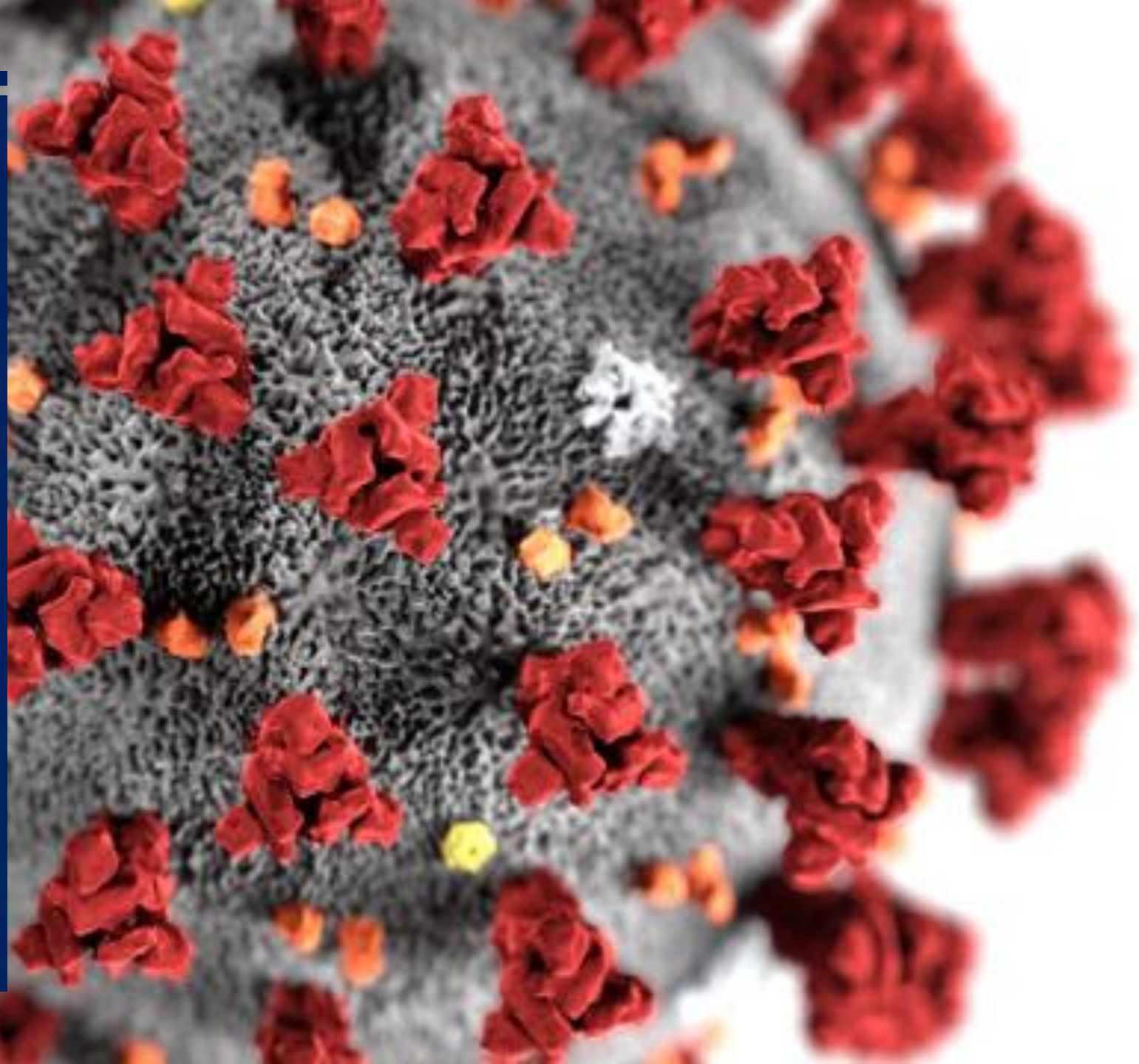
LOOKING FORWARD:

FY21 STRATEGIC PRIORITIES

- Certified Community Behavioral Health Clinic (CCBHC) Demonstration
- Medicaid Health Home Expansions
- Michigan Psychiatric Care Improvement Project (MPCIP)
  - MiCAL
  - Psychiatric Bed Registry
  - Medical Clearance
- 1115 Behavioral Health Demonstration
  - SUD Implementation Plan
  - SUD Health IT Plan
- Strengthen BHDDA's Policy and Operational Oversight
- Optimize PIHP/CMHSP Financial and Operational Structures
- KB Lawsuit
- Diversity, Equity, and Inclusion

BUT 2020 HAD OTHER PLANS

BHDDA'S RECALIBRATION OF RESOURCES TO ATTEND TO THE PUBLIC HEALTH EMERGENCY



COVID-19: SELECT RESPONSE INITIATIVES

- **Medicaid Emergency Authorities**
  - COVID-19 State 1135 Waiver
  - COVID-19 State 1115 Waiver Demonstration
  - COVID-19 Appendix K for 1915(c) HCBS Waivers

- **Awarded and Implemented Federal Grants**
  - SAMHSA COVID-19 Emergency Services for SMI/SUD ($2 million)
  - SAMHSA/FEMA Crisis Counseling Program

- **Crisis Text Line**

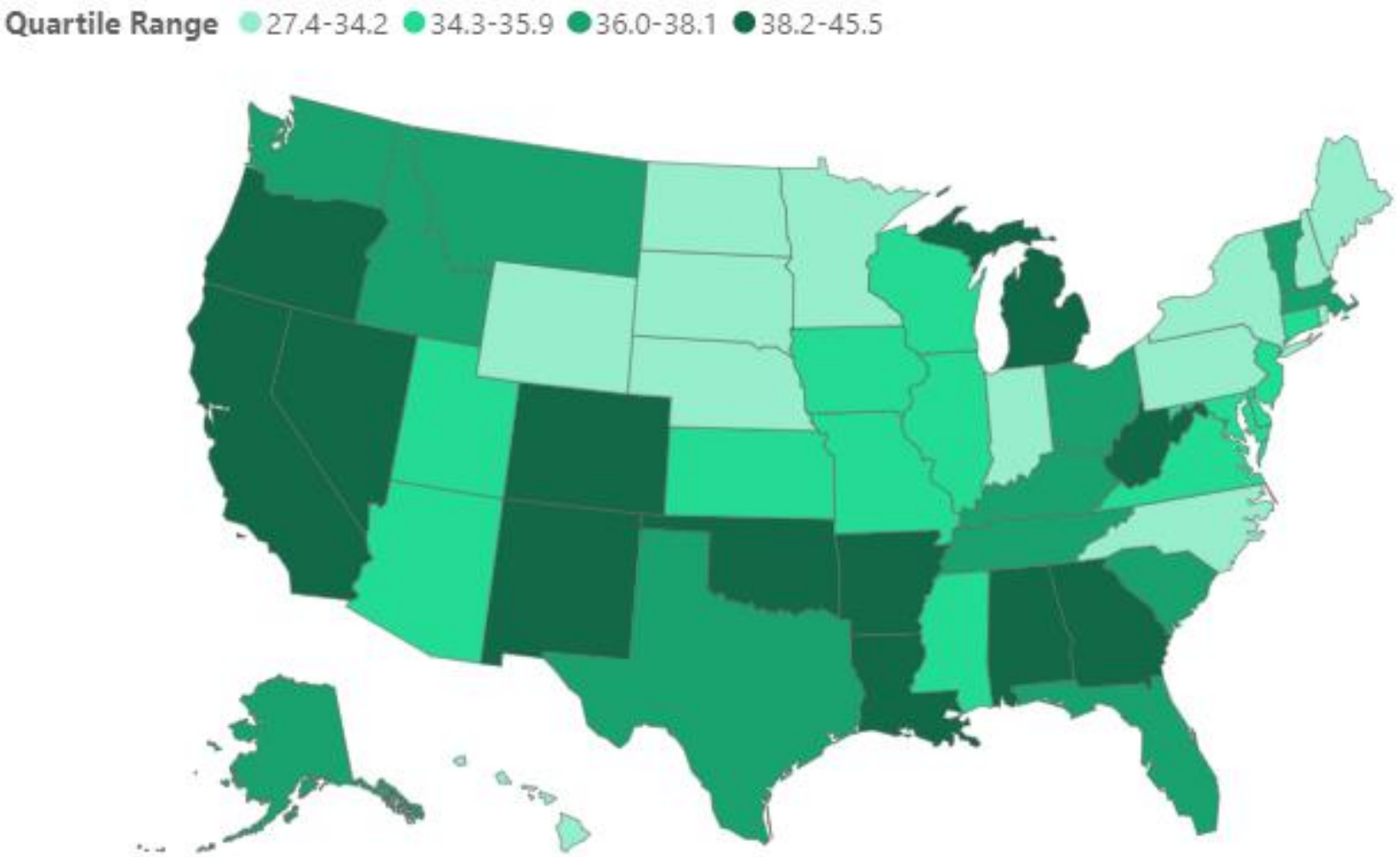
- **$5 million GF to the CMHSPs**

COVID-19: THE IMPACT

- **Behavioral Health**
  - Suicide rates increase by 1.3% for every increase in unemployment of 1%
  - Anxiety/Depression increased by 30.9 %
  - Trauma Disorders increased by 26.3%
  - Use of Substances increased by 13.3 %
- **Utilization of Suicide/Crisis Lines**
  - 1000% increase in use of Disaster/Distress Lines
- **Operational Hindrances**
  - Behavioral Health Providers who have decreased some of their operations 92.6%
  - Behavioral Health Providers who can survive financially more than 3 months is 37.9%
  - Patients have been turned away, cancelled or rescheduled is 31%

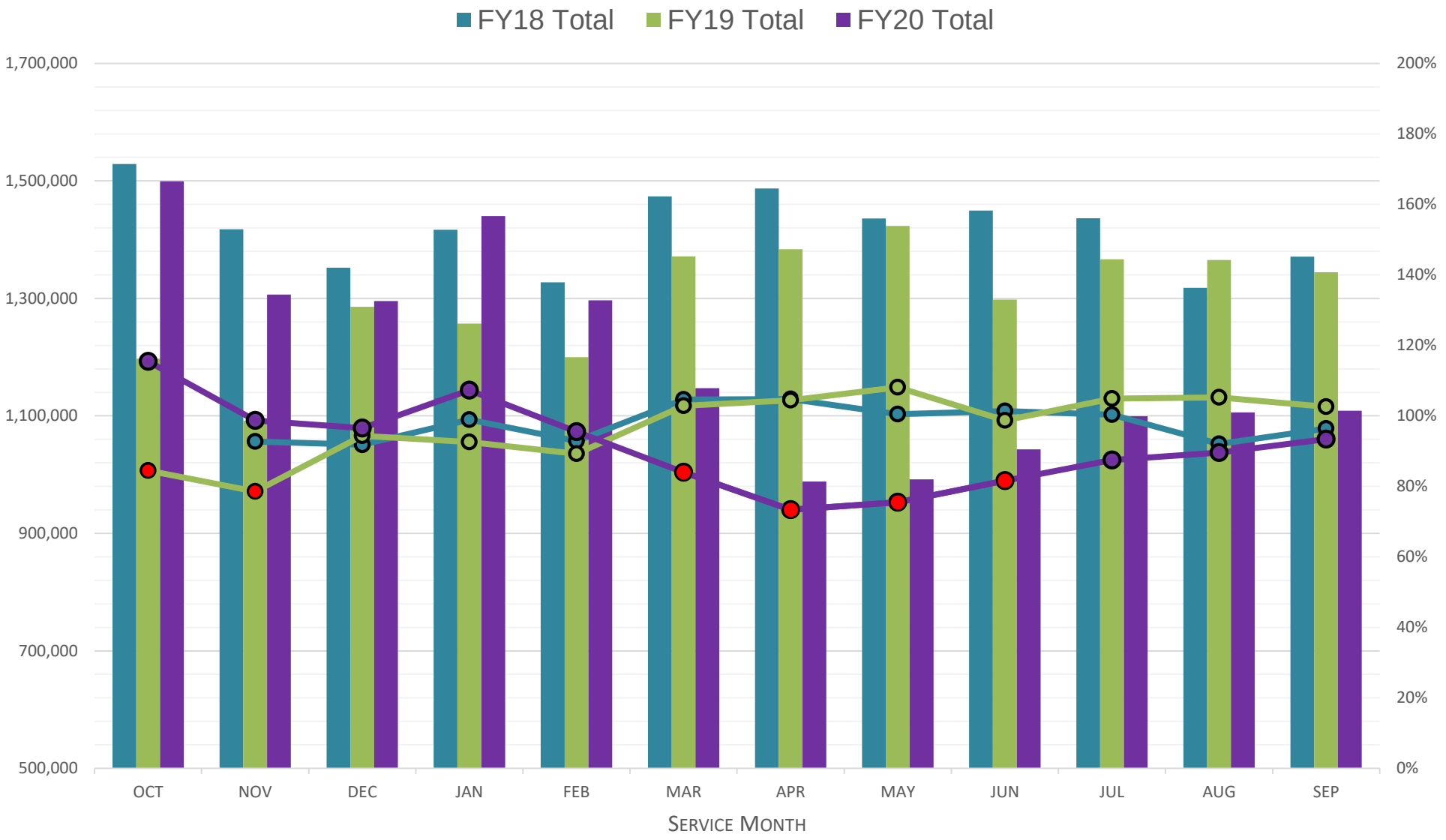
Source: all stats are from 08/2020 and compiled by SAMHSA

SYMPTOMS OF ANXIETY DISORDER

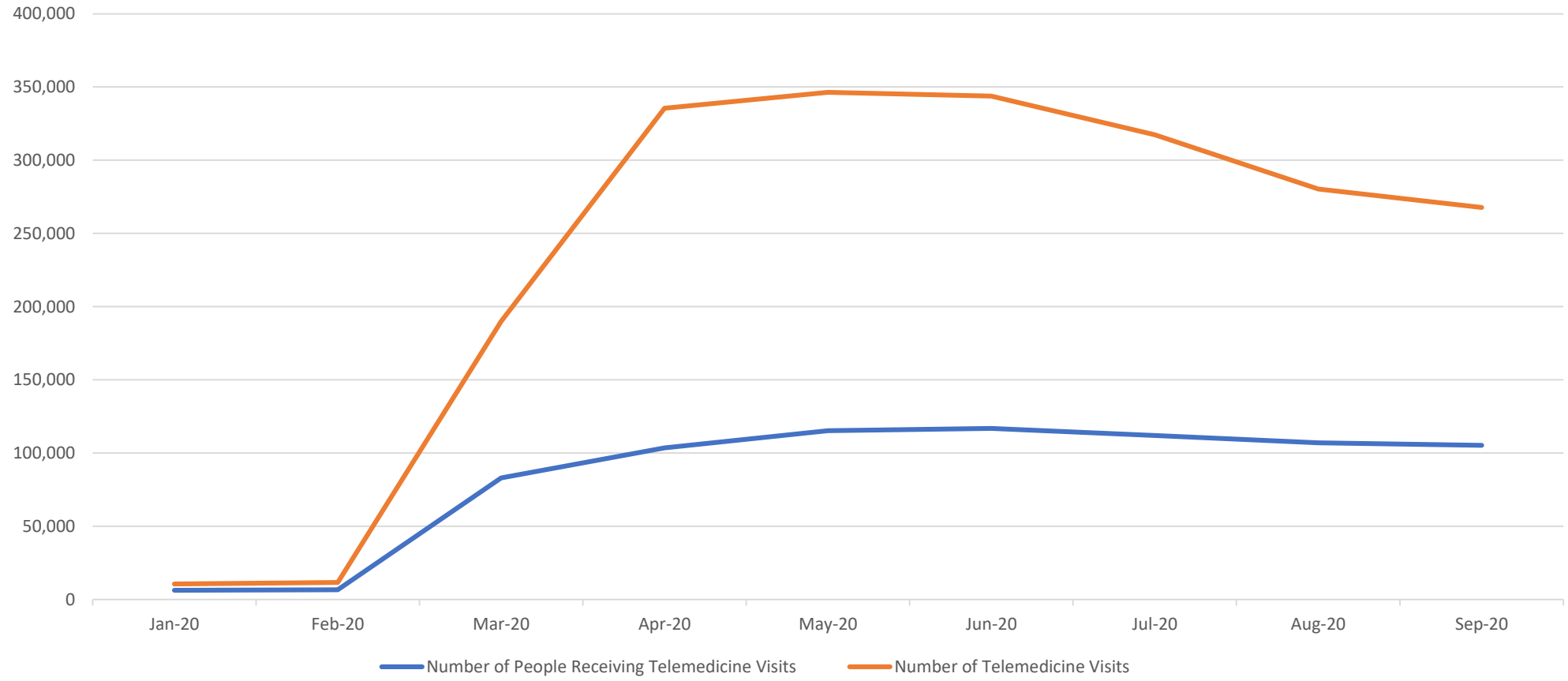


https://www.cdc.gov/

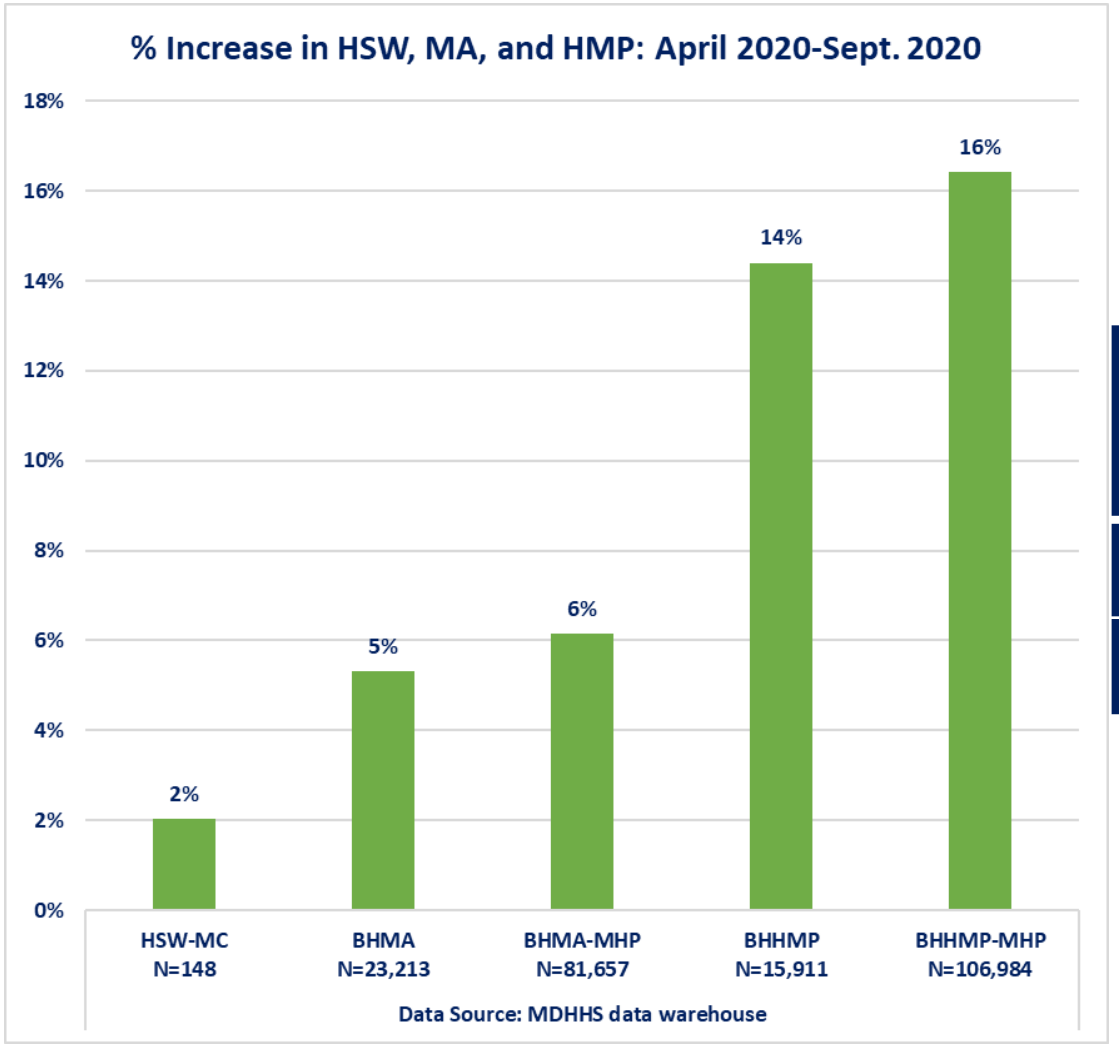
Number of Services Provided by PIHPs and CMHSPs



TELEMEDICINE VISITS FOR SPECIALTY BEHAVIORAL HEALTH
PIHPs and CMHSPs
JANUARY 2020 - SEPTEMBER 2020



THE BELOW GRAPH AND CHART SHOW THE CHANGE IN NUMBER OF ENROLLED INDIVIDUALS FROM APRIL TO SEPTEMBER 2020. (ENROLLMENT NUMBERS HAVE CONTINUED TO CLIMB FROM OCTOBER 2020 TO TODAY.)



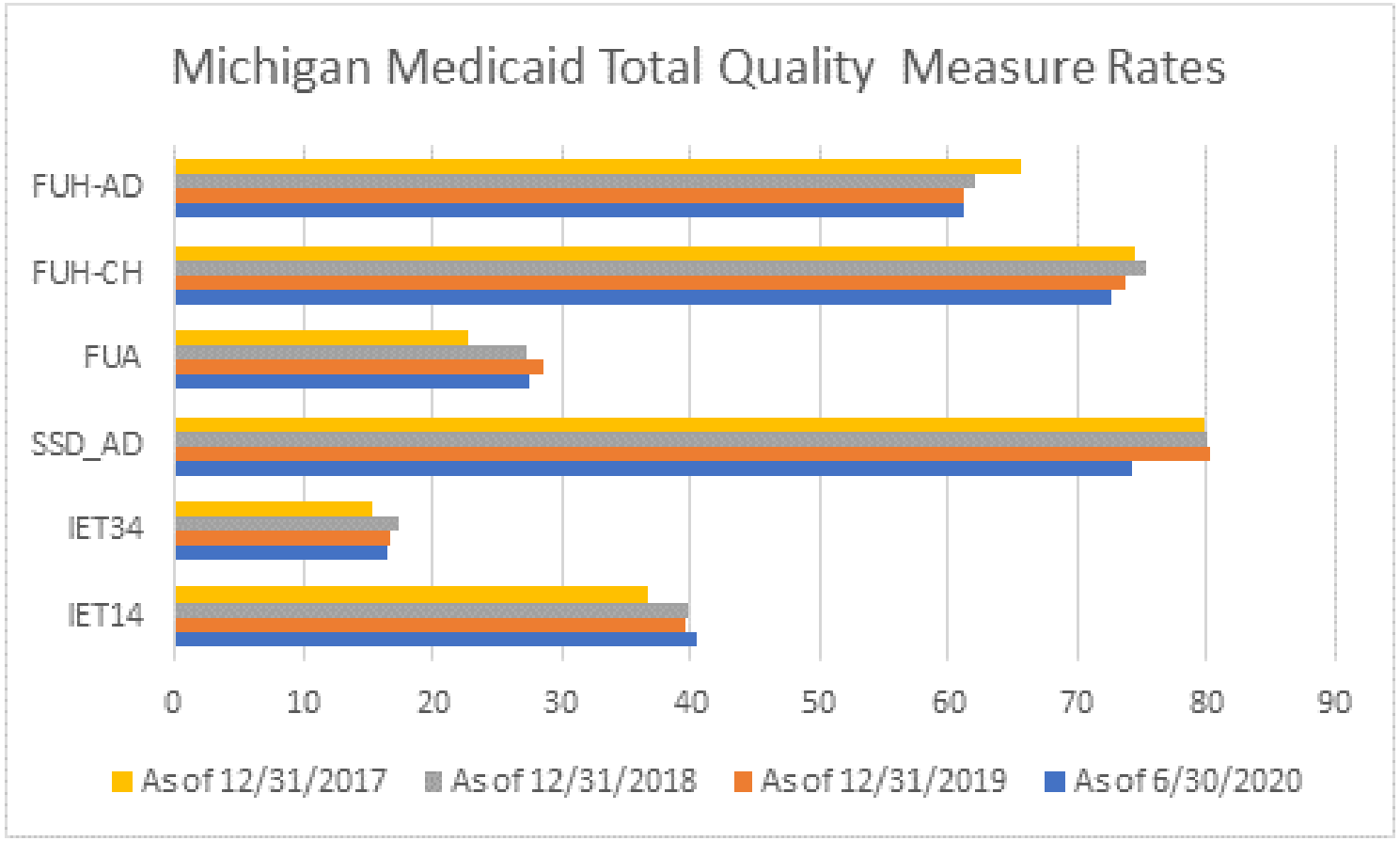
	Hab Waiver	Traditional Medicaid		Healthy Michigan Plan	
# Individuals Enrolled	HSW-MC	BHMA	BHMA-MHP	BHHMP	BHHMP-MHP
As of April 2020	7,124	412,847	1,244,480	94,574	544,266
As of Sept. 2020	7,272	436,060	1,326,137	110,485	651,250

PERFORMANCE INDICATOR SYSTEM REVISION

- BHDDA is in the process of revising its current performance measure system set of sixteen indicators.
- Both CMS and the external quality review organization noted that PIHP had achieved such a high level of performance on these measures that the indicators were no longer useful to facilitate quality improvement.
- To address this, the Performance Indicator Workgroup redesigned the following three indicators:
  - The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.
  - The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.
  - Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.
- BHDDA has received data on these new indicators for the third and fourth quarter 2020.

FULL MEASURE NAMES

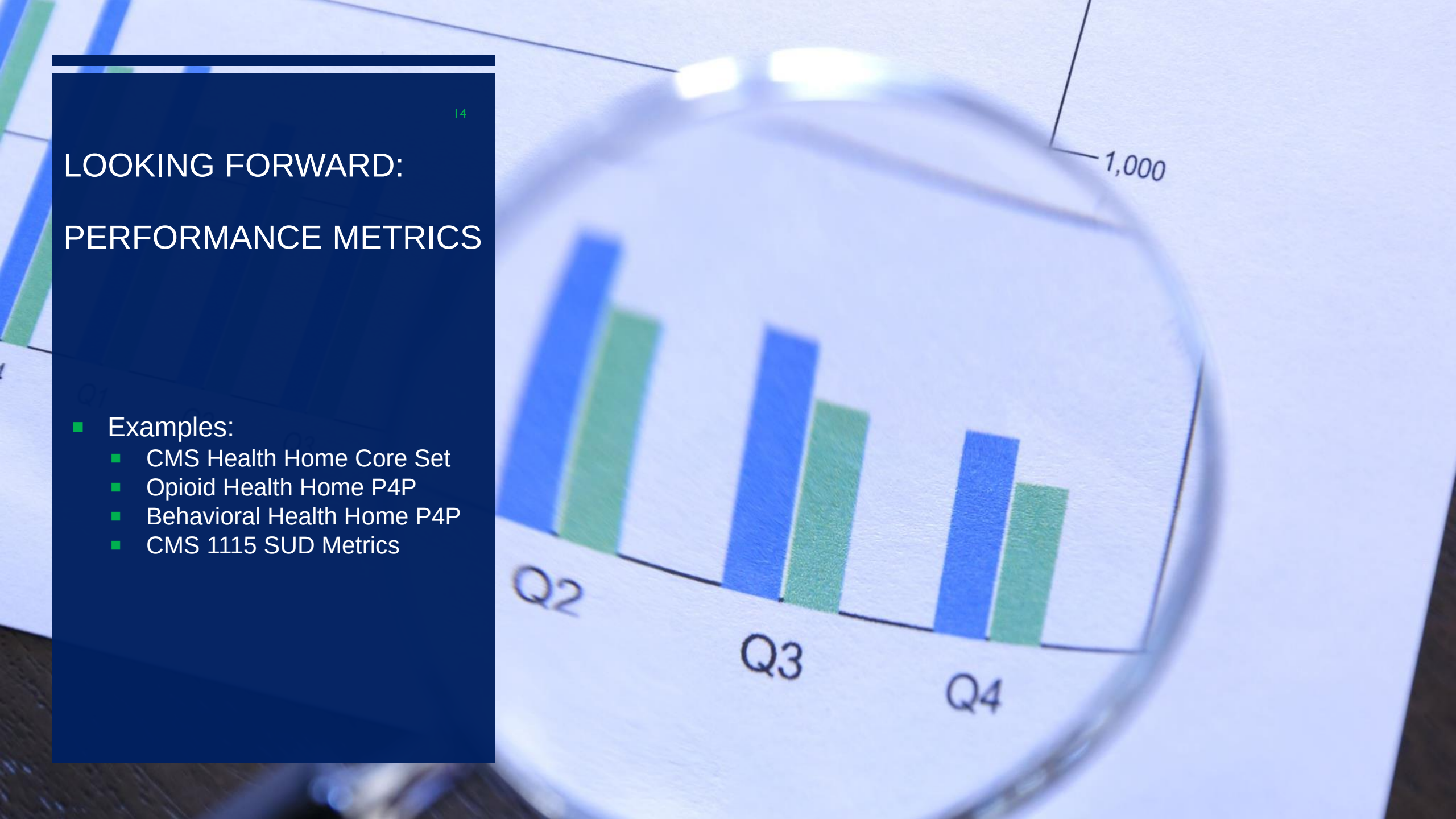
- FUH: Follow-up After Hospitalization for Mental Illness within 30 Days (Child and Adult)
- FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- SSD-AD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder : Who Are Using Antipsychotic Medications
- IET-14 and IET-34: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment



LOOKING FORWARD:

PERFORMANCE METRICS

- Examples:
  - CMS Health Home Core Set
  - Opioid Health Home P4P
  - Behavioral Health Home P4P
  - CMS 1115 SUD Metrics



PERFORMANCE METRICS – HEALTH HOME CORE SET

2020 Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Hea Core Set)

NQF #	Measure Steward	Measure Name	Data Collecti
Core Set Measures			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Administrative o
0018	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, h
0418/0418e	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative o
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)*	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH)*	Administrative
NA	NCQA	Adult Body Mass Index Assessment (ABA-HH)	Administrative o
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Administrative
Utilization Measures			
NA	CMS	Admission to an Institution from the Community (AIF-HH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	Administrative
NA	CMS	Inpatient Utilization (IU-HH)	Administrative

* This measure was added to the 2020 Health Home Core Set. More information on new substance use disorder (SUD) quality measures Health Home Core Set is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112719.pdf.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

PERFORMANCE METRICS – OPIOID HEALTH HOME P4P

P4P Measure	Measure Steward	Allocation % of P4P Budget
Initiation and engagement of alcohol and other drug dependence treatment NCQA (0004)	NCQA	50%
Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)	NCQA	30%
Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	NCQA	20%

PERFORMANCE METRICS – BEHAVIORAL HEALTH HOME P4P

P4P Measure	Measure Steward	Allocation % of P4P Budget
Reduction in Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	NCQA	50%
Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	20%
Access to Preventive/Ambulatory Health Services (AAP)	NCQA	30%

#	Metric name
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)
4	Medicaid Beneficiaries with SUD Diagnosis (annually)
5	Medicaid Beneficiaries Treated in an IMD for SUD
6	Any SUD Treatment
7	Early Intervention
8	Outpatient Services
9	Intensive Outpatient and Partial Hospitalization Services
10	Residential and Inpatient Services
11	Withdrawal Management
12	Medication Assisted Treatment
36	Average Length of Stay in IMDs
13	SUD Provider Availability
14	SUD Provider Availability - MAT
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)[NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[PQA, NQF #2940; Medicaid Adult Core Set]
19	Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA]
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]

PERFORMANCE METRICS – 1115 SUD METRICS

#	Metric name
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge[Joint Commission; NQF #1664]
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]b
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]c
Q1	PDMP Checking by Providers
Q2	Consent Management
Q3	Care Management
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
25	Readmissions Among Beneficiaries with SUD
26	Overdose Deaths (count)
27	Overdose Deaths (rate)
28	SUD Spending
29	SUD Spending Within IMDs
30	Per Capita SUD Spending
31	Per Capita SUD Spending Within IMDs
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) [Adjusted HEDIS measure]
33	Grievances Related to SUD Treatment Services
34	Appeals Related to SUD Treatment Services
35	Critical Incidents Related to SUD Treatment Services
S.1	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]b
S.2	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]c

PERFORMANCE METRICS – 1115 SUD METRICS (CONT.)

QUESTIONS AND CONTACT INFORMATION

STAY WELL
Michigan.gov/StayWell

Al Jansen: JansenA2@michigan.gov

MDHHS
Michigan Department of Health & Human Services

Potential Policy, Regulatory, or Funding Strategies from 1003 Project PIHP Interviews

Blue = policy strategy
Orange = MDHHS practice strategy
Yellow = regulatory strategy
Green = funding strategy

Maintaining SUD Provider Network				
Strategy Description	Decision Maker(s)	Expected Change	Change Process	Potential Timeline
1. **Low reimbursement:** Refine actuarial models to ensure rates are appropriate for all levels of care, taking into account staffing requirements, costs to support clients as they transition through the SUD continuum of care, and costs to coordinate with mental and physical health providers	Al Jansen, Jeff Wieferich	Increased # providers providing these services	Monitor Milliman fee screen process to get baseline, then possibly adjust	Spring 2021 (fee screen baseline), FY22 or later for changes
2. **Low reimbursement:** Identify potential value-based payment models, and engage PIHPs in determining which models are appropriate for different SUD provider types and/or services	Jeff Wieferich, Kate Massey	PIHPs use VBP to pay providers	MDHHS identify VBP options, convene PIHPs and SUD providers to discuss and select, then change contracts or contract allowances	Begin discussions in summer 2021, FY22 or later for changes
3. **Financial burden of licensing/accreditation:** Allocate funding for PIHPs to assist providers with start-up costs	Depends where $ from	Increased # providers	MDHHS identify possible funding sources, establish process	Begin analysis in summer 2021, FY22 or later for changes
4. **Administrative burden of licensing/accreditation:** Allow rural exceptions for certain certification/accreditation requirements	LARA	Increased # rural providers	TBD LARA process	TBD

5. **Administrative burden of licensing/accreditation:** Encourage LARA to adopt efficiency initiatives to reduce administrative requirements and fees (e.g., conduct agency/ organization-wide licensure rather than site-specific actions)	LARA	Reduced admin and fees for PIHPs	MDHHS convene PIHPs to identify scope of this strategy	TBD
6. **Administrative burden of licensing/accreditation:** Develop strategies to guide the sharing of administrative audits for providers who participate in multiple PIHP networks, such as systems to promote standardization of methods	Jeff Wieferich	Reduced admin time used for audits	MDHHS convene PIHPs and multi-PIHP-contracted providers to discuss options	Spring 2021
7. **CMHSPs as SUD providers:** MDHHS convene a workgroup of representatives from PIHPs, CMHSPs, and the Substance Abuse Prevention, Treatment and Recovery provider system to discuss issues and identify best practices related to CMHSPs as SUD providers	N/A	Increased # CMHs providing SUD services	MDHHS convene PIHPs, CMHSPs, OROSC to identify best practices for CMHSPs as SUD providers	Feb 2021
8. **SUD Provider Staffing:** Continue to work with LARA to ensure licensing requirements are in alignment with national staffing standards, allowing flexibility of medical staffing when appropriate	LARA	Increased provider FTE for needed services	MDHHS establish process to review national standards and communicate with LARA annually	Spring 2021
9. **SUD Provider Staffing:** Establish avenues for regular, ongoing interaction between LARA and MDHHS behavioral health officials/PIHP representatives to allow LARA officials to gain a better understanding of SUD guideline and practices, including ASAM levels of care, in order to avoid overregulation	LARA and MDHHS	Increased understanding of SUD services delivery by LARA	MDHHS and LARA establish ongoing communications process	Feb 2021
10. **SUD Provider Staffing:** Establish a standard practice for BHDDA review of the costs of implementing new staffing requirements and, when those costs are significant, allocate short-term funds to assist the affected providers until rates are recalculated	Jeff Wieferich	PIHPs quickly implement and meet new staffing requirements	BHDDA establish process to review costs as part of any staffing change recommendations	Spring 2021
11. **Providers with low patient volume:** Allocate targeted funding for infrastructure support for rural	Jeff Wieferich, Al Jansen	Increased # rural providers	MDHHS / BHDDA identify possible	Begin exploring summer

providers with limited options to achieve financial viability due to low patient volume			funding sources for this, pilot test	2021, pilot FY23?
12. **Providers with low patient volume:** Work with PIHPs to design cross-regional, proactive (not punitive) options for certain low-volume services	Jeff Wieferich	Increased # benes receive low-volume services	MDHHS analyze which services are low-volume and where they happen, review with PIHPs to align	Begin analysis spring 2021
13. **Staff recruitment and retention:** Allocate funds for student loan forgiveness or recruitment/retention incentives for SUD providers in medically underserved areas	Sarah Esty	Increased # providers in medically underserved areas	Carrie Rheingans discuss process with Sarah Esty and Amanda Meier	Began late 2020
14. **Staff recruitment and retention:** Implement targeted educational programs in high-need areas (e.g., programs at rural community colleges/universities) to expand the pipeline of SUD providers	Universities and Erin Emerson, MSA Actuarial (?), legislature	Increased # providers in high-need areas	Assess # SUD training programs in high need areas, identify gap areas, work with educational institutions to add programs	Began Jan 2021
15. **Staff recruitment and retention**: Allocate funds to each PIHP to ensure equitable opportunities for staff training and professional development, including time spent in professional supervision (strategy type depends on how strategy is implemented; could be **regulatory** or **funding**)	Depends on funding source	Increased professional development opportunities for PIHP and SUD staff	MDHHS assess what specific development is needed by PIHPs, identify possible funding sources, establish process to allocate funds	Began late 2020
16. **Staff recruitment and retention:** Revise state regulations to allow masters-level clinicians to use continuing education credits in lieu of certification requirements	Accrediting bodies	Increased # certified providers	MDHHS work with PIHPs to identify which certifications could use CE	Spring 2021
17. **Provider performance:** Initiate a state-level effort, with substantial PIHP involvement, to develop consensus around key performance outcomes	Al Jansen, Jeff Wieferich	Consensus around key performance outcomes	MDHHS continue to participate on MHP/PIHP working group with MSA, BHDDA, and PIHPs	Ongoing

			around PIHP performance, establish baseline	
18. **Provider performance:** Identify potential incentive models and engage PIHPs in discussions of which models are appropriate for Michigan's SUD administrative structure	Jeff Wieferich, Al Jansen	Possible incentive models identified	MDHHS continue MSA, BHDDA, PIHP working group in #17 to identify incentive models that would work in Michigan	Mid 2021
19. **Provider performance:** Explore options to incentivize providers to participate in quality improvement and training related to performance measures and key outcomes	Jeff Wieferich, Al Jansen	Increased # providers trained in quality improvement	MDHHS continue MSA, BHDDA, PIHP working group in #17 & 18 to identify training incentives	Late 2021

Blue = policy strategy
Orange = MDHHS practice strategy
Yellow = regulatory strategy
Green = funding strategy

Enhancing Beneficiary Access and Engagement				
Strategy Description	Decision Maker(s)	Expected Change	Change Process	Potential Timeline
20. **Peer recovery coaches:** Remove requirements related to (A) receiving treatment in the public system and (B) having numerous years free of felony	(A) Al Jansen, (B) CMS	Increased # peer recovery coaches FTE	In process: MDHHS staff edit Medicaid provider manual and seek public comment	Spring 2021
21. **Peer recovery coaches:** Include peer recovery support in per diem rates for recovery housing	N/A			
22. **Peer recovery coaches:** Allow flexibility to use multiple grants to fund peer recovery coaches	Angie Smith-Butterwick	Increased # peer recovery coaches FTE	MDHHS and PIHPs discuss current grant allowances for funding peer recovery coaches	Ongoing

23. **Peer recovery coaches:** Increase reimbursement for peer recovery coaches in recognition of the increased need for supervision	Al Jansen, Jeff Wieferich	Increased # peer recovery coaches FTE	Rate development and potential directed payment authority	TBD
24. **Peer recovery coaches:** Identify longer-term career paths for peer recovery coaches beyond initial certification	Pam Werner, Larry Scott, Jeff Wieferich	Increased # peer recovery coaches	MDHHS review MDHHS' career ladder for options for peer recovery coach growth	Early 2021
25. **Transportation**: Provide clear guidelines on what Medicaid allows under transportation codes, including situations where clients receive both SUD and other types of services (e.g., physical health, other behavioral health)	Jackie Prokop, Jeff Wieferich	Increased # benes receiving transportation to SUD services	Clarify what transportation services currently covered in MHP and PIHP, write and send updated guidance to providers	Began fall 2020
26. **Transportation**: Review reimbursable transportation options to ensure there is equity for SUD treatment vs other services	Jackie Prokop	Equity in transportation for SUD Tx	MSA review options	Early 2021
27. **Transportation**: Implement a policy change to cover transportation for SUD services under Medicaid, by inclusion in PIHP capitation rates or direct billing to Medicaid	Jackie Prokop, Jeff Wieferich	Increased Medicaid coverage of SUD-related transportation services	Regular MSA policy process, including, but not limited to: Actuarial analysis, draft proposed policy, solicit and incorporate public comment	TBD
28. **Transportation**: Consider a carve-out for SUD transportation due to the frequency of services (e.g., with Medication Assisted Treatment)	Jackie Prokop, Jeff Wieferich		Continuation of #27?	
29. **Transportation**: Revise regulations around mobile units to maximize their use in delivering a broad array of SUD services, including methadone, in locations convenient for clients	Depends if changes are federal or state regs	Increased # benes receiving SUD services	Carrie Rheingans compile examples from other states	Begin Feb 2021
30. **Telehealth**: Identify and disseminate information about options to assist clients with technology issues	Al Jansen, Jeff Wieferich	Increased # clients accessing services	Carrie Rheingans work with Laura Kilfoyle to identify options. How does this kind of client-	Spring 2021

		though telehealth	facing info get disseminated?	
31. **Telehealth**: Continue pandemic-related relaxation of telehealth rules, particularly telehealth to home (not just site-to-site) and telephone-based service	CMS, MSA policy	Increased # benes receiving SUD services	MSA policy already proposing to continue telehealth to home. CMS may not allow telephone-only past pandemic emergency	Ongoing
32. **Telehealth**: Allow telehealth to be used for intake (**policy** or **regulatory**)	Depends on type of intake or service			
33. **Telehealth**: Allocate infrastructure support funds for HIPAA-compliant telehealth technology for providers	Depends on funding source	Increased # providers using telehealth services	MDHHS quantify costs to implement HIPAA-compliant technology, identify possible funding sources, establish process to allocate funds	Early 2021
34. **Telehealth**: Participate in statewide or national efforts to track key outcomes for telehealth (e.g., engagement with treatment, overdose)	Laura Kilfoyle, Carrie Rheingans	Consensus about key outcomes	Laura and Carrie continue to participate in such efforts	Ongoing
35. **Justice system:** Ensure that Medicaid coverage is suspended, rather than terminated, when individuals enter jail or prison, and work for prompt re-enrollment as soon as the individual is released			This is already the process. More education needed for providers.	Education during FY2021
36. **Justice system:** Expand advocacy and financial support for enhanced collaborations between PIHPs and jails, prisons, and courts to facilitate access to SUD treatment services, including medication assisted treatment	Dr. Pinals, MDOC, SCAO	Increased # benes accessing services	MDHHS assessing current landscape of collaborations between PIHPs and jails, prisons, and courts	Ongoing

Blue = policy strategy
Orange = MDHHS practice strategy
Yellow = regulatory strategy
Green = funding strategy

Coordinating with Providers Outside the PIHP Network				
Strategy Description	Decision Maker(s)	Expected Change	Change Process	Potential Timeline
37. **Primary care:** Develop options for PIHPs to offer education to primary care providers affiliated with Medicaid Health Plans	?	Increased MHP PCP coordination and referrals to PIHPs	MDHHS ask PIHPs what they think MHP PCPs need education about, then confirm with PCPs. Then, MDHHS co-develop (with PIHPs and PCPs) a process for PIHPs to deliver education	Begin spring 2021
38. **Primary care:** Continue to explore and expand demonstration projects that allow primary care practices to receive technical assistance from SUD specialists (e.g., Opioid Health Homes, Michigan Opioid Collaborative) (**practice** and **funding** strategy)	Al Jansen and Kate Massey	Expansion of OHH, PIPBHIC, BHH, CCBHC	This is already happening	Ongoing
39. **Care coordination:** Allow Medicaid care coordination codes to be used by PIHP and CMH provider networks	Jeff Wieferich, Jackie Hansen, Jackie Sproat	Increased # benes receiving all needed care	Clarify active codes in codebook, then education of PIHPs and CMHSPs which may be used	
40. **Data sharing:** Expedite state efforts to expand data sharing, including eConsent				Ongoing
41. **Data sharing:** Provide ongoing opportunities for PIHPs and Medicaid Health Plans to explore shared responsibilities and collaboration, including data sharing options	Jackie Sproat	Increased collaboration between PIHPs and MHPs	MDHHS continue to participate in convenings of PIHPs and MHPs	Ongoing
42. **Working with MDHHS**: Engage PIHPs early on any new or modified funding or administrative changes	Jeff Wieferich	Increased PIHP input into PIHP funding	MDHHS continue to include PIHPs in potential funding or admin changes	Ongoing

		or admin changes		
43. **Working with MDHHS**: Ensure that PIHPs are aware of supplementary or external funding (e.g., SOR grants) to enable coordination of SUD/behavioral health funding	Jeff Wieferich	Increased funding for PIHP services	Include communications in each PIHP CEO meeting, SUD Director meeting	Ongoing
44. **Working with MDHHS:** Continue to provide flexibility in allowing OUD-targeted funds to be used for activities that will benefit the broader SUD population, whenever possible	Al Jansen	Increased SUD services	Flexibility is already allowed where possible; many grants are very prescriptive	Ongoing
45. **Working with MDHHS**: Assist PIHPs in maximizing the use of block grant funds by removing state policies that are more restrictive than federal rules	Larry Scott	Increased flexibility in the use of block grant funds for SUD services	Clarify what state policies are more restrictive than federal rules, explore process to change identified state policies	Ongoing
46. **Working with MDHHS**: Consider ways to use existing information for internal assessment and innovation rather than punitive reasons (e.g., Medicaid Fair Hearings data)	?	Improved processes to deliver SUD services	BHDDA staff discuss possible internal data sources, identify possible uses of data	Early 2021
47. **Working with MDHHS**: Provide guidance on how PIHPs can share/accept audit data for SUD providers participating /contracting with multiple PIHPs	Jeff Wieferich	Increased administrative data sharing between PIHPs	BHDDA staff review audit data and processes, develop guidelines for sharing audits between PIHPs, discuss and revise guidelines with PIHPs	Early 2021
48. **Working with MDHHS**: Engage PIHPs in efforts to address racial disparities in access to and use of services	Al Jansen, Jackie Sproat	Increased racial parity in access to/use of SUD services, in SUD-related outcomes	BHDDA staff review race data on SUD service access, use, and outcomes; review race data with PIHPs and identify ways to reduce disparities	Began fall 2020

FIRST AMENDMENT TO
INTERGOVERNMENTAL CONTRACT

This First Amendment to the Intergovernmental Contract dated _____, 2021, by and between **SOUTHWEST MICHIGAN BEHAVIORAL HEALTH REGIONAL ENTITY** ("SWMBH"), and **KALAMAZOO COUNTY, ST. JOSEPH COUNTY, BARRY COUNTY, BERRIEN COUNTY, BRANCH COUNTY, CASS COUNTY, CALHOUN COUNTY, and VAN BUREN COUNTY** (individually referred to as "County,": and collectively referred to as "Counties") hereby agree to amend the Intergovernmental Contract ("Intergovernmental Contract") dated October ___, 2020.

RECITALS

WHEREAS, SWMBH and the Counties entered into the Intergovernmental Contract effective October __, 2020 ("the "Parties")

WHEREAS, the Parties desire to amend the Intergovernmental Contract, as provided below.

NOW, THEREFORE, in consideration of the above and in consideration of the mutual covenants and conditions hereinafter contained, SWMBH and the Counties agree to amend the Intergovernmental Contract as follows:

1. ARTICLE V LIABILITY, Section 5.2 Indemnification and Hold Harmless, shall be added to the above-stated Intergovernmental Contract to read as follows:

> "**Section 5.2 Indemnification and Hold Harmless.** To the extent permitted by law and without waiving governmental immunity, the Parties shall, at their own expense, protect, defend, indemnify, and hold harmless the other Parties and their elected and appointed officers, employees, servants, and agents from all claims, damages, costs, and expenses, arising from personal and/or bodily injuries or property damage that any of them may incur as a result of any acts, omissions, or negligence by the Parties, and/or its officers, employees, servants, or agents that may arise out of this Intergovernmental Contract."

2. ARTICLE VI MISCELLANEOUS, Section 6.14 Nondiscrimination shall be added to the above-stated Intergovernmental Contract to read as follows:

> "**Section 6.14 Nondiscrimination.** The Parties agree, as required by law, that they shall not discriminate against a person to be served or an employee or applicant for employment with respect to hire, tenure, terms, conditions or privileges of employment, or a matter directly or indirectly related to employment because of race, color, religion, national origin, age, sex, gender identity, sexual orientation, disability, height, weight, marital

status, or political affiliation that is unrelated to the individual's ability to perform the duties of a particular job or position. The Parties agree to follow all applicable Federal, State and local laws, ordinances, rules, regulations and policies prohibiting discrimination, including, but not limited to, the following:

A. The Elliott-Larsen Civil Rights Act, 1976 PA 453, as amended.
B. The Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended.
C. Section 504 of the Federal Rehabilitation Act of 1973, P.L. 93-112, 87 Stat 355, and regulations promulgated thereunder.
D. The Americans with Disabilities Act of 1990, P.L. 101-336, 104 Stat 327 (42 USC §12101 et seq), as amended, and regulations promulgated thereunder.

Breach of this section shall be regarded as a material breach. In the event a party is found not to be in compliance with this section, the non-breaching party may terminate this Contract effective as of the date of delivery of written notification to the breaching party."

3. All other terms and conditions contained in the above-stated Intergovernmental Contract shall remain in full force and effect except as modified herein. This Amendment shall become effective on the date in which it is fully signed by the authorized representatives of all Parties.

4. The people signing this Amendment on behalf of the Parties to the Intergovernmental Contract certify by their signatures that they are duly authorized to sign this Amendment.

[Signature page to follow]

IN WITNESS WHEREOF, the authorized representative of the Parties hereto has fully executed this First Amendment to the Intergovernmental Contract on the day and year first written above.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH REGIONAL ENTITY

By: _____ Date: _____

Its: _____

THE COUNTIES:

BARRY COUNTY

By: _____ Date: _____

Its: _____

BERRIEN COUNTY

By: _____ Date: _____

Its: _____

BRANCH COUNTY

By: _____ Date: _____

Its: _____

CASS COUNTY

By: _____ Date: _____

Its: _____

CALHOUN COUNTY

By: _____ Date: _____

Its: _____

KALAMAZOO COUNTY

By: _____ Date: _____

Its: _____

ST. JOSEPH COUNTY

By: _____ Date: _____

Its: _____

VAN BUREN COUNTY

By: _____ Date: _____

Its: _____

BYLAWS OF

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH REGIONAL ENTITY

SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD

ARTICLE I
NAME AND FORMATION

1.1 NAME.

The name of the entity is the Southwest Michigan Behavioral Health Regional Entity Substance Use Disorder Oversight Policy Board, referred to as the "Board" in these bylaws.

1.2 FORMATION.

A. Southwest Michigan Behavioral Health Regional Entity ("SWMBH") is a community mental health regional entity formed under the Michigan Mental Health Code (the "Code") which serves the following eight (8) counties commonly referred to collectively as Region 4 by the Michigan Department of Community Health (MDCH")": Barry County, Berrien County, Branch County, Cass County, Calhoun County, Kalamazoo County, St. Joseph County and Van Buren County (referred to individually as a "County," and collectively as the "Counties).

B. SWMBH has qualified for status as a MDCH-designated community mental health entity authorized to coordinate the provision of substance use disorder services in Region 4.

C. As a designated community mental health entity, the Code requires SWMBH to establish a substance use disorder oversight policy board through a written contractual agreement with the Counties in Region 4.

D. SWMBH and the Counties entered into a written Intergovernmental Contract to establish the Board effective January 1, 2014 (the "Intergovernmental Contract").

ARTICLE II
PURPOSES

2.1 PURPOSES.

In accordance with the Code and the Intergovernmental Contract, the purposes of the Board are as follows:

A. Approval of any portion of SWMBH's budget that contains 1986 PA 2 (MCL 211.24e(11)) funds ("PA 2 Funds") for the treatment or prevention of substance use disorders which shall be used only for substance use disorder treatment and prevention in the Counties from which the PA 2 Funds originated;

B. Advise and make recommendations regarding SWMBH's budgets for substance use disorder treatment or prevention using non PA 2 Funds; and

C. Advise and make recommendations regarding contracts with substance use disorder treatment or prevention providers.

ARTICLE III
BOARD MEMBERSHIP

3.1 NUMBER AND SELECTION OF MEMBERS.

The Board shall consist of between eight (8) and sixteen (16) members. The Board of Commissioners of each County shall appoint up to two (2) individuals to serve as members of the Board. Each County Board of Commissioners may appoint any combination of County commissioners or others, as allowed by Michigan law, that it deems best represents the interests of the County. A Board member shall serve until resignation or removal.

3.2 REMOVAL.

The County that appointed a Board member may remove its appointed Board member at any time. The Board Chairperson is responsible for informing the relevant County of any lack of participation or attendance by the County's appointed Board member(s).

3.3 VACANCIES.

Any vacancy occurring on the Board shall be filled by the County that originally filled the vacant position. The county may notify the Board of its intent not to fill the vacant position.

ARTICLE IV
BOARD ACTION

4.1 PLACE OF MEETINGS.

All meetings of the Board shall be held at the principal office of SWMBH or at such other place as shall be determined by the Board members and stated in the notice of meeting.

4.2 ANNUAL MEETING.

The annual meeting of the Board for purposes of reviewing and approving the portions of the SWMBH budget that contain PA 2 Funds, and such other business as may be come before the meeting, shall be held during the month of _____ each year after SWMBH has prepared its budget.

4.3 SPECIAL MEETINGS.

The Board may hold special meetings as needed in order to fulfill the purposes listed in Section 2.1. Special meetings of the Board may be called by the Chairman, and shall be called by the Chairman at the written request of two or more Board members.

4.4 NOTICE OF BOARD MEETINGS.

Written notice of the time, place and purposes of each meeting of the members of the Board shall be given to each Board member and the public in accordance with the Michigan Open Meetings Act, 1976 PA 267, as amended.

4.5 MEETING BY REMOTE COMMUNICATION.

A Board member may participate in a meeting by conference telephone or any other similar communication equipment through which all persons participating in the meeting can hear each other; provided that not all members participate at one time by such means. Participating in a meeting pursuant to this Section constitutes presence in person at the meeting.

4.6 QUORUM.

A majority of the Board members, present in person or by teleconference, as permitted by law, shall constitute a quorum for the transaction of business at an annual or special meeting of the Board. A meeting may be adjourned without a quorum of Board members' being present.

4.7 VOTING.

The Board members shall be entitled to one vote each. The Board shall take action by affirmative vote of the majority of Board members present at a special or annual meeting where a quorum is present.

4.8 COMPLIANCE WITH LAWS.

The Board and its members shall fully comply with all applicable laws, regulations and rules applicable to its operation, including without limitation 1976 PA 267 (the "Open Meetings Act"), 1976 PA 422 (the "Freedom of Information Act"), 2012 PA 500, 2012 PA 501 and 1986 PA 2.

4.9 CONFLICT OF INTEREST.

The Board shall adopt and adhere to a conflict of interest policy. Each member of the Board shall disclose any conflicts of interest while serving on the Board.

ARTICLE V
OFFICERS

5.1 OFFICERS.

The officers shall be a Chairperson and a Vice Chairperson. Only Board members may serve as an officer.

5.2 ELECTION AND TERM OF OFFICE.

Officers shall be elected from among the Board members for a term of one (1) year (or until their successors have been elected) by the Board at its annual meeting.

5.3 REMOVAL.

Any officer may be removed from office with or without cause by the vote of a majority of the Board members at any regular or special meeting of the Board.

5.4 VACANCIES.

In the event of the death, resignation, removal or other inability to serve of any officer, the Board shall elect a successor who shall serve until the expiration of the normal term of such officer or until his or her successor has been elected.

5.5 CHAIRPERSON.

The Chairperson shall preside at and develop an agenda for all meetings of the members of the Board. The Chairperson shall also, in consultation with the Board, form any committees that are necessary to fulfilling the Board's purposes as set forth in Section 2.1.

5.6 VICE CHAIRPERSON.

The Vice Chairperson shall preside at meetings of the Board when the Chairperson is not present, and shall fulfill such other duties as may be appropriately delegated to him/her by the Chairperson or assigned to him/her by the Board.

ARTICLE VI
COMMITTEES

6.1 COMMITTEES.

The Board may establish and define the responsibilities of such standing or special committees from time to time as it shall deem appropriate to fulfill the purposes of the Board set out in Section 2.1. The Chairperson shall, in consultation with the Board, select membership of any committee formed. Only Board members may serve as committee members.

VII
AMENDMENTS

7.1 AMENDMENTS.

These bylaws may be amended by the members of the Board acting in accordance with the voting requirements set forth in Section 4.6. Any amendment of these bylaws must be consistent with the Intergovernmental Contract and the Code.

02-17-14 approved By-Laws