Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone.
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1-844-655-0022
Access Code: 738-811-844
To request accommodation under ADA please call Anne Wickham at 269-488-6982
Monday, July 20, 2020; 4:00-5:30pm

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)**
   - May 18, 2020 Meeting Minutes (d) (pg.2)
6. **Board Education**
   a) Fiscal Year 19/20 YTD Financials (G. Guidry) (d) pg. 6
   b) PA2 Utilization Fiscal Year 20 YTD (G. Guidry) (d) pg.7
   c) Fiscal Year 2021 PA2 Budget Updates (J. Smith)
   d) Strategic Planning (J. Smith) (d) pg. 9
   e) Synar Survey Reporting (J. Smith)
   f) Center for Healthcare Integration and Innovation (CHI2) "Tradition of Excellence and Innovation" (d) (B. Casemore) pg. 17
   g) SWMBH Provider Stability Plans (M. Todd)
7. **Board Actions to be Considered (Randall Hazelbaker)**
   - None
8. **Communication and Counsel**
   a) Legislative and Policy Updates (B. Casemore) (d) pg. 19
   b) Marijuana Taxes (B. Casemore)
   c) Revenue Reductions (B. Casemore)
   d) Intergovernmental Contract Update (d) pg. 34
   e) SWMBH 2020-2022 Strategic Imperatives (d) pg. 41
   f) SWMBH 2020-2023 Strategic Business Plan draft (d) pg. 43
9. **Adjourn**

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SWMBH does not limit or restrict the rights of the press or other news media.
Discussions and deliberations at an open meeting must be able to be heard by the general public participating in the meeting. Board members must avoid using email, texting, instant messaging, and other forms of electronic communication to make a decision or deliberate toward a decision and must avoid "round-the-horn" decision-making in a manner not accessible to the public at an open meeting.

Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting Minutes

May 18, 2020
4:00 – 5:30 pm
Draft: 5/19/20

Members Present via phone: Randall Hazelbaker (Branch County); Richard Godfrey (Van Buren County); Michael Majerek (Berrien County); Gary Tompkins (Calhoun County); Allen Balog (St. Joseph County); Kathy-Sue Dunn (Calhoun County); Ben Geiger (Barry County);

Members Absent: Daniel Doehrman (Kalamazoo County); Lisa White (Kalamazoo County); Don Meeks, (Berrien County); Skip Dyes (Cass County); Paul Schincariol (Van Buren County); Tara Smith (Cass County)

Staff and Guests Present via phone:
Brad Casemore, EO, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Joel Smith, Substance Use Treatment and Prevention Director, 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; Megan Banning; Jen Aniano, Kalamazoo County

Welcome and Introductions
Randall Hazelbaker called the meeting to order at 4:02 pm. Introductions were made.

Public Comment
None

Agenda Review and Adoption

Motion	Richard Godfrey moved to approve the agenda.
Second	Gary Tompkins
Roll Call Vote	
Randall Hazelbaker	yes
Richard Godfrey	yes
Gary Tompkins	yes
Ben Geiger	yes
Allen Balog	yes
Michael Majerek	yes
Kathy-Sue Vette	yes
Motion carried	

Financial Interest Disclosure Handling
Mila Todd stated that there were no Financial Interest Disclosures to discuss.

Consent Agenda

Motion	Richard Godfrey moved to accept the March 16, 2020 meeting minutes.
Second	Gary Tompkins
Roll Call Vote	
Randall Hazelbaker	yes
Richard Godfrey	yes
Gary Tompkins	yes
Ben Geiger	yes
Allen Balog	yes
Michael Majerek	yes
Kathy-Sue Vette	yes
Motion carried	

Board Education

COVID-19 Update
Treatment
Joel Smith stated that there have been dramatic changes due to COVID19 and Governor Whitmer's Executive Orders. SWMBH offices remain closed and the SWMBH call center is operating remotely with SWMBH staff working from home. Calls for services are increasing in both volume and complexity. Outpatient providers are performing services via telehealth or telephonically. Detox, Residential, and Methadone providers remain open with social distancing guidelines in place. Methadone clinics are distributing take homes doses when/where applicable. PPE challenges continue. There are been some positive feedback from clients regarding the ease of telehealth and telephonic services.

Prevention
Achiles Malta stated that prevention work continues during the COVID confinement period. Prevention Coalitions and Substance Abuse Task Forces are meeting as scheduled via various teleconferencing platforms. Prevention services are being delivered through social media, electronic delivery, email marketing and telephone outreach. Revised education efforts are being implemented for prevention of underage alcohol and tobacco use. These programs were not designed for remote use and alternate teaching methodologies had to be developed.

Fiscal Year 19/20 YTD Financials
Garyl Guidry reported as documented.

PA2 Overview and Budget Planning
Joel Smith reported as documented.

2021 PA2 Budget and Three-Year Estimate
Garyl Guidry reported as documented. Discussion followed.

PA2 Utilization FY20 YTD
Garyl Guidry reported as documented.

Fiscal Year 2020 Mid-Year PA2 Reporting
Anastasia Miliadi reported as documented.

Gambling Disorder Prevention Readiness Assessment
Justin Rolin reported as documented noting suicide and co-morbidity statics associated with gambling disorders.

Partnership for Success
Achiles Malta stated that the annual review for this grant is being conducted on May 19, 2020. This is the last year of the three-year grant. The Partnership for Success Grant provided prevention services in St. Joseph and Van Buren counties. Prime for Life continues to provide prevention services for high risk individuals who are referred from the court systems.

Grant Updates
Joel Smith reported on the Opioid Home Health grant as documented.
Joel Smith stated the STR grant ended on April 30, 2020 and reports were submitted to the State. 1,000 persons were served, and 2, 550 Narcan kits were distributed through this grant. Project ASERT screened 1,000 people in local ERs.

Board Action

Intergovernmental Contract
Brad Casemore reviewed the history of the Intergovernmental contract, noting that the current contract is set to expire on December 31, 2020 and needs to be renewed. Brad Casemore referred to the revised Intergovernmental Contract in the meeting materials noting the only changes made to the contract was the date of the contract and the dates in the terms of the contract. Brad stated that, upon Board approval, a letter and contract for signature would be sent to each county commissioner chair and county administrator. Brad noted he would send each Board member (upon request) talking points and would be available to attend county commission meetings to review and discuss if needed /desired. Discussion followed.

Motion	Richard Godfrey moved to approve the revised Intergovernmental Contract as presented.
Second	Ben Geiger
Roll Call Vote	
Randall Hazelbaker	yes
Richard Godfrey	yes
Gary Tompkins	yes
Ben Geiger	yes
Allen Balog	yes
Michael Majerek	yes
Kathy-Sue Vette	yes
Motion carried	

Communication and Counsel

Health Services Advisory Group (HSAG) External Quality Review Report/Results
Brad Casemore reported as documented noting that SWMBH was number one in the State for the best results.

Legislative and Policy Updates
Brad Casemore noted that the May 8th Board retreat was cancelled, rescheduled for August 14, 2020 and invited the Chair and Vice-Chair to attend.
Brad Casemore stated he would discuss marijuana taxes and revenue reductions at the next SUDOPB meeting.
Brad Casemore noted that he is a finalist for the open CEO position at Oakland County Health Network. The final interview is scheduled for May 19, 2020.

Adjourn
Randall Hazelbaker adjourned the meeting at 5:38 pm

Southwest Michigan Behavioral Health

Substance Use Disorders Revenue & Expense Analysis Fiscal Year 2020

For the Fiscal YTD Period Ended 5/31/2020

	MEDICAID				Healthy MI			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
Barry	51,552	120,842	38,979	81,863	100,431	247,950	94,309	153,642
Berrien	403,157	486,507	189,594	296,912	699,564	1,070,644	298,426	772,218
Branch	103,267	127,440	29,726	97,714	128,766	240,177	88,991	151,186
Calhoun	464,298	520,080	294,113	225,967	682,468	942,989	558,409	384,580
Cass	97,713	147,728	56,824	90,904	171,837	311,527	308,329	3,198
Kazoo	499,497	663,311	234,135	429,177	916,367	1,486,557	414,629	1,071,928
St. Joe	165,794	189,544	80,690	108,854	262,347	406,836	203,128	203,708
Van Buren	206,855	256,118	57,053	199,066	355,699	500,916	136,473	364,444
DRM	1,613,814	1,945,700	2,076,284	(130,584)	2,477,055	3,035,225	3,272,793	(237,568)
Grand Total	**3,605,949**	**4,457,270**	**3,057,397**	**1,399,872**	**5,794,535**	**8,242,822**	**5,375,487**	**2,867,335**

	BLOCK GRANT				BLOCK GRANT BY COUNTY			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
EGRAMS								
Community Grant	2,657,035	3,696,963	3,696,963	0	Barry	283,733	283,733	0
Prevention	862,114	1,181,308	1,181,308	0	Berrien	791,805	791,805	0
State's Targeted Response	416,067	440,406	440,406	0	Branch	109,721	109,721	0
Gambling Prevention*	125,789	57,242	57,242	0	Calhoun	694,890	694,890	0
Partnership for Success*	147,437	18,226	18,226	0	Cass	72,910	72,910	0
PMTO*	45,333	18,504	18,504	0	Kazoo	895,814	895,814	0
State's Opioid Response	628,923	347,094	347,094	0	St. Joe	204,235	204,235	0
SOR Supplemental	144,040	101,789	101,789	0	Van Buren	152,660	152,660	0
Clubhouse Engagement*	166,667	39,020	39,020	0	DRM	1,672,504	1,672,504	0
Veterans Navigator*	53,333	57,360	57,360	0				
Crisis Transportation	53,333	11,965	11,965	0	Legend			
State Disability Assistance	85,479	98,523	98,523	0	DRM - Detox, Residential, and Methadone			
Admin/Access	191,651	266,045	266,045	0				
Grand Total	**9,096,353**	**6,334,445**	**6,334,445**	**0**		**4,878,271**	**4,878,271**	**0**

	PA2				PA2 Carryforward			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)		Current Utilization	Prior Year Balance	Projected Year End Balance
Barry	51,408	59,976	24,422	35,554	Barry	35,554	469,938	505,492
Berrien	230,843	269,316	173,906	95,411	Berrien	95,411	485,403	580,814
Branch	42,607	49,708	22,675	27,034	Branch	27,034	334,094	361,127
Calhoun	227,155	265,015	268,115	(3,101)	Calhoun	(3,101)	406,584	403,484
Cass	41,013	47,849	24,983	22,865	Cass	22,865	354,756	377,621
Kazoo	442,367	516,095	399,774	116,321	Kazoo	116,321	1,797,121	1,913,442
St. Joe	66,177	77,207	39,320	37,887	St. Joe	37,887	232,944	270,831
Van Buren	97,078	113,258	49,468	63,790	Van Buren	63,790	233,202	296,991
Grand Total	**1,198,648**	**1,398,423**	**1,002,663**	**395,760**		**395,760**	**4,314,042**	**4,709,803**

* Quarterly Financial Status Reporting

Program	FY20 Approved Budget	Utilization FY 20 Oct-May	PA2 Remaining	YTD Utilization
Barry	**51,650.00**	**24,422**	**27,228**	**47%**
BCCMHA - Outpatient Services	51,650	24,422	27,228	47%
Berrien	**416,341.00**	**186,688**	**229,653**	**45%**
Abundant Life - Healthy Start	70,200	53,075	17,125	76%
Berrien County - Drug Treatment Court	15,000	-	15,000	0%
Berrien County - Trial courts	44,755	-	44,755	0%
Berrien MHA - Riverwood	18,058	-	18,058	0%
CHC - Jail	31,697	21,421	10,276	68%
CHC - Niles Family & Friends	5,739	1,743	3,996	30%
CHC - Wellness Grp	9,328	1,003	8,326	11%
CHC - Women's Recovery House	37,730	16,749	20,981	44%
Sacred Heart - Juvenile and Detention Ctr	73,834	19,337	54,497	26%
Berrien County Health Department - Prevention Ser	110,000	73,360	36,640	67%
Branch	**72,820.00**	**40,699**	**32,121**	**56%**
Pines BHS - Jail Case Management	36,190	21,271	14,919	59%
Pines BHS - Outpatient Treatment	34,430	19,337	15,093	56%
Pines BHS - WSS	2,200	91	2,109	4%
Calhoun	**418,379.00**	**287,046**	**131,333**	**69%**
Calhoun County 10th Dist Drug Sobriety Court	127,807	88,193	39,614	69%
Calhoun County 10th Dist Veteran's Court	6,510	3,149	3,361	48%
Calhoun County 37th Circuit Drug Treatment Court	168,742	128,506	40,236	76%
Haven of Rest	40,320	26,880	13,440	67%
Michigan Rehabilitation Services - Calhoun	25,000	16,667	8,333	67%
Summit Pointe - Jail	25,000	12,360	12,640	49%
Summit Pointe - Juvenile Home	25,000	11,292	13,708	45%
Cass	**82,500.00**	**24,983**	**57,517**	**30%**
Woodlands - Meth Treatment and Drug Court Outp	82,500	24,983	57,517	30%
Kalamazoo	**815,090.50**	**432,462**	**382,629**	**53%**
8th District Probation Court	28,000	6,248	21,752	22%
8th District Sobriety Court	5,000	1,831	3,169	37%
8th District Young Adult Diversion Court	7,000	2,295	4,705	33%
9th Circuit Drug Court	60,000	33,513	26,487	56%
CHC - Adolescent Services	19,619	13,067	6,552	67%
CHC - New Beginnings	77,627	49,485	28,142	64%
Gryphon Gatekeeper - Suicide Prevention	20,000	24,000	(4,000)	120%
Gryphon Helpline/Crisis Response	36,000	16,000	20,000	44%
Interact - IDDT	26,600	14,291	12,309	54%
KCHCS Healthy Babies	87,000	37,389	49,611	43%
KCMHSAS - EMH	56,400	37,600	18,800	67%
KCMHSAS - FUSE	25,000	16,667	8,333	67%
KCMHSAS - Mental Health Court	65,000	43,333	21,667	67%
KCMHSAS - Oakland Drive Shelter	34,000	22,667	11,333	67%
KPEP Social Detox	20,000	5,500	14,500	28%
Michigan Rehabilitation Services - Kalamazoo	17,250	11,500	5,750	67%
Prevention Works - Task Force	50,000	35,119	14,881	70%
Recovery Institute - Recovery Coach	60,623	32,159	28,464	53%
WMU - BHS SBIRT	46,747	629	46,118	1%
WMU - BHS Text Messaging	6,000	2,960	3,040	49%
WMU - Jail Groups	67,225	26,208	41,017	39%
St. Joseph	**136,385.00**	**43,451**	**92,934**	**32%**
3B District - Sobriety Courts	2,200	520	1,680	24%
3B District - Drug/Alcohol Testing	16,640	4,260	12,380	26%
CHC - Hope House	30,345	16,650	13,695	55%
CMH - Court Ordered Drug Testing	53,200	19,801	33,399	37%
CMH Jail Program	34,000	2,220	31,780	7%
Van Buren	**127,882.00**	**49,468**	**78,414**	**39%**
Van Buren CMHA	97,882	38,476	59,406	39%
Van Buren County Drug Treatment Court	30,000	10,992	19,008	37%
Totals	**2,121,048**	**1,089,219**	**1,031,829**	**51%**

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GUIDELINES FOR DEVELOPING THREE-YEAR STRATEGIC PLANS FOR SUBSTANCE USE DISORDER PREVENTION, TREATMENT, AND RECOVERY SERVICES

Fiscal Years 2021-2023

Office of Recovery Oriented Systems of Care

Larry Scott, Director

March 31, 2020

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A narrative, based on the epidemiological profile, identifying and explaining data- driven goals and objectives that can be quantified, monitored, and evaluated for progress 6

A narrative illustrating goals, objectives, and strategies for coordinating services with public and private service delivery systems 6

A summary of key decision-making processes and findings undertaken by the SUD Policy Oversight Board or other regional advisory or oversight board 6

Provision of an allocation plan, derived from input of the SUD Policy Oversight Board or other regional advisory or oversight board for funding a recovery oriented system of care 7

An implementation plan that describes how key prevention, treatment, and recovery services, as well as all other services necessary to support recovery, will be implemented in a three (3) year timeline 7

An evaluation plan that identifies baseline and outcome data for implementing a ROSC that includes prevention and treatment, as well as all other services necessary to support recovery 8

Evidence of a process and procedure for ensuring that policies, programs, and practices will be conducted in a culturally competent manner 8

SUBMISSION REQUIREMENTS FOR THE THREE-YEAR SUBSTANCE USE DISORDER (SUD) STRATEGIC PLANS

All SUD Strategic Plans are due electronically in (Microsoft Word or Adobe PDF format only), no later than 5:00 p.m. on June 5, 2020 to Kimberlee Kenyon at KenyonK@michigan.gov. The strategic plan formatting requirements: single-spaced, Times New Roman, 12pt font, and not to exceed 36 pages (not including transmittal letters and attachments).

TRANSMITTAL OF DATA DUMPS/DOWNLOADS WILL NOT BE ACCEPTED. FURTHER DETAIL REGARDING SUBMISSION FORMATTING IS PROVIDED WITH THE APPLICABLE INFORMATION LISTED LATER IN THIS DOCUMENT.

A transmittal letter signed by the Prepaid Inpatient Health Plan (PIHP) director or designee is required and must verify that the plan submitted has been reviewed and approved by both the PIHP director and the PIHP's governing board and the Substance Use Disorder (SUD) Policy Oversight Board. The signed letter may be scanned and transmitted via e-mail with the implementation plan submission.

Required Components for Submission of the Three-Year SUD Strategic Plans

1. Submission of transmittal letter signed by the PIHP
2. Submission of Three-Year SUD Strategic Plan including:
   - A narrative identifying and prioritizing substance use disorder problems impacting the community
   - A narrative, based on an epidemiological profile, identifying and explaining data driven goals and objectives that can be quantified, monitored, and evaluated for progress.
   - A narrative illustrating the goals, objectives, and strategies for coordinating services with public and private service delivery systems
   - A summary of key decision-making processes and findings undertaken by the SUD Policy Oversight Board or other regional advisory or oversight board
   - A narrative complete with a detailed logic model for selecting and implementing evidence-based programs, policies, and practices for implementing a recovery-oriented system of care that includes prevention and treatment, as well as all other services in your array necessary to support recovery
   - Provision of an allocation plan derived from input of the SUD Policy Oversight Board or other regional advisory or oversight board for funding a recovery-oriented system of care.
   - An implementation plan that describes how key prevention, treatment, and recovery services, as well as all other services necessary to support recovery, will be implemented and a three (3) year timeline that identifies persons or entities responsible for the completion of strategies and completion dates
   - An evaluation plan that identifies baseline and outcome data for implementing a recovery-oriented system of care that includes prevention and treatment, as well as all other services necessary to support recovery
   - A brief narrative illustrating evidence of a process and procedure for ensuring that policies, programs, and practices will be conducted in a culturally competent manner

Technical Assistance: Requests or questions related to these strategic plan guidelines should be directed to Larry Scott at SCOTTL11@michigan.gov or 517-335-0174.

GUIDELINES FOR DEVELOPING THREE-YEAR STRATEGIC PLANS FOR SUBSTANCE USE DISORDER PREVENTION, TREATMENT, AND RECOVERY SERVICES

Introduction

Section 274 of P.A. 500 (Mental Health Code, P.A. 258, as amended) requires designated community mental health entities Prepaid Inpatient Health Plans (PIHPs) to develop three-year strategic plans for substance use disorder (SUD) services that must be consistent with the guidelines established by the Michigan Department of Health and Human Services (MDHHS). This document provides the guidelines for the submission of the three-year strategic plans beginning October 1, 2020 and ending September 30, 2023. The Behavioral Health and Developmental Disabilities Administration (BHDDA) assures that an approved strategic plan for SUD services will satisfy the requirements set forth in P.A. 500, Section 274(a).

The strategic plan guidelines serve to facilitate the development and submission of a strategic plan for SUD services. Close adherence to the guidelines in preparing the strategic plan will provide BHDDA evidence of the PIHP's ability to provide SUD services in a manner that will meet the service needs of the SUD population consistent with the MDHHS 2020 Strategic Priorities, Substance Abuse Block Grant (SABG) priorities, and the 1115 Waiver requirements addressing Substance Use Disorders.

Strategic Plan Guidelines

PIHP Strategic Plans for SUD must provide evidence of implementing a recovery oriented system of care (ROSC) that includes prevention and treatment, as well as all other services necessary to support recovery, and must align with the goals of the Office of Recovery Oriented Systems of Care (OROSC) Strategic Plan and the associated primary focus areas as follows:

- The establishment of a recovery-oriented system of care
- The expansion and enhancement of an array of services within the recovery-oriented system of care
- Reduction in health disparities among high-risk populations receiving prevention, treatment and recovery services
- A reduction in underage drinking
- A reduction in opioid prescription abuse, including a reduction in the misuse and abuse of opioids for non-medical purposes
- A reduction in marijuana use among youth and young adults
- The expansion of behavioral health and primary care services for persons at-risk for and with mental health and substance use disorders
- A reduction in underage youth tobacco access and tobacco use including electronic nicotine devises and vape products
- Increase in access to treatment for persons living with Opioid Use Disorder
- Increase in access to prevention and treatment services for older adults (55 and older)
- Increase in access to treatment for criminal justice involved population returning to communities
- Increase in access to trauma responsive services
- Additional substance abuse issues impacting communities, including the prevention of stimulant use, provided that the selections are based on sound epidemiological evidence

Please prepare narratives consistent with the following components one (1) through nine (9). The total number of pages for components one (1) through nine (9) must not exceed 36 pages. Charts, tables, and graphs may be included in page limitation or attached to the strategic plan.

The strategic plans must include the following key components necessary for implementing a ROSC that is conducive to an individual's recovery, as well as a community's journey toward recovery:

1. **A narrative identifying and prioritizing substance use disorder problems impacting the community** with respect to ROSC that includes prevention and treatment, as well as all other services necessary to support recovery. The narrative should include identification of related long term and short-term consequences at the regional/community level. There should be evidence of an epidemiological profile in the prioritization of substance use disorder issues/problem**s.**

   Evidence should include:

   - A demographic profile of your populations of focus including race, ethnicity, federally recognized tribe, language, gender, age, socioeconomic characteristics, literacy, and sexual identity
   - A description of the relationship of your populations of focus, including sub populations, to the overall population in your PIHP catchment area and target population disparities, if any, relating to access/use/outcomes of prevention, treatment, and recovery support services citing relevant data.
   - A description of current system for providing substance use disorder prevention, treatment, and recovery services that are supported by research and evidence-based in the PIHP region, including the number of prevention, treatment, and recovery support service providers currently funded by public dollars, gaps in service delivery, and barriers to service access
   - A description of the extent (morbidity and mortality) and prevalence of substance use disorder problems in the PIHP region including: a quantification of need for services; capacity of the PIHP service delivery system to provide services; a description of how the SUD focus of service gaps will meet identified needs for SUD service and reduce health disparities. An outline of the process used to determine the prioritized consequences and intervening variables (risk and protective factors) regarding the reduction of underage drinking, underage tobacco use, youth and young adult marijuana use and the reduction of opioid prescriptions and over-the-counter drug abuse, including opiates. When planning for prevention and treatment services pertaining to opioids, you must include data for both heroin and other opiates and consider the prevalence of heroin/other opiates in relation to other substances of abuse
   - A Narrative description of how communicable disease (CD) services will be implemented or maintained in the region in accordance with requirements set forth in *Prevention Policy #2: **Addressing Communicable Disease Issues in the Substance Abuse Network.*** Clearly indicate if the required CD services will be limited to SUD clients, or if all individuals entering the system (including mental health services) will be screened and provided information on local resources. PIHP's are strongly encouraged to include all individuals in this process, particularly those who are identified with co-occurring disorders

Data Sources for Prevention and Treatment Needs Assessment:

- Strategic Prevention Framework – A Guide for Michigan Communities at www.michigan.gov/bhrecovery
- Michigan Substance Abuse Use Disorder Central Data Repository at: www.mi-suddr.com
- Michigan Epidemiological Profile 2019 at www.michigan.gov/bhrecovery → Prevention → Data
- Substance Abuse Annual and Legislative Reports FY19 at: https://www.michigan.gov/documents/mdhhs/Section_9041_PA_207_of_2018_659820_7.pdf
- Treatment Episode Data Set

2. **A narrative, based on the epidemiological profile, identifying and explaining data- driven goals and objectives that can be quantified, monitored, and evaluated for progress** (increase in access to SUD services, behavior change, quality improvement, and positive treatment outcomes, an increase in recovery support services, and improvement in wellness) over time.

3. **A narrative illustrating goals, objectives, and strategies for coordinating services with public and private service delivery systems.** Provide evidence of collaboration or coordination with primary and all other relevant resources as provided in P.A. 500, adult and children's services, faith based communities, education, housing authorities; agencies serving older adults, agencies serving people who inject drugs/Syringe Service Programs, military and veteran organizations, foundations, and volunteer services.

   - **For prevention**, Identify the prevention providers/coalitions and stakeholders implementing activities related to goals and objectives
   - **For treatment,** identify key stakeholders involved in treatment and recovery services and/or collaborating with the PIHP in implementing services and activities related to the goals and objectives

4. **A summary of key decision-making processes and findings undertaken by the SUD Policy Oversight Board or other regional advisory or oversight board**

5. **A narrative complete with a detailed logic model for selecting and implementing evidence-based programs, policies, and practices for implementing a recovery-oriented system of care that includes prevention and treatment, as well as all other services in your array necessary to support recovery.** The logic model approach should include common risk and protective factors contributing to substance use and mental health disorders and its consequences, as well as opportunities for recovery.

   For Prevention: The logic model should include: Identification of an overall goal or goals for prevention, based on epidemiologic data; identification of the consequences of the primary SUD problem the region is attempting to prevent; intervening variables (risk and protective factors) impacting the problems; objectives for remedy; activities to employ for immediate and long term outcomes; and counties where the activity will occur. Please include youth access to tobacco planning activity. (For reference, see the following documents on the OROSC website at: www.michigan.gov/bhrecovery: ***Guidance Documents: Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders; Risk and Protective Factors for Substance Use and Mental Health Disorders;***

Older Adult Well Being Strategic Plan; A Strategic Tobacco Plan; and ***Strategic Prevention Framework SPF - A Guide for Michigan Communities***) and ***A Guide to SAMHSA's Strategic Prevention Framework at https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf***

For Treatment and Recovery: The logic model should include: identification of the primary SUD problem(s) impacting the region based on epidemiological data; identification of inputs or intervening variables; identification of strategies to employ to impact the SUD problem(s); listing of activities leading to immediate outcomes; listing of outputs from the activities; intermediate and long term outcomes; and counties where specific activities will occur. For reference, sample logic models may be found at www.samhsa.gov and https://preventionsolutions.edc.org/sites/default/files/attachments/Examples-of-Community-and-State-level-Logic-Models-for-Addressing-Opioid-related-Overdose-Deaths_0.pdf

6. **Provision of an allocation plan, derived from input of the SUD Policy Oversight Board or other regional advisory or oversight board for funding a recovery oriented system of care** that includes prevention and treatment, as well as all other services in your array, necessary to support recovery in identified communities of greatest need consistent with a data-driven, needs-based approach and evidence-based practices. The allocation plan for prevention, treatment, and recovery targeted services must include the following:

   - Evidence of a commitment to set aside and expend a minimum of 20 percent Community Grant funding for primary prevention services, including an emphasis on: increasing efforts targeting environmental change; integration of SUD prevention and health promotion; collaboration with primary care; collaboration with Michigan Tribal entities, and workforce development activity related initiatives
   - Evidence of the intent to allocate funding to implement a full continuum of research and evidence-based care available to individuals seeking treatment and recovery support services
   - Evidence of the intent to maintain and enhance the provider panel for substance use disorder treatment services. The plan should include any identified deficits and strategies that will be employed to remedy such, including strategies to enhance and/or expand participation of Tribal entities on provider panels
   - Evidence of intent to ensure that priority populations are served first and foremost with SABG funding, and methods for tracking the need for services to increase availability as needed. The plan should also indicate how the priority population wait list will be maintained
   - Evidence that there is knowledge of the problem to be addressed and related research, and that the services plan consists of evidence-based services to impact that issue.
   - A plan for a trauma informed system of care. Highlight the steps taken at the regional entity and provider level to ensure that individuals receive services that are trauma informed at the Access Management System, Prevention Provider, and Treatment and Recovery Support Provider

7. **An implementation plan that describes how key prevention, treatment, and recovery services, as well as all other services necessary to support recovery, will be implemented and a three (3) year timeline** that identifies persons or entities responsible for the completion of strategies and completion dates.

8. **An evaluation plan that identifies baseline, process and outcome data for implementing a ROSC that includes prevention and treatment, as well as all other services necessary to support recover**y, including process and procedures for conducting the evaluation. The evaluation plan should describe how the identified issues/problems, strategic plan, and evaluation data will be used for making adjustments in the implementation of a ROSC.

   - **For prevention services,** the evaluation plan must include the completion of proposed outcomes. The percentage of evidence-based programs must also be captured. These indicators must be addressed in each region as part of overall statewide efforts. If additional substance abuse issues impacting communities, including the prevention of stimulants and marijuana use, are chosen and planned, indicators should be identified for those as well. The plan should also include compliance with administering the MPDS outcomes survey.
   - **For preventing youth access to tobacco**, the evaluation plan must include tools that measure outcomes which include indicators for reducing tobacco sales to minors (Synar compliance).
   - **For treatment and other recovery services,** indicate evaluation mechanisms to track performance in the following indicators:

     - **Domain:** Health and Safety, **Measure:** Sentinel Events
     - **Domain:** Administration: Use of Public Funds, **Measures:** On-time reporting; withdrawal management subsequent services; outpatient continuation; qualitative and quantitative outcomes (employment, housing, education, recidivism) funds spent on services; funds spent on integrated programs; funds spent on recovery supports
     - **Domain:** Treatment Penetration Rates for Selected Populations, **Measures:** Youth (12-17 years-of-age) and Young Adults; Women of Childbearing Age; African American; Hispanic; Native American; and Persons with Opioid Use Disorder

     Please include information on evidence-based interventions implemented in the region, and the integration of trauma responsive services across the continuum of care.
   - **For Women's Specialty Services**, the evaluation plans must include a number and type of services currently available to the individuals in the region, including strengths and deficits. Provide a plan that illustrates and measures the effect of the strategies used to address identified women's issues and expand services, the evidence-based interventions implemented, and the integration of trauma responsive services, including Enhanced Women's Services.
   - **For persons with Opioid Use Disorder,** the evaluation plans must include a number and type of services currently available to the individuals in the region, this should reflect current knowledge and research related to opioid use disorder and the service type based on current standards identified for treatment of opioid use disorder. Provide a plan that illustrates and measures the effect of the research-based strategies and evidence-based services used to address the needs of individuals with opioid use disorder.

9. **Evidence of a process and procedure for ensuring that policies, programs, and practices will be conducted in a culturally competent manner.** For reference, see *Transforming Culture and Linguistic Theory into Action: A Toolkit for Communities, February 2012*, at www.michigan.gov/bhrecovery

For Immediate Release

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Michigan's Public Health System - New Report Finds High Performance and Ability to Bend Healthcare Cost Curve

LANSING, Mich. (May 28, 2020) –Through the use of person-centered community-based rather than institution-based care, Michigan's public mental health system returns a 37-fold investment on the state dollars that fund that system, according to a new report released today by the Center for Healthcare Integration and Innovation (CHI2), the policy arm of The Community Mental Health Association of Michigan. (CMHA). The report, entitled "A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System," examines the performance of Michigan's public mental health system against several state-established and national standards. The report comes at a critical time as communities across Michigan and the U.S. face a growing need for mental health support, resulting from the devastating impact of coronavirus.

The study demonstrates performance from Michigan's public mental health system surpassed other states and systems, measured by dimensions of health care quality and innovation. CHI2 drew from national and Michigan-based sources to demonstrate services available to support residents seeking mental health services. Key data points include:

- **Strong, longstanding performance against state established and nationally recognized performance standards:** Michigan's public mental health system has exceeded the state established standards for 37 of the 38 standards measured. For the one standard not exceeded, the system was below the state standard by only 1.63% from the 95% standard.
- **A national leader in de-institutionalization and community-based care:** Michigan's use of state psychiatric hospitals compared to the rest of the country is significantly less, with other states using state psychiatric hospitals 17 times more, per-capita, than Michigan—a testament to the state's strong movement to a de-institutionalized and community-based system of care. In fact, if the $3.469 billion that are currently used to serve over 350,000 Michiganders per year were spent solely on the provision of long-term care at state psychiatric hospitals and developmental disability centers, then those dollars would only serve 9,500 people per year. This conversion of care from state mental hospitals to community-based care means Michigan's public mental health system serves 37 times more people through the community-based system, for the same dollars, than if these persons were served in state psychiatric hospitals.
- **High rankings against national standards of behavioral health prevalence and services accessibility:** Michigan ranks sixth nationally in serving adults, compared to 50 states and the District of Columbia, as cited by Mental Health in America in 2020.
- **Proven ability to control costs over decades, resulting in major costs savings:** When compared to Medicaid cost increases seen across the country, from 1998 to 2015, Michigan's public mental health system has saved the state of Michigan $5.27 billion. If extrapolated through 2024, Michigan could save over $12 billion. The report found the approaches that the public system uses to control costs—including active management of comprehensive services, a person-centered planning approach, a whole-person orientation that involves hands-on work in addressing the social determinants of health (housing, employment, income, safety, family functioning, transportation) and very low overhead—contrast sharply with the approach of private systems.
- **Pursuit of healthcare integration and evidence-based practices**: More than 620 integration efforts led by the public mental health system—weaving mental health care with primary care—take place throughout the state to lower costs of services, increase access to care, improve preventative intervention and serve the whole person.

“Michigan’s public mental health system has proven reliable and longstanding through financial challenges and pandemics alike, and continues to outperform systems across the country,” said CMHA CEO Bob Sheehan. “We must keep that system a public system and prioritize funding for our public mental health system to continue providing the high-quality mental health supports and services that hundreds of thousands of Michiganders have come to rely on now, and well into the future.”

The data also found factors that make a public system more cost effective than a private system, including active management of comprehensive services, a person-centered planning approach and high medical loss ratios (low spending on administrative costs to allocate those dollars towards Medicaid beneficiaries).

For more information and to access the full study, please visit https://cmham.org/wp-content/uploads/2020/05/CHI2-tradition-of-excellence-and-innovation-May-2020-1.pdf

###

Community Mental Health Association

CMHA Recommendations:
Advocacy and Promotion of a Vision for the Design of Michigan's Public Mental Health System[i]

Adopted by the CMHA Executive Board June 12, 2020

A. Environment in which this process is imbedded

MDHHS proposed system redesign, in December 2019, that called for the creation of a private-public partnership Specialty Integrated Plan (SIP). With the onset of the Corona virus pandemic, **DHHS halted its system design effort** and it is clear that the Whitmer administration is unlikely to spend energy and resources on moving system design forward this year.

In CMHA discussions with MDHHS leadership around the system design effort, they shared that the work related to COVID19 has taken all of the attention and time of MDHHS senior leadership, thus delaying the timetable for the redesign of the public mental health system.

Going farther than that, they indicated that the impact of the pandemic, on the state's economy and, as a result, the tax revenues for the state are projected to be so dramatic that MDHHS and all of state government are reassessing many things, including the redesign effort. The state's FY 2020 budget is expected to have a $3 billion budget gap with a similar gap in FY 2021.

This halt/hibernation and the state budget pressures **opens the door for other options**, now or in future, some offering opportunity, some offering threat

B. Other factors that impact the emergence of these scenarios and the contents of proposals that emerge in these scenarios

1. The public mental health system's strong **response, during the pandemic**

2. The initial success and subsequent expansion of **Michigan's Certified Community Behavioral Health Center (CCBHC)** sites to 18 sites, from the current 8 sites., and the impending designation of Michigan as a CCBHC state.

3. The initial success and subsequent expansion of **Michigan's Behavioral Health Homes and Opioid Health Homes** beyond their initial sites.

4. The **fiscal instability** of some of the state's PIHPs and CMHs will play into the system design models that may come forward.

5. The **proposals, of some private sector organizations – health plans/payers and providers - of system designs** that weaken the core care manager, organizer, provider, convener, and advocate roles of the state's public CMHs and PIHPs

C. Potential scenarios

Scenario 1. System redesign is taken permanently off the table.

> **Analysis**: Seen as highly unlikely, given the momentum of system design across the country and within Michigan, on both sides of the aisle and in both the Executive and Legislative branches, over the last few years.

Scenario 2. Some legislative leaders, with the prompting of the health plans will, once again, **propose a carve-in** (a design in which the management of the Medicaid behavioral health care dollars are moved from the current public management (by the state's PIHPs) to private management (the state's private Medicaid physical health plans). This redesign proposal will continue to float within Michigan's policy circles (MDHHS, Governor's Office, State Legislature) and emerge in some form in the mid-term future – potentially fueled by the false claims that such a carve-in would address state budget concerns.

> **Analysis**: MDHHS has less confidence in the private health plans and the technical complexity of a carve-in may not support a carve-in if proposed by Legislature. Such lack of support would come in the form of the Whitmer administration's negotiations on this point or a veto of statutory or appropriations language that called for a carve-in.
>
> However, if Governor Whitmer or her MDHHS leadership goes to Washington as part of a new administration in DC (dependent, of course, on the outcome of the presidential election), many of the MDHHS leadership who built and championed the SIP model will also exit, leaving the Legislature as a stronger party on this front – and without a counterweight to a carve-in proposal by the Legislature.

Scenario 3. The system design effort is put on hold until the pandemic abates and the debris is cleared and budget gaps are patched, then is picked up again, **under MDHHS leadership, with a proposal containing some or all of the components of the earlier MDHHS proposals and, potentially, other design components.**

> **Analysis**: MDHHS is unlikely to walk away from the SIP model or at least a significant design effort containing some of the elements of the SIP-centered model, given the time, energy, and political capital used to move this model forward. Additionally, the momentum of SIP-like system design efforts across the country and within Michigan, on both sides of the aisle and in both the Executive and Legislative branches, over the last few years, will continue post-COVID.
>
> However, the distraction of the COVID pandemic and the state's budget pressures draws away any of the energy and focus needed to move a SIP-based effort forward.
>
> Additionally, as noted above, if the Governor or many of the MDHHS leadership who built and championed the SIP model go to Washington DC, early in 2021, this will leave the Legislature as a stronger party on this front, weakening the administration's role in system design.

Scenario 4; Both Scenario 2 (Carve in proposed by State Legislature) and Scenario 3 (MDHHS proposal) come forward simultaneously.

D. Likely scenarios in light of analysis

Based on the analysis above, **scenarios 2, 3, and 4 have a high probability of occurring** with scenario 1, given its unlikelihood of occurring, being eliminated as a scenario upon which CMHA should base its system design work.

E. Playing both defense and offense – advocacy and promoting system design proposals

It is key that, in light of probable scenarios, the public system must take the lead in playing both defense and offense through a parallel set of actions:

- The **public system and its allies continue their longstanding advocacy** around the importance of a strong public mental health system in Michigan
- The **public system must take a strong hand in the redesign of the system** and the related statutory, regulatory, and waiver changes, preventing the system design process from being led by others who are not friendly to the public system. Leaving the political arena open for others to propose designs leaves the public system with only a defensive or weakened bargaining position in the design of the new system and its related statutory, regulatory, and waiver changes

Even if redesign pressures come later than expected, **the public system cannot wait** until the emergence of those pressures to take the steps – complex steps – required to mount a sound advocacy effort and alternate vision.

F. Multi-component plan for parallel advocacy and design influencing work

Applying the advocacy and policy-influencing tools that CMHA, its members, and allies have successfully used over the past several years, the following multi-component plan for parallel advocacy and system design influencing efforts will continue to be aggressively pursued:

1. Development and promotion of a set of design elements, based on the principles adopted by CMHA. These design elements and the principles upon which they are founded are contained **in Sections G and H of this document.**

2. Continue partnership with major advocacy group and allies: The Association will build on its longstanding partnership with the **state's major advocacy groups, Michigan Association of Counties (MAC), and other allies** based on a recognition of both common and divergent interests and roles. This effort, built on years of collegial work, is highlighted in the development of a set of principles, collectively, by the advocates and CMHA, as an advocacy partner, that is being provided to the members of the advocacy community as they prepare their testimony at the system design public forums.

3. Government relations: The continual dialogue with elected officials and policy makers by the **Association's team of government relations professionals**: the association's Associate Director (the Association's government relations lead), the Association's CEO, and the staff of the two multi-client lobbying firms on contract with the Association. This team has been and will have discussions, more focused than usual, around the **development of support, within the legislature and the executive branch, for the alternative system design proposed by CMHA.**

4. Activation of grassroots advocacy: The Association will build on its success in activating of grassroots advocacy, through the continual provision of information on key issues to CMHA members and allies and the prudent use of electronic action alerts that bring the voices of thousands of allies to bear on key issues. **Action alerts will be issued by CMHA to its members and allies, over the next few weeks, to speak out on the MDHHS system design proposal and propose the alternative plan outlined by CMHA.**

5. Strong and continual media relations: The collaborative work of the Association with its public relations firm, Lambert (one of most prominent Michigan public relations), the Association's Public Relations workgroup, the Association's members and allies with local and statewide media will be used to **raise awareness of the alternative system design proposal developed by CMHA, its members, and allies.**

6. Foster and highlight system innovation and performance via the CMHA "Accurate Picture Campaign": The Association will continue, with guidance from the **CMHA Accurate Picture Campaign Advisory Group and the CMHA Public Relations Group** to highlight, via media, the high quality, innovative, and effective work of Michigan's public mental health system. Some of the areas highlighted include: high performance in access measures, healthcare integration, promising and evidence-based practices, value basing payment, and community collaborations.

> **Phase 1:** Highlight the work of the public system in response to the **COVID19 pandemic:** The "Heroic Stories" and press coverage of this work is highlighted on CMHA's Newsroom page and have been the focus of the media-relations work of CMHA and its public relations partner, Lambert.
>
> **Phase 2:**
> A. Collect and highlight in media work, **narrative descriptions** of the impactful and innovative work of Michigan's public mental health system- found at CMHA's Newsroom page
>
> B. **Issue a white paper** "**A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System"** that highlights the strength and innovation of Michigan's public mental health system**.** This paper was issued on May 29, 2020 and can be found here.

7. Focused finance/campaign finance-based advocacy: Use of the CMHA's Political Action Committee **(PAC) Fund** and its **Education and Advocacy Fund** (a parallel financing tool, to the Association's PAC) to fuel the finance-driven side of the Association's advocacy. While modest in size, their focused use has built considerable support among the state's elected officials.

8. Policy, fiscal, and legal analysis: At this point, the Association's focused policy, fiscal, and legal analysis, through its **Center for Healthcare Integration and Innovation (CHI2)** and though its **Fiscal Analysts, consultants, and legal counsel** on contract with CMHA, will not be applied to the system design advocacy effort. Given that these analyses have been critical to the advocacy work of the Association, its members, and partners, they will be developed as needed for this effort.

9. National association involvement: Linking to national advocacy efforts and acquiring knowledge of system design efforts in other states, through the active membership in two national associations: the National Council for Behavioral Health and the National Association of County Behavioral Health and Developmental Disability Directors (NACHBDD), **provides CMHA with a clear picture of the impact of a range of system design models on the public mental health system and those served by that system**.

G. Foundational principles guiding the formation of the CMHA's proposed system design elements

*These foundational constructs are **drawn from the principles of CMHA as adopted** by the CMHA Executive Board and/or its officers in February 2020, October 2018/March 2019, December 2019, and August 2016 and related discussions over the past several months.*

1. The design of Michigan's public mental health system must foster **an individual's right to self-determination, person-centered planning, full community inclusion, cultural competence in the services and supports provided them.**

2. Any system design effort should **start with what is best for those served by the system with the financing, operations, and governance infrastructure of the system designed around to achieve what is best for those served.**

3. **Retain and strengthen the place-based structure of the system, with its strong local public governance**. Ensure that the governance (and ownership, if ownership structures are used) of the managed care, provider, and collaborative convener roles of the state's public mental health system remain local and public - **embedded and legally and financially linked to the county governments** served by the system. The need for the linking of foundational service delivery systems, such as behavioral health, physical health, and public safety has been underscored by the events of the past year.

4. **Protect and strengthen the full set of safety net roles played by Michigan's the public mental health system:** The community mental health system's role as the population-based and place-based resource and public safety net committed to the common good, population-health, social determinants, and community collaboration.

The safety net role played by the state's CMHs and PIHPs/Regional Entities is made up of several components:

- **Organizers of care** - Providers, purchasers, and managers of a well-organized comprehensive array of services and supports across a **network of proven providers** in fulfillment of statutory role to serve the individuals, families, and communities regardless of the ability to pay. For this statutorily-defined safety net role to be retained and strengthened, the CMH in each community and, through the CMH, the provider network organized by the CMH, must serve as the **exclusive provider network** of any system redesign. Additional providers can be added to the network as needed and as requested by persons served through the joint work of the risk-bearing care manager and the CMH in each community.
- **Assurers of quality and accountability** – serving to ensure that Michigan's public mental health system provides quality services and supports to Michiganders in all of the state's counties while ensure that the system is accountable to the state's taxpayers and the local, state, and federal governments from which it derives its authority.
- **Community conveners and collaborators** – initiating and participating, often in key roles, collaborative efforts designed to address a broad range of social determinant-related needs of individuals and communities
- **Advocates** for vulnerable populations and a whole-person, social determinant orientation
- **Sources of guidance and expertise**, drawn upon by the public, to address a range of health and human services needs

5. **Recognize and build on the current system's strengths**, building on the nationally-recognized strengths and accomplishments of the state's leading edge public mental health system**:** and its proven performance over the last 60 years and during the COVID pandemic.

6. **Draw upon and learn from proven system design** changes implemented in Michigan and across the country.

6. **Avoid creating unnecessary chaos** to the system and those individuals, families, and communities served by Michigan's public mental health system in any system design effort.

7. While using an overarching design to guide the effort**, implement components in practical and achievable segments - sequentially and, at times, parallel efforts**, refining each component as they are designed, implemented, and evaluated.

8. The design should be **flexible enough to apply in urban, suburban, rural and frontier communities** and mental health organizations working in those communities.

9. **Foster real primary and mental healthcare integration and coordination via clinical integration (where the client/patient receives services and supports) and build structural and financial supports**

10**.** Ensure **adequate and sustainable funding** to the public system to ensure that it is sufficiently strong to meet the growing demand and expectations for access to mental health services by all Michiganders. This growing demand centers around the full range of mental health needs including: ready access to crisis services for all the Michiganders, fostering the ability of those with a range of mental health needs to live a full and productive life, treatment of substance use disorder (with opioid treatment being the highest profile SUD treatment currently), prevention of incarceration, prevention of homelessness, and the provision of services to children with mental health needs and their families.

H. Proposed design elements for Michigan's public mental health system

A number of components – some of which already are being implemented in Michigan and some of which have been discussed by CMHA members and allies for years – offer sound components for any efforts to redesign Michigan's public mental health system. These components/building blocks are outlined below.

Overarching design: A community-based publicly-sponsored system that clinically and structurally integrates behavioral and physical health care to serve Michiganders with mental illness, emotional disturbance, intellectual/developmental disabilities, and/or substance use disorders. **The system design must be built upon and foster the principles listed above:**

- Start with what is best for those served by the system
- Followed by the best service/supports/clinical practices and structures to achieve what is best for those served
- Followed by (and not led by) the design of the financing, operations, and governance infrastructure that supports the service/supports/clinical practices and structures and what is best for those served

This overarching design should be pursued through a **Public Reverse Integration Model**: A healthcare integration model:

- Centered around whole person care
- Using, as a fundamental design feature, healthcare integration at the provider/clinical level
- Led by the public behavioral health care system
- With the aim of serving the needs of persons with both complex mental health and related needs as well as those of the broader public

Design elements:

1. Publicly sponsored, governed, and operated Special Needs Plan (SNP) centered around persons with mental health needs: A Behavioral Health Special Needs Plan (BHSNP) would involve the public system – CMHs and Regional Entities - managing, for **a defined group of enrollees with complex behavioral health and/or intellectual and developmental disabilities and related needs** (based on diagnoses, functional level, or other variables):

- the **full behavioral/IDD health** and **full physical health Medicaid benefit** for a carved-out/well defined population (known, in federal parlance, as a Special Needs Plan)

or

- the **full behavioral health** and **only the physical health needs that fall within the definition of ambulatory care** (known, in federal parlance as Prepaid Ambulatory Health Plans (PAHP) for a carved-out/well defined population)

2. Certified Community Behavioral Health Centers (CCBHC): The success of the **current eight (8) CCBHC sites**, the **recently announced expansion to eighteen (18) CCBHC sites** within Michigan, and the **impending designation of Michigan as a CCBHC state** provide an opportunity to use CCBHC funds and concepts to redesign the system – built around the public system.

CCBHCs ensure that a wide range of integrated whole-person behavioral health services are provided to the full community – regardless of payer, ability to pay, or complexity of mental health needs. Because CCBHCs and their physical health counterparts, Federally Qualified Health Plans (FQHCs), are built around common principles of access and quality, Michigan's CCBHCs are able build strong relationships with the FQHCs in their communities, with these relationships providing access (portals/'on and off ramps") for clients/patients to care across these two systems. CCBHCs, like the two other models, below, are built around healthcare integration at the client/patient level – with the financing, structures, and practices designed around that aim.

A short description of CCHBCs can be found here. The report outlining the impact of the CCBHC initiative, across the country is described can be found here.

3. Behavioral Health Homes and /Opioid Health Homes: Build on Michigan's success in the design and implementation of both behavioral health homes and opioid health homes as part of the system redesign effort – especially as the implementation of these Health Homes are expanding to other regions of the state. As do CCBHCs, health homes ensure whole person care for persons with complex health needs (in these cases, persons with complex behavioral healthcare and opioid treatment needs) via attention to the social determinants of health and real-time and aggressively pursued linking and care coordination. As with CCBHCs, behavioral and opioid health homes are built around healthcare integration at the client/patient level – with the financing, structures, and practices then designed around that aim.

Several reports that underscore the cost savings resulting from Michigan's Behavioral Health Homes can be found here.

4. Clinical integration initiatives led by the public behavioral healthcare system: Michigan's public mental health system - the state's CMHs, Regional Entities, and providers in the CMH or Regional Entity networks- have years of experience in designing and making operational **hundreds of healthcare integration efforts in nearly every Michigan community**. As with CCBHCs and behavioral and opioid health homes, these integration efforts are built around healthcare integration at the client/patient level – with the financing, structures, and practices then designed around that aim.

These efforts included the co-location of primary care providers in mental health settings, co-location of mental health providers in primary care settings, the co-location of mental health practitioners in hospital emergency departments, the linking of electronic health records, high-utilizer care management initiatives, and many others. These efforts must continue to be included in any system design for Michigan's public mental health system.

The most recent study of these healthcare integration initiatives can be found here.

5. State Innovation Model (SIM) initiatives: Through the State Innovation Model (SIM) Initiative, a number of Michigan CMHs and their community partners have been pioneering regionally driven health care reforms, in **five (5) Michigan regions**, from which system design elements can be drawn. The SIM initiative is built around three main umbrellas: Population Health, Care Delivery, and Technology.

- The Population Health component has at its foundation community health innovation regions, or CHIRs (pronounced "shires"), which are intended to build community capacity to drive improvements in population health.
- The Care Delivery component encompasses a patient-centered medical home (PCMH) initiative and the promotion of alternative payment models
- The Technology component is where the state is leveraging its statewide infrastructure and related health information exchange initiatives to enable and support advances in population health and payment and care delivery strategies.

More on Michigan's SIM initiative can be found at Michigan's SIM website and in Michigan's SIM summary.

6. MI Health Link: MI Health Link is a multi-year demonstration project designed to better integrate the care of persons who have both Medicare and Medicaid coverage in four (4) Michigan regions. While some point to the success of this effort, on some dimensions, others – especially advocates for persons with mental health needs – point out the fundamental and practice weaknesses of MI Health Link. **Much can be drawn from the analysis of the MI Health Link design flaws and strengths.**

A critique of the MI Health Link demonstration project and the lessons learned that can be applied in any system redesign effort can be found here.

[i] The terms "mental health system" and "behavioral healthcare system" are used, in this paper, to describe the system that serves persons with mental illness, emotional disturbance, intellectual/developmental disabilities, and/or substance use disorders.

When the terms "public mental health system" of "public behavioral health system" they mean Michigan's CMHs, Regional Entities (PIHPs), and the private providers in the provider networks of the CMHs and Regional Entities/PIHPs.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

MEMORANDUM

DATE: June 11, 2020

TO: Prepaid Inpatient Health Plans and Community Mental Health Services Programs

FROM: Jon Villasurda, MPH, State Assistant Administrator, BHDDA/MDHHS

SUBJECT: Michigan Crisis and Access Line (MiCAL): Overview and Next Steps

Overview

Effective April 26, 2020, Michigan Public Act 12 of 2020 created a new behavioral health integrated crisis and access system called MiCAL.[1] The law codifies MiCAL into Michigan's Mental Health Code at MCL 330.1165, requiring MDHHS to contract with a vendor to develop and operate a command center that provides crisis line services and leverage omni-channel communication methods to support persons in crisis and facilitate coordinated access to care to all essential services cited in the Michigan Mental Health Code at MCL 330.1206.[2] MiCAL will be available for anyone in the state in need of behavioral health and/or crisis response services.

MiCAL will be staffed 24 hours a day, seven days a week. MiCAL staff will provide Michiganders with crisis and warm line services, informational resources, and facilitated coordination with local systems of care (e.g., Community Mental Health Services Programs [CMHSPs], Prepaid Inpatient Health Plans [PIHPs], and other applicable entities). In addition, MiCAL will integrate with treatment registries (e.g., psychiatric beds, substance use disorder services, crisis residential services) as required by Public Act 658 of 2018. To support the work, MiCAL will utilize a customer relationship management (CRM) database infrastructure to track, monitor, assign, follow up, and report on access line operations. The CRM will also be leveraged to bolster internal BHDDA operations. MDHHS will maintain operational oversight of MiCAL and work with PIHPs, CMHSPs, and other entities to ensure it is optimally executed.

There are two fundamental components of MiCAL:

1) Establishment of a centralized crisis command center. This center shall provide crisis line services and leverage omni-channel communication methods to support persons in immediate crisis and facilitate coordinated access to care to all essential services cited in the Michigan Mental Health Code at MCL 330.1206. These services include but are not limited to the following: suicide prevention, behavioral health supports and services, substance use disorder treatment, rehabilitation services, and other services as required and appropriate. Additionally, the center must coordinate access to crisis and other pertinent services with Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs).

2) Development of a Customer Relationship Management (CRM) database. BHDDA is developing a CRM solution to: 1) assist in its oversight of MiCAL operations and the command center cited

[1] Michigan Legislature. (2020). Public Act 12 of 2020. Retrieved from: http://www.legislature.mi.gov/documents/2019-2020/publicact/pdf/2020-PA-0012.pdf.
[2] Michigan Legislature (2020). Michigan Compiled Law at 330.1165. Retrieved from: http://www.legislature.mi.gov/(S(nma2a4iu0gx0rcjdf4gd20iu))/mileg.aspx?page=getObject&objectName=mcl-330-1165.

above, and 2) efficiently manage BHDDA business processes and workflows that are pertinent to administering Michigan's public behavioral health system with MDHHS' PIHP and CMHSP partners (e.g., customer service, contract management, program applications, CMHSP certification, site reviews, etc.). MDHHS, PIHPs, and CMHSPs will have access to the CRM database.

It is the vision of MDHHS to ensure MiCAL is predicated in crisis system best practices and evidence, but more importantly to be of value to the public behavioral health system and the Michiganders we collectively serve. To this end, MiCAL will incorporate values outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care. These values and the centralization of command center operations have shown to produce efficiencies and access improvements in other states where implemented.

MDHHS is working with its partners in the Michigan Department of Technology, Management, and Budget (DTMB) to develop and implement MiCAL. That said, MDHHS will be engaging its PIHPs and CMHSPs soon to assist in the creation of MiCAL protocols. PIHP and CMHSP participation in the development of MiCAL processes is critical for optimal care coordination and efficient program operations. MDHHS will also modify applicable administrative rules or contract language where necessary to ensure optimal integration of MiCAL into existing processes.

Next Steps

In the coming weeks, MDHHS will work with the Community Mental Health Association of Michigan (CMHAM) to engage PIHPs and CMHSPs in the development of MiCAL. This will include the establishment of at least two workgroups: 1) an MiCAL Design Workgroup to create operational protocols for the crisis/referral components, and 2) a BHDDA CRM Workgroup to provide advisement to the development of the internal BHDDA operational components of the CRM.

Prospective High-Level Timeline (subject to change)

- MiCAL Operational Timeline
  - June 2020: Staffing RFP for MiCAL is issued.
  - June/July 2020: Broad CMHSP/PIHP engagement through emails and listening sessions.
  - August/September 2020: CMHSP/PIHP representatives recruited for the Design Workgroup.
  - September 30, 2020: MiCAL vendor contract begins.
  - October 2020: Pilot region selected for phase 1 rollout.
  - October-December 2020: MiCAL Design Workgroup commences.
  - January-March 2021: Pilot region preparation.
  - March 2021: MiCAL pilot region operational.
  - March 2021-March 2022: Statewide expansion in regional phases.

- BHDDA CRM Timeline:
  - July/August 2020: CMHSP/PIHP representatives recruited for the BHDDA CRM Workgroup.
  - August 2020: BHDDA CRM Workgroup commences.
  - September 30, 2020: First phase of CRM operational.
  - March 2021: BHDDA CRM fully operational.

MDHHS is excited to work with its stakeholders to execute the MiCAL law to innovatively transform Michigan's crisis and access system for the ultimate benefit of Michiganders with behavioral health needs. For any questions, comments, or concerns, please feel free to reach out to the MiCAL Team at MDHHS-BHDDA-MiCAL@michigan.gov.

June 1, 2020

The Hon. Gretchen Whitmer, Governor
State of Michigan
PO Box 30013
Lansing, MI 48909

The Hon. Chris Kolb, Budget Director
State of Michigan
KolbC1@michigan.gov

Dear Governor Whitmer and Budget Director Kolb:

We write about the difficult budget situation Michigan is experiencing. Our hope is that Congress provides states with funding that can be used to fill budget holes, and are encouraging our national organizations to advocate for the additional funding. We also know there are no guarantees that the funding will be given in a way that addresses our concerns.

Should Michigan have to make major cuts, we agree with former Budget Directors Emerson & Walsh (Bridge Magazine, May 13) that, "Rather than arbitrary or 'across the board' cuts, however, services should first be prioritized. The health, safety and security of the public should be at the top. We…should also review our social safety net, understand its failings and strengthen it where necessary."

The state must prioritize health care and mental health care in making near-term budget decisions. This means preserving Medicaid-funded services and meeting critical General Fund needs. The state must also learn lessons that the pandemic -- imposing grave collective trauma on our state – has taught us, and the state must address the structural shortcomings in our health care and mental health systems in the long-run.

The COVID-19 pandemic has necessarily revealed the cracks in both our privately funded and publicly funded health care and behavioral health care systems. The crisis has demonstrated that we lack a health care system that works for all. Michigan stands out as being the highest state in the country for Twitter references about depression and anxiety (MLive, May 12); Pine Rest Christian Mental Health Services has reported in a new study that the pandemic could yield a 32% increase in Michigan suicides (MLive, April 27); nearly half of Americans report the coronavirus situation is harming their mental health (Washington Post, May 4); a March 27-29 national poll of 1,062 individuals by McKinsey & Company found high levels of depression/anxiety distress (McKinsey report, 2020); a federal mental health hotline experienced more than a 1,000% increase in April 2020 calls compared to April '19 (MLive, May 16); children and youth are cut off from mental health care through schools (Detroit Free Press, May 17); the World Health Organization says there is a high prevalence of mental distress in countries across the globe due to the pandemic (CNN, May 14); and the US Census Bureau reports a third of Americans are showing signs of clinical anxiety or depression (Washington Post, May 26).

With more and more people losing income and employment-based health insurance, Medicaid is the last lifeline for health care. Medicaid is an entitlement program, with a promise of certain

coverages to individuals who meet eligibility requirements and apply for the program. We must continue to meet the demands of that commitment. Thus, we respectfully urge that Medicaid health care be protected to the maximum degree possible.

One particular Medicaid requirement that needs attention – something our organizations have worked on for years – is the protection Michigan has had since 2004 on access to Medicaid prescriptions for persons experiencing mental illness, epilepsy, HIV-AIDs, conditions requiring organ transplant and (to a partial degree) cancer. This has allowed vulnerable citizens with serious conditions to escape the dangerous practices of prior authorization, step therapy and therapeutic substitution. A legislatively required Michigan Department of Health and Human Services (MDHHS) psychotropic medication workgroup recommended in February '19 that the state continue to carve out Medicaid psychotropic medications (including anti-seizure and substance use drugs) from Medicaid Health Plans (MHPs). Attempting to save a modest amount of money here, per department data, will cost more in the long run because of not matching the right medications to vulnerable consumers' circumstances.

In keeping with the values of equity in healthcare access for all, we call to your attention some vital needs that can only be addressed by state General Fund (GF) dollars:

1. Non-Medicaid Funding for Community Mental Health Services Providers (CMHSPs): The amount allocated for FY-20 ($125 million) is already lower than needed. The well-being of our constituents cannot bear any cuts to this line and reductions would be catastrophic. The Flinn Foundation, Detroit, reported in 2019 a 10% reduction in CMH mental illness clients over a five-year period, during which budget cuts occurred. Individuals so affected have no other service and support alternatives. Further cuts to this line will add more to the rolls of those dropped from service.

2. Community substance use disorder prevention, education & treatment: Much, if not all, of this $109 million line is for serving those not covered by Medicaid. Here, too, cuts would be catastrophic. (Note: Per March 26 and May 1 reports from Metro Times and MLive, Michigan beer and alcohol sales showed considerable March spikes, and the Detroit Free Press April 2 reported that national alcohol sales spiked 55% for the week ending March 21 compared to 12 months prior.)

3. State psychiatric hospitals and forensic mental health services: 75% of this budget section is supported by GF. We cannot do without the Forensic Center, given the great number of people with mental health-related conditions who encounter the justice system. And regarding our state psychiatric hospitals, only one is for children (which suggests it must remain), and the three we have left for adults leave us with one of the worst per capita adult bed rates in the nation (per the Treatment Advocacy Center, Virginia). State hospital beds are the only source at this time of intermediate- and longer-term stays. Private psychiatric hospitals and psychiatric beds in community hospitals (both of which can receive Medicaid reimbursement) offer an average length of stay that is less than a week, which is too short to appropriately reduce symptoms for many. (Note: Based on 2015-19 death reports to LARA from private psychiatric

hospitals and psychiatric units in community hospitals, over 50 Michigan residents during this period died, often from suicide, within days of discharge from such hospitals.) Additionally, we do not have near enough community resources at present to provide the levels of service intensity needed by those who could leave state hospitals if such resources were more plentiful. Further, our system lacks consistency in making community services that presently exist more available and accessible to promote recovery and avoid re-hospitalization. These issues have grown more pronounced in the pandemic; now is not the time for service reductions.

We also respectfully suggest that the current environment represents opportunities for long-term planning toward new health care strategies. By this, we don't mean the proposed MDHHS "behavioral health transformation" SIPs (Specialty Integrated Plans), which have not to date gained support from the mental health community.

In planning for the future, here are some of the key items we have an opportunity to address:

1. We must better coordinate behavioral and non-behavioral health care services at the points which they are delivered. This is not at all guaranteed by the "financial integration" proposals from MDHHS. It is guaranteed by recognizing that many of us operate within multiple environments. These include public and private health care, hospitals, schools, workforce, justice system settings, nursing homes, assisted living, homeless shelters and more.

2. Several of the environments above are congregate settings that have proven deadly in the world of COVID-19, which may be with us for a long time. We need to help people leave a number of these settings when it is safe and appropriate to do so, with adequate compensatory service available in communities. Jails, prisons, and juvenile justice facilities are filled with mental health-related conditions, some of which do not necessarily warrant incarceration/detention. (As of early May, Michigan was one of the top two sates nationally for prison COVID deaths – Detroit Free Press, May 9.) Mental health-related conditions also dominate the homeless population, and Michigan Coalition Against Homelessness has said, "Our shelter and outreach staff…don't have the space, medical and sanitation equipment, funding or other resources to adequately provide for individuals seeking assistance" (GONGWER, April 1). Protective, intensive psychiatric care of reasonable length is presently available only through old and crowded state hospitals. (As of early April, there were 100 COVID-19 cases in these facilities – MLive, April 9.) And nursing home problems have exploded (at least 23% of the state's COVID deaths – GONGWER, May 27) while many residents of these facilities would prefer to be in their own home if available MIChoice waiver slots were used and funding of the program expanded.

3. If we are serious about health care integration, we must do something to make behavioral health parity real, including better monitoring and enforcement by our state of federal mental health parity law. A McKinsey analysis of insurance claims found 23% of the US insured population have behavioral health diagnoses, yet only 7% of national health care dollars are spent on behavioral services (McKinsey report, 2020).

4. We need to comprehensively evaluate the transparency, accountability, and performance of major publicly funded health care players like MHPs, CMHSPs and Prepaid Inpatient Health Plans (PIHPs). We should not automatically be tied to any of these systems.

5. We need to significantly improve person-centered planning, self-determination, and family-driven/youth-guided planning – across the entire spectrum of publicly funded health care. Services and supports are not and cannot be effective if recipients and their families are shut out of advocating for what they want and prefer.

6. Publicly funded health care must have independent case management and independent rights protection, grievances and appeals. The state's new CMH mediation law (PA 55 of 2020) is a step in the right direction, but there is still much to be done so that health care managers and providers are not judge and jury of consumer complaints. Michigan must move toward the implementation of case management that is truly "conflict free" and that contains the elements that are required by the federal government. This has not happened.

7. We need to protect the support mechanisms that have been developed over the years for persons with developmental or intellectual disabilities. At the same time, we must strengthen those same types of supports for adults experiencing mental illness and children and youth with emotional disturbance.

8. We must have a much higher degree of uniformity in service delivery and in the availability of services across the state in publicly funded health care. It is unacceptable that people in different parts of the state are not given the same opportunities and services because of where they happen to live, who their service managers are, and which providers happen to be in those managers' networks.

We recognize that the pandemic has brought forth myriad issues and challenges that necessitate consideration of human service budget cuts. At the same time, we cannot forget that the same individuals who have required, but not necessarily received, access to an array of services and supports pre-pandemic continue to require access to those services and supports, perhaps with even greater intensity. Although the world has significantly changed since the first case of COVID-19 was diagnosed in our state, for individuals with mental health-related conditions, positive change has not yet been forthcoming. The time is now to begin developing such change.

Thank you for your thoughtful attention to the issues that have been raised in this correspondence. We would be pleased to further discuss them with you at your convenience.

Sincerely,

Sherri Boyd, The Arc-Michigan

Jane Shank, Assn. for Children's Mental Health

Brianna Romines, Epilepsy Foundation of Mich.

Marianne Huff, Mental Health Assn. in Mich.

Norm DeLisle, Mich. Disability Rights Coalition

Patricia Streeter, J.D., Mich. Partners in Crisis

Michelle Roberts, Mich. Protection & Advocacy Service

cc: Meghan Groen
The Hon. Jim Stamas
The Hon. Shane Hernandez
The Hon. Curtis Hertel
The Hon. Jon Hoadley
The Hon. Members of the House & Senate DHHS Appropriations Subcommittees
Robert Gordon
Farah Hanley
Elizabeth Hertel

INTERGOVERNMENTAL CONTRACT

This Contract (this "Contract") is made as of this ___day of _____, 2020, by and among Southwest Michigan Behavioral Health Regional Entity ("SWMBH"), Barry County, Berrien County, Branch County, Cass County, Calhoun County, Kalamazoo County, St. Joseph County and Van Buren County (individually referred to as the "County," and collectively referred to as the "Counties").

RECITALS

SWMBH is a community mental health regional entity formed under the Mental Health Code, MCL 330.1204b.

The Counties are located in a region designated by the Michigan Department of Health and Human Services ("MDHHS") as Region 4 under MDHHS's restructuring of PIHPs in Michigan.

Under 2012 PA 500 and 2012 PA 501, the coordination of the provision of substance use disorder services were transferred from prior existing coordinating agencies to community mental health entities designated by MDHHS to represent a region of community mental health authorities, community mental health organizations, community mental health services programs or county community mental health agencies, as defined under MCL 300.1100a(22).

SWMBH represents eight (8) community mental health authorities in Region 4, and is a MDHHS-designated community mental health entity to coordinate the provision of substance use disorder services in Region 4.

SWMBH, as a MDHHS-designated community mental health entity, is required, under MCL 330.1287(5) to establish a substance use disorder oversight policy board (SUD Oversight Policy Board) through a contractual agreement, under appropriate law, between SWMBH and each of the Counties in Region 4.

SWMBH and the Counties are authorized to enter into contracts under 1951 PA 35, Intergovernmental Contracts Between Municipal Corporations, MCL 124.1 et. seq.

SWMBH and the Counties desire to enter into this Contract, under 1951 PA 35, to establish a SUD Oversight Policy Board.

NOW, THEREFORE, in furtherance of the foregoing and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

ARTICLE I

PURPOSE

Section 1.1 PURPOSE. The purpose of this Contract is to set forth the terms and conditions for the establishment of a SUD Oversight Policy Board pursuant to MCL 330.1287(5).

ARTICLE II

SUD POLICY BOARD

Section 2.1 FUNCTIONS AND RESPONSIBILITIES. The SUD Oversight Policy Board shall have the following functions and responsibilities:

2.1.1 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;

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

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

Any other function or responsibilities consistent with P.A. 500 330.1287 (5) (d) and as requested by the Community Mental Health Entities (CMHE)

Section 2.2 APPOINTMENT/COMPOSITION. The Board of Commissioners of each of the Counties shall appoint up to two (2) members of the SUD Oversight Policy Board. The 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 its County.

Section 2.3 VACANCIES. A vacancy on the SUD Oversight Policy Board shall be filled by the County that originally filled the vacated position.

Section 2.4 REMOVAL. The County that appointed a SUD Oversight Policy Board member may remove its appointee at any time. The SUD Oversight Policy Board is responsible for informing the relevant County of any lack of participation or attendance by the County's appointed SUD Oversight Policy Board member. Attendance records shall be provided to County Commissions at least twice annually.

Section 2.5 ETHICS AND CONFLICTS OF INTEREST. The SUD Oversight Policy Board shall adhere to all conflict of interest and ethics laws applicable to public officers and public servants, serving as members of the SUD Oversight Policy Board.

Section 2.6 **COMPLIANCE WITH LAWS.** The SUD Oversight Policy Board shall fully comply with all applicable laws, regulations and rules, 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.

Section 2.7 **BYLAWS.** The SUD Oversight Policy Board shall maintain and periodically review its Bylaws.

Section 2.8 Bylaws may be amended by the SUD Oversight Policy Board as provided in those Bylaws. The parties hereto agree that said Bylaws are not subject to SWMBH's approval.

ARTICLE III

SWMBH

Section 3.1 **FUNDING.** SWMBH shall ensure that PA2 funding dedicated to substance use disorder services shall be retained for substance use disorder services and not diverted to fund services that are not for substance use disorders. MCL 330.1287(2).

ARTICLE IV

TERM AND TERMINATION

Section 4.1 **TERM.** The Term of this Contract shall commence on January 1, 2021, and continue for a term of three (3) years ending December 31, 2024, unless terminated at an earlier date as provided in Section 4.2.

Section 4.2.1 TERMINATION. Any party may terminate their participation in this Contract at any time for any or no reason by giving all other parties thirty (30) days written notice of the termination. Any notice of termination of this Contract shall not relieve either party of its obligations incurred prior to the effective date of such termination.

Section 4.2.2 TERMINATION of CMHE status. This contract shall automatically and simultaneously terminate in the event MDHHS withdraws its authorization of SWMBH as CMHE for PA2.

ARTICLE V

LIABILITY

Section 5.1 **LIABILITY/RESPONSIBILITY.** No party shall be responsible for the acts or omissions of the other party or the employees, agents or servants of any other party, whether acting separately or jointly with the implementation of this Contract. Each party shall have the sole nontransferable responsibility for its own acts or omissions under this Contract.

The parties shall only be bound and obligated under this Contract as expressly agreed to by each party and no party may otherwise obligate any other party.

ARTICLE VI

MISCELLANEOUS

Section 6.1 AMENDMENTS. This Contract shall not be modified or amended except by a written document signed by all parties hereto.

Section 6.2 ASSIGNMENT. No party may assign its respective rights, duties or obligations under this Contract.

Section 6.3 NOTICES. All notices or other communications authorized or required under this Contract shall be given in writing, either by personal delivery or certified mail (return receipt requested) and shall be deemed to have been given on the date of personal delivery or the date of the return receipt of certified mail. Notices shall be delivered to the Executive Officer of SWMBH and the County Administrator of each County in the (8) eight county region.

Section 6.4 ENTIRE AGREEMENT. This Contract shall embody the entire agreement and understanding between the parties hereto with respect to the subject matter hereof. There are no other agreements or understandings, oral or written, between the parties with respect to the subject matter hereof and this Contract supersedes all previous negotiations, commitments and writings with respect to the subject matter hereof.

Section 6.5 GOVERNING LAW. This Contract is made pursuant to, and shall be governed by, construed, enforced and interpreted in accordance with, the laws and decisions of the State of Michigan.

Section 6.6 BENEFIT OF THE AGREEMENT. The provisions of this Contract shall not inure to the benefit of, or be enforceable by, any person or entity other than the parties and any permitted successor or assign. No other person shall have the right to enforce any of the provisions contained in this Contract including, without limitation, any employees, contractors or their representatives.

Section 6.7 ENFORCEABILITY AND SEVERABILITY. In the event any provision of this Contract or portion thereof is found to be wholly or partially invalid, illegal or unenforceable in any judicial proceeding, such provision shall be deemed to be modified or restricted to the extent and in the manner necessary to render the same valid and enforceable, or shall be deemed excised from this Contract, as the case may require. This Contract shall be construed and enforced to the maximum extent permitted by law, as if such provision had been originally incorporated herein as so modified or restricted, or as if such provision had not been originally incorporated herein, as the case may be.

Section 6.8 CONSTRUCTION. The headings of the sections and paragraphs contained in this Contract are for convenience and reference purposes only and shall not be used in the construction or interpretation of this Contract.

Section 6.9 **COUNTERPARTS.** This Contract may be executed in one or more counterparts, each of which shall be considered an original, but together shall constitute one and the same agreement.

Section 6.10 **EXPENSES.** Except as is set forth herein or otherwise agreed in writing by the parties, each party shall pay its own costs, fees and expenses of negotiating and consummating this Contract, the actions and agreements contemplated herein and all prior negotiations, including legal and other professional fees.

Section 6.11 **REMEDIES CUMULATIVE.** All rights, remedies and benefits provided to the parties hereunder shall be cumulative, and shall not be exclusive of any such rights, remedies and benefits or of any other rights, remedies and benefits provided by law. All such rights and remedies may be exercised singly or concurrently on one or more occasions.

Section 6.12 **BINDING EFFECT.** This Contract shall be binding upon the successors and permitted assigns of the parties.

Section 6.13 **NO WAIVER OF GOVERNMENTAL IMMUNITY.** The parties agree that no provision of this Contract is intended, nor shall it be construed, as a waiver by any party of any governmental immunity or exemption provided under the Mental Health Code or other applicable law.

ARTICLE VII

CERTIFICATION OF AUTHORITY TO SIGN THIS CONTRACT

The persons signing this Contract on behalf of the parties hereto certify by said signatures that they are duly authorized to sign this Contract on behalf of said parties, and that this Contract has been authorized by said parties pursuant to formal resolution(s) of the appropriate governing body(ies), copies of which shall be provided to SWMBH.

IN WITNESS WHEREOF, the parties hereto have entered into, executed and delivered this Contract as of the dates noted below.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH REGIONAL ENTITY

By: _____ Date: _____
Its: _____

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: _____

IA 7-1-20
MJ

2020-2022 Strategic Imperative Descriptions & Priorities

Reviewed and Approved by SWMBH Board 5-8-20

- **1) Public Policy Legislative Education**
    - Inform legislators of Michigan statutory changes necessary for publicly led Specialty Integrated Plan
    - Inform executive branch of Michigan regulatory changes necessary for publicly led Specialty Integrated Plan
    - Inform legislators of potential negative impacts of Reforms on CMHSPs.
    - Inform Legislators of key Behavioral Health and SUD issues
    - Hold public policy & legislative education events

- **2) Uniformity of Benefits**
    - Ensure that persons served receive objectively appropriate services across all specialty populations
    - Automate Level of Care Guidelines and Utilization Management processes

    - **Use Level of Care Guidelines (LOCG) for service authorization consistency**
        - Consistent use, attached to Assessment Tool scores
        - Embedded in EMR and MCIS
        - Update LOCG Tables and business processes as necessary and indicated

    - **Consistent Use of Assessment Tools**
        - CMHSPs and Providers submit scores in detail as discrete data fields
        - Real-time, accessible analytics and reporting
        - Identification of outliers and trends for over- and under-utilization monitoring

- **3) Integrated Health Care**
    - Michigan Health Endowment Fund Grant success
    - Extend MI Health Link with Integrated Care Organizations beyond 12/31/2020
    - Multi-agency Performance Improvement Projects
    - Improve CMHSP and PIHP communications with primary physical health providers
    - Improve SWMBH communications with Medicaid Health Plans

- **4) Revenue Maximization/Diversification**
    - Assure capture of Performance Bonus Incentive Pool funds
    - Continue assertive efforts internally and externally to maximize regional capitation funds
    - Assess SWMBH opportunities for Grants, alternative funding streams, and expanded or new business lines
    - Assess CMHSP opportunities for Grants, alternative funding streams, and expanded or new business lines, upon request

    - **Cost reductions in Medical Loss Ratio and Administrative Loss Ratio**
        - Support CMHSP cost reduction strategies, upon request

- **5) Improve Healthcare Information Exchange, Analytics and Business Intelligence**
    - Improve Health Information Exchange systems
    - Improve healthcare data analytics capabilities
    - Regional individual access to industry standard management information tools

- **6) Managed Care Functional Review**
    - Build consistency, replicability and scalability for all managed care functions
- **7) Proof of Value and Outcomes**
    - Create, monitor and publish proofs of clinical and administrative performance
    - Maintain NCQA MBHO Accreditation
    - Consider other NCQA Accreditations and/or Certifications
    - Assure Program Integrity

Southwest Michigan Behavioral Health Regional Strategic Business Plan

2020 - 2023

Prepared by Bradley P. Casemore, CEO
WITH MANY ABLE OTHERS

Southwest Michigan Behavioral Health Regional Strategic Business Plan

Fiscal and Calendar Years 2020 – 2023

DRAFT CONFIDENTIAL version 6/18/20

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Executive Summary

Healthcare and behavioral healthcare are at an evolutionary disrupted crossroad. Federal and state policy, politics and fiscal strains mandate significant modifications to healthcare service eligibility, payer responsibilities, and individual responsibility. Michigan's public behavioral health system has received deep and broad criticism from Advocacy Group Representatives, the legislature and the public, largely without basis. Systemic flaws emanating from legacy federal and state policy, statutes and regulations go largely unaddressed by legislative and executive branch leaders who prefer to obsess on system symptoms rather than fundamental causes.

While there was an overt plan from the Whitmer Administration's MDHHS to do away with PIHPs as of September 30, 2022 the COVID-19 pandemic has further stressed available subject matter experts and resources. MDHHS has said the pursuit of major public behavioral health system transformation to Specialty Integrated Plans (SIPs). Some in the public health system rejoice assuming *status quo* or minor modifications in state policy. Others see this development as more threatening believing the abandonment of SIPs especially the publicly led Model encouraged to CMHAM by MDHHS Director Gordon in January 2020 (see Attachment A) combined with a dire Michigan General Fund deficit position for the foreseeable future creates a widened opening for Medicaid Health Plans and their advocates in the legislature to simply move to a straight carve-in by October 1, 2023.

Regardless the reader's view on this dichotomous path prediction we owe it to our stakeholders to discuss, deliberate and decide the multi-year strategic plan for our Regional Entity and Participant CMHs. Due to the pandemic we are several months behind our planned schedule and have many more current variables to consider as well as a less than clear future state. Thus, active engagement, introspection and candor amongst all participating leaders is required. Conversations will fall into two main categories: What development needs to our CMHs must be successful in the future and how does SWMBH support this; and What role, if any, do the Participant CMHs see for SWMBH in the event the PIHPs are terminated or consolidated?

Key Facts and Recommendations found herein include but are not limited to the following:

- The carve-in remains a material threat.

- Regionalism is less in favor than ever; state-wide coverage and competence is almost a keystone for future success.
- Significant interaction amongst the Regional Entity Participants including direct contact from SWMBH CEO to CMH Boards.
- PIHP staff are dear resources under performance pressures, undeserved external criticism and increasing opportunities elsewhere; they must be retained.
- SWMBH our region and our CMHs have developed and maintained performance and reputations amongst related thought leaders superior to the majority of PIHPs and CMHs.
- SWMBH has significant latitude for new and expanded roles under the Michigan Mental Health Code 330.1204(b) and its Bylaws.
- SWMBH's financial situation has improved greatly with the MDHHS acknowledgement of under-funding and the revised fiscal year 2020 capitation rates.
- CMH leaders and Boards need adequate time without SWMBH present to openly deliberate many of these existential questions. Resourcing with knowledgeable external experts is recommended.

We invite the reader to become and stay actively involved and constructive in these discussions. After all, the eight CMHs "own" SWMBH and only they can significantly modify our course from the current.

Why the Need for Planning?

To some the previously announced expiration date for PIHPs of October 2022 seems a long way away and the likelihood of major system change seems remote or even improbable. While we can discuss, differ and perhaps achieve consensus on these core predictions we must not be dissuaded from collaborative regional exploration of two key questions:

A. What is the likely future state for CMHSPs after implementation of Specialty Integrated Plans (SIPs) or a carve-in are implemented and what role, if any does the region want SWMBH to play in the identification and implementation of opportunistic CMHSP changes and transitions?

B. What is the future state for the Regional Entity SWMBH after implementation of SIPs or a carve in for opportunities and value to the Participant CMHSPs?

Some major system reforms will emerge in the short-, medium- and long-terms. As the originators of the Regional Entity SWMBH only the Participant CMHs and ultimately the Regional Entity Board can speak definitively on the questions above.

Thus, the urgency of pondering these questions. While it is problematic to make the wrong decisions, it is equally problematic to make the right decisions too slowly. Thorough

deliberations take time and effort. All transformations necessary at both CMHSPs and SWMBH are complex with significant need for attention and resources.

This does not mean that incrementalism is discarded. There are certain steps and milestones that maintain evolutionary pace and positive directionality without prohibiting future modifications in response to environmental market changes and/or internal review and resourcing revisions.

SWMBH has assembled an unparalleled group of staff who are subject matter and stylistic experts with lives, homes and families. Soon current Health Plans, new market entry Health Plans and other opportunistic agencies will begin to actively poach these experts, if they have not yet begun to do so already. Absent a reasonably clear and public Board endorsement of a future beyond 10/1/22 there is little reason for SWMBH staff to remain with us past an increasingly near-term milestone date. As staff resources diminish so does the probability of realistic pursuit of future options.

We have collectively developed significantly resourced and sophisticated healthcare information exchange and healthcare data analytics, management information-business intelligence, National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organization (MBHO) Accreditation and other differentiating characteristics from most Regional Entities/PIHPs. Maintenance and development of these assets are significant and many of these vendor resources have upcoming renewal and resourcing considerations. Future success is not possible without these being leading edge.

New enterprises, business models, alliances, opportunities, threats and financing are certain. Design, development and deployment of related changes require commitment and persistence as well as deep and broad communications. Most especially, they take time.

The way forward in the starkest terms is the proverbial fork in the road: downsize the Regional Entity throughout fiscal years 2021 and 2022 and shut out the lights asap after 10/1/22 or 10/1/23 *or* support and resource sincere exploration of the following:

A. What is the likely future state for CMHSPs after implementation of Specialty Integrated Plans, a straight carve-in or hybrid deleting or diminishing PIHPs and what role, if any does the region want SWMBH to play in the exploration of CMH threats & opportunities, changes and transitions?

B. What is the future state for the Regional Entity SWMBH in opportunities and value to the Participant CMHSPs, and what role, if any does the region want SWMBH to play in the exploration of changes and transitions?

SWMBH CEO is now posing these questions to the Participant Members as embodied in the Board and CMH CEOs for affirmative or negative replies and/or revisions. Strength and stamina are required of all.

SWMBH is a Regional Entity created under the Michigan Mental Health Code 330.1204(b), attached to this document. ***This section explicitly grants a wide range of powers*** *including "The power, privilege, or authority that the participating community mental health services share in common and may exercise separately under this Act, whether or not that power, privilege, or authority is specified in the bylaws establishing the regional entity." And "The power to accept funds, grants, gifts, or services from the federal government or federal agency, the state or a state department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the regional entity, and from a private or civic source." And "The power to enter into a contract with a participating community mental health services program for any service to be performed for, by or from the participating community mental health services program." And "The power to create a risk pool and take other action as necessary to reduce the risk that a participating community mental health services program otherwise bears individually."*

Please note that current SWMBH Regional Entity Bylaws Article II Purposes and Powers 2.1 Purposes states **"Additional purposes may be added by the Regional Entity Board".**

Please see Attachment B for a Strengths, Weaknesses, Opportunities and Threats analysis for SWMBH and the Region as developed by SWMBH. Management proposes a CMH leadership only session facilitated by external subject matter experts to perform and report out this same exercise.

SWMBH Overview TURN THIS SECTION INTO AN ATTACHMENT

SWOT

Strengths

- Good, strong, dedicated, hardworking, high capacity, competent staff
- Competent management team
- NCQA MBHO Accreditation
- Historical knowledge
- Dedicated to persons served
- Consistently score highest amongst other PIHPs on audits/reviews and state reporting measures
- Great relationships with ICOs and community partners
- External partners realize their jobs will become more difficult without SWMBH
- Developed and established business processes
- Visibility & credibility at MDHHS and legislature
- Took lead, facilitated major projects at/for state level implementation
- Risk takers
- Excellent CMHs
- Highly collaborative regional culture
- Solid working relationships with our Participant CMHSPs
- Participated with MHL project, first in state

- First adopter of Coordinating Agency role 9 months before others; established precedents and early subject matter expertise
- Seen as a Leader among PIHPs
- Excellent reputation
- Located under one roof
- Oversight & experience of Specialty Populations
- EMR Platform agnostic
- Possibly Only PIHP Using Tableau?
- Understanding of the level of oversight needed and attempt to reduce CMH burdens related thereto
- Experienced with Data Exchange/Data Handling
- Secure Date Center Nearby
- Safety Net
- Partnerships with other safety net entities
- Resources for the neediest
- CMHs have already broadened their scope
- Insight into consumer details
- Peer Support
- PCE is fast at making state reporting changes
- Community Relations
- Progressive
- Responsive
- Partnerships
- Innovation
- Experience with Specialty Populations
- Identified as Specialty Providers for State
- More Grants
- Creative approaches to Wellness
- Care about their clients
- Great Care Coordination
- Live safety net for years
- Increased willingness to take a Regional approach to solve issues

Weaknesses

- Over Ambitious
- Too Many Initiatives
- Take on Too Much
- Time Lost on New Projects
- Workloads with Projects are too Many and are Difficult to Manage
- Lack of Advocacy Group Recognition
- MDHHS few comparison's/reports that highlight PIHP performance
- Attrition of staff
- Streamline dependency, little bench strength

- Lack of Structured/Consistent Marketing/Promotion
- CMHs Varying in evolution
- Costs above market rates
- Some CMHs are not majority percentage Providers
- Modest collaboration in IT
- Staff turnover
- Two Vendor software systems

Opportunities

- Streamlining requests for information and reports to eliminate duplication
- Make a case for scoring/ranking methodology based on past/present performance with contractually obligated metrics and results
- Value Based Purchasing
- Demonstrating value of behavioral Health services to stakeholders
- Examine opportunities with other organizations to create a health alliance (hospitals, FQHCs, Tribes, CMHSPs)
- Second check ASO services
- Partner with Health Plan
- Develop Center(s) of Excellence for export of expertise for hire
- Process Improvement – Report Request, Onboarding, Project Planning
- Predictive Analytics
- Better Data Warehouse
- Opportunity for ICOs, MHPs, SIPs
- Clinical expertise with Specialty Population
- Coordination of Care between Medical & Behavioral Health
- Focus on Wellness/Whole Health
- CMHs to Become Great Providers
- Keep an ASO

Threats

- Staff Exodus
- Knowledge leaving
- Brain drain
- Difficulty to obtain new staff
- MDHHS and some in legislature preconceived notion that MHPs hold the keys to the future and will be one size fits all for the system
- How to collaborate with others without hurting chances
- Lack of Member CMHSP support for out of Region business
- MHPs, ICOs, SIPs doing benefits management
- Other ASOs – Optum, Beacon
- Too much duplication
- Reporting burden from ICOs

- PIHP Board says go away
- Can't compete with private sector without clear value differentiators
- Privatization of Healthcare in Michigan
- Quality will be looked at
- Standards will be looked at
- Large Providers Like Hope, Pine Rest, etc.
- County Match
- Overhead high
- SWMBH roles and experience from MHL not clearly known/valued

Special Circumstances

There are several special circumstances the SWMBH Board would need to handle if SWMBH were to cease to exist. There are others yet uncontemplated.

MI Health Link

SWMBH hold two delegated benefits management contracts with MI Health Link (the Medicare-Medicaid dual eligibles federal-state demonstration) Integrated Care Organizations (also with traditional Medicaid managed care and other products in Michigan) Aetna Better Health and Meridian of Michigan Health Plan. These contracts have been in place since 2015 and continue at least through the end of calendar year 2021. These contracts, their terms and conditions, financial arrangements and operations at SWMBH to support them are complex, scrutinized by many and have a political aspect to them. Very few in the state understand the Demonstration and PIHP roles, duties, benefits and exposures. These contracts are not transferable to CMHs and have a minimum six month no-cause termination notice period.

Substance Use Disorder Prevention and Treatment

SWMBH holds all substance abuse prevention and treatment (SAPT) provider contracts. SAPT providers are especially scarce, deal and fragile. Few in the state know how to operationalize the Prevention requirements. These contracts are not readily transferable to CMHs.

Master Healthcare Information Exchange, Healthcare Data Analytics and Management Information-Business Intelligence Operations and Agreements

With the participation and support of CMHs our region has expended many millions of dollars for healthcare information exchange, healthcare data analytics and management information-business intelligence, with significant benefit to SWMBH and our CMHs. These efforts have enabled performance success in all areas including but not limited to MMBPIS, Performance Bonus Incentive earnings, Health Services Advisory Group top-shelf Audit results, MHL Integrated Care Organization delegation review success, and more. By design and fiscal prudence contracts with partners and vendors (MIHIN, Relias PopHealth, Tableau, etc.) rest at SWMBH. These contracts and especially the data flows, exchanges and reports would all have to be reworked at material expense, assuming these vendors would pursue individual CMH

contracts. If they did, the base expenses would certainly be higher, and the direct and opportunity conversion costs would be high. Losses of these technologies and products would be a significant strategic and tactical loss for the region.

As required by MDHHS all Data Use Agreements (DUAs) which are required to receive or access any state data rest with SWMBH. SWMBH in turn executes DUAs with CMHs. The DUA development and execution processes are significant. It is uncertain if anyone at the state has an awareness of this impact of PIHP extinction.

Governance Issues

Some 16 months ago we considered, and the SWMBH Board approved exploring a SWMBH role in managing the unenrolled population in Section 298 counties which are outside our region. We noted that the SWMBH Bylaws restrict the "geographic region" in which it can operate to our current eight counties. While the SWMBH Board readily approved enabling Bylaws changes, the SWMBH CEO's approach to four CMH Boards resulted in two Participant Boards rejecting the revisions formally and two reserving judgement until more information was available. Given that SWMBH Regional Entity Bylaws require unanimous consent from all eight Participant CMH Board, the effort was dropped. The SWMBH approval of the revisions still stand; the SWMBH Board has not rescinded them.

Regardless of the magnitude of any system transformation changes, the Regional Entity system and PIHPs have clearly fallen out of favor by most in Lansing. More importantly, all Health Plans will experience consolidation and a future predominately state-wide market presence. For any risk or non-risk Health Plan partner or administrative service organization contractor to be considered let alone valued it must have a state-wide presence or at least a geographic presence which mirrors that of the Health Plan partner target.

***Board Action Required**: An early decision by the SWMBH Board to consider is whether to authorize the SWMBH CEO to begin Bylaws revisions conversations with Participant CMH Boards of Directors using currently Board-approved revised Bylaws or a freshened review and revision. Management recommends that this become an early topic of deliberation, and that the Board again review and approve or revise the approved freshened Bylaws to permit expansion of SWMBH pursuits to state-wide and begin meeting with Participant CMHSP Boards on this topic.*

Alliances and Partnerships

SWMBH is a founding Member of Michigan Consortium for Healthcare Excellence (MCHE) as were all ten Regional Entities/PIHPs. MCHE now has nine Participant Regional Entities/PIHPs, all bur Northern Michigan Regional Entity. MCHE has proven to be a useful vehicle for group purchasing and state-wide initiative organization and resourcing. It is conceivable that MCHE may become a vehicle for further Regional Entity initiatives protective of CMHSPs. Thus, our participation as a Member ought to be continued.

When we considering pursuit of Section 298 Pilot regions benefits management for unenrolled Medicaid beneficiaries, we co-developed a SWMBH majority-controlled public-private partnership with a national well-regarded Health Plan. Design details included Governance and management roles & authorities, financial arrangements and more. While this effort ceased long ago, connection to that Health Plan or other private partners can be considered and pursued.

If DHHS maintains the Regional Entity/PIHP system but with a lesser number of Regional Entities/PIHPs we would want to be ready with our Plan and leadership for consolidation.

Other options exist, and each should be identified and vetted.

Less formal arrangements have been and will continue to be useful. Examples include bi-lateral and multi-lateral RE/PIHP shared services arrangements, evolving to common healthcare information exchange, healthcare data analytics and management information – business intelligence systems, etc. These have and can continue to occur within CEO authority under Board Policy guidance.

SWMBH Financial Status

Medicaid funds generally can be used to pursue state-mandated or state-supported systemic transformations, including the exploration and resourcing of behavioral and physical health care integration programs, healthcare information exchange, healthcare data analytics, etc. Medicaid funds generally cannot be used to develop and operationalize new Regional Entity business lines or directly support new SWMBH Customer acquisition. Medicaid funds can be used to support CMHs transitions to the new realities and ready themselves further for administrative cost reductions, value-based purchasing success, leadership and change management development. It is a certainty that SWMBH Medicaid Internal Reserve Fund (ISF) balance, if any, at 9/30/22 (or any PIHP close-out date) will revert to the state. This amount will be reported to MDHHS on 2/28/23 and cost settled at some unknown date thereafter, historically years after the fact. Thus, absent a local funds capital infusion by Member CMHSPs, SWMBH will rely on its Local Fund Balance earned through the PIHP Performance Bonus Incentive Pool and margin on the MI Health Link program for its capital support of business line development and customer acquisition, if these objectives and efforts are approved by the SWMBH Board. We are currently in cost reconciliation discussions with the MI Health Link Integrated Care Organizations and will have an estimate of SWMBH Local Fund Balance soon.

Marketplace & Industry Overview

Publicly funded healthcare costs in Michigan exceed $13 billion annually. Twelve Medicaid Health Plans cover approximately 2.1 million Medicaid and Healthy Michigan Plan eligibles. The subset of 335,000 eligibles with severe mental illness, serious emotional disturbance, substance use disorders, intellectual and developmental disabilities and autism spectrum disorders are served under contract to Prepaid Inpatient Health Plans (PIHP) such as SWMBH with a state-

wide annual expense of approximately $2.8 billion for an average of $8,500 per eligible annually. Please note that annual specialty services cost per person served varies widely from $1,000 as a low-end outlier and $240,000 as a high-end outlier.

Forty-six Community Mental Health Services Programs provide or contract for virtually all publicly funded services under contract to ten PIHPs, except for General Fund services, roughly 5% of a CMH budget. Seven PIHPs are multi-CMH and three PIHPs are both PIHPs and CMHSPs (Detroit-Wayne, Oakland and Macomb).

MDHHS said the Specialty Integrated Plan reform will occur before the mandatory Medicaid Health Plan re-bid in fiscal year 2023. This places additional urgency for MDHHS in assuring SIP go-live 10/1/22. It is anticipated that during the MHP re-bid new Medicaid Health Plans for non-specialty public eligibles will attempt to enter the Michigan market and that the number of Michigan MHPs is likely to settle in at 7-9 from the current 11. Leading contenders for future operations include Meridian (owned by Centene), United Health Care Community Plan, Aetna Better Health, Priority Health Plan, McLaren Health Plan, Health Alliance Plan and Upper Peninsula Health Plan with Molina being evenly handicapped. Thus, there will be active involvement of current MHPs *and interested new entrants* considering and developing SIPs and/or other models as a competitive advantage for the re-bid.

Michigan's participation in the federal Financial Alignment Initiative is called MI Health Link and combines funding and benefits management for dual eligibles (Medicare & Medicaid) into a single Medicaid Health Plan known as an Integrated Care Organization began in spring 2015. Intended as a three-year Demonstration, CMS and Michigan extended it through 12/31/2020. SWMBH is one of four out of ten PIHPs that have participated in the MI Health Link Demonstration with two ICOs – Meridian and Aetna. CMS, MDHHS and the ICOs have extended the Demonstration for another five years through 12/31/25. Note: MDHHS recently announced that the extension will now be through December 31, 2021 due to COVID-19 distractions and complications, with active pursuit of a multi-year extension thereafter.

Our performance in this Demonstration has benefited our enrollees and the ICOs such that our participation into 2021 is certain. We have seen no evidence of ICOs ceasing their Agreements with us. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination

Michigan Healthcare Policy Environment

In the fiscal year 2020 budget supplemental related to COVID-19, the Governor vetoed a wide range of funded programs and initiatives. One item vetoed was the Public Behavioral Health System Transformation $5 million line item which was intended to support 15 FTEs and consultants. In addition, MDHHS staff have been furloughed a day a week for several months and this is likely to continue. Thus, MDHHS has neither the funds nor the resources to focus well on Transformation. The new MHDDH Senior Deputy for BHDDA has said he believes the

Administration will make some clarifying Policy regarding its Public Behavioral Health Transformation views and intent by early June.

Many believe that the lack of resources for Specialty Integrated Plan (SIP) development combined with the FY '20 and FY '21 combined $6-7 billion projected state deficit which must be remedied will make more legislators and the Governor's office more receptive to a pure carve-in sooner rather than later, skipping the SIP approach altogether.

MDHHS had set a clear policy direction of desiring Specialty Integrated Plans (SIPs) which combine financially and contractually the physical health and behavioral health benefits, capitation funding, accountability and risk into a single Plan. MDHHS has cited the states of Arizona, Arkansas and North Carolina as each having elements and/or results attractive to them. We continue to produce Intel on these three states. Thus, SIPs are carve-in Plans despite some persons avoiding that moniker. MDHHS had expressed a desire for a "publicly-led SIP" with an explicit written invitation to CMHAM in early January 2020 to begin work on such a vehicle. There is no evidence that the public system has made efforts in this regard. It is certain that subsets of public system PIHPs, CMHs and Providers have deeply explored public-private partnership models with Health Plans and related others. MDHHS has made it plain that a publicly led SIP must meet all current Michigan Insurance Code requirements for MCOs. MDHHS has also made explicit the necessity to revise the Mental Health Code and Public Health Code to support SIPs. MDHHS claims they began the statutory review internally some months ago. We have encouraged them to continue to review in the light of day and in a widely inclusive manner.

The public behavioral health system, MDHHS and leaders in the Legislature acknowledge that the current statutory environment does not permit a publicly led SIP so work on Michigan statutory language revisions has begun in the Legislature, executive branch and across the public behavioral health system. Connectivity across these efforts appears to be non-existent. It is certain that MHPs and their Association MAHP are deeply and broadly involved in statutory reviews with their own interests top of mind.

Early criticism of the MDHHS SIP plan comes from many quarters and falls into several main categories, few of which are new:

- Privatization, reduction in services and profiteering by current and future MHPs
- Inadequate requirements for genuine participation in governance and management from persons served, their loved ones and formal advocacy group representatives
- Low level of acknowledgment by legislature and MDHHS of statutory change process complexity, politics and resource/time consumption and need for joint stakeholder efforts
- Minimal to non-existent mention or consideration of the place for substance use disorders treatment and prevention, Block Grant and PA2 funding for substance abuse

treatment and prevention, or the statute requiring county involvement in PA2 budgets via Substance Use Disorder Oversight Policy Boards.

- Minimal acknowledgement from MDHHS of significant direct, indirect and opportunity transition costs of standing up new entities, creating new ventures, closing seven regional PIHPs and materially down-sizing three stand-alone PIHPs.
- Minimal acknowledgement from MDHHS and the legislature that MDHHS lacks the capacities and competencies to successfully manage changes of these magnitudes.
- Lack of MDHHS details or "meat on the bone". MDHHS replies that a stakeholder involvement process will inform more detailed policy and decision-making around the reforms.

Per MDHHS major topics under review include:

- Management of the unenrolled and Medicare-Medicaid Dual eligible population
- SUD funding and care delivery system
- Regional versus state-wide SIPs
- CMH safety net services vs SIP services and blended funding model
- Requirements to serve as a SIP
- SIP procurement process
- Care Management Model in SIPs
- Quality Metrics and Performance Reporting
- Rate structure
- Eligibility criteria for SIP enrollment
- Enrollment and transition process for beneficiaries
- Recipient Rights structure for SIPs
- And many more…

The upcoming Medicaid Health Plan renewal cycle is as follows:

- Current MHP contracts expire 9/30/2020
- A maximum of three one-year extensions is possible through 9/30/21, 9/30/22 and a mandatory rebid completion finalization date for new Plans to begin 9/30/23.

The renewal and rebid process historically has consumed significant MDHHS and OTMB resources as well as that of current and new entrant Plans and has occurred over a scheduled time frame of 2.5 +/- years.

Note: On May 27, MDHHS Senior Deputy for Behavioral Health and Developmental Disabilities Administration Al Jansen said he expected soon a letter from senior DHHS executives announcing a cessation of public behavioral health system transformation efforts. This communication has not yet been published.

Note: On June 11 MDHHS Senior Deputy for Behavioral Health and Developmental Disabilities Administration Al Jansen said the BHDDA key goal areas for the next year (paraphrased) are:

- Increase access to and use of data
- Review and address health disparities and healthcare access inequities for persons of color
- Enhance behavioral health prevention efforts
- Enhance integration of physical and behavioral healthcare with a focus on Behavioral Health Homes, Certified Community Behavioral Health Clinics and Opioid Health Homes
- Enhance alternative systems of care including but not limited to tele-health and other remote methods
- Address Governance; move away from active system design "we are moving away from active system redesign"
- Focus on beneficiaries

Planning Assumptions

NOTE: See modifying comments above. Assumptions under revision due to COVID-19 pandemic in discussions with internal stakeholders and external knowledgeable others.

These assumptions are based on the foundational assumptions that a. the MDHHS Vision will survive and transition to SIPs on 10/1/22; b. the statutory & regulatory barriers will be revised to become permissive to the establishment of a publicly led SIP; and c. that numerous Plans of varying natures such as Medicaid Health Plans, Integrated Care Organizations for Medicaid-Medicare dual eligibles, Specialty Integrated Plans, Medicare Advantage Plans and the like will thrive well beyond 1/1/22.

- PIHPs, including SWMBH will lose their PIHP MDHHS Agreement and funds at 9/30/22.
- Member CMHSPs created the Regional Entity SWMBH; only they can remove that status achieved under Mental Health Code Act 258 of 1974 section 330.1204b.
- SWMBH has latitude in designing its future, subject to approval by the SWMBH Board. See Mental Health Code see Act 258 of 1974 section 330.1204b Regional Entity in Appendices.
- There is no opportunity for SWMBH to unilaterally develop and propose a Specialty Integrated Plan. Assuming support and invitation from Member CMHSPs, SWMBH can participate in and support CMHSP considerations related to SIPs and/or be a Participant in the design and development of a SIP.
- *Beginning immediately and accelerating over time the probability of SWMBH management and line staff departures continues to grow higher.* Once SIPs begin to congregate and aggregate, they will poach PIHP subject matter experts and leaders with increasing aggressiveness. As 9/30/22 grows nearer it is a certainty that most staff will depart, absent a clear pathway for SWMBH to new business lines and new customers.

- Any proposal must be vetted by and supported by a majority of Member CMHSP CEOs and address identified and new CMHSP concerns including but not limited to value to CMHSPs; little or no financial risk to CMHSPs; and the like.
- All business opportunity proposals will require a *pro forma* budget.

The Emerging New World for CMHSPs

Using October 1, 2022 as a future date one can somewhat predict the business environment for CMHSPs. PIHPs will be gone having begun to atrophy as early as January 1, 2021 or sooner. Investments in PIHP supports of staff, information technology, clinical & program initiatives will have been severely curtailed at October 1, 2020 and ceased at October 1, 2021. Reversion by SWMBH to PIHP contractual mandates only will begin October 1, 2021 at the latest.

Medicaid and Healthy Michigan Plan in whatever form they exist - or not - will aggregate physical health and behavioral health into Specialty Integrated Plans or a straight carve-in. DHHS is likely to require Plans to contract with CMHs *as well as permit any other providers of their choice* and to fund Plans for behavioral health services in capitation based upon set fee schedules and actuarial estimates of utilization times enrollees equating to Plan capitation total dollars. Plans will refuse to pay providers above fee schedule rates except perhaps in the most extreme circumstances for Plans to acquire rare clinical resources. Plans will move risk to CMHSP and other providers via some or all the following and other mechanisms: volume-assured discounts, Value Based Purchasing, Incentives, Sanctions, Alternative Payment Methods, etc. CMHSPs who fail to assess, scope and significantly reduce expenses and unit rates will immediately find themselves in a negative margin situation without recourse to others for remediation. Local Fund Balances are likely to be quickly used.

Plans will desire to contract for varying commodity benefits management services such as provider network management. It is highly unlikely that Plans will be willing to contract with each CMHSP singly, rather Plans will demand state-wide or mega-regional benefits management and contracting mechanisms or in many instances perform all behavioral health functions in-house or contract with a single state-wide private or perhaps public entity. Plans are unlikely to delegate authorities to CMHSPs and are unlikely to purchase benefits management services from an agency not NCQA MBHO Accredited. Regardless, administrative fees will be low PMPMs and CMHSP and/or RE/MBHO up-side gainsharing will be available only if specifically negotiated with details into the Agreement.

Despite assurances to the contrary history has shown an inability of the legislative and executive branches to reduce statutory, regulatory and contractual burdens all of which carry significant expense for the public behavioral health system. MHPs have been very aggressive in limiting and tightly specifying their beneficiaries, service arrays and obligations to reduce the state spend “proving efficiencies and savings” while leaving so-called Community Benefit roles to the state and presumably to the CMHSPs. Given these contractions one must ponder the

minimum size and scope necessary for a CMHSP to remain independent. Some CMHSPs may consider consolidations with other CMHSPs.

CMHSPs will retain General Fund contracts for state hospital and safety net services which are yet to be fully defined, let alone costed with a financing model. The probability these services will be properly scoped, defined and funded is low, leaving CMHSPs to perform a "floor" of community services with little ability to go beyond these. This will put further pressure on CMHs to perform financially and open them up to even more criticism as CMHs must contract, not expand both fee for service and community benefit services. The required county match now being incrementally reduced will have disappeared altogether. This relieves counties of statutory financial obligations to CMH and may serve to paradoxically increase county interest in and oversight of CMH or reduce it further largely based upon county dynamics.

Expansions in numbers of state hospital beds will have come on line further expanding utilization and expenses for CMHs, most likely without commensurate General Fund increases to support the added utilization.

CMHSPs may continue to perform at their discretion Medicare, Medicaid fee for service, BCBSM and other commercial services under contract at set rates. Objective analyses of Mission versus Margin for these services will need to occur, with receipt of adequate fees/rates, underwriting with slim GF dollars, contracting or ceasing these and other non-mandatory services.

Few outside the public behavioral health system grasp the difference between and dynamics around Medicaid entitlements, "priority populations," and Ability to Pay General Fund services. CMHs would be wise to assure their community stakeholders and policymakers are clear on these and supportive of or at least tolerant of service array modifications related to finances *and* become or remain active advocates for CMH funding in Lansing.

Grant projects and funds may become more attractive to CMHs. This may increase the need to be competitive and competent in securing and managing these projects. On the other hand, some Grants prohibit allocation of indirect costs to the Grants, further pressuring the CMH cost structure.

More CMHSPs and counties will have considered, pursued or achieved county mental health millages to complement state funds. This will further exacerbate the dreaded dis-uniformity of benefits across counties.

Per MDHHS documents CMHs should expect:

- Continue serving as safety net for all citizens
- Be part of provider network for all SIPs
- An opportunity for expanded role as leader(s) of SIP(s) managing both behavioral health and physical health needs

Per MDHHS changes CMHs will need to make include:

- Form new partnerships to swerve as managed care entities
- Build new (provider) networks, clinical expertise, capital reserves and managed care functions
- Adjust accounting and billing

SWMBH CEO attended with several SWMBH CEOs a "298 Lessons Learned" session with the four 298 CMH CEOs. Key points included:

- The group mostly did not even discuss BH service delivery. CMHs did do a few client tracer/movement studies to inform the MHPs.
- MHPs do not grasp public system roles, benefits and costing. They claim public system administration expenses are too high. MDHHS is on a fast track to alter CMH/PIHP costing and payments to be more like that for MHPs. MHPs are pressing for the BH unit cost state rates to become "fee screens" upon which they are paid and can dictate rates to BH providers, including CMHSPs and inpatient psych providers.
- MHPs are all about their current and future enrollees. "Population Health" to them means their beneficiaries, not the larger community.
- MHPs are over-confident about their care coordination and care management resources, functions and results.
- Many but not all MHPs were willing to shed mild moderate mental health to the 298 CMHs.
- They are adamant that they will not pay for so-called safety net and community benefit CMH activities. They are heavily focused on Community Living Supports issues given the preponderance of costs in this area state-wide.
- SUD was a particularly complex conversation, with MHPs split on their desire to manage it, especially Block Grant and PA2 services. They do not want the cost exposure related to SUD.
- MDHHS largely sees unenrolled, duals and SUD as an after-thought deferred to future discussion.
- MHPs want I/DD services and capitation.
- MHPs were very sophisticated in developing and producing data tables and charts to make their points.
- MHPs want nothing to do with CMHSP General Fund issues.
- The group discussed the problems caused by spend-downs, MHP enrollee movement, beneficiary movement between Medicaid and Healthy Michigan Plan, GF, etc. Problems were identified with few or no solutions.
- MHPs are highly competitive and loath to reveal their business processes, performance data, etc.

- MHPs seem to understand the fragility of the BH provider network and many MHPs expressed desire to contract for (not "delegate") BH provider network management.
- MDHHS was largely unable (and/or unwilling) to produce any objective data about BH or MHPs to inform the discussion.
- Sub group discussion areas included Policy, Finance, Provider Network, Technology, Case Management/Care Management, and Reporting.
- MHPs were aghast at the types and volumes of data CMHs/PIHPs must report to MDHHS. Their position was oppositional to the reporting burdens.
- Some MHPs openly expressed opposition to Self-Determination, Person-Centered Planning, Independent Facilitation and Fiscal Intermediaries. Some went so far as to say they would get those removed from Mental Health Code and MDHHS Policy directives.
- National Plans said it can take 6 months to get approval for a Business Associate Agreement and 18 months to get technology/data systems development achieved.
- Don't confuse MHPs with their Association MAHP. MAHP is there to be aggressive and inflammatory. Most all MHP representatives were competent and caring about health services effectiveness.
- Legislative leaders are always involved and influential, sometimes apparently sometimes not.
- MAHP/MHPs have always received the full raw files Milliman uses for rate-setting and they have their own actuaries under contract to inform rate discussions with MDHHS to their favor.

Losses and Needs *Attachment under construction*

Please see Attachment C for a CMH Losses and Needs Table developed by SWMBH. This document summarizes what CMHs can expect to disappear (Losses) if SWMBH disappears and our views on potential CMH Needs if SWMBH disappears. Management proposes a CMH leadership only session facilitated by external subject matter experts to perform and report out this same exercise.

Market Analysis (largely a Placeholder for now awaiting Board authorization to invest in development)

Current Market Overview

Current Customers

- CMHSPs
- Integrated Care Organizations (ICOs) Meridian (now owned by Centene www.centene.com) and Aetna Better Health.

Potential New Customers

- Specialty Integrated Plans (SIP, under development)
- Medicaid Health Plans (MHP)
- Medicare Advantage Plans
- Workers Compensation Plans
- Auto Insurers
- Hospitals & Health Systems
- Accountable Care Organizations (ACO)
- Federally Qualified Health Centers
- Rural Health Centers
- School-based Health Centers
- Individual, aggregated or incorporated Provider Groups
- Hospital, health system and Primary Care Physician groups
- State of Michigan MDHHS, MDOC and other Departments
    - MDHHS
        - Substance abuse treatment Medicaid and Healthy Michigan and Block Grant benefits management
        - Substance abuse Prevention services
    - MDOC
        - Community substance abuse services for supervisees (parolees and probationers)

Current Business Lines – to be completed

Potential New Business Lines for CMHs, Provider Groups, Health Plans

- Recruitment, employment, management and deployment of physicians, psychologists and other clinical staff
- Recruitment, employment, management and deployment of provider auditors, claims processors and other administrative staff
- County millage pursuit subject matter experts and technical assistance
- Philanthropy (fund raising) subject matter experts and technical assistance
- Grant and United Way pursuit subject matter experts and technical assistance
- Analyses and enhancements of external provider services such as Personal Care, Community Living Services, Supported Employment, Skill Building, Supported Independent Living, etc.
- Design and development of Value Based Purchasing (VBP) and Alternative Payment Methods (APMs)
- Joint contracting with MHPs for mild to moderate mental health services management and other commercial payer BH services
- Shared General Counsel, Labor Counsel, etc.
- Shared and joint Program Integrity-Compliance Program
- Provider contract development and negotiations
- Payer contract negotiations
- Shared and joint enrollee rights and protections program

- Shared and joint Complex Care Management
- Complex case consultation
- Evidence-based practices installation, training and monitoring
- Management Information – Business Intelligence support
- Program Portfolio Analyses
- New Program Analyses
- Scaling and replication of successful Programs
- Sales and services to non-SWMBH CMHs
- Healthcare Information Exchange support
- Healthcare Data Analytics support
- Strategic Planning support
- Public Relations, Media Relations and Marketing support
- Group Purchasing support
- Etc.

Note: Only one or more SWMBH CMH(s) need to be interested to consider each option; it need not be all eight.

A special opportunity in multi-regional or state-wide management of gambling disorder prevention and treatment is possible.

A special opportunity in multi-regional or state-wide management of substance abuse prevention and treatment is possible.

One or more PIHPs may drop out of the MI Health Link Demonstration, creating expansion opportunity(ies) for us to become the behavioral health benefits manager for one or more of those Regions or ICOs.

The unenrolled population is a particularly problematic issue for the state, and has multiple related access, quality, and care coordination business opportunities. Prior to the pandemic, all ten PIHPs agreed to design for MDHHS a NCQA MBHO adherent Complex Care Management program for persons with severe mental illness and one or more chronic medical conditions. MDHHS Director Gordon and his Senior Chief Deputy for Policy and Planning were scheduled to attend the April regional Entity/PIHP CEO meeting but canceled due to the pandemic. Regardless, PIHPs continue with detailed design documentation.

Competitive Analysis

There is a high likelihood that other current Regional Entities, new CMH-sponsored, CMHA, Provider Groups and related agencies will develop similar approaches to post 9/30/22 opportunities in behavioral health benefits management and other value-added activities with an intent to sell various Administrative Service Organization (ASO) solutions. The ten RE/PIHP Directors met on February 14, 2020 for a discussion of system issues.

Multiple well-known national Managed Behavioral Health Organizations have had eyes on our Medicaid managed care program for decades and contact with key leaders in Michigan and

Medicaid Health Plans for decades making assertive pitches for their ASO offerings and capital funds. Top contenders include but are not limited to Beacon Health Options www.beaconhealthoptions.com Magellan www.magellanhealth.com Envolve www.envolvehealth.com Optum www.optum.com See Appendix D. for a list of NCQA MBHO Accredited entities. These national for-profit companies have long histories, sophisticated offerings complementing behavioral health benefits management, intense promotional pitches, and significant capital funds. A credible case will have to made to prospective Customers for why SWMBH is as or more attractive than these firms. We should not rule out future partnership(s) with one or more of these firms.

Key strengths SWMBH & CMHs must have at industry standard or better levels to assure chance at success include, but are not limited to:

- Sophisticated Information Systems & Technologies
    - All HIPAA Standard Transactions
    - Health Information Exchange connectivity (MIHIN)
    - Healthcare Data Analytics such as Care Management Technologies
    - Management Information and Business Intelligence
- Industry Standard or better finance and accounting reporting and business intelligence
- Industry Standard or better clinical productivity
- Real time client assessment scores, treatment history, physical health status and physical health services avoidance/reduction savings estimates
- Ability to adopt Alternative Payment Methods (APMs) as Provider and perhaps as Payer
- Evidence-based clinical pathways, protocols and guidelines with automated surveillance of adherence
- Automated clinical and administrative alerts
- Functionality and Outcomes assessments, scores and analyses
- Proofs of performance internal and external reporting
- Catalogue and brief descriptions of current and planned integrated care initiatives across our region
- To be continued

Sales and Marketing

This section is reserved for a future date when the SWMBH Board approves additional effort. This development will necessitate competencies not currently available at or to SWMBH. In simple terms the process includes **S**egmenting, **T**argeting, **R**esearching, **A**ppraising and **P**laying with the **4P**s of **P**roduct, **P**rice, **P**lace and **P**romotion.

Ownership

Provided that the current Member CMHSPs do not relinquish their Membership in SWMBH, they will remain the Participants with the Regional Entity structure intact and the Governing

Body (Board) made up of appointed representatives from each Participant CMH Board. It is conceivable that any individual CMHs could depart SWMBH under the rules of the Bylaws. We recommend that the region's CMHSP leaders not dismiss the idea of inviting other CMHSPs into the Regional Entity as equals or as Tier 2 Members, with Tier 2 not yet defined but conceptually having less authority and thus risk that a Founding Member.

Operations

This section is reserved for a future date when the SWMBH Board approves additional effort. A full consideration of actual and potential business lines, customers, volumes and margin expectations will drive the operational design.

Mandatory Enabling Decisions

There are certain deliberations and decisions which need to occur at and with the Board to provide authorization and visible support to the SWMBH EO in these endeavors. The first is Board authorization to pursue Bylaws revisions to expand geographic reach with Participant CMHSPs. The second is Board review, modification and approval of varying severable parts of this Strategic Business Plan. The third is Board authorization to begin the Customer identification process. These decision points will inform and drive current and future staff behavior; more staff will likely remain with SWMBH if there is visible Board support for a future beyond lights out on 9/30/22.

Proposed Milestones and Timelines

Discussion and deliberation with and amongst the Board and Operations Committee will commence in February culminating with the August Board planning meeting and September and October Board deliberations. It is during this time and ideally no later that the Board must affirmatively authorize management to proceed with a. [1]Regional Entity Bylaws revisions attempts enlarging geographic service area at each Member CMHSP Board of Directors; and b. business line design (not yet development) concurrent with customer mining. Each of these require substantial resources, primarily from SWMBH EO, other SWMBH senior managers, external Subject Matter Experts and Member CMHSP talent.

Exhibits

- **A.** Key Milestones Timetable
- **B.** PIHP Map
- **C.** MHP Map
- **D.** MHP eligibles in SWMBH counties
- **E.** Current MDHHS Reform documents

[1] It is our assessment that an ability to be an attractive ASO services provider beyond our current geography is very nearly a mandate for the possibility of future business lines for additional customers. Be they SIPs, ICOs, MHPs, CMHSPs, or other customers, it is almost a certainty that they will require multi-regional or state-wide performance of delegated or contracted benefits management or population health contractual obligations.

a. January 7, 2020 MDHHS Gordon letter to CMHAM Sheehan

Appendices

A. Definitions and Acronyms
   a. Administrative Service Organization (ASO)
   b. Care Coordination
   c. CMHSP
   d. Specialty Integrated Plan
   e. Medicaid Health Plan
   f. CMHAM
   g. MAHP

B. Michigan Mental Health Code 330.1204b Regional entity statute

mcl-330-1204b.pdf

C. Michigan Mental Health Code <citation> SUDOPBs, etc.

D. NCQA MBHO Accredited List https://reportcards.ncqa.org/#/other-health-care-organizations/list?p=1&program=Managed%20Behavioral%20Healthcare%20Organization

E. SWMBH Bylaws and Bylaws as revised by SWMBH Board

F. Michigan Medicaid Health Plans service regions

Key Milestones Table

Topic	What	Whom	By When	Notes