CEO Report
September 27, 2023

Hello and good afternoon, it is a Great Day to be a part of the Lakeshore Regional Entity!

<u>PIHP/REGIONAL Update</u>

1. **<u>LRE Updates</u>**
    - I would like to give a shout out to the Quality Department lead by Wendi Price as well as all LRE staff for the recent success of the Performance Measurement Validation (PMV) by Health Services Advisory Group (HSAG). The LRE received validation on the PMV after extensive advocacy by LRE to identify why validation was reasonable.
    - Bi-weekly discussions with MDHHS have resumed. I have been meeting with Kristen Jordan. If you recall, she has replaced Jeff Wieferich. The main topic during the last meeting was MDHHS cost settlement process with LRE. An additional meeting was scheduled to discuss further (more details given later in this report).
    - I would like to recognize that September marks National Recovery Month. The tagline, “Every Person, Every Family, Every Community,” emphasizes that recovery is possible for everyone. Treatment can save a life and can help people with substance use disorders recover from addiction's powerful effects on their brain and behavior. During the month of August, I was fortunate to be able to attend:
        - The Tall Cop Professional Development Day. The presentation was with a nationally recognized speaker on drug paraphernalia and the culture surrounding youth use.
        - The Muskegon Community Opiate Task Force held an Opiate Task Force Summit on August 18th. The event was well attended and wrapped up with a lived experience panel discussion. It was an excellent educational experience.
    - August 31 marked International Overdose Awareness Day (IOAD), the world's largest annual campaign to end overdose. The day remembers those who have died from drug overdose and acknowledge the grief of the family and friends left behind. It also continues to remind us that the battle is not over and that the professional field needs to stay vigilant in the battle. Lakeshore Regional Entity is honored to partner with other professional organizations in the community to support individuals in recovery and/or seeking recovery.

2. **Regional Updates**

- Historical Deficit Update
  Update: All Agreements have been signed and as of 9/20/2023 the final 20% payment was made. The CMHs that had a historical deficit have been paid in full.

  HW continues to have pending litigation against the LRE as of present date. The intent is to keep the lawsuit open until May '24 which will pass the recoupment date.

- LRE has received the FY24 Contract with MDHHS. LRE staff are drafting new PIHP/CMHSP contracts. At this time there is an amendment in place extending the current PIHP/CMH contracts to allow for a new contract to be drafted. The new template is intended to be more streamlined than previous contracts with the CMHs.

- Funding Revenue Streams/HAB or HSW (Habilitation Supports) Waiver Slots/Behavioral Health Homes (BHH)/Opioid Health Homes (OHH)
  - HAB Waiver – During weekly meetings with MDHHS there has been ongoing discussion about the allocation of HSW slots. Region 3 has historically been under the state average number of slots although we consistently utilize every slot and have a need for more. LRE has requested 269 additional waiver slots which will bring us up to the state average. Mr. Wieferich has agreed to review this request internally and stated that this is a good opportunity because the state is re-evaluating the waiver slots because their 372 report is being completed for CMS.
    Update: LRE has sent another follow-up communication to MDHHS on 9/22/2023 regarding this matter. The email followed a discussion and information that was part of the CFI agenda this week. The LRE continues to wait for communication on this matter from MDHHS.

  - BHH/OHH – LRE met with the state about BHH/OHH. The state had originally stated that LRE did not qualify based on how we are set up because they are supposed to be run at the PIHP. LRE met with Lindsey Naeyaert and explained that these are already being run through the CMHs and CCBHC. Lindsey stated that she is going to try to revise what was submitted to Centers for Medicare and Medicaid Services (CMS) or to get a waiver to move forward. This will add additional revenue to the region for the people that are already being served in the CCBHC.

As part of the process the LRE agreed to review the handbooks for OHH and BHH and made notations for MDHHS to identify areas that are conflictual between the CCBHC and the OHH/BHH programs.
Last Month's Update: MDHHS has reviewed the feedback submitted by LRE and provided information back to the LRE, and the LRE is working through the information now. The LRE is planning an internal discussion and then will ask to meet with MDHHS again. The individual is presently on parental leave until November so the meeting will take place upon her return.
No Current Update

- FY 18-22 Cost Settlement with MDHHS and LRE Financial Audits –
    - Cost Settlement Letter (Attached) – On 9/21/2023, LRE met with MDHHS and discussed a timeline that RPC estimated was reasonable for them to complete the open audits. MDHHS is aware of the timeline and will support it. The FY21 audit will be complete by October 31, 2023, and FY22 audit will be completed by December 31, 2023. As these audits are completed MDHHS will be able to work with LRE to complete the cost settlement process.
    - The cost settlement letter required LRE to notify MDHHS of the allocation amounts and dates of the deficit payments within 10 days of receipt of the letter. The Department was given all pay-out information on 9/21/2023 following the call with MDHHS.
    - Kristen Jordan has spoken to MDHHS legal and will continue to notify them as the LRE completes the FY21 audit. It appears that the $200,000 sanction may be waived as both MDHHS and LRE work through the resolution of the past historical deficit, completing the compliance audits, and the cost settlement process.

- Wakely Update
    - LRE will be wrapping up the work with Wakely over the next few months. The contract has been extended to 9/30/2023 to continue working on a regional rate analysis and the ISF analysis. Wakely will present the information to the Board when it is complete.
      Update: A total of three meetings have taken place between Wakely and Region 3. Due to final rates not being available in time for the September Board meeting, Wakely will be presenting during the October Work Session prior to Board meeting.

- FY 24 Draft Rates
    - The LRE will receive a 2.5% revenue reduction as the 2nd year of the 5% revenue cut across FY23 and FY24.
      Update: Final rates as of 9/22/2023 are not available. The LRE will be able to provide updates to the CMHs as well as the LRE BOD when we receive final rates.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

MDHHS is scheduling meetings with each PIHP.
Update: The first meeting with LRE was held virtually on September 18th, 2023. The meeting discussed provider network concerns, barriers, and trends. The LRE was pleased at the discussion and felt that the meeting was very collegial with MDHHS staff. The second meeting described as a "meet and greet" is in person at LRE offices and scheduled for October 16th.

OTHER

- Presentation from Alan Bolter regarding FY 24 budget and CMHA priorities. (Attached)

- **Board Works Videos Available Online**:
  The CMHA BoardWorks program was developed to assist Board members in fulfilling their obligations as CMH leaders, directors of policy, and advocates for those they serve. Traditionally, these modules have been offered at conferences and through DVDs. CMHA now offers updated modules available for viewing on our website. The following BoardWorks modules are currently available with more to come!
  Click here to view.

    - Foundations – Intended Beneficiary Command
    - Foundations – Public Policy
    - Management – Systems
    - Current and Future Funding for CMHSPs and PIHPs (formerly Budgets)
    - Leadership – Participatory Governance and Ethical Implications (formerly Character)

Report by Mary Marlatt-Dumas, CEO, Lakeshore Regional Entity

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

DATE: September 12, 2023

TO: Mary Marlatt-Dumas, CEO, Lakeshore Regional Entity

FROM: Kristen Jordan, Director KJ
Bureau of Specialty Behavioral Health Services

SUBJECT: Lakeshore Regional Entity Cost Settlement Fiscal Years 2018-2022

Michigan Department of Health and Human Services (MDHHS) is providing instruction and details to Lakeshore Regional Entity (LRE) pertaining to the cost settlement process for Fiscal Years (FY) 2018 through 2022.

In the Declaratory action filed in 2022, LRE contends to have sufficient funds in its Internal Service Fund (ISF), the Medicaid Savings Funds (MSF), and FY22 surplus to fully reimburse LRE's CMHs for the FY2018 and 2019 deficit, while still appropriately funding all its CMHs. *Lakeshore Reg'l Entity v. Michigan*, Case No. 22-000146 -9 (Mich. Ct. Cl. Mar. 23, 2023).

MDHHS will consider the FY22 contract requirements, as it relates to the proper use of ISF/MSF and surplus funds, as modified to allow LRE to pay historic deficits. The court order did not modify Section 7 – Risk Corridor of the contract. The only expenditures counted in calculating a PIHP's Risk Corridor for a FY are those expenditures that are for services and other activities attributable to that same FY.

To effectuate this order, the Financial Status Report (FSR) reporting requirements, application of the FY22 Risk Management Strategy, compliance with generally accepted accounting principles (GAAP), and contractually required audits and examinations the Department will cost settle the FY2018 through FY2022 Medicaid contracts following traditional reporting requirements and risk corridor calculations as instructed on Attachment A of this letter. The traditional reporting requirements outlined in Attachment A will allow LRE to meet the FY18 and FY19 local share of risk obligation, the FY21 and FY22 savings corridor payment to MDHHS, and to fund the ISF.

FY18, FY19, and FY20FSR Submissions

MDHHS accepted the original FSRs for FY18 submitted on February 28, 2019, FY19 submitted on March 13, 2020, and FY20 on April 12, 2021. These FSRs were used for compliance exam financial status reporting guidelines for each respective year.

Guidelines can be found here: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting, Financial Status Reporting. These submissions should be used for the contract year cost settlements with the Department.

FY21 and FY22 FSR Submissions and Compliance Exams
LRE's FSR for FY21 submitted February 28, 2022, and FSR for FY22 submitted on March 4, 2023, were accepted by MDHHS. These submissions should be used for compliance examinations due annually by June 30th and the contract year cost settlements with the Department.

The FY21 Compliance Exam report is past due and must be submitted as soon as possible. The FY22 Compliance Exam report was granted an extension to August 31, 2023. As of this writing, an additional extension request has not been received. Failure to comply with reporting requirements may result in penalties or adverse actions as indicated in your contract/agreement with MDHHS.

FY21 and FY22 Financial Statement Audit and/or Single Audit
LRE remains out of compliance with the FY21 and FY22 Audit requirements per MDHHS-PIHP Contract, Schedule A-Statement of Work, 1. General Requirements, S. Fiscal Audits and Compliance Examinations and Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards guidance located at 2 CFR 200.501.

The FY21 Single Audit report is past due and must be submitted as soon as possible. The FY22 Single Audit was granted an extension to August 31, 2023. As of this writing, an additional extension request has not been received. Failure to comply with reporting requirements may result in penalties or adverse actions as indicated in your contract/agreement with MDHHS.

LRE Schedule of Payments
LRE shall submit a schedule of payments of past deficits, to include FY, whom payment was made to, and date of payment, **within ten (10) business days** of the date of this letter to contract management at MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

State Share
The MDHHS state share of the risk corridor will be disbursed once LRE has resolved the FY18 - FY19 deficits and all risk corridor payment obligations owed by LRE to MDHHS.

c: Farah Hanley, MDHHS
Meghan E. Groen, MDHHS
Amy Epkey, MDHHS
Shannah Havens, MDHHS
Leslie Asman, MDHHS
Kidada Smith, MDHHS
Jackie Sproat, MDHHS
Tim Kubu, MDHHS
June White, MDHHS
Debi Andrews, MDHHS
Ashley Seeley, MDHHS
William Anderson, MDHHS

Attachment A

FY2018 and FY2019

- MDHHS will allow the FY18 and FY19 FSRs to reflect the unfunded local share of the risk corridor with acknowledgement that the deficits will be addressed with future year funds.
- The State share of the risk corridor will be disbursed once all deficits and amounts due MDHHS are satisfied.

FY2020

- The earned Medicaid savings will be reported and expended in the FY21 FSR (Attachment P.7.7.1.1, Medicaid Contract Settlement Worksheet, Section 5.5).

FY2021

- The earned Medicaid savings will be reported and expended in the FY22 FSR (Schedule E, Medicaid Contract Settlement Worksheet, Section 5.5).
- The Medicaid lapse shall be returned to MDHHS.

FY2022

- The earned Medicaid savings will be utilized to cover the FY18 and FY19 unfunded local share of the risk corridor.
- Section 6 of the Medicaid Contract Settlement Worksheet will be utilized to report the earned Medicaid savings balance and disposition of the FY18 and FY19 unfunded local share of the risk corridor.
- A balance of the earned Medicaid savings will be identified in the settlement letter and should be reported and expended in the FY23 FSR.
- The Medicaid lapse shall be returned to MDHHS.

Fall 2023 Public Policy Updates

2022 Election Recap – Historic Shift in Power

The November 8 2022 election results were truly historic for Michigan Democrats, defying historical trends and the prognostications.

* Democrats were able to take control of every aspect of state government for the first time in over 40 years.
* Democratic Governor was able to win reelection in Michigan with a sitting Democrat in the White House for the first time in over 50 years.
* Democrats flipped both legislative chambers – Republicans had a 22-16 majority in the Senate and a 57-53 majority in the House
    * 2023-2024 Democrats have a 20-18 majority in the Senate and a 56-54 majority in the House
    * 2016 Republicans had the Governors office, 26-12 supermajority in the Senate and had over 60+ seats in the House.

It is very apparent that Democrats were helped a great deal by the newly drawn legislative districts as well as Proposal 3, which many believed helped boost Democratic enthusiasm across the state.

Legislative Accomplishments

During the first 100 days of the new legislative session Governor Whitmer and the democratic led legislature were able to:

* Eliminated the retirement tax
* Increased the Earned Income Tax Credit
* Expanded Michigan's Elliott-Larsen Civil Rights Act to protect sexual and gender identity
* Eliminated the 1931 abortion law to protect reproductive freedoms
* Repealed Right to Work
* Restored the state's prevailing wage law
* Passed gun reforms – background checks, safe storage, and extreme risk protection orders (red flag)
* Passed a bill to move up the Democratic Presidential Primary election to the end of February
* Passed supplemental budgets to support hundreds of millions of dollars for corporations to build batteries for EVs, paper mill in UP and other items.

CMHA Priorities

Our members have been active

CMHA & our members have been in front of a number of legislative committees over the past few months.

- CMHs / PIHPs / Providers
- from all parts of the state

* House Behavioral Health Subcommittee (3 times)
* House MDHHS Budget Subcommittee
* Senate Health Policy Committee
* Senate MDHHS Budget Subcommittee (2 times)

Topics included:

CCBHC	Workforce	Funding needs
BHH/OHH	Crisis services	Admin burdens

CMHA Priorities

ACCESS TO CARE

* SUPPORT fully funding the permanent implementation of Michigan's State Demonstration Certified Community Behavioral Health Clinics (CCBHC) pilot, and Behavioral Health Homes and Opioid Health Home initiatives as features of Michigan's Medicaid mental health landscape.

* SUPPORT the passage of Mental Health Parity legislation which leads to true parity for those with commercial insurance plans for mental health and substance use disorder services.

* RESTORE STATE GENERAL FUND DOLLARS cut from the CMH funding reserved to serve persons not enrolled in Medicaid

* SUPPORT initiatives on improving access to and quality of care for children.

* SUPPORT the establishment of a recipient rights appeal process at the MDHHS level – outside of the CMH, hospital, or provider who conducted the initial recipient rights investigation.

CMHA Priorities

WORKFORCE

- SUPPORT an $18/hour floor funding rate for direct care workers in the public mental health system to allow for competitive wages for frontline staff workers , including paid time off, overtime, and supervision, and also SUPPORT additional funds for other staff to avoid wage compression issues.

- INCREASE the Medicaid funding for the public mental health system to reflect the increased wages and provider rates needed to recruit and retain clinicians from a wide variety of clinical disciplines.

- ELIMINATE / REDUCE a number of administrative burden on the public mental health system.

  - **Reduce clinical and contractual paperwork demands**
  - **Reverse the recent explosion in the number of procedure codes required of the community-based system:** Two developments on this front are in immediate attention:
    - **MDHHS and Milliman-led move to 15-minute codes for community living supports (CLS) vs 1 report per day.**
    - **MDHHS and Milliman-led dramatic increase in service code combinations –** the complexity and burden on the clinicians and other service delivery staff, finance, and information technology staff of the community-based system have grown exponentially, **7,169 combinations of unit costs that must reported by the community-based system.**

- **Overhaul the large number of site visits and reporting requirements on Michigan's public mental health system**

- **Streamline training and credentialing requirements for clinicians**

CMHA Priorities

INPATIENT CARE

* SUPPORT the further development and expansion of psychiatric residential treatment facilities (PRTF) and crisis stabilization units (CSU) which will help add to the continuum of care for crisis services.

* SUPPORT inpatient psychiatric hospitals and wards with physical plant and staffing changes, helping hospitals better serve persons with complex mental health needs.

* SUPPORT legislative changes that would allow children's residential group homes to use restraint in emergency situations to better protect residents of the group home and staff.

* SUPPORT policy changes to psychiatric hospitals that would mirror the federal Emergency Medical Treatment & Labor Act (EMTALA) to prevent individuals from being denied access to emergency services regardless of ability to pay.

Budget Items

Figure 1

A Legislator's Guide to Michigan's Budget Process
Page 8

House Fiscal Agency
October 2014

Budget Update

* Legislature finalized the FY24 budget in late June, passing the largest budget in the state of Michigan ever – total was over $87 billion.

* What's left over? Beginning on the FY24 budget process the state had nearly a $9 billion budget surplus (much of it was federal COVID relief and other federal dollars)

  * Income tax rollback, EITC tax credit and retirement tax reduced surplus by over $1.5 billion.
  * After the passage of the FY24 budget the state has roughly a $300-400 million surplus.

FY24 Budget Update

FY24 Senate & House Budget Proposals

Specific Mental Health/Substance Abuse Services Line items

	FY'22 (Final)	FY'23 (Final)	FY'24 (Final)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$3,124,618,700	$3,044,743,000	$3,160,958,400
-Medicaid Substance Abuse services	$83,067,100	$94,321,800	$95,264,000
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,705,200	$79,705,200	$79,599,700
-Health Homes Program	$33,005,400	$61,337,400	$53,400,100
-Autism services	$339,141,600	$292,562,600	$279,257,100
-Healthy MI Plan (Behavioral health)	$603,614,300	$570,067,600	$590,860,800
-CCBHC	$25,597,300	$101,252,100	$386,381,700
-Total Local Dollars	$15,285,600	$10,190,500	$10,190,500

FY24 Budget Highlights

- Medicaid Actuarial Soundness – estimated 2.5% actuarial soundness adjustment for prepaid inpatient health plans (PIHPs)

- Direct Care Wage Increase – Conference includes $120.2 million Gross ($42.7 million GF/GP) to support a $0.85 per hour wage increase

- Behavioral Health Recruiting and Retention – Conference includes $2.5 million SFRF on a one-time basis for recruitment and retention programs for behavioral health professionals.

- Behavioral Health Accelerated Degree Program – Conference includes $5.0 million GF/GP on a one-time basis to provide grants to individuals who agree to enter into an accelerated social work degree program and to work for at least 2 years within the public behavioral health sector after completion of their degree.

FY24 Budget Highlights

* Certified Community Behavioral Health Clinics – Conference includes $279.7 million Gross ($65.4 million GF/GP) to expand the current 13 CCBHC provider organizations/sites by 19 additional provider organizations/sites.

* Behavioral Health – One-time funding – Conference includes $79.8 million GF/GP for the following:

- ACCESS substance use disorder clinic ($10.0 million)
- Multicultural integration funding ($8.6 million)
- Corewell Health/Beaumont psychiatric outpatient clinic ($8.0 million)
- Child and Family Services Ingham behavioral health campus ($6.0 million)
- Families Against Narcotics ($5.0 million)
- First responder mental health funding ($5.0 million)
- Michigan Crisis and Access Line (MiCAL) ($5.0 million)
- CEI CMH (4.0 million)
- Western Michigan University Autism Center ($4.0 million)
- Biomarker testing Team Wellness ($3.5 million)
- Sacred Heart Rehabilitation Center ($3.5 million)
- Tecumseh Psychiatric Hospital ($3.0 million)
- Jail Diversion Fund ($2.5 million)
- Kalasho Education and Youth Services (KEYS) ($2.5 million)
- Michigan Clinical Consultation and Care (MC3) ($2.5 million)
- Altarum behavioral health integration software ($2.0 million)
- Recovery Community Organization ($1.8 million)
- Hype Athletics SUD ($1.0 million)
- Developmental milestones toolkit ($500,000)
- Michigan Osteopathic Association – Safe Opioid Use Task Force ($500,000)
- Preserve Independence adult day center ($500,000)
- Dutton Farms ($250,000)
- Living and Learning Center ($150,000)

FY24 Boilerplate Items

Sec. 917. Michigan Opioid Healing and Recovery Fund – REVISED (Agrees with House language)
(1) From the funds appropriated in part 1 for opioid response activities, the department shall allocate $23,200,000.00 from the Michigan opioid healing and recovery fund created under section 3 of the Michigan trust fund act, 2000 PA 489, MCL 12.253, to create or supplement opioid-related programs and services in a manner consistent with the opioid judgement judgment, settlement, or compromise of claims pertaining to violations, or alleged violations, of law related to the manufacture, marketing, distribution, dispensing, or sale of opioids.
(2) On a semiannual basis, the department shall provide a report to the report recipients required in section 246 of this part on all of the following: (a) Total revenues deposited into and expenditures and encumbrances from the Michigan opioid healing and recovery fund since the creation of the fund. (b) Revenues deposited into and expenditures and encumbrances from the Michigan opioid healing and recovery fund during the previous 6 months. (c) The estimated revenues to be deposited into and the spending plan for the Michigan opioid healing and recovery fund for the next 12 months.

Sec. 1005. Health Home Programs – REVISED Requires DHHS to maintain the number of behavioral health homes in PIHP regions 1, 2, 6, 7, and 8 and the number of opioid health homes in PIHP regions 1, 2, 4, 6, 7, 9 and 10, and permits expansion into additional PIHP regions; requires a report. Executive revises to update location of health homes, permits expansion into at least one additional PIHP region and strikes report. Conference concurs with Execute update, with technical revisions, and expansion into at least one additional PIHP region and revises to a semiannual report.

Fall Agenda

What does the Fall Legislative agenda hold?

How will politics play a role? Short fall session?

On Wednesday, August 30, Governor Gretchen Whitmer delivered her first-ever fall policy address, outlining the state's accomplishments thus far and upcoming policy priorities for the fall. In her "What's Next?" address, the Governor announced the following priorities:

* Protecting fundamental rights by enacting the Reproductive Health Act to remove harmful restrictions and barriers to reproductive care.
* Passing Paid Family/Medical Leave to ensure all workers, even employees of small businesses, have access to paid leave to create a pro-family state and economy.
* Lowering prescription drug prices by establishing the Prescription Drug Affordability Board to address prescription drug prices and encourage R&D in Michigan.
* Enacting clean energy standards in Michigan by investing in solar and wind energy projects and ensuring the Michigan Public Service Commission have the appropriate tools at their disposal to "get it done".
* Updating Michigan's process for permitting advanced manufacturing, infrastructure, housing, and much more.
* Citing the need for election security by ensuring all Michiganders and their votes are heard and respected, as well as protecting the state from threats against our democracy.
* Fostering a healthy economy by continuing to support safe roads, affordable housing, quality education, and unions.

Fall Agenda

HB 4707

Medically necessary treatment of a mental health or substance abuse disorder

* It is in accordance with the generally accepted standards of mental health and substance use disorder care.
* t is clinically appropriate in terms of type, frequency, extent, site, and duration.
* It is not primarily for the economic benefit of the insurer or purchaser or for the convenience of the patient, treating physician, or other health care provider.

An insurer would be required to provide coverage for the full continuum of service intensities and levels of care described in the most recent versions of the following:

* The ASAM Criteria by the American Society of Addiction Medicine.

Out-of-network services

If services for the medically necessary treatment of a mental health or substance use disorder are not available in-network within the geographic or timeliness access standards under law, the insurer would have to arrange coverage to ensure the delivery of medically necessary out- of-network services and any medically necessary follow-up that meet those geographic and timeliness standards to the maximum extent possible. **In these cases, the insured would not have to pay more in total for benefits rendered than the cost-sharing they would pay for the same covered services received from an in-network provider.**

Other Items of Importance

CCBHC Expansion

MDHHS recently announced the Certified Community Behavioral Health Clinic (CCBHC) Demonstration Expansion Opportunity. The expansion will be allowing new CMHSPs to join, those sites interested in participating in the demonstration must complete an intent to submit certification application survey by May 5.

To receive certification from MDHHS and participate in the demonstration, CCBHCs must also demonstrate that they meet stringent standards for care coordination, quality and financial reporting, staffing, and governance. Clinics are reimbursed using a prospective payment system intended to cover costs of providing CCBHC services.

MDHHS is soliciting requests for new clinics to join the CCBHC demonstration beginning October 1, 2023 (FY24). *MDHHS does intend to seek funding to further expand the CCBHC Demonstration in the future, as well.*

- 34 sites in total have received various CCBHBC expansion and innovation and advancement grants. The federal government has just released guidance that would allow Michigan to expand its state demonstration to include all of its CCBHC sites.
  - 21 of those sites are CMHSPs (10 in current demo and 11 have received grants)
  - On a April 24 call, MDHHS recently announced that expansion to the demo would only be eligible CMHs and current demonstration sites.

Dual Eligible Special Needs Plan D-SNP

* On a February 8, 2023 MDHHS informed Centers for Medicare and Medicaid Services (CMS), of its intent to transition its MI Health Link program to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) that integrates long-term service and supports (LTSS).
* In this new model, contracted managed care plans will provide most covered benefits for their dual-eligible enrollees, but specialty behavioral health services will remain carved out. This decision reflects current state statute that requires a carve out of specialty behavioral health services.
* Critical Timelines:
  * Procurement of HIDE + LTSS SNPs to be completed by October 31, 2024
  * Procured HIDE + LTSS SNPs to submit D-SNP applications to CMS by November 2024
  * Program transition to the HIDE + LTSS SNP must be completed by January 1, 2026
* **THREAT REMAINS:** While this announcement is very good news, most state's use a HIDE model as a stepping-stone to what is known as a Fully Integrated Dual Eligible Special Needs Plan (FIDE). Given this threat, CMHA will be working with you, our members, and our allies across the state, to thwart this threat, if and when it emerges. Additionally, CMHA will be working with our allies to oppose any components of the HIDE initiative, that my fuel the emergence of the FIDE threat, while advocating for the addition of components that thwart that threat.

MI Healthy Life – MHP Rebid

* After hearing from nearly 10,000 residents, the Michigan Department of Health and Human Services (MDHHS) has identified focus areas for its MIHealthyLife initiative to improve the health of residents covered by Medicaid.
  * Of the responses, 85%, or more than 8,300, came from people enrolled in Medicaid or a family member. The remaining 15% came from other health care stakeholders, including health plans, primary care providers, behavioral health providers and hospitals or health systems

The five pillars are:

* Serve the Whole Person, Coordinating Health and Health-Related Needs.
* Give All Kids a Healthy Start.
* Promote Health Equity and Reduce Racial and Ethnic Disparities.
* Drive Innovation and Operational Excellence.
* Engage Members, Families and Communities.

MDHHS established six design teams consisting of subject matter experts from across the department to create actionable policies to support these strategic pillars.

MDHHS will accept proposals for Comprehensive Health Care Program Medicaid health plans in fall 2023.

Standard Cost Allocation

Michigan's public mental health system is strong supporter of a standard cost allocation approach.

CMHA and its members are concerned with a number of the constructs and methods proposed by Milliman and mandated by MDHHS. The constructs of greatest concern center around a misunderstanding of the roles played by the state's CMHSPs relative to provider and managed care functions.

1. **Violates a decades-long set of constructs, contained in federal law and regulations, state law, the state's Medicaid waivers, and in contract**, defining the roles played by the state's CMHSPs and PIHPs relative to provider and managed care functions.

2. **Misstates both managed care administrative and service-related costs** – resulting in artificially reduced service costs and artificially inflated managed care administration costs (e.g., credentialing of providers and claims processing costs which have always been and continue to be a CMHSP functions as a core part of the CMHSP comprehensive network provider role, long before managed care, would be inaccurately considered managed care administration)

We were able to SCA waiver for CCBHC sites because there was a conflict with the some of the key functions, which negatively impacted the PPS payments:

- Care coordination
- Network management
- Access related work

Conflict-Free Access and Planning Options

- Meeting coming up soon with MDHHS leadership.
- Seeking legal option on CFAP – we believe MI has approval for its HCBS plan and it allows for integration (access and planning & services done in the same place but by different staff persons)

Concerns w/ CFAP:

- 1. The structural separation of access and planning from service delivery, proposed by MDHHS, presents an artificial access barrier to persons seeking services, weakens continuity and coordination/integration of care, and makes an already complex system more complex.
  - In fact, the comments received by MDHHS during the listening sessions with persons served underscore their concern that the structural separation, proposed by MDHHS, hampers continuity of care
- 2.The options outlined dismantle Michigan's comprehensive risk-sharing public safety net system when a range of other conflict mitigation tools exist.
- 3. The core characteristics of Michigan's community mental health system – statutorily defined public safety net role; financed through a shared-risk Medicaid capitation payment system; with mandated roles including access, clinical plan development, and network management – call for conflict-mitigation approaches that reflect these dimensions, unlike those applied to private, fee-for-service provider networks.

Redesign Dangers

Redesign Dangers

* Sen. Shirkey is gone – his bills did not pass
  Rep. Curt VanderWall (former Senator) is planning on reintroducing the bills.

* Sen. Ed McBroom has been meeting with his locals in the UP to discuss a "new plan".
  * Consolidate 5 UP CMHs to 1 (eliminate multiple CEO & CFO positions)
  * Create district hub offices throughout the UP
  * Eliminate Northcare PIHP and create a new entity that involves the UP Health and hospital system (hospital would guarantee access for UP) .
    * Not talking to CMHA or UP CMHs, only taking to UP county commissioners

Other threats remain

* The most common approach to privatization is done through the contacting/procurement process vs legislative changes
  * Medicaid Rebid process
  * Moving D-SNP to FIDE

* Many other states that have moved towards privatization / health plan control were done under Democratic control (Colorado & Maryland – recent examples)

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