AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
PROGRAM COMMITTEE MEETING

Thursday, April 11, 2024 at 5:00 pm

William B. Cammin Clinic, Bay Room, 1010 N. Madison Avenue, Bay City, MI 48708

Committee Members:	Present	Excused	Absent	Committee Members:	Present	Excused	Absent	Others Present:
Chris Girard, Ch				Toni Reese				BABH: Heather Beson, Chris Pinter, and Sara McRae
Sally Mrozinski				Richard Byrne, Ex Off				

Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Youth Mental Health First Aid Training 4.2) Independent Facilitation Stakeholder Workgroup Report 4.3) Michigan Department of Health and Human Services (MDHHS) Conflict Free Access & Planning Update		4.1) No action necessary 4.2) No action necessary 4.3) No action necessary
5.	Adjournment	M - S - pm	MA

Link for those interested to pre-enroll:
https://forms.office.com/r/xiEpd270d3

Date: Monday, May 20, 2024
Time: 8:30 AM- 4:30 PM
Location: BABH Staff Development Center, 1010 N. Madison Ave. , Bay City MI, 48708
Pre- Enrollment:
https://forms.office.com/r/xiEpd270d3

WHY YOUTH MENTAL HEALTH FIRST AID?

Youth Mental Health First Aid teaches you how to identify, understand and respond to signs of mental health and substance use challenges among children and adolescents ages 12-18.

10.2%
of youth will be diagnosed with a substance use disorder in their lifetime.
*Source: Youth Mental Health First Aid***

1 IN 5
teens and young adults lives with a mental health condition.
*Source: National Alliance for Mental Illness**

50%
of all mental illnesses begin by age 14, and 75% by the mid-20s.
*Source: Archives of General Psychiatry****

WHO SHOULD KNOW MENTAL HEALTH FIRST AID?

- Teachers.
- School Staff.
- Coaches.
- Camp Counselors.
- Youth Group Leaders.
- Parents.
- Adults who Work with Youth.

WHAT MENTAL HEALTH FIRST AID COVERS

- Common signs and symptoms of mental health challenges in this age group, including anxiety, depression, eating disorders and attention deficit hyperactive disorder (ADHD).
- Common signs and symptoms of substance use challenges.
- How to interact with a child or adolescent in crisis.
- How to connect the youth with help.
- Expanded content on trauma, substance use, self-care and the impact of social media and bullying.

Learn how to respond with the Mental Health First Aid Action Plan (ALGEE):

- **A** ssess for risk of suicide or harm.
- **L** isten nonjudgmentally.
- **G** ive reassurance and information.
- **E** ncourage appropriate professional help.
- **E** ncourage self-help and other support strategies.

Independent Facilitation Stakeholder Workgroup: Summary

Michigan Developmental Disabilities Institute

Community Service
Education
Research
Dissemination

WAYNE STATE UNIVERSITY

Angela Martin

Agenda

- Summarize the purpose of Stakeholder Group
- Identify the Stakeholder Group membership
- Describe the issues impacting utilization of Independent Facilitation for the planning process
- Share workgroup outcomes and recommendations

Stakeholder Purpose

Michigan Developmental Disabilities Institute (MI-DDI) collaborate with the Michigan Department of Health and Human Services (MDHHS)/Behavioral and Physical Health and Aging Services Administration (BPHASA) to convene a group of stakeholders to support Independent Facilitation for the Person-Centered Planning process.

Workgroup members: staff from Pre-Paid Inpatient Health Plans, local Community Mental Health Service Providers, and BPHASA; trained Independent Facilitators; Individuals with disabilities and Family Members; and several statewide disability partners.

Topics

Independent Facilitator role and responsibilities with a planning process	**Review current Independent Facilitator statewide utilization rates (H0032-WQ)**	**Draft an Independent Facilitator template agreement and invoice**	**Draft language on Independent Facilitation for the Medicaid Provider Manual**

Issues Impacting Independent Facilitation

PIHPs, CMHSPs

Billing, Payment Processing

Service Fees

Facilitator Qualifications

Contract Requirements

Information & Training for Support Coordinators/Case Managers

Independent Facilitators

Contracting

Training

Requirements

Individual, Families

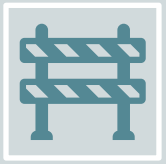
Information & Training

Support to Choose an Independent Facilitator

Workgroup Outcomes

Developed materials to enhance the utilization of Independent Facilitators

Recommendations for the MDHHS' Person-Centered Planning Technical Guidance



Identified system barriers and developed solutions

Few requests for IF

Individuals are informed about IF

SCs/CMs have information & training; facilitator is a planning partner

Encounter Data

Independent Facilitation HCPCS: H0032-WQ

		FY 22		FY 23		Combined	
PIHP	CMH	Billed Units	Beneficiaries	Billed Units	Beneficiaries	Billed Units	Beneficiaries
Detroit-Wayne MH Authority	Detroit-Wayne	3	3	2	2	5	5
Lakeshore Regional Entity	Ottawa CMH	5	2			5	2
	West Michigan CMH	1	1			1	1
Mid-State Health Network	Bay-Arenac CMH	6	6	2	2	8	8
	CEI CMH			3	2	3	2
	Central Michigan CMH	3	2	4	4	7	6
	LifeWays	18	5	10	7	28	12
	Saginaw CMH	3	3			3	3
Southwest MI Behavioral Health	Barry CMH			1	1	1	1
	Kalamazoo County CMH			6	4	6	4
TOTAL		39	22	28	22	67	44

Addition to Medicaid Provider Manual

Medicaid Provider Manual draft language: "Individuals who receive behavioral health supports and services have the right to choose an independent facilitator (IF) to facilitate the person-centered planning (PCP) process that is used to develop the Individual Plan of Service (IPOS). Independent Facilitators are independent from the public behavioral health system."

The recommended language:

- will include all populations served by the behavioral health system,
- provide consistency within the Medicaid Provider Manual, and
- will be accessible throughout the Manual.

Citations:

- page 356: "3.30 TREATMENT PLANNING [RE-NUMBERED 4/1/23]"
- page 429: "13.3 CORE REQUIREMENTS [CHANGES MADE 4/1/23]"to the 2nd bullet
- page 461: "15.1 WAIVER SUPPORTS AND SERVICES [CHANGES MADE 4/1/23 & 7/1/23]" to the 8th bullet

Additional information for this guidance

"The functions and duties of the PCP facilitator (independent facilitator or SC/CM) include the following:

- Get to know and learn about the person, including likes/dislikes, goals, preferences, communication methods, and who/what is important to and for them.
- Support the person with pre-planning. Pre-planning involves setting the agenda for the PCP meeting, including who the person wants to invite, topics they want to discuss or avoid at the PCP meeting, where and when the PCP meeting will take place.
- Help the person choose a PCP planning tool, if desired by the individual.
- Provide support to the person so they can direct their own PCP process, if desired by the individual.
- Ensure the individual is heard, understood, and respected throughout the PCP process.
- Keep PCP process participants on track and ensure that the focus remains on the individual.
- When an independent facilitator (IF) is used, the IF will organize information from the PCP meeting and assist the individual's supports coordinator in their duty and responsibility to draft an IPOS that is written in plain language understandable by the person, expresses the individual's goals, and provides for services/supports to help the person achieve their goals.
- Follow up with the individual within thirty (30) days after the submission of the planning process material to confirm the IPOS reflects what was discussed in the PCP meeting, including the person's needs and goals, and provides for necessary services/supports.

Independent Facilitation is a component of treatment planning and is an authorized service. Treatment planning is an authorized code; the IF modifier does not require a distinct authorization."

Clarify: Provider Qualifications

Paid Independent Facilitators

- **One-year experience**: Lived experience with disabilities or experience working with individuals with disabilities (I/DD, MH, or SUD)
- **Independent from local and/or state behavioral health system**
- **Eligible to be contracted as a provider of behavioral health services**:
  - Be at least 18 years of age,
  - Be in good standing with the law (i.e. not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien), and
- **Not employed by a Community Mental Health or contracted service provider agency**. Peer Mentors, Peer Support Specialists, Recovery Coaches and Parent Support Partners may not provide Independent Facilitation to individuals receiving services from the behavioral health agency the peer is employed by. They may provide Independent Facilitation to individuals receiving services from other behavioral health agencies.

Note: Good standing with the law is evidenced by passing a background check to the satisfaction of the individual and the contracting behavioral health agency.

Training, Tasks, Other Requirements

Required Training

Completion of the MDHHS "Improving My Practices" courses on Person Centered Planning (4 Course Modules) or a Person-Centered Planning training course from a recognized international, national, or state organization in Person-Centered Planning

Completion of Office of Recipient Rights training (any CMHSP is acceptable)

Other, Essential Tasks

Work in collaboration with a qualified supports coordinator or case manager to support the development of an individual plan of service.

Training Not Required

First Aid/CPR

Other, Not Required

National Provider Identification (NPI) Number or registration in CHAMPS. Independent Facilitators are to use the CMHSP's NPI number if they don't have their own.

Provider Insurance Coverage (General liability insurance or Professional liability insurance)

Service Rates: Examples

Region 1, CMHSP

$150.00 per meeting; Reimbursement Rate, per each individual's Person-Centered Plan (PCP), including, but not limited to pre planning and attendance at the planning meeting, and/or $20.00 per CMH-required training.

Region 2, CMHSP

$150 for plan facilitation

Region 3, CMHSP

- Pre-planning: $45/event, not to exceed 2 hours per individual.
- Planning Meeting and Follow-up Calls: $45 for the first hour, $11.25 per 15-minute unit after the first hour, not to exceed 4 hours per individual.
- Post-plan interview: $45/event, not to exceed 1 hour per individual.
- Mileage: reimbursement per current IRS rate at time of service, from home/workstation to place where IF pre- and post-planning activities are occurring.

Region 4, CMHSP

$165 per encounter, typically with multiple encounters (e.g. pre-planning, planning and follow-up meeting(s)). Rate may vary somewhat by educational level.

Service Rates: Examples

Region 5, CMHSP

$145 for each encounter or approximately $70 per hour

Region 6, CMHSP

$150 in total for the pre-planning and planning process

Region 7, CMHSP

$180 in total for the entire process (Pre-plan/plan/follow up)

Region 8

$150 for completing the Preplanning, $225 for completing the Person-Centered Planning sessions.

Note: If a person starts with IF and chooses not to complete planning with IF, the IF is compensated $50. Additional items: a) compensated at a rate of $25 for each Post Plan Interview completed and submission of the required documentation; b) compensated at a rate of $35 per hour for any educational activities or non-PCP related meeting attendance, including travel time, in regard to the Contractor's IF role.

Invoice Template

Invoice Template

Date:

Vendor: Independent Facilitator (Name, Contact Information)

Supports Coordinator or Case Manager of Person:

Send to: [Insert PIHP or CMHSP contact, address]

Service	Rate	Amount
Pre-Planning: [Enter dates of service] Encounter Code: H0032-WQ	$	$
Planning: [Enter dates of service] Encounter Code: H0032-WQ	$	$
Post-Planning: [Enter date of service] Encounter Code: H0032-WQ	$	$
Mileage: [Enter number of miles], Reimbursed at federal rate	$[enter current federal rate]	$
Total		**$**

Service descriptions

Pre-Planning: Assist the individual with all pre-planning activities including determining whom to invite, where to meet, establishing an agenda and meeting ground rules [what to discuss/what not to discuss], determine any accommodations for optimal participation, and review ethnic or cultural issues. Discuss the individual's current plan of service and plans for one's future to prepare for the planning process. Deliver a written summary, clearly handwritten or typed, of the pre-planning activities to the Support Coordinator/Case Manager three (3) days prior to the scheduled planning meeting.

Planning: Attend and facilitate or co-facilitate the planning process. Encourage and support the person and planning participants to support the person's vision for one's life. Assist the individual and planning participants to identify behavioral health services and community resources to support the individual's vision. Deliver notes from the planning meeting(s), clearly handwritten or typed, shall be provided to the Supports Coordinator/Case Manager at the Community Mental Health or Pre-Paid Inpatient Health Plan five (5) days after the planning process is completed.

Post-Planning: Contact the individual, who received Independent Facilitation services, within thirty (30) days after the submission of the planning process material to determine if the individual's dreams, goals, and objectives are reflected in the completed Person-Centered Plan and supporting Individual Plan of Service (IPOS). The contractor will provide documentation for the post-plan interview.

Updated: November 2023

Post-Planning Follow-up

Name of Independent Facilitator:

Contact information of Independent Facilitator:

Initials of Person:

Date of PCP meeting:

Name of Supports Coordinator/Case Manager:

CMHSP:

Questions for Person

1. Does your Individual Plan of Service (IPOS) reflect what was discussed in your person-centered planning (PCP) meeting held on _____ (insert PCP meeting date(s))?

2. Is anything missing from the IPOS you just received?

3. Do you have any questions or concerns about the IPOS or PCP process?

Independent Facilitator to send the post-planning follow-up form to:

- ❑ Supports coordinator/Case Manager for entry into person's electronic health record.
- ❑ If follow-up action needed, send to CMHSP Customer Service.

Updated: November 2023

Independent Facilitator Template

Independent Facilitator Agreement Template

Individual [ENTER Name of Independent Facilitator] will be contracted as an independent contractor of Independent Facilitation services for the Person-Centered Planning process. Individual [ENTER Name of Independent Facilitator] will provide some or all of the following activities for a recipient of behavioral health services at [ENTER Name of Pre-Paid Inpatient Health Plan or Community Mental Health Services Programs]. The recipient of behavioral health services determines which services the Independent Facilitator will provide.

I. **Service descriptions**

A. Pre-Planning: Assist the individual with all pre-planning activities including determining whom to invite, where to meet, establishing an agenda and meeting ground rules [what to discuss/what not to discuss], determine any accommodations for optimal participation, and review ethnic or cultural issues. Discuss the individual's current plan of service and plans for one's future to prepare for the planning process. Deliver a written summary, clearly handwritten or typed, of the pre-planning activities to the Support Coordinator/Case Manager within three (3) days prior to the scheduled planning meeting.

Compensation for Pre-Planning:

B. Planning: Attend and facilitate or co-facilitate the planning process. Encourage and support the person and planning participants to support the person's vision for one's life. Assist the individual and planning participants to identify behavioral health services and community resources to support the individual's vision. Deliver notes from the planning meeting(s), clearly handwritten or typed, shall be provided to the Supports Coordinator/Case Manager at the Community Mental Health or Pre-Paid Inpatient Health Plan within five (5) days after the planning process is completed.

Compensation for Planning:

C. Post-Planning: Contact the individual, who received Independent Facilitation services, within thirty (30) days after the submission of the planning process material to determine if the individual's dreams, goals, and objectives are reflected in the completed Person-Centered Plan and supporting Individual Plan of Service (IPOS). The contractor will provide documentation for the post-plan interview.

Compensation for Post-Planning:

II. **Provider qualifications:** The contractor must check all boxes to certify their qualifications.

❑ *I certify that I meet all of the following qualifications.*

- I have at least one year of experience, either lived experience with disabilities or experience working with individuals with disabilities (I/DD, MH, or SUD).
- I am eligible to be contracted as an independent facilitator:
  - 18 years or older, and
  - In good standing with the law, and
  - Not employed by a Community Mental Health or contracted service provider agency. Peer Mentors, Peer Support Specialists, Recovery Coaches and Parent Support Partners may not provide Independent Facilitation to individuals receiving services from the behavioral health agency the peer is employed by. They may provide Independent Facilitation to individuals receiving services from other behavioral health agencies.

❑ *I have completed the required training:* training on Person-Centered Planning and Recipient Rights. *Specify the name and date of the training and attach copies of your training certificates when submitting this signed agreement.*

❑ MDHHS "Improving My Practices" courses on Person Centered Planning (4 Course Modules)

Date: [ENTER DATE]

❑ A Person-Centered Planning training from a recognized international, national, or state organization in Person-Centered Planning

Training Provider: [ENTER NAME OF PROVIDER]
Date: [ENTER DATE] **AND**

❑ Completion of Office of Recipient Rights training (any CMHSP is acceptable)

Training Provider: [ENTER NAME OF PROVIDER]
Date: [ENTER DATE]

❑ I attest that I am able to prevent transmission of any communicable disease from myself to others in the context of independent facilitation.

By signing this agreement, I certify all the statements are true.

Signature:

Date:

Next Steps

Present this information to key stakeholders and groups

- PIHP Directors (1/4/24)
- CMHSP Directors (1/24/24)
- Quality Improvement Council (2/7/24)
- Developmental Disabilities Practice Improvement Team (2/14/24)
- Trained Independent Facilitators (Date: TBA)

Include materials and recommendations in the Person-Centered Planning Technical Guidance

Disseminate templates

- MDHHS/BPHASA webpage
- MI-DDI Independent Facilitation webpage (https://ddi.wayne.edu/if)

Increase awareness of individuals served, their families, and Case Managers

Contact information

Michigan Developmental Disabilities Institute

WAYNE STATE UNIVERSITY

Michigan's Center for Excellence in Developmental Disabilities

268 Leonard N. Simons Building
4809 Woodward Avenue
Detroit, Michigan 48202
Phone: (313) 577-2654
Website: www.ddi.wayne.edu

An Alternative to MDHHS's Approach to Meeting Federal Conflict Free Standards:

One that ensures access and minimizes complexity

The Michigan Department of Health and Human Services (MDHHS) recently proposed new requirements for individuals seeking mental health services through the public mental health system. While the new requirements would comply more directly with federal Conflict-Free Access and Planning (CFA&P) guidelines, they would create access challenges for those seeking care, service delays and additional costs to providers.

What is Conflict-Free Access and Planning?

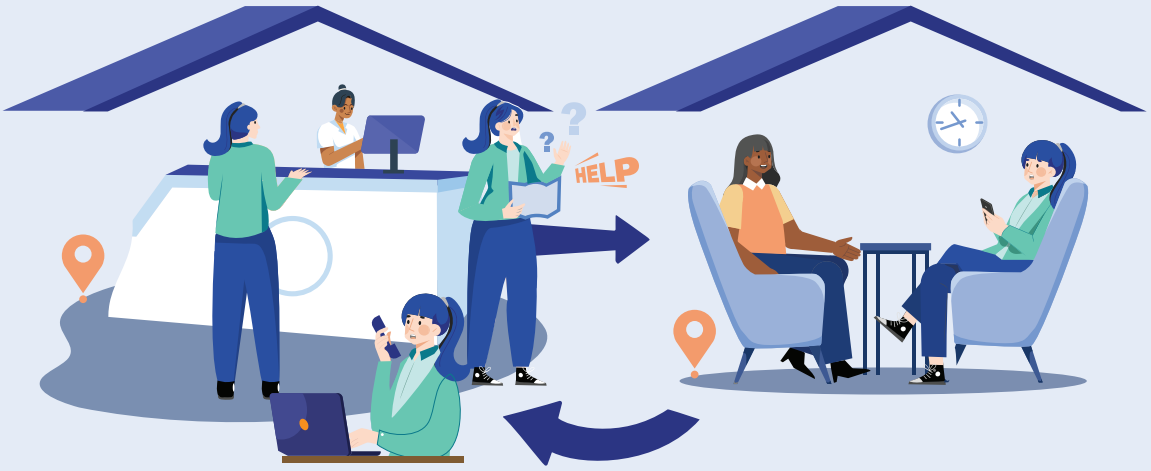
Public mental health providers receive payment through capitation payments. **Capitation payments** are fixed monthly allocation provided to a medical provider through a state or private health plan – simply put, the more people enrolled means more overall financial support being allocated to the mental health services. **These payments are paid monthly to providers for each member enrolled in the health care plan no matter how many times the member utilizes services.** Increased enrollment in the Medicaid system throughout the public health emergency boosted budgets allowing for increased services and better mental health support throughout the state.

Michigan's Current CMH-based Model

Allows a 1-stop shop for people to do an assestment, planning, case management and receive services

Approach Proposed by MDHHS

Requires you to go to one "provider" for assestment, planning, and case management, and another "provider" to receive services. If you change your service plan, you must go back to the planning "provider."



DISADVANTAGES OF MDHHS' PROPOSED APPROACH

- Delays service delivery
- Increases costs
- Increases administrative burden
- Adds confusion and barriers for people served

CMHA's Recommendations

CFA&P rule does not apply to Michigan's Public Mental Health System

1. CMHSPs are governmental bodies prohibited from profit-taking.
    - There is no risk of revenues being generated for CMHSPs due to the structure of risk-based prepaid capitation.
2. The federal government has already granted Michigan an exception to HCBS regulations because of our unique public mental health structure:
    - CMS approval of Michigan's 1915(i) State plan amendment indicates that CMS agreed with Michigan that the premise for the CFA&P exception (that "the State demonstrates that the only willing and qualified agent to perform independent assessments and develop person centered service plans in a geographic area also provides HCBS") was met. **This appears reasonable, given that the State Mental Health Code and its implementing regulations require that the person-centered care planning process be completed by the "responsible mental health agency," indicating the CMHSP**. It appears to be an integral component of Michigan's community mental health structure that local government-based CMHSPs bear the primary responsibility for HCBS, including development of the care plan.

Recommendations to Ensure Compliance with Federal Requirements

- Apply the conflict mitigation firewall structure that is contained in Michigan's 1915i State Plan Amendment.- a plan already approved by CMS
- Develop certain firewalls between the person-centered planning process and eligibility determination.
- Ensure robust monitoring and processes to ensure the person served can choose their case manager and supports coordinator employed by a CMHSP or PIHP or can choose an independent case manager or supports coordinator.
- Provide accessible, frequent, and readily available information to persons served regarding the planning process and service delivery.

PUBLIC COMMENTS REGARDING PROPOSED POLICY 2153-BH
1915i Conflict of Interest requirements 42 CFR § 441.730(b)(5)
Submitted by Christopher Pinter

Summary
Michigan has been in the process of converting many Medicaid services previously covered under the 1915(b) waiver authority to the 1915i state plan amendment. This requires states to provide assurance that necessary safeguards have been taken to protect the health and welfare of the enrollees in State plan home and community based services (HCBS) by provision of adequate standards for all types of providers. States must define qualifications for providers of HCBS, and for those persons who conduct the independent evaluation of eligibility for State plan HCBS and independent assessment of need, and who are involved with developing the person-centered service plan.

- The final requirements refer to persons or entities responsible for the independent evaluation, independent assessment, and the person-centered service plan as ''agents'' to distinguish them from ''providers'' of HCBS. *Requires that "agent" functions be open to "any willing provider"*.

- The standards imply that assessment and person-centered service plan development should not be performed by providers of the services prescribed. This does not preclude the inclusion of input from other individuals with expertise in the provision of long-term services and supports, or the delivery of acute care medical services, as long as an "independent agent" retains the final responsibility for the evaluation, assessment, and person-centered service plan functions.

Larger Context
Michigan has operated a Medicaid specialty mental health service and supports 1915(b) and (c) waiver since 1999. The foundation of these waivers is the continuation of the state and county partnership for community mental health services programs (CMHSPs) originally established in 1963 to promote deinstitutionalization of persons otherwise segregated in state psychiatric hospitals or centers. The state mental health authority, i.e., Michigan Department of Health and Human Services (MDHHS), has gradually transitioned many Medicaid agent and provider responsibilities to the CMHSPs during the last several decades. These transitions often coincided with significant changes in federal and state health care policy including movement to full local management in the 1980s, Medicaid managed care in the 1990s and regional pre-paid inpatient health plans (PIHPs) in the 2000s. However, the foundation has always been the shared state and county obligations to provide a mental health safety net for its most vulnerable citizens, many of whom are eligible for Medicaid due to their disability.

Role of CMHSPs
CMHSPs have been the instrument deployed by counties to meet their safety net obligations under the Michigan Mental Health Code, first as departments within the overall county organization and subsequently as separate governmental entities under state law. CMHSPs are mandated to provide a comprehensive array of mental health services to the residents in their geographic catchment area, regardless of their ability to pay. The services required under MCL 330.1206 include, but are not limited to, crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service; Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services; Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services; and Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.

These requirements clarify that CMHSPs in Michigan have been designed to serve both as an "agent" (i.e. *Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services)* and a "provider" function (Specialized mental health recipient training, treatment, and *support, including therapeutic clinical interactions, socialization* and *adaptive skill and coping skill training*, *health and rehabilitative services)* in the delivery of services. This has remained constant throughout various changes in mental health policy due to the CMHSPs exclusive public role as the safety net provider for its service area and designation as a "Comprehensive Services and Support Network" (CSSN) for Medicaid. In fact, strong beneficiary, advocate, and public support for this exclusive role has been the foundation of subsequent waiver accommodations related to sole-source procurement, regional PIHPs and maintaining a behavioral health carve-out for Medicaid services.

Existing Conflict of Interest Protections

CMHSPs as governmental organizations with statutorily-defined obligations have conflict of interest protections inherent to its public nature. These include regularly scheduled meetings open to public inspection and participation, transparent annual needs assessment and budgetary processes that are subject to public review and modification, appointment/removal of board members and CMHSP dissolution authority vested in the county board of commissioners and downstream accountability to the community via local constituent democratic processes including elections, petition, initiative, and recall. These protections have been augmented over time with mandatory consumer representation on board governance, a guaranteed recipient rights appeal & grievance system, expansion of Medicaid enrollee rights, establishment of independent person-centered planning facilitation requirements, and broadening availability of consumer self-determination/self-directed options. This is a complex set of requirements that goes far beyond those inherent to other 1915i HCBS providers and serves as a check to balance provider self-interest.

1915i Requirements

As mentioned earlier, states are required to provide assurance that necessary safeguards have been taken to protect the health and welfare of the enrollees in State plan HCBS by provision of adequate standards for all types of providers. States must define qualifications for providers of HCBS, and for those persons who conduct the independent evaluation of eligibility for State plan HCBS and independent assessment of need, and who are involved with developing the person-centered service plan. These qualifications include conflict of interest standards and training in assessment of individuals whose physical or mental condition may trigger a need for HCBS and supports, and an ongoing knowledge of current best practices to improve health and quality of life outcomes.

The minimum conflict of interest standards require that the agent is not a relative of the individual or responsible for the individual's finances or health-related decisions, nor may an agent hold a financial interest in any of the entities that provide care. These requirements are sound and reasonable.

1915i Agent v. Provider Responsibilities

In the final rules discussions for 42 CFR § 441.730(b)(5), it was noted that federal experience with HCBS waivers indicated that assessment and person-centered service plan development should not be performed by providers of the services prescribed. This separation of "agent" vs. "provider" roles for HCBS was an extension of the conflict of interest provisions noted above. However, it was also noted that in some circumstances there are acceptable reasons for a single provider of service that performs all of those functions, all administrative safeguards should consider the unique characteristics and

individual needs of each state and include conflict free protections that address the development of the plan and choice of providers with an emphasis on individual preferences.

As a result, states can allow providers of State plan HCBS, or those who have an interest in or are employed by a provider of State plan HCBS, to be the entity responsible for the assessment and person-centered service plan functions, if the state demonstrates that they are the only "willing and qualified" agent to perform these two functions in a geographic area. This is analogous to the existing designation of CMHSPs as the Medicaid CSSN for a defined geographic subdivision**.** In addition, the state must devise conflict of interest protections including separation of agent and provider functions within provider entities including ''firewall'' policies separating staff that perform assessments and develop person-centered service plans from those that provide any of the services in the plan; and meaningful and accessible procedures for individuals and representatives to appeal to the state.

Implications for Michigan

As previously noted, CMHSPs by design occupy a central role on the state and county partnership for safety net mental health services. This is reflected not only in state law but also in subsequent Medicaid state plan and waiver designs under both fee for service and managed care requirements. These include the existing sole-source procurement plans and behavioral health carve-outs underlying the combined 1115, 1915(c) and 1915(i) arrangements for specialty mental health services and supports. These elements bond the comprehensive public mental health safety net role for all Michigan residents including Medicaid beneficiaries, to county based CMHSPs and ensure a 24/7 local crisis response throughout the state.

A strict application of the 1915i requirement would prohibit CMHSPs from serving in the "agent" role (i.e., independent evaluation of eligibility for State plan HCBS, independent assessment of need, and person-centered service plan development) for ANY consumer also receiving HCBS directly from the CMHSPS. However, this implication ignores the fact that CMHSPs in Michigan as public, non-profit organizations have always held both agent and provider responsibilities for Medicaid beneficiaries and that this combination is a central component in the specialty mental health safety net design in both the state plan and waiver documents.

CMHSPs hold the agent role for eligibility, assessment and service planning but were always expected to outsource provider responsibilities to the maximum extend allowable by market competition. In larger geographic areas such as Wayne, Oakland, and Kent Counties, this has often been the case. However, rural counties such as Huron, Tuscola and Arenac most often do not have multiple provider options, at least to the degree of ensuring a comprehensive service network. As a result, CMHSPs have served as the agent and provider roles not by choice or financial interest, *but due to their obligations to fill gaps in their safety net jurisdiction*. CMHSPs do not have the option available to non-safety net organizations to defer until another provider is "willing". In many cases, this is the sole reason that CMHSPs provide certain HCBS as defined in the 1115i requirements. In contrast, most other agents for HCBS do not have these kinds of public obligations to their community, regardless of their level of independence from the provider systems.

It is also important to note that Michigan has been providing a comprehensive array of HCBS long before establishment of the 1915i state plan option. The state's previous 1915(b) and (c) waiver designs expanded certain HCBS far beyond traditional Medicaid programs. This permitted CMHSPs to offer a

wide variety of alternative mental health services to support individuals remaining in their home and community. This often included an integrated agent and provider role. This was successful because the CMHSPs are public agencies inherently subject to local democratic processes ultimately rendering almost any financial or resource decision subject to public review and audit. In addition, these protections have been augmented over time and experience with expanded recipient and Medicaid enrollee rights systems, establishment of independent person-centered planning facilitation requirements, and enhanced self-determination/self-directed options. These elements have mitigated against any agent and/or provider financial conflicts of interest.

Recommendation
It is important that the role of CMHSPs in the 1915i services align with the other waivers that make up the comprehensive Medicaid Mental Health Specialty Supports and Services program. Michigan had robust HCBS prior to the addition of the 1915i requirements and these were mitigated by the unique CSSN design in existing waivers. This recognition is symmetrical with the federal intent to consider the unique experiences of each individual state design. The roles of the sovereign county governments in the CMHSP system ensures that mental health policy decision is reflective of the broadest continuum of stakeholders at the federal, state, and local levels and mitigates against provider self-interest.

Making a hard distinction between CMHSP agent and provider roles specific to the 1915i will only increase the administrative burden on existing CMHSP provider systems without improving access to services, particularly in rural areas. An independent "agent" cannot accommodate the lack of available providers, regardless of the level of consumer need. In these cases, CMHSP safety net systems have a legal and ethical obligation in Michigan to fill that role, often regardless of the individual financial consequences. The larger context of CMHSP service and budget obligations mitigate against any short term gains or losses in the individual HCBS assessment, planning and delivery process.

As an alternative, MDHHS needs to recognize that the exclusive CSSN role and obligations in existing Medicaid waiver documents has already established the CMHSPs as the only "willing and qualified" agent to perform these two functions in a specific geographic area. The qualified standard needs to acknowledge the exclusive CSSN responsibilities in their defined service areas that distinguishes them from other agents and providers including the requirements under MCL 330.1206. Only the CMHSPs are obligated to make these services available to county residents regardless of ability to pay and have a legal obligation to fill both roles to protect the health and safety of the consumers.

The independence of these functions can be guaranteed at the CMHSP level as follows:

- Ensuring that assessment and person-centered planning development is performed at the CMHSP primary care level such as case management or outpatient services with a distinct organizational structure separate from the direct HCBS provider function
- Ensure that all consumers under consideration for services have the option to use independent facilitation or self-directed service arrangements to also mitigate potential conflicts
- Consider potential conflict of interest allegations to be subject to the consumer choice protections in the MDHHS Recipient Rights system.

The PIHPs **may** also provide an eligibility oversight function on behalf of the state and serve as an alternative mechanism for meaningful appeal by individual consumers and families. This preserves the current balance between inherent agent and provider roles at the CMHSP but adds additional remedial options to meet the intent of the 1915i requirements.