Michigan Health Endowment Fund

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Act No. 4
Public Acts of 2013
Approved by the Governor
March 18, 2013
Filed with the Secretary of State
March 18, 2013
EFFECTIVE DATE: March 18, 2013

STATE OF MICHIGAN
97TH LEGISLATURE
REGULAR SESSION OF 2013

Introduced by Senators Hune and Smith

ENROLLED SENATE BILL No. 61

AN ACT to amend 1980 PA 350, entitled "An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts," by amending the title and sections 218, 401e, and 414b (MCL 550.1218, 550.1401e, and 550.1414b), the title as amended by 1994 PA 169, section 218 as added by 2002 PA 559, section 401e as added by 1996 PA 516, and section 414b as added by 2006 PA 413, and by adding sections 201a, 220, 400, 401m, 410b, 501c, and 620 and part 6A.

The People of the State of Michigan enact:

TITLE

An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for the creation of and the powers and duties of certain nonprofit corporations for the purpose of receiving and administering funds for the public welfare; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal acts and parts of acts.

Sec. 201a. Notwithstanding section 201, a health care corporation shall not be formed in this state on or after January 1, 2014.

Sec. 218. A health care corporation shall not do any of the following:

(a) Take any action to change its nonprofit status.

(b) Except as otherwise provided in section 220, dissolve, merge, consolidate, mutualize, or take any other action that results in a change in direct or indirect control of the health care corporation or sell, transfer, lease, exchange, option, or convey assets that results in a change in direct or indirect control of the health care corporation.

Sec. 220. (1) Notwithstanding any provision of this act to the contrary, a health care corporation may establish, own, operate, and merge with a nonprofit mutual disability insurer formed under chapter 58 of the insurance code of 1956, 1956 PA 218, MCL 500.5800 to 500.5840. The surviving entity of a merger described in this subsection is the nonprofit mutual disability insurer. A merger described in this subsection is exempt from the application of sections 1311 to 1319 of the insurance code of 1956, 1956 PA 218, MCL 500.1311 to 500.1319.

(2) The merger of a health care corporation with a nonprofit mutual disability insurer is effective upon completion of both of the following:

(a) The adoption of a plan of merger by the majority of the boards of directors of both the health care corporation and the nonprofit mutual disability insurer. The health care corporation shall include in the plan of merger that beginning in April of the first full calendar year after the adoption of the plan of merger the surviving entity of a merger described in subsection (1) shall use its best efforts to make annual social mission contributions in an aggregate amount of up to $1,560,000,000.00 over a period of up to 18 years beginning in April of the first full calendar year after the adoption of the plan of merger to a nonprofit corporation created under part 6A. If adopted, the boards of directors shall submit the plan of merger to the commissioner for his or her consideration as provided in subdivision (b). A nonprofit mutual disability insurer is considered to be making its best effort under this subdivision if it makes the annual social mission contribution to a nonprofit corporation created in part 6A when the nonprofit mutual disability insurer's surplus is at least 375% of the authorized control level under risk-based capital requirements.

(b) The approval of the plan of merger by the commissioner. The commissioner shall make a determination to approve or disapprove a plan of merger within 90 days of receipt of the plan, and the commissioner shall not unreasonably withhold approval of a plan of merger submitted under subdivision (a).

(3) Notwithstanding any other provision of this act to the contrary, the directors of a health care corporation may serve as incorporators of the corporate body of, directors of, or officers of the nonprofit mutual disability insurer formed through a merger described in subsection (1).

(4) A merger described in subsection (1) is the dissolution of the health care corporation, and the surviving nonprofit mutual disability insurer assumes the performance of all contracts and policies of the merged health care corporation that exist on the date of the merger, including the participating hospital agreement, and its definition of certificate which excludes as covered services benefits provided pursuant to automobile no-fault or worker's compensation coverage, and all related contract obligations that result from orders relating to hospital provider class plans that are issued by the commissioner after July 1, 2012. However, the officers of a health care corporation may perform any act or acts necessary to close the affairs of the merged health care corporation after the date of the merger.

(5) Notwithstanding anything in this act to the contrary, if the merger of a health care corporation and a nonprofit mutual disability insurer becomes effective as described in subsection (2), the property of the health care corporation is subject to the collection of general ad valorem taxes and applicable specific taxes under the general property tax act, 1893 PA 206, MCL 211.1 to 211.155, beginning December 31, 2013. As provided in section 201, the property of a health care corporation is exempt from taxation before December 31, 2013. This act does not confer an exemption from taxation on a nonprofit mutual disability insurer that merges with a health care corporation.

Sec. 400. (1) Notwithstanding any provision of this act to the contrary, this section applies to the use of a most favored nation clause in a provider contract on and after February 1, 2013.

(2) Subject to subsection (3), beginning February 1, 2013, a health care corporation shall not use a most favored nation clause in any provider contract, including a provider contract in effect on February 1, 2013, unless the most favored nation clause has been filed with and approved by the commissioner. Subject to subsection (3), beginning February 1, 2013, a health care corporation shall not enforce a most favored nation clause in any provider contract without the prior approval of the commissioner.

(3) Beginning January 1, 2014, a health care corporation shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

(4) As used in this section, "most favored nation clause" means a clause that does any of the following:

(a) Prohibits, or grants a contracting health care corporation an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(b) Requires, or grants a contracting health care corporation an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(c) Requires, or grants a contracting health care corporation an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(d) Requires a provider to disclose, to the health care corporation or its designee, the provider's contractual payment or reimbursement rates with other parties.

Sec. 401e. (1) Except as otherwise provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.

(2) Except as otherwise provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the certificate at the option of the sponsor of the plan.

(3) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health care corporation no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(4) A health care corporation shall not discontinue offering a particular plan or product in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each covered individual or group, as applicable, provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the nongroup market or group market, as applicable, by that health care corporation without excluding or limiting coverage for a preexisting condition or providing a waiting period.

(c) Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may become eligible for coverage in making the determination to discontinue coverage and in offering other plans or products.

(5) A health care corporation shall not discontinue offering all coverage in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, of the discontinuation at least 180 days before the date of the expiration of coverage.

(b) Discontinues all health benefit plans issued in the nongroup or group market from which the health care corporation withdrew and, except as allowed under subsection (6), does not renew coverage under those plans.

(6) If a health care corporation discontinues coverage under subsection (5), the health care corporation shall not provide for the issuance of any health benefit plans in the nongroup or group market from which the health care corporation withdrew during the 5-year period beginning on the date of the discontinuation of the last plan not renewed under that subsection.

Sec. 401m. Until January 1, 2014, a health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state regardless of health status.

Sec. 410b. Notwithstanding section 410a(8), for a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, the premium for a group conversion certificate under section 410a shall be determined only by using the rating factors set forth in section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

Sec. 414b. (1) A health care corporation may offer group wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer shall provide evidence of demonstrative maintenance or improvement of the members' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the health care corporation. Any rebate or premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to employers all wellness coverage plans that it markets to employers in this state.

(2) A health care corporation may offer nongroup wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the health care corporation. The member shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators

between the member and the health care corporation. Any rebate of premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to individuals all wellness coverage plans that it markets to individuals in this state.

(3) A health care corporation is not required to continue any health behavior wellness, maintenance, or improvement program or to continue any incentive associated with a health behavior wellness, maintenance, or improvement program.

Sec. 501c. Beginning January 1, 2014, a health care corporation shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the commissioner pursuant to federal law.

Sec. 620. (1) Notwithstanding any provision of this act to the contrary, a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014 by a health care corporation is subject to the policy and certificate issuance and rate filing requirements of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, including the rating factor requirements of section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

(2) For a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, subject to the prior approval of the commissioner, a health care corporation may establish reasonable open enrollment periods.

(3) The commissioner shall establish minimum standards for the frequency and duration of open enrollment periods established under subsection (2). The commissioner shall uniformly apply the minimum standards for the frequency and duration of open enrollment periods established under this subsection to all health care corporations.

(4) A health care corporation offering coverage during an open enrollment period established under subsection (2) shall not deny or condition the issuance or effectiveness of a certificate and shall not discriminate in the pricing of the certificate on the basis of health status, claims experience, receipt of health care, or medical condition.

PART 6A

HEALTH ENDOWMENT FUND CORPORATIONS

Sec. 651. As used in this part:

(a) "Board" means the board of a health endowment fund corporation incorporated under this part.

(b) "Executive director" means the executive director of a fund appointed by the board.

(c) "Fund" means a health endowment fund corporation organized as a nonprofit corporation under section 653.

Sec. 652. (1) A health endowment fund corporation shall not be incorporated in this state except under this part.

(2) A board shall adopt a conflict of interest policy. A board member with a direct or indirect interest in any matter before the fund shall disclose the member's interest to the board before the board takes any action on the matter. The board shall record the member's disclosure in the minutes of the board meeting. If a board member or a member of his or her immediate family, organizationally or individually, would derive a direct and specific benefit from a decision of the board, that member shall recuse himself or herself from the discussion and the vote on the issue.

(3) Subject to this subsection, the governor shall appoint the members of a board with the advice and consent of the senate. An individual who is an employee, officer, or board member of a health care corporation; a lobbyist affiliated with a health care corporation; or an employee of a health insurer, health care provider, or third party administrator is not eligible to be appointed and shall not be appointed to a board under this subsection. On or before the expiration of 60 days after the incorporation of a fund under section 653, the governor shall appoint the following initial members of the board with the advice and consent of the senate:

(a) One member from a list of 3 or more individuals recommended by the senate majority leader.

(b) One member from a list of 3 or more individuals recommended by the speaker of the house of representatives.

(c) One member representing the interests of minor children.

(d) One member representing the interests of senior citizens.

(e) Two members of the general public.

(f) One member representing the business community.

(g) One member from a list of 3 or more individuals recommended by the house minority leader.

(h) One member from a list of 3 or more individuals recommended by the senate minority leader.

(4) A vacancy on a board shall be filled in the same manner as the initial appointment under subsection (3). Except as otherwise provided in this subsection, a board member shall be appointed for a term of 4 years or until a successor is appointed, whichever is later. For the initial members appointed under subsection (3), 3 members shall be appointed for 2-year terms, 3 members shall be appointed for 3-year terms, and 3 members shall be appointed for 4-year terms.

(5) Six members of a board constitute a quorum for the transaction of business at a meeting of the board. An affirmative vote of 5 board members is necessary for official action of a board.

(6) The business that a board may perform shall be conducted at a meeting of the board that is held in this state, is open to the public, and is held in a place that is available to the general public. However, a board may establish reasonable rules and regulations to minimize disruption of a meeting of the board. At least 10 days and not more than 60 days before a meeting, a board shall provide public notice of its meeting at its principal office and on its internet website. A board shall include in the public notice of its meeting the address where board minutes required under subsection (7) may be inspected by the public. A board may meet in a closed session for any of the following purposes:

(a) To consider the hiring, dismissal, suspension, or disciplining of board members or employees or agents of the fund.

(b) To consult with its attorney.

(c) To comply with state or federal law, rules, or regulations regarding privacy or confidentiality.

(7) A board shall keep minutes of each meeting. Board minutes shall be open to public inspection, and the board shall make the minutes available at the address designated on the public notice of its meeting under subsection (6). A board shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying. A board shall include all of the following in its board minutes:

(a) The date, time, and place of the meeting.

(b) Board members who are present and absent.

(c) Board decisions made at a meeting open to the public.

(d) All roll call votes taken at the meeting.

(8) Board members shall serve without compensation. However, board members may be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board members.

Sec. 653. (1) A charitable purpose nonprofit corporation may be incorporated on a nonstock, directorship basis, under the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192 consistent with this part and, if incorporated under this section, shall be organized to receive and administer funds for the public welfare. The articles of incorporation must include the word "Michigan" and the phrase "health endowment fund" in the name of the fund. As soon as practicable after the incorporation of a fund under this subsection, the fund shall apply for and make its best effort to obtain tax-exempt status under section 501(c)(3) of the internal revenue code, 26 USC 501.

(2) The articles of incorporation of a fund must provide that the fund is organized for the following purposes:

(a) Supporting efforts that improve the quality of health care while reducing costs to residents of this state.

(b) Benefitting the health and wellness of minor children and seniors throughout this state with a significant focus in the following areas:

(*i*) Access to prenatal care and reduction of infant mortality rates.

(*ii*) Health services for foster and adopted children.

(*iii*) Access to healthy food.

(*iv*) Wellness programs and fitness programs.

(*v*) Access to mental health services.

(*vi*) Technology enhancements.

(*vii*) Health-related transportation needs.

(*viii*) Foodborne illness prevention.

(c) Awarding grants for a term not exceeding 3 years in duration for projects that will promote the purposes of the fund.

(d) Subsidizing the cost of individual medigap coverage to medicare-eligible individuals in this state who demonstrate a financial need in order to be able to purchase individual medigap coverage.

(3) The board shall establish a comprehensive and competitive process to award grants.

(4) The nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, applies to a fund. If a provision relating to a fund under this part conflicts with other state law, this part controls.

(5) If a fund is eligible to receive social mission contributions under section 220(2), the eligible fund shall implement a program to disburse money to subsidize the cost of individual medigap coverage to medicare-eligible individuals in this state who demonstrate a financial need in order to be able to purchase individual medigap coverage. The commissioner shall develop a means test to be used to determine if a medicare-eligible individual applicant is eligible for the medigap coverage subsidy provided for in this subsection and shall submit the test developed to the attorney general for approval.

(6) If a fund is eligible to receive social mission contributions under section 220(2), beginning on the first day of the third August after the fund receives its initial social mission contribution, and ending on the thirty-first day of the eighth December after the fund receives its initial social mission contribution, the fund shall disburse $120,000,000.00 to subsidize the cost of individual medigap coverage purchased by medicare-eligible individuals in this state, subject to subsection (5).

(7) A fund is a private, nonprofit corporation organized for charitable purposes and is not a state agency, governmental agency, or other political subdivision of this state. Money of a fund is held by the fund for the purposes consistent with this part and is not money of this state or a political subdivision of this state and shall not be deposited in the state treasury. A member of a board is not a public officer of this state.

Sec. 654. (1) A board shall appoint an executive director to serve as the chief executive officer of the fund. The executive director shall serve at the pleasure of the board. The executive director may employ staff and hire consultants as necessary with the approval of the board. The board shall determine compensation for the executive director and staff employed under this subsection and shall approve contracts under this subsection.

(2) The executive director shall display on the fund internet website information relevant to the public, as defined by the board, concerning the fund's operations and efficiencies, as well as the board's assessments of those activities.

Sec. 655. (1) Subject to this section, a fund may disburse money contributed to the fund each year, not including any interest, earnings, or unrealized gains or losses on those contributions, for the purposes of the fund as described in section 653. A fund may expend a portion of the money contributed to the fund in each year following the initial contribution to the fund according to the following schedule:

(a) Years 1 through 4, 80%.

(b) Years 5 through 8, 67%.

(c) Years 9 through 12, 60%.

(d) Years 13 through 18, 25%.

(2) On and after the date that the accumulated principal of money held by a fund reaches $750,000,000.00, the fund shall maintain that amount for investment to provide an ongoing income to the fund. On and after the date that the accumulated principal in the fund reaches $750,000,000.00, the board shall not allow the accumulated principal of the fund to fall below $750,000,000.00 due to expenditures made for the purposes of the fund as described in section 653.

(3) A fund may expend money received by the fund from any source in a fiscal year of the fund that is in excess of the amount required to maintain the accumulated principal goals as described in subsection (2), not including any interest, earnings, or unrealized gains or losses on those funds, on the reasonable administrative costs of the fund and for the purposes of the fund as described in this part. The investment of fund money and donations by the fund are under the exclusive control and discretion of the fund and are not subject to requirements applicable to public funds.

(4) A fund may invest accumulated principal in the fund only in securities permitted by the laws of this state for the investment of assets of life insurance companies, as described in chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947.

(5) A fund's articles of incorporation or bylaws must provide for a system of financial accounting, controls, audits, and reports. The board annually shall have an audit of the fund conducted by an independent public accountant firm, and the auditor's audit report and findings shall be submitted to the board. The expense of an audit required under this subsection is considered a reasonable administrative cost under subsection (3).

(6) A fund's articles of incorporation or bylaws must require that the board shall appoint from its members an audit committee consisting of no fewer than 3 members and for the audit committee to contract with an independent auditing firm to provide an annual financial audit in accordance with applicable auditing standards.

(7) The executive director shall do all of the following:

(a) Review and certify external auditor reports.

(b) Make external auditor reports available to the board and to the general public.

(c) Develop and implement corrective actions to address weaknesses identified in an audit report.

(8) The articles of incorporation or bylaws of a fund must require the fund to keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the board, the governor, the senate and house of representatives appropriations committees, and the senate and house of representatives standing committees on health policy a report regarding those accountings.

(9) A fund and its directors, officers, and employees shall fully cooperate with any investigation conducted by this state or a federal agency under its authority under state or federal law, to do any of the following:

(a) Investigate the affairs of the fund.

(b) Examine the assets and records of the fund.

(c) Require periodic reports in relation to the activities undertaken by the fund in compliance with applicable law.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 62 of the 97th Legislature is enacted into law.

This act is ordered to take immediate effect.

Carol Morey Viventi

Secretary of the Senate

Clerk of the House of Representatives

Approved .....

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Governor

Adopted: March 24, 2014

BYLAWS

OF

MICHIGAN HEALTH ENDOWMENT FUND

(A Michigan Nonprofit Corporation)

ARTICLE I
Board of Directors

Section 1. Directorship. The Fund is organized upon a directorship basis. The property, business and affairs of the Fund will be managed by its Board of Directors.

Section 2. Number, Qualification and Term of Office. The Board of Directors of this Fund will consist of nine persons.

The Governor of the State of Michigan shall appoint the members of the board with the advice and consent of the Michigan Senate. An individual who is an employee, officer, or board member of a health care corporation; a lobbyist affiliated with a health care corporation; or an employee of a health insurer, health care provider, or third party administrator is not eligible to be appointed and shall not be appointed to the board. On or before the expiration of 60 days after the incorporation of the Fund, the Governor shall appoint the following initial members of the board with the advice and consent of the Senate:

(a) One member from a list of 3 or more individuals recommended by the Senate Majority Leader.

(b) One member from a list of 3 or more individuals recommended by the Speaker of the House of Representatives.

(c) One member representing the interests of minor children.

(d) One member representing the interests of senior citizens.

(e) Two members of the general public.

(f) One member representing the business community.

(g) One member from a list of 3 or more individuals recommended by the House Minority Leader.

(h) One member from a list of 3 or more individuals recommended by the Senate Minority Leader.

A vacancy on the board shall be filled in the same manner as the initial appointment under this Section 2. Except as otherwise provided in this section, a board member shall be appointed for a term of 4 years or until a successor is appointed, whichever is later. For the initial members appointed under this Section 2, 3 members shall be appointed for 2-year terms, 3 members shall be appointed for 3-year terms, and 3 members shall be appointed for 4-year terms.

Section 3. Resignation, Removal and Vacancies. A Director may resign by written notice to the Governor. The resignation will be effective upon its receipt by the Governor or a subsequent time as set forth in the notice of resignation. A Director may be removed, either with or without cause, by written direction of the Governor.

Section 4. General Powers as to Negotiable Paper. The Board of Directors may, from time to time, authorize the making, signature or endorsement of checks, drafts, notes and other negotiable paper or other instruments for the payment of money and designate the persons who will be authorized to make, sign or endorse the same on behalf of the Fund.

Section 5. Powers as to Other Documents. All material contracts, conveyances and other instruments may be executed on behalf of the Fund by the Executive Director, the Chairperson or any Vice Chairperson, and, if necessary, attested by the Secretary or the Treasurer.

Section 6. Compensation. Directors will serve without compensation but may be reimbursed for actual and necessary expenses incurred by a Director in the performance of his or her official duties as a Board member consistent with policies adopted by the Board.

ARTICLE II
Meetings

Section 1. Annual Meeting. The annual meeting of the Directors of the Fund will be held at the principal office of the Fund during the month of January of each year, or at any other place and date as designated by the Directors for the purpose of installing Directors and electing officers for the ensuing year, presenting to the Directors a copy of the Fund's financial report for the preceding fiscal year and for the transaction of other business properly brought before the meeting.

Section 2. Open Meetings. The business that the board may perform shall be conducted at a meeting of the board that is held in this state, is open to the public, and is held in a place that is available to the general public. However, the board may establish reasonable rules and regulations to minimize disruption of a meeting of the board. At least 10 days and not more than 60 days before a meeting, the board shall provide public notice of its meeting at its principal office and on its internet website. The board shall include in the public notice of its meeting the address where board minutes may be inspected by the public. The board may meet in a closed session for any of the following purposes:

(a) To consider the hiring, dismissal, suspension, or disciplining of board members or employees or agents of the Fund.

(b) To consult with its attorney.

(c) To comply with state or federal law, or regulations regarding privacy or confidentiality.

Section 3. Notice of Meeting. Except as otherwise provided by these Bylaws or by law, and in addition to the public notice described in Section 2 above, written notice containing the time and place of all meetings of the Board of Directors will be given personally, by mail, or by electronic transmission to each Director not less than ten days before a meeting. Notice by electronic transmission will be deemed to have been given when electronically transmitted to the person entitled to the notice or communication in a manner authorized by the person. Notice of a meeting need not state the purpose or purposes of the meeting nor the business to be transacted at the meeting.

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting, except where the Director attends the meeting for the express purpose of objecting to the transaction of any business because the meeting was not lawfully called or convened.

Section 4. Quorum and Voting. Six members of the Board constitute a quorum for the transaction of business at a meeting of the Board. An affirmative vote of 5 Board members is necessary for official action of the Board.

Section 5. Conduct at Meetings. Meetings of the Directors will be presided over by the Chairperson. The Secretary or an Assistant Secretary of the Fund or, in their absence, a person chosen at the meeting will act as Secretary of the meeting.

Section 6. Minutes. The Board shall keep minutes of each meeting. Board minutes shall be open to public inspection, and the Board shall make the minutes available at the address designated on the public notice of its meeting under Section 2. The Board shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying. The Board shall include all of the following in its Board minutes:

(a) The date, time, and place of the meeting.

(b) Board members who are present and absent.

(c) Board decisions made at a meeting open to the public.

(d) All roll call votes taken at the meeting.

Section 7. Participation by Remote Communication. A Director may participate in a meeting of Directors by conference telephone or other means of remote communication by which all persons participating in the meeting may communicate with

each other. Participation in a meeting pursuant to this section constitutes presence in person at the meeting.

ARTICLE III
Officers

Section 1. Election or Appointment. The Board of Directors will elect a Chairperson, a Vice Chairperson, a Secretary and a Treasurer of the Fund at each annual meeting. The Board will appoint an Executive Director to serve as the chief executive officer of the Fund. The same person may hold any two or more offices, but no officer will execute, acknowledge or verify any instrument in more than one capacity. The Directors may also appoint any other officers and agents as they deem necessary for accomplishing the purposes of the Fund.

Section 2. Term of Office. The term of office of all officers will commence upon their election or appointment and will continue until the next annual meeting of the Fund and until their respective successors are chosen or until their resignation or removal. Any officer may be removed from office at any meeting of the Directors, with or without cause, by the affirmative vote of a majority of the Directors then in office, whenever in their judgment the best interest of the Fund will be served.

An officer may resign by written notice to the Fund. The resignation will be effective upon its receipt by the Fund or at a subsequent time specified in the notice of the resignation.

Section 3. Compensation. Any officer who is an employee of the Fund will receive reasonable compensation for his or her services as fixed by the Board of Directors.

Section 4. Chairperson. The Chairperson will preside over all board meetings and will perform such other duties prescribed by the Board of Directors.

Section 5. Vice Chairperson. The Vice Chairperson will, in the absence or disability of the Chairperson, perform the duties and exercise the powers of the Chairperson and will perform any other duties prescribed by the Board of Directors or the Chairperson.

Section 6. The Executive Director. The Executive Director will be the chief executive officer of the Fund and will have general and active management of the activities of the Fund. The Executive Director will see that all orders and resolutions of the Board of Directors are carried into effect. The Executive Director will execute all authorized conveyances, contracts or other obligations in the name of the Fund except where required by law to be otherwise signed and executed and except where the signing and execution is expressly delegated by the Directors to some other person.

The Executive Director shall serve at the pleasure of the Board. The Executive Director may employ staff and hire consultants as necessary with the approval of the

Board. The Board shall determine compensation for the Executive Director and staff and shall approve contracts under this Section 6.

The Executive Director shall display on the Fund internet website information relevant to the public, as defined by the Board, concerning the Fund's operations and efficiencies, as well as the Board's assessments of those activities.

The Executive Director shall do all of the following:

(a) Review and certify external auditor reports.

(b) Make external auditor reports available to the Board and to the general public.

(c) Develop and implement corrective actions to address weaknesses identified in an audit report.

Section 7. The Secretary. The Secretary will attend meetings of the Board of Directors and record or cause to be recorded the minutes of all proceedings in a book to be kept for that purpose. The Secretary will give or cause to be given notice of all meetings of the Board of Directors for which notice may be required and will perform any other duties prescribed by the Directors.

Section 8. The Treasurer. The Treasurer will oversee the financial activities of the Fund. The Treasurer will perform all duties incident to the office of Treasurer and other administrative duties as may be prescribed by the Board of Directors. All books, papers, vouchers, money and other property of whatever kind belonging to the Fund which are in the Treasurer's possession or under his or her control will be returned to the Fund at the time of his or her death, resignation or removal from office.

ARTICLE IV
Committees

Section 1. Executive and Compensation Committee. The Board of Directors shall establish an Executive and Compensation Committee consisting of the elected officers of the Board. Minutes of the Executive and Compensation Committee meetings will be made available to the public. The Executive and Compensation Committee, subject to those limitations as may be required by law or imposed by resolution of the Board of Directors, may make recommendations to the Board of Directors regarding the business and affairs of the Fund, but shall not conduct the business that the board may perform.

The Executive and Compensation Committee shall review staff performance and make recommendations to the Board of Directors with respect to compensation and benefits to be paid to the Fund's staff and personnel. Notwithstanding anything contained in this Section 1 to the contrary, the Board of Directors will be responsible for approving compensation and benefits.

Section 2. Audit Committee. The Board shall appoint from its members an Audit Committee consisting of no fewer than 3 members. The audit committee will contract with an independent auditing firm to provide an annual financial audit in accordance with applicable auditing standards.

The Audit Committee will insure that the Fund will keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Board, the Governor, the Senate and House of Representatives appropriations committees, and the Senate and House of Representatives standing committee on health policy a report regarding those accountings.

The Audit Committee will establish and maintain a system of financial accounting, controls, audits, and reports. The Board annually shall have an audit of the Fund conducted by an independent public accountant firm, and the auditor's audit report and findings shall be submitted to the Board. The expense of an audit required under this subsection is considered a reasonable administrative cost of the Fund.

Section 3. Governance Committee. The Board shall appoint a Governance Committee to review and make recommendations to the Board of Directors regarding matters of the Fund's governance, including its Articles of Incorporation, Bylaws, committee structure, and policies and procedures.

Section 4. Other Committees. The Board of Directors may designate other committees as deemed appropriate. The committees will have the authority as delegated to them by the Board of Directors. Notwithstanding the foregoing, all committees shall be advisory in nature and may not transact the business of the board.

Section 5. Procedure. All committees, and each member thereof, will serve at the pleasure of the Board of Directors. Except as provided in the law, the Board of Directors will have the power at any time to increase or decrease the number of members of any committee, to fill vacancies thereon, to change any member thereof, and to change the functions or terminate the existence of any committee. Regular meetings of any committee may be held in the same manner provided in these Bylaws for meetings of the Board of Directors, and a majority of any committee will constitute a quorum at the meeting.

ARTICLE V
Indemnification

Section 1. Indemnification. The Fund will, to the fullest extent now or hereafter permitted by law, indemnify any Director or officer of the Fund (and, to the extent provided in a resolution of the Board of Directors or by contract, may indemnify any volunteer, employee or agent of the Fund) who was or is a party to or threatened to be made a party to any threatened, pending, or completed action, suit or proceeding by reason of the fact that the person is or was a Director, officer, volunteer, employee or agent of the Fund, or is or was serving at the request of the Fund as a director, trustee, officer, partner, volunteer, employee or agent of another corporation, partnership, joint

venture, trust or other enterprise, whether for profit or not for profit, against expenses including attorneys' fees (which expenses may be paid by the Fund in advance of a final disposition of the action, suit or proceeding as provided by law), judgments, penalties, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with the action, suit or proceeding if the person acted (or refrained from acting) in good faith and in a manner the person reasonably believed to be in or not opposed to the best interests of the Fund, and with respect to any criminal action or proceeding, if the person had no reasonable cause to believe his or her conduct was unlawful.

Section 2. Rights to Continue. This indemnification will continue as to a person who has ceased to be a Director or officer of the Fund. Indemnification may continue as to a person who has ceased to be a volunteer, employee or agent of the Fund to the extent provided in a resolution of the Board of Directors or in any contract between the Fund and the person. Any indemnification of a person who was entitled to indemnification after such person ceased to be a Director, officer, volunteer, employee or agent of the Fund will inure to the benefit of the heirs and personal representatives of that person.

ARTICLE VI
Miscellaneous

Section 1. Fiscal Year. The fiscal year of the Fund will end on the last day of December.

Section 2. Amendments. These Bylaws may be amended or repealed by the affirmative vote of a majority of the Directors of the Fund then in office.

Section 3. Loans and Guarantees. The Fund will not provide loans to or guarantee obligations of an officer or Director of the Fund, unless expressly permitted under State law.

Michigan Health Endowment Fund
Board Meeting

Monday, July 21, 2014
Kellogg Hotel and Conference Center – East Lansing, Michigan

Meeting Minutes

Call to order
The board meeting of the Michigan Health Endowment Fund is called to order at 9 a.m. by Chairman Robert Fowler.

Roll call
Quorum is established based on the presence of the following Board Members:

Board Members present:
Lynn Alexander
Tim Damschroder
Cindy Estrada
Rob Fowler
Sue Jandernoa
Jim Murray
Keith Pretty
Michael Williams

Participating by phone:
Marge Robinson

Others present:
Geralyn Lasher
Mark Neithercut
Jeff Padden
Beka Guluma
Jennifer Smith
Deanna Deldin

Approval of agenda
Chairman Fowler approves the agenda.

Public comment
There were no public comment cards submitted.

Review and adoption of the minutes from the previous meeting
Board Member Pretty moves to approve the minutes from the June 16, 2014, board meeting. Board Member Williams seconds. The motion passes by a vote of nine to zero.

Learning session: Health and Health Care Trends
Marianne Udow-Phillips, Director of the Center for Healthcare Research & Transformation at the University of Michigan, presents to the Board on the health and health care trends of children and seniors in Michigan.

Report of the Chair

I. Jeff Padden notes that the Council of Michigan Foundation Conference is in October.

II. With the board's approval, the extension of Geralyn Lasher's contract as interim executive director will be confirmed and extended for 90 days.

III. With the board's approval, the extension of Public Policy Associates contract will be confirmed and extended for 90 days.

Report of the Interim Executive Director

I. Listening tour

The listening tour sessions are being coordinated and dates have been finalized. The first listening tour session will follow the current meeting in the Kellogg Center. Ms. Lasher adds that the purpose of these sessions is to get further information from the various regions around the state. Jane Powers and Peter Pratt from Public Sector Consultants will guide the discussions.

II. Email addresses

Ms. Lasher reports that the email addresses for the Board Members have been obtained and that staff will be reaching out to their individual offices with instructions and options on how access the accounts.

III. Accounting

All bills have been paid and the Fund is current on all of its accounts.

IV. Memberships

The Michigan Health Endowment Fund is now a member of the Council of Michigan Foundations.

V. Branding

Ms. Lasher has had initial conversations with Brogan and Partners regarding creative options, logo design, and overall visual representation for the Michigan Health Endowment Fund.

VI. Office space

Ms. Lasher reports that she is identifying options and opportunities for physical locations for the Board and its staff. While there is nothing to act on today, it is something to start thinking about. The Board may be presented with some options as soon as the August meeting.

BREAK

Committee reports

I. Executive and Compensation Committee

Board Member Fowler states that the next Executive and Compensation Committee meeting will be on August 4, 2014.

II. President and CEO Recruitment Committee

During the June meeting, the Board approved the position guides. Since then, the position announcements have been posted and the interviewing process has begun. Rick King of Kittleman and Associates will be at the August Board meeting to provide a full report to the Board.

III. Investment Committee

Board Member Damschroder states that there is $90 million in Huntington in commercial paper and corporate bonds which are short-term vehicles with lower return rates. $10 million remains invested in low return investments with Chemical Bank.

Kittleman has put together the CFO position description. However, the Board does not intend to hire a CFO until the CEO is in place. The Board is considering hiring someone on an hourly basis to do background work including RFPs and investment policies.

IV. Grantmaking Committee

Board Member Jandernoa presents the grantmaking plan for the Board's approval. The full plan is included in the board book, and proposes that the board embark upon two grantmaking paths:

1. Focus on developing open, competitive grantmaking strategy that will allow a large number of Michigan organizations to apply for grants to improve the health of the state, and

2. Make a few pilot grants to a small number of statewide organizations in 2014 to demonstrate the Fund's commitment to help Michigan residents as soon as possible.

a. Pilot Grant Objectives for 2014
   i. Address key issues including children, seniors, and the cost of healthcare.
   ii. Grants that demonstrate innovation and learning opportunities.
   iii. Set a precedent for incoming staff and the CEO.
   iv. Establishing funds to support and focus on our mission.
   v. Opportunities to learn from those who we are serving.
   vi. Work with organizations that have systems in place.
   vii. Work with organizations that have infrastructure to comply with financial reporting requirements.
   viii. Make every effort to distribute grants in October or November of 2014.

The next Grantmaking Committee meeting is August 5, 2014.

Board Member Estrada brings up the possibility of an emergency funds component to grantmaking. For example, the current water shutoff issue in Detroit. Board agrees to revisit the issue of emergency funding at the next board meeting and tasks Ms. Lasher with gathering more information on the Detroit water issue.

Board Member Jandernoa moves to adopt the grantmaking plan, as presented. Board Member Pretty seconds the motion. Motion passes by a vote of nine to zero.

V. Governance Committee

Board Member Williams presents the committee workplan. The Governance Committee will create a policy manual to present to the Board at a future meeting. From there, the board will approve the policy manual to ensure that committees and their decision making are in line with the Board's processes.

VI. Audit Committee

Board Member Pretty provides update to the Board and states that the Audit Committee will review the RFP for accounting firms at its Audit Committee meeting scheduled following today's board meeting. The committee wants to make sure that the CEO is hired before the final CFO hiring decision is made, but the committee will have a list of firms to which the RFP will be submitted for the Board to review at the next board meeting.

Legal issues
The non-gift acceptance policy will go to the Governance Committee for review.

Business for action

I. Extension of the Interim Executive Director contract for Geralyn Lasher, and extension of Public Policy's contract.

Board Member Pretty moves to approve the extensions. Board Member Estrada seconds the motion. Motion passes by a vote of nine to zero.

II. CFO Position Description

Board Member Alexander moves to approve the CFO position description. Board Member Williams seconds the motion. Motion passes by a vote of nine to zero.

The next meeting of the board will be August 18, 2014.

Adjournment
Chairman Fowler adjourns the meeting at 12:25 p.m.

Elizabeth Hertel

Elizabeth joined the Michigan Department of Community Health (MDCH) in February, 2013, as Senior Assistant for Policy and Planning, where she worked on interdepartmental policy development and implementation. In March 2014, Elizabeth became the Director for Health Policy and Innovation, overseeing policy development and healthcare transformation initiatives.

Prior to working for MDCH, Elizabeth graduated from Grand Valley State University in 2000 with a Bachelor's degree in Public Administration. After graduating, she worked for the Alzheimer's Association in public policy and advocacy, focusing mostly on long-term care issues, until 2005. From 2005 to 2009, she worked with Representative Bruce Caswell, chair of the Department of Community Health Appropriations subcommittee, and subsequently in the policy office, where she focused on health and human services issues.

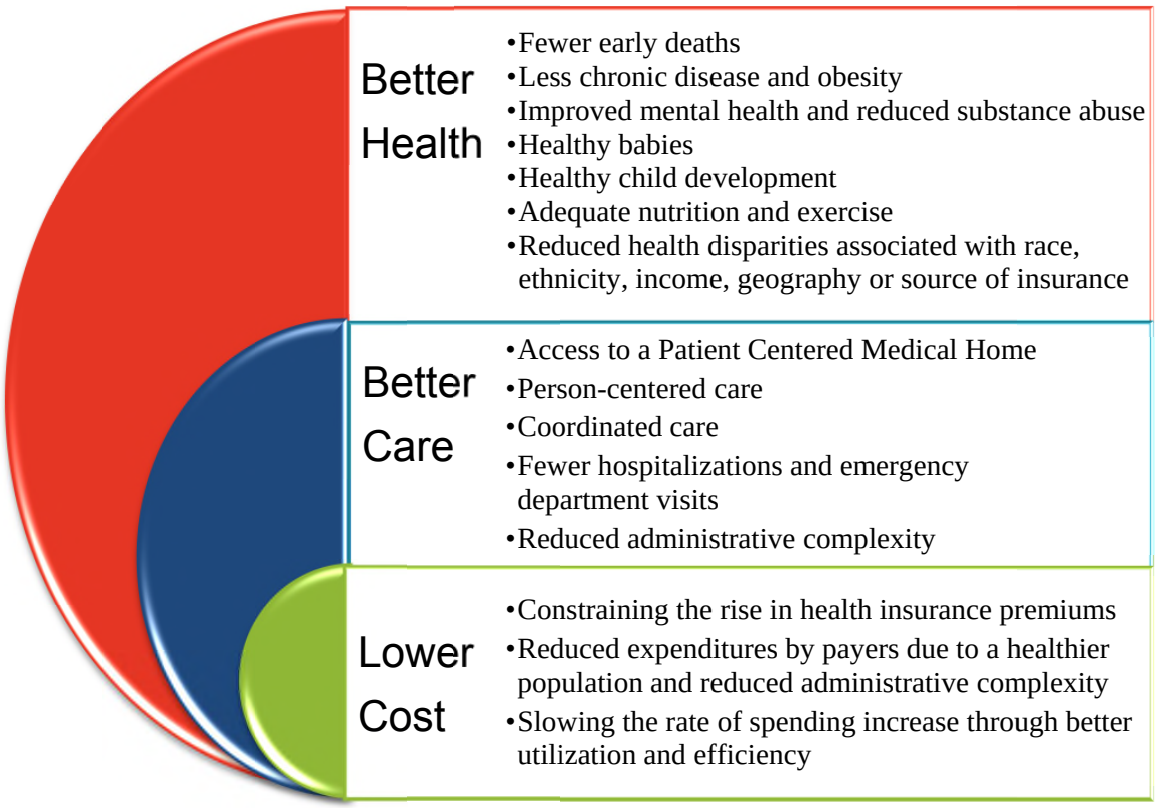
In 2009, Elizabeth had the opportunity to explore the private sector, both as a senior health consultant for Public Sector Consultants, Inc. and policy analyst with Blue Cross Blue Shield. In 2011, she returned to the House Republican Policy Office to again explore health and human services policy and appropriations issues.

In her free time, she enjoys gardening, reading, traveling and spending time with her family.

Executive Summary[1]

> ***To build a stronger Michigan, we must build a healthier Michigan. My vision is for Michiganders to be healthy, productive individuals, living in communities that support health and wellness, with ready access to [an] affordable, patient- centered and community-based system of care. Health and wellness are important across the continuum of life from prenatal care, to providing children and adults with opportunities for nutritious food and physical activity, to the option of home-based long-term care for seniors who need it.***
>
> ***– Governor Rick Snyder***

Reinventing Michigan's health care system is one of Governor Rick Snyder's top priorities. This vision is shared by individuals and organizations across the State who desire to improve the health of all Michiganders and have a health care system that provides better quality and experience at lower cost.



Critical Health Indicators in Michigan Compared to the United States Average

Better than Average

- Binge drinking
- Cholesterol testing
- Education attainment
- Human immunodeficiency virus/acquired immunodeficiency syndrome infection
- Injury mortality
- Insurance coverage
- Mammograms
- Childhood obesity
- Adult physical activity
- Teen birth rate

Worse than Average

- Cancer mortality
- Cardiovascular disease
- Chlamydia
- Cigarette smoking
- Diabetes
- Hypertension
- Infant mortality
- Unemployment
- Life expectancy
- Nutrition
- Adult obesity
- Pap tests
- Child physical activity
- Poverty
- Veterans' access to health care

The Current State of Health Care in Michigan

Michigan is in the process of rebounding from a recession that hit the industrial Midwest especially hard. Governor Snyder came into office in 2011 with the goal of reinventing Michigan. Health care is one of his top 10 priorities.[2] Governor Snyder recognizes that health and wellness are fundamental to the overall economic success of the State.

Michigan continues to grapple with obesity, diabetes, and heart disease. The rate of obesity has increased consistently among both adults and children, and is especially high among low income and minority groups.[3] Michigan faces challenges addressing health disparities with issues such as infant mortality and obesity-related chronic diseases disproportionately affecting Michigan's African American and Hispanic communities. According to the National Healthcare Quality Report, Michigan's overall health care quality is average[4] and Michigan is underperforming on many of its Healthy People 2020 goals.[5]

Despite the State's challenges, health care innovation is already underway in Michigan. The Michigan Primary Care Transformation demonstration project is the largest multi-payer Patient Centered Medical Home demonstration in the country. Physician organizations across the State are recruiting specialists to enhance communication with primary care providers. Provider groups, health systems and other entities are participating in federal innovation initiatives. Hospitals are working to reduce admissions by following up with patients after discharge. The State of Michigan and the federal government are working collaboratively on a plan to coordinate care for individuals eligible for both Medicaid and Medicare. The Michigan Department of Community Health and providers across the state are preparing to serve 477,000 new Medicaid beneficiaries under the Healthy Michigan Plan to extend benefits to previously ineligible adults[6] below 133% of the Federal Poverty Level. A detailed description of the Healthy Michigan Plan and its impacts is provided in chapter B. Community Mental Health Service Providers are working with the State of Michigan to design a Health Home model to

Michigan was ranked the 37th healthiest state in the country in 2012, compared to 33rd in 2011.
http://www.americashealthrankings.org/MI/2012

integrate primary care with behavioral health care for those with serious and persistent mental illness. Community coalitions and organizations are engaging stakeholders to improve health care delivery systems and address how environments affect healthy behavior. Michigan providers are increasingly exchanging electronic health information to streamline patient care. These are just a few examples of what health care providers, health insurance companies, citizens, businesses, communities, and government are already doing to promote health and well-being in Michigan.

Michigan is making great progress, but care continues to be fragmented, with payment systems that reward volume over value, and the performance of procedures over time spent thinking, educating, talking, and coordinating care. Michigan achieves the health outcomes that the current payment system rewards, and it can achieve better.

Working Together to Create a Better Future

The State Innovation Model initiative, funded by the Center for Medicare and Medicaid Innovation, provided an opportunity to continue the work of breaking down silos and bringing stakeholders together to innovate. Governor Snyder's commitment and support for building a stronger Michigan, along with the creative initiatives already occurring around the state, served as the starting point for stakeholder discussions and planning.

The Michigan Department of Community Health was tasked with forming a State Innovation Model advisory committee in April 2013. The committee consisted of representatives from payers, state agencies, business representatives, consumer groups, providers, community service entities, and academia. The advisory committee met on a monthly basis, serving as the primary conduit for the input of a wide variety of stakeholders in the design of an initial working concept of a redesigned service delivery system. Additional stakeholders were engaged through focus groups, work groups, public outreach meetings, key informant interviews, and the Michigan State Innovation Model web site.

The advisory committee focused first on providing detailed specifications for how an ideal health system – and the people within it – would function. They then considered what would make that vision a reality – including payment models that would support the reimagined delivery system. The Michigan Department of Community Health and other State officials carefully considered all of the stakeholder input throughout every part of the process, and crafted a to-be model of health care delivery and payment reform that embodies a "bottom-up, top enabled" approach in line with Governor Snyder's "Bureaucracy Busters" initiative. The result of the State Innovation Model Initiative is this document: Reinventing Michigan's Health Care System: Blueprint for Health Innovation.

Health System Design and Performance Objectives

The Blueprint is founded on the belief that Michigan can achieve better health and better care while containing costs. The advisory committee formulated six goals for Michigan's reinvented health system:

Goal I.	Strengthen the primary care infrastructure to expand access for Michigan residents
Goal II.	Provide care coordination to promote positive health and health care outcomes for individuals requiring intensive support services
Goal III.	Build capacity within communities to improve population health

Goal IV. Improve systems of care to ensure delivery of the right care, by the right provider, at the right time, and in the right place

Goal V. Design system improvements to reduce administrative complexity

Goal VI. Design system improvements that contain health care costs and keep insurance premiums affordable for individuals/families and employers/businesses

Building on these goals, the advisory committee further specified Michigan's reinvented health care system as possessing the following characteristics: accountability; person- and family-centered care; community-centered design; focus on prevention, wellness, and development; community integration; system-wide linkages; evidence-based approaches; and payment for value. Payment reform is recognized as one driver to an improved delivery system. These characteristics align with Michigan's vision for health system reinvention.

Shortly after he came into office in 2011, Governor Snyder created the Michigan Health and Wellness dashboard to measure the State's performance on several key areas of health, including access to health care, health behaviors and preventable hospital stays. Michigan's Blueprint calls for monitoring a variety of metrics, including measurements from Governor Snyder's dashboard, as part of a process for continuous improvement. The Blueprint also requires monitoring access to primary care, clinical quality, patient experience of care, and utilization – gathering information from the dashboards implemented throughout the Michigan Department of Community Health.

Proposed Delivery System Transformation

In order to strengthen primary care capacity and capabilities, and increase recruitment and retention of primary care providers, the advisory committee agreed that there must be ongoing support for existing Patient Centered Medical Homes. Furthermore, the advisory committee agreed that there must be transformation of additional primary care practices to Patient Centered Medical Homes, as well as an expansion of Michigan's primary care workforce.

The Patient Centered Medical Home is the core of Michigan's Blueprint for Health Innovation

Michigan's Blueprint rests upon the Patient Centered Medical Home, but also goes beyond it. Primary care physicians, nurses, and practice staff cannot bear the entire burden of health reform. Networks of primary care providers, specialists, and hospitals are developing capacity to integrate clinical care across settings, providing safer, more efficient, and less redundant (and therefore less expensive) care – as well as a better experience for patients. The Blueprint proposes to recognize these networks as formal entities called Accountable Systems of Care. Accountable Systems of Care will be responsible for ensuring high quality and person-centered care while lowering costs for a defined population. As formal entities that organize providers and are accountable for outcomes, Accountable Systems of Care will enter into contracts with payers that shift progressive amounts of financial benefit and risk to providers.

Infrastructure created at the community or regional level will support the efforts of all health care providers to improve the health of the populations they serve. Community Health Innovation Regions will form out of broad partnerships among stakeholders, to leverage Michigan's Prosperity Regions and

contributions of health care, public health, community organizations, businesses, schools, higher education, economic development organizations, and local government to address issues that affect the health of the entire community. This collective impact model is based on the idea that complex problems are better solved through cross-sector coordination than the isolated interventions of individual organizations.[7] Coordination cannot be sustained at the level needed through voluntary efforts, however, so Community Health Innovation Regions will be formal associations supported by 'backbone' organizations that have a small number of paid staff.

The Michigan Department of Community Health will support the success of Accountable Systems of Care and Community Health Innovation Regions through investments in health information technology infrastructure when needed, the development of a performance measurement and recognition committee, and the provision of technical assistance resources to spread best practices and promote success.

Health Information Technology

Patients and providers having access to relevant health information when they need it is critical for a safe, efficient, and coordinated health care system. Recognizing this, providers across the state are investing in electronic health records. Networks to facilitate exchange of health data between patients and providers in different settings have been encouraged through the Office of the National Coordinator for Health Information Technology's State Health Information Exchange Cooperative Agreement Program. However, many are frustrated that change is not happening fast enough. To date, investment has been driven by incentive programs offered by Medicare, Medicaid, and commercial health insurers. Implementation of Michigan's Blueprint will change the value proposition for investing in health information technology: when providers are paid for value rather than volume, the adoption of health information technology will become essential to meeting health, quality, and cost goals. Software vendors and health information exchange organizations will then be oriented to providing solutions that help providers reach those value targets.

While the public-private partnership led by Michigan Health Information Network Shared Services (the State-designated entity in the State Health Information Exchange Cooperative Agreement Program) continues to achieve greater coordination and useful exchange of health information, Michigan is finding creative ways to leverage mobile technology to improve health care delivery and services at many levels. The Southeastern Michigan Beacon Community pioneered Txt4Health diabetes management text alerts, and the MI Healthier Tomorrow 4x4 Wellness tool also offers a mobile link to motivational health and wellness messaging. Michigan Medicaid is scaling up a mobile application called "MyHealthButton" which allows beneficiaries to find real-time coverage information, nearby providers, and track payment arrangements. Interfaces with Women, Infants and Children Program benefit information and the 4x4 wellness tool engage consumers in taking an entire portfolio of services and health information with them wherever they go. Web portals into electronic health records will further integrate health care into Michiganders' daily lives and take health information technology into the mainstream.

Michigan's Blueprint for Health Innovation proposes a transformation that includes the following structural elements:

Patient Centered Medical Homes put the individual in charge of their health care: clinicians are more accessible, care teams engage patients with complex needs, and providers monitor their patient population to assure that everyone is getting the care they need.

In **Accountable Systems of Care**, providers are organized to communicate efficiently, coordinate patient care across multiple settings, and make joint investments in data analytics and technology. Through clinical integration – supported by formal governance and contractual relationships – providers co-create tools, workflows, protocols, and systematic processes to provide care that is accessible to patients and families, supports self-management, is coordinated, and incorporates evidence-based guidelines. As the capacities of an Accountable System of Care grow, the system can be held responsible for performance in terms of quality of care and the health outcomes of their assigned population. Health plans will continue to fulfill their current role in managing insurance risk, while contracting with Accountable Systems of Care to take on performance risk. Plans will collaborate with Accountable Systems of Care to provide wrap-around services and benefits; beneficiary outreach, engagement, education, and other member services; data analytics; and information on utilization outside of the Accountable System of Care.

In **Community Health Innovation Regions**, partners act cohesively with a broad-based vision for region-wide impact, to make the environment healthier and to connect health services with relevant community services. The process begins with a collaborative community health needs assessment that identifies key health concerns, illuminates root causes of poor health outcomes, and sets strategic priorities. Action plans are developed to organize and align contributions from all partners for collective impact.

Payment models are designed to incentivize value over volume – aligning the interests of patients, communities, primary care providers, specialists, hospitals, payers, and policy makers toward the aims of better population health, high quality health care, and lower cost. To do this, a staged approach to payment reform is proposed in which Patient Centered Medical Homes and Accountable Systems of Care are supported in moving away from fee-for-service and adding capacity for coordinated care and responsibility for outcomes.

A **statewide infrastructure** will be put in place to provide governance for the implementation of Michigan's Blueprint and to respond to the needs of patients, providers, communities, and payers. State government must align policy, payment, and programming to reinforce the Blueprint elements and incentivize the desired outcomes. The State is a major purchaser of health care services for Medicaid beneficiaries and for its own employees. The State has an important role in guiding investment in shared infrastructure and promoting practice transformation through statewide data monitoring, evaluation and dissemination. It establishes systems to monitor and reward performance, and to disseminate information, including recognition of top performers.

Paying for Value

Payment for value involves movement from a volume-driven health care delivery system to one that pays for performance, as measured by the quality of health care, the health of the population, and efficiency. This shift has many challenges. As Michigan transitions to new ways of paying for health care, several considerations must be kept in mind:

- Physicians and other providers cannot control all factors that lead to better outcomes
- Patients, through healthy behaviors, are also responsible for their own health
- Payment models work best – and save the most money – when expectations and administrative processes are aligned across payers
- Transparency of cost, quality, and health outcomes will promote good decision-making

Reforming the fee-for-service payment model is integral to the proposed health system reinvention. Michigan's Blueprint promotes multi-payer alignment in testing innovative approaches to paying for value. The Blueprint proposes staging a continuum of health care reimbursement models that require increasing amounts of provider accountability. Benefit design elements that encourage patients to make healthy choices are desired, and a performance recognition program that makes information about provider quality and outcomes publicly available engages consumers in driving the demand for value-based payment models.

Payment Type	Description
Care Management Reimbursement	A fee-for-service adjustment or capitated payment for comprehensive and coordinated care management of an assigned panel of patients.
Shared Savings	A financial award based on a percent of aggregate total cost of care savings achieved during a specified performance period.
Pay-for-Performance	Incentives that reward providers for achieving target performance levels or specific outcomes over a defined period: this form of payment is designed to encourage health care providers to produce incremental improvements in performance on health outcomes over time.
Population-Specific Global Payment	Fixed prepayment made to an accountable provider organization or a health care system, which covers most or all of a patient's care during a specified period: global payment for children with special health care needs is an example of how global payments have been used in Medicaid.
Partial Risk-Based Capitation	A payment method in which the accountable provider organization or a health care system receives a monthly per member per month payment for an assigned/enrolled group of patients to provide or arrange for a broad range of inpatient, outpatient, and/or diagnostics services (but not all the benefits and services that a health plan or payer may be obligated to provide). The Accountable System of Care may be at full risk or have limited risk for the total cost of services provided under as part of the capitation payment.

Implementing Michigan's Blueprint for Health Innovation

Michigan will test the Innovation Model in several communities before scaling it up across the state using a rapid-cycle improvement process to implement, evaluate, refine, and disseminate change. A rapid-cycle improvement process is one in which target measures and milestones are established, data is collected, progress is assessed, and improvements are incorporated into the system on an ongoing basis. Testing the models proposed as part of Michigan's Blueprint on a small scale allows the participants in the test sites to learn from the results and to make adjustments before making the change permanent. Also, smaller-scale tests minimize risks and provide the State with the opportunity for making adjustments to the Blueprint to avoid unintended consequences as the system reacts to changes over time. Michigan's proposed service delivery and payment models will be implemented on a test basis in select areas. As the models are refined, they will be scaled up to other communities and to other payers.

During the planning period, the State will:

- Submit a grant application for a test of the service delivery and payment models contained in the Blueprint to the Center for Medicare and Medicaid Innovation
- Establish multi-payer steering and performance recognition committees
- Engage providers, payers, patients, and others to develop multi-payer metrics
- Work with stakeholders to refine the models
- Select test sites and assess capacity using a methodology developed by project stakeholders and staff
- Identify technical assistance needs

During the test period, the State will:

- Continue investments into shared information exchange capabilities and data systems
- Invest in the education and training of health care teams
- Implement service delivery and payment models
- Refine the models based on participant feedback and rapid-cycle improvement processes
- Provide participants with performance feedback and technical assistance
- Identify needed policy change
- Evaluate outcomes

During the dissemination period:

- The elements of a high quality service delivery model will be spread to other geographies, populations, and systems
- All Michiganders will have a relationship with a Patient Centered Medical Home
- Health care payment in Michigan will drive value not volume

- Communities will have an infrastructure and sustainable funding that support effective collaboration to continuously improve local service and population health systems

Governor Snyder is committed to the vision, goals, and culture of a healthier Michigan. The provision of health care involves the interaction of multiple complex systems. The Blueprint provides a process for learning the way to a better system: testing and implementing change in ways that involve individuals and organizations to co-create this new system with tools and processes to continuously monitor and adjust performance.

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[1]State of Michigan. Full document available: https://www.michigan.gov/mdch/0,4612,7-132-2945_64491---,00.html. Published January 24, 2014. Accessed April 25, 2014.

[2]State of Michigan. Reinventing Michigan. http://www.michigan.gov/documents/snyder/ReinventingMichiganCard_368353_7.pdf.

[3] Michigan Department of Community Health. Overweight and Obesity in Michigan: Surveillance Update 2011. http://www.michigan.gov/documents/mdch/Overweight_and_Obesity_in_Michigan_Surveillance_Update_2011_432811_7.pdf.

[4] National Healthcare Quality Report. Michigan Dashboard on Health Care Quality Compared to All States. Agency for Healthcare Research and Quality, Department of Health and Human Services. http://nhqrnet.ahrq.gov/inhqrdr/Michigan/snapshot/summary/All_Measures/All_Topics. Accessed January 21, 2014.

[5] Michigan Department of Community Health. Comparison of Michigan Critical Health Indicators Report & Healthy People 2020 Targets. https://www.michigan.gov/documents/mdch/CHI_HP2020_Comparison_2012_FINAL_387635_7.pdf. Published May 30, 2012. Accessed November 13, 2013.

[6] Office of the Governor of Michigan. Gov. Snyder signs Healthy Michigan into law, bringing health care to 470,000 Michiganders. September 16, 2013. http://www.michigan.gov/snyder/0,4668,7-277-57577-312514--,00.html. Accessed September 16, 2013.

[7] Kania J, Kramer M. Collective Impact. *Stanford Social Innovation Review*. 2011;9. http://www.ssireview.org/articles/entry/collective_impact. Accessed November 13, 2013.

Overview of the Blueprint for Health Innovation	
Element	**Approach**
Patient Centered Medical Home	• Build upon current Michigan Primary Care Transformation demonstration project across the State, promoting interprofessional teams • Increase the number of providers and payers participating, while maintaining the support of existing payers • Include risk-adjusted monthly payments for care management in Medicaid contracts • Ensure Patient Centered Medical Homes achieve specified performance standards to retain designation • Align performance metrics, reporting, and incentives across multiple payers • Make Patient Centered Medical Homes the foundation for Accountable Systems of Care that provide common infrastructure investments and coordinated linkages to medical, behavioral, and community care providers
Accountable System of Care	• Build upon formal legal entities that: o Integrate providers and services to proactively manage and coordinate comprehensive care for a defined population o Support primary care providers to become Patient Centered Medical Homes, and support current Patient Centered Medical Homes to achieve greater capacity for improving health care while reducing cost o Are accountable to payers to improve quality while controlling costs • Test a graduated range of payment models that support Accountable Systems of Care to move on a continuum away from fee-for-service payments and toward payment for performance outcomes • Ensure Accountable Systems of Care achieve specified performance standards in order to participate • Engage in community-based population health strategies championed by Community Health Innovation Regions
Community Health Innovation Region	• Build upon formal entities, with a backbone infrastructure, that: o Engage cross-sector partners within a geographic region in population-level strategies to improve health and wellness o Partner with public health o Assure community assessments are conducted and set strategic priorities with the community o Engage and mobilize patients and community members in community-centered health and wellness strategies o Engage Accountable Systems of Care to create integration across clinical, behavioral, and social care services o Organize regions to take a “health-in-all-policies” approach • Demonstrate the added value of investments in Community Health Innovation Regions to reduce health risks in the community • Secure sustainable financing mechanisms for the backbone infrastructure and population-level activities

Overview of the Blueprint for Health Innovation	
Element	**Approach**

Payment Reform	• Continue multi-payer participation in Patient Centered Medical Home transformation
	• Test payment models that:
	  o Reward providers for improving outcomes in population health, health care quality, and cost
	  o Offer Accountable Systems of Care flexibility to make the necessary investments in system redesign, including health information infrastructure
	  o Provide the Accountable Systems of Care and Community Health Innovation Regions incentives to address environmental and social determinants of health
	• Test benefit designs that encourage desired behaviors among beneficiaries for:
	  o Maintaining a long-term relationship with their Patient Centered Medical Home care team
	  o Appropriate, value-based utilization of health care services
	  o Healthy lifestyles
	• Test payment models that support providers to move on a continuum toward payment for performance outcomes, including:
	  o Shared savings with and without down-side risk: financial reward or loss to an Accountable System of Care based on a percent of aggregate total cost of care savings achieved during a specified performance period
	  o Partial capitation: monthly payment to an Accountable System of Care for enrolled patients to provide or arrange for a broad range of inpatient, outpatient, and diagnostic services (but not all the benefits and services that a health plan or payer may be obligated to provide)
	  o Global capitation: fixed prepayment made to an Accountable System of Care that covers most or all care for a specific health condition, or a specific population, during a specified time period

Infrastructure	• The Policy and Planning Office of the Michigan Department of Community Health will work to align programming across governmental units, coordinate policy and funding levers, and provide overall accountability for the Blueprint for Health Innovation
	• Convene two multi-stakeholder entities:
	  o Innovation Model Steering Committee: responsible for guidance on implementation, monitoring, and continuous improvement of the Blueprint for Health Innovation
	  o Innovation Model Performance Measurement and Recognition Committee: responsible for developing and maintaining core performance measures that are acceptable to, and used by, multiple payers, providers, and consumers
	• Leverage and invest in Michigan's existing health information exchange infrastructure that is responsible for data standardization, analytics, and public reporting in order to:
	  o Inform patient decisions regarding health and health care choices
	  o Ensure providers have data for clinical decision-making, care coordination, and population health management
	  o Monitor progress, track performance, and inform policy decisions

Michigan Health Endowment Fund

201 Townsend Street, Lansing, MI 48913

MHEF Financial Statement

Asset Value

Cash – Chemical Bank as of July 31, 2014	$9,747,356.09
Investments – Huntington as of August 8, 2014	$88,467,190.59
Total Assets	$98,214,546.68

Income Statement as of July 31, 2014

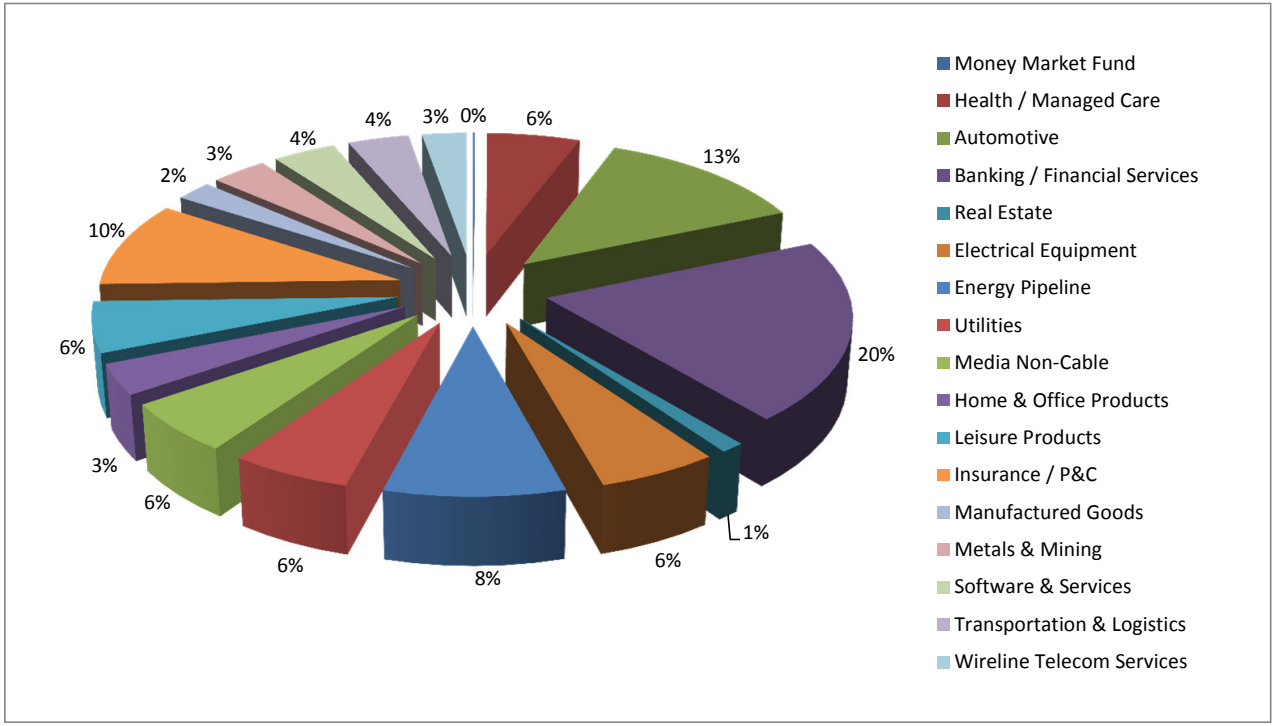
Income	Year-to-Date
Funds Contributed from Blue Cross Blue Shield	$100,000,000.00
Interest Earned	$896,395.26
Total Contributions and Income	$100,896,395.20
Operating Expenses	
Professional Services	$257,722.55
Memberships	$9,700.00
Meeting/Facilities	$6,777.05
Postage and Shipping	$808.36
Travel	$246.65
Filing Fees	$850.00
Total Expenses	$276,104.61

Portfolio Positions
MI Health Endowment Fund x-xxxxx

Security ID	Description	Industry	Credit Rating	Maturity	Yield	Purhcase Price	Maturity Value	Market Value	Principal Cost	$ Gain/Loss	Acrd Int Paid
Cash / Cash Equivalents											
Inst. Class MMKT	Fidelity Prime	Money Market Fund	AAA	Daily	0.10%	$ 100.000	$ 114,921.94	$ 114,921.94	$ 114,921.94	$ -	$ -
						Total	$ 114,921.94	$ 114,921.94	$ 114,921.94	$ -	$ -
Commercial Paper											
	AON CORPORATION DISC COMML PAPER	Property & Casualty Insurer	A2 / P2	8/18/2014	0.24%	$ 99.970	$ 5,000,000.00	$ 4,999,687.00	$ 4,998,600.00	$ 1,087.00	$ -
	VW MOTOR CREDIT	Automotive	A2 / P2	9/9/2014	0.23%	$ 99.980	$ 5,000,000.00	$ 4,998,977.78	$ 4,998,977.78	$ -	$ -
	DISCOVERY COM LLC DISC COMML PAPER	Media Non-Cable	A2 / P2	9/8/2014	0.28%	$ 99.950	$ 5,000,000.00	$ 4,998,964.50	$ 4,997,588.89	$ 1,375.61	$ -
	HARLEY DAVIDSON FINL DISC COMML PAPER	Automotive	A2 / P2	9/8/2014	0.20%	$ 99.960	$ 5,000,000.00	$ 4,998,964.50	$ 4,998,277.78	$ 686.72	$ -
	HASBRO INC DISC COMML PAPER	Leisure Products	A2 / P2	9/18/2014	0.24%	$ 99.950	$ 5,000,000.00	$ 4,998,565.00	$ 4,997,566.67	$ 998.33	$ -
	HITACHI CAP AMER DISC COMML PAPER	Electrical Equipment	A2 / P3	9/9/2014	0.28%	$ 99.980	$ 5,000,000.00	$ 4,998,755.56	$ 4,998,755.56	$ -	$ -
	SANTANDER CP DISC COMML PAPER	Banking / Financial Services	A2 / P3	10/21/2014	0.40%	$ 99.860	$ 5,000,000.00	$ 4,997,187.50	$ 4,993,333.33	$ 3,854.17	$ -
	SUNCORP MTWY LTD DISC COMML PAPER	Banking / Financial Services	A1 / P1	11/5/2014	0.28%	$ 99.890	$ 5,000,000.00	$ 4,997,625.00	$ 4,994,750.00	$ 2,875.00	$ -
	WELLPOINT INC DISC COMML PAPER	Managed Care	A2 / P2	10/1/2014	0.18%	$ 99.950	$ 5,000,000.00	$ 4,998,243.00	$ 4,997,850.00	$ 393.00	$ -
						Total	$ 45,000,000.00	$ 44,986,969.84	$ 44,975,700.01	$ 11,269.83	$ -
Corporate Bonds											
	AMERICAN INTL GROUP INC 2.37500%	Property & Casualty Insurer	Baa2 / BBB+	8/24/2015	0.79%	$ 101.833	$ 1,000,000.00	$ 1,016,840.00	$ 1,016,454.17	$ 385.83	$ 7,982.64
	BNP PARIBAS US MEDIUM TERM NT 5.12500%	Banking / Financial Services	Baa2 / BBB+	1/15/2015	0.66%	$ 102.470	$ 500,000.00	$ 508,480.00	$ 509,699.07	$ (1,219.07)	$ 11,388.89
	BLOCK FINL CORP SR GLBL NT 5.12500%	Financial Services	Baa2 / BBB	10/30/2014	0.61%	$ 101.550	$ 1,000,000.00	$ 1,008,240.00	$ 1,010,249.97	$ (2,009.97)	$ 7,972.22
	DEUTSCHE BK FINL LLC MTN 5.37500%	Banking / Financial Services	Baa3 / BBB	3/2/2015	0.70%	$ 103.100	$ 1,500,000.00	$ 1,539,135.00	$ 1,539,493.17	$ (358.17)	$ 29,114.58
	DUKE CAPITAL LLC NOTES 5.668%	Energy Pipeline	Baa2 / BBB-	8/15/2014	0.57%	$ 100.776	$ 2,500,000.00	$ 2,501,175.00	$ 2,502,469.07	$ (1,294.07)	$ 49,201.39
	DUN & BRADSTREET CORP DEL NEW 2.87500%	Software & Services	BBB- / BBB	11/15/2015	0.85%	$ 102.791	$ 3,300,000.00	$ 3,382,500.00	$ 3,384,213.05	$ (1,713.05)	$ 10,541.67
	ENERGY TRANSFER PRTNRS L P 5.95000%	Energy Pipeline	Baa3 / BBB-	2/1/2015	0.68%	$ 103.064	$ 2,854,000.00	$ 2,926,719.92	$ 2,926,045.17	$ 674.75	$ 70,755.42
	FORD MOTOR CREDIT CO LLC 12.00000%	Automotive	Baa3 / BBB-	5/15/2015	0.67%	$ 109.835	$ 1,130,000.00	$ 1,227,146.00	$ 1,228,058.75	$ (912.75)	$ 17,326.67
	FORD MOTOR CREDIT CO LLC 2.75000%	Automotive	Baa3 / BBB-	5/15/2015	0.64%	$ 101.829	$ 1,100,000.00	$ 117,556.00	$ 117,751.56	$ (195.56)	$ 3,865.28
	GOLDMAN SACHS GROUP INC 5.12500%	Banking / Financial Services	Baa1 / A-	1/15/2015	0.62%	$ 102.410	$ 1,500,000.00	$ 1,529,055.00	$ 1,529,353.08	$ (298.08)	$ 35,447.92
	MERRILL LYNCH CO INC MTN BE 5.00000%	Banking / Financial Services	Baa2 / A-	1/15/2015	0.60%	$ 102.360	$ 1,596,000.00	$ 1,626,850.68	$ 1,626,527.37	$ 323.31	$ 36,796.67
	NEWELL RUBBERMAID INC 2.00000%	Home & Office Products	Baa3 / BBB-	6/15/2015	0.59%	$ 101.367	$ 3,000,000.00	$ 3,034,560.00	$ 3,035,978.84	$ (1,418.84)	$ 1,666.67
	PENSKE TRUCK LEASING CO L P 3.12500%	Transportation & Logistics	Baa3 / BBB-	5/11/2015	0.60%	$ 102.220	$ 2,849,000.00	$ 2,904,413.05	$ 2,903,328.35	$ 1,084.70	$ 10,386.98
	PETROBRAS INTERNATIONAL 2.875%	Integrated Oils	Baa1 / BBB	2/6/2015	0.95%	$ 101.074	$ 2,057,000.00	$ 2,072,221.80	$ 2,079,092.18	$ (6,870.38)	$ 25,955.34
	PRUDENTIAL COVERED TRUST 2.99700%	Life Insurance	Baa1 / A	9/30/2015	0.73%	$ 102.630	$ 3,000,000.00	$ 2,459,880.00	$ 2,463,240.00	$ (3,360.00)	$ 16,983.00
	QWEST CORP SR GLBL NT 7.50000%	Wireline Telecom Services	Baa3 / BBB-	10/1/2014	0.65%	$ 101.858	$ 2,378,000.00	$ 2,399,925.16	$ 2,401,894.99	$ (1,969.83)	$ 40,624.17
	STRUCT REP ASSET BKD NOTES SER GECC	Banking / Financial Services	A1 / AA+	9/15/2014	0.88%	$ 100.550	$ 750,000.00	$ 747,142.50	$ 754,125.00	$ (6,982.50)	$ -
	TIMKEN CO MAKE WHOLE 06.00000%	Manufactured Goods	Baa2 / BBB-	9/15/2014	0.61%	$ 101.267	$ 1,955,000.00	$ 1,963,758.40	$ 1,965,782.16	$ (2,023.76)	$ 30,954.17
	TRANSALTA CORP 6.00%	Utilities	Baa3 / BBB	1/15/2015	0.78%	$ 101.988	$ 975,000.00	$ 991,994.25	$ 994,383.00	$ (2,388.75)	$ 23,027.60
	XSTRATA FINANCE CANADA LIMITED NOTE 02.85000%	Metals & Mining	Baa2 / BBB	11/10/2014	0.70%	$ 100.797	$ 3,000,000.00	$ 3,015,147.00	$ 3,023,917.55	$ (8,770.55)	$ 10,925.00
	ZIONS BANCORPORATION SR GLBL NT 7.75000%	Banking / Financial Services	BBB- / BBB-	9/23/2014	0.51%	$ 101.720	$ 1,000,000.00	$ 1,007,740.00	$ 1,009,020.88	$ (1,280.88)	$ 20,236.11
	CSX TRANSPORTATION 8.375%	Railroad	A1 / A+	10/15/2014	0.41%	$ 101.368	$ 375,000.00	$ 380,122.05	$ 380,122.05	$ -	$ 10,294.06
	SIMON PROPERTY GROUP 5.625%	Real Estate	A2 / A	8/15/2014	0.30%	$ 100.103	$ 1,000,000.00	$ 1,001,033.00	$ 1,001,033.00	$ -	$ 27,031.25
	PUBLIC SVC ELECTRIC AND GAS	Utilities	Aa3 / A	8/15/2014	0.28%	$ 100.092	$ 4,000,000.00	$ 4,003,664.00	$ 4,003,664.00	$ -	$ 96,111.11
						Total	$ 44,319,000.00	$ 43,365,298.81	$ 43,405,896.43	$ (40,597.62)	$ 594,588.81
Corp. Structured Notes											
										$ -	
										$ -	
						Total	$ -	$ -	$ -	$ -	$ -
						Portfolio Totals:	**$ 89,433,921.94**	**$ 88,467,190.59**	**$ 88,496,518.38**	**$ (29,327.79)**	**$ 594,588.81**

Portfolio Diversification Report
MI Health Endowment Fund 8-8-2014

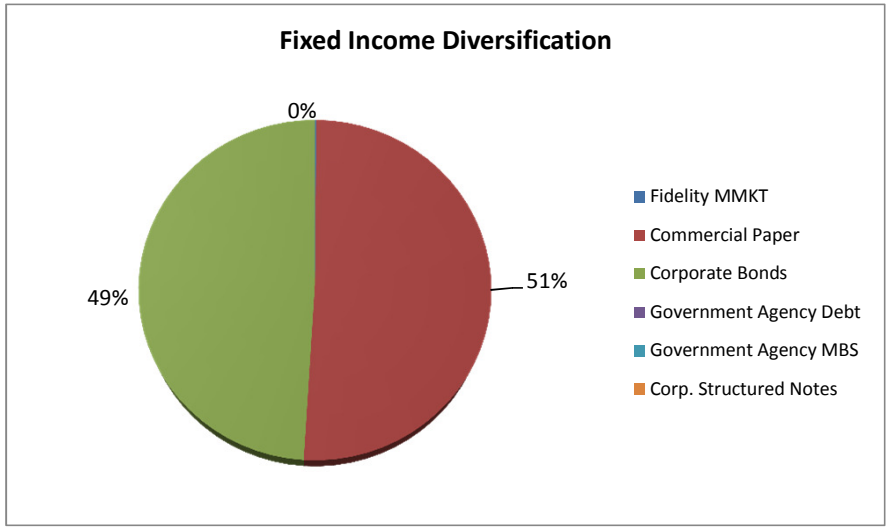
Industry Description	Market Value	Percentage
Money Market Fund	$ 114,921.94	0%
Health / Managed Care	$ 4,998,243.00	6%
Automotive	$ 11,342,644.28	13%
Banking / Financial Services	$ 17,961,455.68	20%
Real Estate	$ 1,001,033.00	1%
Electrical Equipment	$ 4,998,755.56	6%
Energy Pipeline	$ 7,500,116.72	8%
Utilities	$ 4,995,658.25	6%
Media Non-Cable	$ 4,998,964.50	6%
Home & Office Products	$ 3,034,560.00	3%
Leisure Products	$ 4,998,565.00	6%
Insurance / P&C	$ 8,476,407.00	10%
Manufactured Goods	$ 1,963,758.40	2%
Metals & Mining	$ 3,015,147.00	3%
Software & Services	$ 3,382,500.00	4%
Transportation & Logistics	$ 3,284,535.10	4%
Wireline Telecom Services	$ 2,399,925.16	3%
Total	**$ 88,467,190.59**	**100%**



Summary of Investments
MI Health Endowment Fund 8-8-2014

Fixed Income Diversification

Description			Percentage
Fidelity MMKT	$	114,921.94	0%
Commercial Paper	$	44,986,969.84	51%
Corporate Bonds	$	43,365,298.81	49%
Government Agency Debt	$	-	0%
Government Agency MBS	$	-	0%
Corp. Structured Notes	$	-	0%
Total	**$**	**88,467,190.59**	**100%**

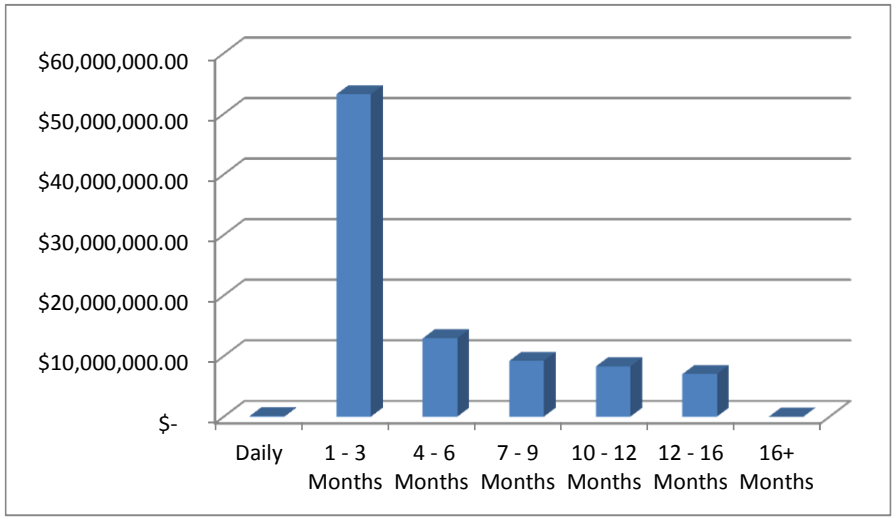


Portfolio Analysis

Description	
Weighted Average Yield	0.45%
Weighted Average Life in Years / Duration	0.30
Interest Income Earned to 8/8/14	$ 874,046.37

Maturity Schedule

Description			Percentage
Daily	$	114,921.94	0%
1 - 3 Months	$	53,197,249.00	59%
4 - 6 Months	$	12,932,934.38	14%
7 - 9 Months	$	9,193,565.63	10%
10 - 12 Months	$	8,283,878.13	9%
12 - 16 Months	$	7,023,648.13	8%
16+ Months	$	-	0%
Total	**$**	**90,746,197.21**	**100%**



Michigan Health Endowment Fund

2014 Pilot Grantmaking Proposed Timeline

August 7, 2014

Activity	Timing
1. Establish list of recommended organizations who will be invited to apply for grants	July 29
2. Present list to Grantmaking Committee for review and approval	August 5
3. GL places calls to organizations to inform them of grant invitation	August 5
4. Invitation letters and application format sent to organizations	August 6
5. Bidder's teleconference	August 13
6. Staff conducts due diligence and provides guidance to potential grantees	August 8-September 5
7. Grant applications due	September 5
8. Staff review applications and provide summaries/recommendations	September 5 – 25
9. Mail book to Grantmaking Committee	September 26
10. Grantmaking Committee reviews organizations recommended for grants	October 15
11. Board meets to review recommendation from Grantmaking Committee	October 20
12. Grant award letters and contracts mailed	November 1

TO: **Michigan Health Endowment Fund**
FROM: **Geralyn Lasher, Interim Executive Director**
RE: **Detroit Water situation**
DATE: **August 11, 2014**

The Michigan Health Endowment Fund requested additional information on the Detroit water shutoff issue at its board meeting on July 21, 2014. The board expressed interest in determining if there was a way to assist the children and senior citizens who may be experiencing difficulty following the shutoffs of the Detroit Water and Sewerage Department (DWSD).

Background:

According to DWSD there are:

- 176,879 total residential accounts, of which 80,338 were delinquent
- Of the 15,266 residential accounts were suspended
    - 7,725 were restored within 24 hours
- Potentially 7,541 accounts that have not been restored. Difficult to determine an exact number with legal household residents as some of these may be illegal water hookups.

Resources currently available:

There are various local programs available to assist people with water bills including:

- Detroit Water and Sewerage Department. The department is setting up payment plans and taking requests for assistance from a nonprofit organization.
    - Detroit Water and Sewerage District has worked with The Heat and Warmth Fund – better known as THAW – to assist low-income Detroit water customers.

- Water Access Volunteer Effort (WAVE)
    - WAVE assistance is intended to be a one-time emergency fund in a calendar year to prevent shut-off. The WAVE Fund works with established service agencies, the Detroit Water and Sewerage Department and Department of Human Services, and others where families and individuals in need typically apply for help.

- Wayne Metropolitan Community Action Agency
    - Wayne Metro has provided $1 million in water bill assistance to Detroit residents since August 2013 through a contract with DHS and has about $300,000 still available. Those dollars came to DHS from a federal Community Services Block Grant. Assistance is available to low-income households. Recipients are required to take a financial literacy or utility conservation course.

Mayor Duggan's 10-point plan for water assistance

On Thursday August 7, Mayor Duggan announced his 10-point plan for water assistance. The United Way for Southeastern Michigan will serve as the fiduciary for the program and the Mayor is actively calling for foundations, business and individual financial support for the program.

Materials from the Mayor's office indicate "Highlights of the plan include the waiving of turn on fees and late payment penalties through the end of the moratorium, a payment plan structure that requires only a valid ID to enter and increasing staffing at customer service and call centers. The plan also includes the establishment of a new assistance fund for low income families, called the Detroit Water Fund."

The program is modeled after DTE Low Income Self-Sufficiency Plan that the United Way for Southeastern Michigan manages that assists individuals below 150% of the Federal Poverty Level ($17,505 for one individual, $35,755 for a family of four) and will require them to have average or less than average water usage to participate.

People need to have bills in arrears of $1,000 or less to participate. The United Way would screen individuals promptly to determine eligibility and get people in a payment plan.

Consumers would have to pay a 10% down payment on arrearages. Water department will then spread the remainder of arrearages over payments the next 24 months. Consumers would need to pay their current bills as well to receive a 25% discount on their current bill for one year.

If a consumer misses a payment they would no longer be eligible to participate and would not qualify for the 25% discount. If they want to return to the program, they would need to pay 30% of the remaining amount in arrears to continue paying the arrears over 24 months. If they miss another payment they must pay 50% of the remaining arrears to resume payment plan.

The Mayor's office is actively working with the Detroit Area Agency on Aging (DAAA) to educate senior citizens about the program and options available to them for assistance.

Is this issue aligned with the Michigan Health Endowment Fund?

Providing for access to clean drinking water and safe sanitation is a health priority so that fits well within the focus of the Michigan Health Endowment Fund. While it does not follow the same criteria for funding developed for 2014 the fund is not precluded from making a grant.

What form of grant could the Michigan Health Endowment Fund make?

The Michigan Health Endowment Fund could provide $2 million in funding to the United Way for Southeastern Michigan to assist in resolving this effort. The fund could make the grant all at once or could provide an initial award of $1 million to the United Way for Southeastern Michigan with a commitment for an additional $1 million to be used as "match" incentive funding to bring other partners to the table.

Press Release

City of Detroit • Mike Duggan, Mayor

FOR IMMEDIATE RELEASE
August 7, 2014

CONTACT:
John Roach, Communications Director
313.244.7857 (cell)
roachj@detroitmi.gov

Mayor, DWSD announce 10-point plan to help residents stay current on their water bills

Detroit Mayor Mike Duggan and Detroit Water & Sewerage Director Sue F. McCormick, along with a team of community partners today announced a 10-point plan that would allow DWSD to collect on overdue water bills while making it easier for customers to make payments, enter into payment arrangements and access financial assistance.

On Monday, the Mayor and DWSD announced they were extending the moratorium on residential water shut offs through August 25th. The Mayor and Director McCormick felt the extension was necessary because it was clear their Detroit customers needed more time to understand the department's policies and more ways to avoid shutoff.

Highlights of the plan include the waiving of turn on fees and late payment penalties through the end of the moratorium, a payment plan structure that requires only a valid ID to enter and increasing staffing at customer service and call centers. The plan also includes the establishment of a new assistance fund for low income families, called the Detroit Water Fund.

"It was clear by the turnout at our fair last weekend at our east side center that Detroiters want to stay on top of their bill. We just needed to give them a better process. Under this plan, anyone who wants to address their overdue balance will have every opportunity to do so," Mayor Duggan said.

DWSD Director Sue McCormick said her department is committed to assisting Detroit residents so they can avoid being placed into a shut off status. She also said that this 10-point plan will benefit all Detroiters - those who pay every month and those who need to catch up.

-more-

"This plan provides great resources for those Detroiters who need some guidance and support in paying their bills," she said. "As more Detroiters get current on their bills, that means there is less of a deficit for other Detroit residents to pick up in the form of added charges on their bill. It really benefits everyone."

The city will host a Water Fair at Cobo Center from 9AM - 5PM on August 23rd, just before the moratorium on residential water shut offs ends on the 25th. McCormick said the fair will give Detroit customers one final opportunity to access all of the support they need in one location before water shut offs resume on August 26th.

DWSD 10-point Plan

1. **Waive Turn-On Fees and Late Payment Penalties.**
   During the moratorium, which ends August 25th, DWSD will waive turn-on fees for customers whose water had been shut off, as well as all late payment penalties.

2. **Cut red tape.**
   To simplify getting into a payment plan, customers only need to present a valid state ID. Once a payment is made, service will be restored within 48 hours.

3. **Extend hours at DWSD Customer Care Centers.**
   The DWSD has expanded hours at all of its Customer Care Centers, from 8:00 AM – 6:00 PM Monday - Friday (previously 8:30AM – 5:30 PM) and 8:00 AM – 3:00 PM on weekends (previously 9AM – Noon) to make sure customer service agents are available at all times. The DWSD has also added staff to reduce wait times.

4. **Increase staffing at the DWSD Call Center and extend hours.**
   DWSD has also expanded hours at its Call Center to 8:00 AM – 7:00 PM daily (previously 8:30 AM – 5:30 PM) and 8:00 AM – 3:00 PM on weekends (weekend hours for the Call Center are new). Starting August 18th, the Call Center will have 50 percent more staff and new phone technology to better serve customers.

5. **Cobo Water Fair August 23rd.**
   A Water Affordability Fair will be held at Cobo Center Saturday August 23rd to give customers one last opportunity to connect with all of the DWSD and community resources available to them before the moratorium ends August 25th.

6. **Improve notification for customers in danger of shut-off.**
   The DWSD is expanding its efforts to communicate with customers who are late on their payments or may be facing shut-off. Bills will more clearly explain their status and assistance information will be included with the bill. Workers also will hand-deliver notices to all homes in shut-off status one week before their scheduled shut-off to give them time to enter into a payment plan.

7. **Implement an Affordable Payment Plan.**
   Any resident with a delinquent account can enter into a 24-month "10/30/50" payment plan by coming to their local DWSD Customer Care Center, showing a valid state ID and paying down only 10 percent of their past-due balance. (The previous down payment requirement was 30 percent of the past-due balance.) If a customer misses a payment, they can reapply for the program by putting down 30 percent of their past-due balance. A second missed payment will require a 50 percent down payment of their past-due amount. Any customer who misses a third payment will no longer be eligible for the payment plan.

8. **Provide financial assistance for low-income Detroit customers.**
   Starting August 11th DWSD Customer Care Centers will begin processing applications for the Detroit Water Fund. By paying down only 10 percent of their past-due balance, eligible city residents will receive up to 25 percent assistance with their bill from the new Detroit Water Fund. DWSD has partnered with the United Way for Southeastern Michigan, which will prequalify residents. To be eligible for Detroit Water Fund assistance, customers must be Detroit residents who:

   - Have an outstanding balance between $300 and $1000; AND
   - Maintain Average Water Usage for their household size; AND
   - Are either enrolled in DTE's Low Income Self-Sufficiency Plan (LSP); OR,
   - Have income at or below 150 percent of the federal poverty level (for example, a family of 4 must have an annual income below $35,775).

   This funding is available on a first come first served basis and is subject to availability.

9. **Build Neighborhood Partnerships.**
   DWSD customers are not alone. We've established a support network to assist individuals who may not qualify for some of the DWSD assistance programs. Our partners include United Way 211, THAW, WAVE and Wayne Metro.

10. Provide a clear way to give.

Many people have offered to help Detroiters who are struggling to pay their water bills. There are several ways to donate to the Detroit Water Fund: online, by text message, by check or by phone. Details are available at www.DetroitWaterFund.org.

Where to reach customer assistance:

All DWSD Customer Care Centers are now open from 8:00 AM to 6:00 PM and all centers have new Saturday hours from 8AM to 3PM. Locations are:

- Downtown Center, 735 Randolph
- Eastside Center, 13303 E. McNichols (West of Gratiot)
- Westside Center, 15600 Grand River (West of Greenfield)

The DWSD Customer Care Call Center is now open from 8:00 AM to 7:00 PM weekdays and also has added the same Saturday hours as the walk-in centers of 8:00 AM – 3:00 PM. The Call Center number is: (313) 267-8000.

DWSD 10 30 50 PLAN

Having trouble paying your water bill?

DWSD Introduces 10/30/50 – a NEW payment plan so you can keep your water ON

How it works:

1. Make a down payment of as little as 10 percent of your past due balance and you're enrolled in the plan!
2. DWSD will spread the remainder of your past due balance over a period of 24 monthly payments*
3. If you miss a payment, you can re-enroll by making a payment of 30 percent of your remaining balance. If you miss another payment, you can re-enroll by making a payment of 50 percent of your remaining balance.**

**Plan payments are in addition to your normal monthly bill*

***The total length of time allowed to stay on the plan is 24 months, regardless of how many times you enroll*

DWSD 10-POINT PLAN

1 **Waive Turn-On Fees and Late Payment Penalties.**
During the moratorium, which ends August 25th, DWSD will waive turn-on fees for customers whose water had been shut off, as well as all late payment penalties.

2 **Cut red tape.**
To simplify getting into a payment plan, customers only need to present a valid state ID. Once a payment is made, service will be restored within 48 hours.

3 **Extend hours at DWSD Customer Care Centers.**
The DWSD has expanded hours at all of its Customer Care Centers, from 8:00 AM – 6:00 PM Monday - Friday (previously 8:30AM – 5:30 PM) and 8:00 AM – 3:00 PM on weekends (previously 9AM – Noon) to make sure customer service agents are available at all times. The DWSD has also added staff to reduce wait times.

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DETROIT WATER fund

While many DWSD customers have the financial ability to make their monthly water payments, other customers need a helping hand. United Way for Southeastern Michigan and the City of Detroit are joining forces to establish a single water support fund to help those customers who want to pay their bills. It's a way to help them catch up on overdue bills and stay above water.

4 WAYS YOU CAN DONATE

TEXT

'DETROITWATER' TO '41444'

WEBSITE

BIT.LY/DWATERFUND

MAIL

UNITED WAY FOR SOUTHEASTERN MICHIGAN
ATTN: DETROIT WATER FUND
660 WOODWARD AVE., 300
DETROIT, MI 48226

CALL

313.226.9300

FOR MORE INFORMATION VISIT DETROITWATERFUND.ORG

LIVE UNITED

United Way

United Way
for Southeastern Michigan

Neithercut
Philanthropy Advisors, LLC

Michigan Health Endowment Fund

2014 GRANTMAKING PLAN

Report of the Grantmaking Committee

(Approved by the MHEF Board of Directors July 21, 2014)

The Board of the Michigan Health Endowment Fund has, at different times, discussed its dual interests in conducting significant grantmaking in 2014 and in doing grantmaking on a competitive basis, open to many organizations. During its May meeting, the Board indicated that $25 million could be made available for current-year grantmaking to a limited number of grantees, with the balance of $15 million used for individual grantmaking in 2015.[1] The Board has also adopted a formal mission statement that must guide all of its grantmaking activities.

With this document, the Grantmaking Committee has attempted to create a process that, consistent with the mission, advances these dual goals in a manner than honors the Board's previous discussions. To do so, the Committee proposes that the Fund immediately embark upon two grantmaking paths:

1. Develop a competitive grantmaking strategy that will allow a large number of Michigan organizations to apply for grants to improve the health of the state, and

2. Make a few pilot grants to a small number of statewide organizations in 2014 to demonstrate the Fund's commitment to help Michigan residents as soon as possible.

This document sets forth the Grantmaking Committee's recommended plans for implementing both programs.

[1] It bears noting that funds not granted in 2014 can, at the Board's discretion, be placed in an expenditure account for grantmaking in 2015 or future years. Of its current-year assets, only $20 million must be placed in the permanent endowment.

I. DEVELOP COMPETITIVE GRANTMAKING STRATEGIES FOR OPEN APPLICATION PROCESS

Now that the Board has approved a mission statement, the Grantmaking Committee has begun to develop the appropriate grantmaking strategies to implement the Fund's mission. This process will take some months of work and, depending on the Committee's interest, will involve the creation of a number of separate strategies. For example, the Committee may wish to implement separate strategies for improving the health of children and improving the health of seniors. Within each strategy, the size of grants might vary widely, possibly between $100,000 and $5 million, with terms from one to three years depending on the nature of the project and its intended outcomes.

The Grantmaking Committee began this process at its July 7 meeting by discussing the nature of the grantmaking strategy and the appropriate process required when building a grantmaking strategy for an open competitive grantmaking program. This process will continue at the committee's August meeting.

The goal of this effort will be the development of a few grantmaking strategies that will be open to applications from a wide variety of Michigan organizations on a competitive basis.

SCHEDULE

The entire process will likely take three to six months depending upon the availability of Committee members and the other work of the Committee. If all goes well, the first strategy might be complete by the end of the year so that grantmaking can begin in the spring of 2015.

II. PILOT GRANTS IN 2014

The Grantmaking Committee proposes a process to award a few pilot grants in 2014 that will achieve the strategic goals of 1) demonstrating the Fund's impact in 2014 and 2) allowing the Fund to learn more about the health needs of the state. The Grantmaking Committee proposes that this pilot grantmaking program have the following components:

Timing: Grants will be awarded before the end of 2014.

Amount: The initial budget for the program is $25 million.

Mission: Grants will be made for projects that clearly fall within the Fund's approved mission.

Geography: The impact of the grants will have widespread impact throughout the state.

Existing Channels: As approved by the Board of Directors in May, grants will be awarded to a small number of existing statewide organizations that have local branches or affiliates.

Re-granting: If possible, the Board wishes to avoid situations where a grantee would conduct a re-granting process to distribute funds to its local branches or affiliates.

Working with staff, the Grantmaking Committee proposes to seek out a small group of organizations to submit applications. The invited organizations must:

- Have a previous history of exceptional achievement in the area of health.
- Have local affiliates or branches that allow widespread, statewide impact.
- Have the capacity and infrastructure to manage a large-scale, innovative statewide project.
- Demonstrate financial stability and the ability to comply with the financial reporting requirements.

Further, the Grantmaking Committee proposes to use the following criteria in assessing the merits of the submitted applications:

Impact: The proposed project must have meaningful, measurable, statewide impact.

Issues: The project must address key issues that are central to the Fund: youth, seniors, health care cost(s), accessibility, etc.

Innovation and Transformation: The proposed project must implement the latest thinking on health issues and could lead to significant systems improvement.

Learning: The proposed project must be measurable and provide an opportunity to add to knowledge about how to address health needs of the state, particularly challenges that children and seniors face related to health and the organizations that serve them.

PARAMETERS

The Grantmaking Committee proposes to award approximately six pilot grants to statewide organizations that, taken together, could address a broad range of opportunities relevant to its mission. These organizations will likely be statewide nonprofits with local members, chapters, or affiliates.

Grant Size: The Board has tentatively budgeted $25 million for this effort.

Potential grantees:	Approximately 6 organizations
Grant range:	$3 million to $5 million
Average grant:	$4 million
Number of grants:	If 6 x $4m = $24m
Amount per affiliate:	If 20 affiliates, and $4m grant, then avg. $200,000 each

Grant Length: One to three years, depending on how well projects are developed at the time of application, unforeseen policy changes, etc.

Grant Requirements: The Fund's legal counsel will develop an appropriate grant contract to ensure that all the appropriate requirements are in place. At a minimum, each grantee will be required to have accounting procedures to track the use of the grant dollars and to provide thorough annual and final reports on the progress and success of the funded project. In addition, the Fund will require each grantee to provide a financial report on how the funds were spent and to declare that all of the funds were spent for charitable purposes and for their intended outcome.

SCHEDULE

The proposed schedule for the 2014 pilot grants process is listed below. Key Board actions are in bold.

Task	Deadline
Board adopts mission statement	**June [Done]**
Grant Committee has first meeting; reviews plan	July [Done]
Board approves revised plan for its 2014 grantmaking	**July 21**
Staff works to identify potential grantees, meetings occur	July
Staff reports to Grantmaking Committee on results of meetings	Aug. 5
Invitation for applications is provided to select groups	Aug. 5
Organizations submit applications for approved projects	Sept. 5
Staff reviews applications and conducts due diligence	September
Grantmaking Committee meets to review applications	October
Board reviews and approves Grantmaking Committee recommendations	**Oct/Nov**

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Creating strategies for effective, rewarding philanthropy.

Michigan Health Endowment Fund

Organizations to be considered for 2014 Grantmaking

The Grantmaking Committee met on August 5, 2014 to review a proposed list of organizations that would be invited to submit application for grants through the 2014 Pilot Grantmaking process. The committee briefly reviewed information about each organization, and evaluated it against the criteria outlined in the 2014 grantmaking plan approved by the Board on July 21, 2014. Decision criteria included:

- Does the organization have a state-wide presence?
- Does the organization provide (or support organizations that provide) direct services to Michigan residents?
- Do the organization's mission/services align with the mission of the Fund?

Organizations invited to apply for grants in 2014 include:

1. Area Agencies on Aging Association of Michigan
2. Easter Seals Michigan
3. Food Bank Council of Michigan
4. Michigan Association for Local Public Health
5. Michigan Association of Community Mental Health Boards
6. Michigan Association of United Ways
7. Michigan Dental Association
8. Michigan Fitness Foundation
9. Michigan Primary Care Association
10. Michigan Recreation and Parks Association
11. Michigan State Alliance of YMCA's
12. Michigan Alliance of Boys and Girls Clubs, Inc.

Michigan Health Endowment Fund
201 Townsend Street, Lansing, MI 48913

Michigan Health Endowment Fund
Governance Committee

Policy Manual Purpose Statement

This Policy Manual is an annotated compilation of polices and standards adopted by the Michigan Health Endowment Fund (MHEF) Board to ensure that the management and implementation of the MHEF is consistent with the provisions of the State of Michigan enabling legislation (Public Acts 4 and 5 of 2013). The policy manual is also intended as a resource document for the Board and the staff of the MHEF, as well as the public.

The manual includes the enabling legislation and existing governance, stewardship policies, executive leadership, financial, and grantmaking policies. The manual will be amended regularly to reflect future and revised policies, approved by the MHEF Board.

The management responsibility for several of the policies in the manual has been delegated to specific standing committees of the MHEF Board. The Governance Committee, however, holds ultimate responsible for developing and making recommendations for revisions to the organizational governing documents. In this role, the Governance Committee will work closely with other MHEF committees to assure that the MHEF policies and procedures are consistent with the enabling legislation, and the MHEF articles of incorporation and bylaws.

Michigan Health Endowment Fund Policy Manual Development Work Plan

Policy	*Source*	*Origin Committee*	*Secondary Committee*	*Status*
Introduction				
Policy Manual Purpose Statement		Governance		DRAFT Completed
Mission Statement		Executive & Compensations		COMPLETED
Vision & Goals Statements		Executive & Compensations	Governance	To Be Developed
Corporate Documents				
Enabling Legislation	Public Act 4 of 2013	Governance		COMPLETED
Articles of Incorporation	Statute	Governance		COMPLETED
Bylaws	Bylaws	Governance		COMPLETED
Governing Board				
Board Appointment & Officer Position Descriptions	Statute Bylaws	Executive & Compensations	Governance	COMPLETED
Member Position Description	Bylaws	Executive & Compensations	Governance	COMPLETED
Learning & Development Plan, and Board Recruitment	Board Source	Governance		Initial Board Learning Plan – COMPLETED Revisions re for long range Board development actions – pending.
Board Committees				
Structure & Charge	Statute & Bylaws	Executive & Compensations	Governance	COMPLETED
Non-Board, Non-voting members		Executive & Compensations	Governance	COMPLETED
Executive Leadership				
CEO - Position Description, Appointment Process, Performance Standards	Statute & Bylaws	Executive & Compensations		COMPLETED
CFO - Position Description, Appointment Process, Performance Standards	Statute & Bylaws	Investment	Governance Executive & Compensations	COMPLETED

Auditor - Position Description, Appointment Process, Performance Standards	Statute & Bylaws	Audit	Governance >>>>>>>>>>> Executive & Compensations	To Be Developed
Consultants (Legal/Financial/Policy) - Position Description, Appointment Process, Performance Standards		Various	Governance >>>>>>>>>>> Executive & Compensations	To Be Developed
Financial Policies				
Spending & Endowment Policy		Investment	Governance >>>>>>>>>>>>>> Executive & Compensations	COMPLETED
Banking Resolution		Investment	Governance >>>>>>>>>>>>>> Executive & Compensations	COMPLETED
Investment & Spending Policy		Investment	Governance >>>>>>>>>>>>>> Executive & Compensations	Short Term Investment Policy – COMPLETED Long Term Investment Plan – To Be Developed
Grantmaking Policies				
Grantmaking Plan, Policies & Procedures		Grantmaking	Governance	2014 Plan COMPLETED
Grantmaking Learning & Evaluation		Grantmaking	Governance	To Be Developed
Operational Policies				
Conflict of Interest Policy		Executive & Compensations	Governance	COMPLETED
Open Meetings Policy		Executive & Compensations	Governance	COMPLETED
Equal Opportunity Policy • Employment • Procurement & Contracts • Grantmaking		Governance		Under Development

Public Policy Associates Incorporated

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Michigan Health Endowment Fund
Educational Materials Update
August 7, 2014

Conferences/Meetings

Michigan Health Policy Forum

Fall Policy Forum
Harold D. Miller, Executive Director of the Center for Healthcare Quality and Payment Reform and President and CEO of the Network for Regional Healthcare Improvement
Presentation: WIN-WIN-WIN Approaches to Accountable Care: How Providers, Hospitals, Employers and Patients Can All Benefit from Healthcare Payment and Delivery Reform
Michigan State University (Henry Center or University Club), East Lansing, Michigan
October 21, 2014
http://tinyurl.com/qb8m6q7

Council of Michigan Foundations Annual Conference

Growing the Impact of Michigan Philanthropy
Traverse City, Michigan
October 12 – 14, 2014
Grand Traverse Resort and Spa
http://conference.michiganfoundations.org/
You are entitled to the member rate.

Grantmakers in Health

2015 Grantmakers in Health Annual Conference on Health Philanthropy
Theme: Pathways to Health
Austin, Texas
March 4 – 6, 2015
JW Marriott Austin Texas
Preconference Session: The Art & Science of Health Grantmaking
Austin, Texas
March 4, 2015
http://tinyurl.com/pdmquyl

Book

The Savvy CEO: Advice from Those Who Have Been There.
By Marcia Sharp. Washington, DC: Council on Foundations, 2007.
http://tinyurl.com/ouzhlfd

Summary:
As the MHEF Board of Directors engages in recruiting and vetting candidates for MHEF CEO, it is important for Board members to be prepared with an understanding of some of the most important skills that candidates will be asked about and issues that candidates will be asked to address. As noted in the introduction, the case studies in

this volume frames the "critical skills for CEOs who aspire to stay—and thrive—in the job." This publication grew out of a Council on Foundations program designed to provide executives with practical guidance from experienced peers on critical governance and leadership issues. The Senior Advisors Program was part of the Council's Building Strong and Ethical Foundations: Doing it Right Initiative.

Focus: Philanthropy; leadership

Fostering Health: Health Care for Children and Adolescents in Foster Care, 2nd Edition

by Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics, District II, New York State, 2005
"Executive Summary" (pages ix to xii) and "Statement of Purpose" (pages 1 to 9)
http://tinyurl.com/prtfxse

Summary: As stated in the introduction to this volume, "Children and adolescents in foster care have a higher prevalence of physical, developmental, dental, and behavioral health conditions than any other group of children. Typically these health conditions are chronic, under-identified, and undertreated and have an ongoing impact on all aspects of their lives, even long after these children and adolescents have left the foster care system." The executive summary and statement of purpose provide a broad overview of the extensive health care needs of children in foster care that derive from the environments from which they are removed, the general physical and mental health status of children entering foster care, and the frequent lack of systematic and consistent health care services for children in foster care. These factors have driven the establishment of standards of care for foster children and the recognition that health care plans be integrated with the overall child welfare plans for foster children.

Focus: Adopted and Foster Children

Article

"The Health and Well-Being of Adopted Children"

by Matthew D. Bramlett, Laura F. Radel, and Stephen J. Blumberg
Source: *Pediatrics: the Official Journal of the American Academy of Pediatrics* 119 (2007),
http://tinyurl.com/n7glm3e

Summary: Adopted children are more likely to have special health care needs, learning disabilities, development delays, physical impairments, or mental health problems than biological children. In contrast, adopted children are more likely than biological children to have received preventive health care and dental services, receive mental health services, have health insurance, and have a medical home.

Focus: Adopted and Foster Children

Research Report

Economic Impact of Lead Exposure and Abatement in Michigan

by Tracy Swinburn, MSc, Research Specialist at the University of Michigan School of Public Health Risk
http://tinyurl.com/m876wyu

Summary: This analysis reviews four social and economic consequences of childhood exposure to lead paint and other sources of lead poisoning: (1) increased need for health care services; (2) increased crime; (3) increased need for special education services; and (4) a decline in earnings over the course of a lifetime. This report specifically examines these impacts as they apply to Michigan children and calculates the costs of these outcomes in terms of Michigan taxpayer costs.

Focus: Children's Health

Michigan Health Endowment Fund
201 Townsend Street, Lansing, MI 48913

Request for Proposal: Auditing Services
Issued August 7, 2014

Notice

The Michigan Health Endowment Fund (MHEF) is seeking the services of a highly experienced firm to conduct financial audits of its operations. This firm should also advise MHEF on opportunities to establish or refine accounting and administrative controls and efficiencies.

The successful bidder is expected to provide:

- Audited financial statements annually, beginning with the 2014 calendar year.
- Preparation of a management letter, to include recommendations for system improvements.
- Annual completion and submission of Form 990.
- Meetings in preparation for audits and reviews of audit findings.
- Presentation of final audited financial statements and management letter to the Executive Committee and Board of Directors as requested.
- Counsel on audit-related questions throughout the contract.

About the MHEF

Created through Public Act 4 of 2013 to benefit the health and wellness of Michiganders—particularly seniors and children—the MHEF seeks to make a meaningful difference in people's lives. The MHEF is a grantmaking nonprofit organization that expects to be funded with up to $1.56 billion over the next 18 years. Its grantmaking will support health services for some of the state's most vulnerable residents. It expects to begin awarding grants in the last quarter of 2014.

Priority areas for the MHEF include infant mortality, wellness and fitness programs, access to healthy food, technology enhancements, health-related transportation needs, and foodborne illness prevention. In addition, the Fund is required to implement a program to subsidize the cost of individual Medicare supplemental, or "Medigap," coverage to help senior citizens who demonstrate financial need.

The MHEF currently operates with a nine-member Board of Directors and an interim executive director; however, the staffing and the complexity of the MHEF are expected to increase rapidly within a year. The Fund is seeking the services of an independent accounting firm. The MHEF's fiscal year runs from January to December, and the Board meets monthly.

The MHEF is required to report annually to the Governor and Senate and House of Representatives Appropriations Committees, among others. The Fund is in the process of obtaining tax-exempt status and expects to receive exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code. It is seeking status as a Type I Supporting Organization under Section 509(a)(3).

Proposal Content

- *Work Plan.* Explain how your firm will meet the needs of the MHEF as described above and the timeline necessary to complete these tasks. Explain the engagement you will require of the MHEF staff and the Audit Committee during the audit process and your approach to communication.

- *Qualifications of Firm.* Demonstrate your firm's experience with conducting nonprofit and public foundation audits. Provide a brief description of your firm's history, service range, structure, and approach to ensuring quality. Provide a list of current clients (local office), a copy of your most recent peer review report covering single audits, and your firm's response to the related letter of comments.

- *Staffing.* Describe how you will organize staff to perform the services requested and their office location. Provide affirmation of licensing to practice as a certified public accountant in the State of Michigan. Include resumes for key personnel. Any substitutions of key personnel on this project will need to be approved by the MHEF's Audit Committee 30 days in advance of the change, or as soon as possible after the necessary change in staffing is known by your firm.

- *Conflicts of Interest.* Explain any existing or potential relationships between your firm and the MHEF and any employee or officer of the MHEF that could affect your independence and objectivity because of an actual or perceived conflict of interest. Demonstrate that your firm meets the independence requirements of the American Institute of Certified Public Accountants (AICPA).

- *References.* Provide three references from large-scale organizations for which you have performed auditing services. References from entities similar in nature to the MHEF are preferred. Include the contact person's name, title, e-mail, and telephone number, along with a brief description of the work and the duration of service.

- *Budget.* In a table, detail the costs associated with carrying out the proposed work plan by year. Explain in a narrative the assumptions built into this budget, as well as your rates and fees. Describe how you manage against cost overruns.

- *Additional Information.* Provide any additional information that may be helpful in distinguishing your firm.

The proposal should be no more than 20 pages in total (inclusive of proposal and any attachments), with 1.5-inch line spacing (except resumes) and no less than 1-inch margins on all sides. Proposals must be signed by a duly authorized individual of the bidding firm.

This will be a three-year time and materials contract, with the potential to renew for additional years upon satisfactory performance.

Contact for Questions
Questions on this RFP will be accepted through August 18, 2014. Submit questions to Geralyn Lasher, Interim Executive Director, at glasher@michiganhealthendowmentfund.org. The full set of questions and answers will be e-mailed to all invited firms by August 20, 2014. No other communication with Board members or staff about this request is permitted.

Proposal Submission
Proposals must be received at the MHEF office no later than August 29, 2014, 5:00 p.m. Eastern (Attention: Geralyn Lasher, 201 Townsend, Lansing, MI 48913). Late proposals will not be considered.

Proposal packages must include five complete hard copies, individually bound. Please mark the original as such.

Proposal Review
Staff and members of the MHEF Audit Committee will review the proposals received by the deadline against the criteria noted above. The selection team will also check references at this stage.

The public is expecting quality stewardship of all available resources of the MHEF. As such, proposals will be evaluated with a strict emphasis on quality and the technical capabilities of the firm. Attributes that will be evaluated include:

1. Number and size of not-for-profit organizations audited by the office of the firm proposing.
2. Firm not-for-profit resources available.
3. Involvement in not-for-profit activities and organizations.
4. Qualifications and training of staff proposed.
5. Reference responses.
6. Firm internal quality-control procedures and external quality-control reviews.
7. Timeliness of services to be provided.
8. Cost of services.

The top candidate firms may be asked to participate in interviews as part of the proposal consideration process. Interviews will occur in Lansing or southeastern Michigan.

Once all factors have been evaluated, the audit firm that is most qualified and reasonable in cost, in the sole discretion of the MHEF, will be selected.

The MHEF reserves the right to reject all bids, to request clarification from bidders on specific points of their proposals, and to negotiate on price as appropriate. The Committee expects to submit its recommendation to the Board of Directors at the November meeting, after the MHEF CEO is selected. The decision of the MHEF Board is final.

Michigan Health Endowment Fund
201 Townsend Street, Lansing, MI 48913

Michigan Health Endowment Fund

Public Calendar 2014

August

August 18 – Board Meeting, Kellogg Center- Big Ten C, Lansing, MI

September

September 4 – Listening Tour Session Two, Northern Michigan University, Marquette, MI
September 15 – Board Meeting, Northwood University, Midland, MI
September 15 – Listening Tour Session Three, Northwood University, Midland, MI

October

October 14 – Listening Tour Session Four, Traverse City
October 20 – Board Meeting, Detroit
October 20 – Listening Tour Session Five, Detroit

November

November 21 – Board Meeting, Grand Rapids
November 21 – Listening Tour Session Six, Grand Rapids

December

December 15 – Board Meeting (tentative), Lansing

–Michigan Health Endowment Fund–

Board Meeting

August 18, 2014

https://www.surveymonkey.com/s/H99MXJX

Attendee Feedback

1. Are you a member of the MHEF Board? _____Yes _____No

2. Using the scale provided, please rate your agreement or disagreement with each of the following statements. *For each statement, please circle one number.*

	Disagree strongly				Agree strongly
a. The meeting topics were the right ones to discuss.	1	2	3	4	5
b. We used our meeting time effectively.	1	2	3	4	5
c. I had sufficient opportunity to contribute my ideas.	1	2	3	4	5
d. I felt my voice was heard.	1	2	3	4	5
e. The meeting was facilitated well.	1	2	3	4	5
f. What I learned at the meeting makes me better prepared to play my role as a Board member.	1	2	3	4	5
g. The facilities were appropriate.	1	2	3	4	5
h. Overall, the meeting advanced the work of the MHEF Board.	1	2	3	4	5

Please use the back if you need more space for your answers to the following questions.

3. What was the best part of the meeting?

4. What would have made this meeting more valuable?

5. What do you see as the next priorities for Board learning or action?

Thank you for your participation and input!

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