Northern Michigan Regional Entity

Board Meeting

February 22, 2023

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – January 25, 2022	Pages 2 – 10
7.	Correspondence	Pages 11 – 123
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – No report	
	c. CEO's Report – February 2023	Page 124
	d. Financial Report – December 2022	Pages 125 - 146
	c. Operations Committee Report – Next meeting is February 21st	
	e. NMRE SUD Oversight Board Report – Next meeting is March 6th	
11.	New Business	
12.	Old Business	
	a. Grand Traverse County and Northern Lakes	
13.	Presentation/Discussion	
	Public Act 2/Liquor Tax Funding	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – March 22, 2023	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – JANUARY 25, 2023
GAYLORD BOARDROOM

ATTENDEES:	**Ed Ginop, Angie Griffis, Gary Klacking, Eric Lawson, Christian Marcus, Mary Marois, Gary Nowak, Jay O'Farrell, Richard Schmidt, Karla Sherman, Don Smeltzer, Don Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Kate Dahlstrom**
ABSENT:	**Terry Larson**
NMRE/CMHSP STAFF:	**Chip Johnston, Eric Kurtz, Brian Martinus, Tema Pefok, Diane Pelts, Kim Rappleyea, Brandon Rhue, Nena Sork, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Susan Pulaski, Sue Winter**

CALL TO ORDER
Let the record show that Chairman Don Tanner called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that Terry Larson was excused from the meeting on this date; all other NMRE Board Members were in attendance either virtually or in Gaylord.

PLEDGE OF ALLEGIANCE
Let the record show that the Pledge of Allegiance was recited as a group.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST
Let the record show that no conflicts of interest to any of the meeting Agenda items were declared.

APPROVAL OF AGENDA
Let the record show that no changes to the meeting agenda were proposed.

MOTION BY DON SMELTZER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR JANUARY 25, 2023; SUPPORT BY GARY KLACKING. MOTION CARRIED.

APPROVAL OF PAST MINUTES
Let the record show that the December minutes of the NMRE Governing Board were included in the materials for the meeting on this date.

MOTION BY MARY MAROIS TO APPROVE THE MINUTES OF THE DECEMBER 7, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY GARY NOWAK. MOTION CARRIED.

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CORRESPONDENCE

1) The minutes from the December 1st MPHI PIHP CEO meeting.
2) The minutes from the December 6th MDHHS PIHP CEO meeting.
3) The MDHHS Michigan Psychiatric Care Improvement Project (MPCIP) December 2022 update.
4) The MDHHS Service Delivery Transformation Section January 2023 update.
5) Email correspondence from CMHAM advocating for defending and advancing the public mental health system.
6) Substance Abuse and Mental Health Association (SAMHSA) Presentation from David deVoursney on the Certified Community Behavioral Health Clinic (CCBHC) criteria dated January 5, 2023.
7) Information from the Health Department of Northwest Michigan on Syringe Service Programs (SSP).
8) The fourth quarter FY2022 statewide Performance Indicator report.
9) The draft minutes of the January 11, 2023 regional Finance Committee meeting.

Mr. Kurtz explained that the information on the Syringe Service Program was provided at the request of the Board during the December meeting, in response to a request for liquor tax funds to fund an SSP in Antrim County. The Health Department of Northwest Michigan's Medical Director, Josh Myerson, MD, presented the material to the NMRE Substance Use Disorder Oversight Board on January 9, 2023. Since that time, however, the Chair of the Health Department of Northwest Michigan's Board of Health indicated that he is opposed to funding the program and approval will not be sought.

ANNOUNCEMENTS

It was announced that the IRS reimbursable mileage rate was increased to $0.655/mile effective January 1, 2023. North Country CMHA Chief Operating officer, Kimberly Rappleyea, sitting in for Brian Babbitt, was introduced to the Board.

PUBLIC COMMENT

Let the record show that the members of the public attending the meeting virtually were recognized.

Executive Committee Report

Let the record show that no meetings of the NMRE Executive Committee have occurred since the December Board Meeting.

CEO Report

The NMRE CEO Monthly Report for December 2022 and January 2023 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to a series of dialogues occurring with CMHAM to determine an approach to take with MDHHS on the Standard Cost Allocation (SCA) process and Self-Determination arrangements; a draft will be included in future correspondence.

Mr. Tanner asked whether there has been any movement on a rural exemption. Mr. Kurtz noted that there has been a change at the CEO level at NorthCare Network; Megan Rooney, CFO has taken on the additional position of Interim CEO. There has been some interest in policy discussions regarding tailoring Medicaid services to be less prescriptive in rural areas. Another meeting with regional legislators may be warranted at this time.

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Mr. O'Farrell asked how medical services are paid for immigrants placed in sanctuary cities. Mr. Kurtz responded that there is targeted funding; MDHHS works directly with immigration. Ms. Marois referenced a state-level refugee program.

Ms. Dahlstrom asked whether anything is being done at the state to address the worker shortage. Ms. Pelts responded that the TPM Behavioral Healthcare Talent Development Project, an employer-led collaborative, is utilizing sector strategies, industry-focused approaches, to building skilled workforces.

November 2022 Financial Report

- Net Position showed net surplus Medicaid and HMP of $2,728,460. Medicaid carry forward was reported as $16,357,583. The total Medicaid and HMP Current Year Surplus was reported as $19,096,043. Medicaid and HMP combined ISF was reported as $16,357,583; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $35,463,626.
- Traditional Medicaid showed $32,887,425 in revenue, and $31,034,045 in expenses, resulting in a net surplus of $1,853,380. Medicaid ISF was reported as $9,302,629 based on the interim FSR. Medicaid Savings was reported as $10,911,722.
- Healthy Michigan Plan showed $5,545,287 in revenue, and $4,670,207 in expenses, resulting in a net surplus of $875,080. HMP ISF was reported as $7,064,954 based on the interim FSR. HMP savings was reported as $5,455,861.
- Health Home showed $327,575 in revenue, and $240,911 in expenses, resulting in a net surplus of $86,664.
- SUD showed all funding source revenue of $4,767,058, and $4,087,902 in expenses, resulting in a net surplus of $679,156. Total PA2 funds were reported as $5,175,945.

Ms. Yockey clarified that the DCW will not be cost settled in FY23.

Emphasis was placed on the need for County Commissioners to receive education regarding the use of liquor tax/PA2 funds. Clarification was made that PA2 funds may only be used for Substance Use Disorder prevention and treatment. Making sure actual county balances are precise is somewhat difficult or adds to confusion at the end of the year; block grant funds are reconciled and if there are excess funds those are exhausted before tapping into liquor tax funds.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2022; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

Operations Committee Report

The minutes from December 20, 2022 and January 17, 2023 were included in the materials for the meeting on this date. Mr. Kurtz announced that Medicaid redeterminations are being uncoupled from COVID Public Health Emergency and are scheduled to resume June 1, 2023. It is hoped that some beneficiaries may opt to migrate back to Medicaid from the Healthy Michigan Plan.

NMRE SUD Oversight Board Report

The minutes from the January 9, 2023 Substance Use Disorder Oversight Board meeting were included in the materials for the meeting on this date. Liquor tax requests will be reviewed under "New Business."

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NEW BUSINESS

PA2 Requests

The NMRE Substance Use Disorder Oversight Board reviewed liquor tax request applications during its meeting on January 9, 2023. Fund balances for Cheboygan, Grand Traverse, and Otsego counties were in jeopardy of falling below the recommended balance equivalent of one year's receipts; as such, requests that included these counties were reduced by the amounts allocated to them. Mr. Kurtz questioned the appropriateness of multi-county requests.

Ms. Sircely reported that she intends to review all FY23 requests to address the disparity between approved and requested funding.

Ms. Marois voiced that it is unrealistic to pass the adjusted liquor tax requests without first addressing the issue with the providers making the requests. Ms. Marois also stressed the need for feedback to the SUD Board (and ultimately the Governing Board) on the efficacy of PA2 funded projects.

MOTION BY MARY MAROIS TO REQUIRE RECIPIENTS OF LIQUOR TAX FUNDS TO PROVIDE A PROGRAM EVALUATION TO THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD AT THE END OF THE FISCAL YEAR; SUPPORT BY GARY NOWAK. MOTION CARRIED.

MOTION BY RICHARD SCHMIDT TO INSTRUCT THE NORTHERN MICHIGAN REGIONAL ENTITY TO COMPOSE LETTERS BACK TO THE PROVIDERS WHO REQUESTED LIQUOR TAX FUND APPROVALS ON THIS DATE INFORMING THEM OF THE FUND BALANCE ISSUES AND REQUESTING DIRECTION ON HOW TO PROCEED; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

Mr. Kurtz recommended that future PA2 requests obtain a buy-in from the counties prior to being submitted to the NMRE for approval, though he acknowledged that this would cause a delay in the process.

Milliman Internal Service Fund (ISF) Analysis Proposal

A proposal from Milliman (Wisconsin) to perform an analysis of the NMRE's Internal Service Fund (ISF) was included in the materials for the meeting on this date. The NMRE has never had a study of its ISF performed. Mr. Kurtz noted that the 7½% cap to the ISF has been contractually required since around 2002 but during a change in the contract template beginning in 2021 ISF language was inadvertently removed. Due to bringing this issue to the department's attention, Mr. Kurtz believes it is a prudent time to have the ISF study completed.

MOTION BY MARY MAROIS TO APPROVE OF THE PROPOSAL FROM MILLIMAN TO CONDUCT AN ANALYSIS OF THE NORTHERN MICHIGAN REGIONAL ENTITY'S INTERNAL SERVICE FUND AT A COST NOT TO EXCEED TWENTY THOUSAND DOLLARS ($20,000.00); SUPPORT BY ERIC LAWSON. ROLL CALL VOTE.

"Yea" Votes:	**E. Ginop, G. Klacking, E. Lawson, M. Marois, G. Nowak, J. O'Farrell, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner, C. Varner**
"Nay" Votes:	**Nil**

MOTION CARRIED.

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MDHHS-PIHP Contract Change Order No. 8

A summary of MDHHS-PIHP Contract Change Order No. 8 was sent to Board Members on January 24, 2023.

1) Language was added that the State may request from the PIHP, on an ad hoc basis, reporting to ascertain compliance with the provisions of the Contact with 30 days' notice.
2) Letters d – g were added under Section 8, Payment Terms, Subsection B, State Funding, Number 1, Medicaid Payments.
   a. Savings and Reinvestment
      Provisions regarding the Medicaid, Healthy Michigan Plan, and the Flint 1115 Waver savings and the PIHP reinvestment strategy were included in sections e – f below. It was noted that only A PIHP may earn and retain Medicaid/Healthy Michigan Plan savings.
   b. Medicaid Savings
      The PIHP may retain unexpended Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization. These funds must be included in the PIHP's reinvestment strategy. All Medicaid and Healthy Michigan Plan savings reported at fiscal year-end must be expended within one fiscal following the fiscal year earned for Medicaid or Healthy Michigan Program services to Medicaid or Healthy Michigan Plan covered consumers.
   c. Reinvestment Strategy
      The PIHP must develop and implement a reinvestment strategy for all Medicaid savings according to item g below. Any funds that remain unexpended at the end of the fiscal year must be returned to MDHHS as part of the year-end settlement process.
   d. Community Reinvestment Strategy
      Funds must be expended in the fiscal year following the year they are earned and directed toward services and supports to the Medicaid population. Community reinvestment funds must be invested in accordance with the following criteria:
      i. Development of new treatment, supports, and/or service models as allowed under the 1915(c) waiver.
      ii. Expansion or continuation of existing state plan or 1915(c) approved treatment, supports, and/or service models to address projected demand increases.
      iii. Community education, prevention, and/or early intervention initiatives.
      iv. Treatment supports and/or services model research and evaluation.
      v. The PIHP may use up to 15% of Medicaid savings for administrative capacity and infrastructure extensions, augmentations, conversions, and or developments to:
         1. Assist the PIHP to meet new federal and/or state requirements related to Medicaid or Medicaid-related managed care activities and responsibilities.
         2. Implement consolidation or reorganization of specific administrative functions related to the Application for Participation and pursuant to a merger or legally constituted affiliation.
         3. Initiate or enhance recipient involvement, participation, and/or oversight of service delivery activities, quality monitoring programs, or customer service functions.
         4. Identify benefit stabilization purposes.

      The PIHP's reinvestment strategy will become a contractual performance objective. Any funds that remain unexpended at the end of the fiscal year must be returned to MDHHS as part of the year-end settlement process.

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MOTION BY MARY MAROIS TO APPROVE AND AUTHORIZE THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUTIVE OFFICER TO SIGN CHANGE ORDER NUMBER EIGHT (NO.8) TO THE CONTRACT BETWEEN THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE NORTHERN MICHIGAN REGIONAL ENTITY; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

OLD BUSINESS

Senate Bills 597 & 598/House Bills 4925 – 4929 – The Latest

Mr. Kurtz announced that this topic will be removed as a standing agenda item as the bills failed to move through the legislature.

It was noted that in September of 2022, MDHHS indicated to CMS that it intends to pursue the creation of a Dual Enrollees Special Needs Plan (D-SNP), operated by private health plans - that would manage the Medicaid and Medicare benefit for persons who are dually enrolled in both Medicaid and Medicare.

Grand Traverse County and Northern Lakes CMHA

The six County Administrators (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford) continue to meet monthly and are working on revising the Enabling Agreement that formed Northern Lakes CMHA. An additional meeting is scheduled for January 30th.
The dismissal of two Northern Lakes CMHA Board Members by the Grand Traverse Board of Commissioners has been taken up by the ACLU and has been referred to the Attorney General's office. No official response has been released to date.

Ms. Marois thanked Mr. Kurtz and Mr. Martinus for their involvement with and on behalf of Northern Lakes CMHA.

PRESENTATION

Compliance Program Plan and Quality Assurance and Performance Improvement Program (QAPIP) Plan

NMRE Compliance Director, Tema Pefok, was in attendance to present the Compliance Program and QAPIP FY22 evaluations and FY23 workplans.

FY22 Compliance Program Evaluation

- The NMRE updated several policies/procedures and consumer materials.
- The NMRE successfully transitioned the Excluded Provider check function to its member CMHSPs; the NMRE continues to run EPS checks for SUD services providers.
- A total of 275 grievances were closed in FY22.
- A total of 51 appeals were reviewed in the region; 66.67% were upheld.
- A total of 1,502 denials were reported in FY22, 86% of which were made timely.
- The NMRE provided several trainings both to internal and provider staff.
- The NMRE conducted Medicaid Encounter Verification audits of its CMHSP (99.5% validated) and SUD providers (85% validated).
- The NMRE conducted audits of its four prevention program providers.
- The NMRE held a regional Day of Mental Health Education on May 20, 2022.

- The NMRE worked with its member CMHSPs to try to bring facilities into compliance with the HCBS Final Rule.
- The NMRE implemented DocuSign to improve its contracting process.

FY23 Workplan (each Goal includes Objectives that are not listed)

Goal 1: Transition Substance Use Disorder (SUD) exclusion check activities from the NMRE to the SUD Providers. (The NMRE will continue to run exclusion checks for the SUD providers until the transition is complete.)
Goal 2: Improve Medicaid Encounter Verification (MEV) reporting capability by transitioning into Power BI.
Goal 3: Strengthen the Medicaid Encounter Verification (MEV) review process.
Goal 4: Update training material.
Goal 5: Update some existing policies and create new policies and procedures. These policies are required to ensure the effectiveness of the Compliance Program.

FY22 QAPIP Evaluation

- The NMRE increased enrollment in the Opioid Health Home (OHH) 2.8 percentage points from the previous year.
- The NMRE implemented a Performance Improvement Project to increase the percentage of individuals who are enrolled in the Behavioral Health Home (BHH) by the end of FY23.
- The NMRE implemented a Performance Improvement Project to decrease the no-show/missed appointment rate for psychiatric appointments by the end of FY23.
- The NMRE completed the Health Services Advisory Group (HSAG) audit of 7 program standards.
- The NMRE conducted site reviews of its CMHSP and SUD providers.
- The NMRE team worked with the CMHSPs and MDHHS to complete the initial 2022 (c) Waiver (HSW, CWP, SEDW) review.
- The NMRE conducted satisfaction surveys for CMHSP and SUD programs.
- The NMRE reviewed critical incident, risk events, sentinel events data quarterly.
- The NMRE reviewed performance indicator data quarterly.
- The NMRE implemented a regional Utilization Review Committee.
- THE NMRE implemented a regional Behavior Treatment Review Committee.
- The NMRE used Power BI to build reporting structures to measure network adequacy.

FY23 QAPIP Workplan (each Goal includes Objectives that are not listed)

Goal 1: The NMRE will conduct Performance Improvement Projects (PIPs) that achieve ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction.
Goal 2: The NMRE QOC, as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm.
Goal 3: The NMRE will conduct quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports and services (i.e.,

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individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract whit the State. Assessment results will be used to improve services, processes, and communication.

Goal 4: The NMRE will monitor its network providers at least annually.

Goal 5: The reginal Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and review data analyses from the CMH providers where intrusive, or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.

Goal 6: The NMRE will establish regional HEDIS measures to demonstrate the effectiveness of improvements in the quality of health care and services for members as a result of the NMRE quality assessment and improvement activities and interventions carried out by the NMRE provider network.

Goal 7: The NMRE will implement the Supports Intensity Scale (SIS) Assessment in the region. SIS is a strengths-based, comprehensive assessment tool that measures an individual's support needs in personal, work-related, and social activities to identify and describe the types and the intensity of the supports an individual requires.

Goal 8: The Compliance Director will continue to provide quarterly updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities.

Goal 9: The NMRE and its network providers will implement a process to adopt and adhere to practice guidelines established by MDHHS, which can be found on the MDHHS Policies and Practice Guidelines page. The NMRE will also develop and adopt additional regional practice guidelines.

Goal 10: The NMRE will update Sub-contractual Relationships and Delegation Agreements to include the recommendation from HSAG during the compliance review.

Goal 11: The NMRE will update its credentialling standards to align with its Specialty Supports and Services Contract with the State and federal regulations.

MOTION BY RICHARD SCHMIDT TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY COMPLIANCE PROGRAM DESCRIPTION, FISCAL YEAR 2022 EVALUATION, AND FISCAL YEAR 2023 WORKPLAN AND THE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM DESCRIPTION, FISCAL YEAR 2022 EVALUATION AND FISCAL YEAR 2023 WORKPLAN; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

COMMENTS

Board Members

Mr. Lawson commented that he is an Alpena County School Board Member. He asked what might account for the increasing number of students with behavioral health issues and a large increase in the number of students with Individualized Education Plans. Others responded that the impact of COVID and the shutdown, the increase in school shootings, social media, and cell phone usage all likely play a role. Mr. Kurtz noted there may have also been changes to IEP criteria.

Ms. Dahlstrom requested an update on the Alpine CRU adult crisis residential unit scheduled to open in Gaylord. Mr. Kurtz said the facility's license is currently pending.

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NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on February 22, 2023.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 12:15PM

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PIHP CEO Meeting
January 5, 2023
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

Recovery Incentives Pilot

Assessment Recommendations from Outside Providers

Children's Bureau Update

Strategic Behavioral Health Integration and Coordination Initiatives

HCBS Update

Public Health Emergency Unwind

Behavioral Health Crisis Services Update

Opioid Advisory Commission Update

Ability to Pay/Fee Schedule

H 0020 Methadone Dispensing

Hope, Not Handcuffs

Facilitation Transition

Attendees

Pre-paid Inpatient Health Plans (PIHP)

Dr. Timothy Kangas (Northcare Network)	Region 1
Eric Kurtz (Northern MI Regional Entity)	Region 2
Mary Marlatt-Dumas (Lakeshore Regional Entity)	Region 3
Brad Casemore (Southwest Michigan Behavioral Health)	Region 4
Joe Sedlock (Mid-State Health Network)	Region 5
James Colaianne (CMH Partnership of Southeast Michigan)	Region 6
Eric Doeh (Detroit Wayne Integrated Health Network (DWIHN))	Region 7
Dana Lasenby (Oakland Community Health Network)	Region 8
Adam Jenovai (Oakland Community Health Network)	Region 8
Dave Pankotai (Macomb County CMH Services)	Region 9
Jim Johnson	Region 10

Monroe Community Mental Health Authority

Richard Carpenter

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie
Alicia Cosgrove
Audrey Dick
Farah Hanley
Darrell Harden
Krista Hausermann
Belinda Hawks
Leah Julian
Amy Kanouse
Brian Keisling
Phil Kurdunowicz
Lindsay McLaughlin
Lindsey Naeyaert
Patricia Neitman
Ernest Papke
Kelsey Schell
Angie Smith-Butterwick
Brenda Stoneburner
Rita Subhedar
Scott Wamsley
June White
Keith White
Jeff Wieferich
Amanda Zabor

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

Recovery Incentives Pilot

1. Rita Subhedar presented the Michigan Medicaid Recovery Incentives Pilot Introduction PowerPoint. The slides have been distributed to the group.
    a. The presentation covered stimulant use and overdose deaths in MI, an overview of contingency management, the recovery incentives overview and timeline, and pilot design and discussion.
2. A PIHP asked if Opioid Health Home providers would be eligible to participate in this pilot as well.
    a. Rita Subhedar would like to consult with the team working with the Opioid Health Homes to answer that.
3. A PIHP asked if this Medicaid benefit would be funded outside of the PIHP capitation.
    a. Rita Subhedar answered that this was something they were still discussing as well.
4. A PIHP requested this topic be added to the agenda for February for follow-up.

Assessment Recommendations from Outside Providers

1. Jeff Wieferich explained that this topic focused on PIHPs and CMHs accepting or not accepting recommendations from outside entities, frequently tribal entities.
    a. He gave the example in which a tribal entity provider recommends an in-patient stay for someone with Medicaid. The tribal entity provider contacts the CMH. The CMH requires the patient to have another assessment, and the assessment finds the person does not meet the needs requirements for an inpatient stay level of care.
2. Jeff Wieferich informed the group that the tribal entities have requested a meeting with MDHHS and the PIHPs to discuss an issue with assessment recommendations from outside providers. There will be a regional meeting of the tribes in April 2023, and he let the PIHPs know that there will be a request for them to take part in that.
    a. The PIHPs agreed that they would be happy to take part in any meeting.
    b. They also reinforced their request that the tribal entity's staff directly contact the PIHP of the region in which an issue occurs.
3. Jeff Wieferich asked if the PIHPs would prefer the meeting involve the CMHs, or if they would rather it stay at the PIHP level due to the difficulty of organizing more people.
    a. The PIHPs said the PIHP level was preferred.
4. Jeff Wieferich pledged to get questions and conversation topics to PIHPs ahead of time so that the meeting in April can be productive.

Children's Bureau Update

1. Lindsay McLaughlin provided the Key Priorities Overview Presentation. The slides have been distributed to the group.
2. A PIHP asked to what extent MDHHS addresses child and youth behavioral and physical health services provided through the Medicaid Health Plans and fee-for-service Medicaid.
    a. Lindsay McLaughlin said it was still in development.

3. A PIHP expressed concern about having sufficient staff to comply. Their concern was that many of the master-level social workers from the CMHs transitioned to working in the schools, but that the CMH workload did not drop, as the social workers in schools would refer children back to the CMHs for care. Referrals are up while staffing is down, which the PIHP felt was not sustainable.
    a. Lindsay McLaughlin agreed that it is a dilemma MDHHS is aware of. MDHHS wants to increase physical access to behavioral health services in schools, as evidence shows it is very important. At the same time, carrying the support for those children on into the CMHs is challenging with different staffing levels.
    b. Lindsay McLaughlin added that continued conversation is needed about how to be as creative and innovative as possible. MDHHS is willing to be flexible.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Lindsey Naeyaert provided the Strategic Behavioral Health Integration and Coordination Initiatives update. A written update was also sent to the group via email.
    a. This section is working to fill three vacancies.
    b. Her team is working to provide a series of trainings to organizations participating in Certified Community Behavioral Health Clinics (CCBHCs), the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Grant, and health homes. The training focuses on integrated and coordinated care topics.
        i. The first webinar will be on January 24, 2023. It will be an overview of the statewide rollout of the MI Crisis and Access Line and 988, and how those organizations can coordinate with that rollout.
        ii. Lindsey Naeyaert has sent registration links to the PIHP contacts for the mentioned programs.
        iii. Her team also hopes to hold an integrated summit near the end of FY 2023.
    c. For CCBHC, MDHHS is currently reviewing Demonstration Year 1 data. They hope to have preliminary data to share by February or March.
        i. SAMHSA also released proposed changes to the certification criteria for CCBHCs that MDHHS is reviewing. The PIHPs should have received a link for the draft recommendations, but if not, she requests the PIHPs contact her. The public comment period is open until January 20, 2023.

HCBS Update

1. Belinda Hawks reported that for the HCBS rule implementation, MDHHS is amending the State Transition Plan for submission to CMS.
    a. MDHHS is on the last leg of getting leadership approval for the summary of public comment, and when that is approved MDHHS will submit the amendment.
    b. MDHHS has submitted the heightened scrutiny list to CMS; all providers on that list have gone through the processes and were able to be submitted to CMS for their review. She

expects CMS will reach out to MDHHS for any more information it requires to conduct the review.

   c. MDHHS will be posting the heightened scrutiny list to their website and will be sending out invitations to listening sessions.

2. Belinda Hawks noted that she is still waiting to hear from most of the PIHPs about the work the PIHPs have done to fill the SUD Director positions they are actively recruiting for.
   a. She requested the PIHPs reach out to MDHHS to let them know what the PIHPs efforts were in that space.
3. Belinda Hawks informed the PIHPs that MDHHS had incorporated critical incident reporting through the CRM process.
   a. MDHHS is now working to develop a site review process through the same platform. MDHHS will be actively engaging with CMHs and PIHPs throughout the process.

Public Health Emergency Unwind

1. Jeff Wieferich explained that a big component of the recently signed Consolidated Appropriations Act disconnected continuous enrollment for Medicaid from the public health emergency.
   a. Until now, no one could be disenrolled from Medicaid during the public health emergency.
   b. Starting April 1, 2023, MDHHS can return to the usual eligibility process and begin to initiate renewals for June 2023 terminations. This can be done even if the public health emergency continues.
   c. MDHHS is conducting internal meetings to look at the information they can send out to enrollees about this process. They will have to make changes to their planned documentation to reflect that the renewals now are not connected to the end of the public health emergency.
   d. MDHHS is waiting for further guidance from CMS that it hopes to receive the week of January 8, 2023.
2. A PIHP asked if the unwind would take place over a 12-month period.
   a. Jeff Wieferich answered that it would be spread over several months at least, and that there was a stepdown F-map.
   b. Farah Hanley added that CMS allows for a 12-month period, and Michigan will take that option.
3. A PIHP asked if there would be any funding mechanisms put in place to alleviate the stress on the PIHPs as they help individuals who rely on services and may not be eligible going forward. The last time something occurred where many individuals became ineligible, general fund dollars were exhausted at the PIHP level.
   a. Another PIHP noted that as people lose Medicaid coverage but continue to receive services and supports, the general fund will be stressed almost immediately. The PIHP requested MDHHS help identify ways to buffer or have a contingency fund established for serving individuals who fall off Medicaid.

b. The PIHP recommended an emphasis on spenddowns, as they expected that would have the most effect.
c. Farah Hanley said a consolidated request from PIHPs and CMHs identifying stressors, challenges, and recommendations would be helpful. MDHHS wants to be supportive wherever they can be.
d. She shared that MDHHS is in active conversation with the Department of Insurance and Financial Services to shift individuals who are not eligible for Medicaid to the marketplace.

Behavioral Health Crisis Services Update

1. Krista Hausermann stated that the next written update would be provided at the beginning of February. This update has been renamed to the Behavioral Health Crisis Services update.
2. Krista Hausermann provided a verbal update.
    a. For MI CAL and the 988-line, speed of answer is a primary focus. In December, more than 80% of calls to MI CAL and 988 were answered within 20 seconds, and more than 90% within 30 seconds. Almost 90% of calls were answered in Michigan, by Michigan centers. Common Ground is bringing on more staff to increase the rate and speed of answer.
        i. MDHHS is also focused on referrals and follow-ups; MDHHS wants to integrate the National Suicide Prevention Lifeline into the crisis continuum of care to ensure that those who want additional crisis services can access them.
        ii. There was a 988 outage at the federal level in December 2022. MDHHS let stakeholders know as soon as MDHHS knew and put out information on their websites and social media to share the MI CAL number during that time. The 988 line is now back up and running.
        iii. The centers and the 911/988 work group completed a protocol for all callers at imminent risk. Now they are working on sharing that protocol more broadly with 911 to make processes consistent across the state.
        iv. In November and December 2022, MDHHS held meetings with stakeholders to develop a marketing plan. The focus is on existing communication channels. MDHHS will use trusted community partners to get the word out.
    b. For Crisis Stabilization Unit certification rules, there have been no major updates. MDHHS continues to work through the rules in partnership with local entities.
    c. Wayne State University received boilerplate funding to develop crisis stabilization training. It is a four-year pilot. This training will be for existing mental health professionals and those in the certification process for social work students.
        i. This project is in the very beginning stages.
        ii. The focus is to be on developing a comprehensive training program that may result in a certificate for even the existing mental health professionals.
        iii. MDHHS will ensure training aligns with other training initiatives that already exist, such as the behavioral health emergency partnership training. Updates on this training will be added to the written bimonthly update.

Opioid Advisory Commission Update

1. Brad Casemore reported that the commission continues to work towards the first report, due March 30, 2023. There has been a lot of background research and stakeholder engagement.
    a. Full-time Opioid Advisory Commission coordinator Tara King is doing well, and he said that the group could invite her to meetings if desired.

Ability to Pay

1. Jeff Wieferich sought clarification on what the PIHPs were asking for surrounding ability to pay. He asked if the goal was one ability to pay process.
2. Richard Carpenter explained that the goal is one process with a firm understanding of where responsibility lies for the final rule. He shared the biggest concerns from a finance perspective, with an understanding that there would be details to work out later.
    a. The first concern is how to calculate a consistent amount to charge per session based on an individual's ability to pay. The administrative rule talks about a per month maximum for an individual's ability to pay. The providers can calculate an amount to charge per session, but there is not much guidance on how to do so other than in the case of respite, where the monthly ability to pay is divided by 30 to get a maximum per diem amount.
        i. The SUD block grant requires a sliding fee schedule, as does CCBHC non-Medicaid.
        ii. The providers want equivalent services feel like equivalent charges at the different locations.
    b. The second concern providers have is identifying who is responsible for managing the per month maximum that a consumer should be billed if an individual is going to multiple providers.
        i. In theory, a person could have a $150 per month maximum. That person could be going to a CCBHC, another non-SUD provider in the county, and to an SUD service provider. Each provider could be applying their per-session amount.
        ii. The question is, who is responsible for making sure the $150 is not exceeded? Does it fall to the CMHs, PIHPs, State, or to the consumer themselves?
3. Jeff Wieferich thanked him for the clarification and agreed that these topics would need a workgroup to discuss. He will reach out to the Chief Financial Officers to get a work group set up.
4. Richard Carpenter added that the next concern providers had was from a compliance perspective.
    a. The ability to pay process is something CMHs and SUDs both have in their compliance audit guides.
    b. He said it would be helpful if MDHHS would send a formal communication so that the audit firms are aware that there was a legislative change in midyear 2022, that the rules were updated as of a particular date, that MDHHS is still in the process of providing additional guidance to the system for how to implement it, and that MDHHS recognizes that compliance with ability to pay is compromised during that time.
    c. Otherwise, the CMHs and PIHPs will be expected to explain to the audit group why they were all out of compliance.

5. Jeff Wieferich said he believed they could figure something out as a part of the workgroup so that it would all be consistent.

H 0020 Methadone Dispensing

1. James Colaianne reported that the PIHPs are starting to implement the legislatively required rate increase. However, the PIHPs are concerned with the requirement that the block grant be paid at the same rate as Medicaid for this service.
    a. Block grant treatment was cut prior to COVID-19, and the PIHPs have concerns about block grant availability post-COVID-19.
    b. In his region, of the $1.7 million increase, $175,000 of that is expected to be block grant.
        i. He is also concerned for when individuals are transitioned off Medicaid when eligibility restarts.
        ii. The PIHPs are trying to live within their budgets, but they are already expected to exceed them.
    c. Another PIHP reported that they are looking at $250,000 in block grant increase based on the service utilization they have had for the H 0020 code.
    d. Three other PIHPs agreed that they face similar cost pressures.
    e. A PIHP provided an excerpt that stated, "REIMBURSEMENT RATES FOR SUBSTANCE USE DISORDER SERVICES – The Grantee must pay the same rate when purchasing the same service from the same provider, regardless of whether the services are paid for by Block Grant, Medicaid, or other Department administered funds."
2. The PIHPs are also concerned that federal funding sources require that rates be justified and built, but this rate was imposed by legislature. PIHPs are not allowed to do that with block grant funding; a legislature can set a rate, but the PIHPs must build one for block grant funding.
3. Jeff Wieferich said he did not have an answer for the PIHPs now, but that MDHHS will do what it can to offer assistance or guidance.
    a. A PIHP asked when they could expect a response; they are concerned they will not get one or that it will come too late.
    b. Jeff Wieferich did not have a timeframe yet but put this item back on the agenda for February to provide information as he can.

Hope, Not Handcuffs

1. Dave Pankotai reported that his region's providers and substance use director are upset with the launch of the Hope Not Handcuffs Call Center.
    a. This new center receives special earmarked funding to create a system outside the existing system. This pulls resources and staff out of the existing system, only to then refer callers back to the existing system. It is redundant and complicated.
        i. Another PIHP noted that when those workarounds occur, they create more circles and frustrations for families and the individuals the PIHPs are trying to assist.

   b. He stated that Families Against Narcotics currently oversees and manages that contract, which only recently got an outpatient clinic license and is not yet accredited. Not being accredited means this organization does not meet the PIHPs' contracting guidelines.
2. Angie Smith-Butterwick shared that she oversees the contract in EGrAMS, and that the language in the boilerplate for this program is limited in amount, and extremely broad in interpretation.
   a. This is the second year Hope Not Handcuffs has received an earmark, and the amount has increased from the previous year.
   b. So far, the organization has not spent the full amount, as it is difficult to spend that amount of money in a year without infrastructure.
   c. Hope Not Handcuffs also received a SAMHSA grant this year for the Strategic Prevention Framework Prescription Drug Grant.
   d. She hopes to keep the organization focused on the things they do well, such as naloxone distribution and training and connecting with law enforcement agencies to ensure people can walk in anywhere and be connected with the care system in some shape or form.
3. Dave Pankotai has talked to his region's providers to encourage them to market themselves better. He foresees a time when Hope Not Handcuffs will be accredited, but for now it is an issue in his region.
4. Another PIHP worried that, given the pattern of earmarks for outside programs, the legislature was not aware that programs created outside the system burden the system more than benefit it. The PIHP requested that MDHHS try to communicate that to the Legislature.
   a. Jeff Wieferich responded that MDHHS does have these conversations with the Legislature, but that MDHHS is not the ultimate decisionmaker. He added that the PIHPs should continue to advocate as well so that the Legislature is aware of where the PIHPs stand on the issues.
5. A PIHP said their largest concern was that the individuals in need of help have been misled to think that Hope Not Handcuffs could get them immediate help, and that it would get the individual's hopes up when the system does not work that way at times when it is already backed up. The PIHP worried that the individual would then use out of frustration when the help was not as immediate as expected.

Facilitation Transition

1. Jeff Wieferich thanked Kristi Bente for her facilitation services over the years.
   a. The PIHPs agreed.
2. Jeff Wieferich has sent out transition information.
   a. Teri Baker will be scheduling a new set of meetings, and MPHI will pull back current invitations so there is no confusion.
   b. MDHHS requests that additional topics be requested a week prior to the meetings so that MDHHS has the information to speak to them.
   c. MDHHS will be facilitating the meetings and taking notes internally while recording the meetings as MPHI does now for good notes.

    d. MDHHS anticipates a simple transition, as this is to bring the meeting more in line with how MDHHS communicates with other managed care organizations.
3. A PIHP noted that one of the advantages to working with MPHI was access to a sizable conference room. The PIHP questioned if the group intended to ever meet in person, and if so, where that could be conducted.
    a. Jeff Wieferich answered that if the group did need to meet in person, MDHHS has access to large spaces in the Capitol Commons building.

PIHP CEO Meeting
February 2, 2023
9:30 a.m. – 12:00 p.m.
Microsoft Teams Meeting

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Attendees

Pre-paid Inpatient Health Plans (PIHP)

Megan Rooney (NorthCare Network)	Region 1
Eric Kurtz (Northern MI Regional Entity)	Region 2
Mary Marlatt-Dumas (Lakeshore Regional Entity)	Region 3
Brad Casemore (Southwest Michigan Behavioral Health)	Region 4
Joe Sedlock (Mid-State Health Network)	Region 5
James Colaianne (CMH Partnership of Southeast Michigan)	Region 6
Manny Singla (Detroit Wayne Integrated Health Network (DWIHN))	Region 7
Dana Lasenby (Oakland Community Health Network)	Region 8
Dave Pankotai (Macomb County CMH Services)	Region 9
Jim Johnson	Region 10

Michigan Department of Health & Human Services (MDHHS)
Kim Batsche-McKenzie
Kendra Binkley
Mary Chaliman
Lisa Collins
Audrey Dick
Erin Emerson
Farah Hanley
Belinda Hawks
Stephanie Heywood
Karolyn Jones
Leah Julian
Phil Kurdunowicz
Lindsay McLaughlin
Dana Moore
Lindsey Naeyaert
Patricia Neitman
Ernest Papke
Kelsey Schell
Ashley Seeley
Jackie Sproat
Brenda Stoneburner
Rita Subhedar
Scott Wamsley
June White
Keith White
Jeffery Wieferich
Amanda Zabor

Michigan Department of Technology, Management & Budget (MDTMB)
Herve Mukuna

TBD Solutions
Remi Romanowski-Pfeiffer

Recovery Incentives Pilot

1. Rita Subhedar shared information on the Recovery Incentives Pilot, which is a contingency management program that provides motivational incentives for non-use of certain substances with a planned start date of October 1, 2024 (FY2025).
    a. It was confirmed with the service delivery transformation section that OHH Providers will be eligible to provide recovery incentive services. They already have interdisciplinary care teams in place.
    b. The OHH providers would submit claims for the services outside the OHH framework as the recovery incentives are not currently in the OHH contract.
    c. A PIHP asked how the provider will receive the incentive to give to the enrollee.
        i. Rita Subhedar said that the incentive itself would be managed through a web-based incentive manager vendor, with the vendor distributing the incentives. The Provider would then submit the claim for reimbursement to the PIHP.
    d. A PIHP asked if there is communication with the PIHP SUD Director Group.
        i. Rita Subhedar answered yes and that she had presented to the group recently.
    e. A PIHP had asked at the last meeting if this Medicaid benefit would be funded outside of the PIHP capitation.
        i. Rita Subhedar indicated that this hasn't been decided at this point.
        ii. Keith White said input would be sought internally and from external stakeholders as well.
    f. Rita Subhedar shared that internal discussions are occurring about possibly expanding the pilot to include Opioid Use Disorder (OUD) as well. Outreach to the PIHPs will occur to see if there is interest in participating in the pilot.

Assessment Recommendations – Tribal Meeting

1. Jeff Wieferich updated the group, explaining that he had spoken with the Tribal Liaison and a meeting is being arranged to discuss specific challenges surrounding the assessments.
    a. Jeff asked that questions and information be sent in advance so MDHHS can prepare for the meeting appropriately.

Children's Bureau Update

1. Kim Batsche-McKenzie shared information related to Children's Therapeutic Foster Care. There are interagency teams at the State level that have been working together identifying needs. Once the needs were identified, proposals were assembled and moved from the interagency team level to a coordinating committee level process and then to an executive team level process. One of these proposals involves an opportunity for the PIHP/CMH system to grow Children's Therapeutic Foster Care.
    a. Children's Therapeutic Foster Care is in the SED Waiver and has historically been hard to grow in our system, as it requires a lot of infrastructure.
    b. MDHHS has partnered with Wayne State University to pilot the use of an evidence-based practice to grow the service beginning at the foundational level.
    c. MDHHS proposed that in FY2024, MDHHS will fund four additional children's therapeutic foster care sites to support the administrative core work that needs to occur in that first year including establishing the agency, developing policies and procedures, and certifying the agency as a Medicaid service with the State.
    d. The proposal to fund the new sites has been submitted for approval.
    e. Kim Batsche-McKenzie and Phil Kurdunowicz are the leads currently. There will webinars, technical assistance, and information developed with the intent of identifying sites that might be interested. Kim indicated those who have questions or are interested can send her an email.

2. Mary Chaliman provided information regarding another new program that has been developed in a similar fashion to the Children's Therapeutic Foster Care. This program, Enhanced Treatment Foster Care, is a family-based services that provides individual treatment for children who present with complex behavioral and emotional needs. The treatment team will go into the home to work with the family, to coach and provide skill-building activities to assist families in creating a living environment designed to minimize the occurrence of disruptive behaviors. The intention is to keep the child in the community and in the home.
    a. During the home visits, the team will be learning what services are currently being provided to the child/family, what services need to be provided, and if there are referrals to a CMH Provider or other behavioral health providers needed to support the family in the longer term.
    b. The program will be using an evidence-based model called Together Facing the Challenge, which is a training consultation approach to improving practices in Enhanced Treatment Foster Care.
    c. A PIHP asked for clarification surrounding the connection to home-based services and foster care.
        i. Mary Chaliman indicated there could be intersections at times, with the example given of a foster parent being in crisis and needing additional support. The team will go into the home, assess the situation, and bring the appropriate entities together or determine from the entities what more is needed.
    d. A PIHP asked if the enrollee is in both systems, what would the coordination of benefits rules be.
        i. Phil Kurdunowicz explained that the coordination of benefit rules really applies to insurance, so it is an important set of requirements, but this isn't necessarily a reimbursement services and it's actually not a Medicaid match at this point. There could be some Medicaid matchable elements in the future. It is general fund right now.
3. Lisa Collins presented information related to the Workforce Development Interagency Teamwork regarding the MI Kids Now Internship Stipend Program. The main idea of the program is to incentivize internship opportunities with the goal of increasing availability of behavioral health professionals within the State by providing internship stipends to students who are in the process of obtaining behavioral health credentials from an accredited program.
    a. Eligibility would include a student must be enrolled in an accredited bachelor's or graduate level behavioral health program, and the internship must be completed at a local community mental health or subcontracted entity, an Indian Health Service tribally operated facility/program, or Urban Indian Clinic or public school. The applicant must also be working toward a degree in marriage or family therapy, social work, professional counselor, or psychologist.
    b. Eligible participants will receive an hourly rate of $25 per hour up to a $15,000 maximum stipend. Participants who are granted the stipends are eligible only for one time funding under this program. The hourly rate allows the intern to receive regular payments throughout their internship versus a lump sum at the end of their internship.
    c. There is a slide deck that will be sent out after the meeting today.
    d. The plan is to begin the program in October 2023.
    e. A PIHP stated that many graduate level internships start to get arranged in May/June for the next year and asked if the program has been approved and the funding will be available in October this year or are there steps still to release that funding.
        i. Lisa Collins indicated that the program has been approved, and MDHHS is in the process of finalizing the process and associated tasks.
        ii. Lindsey McLaughlin would like to see the process up and running as soon as possible so MDHHS doesn't miss a single round of interns that would be helped by this program.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Lindsey Naeyaert shared that three new staff are being brought on board within the next few weeks, including a Behavioral Health Innovation Specialist, a CCBHC Certification Specialist, and a CCBHC Analyst.
2. She gave an update regarding CCBHC, including wrapping up financial requirements and documentations, as well as completing metric reports and cost reports.
    a. Her section continues to review data from the first year of the Demonstration and will be providing a summary once completed.
3. The Lunchtime Learning Collaborative for CCBHC continues with a meeting today.
    a. The focus is on zero suicide and implementing that framework.
4. Mid-State Health Network (Region 5) will be expanding, adding a Behavioral Health Home (BHH) to that region beginning on May 1, 2023. Originally scheduled for April, the policy was delayed for one month, resulting in the May 1 start.
5. Lindsey Naeyaert reported that there are over 3000 enrollees in the Opioid Health Home (OHH) program. There is one Region that makes up 1/3 of the enrollment with 1000 people enrolled – Region 2.
    a. There has been a 68% increase in enrollment for both the OHH and BHH programs.

HCBS Update

1. Belinda Hawks provided the HCBS update, introducing Remi Romanowski-Pfeiffer from TBD Solutions who presented on Conflict-Free Access and Planning.
    a. Remi shared a PowerPoint, which will be sent to the attendees following the meeting.
    b. The requirements for Conflict-Free Access and Planning were shared with high level information given regarding the work group's progress over the past 12 months.
        i. The group was tasked with identifying key characteristics that they'd like to see in the system, outlining an ideal option for the State to consider, and so
        ii. The important decision points for the State to consider were identified. That criteria development took place in several breakout sessions.
        iii. PIHPs can look forward to FY23 training schedules with dates, times, and details coming out soon.
    c. Seven (7) criteria were finalized.
        i. There was opportunity for the group to prioritize them and that took place with the work group.
        ii. A listening session with people receiving services and supports was conducted.
        iii. Both the workgroup and listening session participants indicated that access, autonomy, and continuity were the most important criteria and are the most important considerations for the State to keep in mind as it makes its decision.
    d. Remi said an updated timeline was provided to workgroup members in early January. On Monday this week, there was discussion with the workgroup regarding the timeline and the timeline is being shared with the PIHPs today.
        i. In the timeline, there's an item about developing and refining initial options. Internally, MDHHS is looking at options in defining those, and then the workgroup will be invited to test those options.
    e. Belinda Hawks said they will continue to provide updates at this meeting as they move along with the workgroup.
    f. Belinda reminded everyone that the National Core Indicators, which is a survey for adults with IDD who access our system is beginning again for this next fiscal year.
    g. Belinda updated the group on the extension request for the HCBS Rule Implementation.
        i. The current timeline is March 17, 2023, but MDHHS has requested the extension to allow MDHHS to work with the PIHPs on heightened scrutiny

settings that may still be able to come into compliance and the heightened scrutiny settings that have individuals that need to be transitioned.

ii. CMS asked a point of detail question, which MDHHS will be answering this week and then will be awaiting a response.

Public Health Emergency Unwind

1. Farah Hanley provided information surrounding the Public Health Emergency Unwind. In December, the President signed the Consolidated Appropriations Act that included the delinking and the decoupling of the Medicaid continuous enrollment requirement from the public health emergency. MDHHS has been working with CMS to get more guidance on what the continuous enrollment decoupling looks like with the goal of maximizing Medicaid coverage. MDHHS will begin redeterminations in April 2023 with "passive renewals," along with sending out mailings. There are 3.1 million people enrolled in Medicaid and all must be redetermined. The earliest date an enrollee could have their coverage terminated if they don't qualify will be July 1, 2023.
2. The President said the public health emergency is ending on May 11, 2023, which means moving back to a traditional approved CMS policy. MDHHS is very active in efforts to ensure a seamless transition during this time.
    a. A PIHP asked how the redetermination process will work.
        i. Farah Hanley said that if an enrollee has a redetermination date in June, they will have that conducted in June, and so on. This is going to be a 12-month process. If an enrollee signed up for Medicaid in the month of November, the redetermination won't occur until the month of November.
    b. A PIHP asked if Milliman will use this key variable in FY2024 Medicaid Rate Setting.
        i. Farah Hanley answered yes.
    c. A PIHP asked if the redetermination process of submissions to DHHS offices start prior to receiving letters in May to ensure there is enough time given the volume.
        i. Farah Hanley stated that MDHHS is working through how to best provide outreach to individuals. Part of that effort will be informing people as far in advance as possible.

MPCIP & MI CAL Update

1. A written update will be sent to the PIHPs.

Social Determinants of Health and SNAP Data

1. Jackie Sproat said that the Medicaid Health Plans had an update made to their contracts that requires them to do more work in addressing social determinants of health.
    a. To support them, MDHHS has developed a process to share SNAP Data (food stamps data) monthly.
        i. The process has not been implemented yet.
    b. Jackie indicated that the SNAP data could be available to the PIHPs also if there is interest in receiving that information since the behavioral health system has been addressing social determinants of health for a long time.
        i. There will be a data use agreement
        ii. PIHPs should contact Jackie Sproat if interested
    c. A PIHP asked what data is included.
        i. Jackie Sproat answered that SNAP data would include SNAP Member ID, Medicaid ID, and SNAP effective date.
    d. A PIHP asked about where and how the data is available.

        i. Jackie Sproat answered that the data would be sent out monthly through the DCH File Transfer System after a Data Use Agreement is on file between MDHHS and the PIHP.

Opioid Advisory Commission Update

1. Brad Casemore indicated this item can be removed the standing agenda. Updates and items for discussion will be brought to this group when needed.

Methadone Rate Increase Impact on Block Grant Funding

1. Jeff Wieferich acknowledged that the PIHPs sent information about the impact on block grant funding with the Methadone rate increase.
    a. Amendments will be processed through EGrAMS to increase block grant funding to address the Methadone rate increase.
    b. A PIHP thanked MDHHS for the prompt response in addressing the issue.

Ability to Pay

1. Jeff Wieferich said that, based on discussion at last month's meeting, Debi Andrews will be taking lead for more Ability to Pay discussion in a workgroup setting. MDHHS internal staff have been identified, external members are being invited, and a meeting will be scheduled soon.

MDHHS Network Adequacy Communication

1. The PIHPs commented on the communication from MDHHS that extended the due date for the Network Adequacy Certification Report from February 28 to May 31. MDHHS is developing a template for the submission, which resulted in the extension.
    a. The PIHPs would like to submit the report as usual for 2023 and begin using the template in 2024.
    b. MDHHS will discuss internally and provide a response to the PIHPs.

Michigan Behavioral Health Crisis System

February 2023 Update

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MI Behavioral Health Crisis System Overview

Michigan Department of Health and Human Services (MDHHS), in partnership with stakeholders across the state, is in the process of developing a crisis services system for all Michiganders; following the Substance Abuse and Mental Health Services Administration (SAMHSA) model. We envision a day when everyone across our state has someone to call, someone to respond, and a safe place to go for crisis care.

Michigan House CARES Task Force and the Michigan Psychiatric Admissions Discussion evolved into Michigan Psychiatric Care Improvement Project (MPCIP), which is now called Michigan Behavioral Health Crisis System (MI BH Crisis System).

Two-part Crisis System

1. Public service for anyone, anytime, anywhere: Michigan Crisis and Access Line (MiCAL) per PA 12 of 2020, Mobile Crisis, and Crisis Receiving and Stabilization Facilities.
2. More intensive crisis services that are fully integrated with ongoing treatment both at payer and provider level for people with more significant behavioral health and/or substance use disorder issues through Community Mental Health Service Programs.

Opportunities for Improvement

1. Increase recovery and resiliency focus throughout entire crisis system.
2. Expand array of crisis services.
3. Utilize data driven needs assessment and performance measures.
4. Equitable services across the state.
5. Integrated and coordinated crisis and access system – all partners.
6. Standardization and alignment of definitions, regulations, and billing codes.

988/MiCAL Implementation

The MiCAL, 988, Peer Warmline, and Frontline Strong sections of this report are combined because MiCAL (staffed by Common Ground) answers the calls, texts, and chats to these lines statewide.

Michigan Crisis and Access Line (MiCAL) Overview

- Legislated through PA 12 of 2020 and PA 166 of 2020.
- Based on SAMHSA's Model: One statewide line which links to local services tailored to meet regional and cultural needs and is responsible for answering Michigan 988 calls. MiCAL will provide a clear access point to the varied and sometimes confusing array of behavioral health services in Michigan.
- Supports all Michiganders with behavioral health and substance use disorder needs and locates care, regardless of severity level or payer type. Warm hand-offs and follow-ups, crisis resolution and/or referral, safety assessments, 24/7 warm line, and information or referral offered.
- MiCAL will not replace CMHSP crisis lines. It will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, Mobile Crisis Teams, and Crisis Stabilization Units.
- Piloted in Upper Peninsula and Oakland April 2021; Operational Statewide October 2022.

988 Overview

- **988 went live on July 16, 2022,** as the new three digit dialing code for the National Suicide Prevention Lifeline. It is not a new crisis line. It is managed by Vibrant at the Federal Level.
- **988 Expanded Purpose**: With the addition of 988, the Lifeline is expanding crisis coverage for all behavioral health, emotional, and substance use crises in addition to people feeling suicidal.
- **988 Implementation Plan**: Michigan's Official 988 Implementation Plan was submitted to Vibrant and SAMHSA on January 21, 2022. It was developed by a cross sector stakeholder group through a Vibrant funded planning process.
- **Michigan Coverage**: As of June 1, 2022, Michigan has active statewide coverage for all 988 calls originating from Michigan counties through MiCAL. Seven counties have primary coverage through Network 180, Gryphon Place, or Macomb CMH.
- **988 Chat and Text**: MiCAL will also be responsible for answering 988 chats and texts.
- Vibrant is contracting with federally funded back up centers to answer call, chat, and text overflow.
- **988 Statewide Metrics:** December 2022
    - Total Calls Received: 6,466
    - Average Speed of Answer: 25 Seconds
    - Answer Rate: 90%
    - Involuntary Emergency Interventions: 15
        - Total Calls Received & Average Speed of Answer were pulled from Vibrant's State Report
        - The Answer Rate was calculated using the Total Calls Answered as reported by the centers divided by the Total Calls Received as reported by the center. Due to the data discrepancies between Vibrant's and centers' data, Michigan will rely on the 988 Center's total calls received when reporting the answer rate.

Current Activities for 988/MiCAL

- MDHHS received a 2 year SAMHSA 988 Implementation grant mid-April 2022. Key focus areas are (1) adequate statewide coverage, (2) common practices for centers, (3) stakeholder engagement/marketing, (4) stable diversified funding, and (5) 911/988 collaboration.
- **MiCAL Rollout**: MiCAL will rollout statewide in two phases.
    - **Phase 1 FY 22**: January 2022 - MiCAL rolled out statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time. MiCAL is rolling out care coordination protocols with publicly funded crisis and access services (CMHSPs, PIHPs, state demo CCBHCs, and CMHSP contract providers).
    - Coordination is in place with services in all PIHP geographic regions as of October 31, 2022. Map of the Prepaid Inpatient Health Plans (michigan.gov).
    - **Phase 2 FY 23**: CMHSP After Hours Crisis Coverage. Afterhours coverage services are currently provided as a pilot in the Upper Peninsula. MiCAL is beginning to plan for Phase 2 FY 23 CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage.
    - Rollout will occur one CMHSP at a time and will start with regions that volunteer participation beginning in January 2023. Afterhours Process Improvement meetings occurred throughout September and October 2022 to gather CMHSP and PIHP feedback and recommendations.
- MiCAL integration with OpenBeds/MiCARE is in progress.
- A considerable change that was made to our original project timeline was postponing our in-state answering of 988 chat and text until early FY 24. The decision to postpone in-state coverage was discussed in depth and the

choice was made to postpone this activity until the MiCAL platform can integrate with the universal platform to allow MiCAL staff access to MiCAL customer relationship management (CRM) technology functionality when answering chats and texts.

- **There have been 89,101 MiCAL encounters since go-live on April 19, 2021 (this includes MiCAL number, NSPL, and CMHSP afterhours calls). See attached metrics for more details.**
- **988 Center Practices:** Operations workgroup meetings with current 988 centers are focused on developing common practices around Imminent Risk, Active Rescues and Follow Up.
  - Michigan's 988 workgroup finalized Michigan's Center Protocol document, which has incorporated Vibrant's requirements and standards and will be utilized and adopted by all of Michigan's 988 call centers as the framework for expected operations.
  - January's meeting discussion focused on updating Vibrant's policy on imminent risk and added one protocol about supervisory reviews on emergency interventions. All protocols are finalized and currently are up to date per Vibrant's requirements.
- **911/988 Collaboration:** State level 911/988 workgroup is meeting at least monthly to develop collaborative practices, with the initial focus on coordinated active rescues.
  - Michigan's 988/911 workgroup finalized the Involuntary Emergency Intervention Workflow. The workflow was created to standardize the way in which staff at all centers are expected to be trained and handle 988 involuntary emergency intervention processes. It will also be shared with 911 centers as an informational tool.
  - The 988/911 workgroup is currently working on creating a diversion plan that includes best practices to consider for instances where 911 receives calls that should be diverted to 988.
- **Public Relations**: 988 Implementation had initially focused on ensuring that there is adequate staffing and coordination with 911 and other crisis service providers before openly marketing the 988 number. This was a rollout approach that was recommended by SAMHSA and Vibrant. Targeted marketing will begin early 2023.
  - MDHHS developed a website to share with its stakeholders: 988 Suicide & Crisis Lifeline and Michigan Crisis & Access Line, as well as a MiCAL/988 Quick Facts document for reference.
  - MDHHS has been providing presentations to key stakeholder groups. Presentations include but aren't limited to: Michigan Suicide Prevention Commission, Governor's Diversion Council, Michigan NAMI, TYSP-Emergency Department Community of Practice, Tribal Nations Behavioral Health Meeting, and attending the Blue Cross Blue Shield of MI Healthy Safety Net Symposium.
  - Starting in January 2023 marketing efforts for 988 in Michigan have officially gone live! Prior to 2023 we had asked stakeholders to hold off on any and all 988 marketing and advertising efforts in Michigan. Now we are encouraging all Stakeholders to feel free to openly publish, share, advertise, and market 988 and 988 relevant information through their designated communication channels. MDHHS would like to ensure that 988 in Michigan is accessible to all Michiganders, especially those who may be at a statistically heightened risk for a behavioral health crisis. Thus, MDHHS is currently actively partnering with Michigan Stakeholders to identify public awareness activities that specifically focus on targeting and reaching high-risk or underserved populations. Through our trusted Stakeholders we will also be focusing on how best to utilize existing trusted channels to assist in reaching all Michiganders in order to help spread information and awareness about 988, who can utilize it, and what other resources exist.
- **Stakeholder Participation:** As of January 2023, partners can openly advertise 988 and utilize SAMHSA's promotional materials. At this time, partners can freely and actively advertise and market the 988 number We are asking stakeholders to continue replacing the former NSPL number (the 800 number) with 988 and to maintain an active partner with us in identifying and notifying us of places where the 800 number needs to be replaced.
  - We had our first kick off stakeholder meeting November 10th. The intention for the meeting was to provide an overview of SAMHSA and Vibrant's marketing recommendations, discuss Michigan's current

and future approach to marketing 988, and provide a space to collaboratively work together to develop a comprehensive public awareness/marketing plan that utilizes existing communication channels that target people most at risk for a behavioral health crisis.
- In December, MDHHS hosted a series of breakout sessions with Michigan stakeholders to engage in more in-depth conversations around tailoring support and resources to all Michiganders, especially those who are considered to be high-risk or underserved populations. The meetings were immensely informative and enlightening in outlining individual community needs regarding marketing 988 in Michigan. Based on stakeholder feedback bi-monthly stakeholder breakout sessions will be continued moving forward.

Current Activities for Michigan Peer Warmline and Frontline Strong Together

- Michigan Peer Warmline is operated under MiCAL by Common Ground. It is statewide. It operates 10 am to 2 am 7 days per week.
- Michigan Peer Warmline is refining data gathered during the call, i.e. reason for the call and services provided to compile a dashboard.
- **There have been 67,705 Warmline encounters since go-live at the end of April 2021. See Warmline Report for details.**
- Frontline Strong First Responder Crisis support project called Frontline Strong Together in partnership with Wayne State is operated under MiCAL by Common Ground and is available statewide 24/7. Frontline Strong Together is a crisis line specifically for first responders (police, EMS, fire, dispatch, and corrections) to provide free, confidential support and effective resources.
- Common Ground has hired a Project Manager who brings a wealth of first responder, training, and crisis line experience. Frontline Strong Together went live in August 2022.
- Specialty first responder-specific resources have been incorporated into the Customer Relationship Management System to provide readily available resources to those calling in.
- The Project Manager has set up an office at the All for Oxford Resiliency Center once a week to reach out and serve as a resource to first responders.
- Frontline Strong Together is currently working on expanding visibility, including marketing, QR codes for easy access, and outreach to relevant stakeholder groups to increase awareness of the number.
- **There have been 68 Frontline Strong Together encounters since go-live mid-August 2022.**

Crisis Stabilization Units

Overview

Michigan Public Act (PA) 402 of 2020 added Chapter 9A (Crisis Stabilization Units) to the Mental Health Code, which requires the Michigan Department of Health and Human Services (MDHHS) to develop, implement, and oversee a certification process for CSUs (certification is in lieu of licensure). CSUs are meant to provide a short-term alternative to emergency department and psychiatric inpatient admission for people who can be stabilized through treatment and recovery coaching within 72 hours.

To encourage participation and creation of CSUs, MI Legislature has designated funding in the FY 2023 budget to account for at least 9 CSUs. To develop a model and certification criteria for CSUs in Michigan, MDHHS engaged Public Sector Consultants (PSC) to convene and facilitate an advisory group of stakeholders. The stakeholder workgroup reviewed models from other states and Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders.

Michigan Model developed by 12/1. MDHHS is developing draft certification rules for adult CSUs and will solicit feedback in fall of 2022, with goals of finalizing the criteria during Q1 of 2023. The certification criteria for children CSUs will be developed during FY 2023, with an implementation date in FY 2024.

Current Activities

- **CSU Certification Rules** workgroup was developed including potential CSU sites and a series of meetings were held to discuss key issues and areas of concern throughout December 2022 and January 2023.
    - Based on feedback from the workgroup, the Draft CSU Certification standards are being finalized to share with stakeholders for their feedback.
    - Once the rules workgroup is supportive and comfortable with the rules, we will begin the administrative rules process. We aim to start the administrative rules process in Spring 2023.
    - The CSU Certification Rules workgroup will also assist MDHHS in addressing all feedback we receive during the Administration rules process.
- A survey was issued in late September to acute and psychiatric hospitals as well as CMHSPs to assess the existence of any walk-in urgent care or crisis care behavioral health services similar to a CSU, such as an EMPATH unit and a psychiatric emergency room. This survey also assessed entities' interest in providing CSU services.
- MDHHS issued a CSU Pilot Readiness Application to those who expressed interest in learning more as a potential participant (via the survey).
    - In early January 2023 we received 8 applications that are currently being reviewed.
    - Once the list of participating sites is finalized, we will be sending out formal approvals. This will occur during the second or third week in February.
    - Monthly Learning Cohort meetings with pilot sites will begin March 2023 (tentatively).
- MDHHS will operate a CSU Community of Practice Pilot which will result in a Best Practice Implementation Handbook and pilot entities receiving CSU certification. Participants are recruited through the CSU survey.
- The Michigan Model has been tailored to include Children and Families. It has been shared for public feedback. Listening sessions with people with lived experience for child/ family specific feedback will occur in early 2023.

Adult Mobile Crisis Intervention Services

Overview

- Mobile crisis services are one of the three major components that SAMHSA recommends as part of a public crisis services system.
- MDHHS goal is to eventually expand mobile crisis across the state for all populations.
- MDHHS has contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan, with special attention on strategies for rural areas.
- Per Diversion Fund legislation MDHHS will pursue the advanced Medicaid match and ensure that the model meets requirements.
- There is coordination with the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) and their intensive mobile crisis stabilization services.

Current Activities

- Multiple areas of MDHHS are working on the expansion of mobile crisis services: Diversion Council, BCCHPS, and Bureau of Specialty Behavioral Health Services.
- Internal meetings are occurring to ensure that models for children/families and adults stay aligned whenever possible.

- PA 162 and 163 of 2021 set up a Diversion Fund and pilot program for mobile crisis. MDHHS is coordinating around implementation plans internally, prior to stakeholder involvement.
- Public Sector Consultants has pulled together legislative and funding requirements, recommendations from Wayne State Center for Behavioral Health Justice (CBHJ), and other best practices to develop a draft model for adults. This model will be altered over the next couple of years based on stakeholder feedback from Diversion Fund pilots, CCBHC discussions, and feedback from people with lived experience.
- MDHHS is in the process of hiring staff to initiate an RFP process for mobile crisis intervention through the Diversion Fund and develop the application for the Medicaid mobile crisis enhanced match.

MI-SMART (Medical Clearance Protocol)

Overview

- Standardized communication tool between EDs, CMHSPs, and Psychiatric Hospitals to rule out physical conditions when someone in the Emergency Department (ED) is having a behavioral health emergency and to determine when the person is physically stable enough to transfer if psychiatric hospital care is needed.
- Broad cross-sector implementation workgroup.
- Implementation is voluntary for now.
- **Target Date: Soft rollout has started as of August 15, 2020.**
- www.mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/

Current Activities

- As of 1/19/23: Adopted/accepted by 55 Emergency Departments, 27 Psychiatric Hospitals, and 16 CMHSPs.
  - Over 25 facilities are pursuing the implementing of MI-SMART at their facility, including McLaren Bay Region and Helen Newberry Joy Hospital.
  - We are excited to welcome Trinity Health Grand Haven as our newest MI-SMART user!
- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption.
- MHA sent communication to members from their small and rural hospitals informing them about the MI-SMART Form. They were sent a link which they can fill out if they are interested in learning more about how to implement the MI-SMART Medical Clearance Process at their facility.
- MHA and MDHHS co-signed a letter encouraging the use of the MI-SMART Medical Clearance Process. This letter was signed by MDHHS Chief Medical Executive Dr. Natasha Bagdasarian and MHA Executive Vice President Laura Appel. MHA distributed the letter to their members in August.
- Provided a presentation on the MI-SMART Medical Clearance Process at the MHA Small and Rural Hospital Council meeting in September.
- Drafted a letter to send to PIHPs/CMSHPs aiming to work regionally to increase adoption of the MI-SMART Form.
- Partnered with LARA to develop a crosswalk that outlines regulatory practices that MI-SMART can help meet.
- Transitioning Medical Clearance Workgroup to an Advisory Group.
- High COVID numbers in Emergency Departments are impeding progress.

Psychiatric Bed Treatment Registry

Overview

- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.

- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- The Psychiatric Bed Registry is housed in the MiCARE/OpenBeds platform, which is Michigan's behavioral health registry/referral platform, operated and funded by LARA.
- MiCARE will eventually house all private and public Behavioral Health Services and will have a public facing portal.
- The Psychiatric Bed Registry Advisory Group's purpose is supporting the successful rollout and maximization of the OpenBeds platform to meet Michigan's needs. The Psychiatric Bed Registry has transitioned to meet on an as needed basis.
- LARA is rolling out MiCARE regionally.
- Target audience: Psychiatric Hospitals, Emergency Departments, CMHSP staff, PIHP staff.
  - Public and broader stakeholder access through MiCAL.
  - Broad cross-sector Advisory Workgroup.

Current Activities

- LARA is in the process of rolling out MiCARE statewide one PIHP region at a time. The focus is on substance use disorders treatment services. They have held meetings to continue the rollout process for providers in the remaining PIHP regions. They will reach out shortly to CMHSPs to bring them on as searchers. Please watch for emails.
- All inpatient psychiatric facilities received communication from LARA and MDHHS notifying them that the goal deadline to complete the onboarding into MiCARE (OpenBeds®) was extended. MDHHS has been, and will continue, contacting and working with psychiatric facilities. With the support from LARA, all facilities will be fully onboarded into MiCARE/OpenBeds within the coming months. MDHHS will begin ensuring psychiatric facilities' bed availability is regularly updated.
- Psychiatric hospitals are being encouraged to onboard as they are able. There are 58 facilities. Nearly two-third of all psychiatric hospital have been fully onboarded into MiCARE (OpenBeds) and almost all have begun the onboarding process.
- MDHHS and LARA, in partnership with Bamboo Health, hosted a demonstration of the OpenBeds platform for all bed searchers in September. This allowed those who have not had a chance to attend a demonstration the opportunity to learn more about the OpenBeds platform. A recording of the demonstration is available at https://mpcip.org/mpcip/micare/.
- Over the past few months, MDHHS has conducted a series of small group listening sessions with representatives from Psychiatric Hospitals, Community Mental Health Services Programs, and Emergency Departments. The goal is to understand partner requirements so that MDHHS could provide technical assistance and support to facilities utilizing OpenBeds and to develop usage protocols for MiCARE. In doing so, MDHHS would like to gain an understanding of how to implement the platform in the most optimal and cost neutral way. MDHHS most recently met representatives from Emergency Departments in October. MDHHS will continue to meet individually with stakeholders to gain feedback. If you are interested in providing feedback, please contact us at mpcip-support@mphi.org.
- All Emergency Departments received communication form LARA notifying them of the MiCARE/OpenBeds rollout. Facilities were encouraged to work with Bamboo Health's OpenBeds® team to onboard their Emergency Department in the network.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e., bed categorization, acuity, the rollout, and referral process.

Crisis Response Training Program

Overview

The Wayne State School of Social Work's crisis response credentialing program aims to support the development and expansion of a workforce with skills to work within Michigan's Behavioral Health Crisis Services. The project will offer cutting-edge education and training to individuals who have direct practice experience working within mental health settings and college students enrolled in a professional program aimed at becoming a mental health professional. The credentialing program will provide education and skill-building courses that enhance crisis assessment and practice techniques necessary to intervene in behavioral health crises, performing skills-based support when engaging as a first responder.

WSU School of Social Work will develop the training modules and university credit courses around performing rapid clinical assessments, de-escalation, providing contextual diagnosis, and effectively interacting with other first responders and family members within the community. WSU School of Social Work will also manage the project's data collection and performance measurement, which will serve as the routine progress monitoring for the project.

Current Activities

- Contract formalized. Egrams objectives, budget, budget narrative completed and submitted (12/16/22).
- Formation of Advisory Board. Consultants with various expertise selection; formalization of consultation contract underway.
- Faculty Expertise. WSU SSW is negotiating with a nationally renowned scholar on crisis response. Hopeful that the contract will be finalized the week of 12/19.
- Exploration of Peer training. Meeting set with Pam Werner for January.

Intensive Crisis Stabilization Services for Children - Bureau of Children's Coordinated Health Policy and Supports

Overview

The Bureau of Children's Coordinated Health Policy and Supports is leading and responsible for Kids' Intensive Mobile Crisis Stabilization Services. Intensive Crisis Stabilization Services (ICSS) for Children is a current Medicaid service in the Medicaid Provider Manual. MDHHS identified ICSS for Children as a key service in the MI Kids Now Service Array, and MDHHS will work towards expanding and ensuring access to this service on a statewide basis.

MDHHS established a new grant program to provide up to $200,000 to each Community Mental Health Service Program (CMHSP) to expand ICSS for Children. MDHHS awarded grants to 18 CMHSPs in fiscal year 2023, and MDHHS will provide ongoing funding opportunities in fiscal years 2024 and 2025. MDHHS launched the first cohort on January 1, 2023 and established a learning community to support grantees in implementation and encourage peer-to-peer sharing of best practices.

As part of this grant program, CMHSPs will expand ICSS for Children to address crisis situations for young people who are experiencing emotional symptoms, behaviors, or traumatic circumstances that have compromised or impacted their ability to function within their family, living situation, school/childcare, or community. The awarding of these grants will allow CMHSP to develop staffing at the local level and increase access. Increased utilization will also help inform the development of Medicaid rates through the Prepaid Inpatient Health Plans (PIHPs) to allow for sustainable provision of these services. This program will allow CMHSPs to test different models (e.g., rural service delivery, 24/7

coverage, collaboration with other child-serving systems, etc.) using flexible General Fund dollars, and "lessons learned" will be integrated into Medicaid policy as permissible under federal law and regulations.

Current Activities

- MDHHS is developing a widescale outreach plan to ensure children and families are aware of ICSS services available to them.
- MDHHS is collaborating with the Association for Children's Mental Health and Michigan State University to develop a survey to gain feedback from youth and families regarding their ICSS experience. This survey will be distributed to youth and families following every deployment of a mobile response team.

MDHHS - Crisis Services & Stabilization Section Updates

The MDHHS Behavioral Health (BH) Customer Relationship Management (CRM) System

The Crisis Services and Stabilization Section is tasked with ownership of the BH CRM from a technical and development perspective. We work with MDHHS business owners to design and implement processes into the system (i.e., MiCAL, Customer Inquiries, CMHSP Certification, ASAM Level of Care, and Critical Incidents). We act as a liaison between our MDHHS colleagues and the application developers and provide training and technical support to MDHHS and partners (CMHSPs, PIHPs, MiCAL, SUD entities, CCBHCs, etc.).

Many of you may be familiar with this system or have heard of it by one of various names, such as the BHDDA CRM or MiCAL CRM. As we continue to move forward with the rollout of MDHHS BPHASA business processes, we want to clear up any confusion and announce that this system is to be formally named the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). Effective immediately, please ensure all communications align with the name change.

Additionally, we have updated the shared team email address to encompass all facets of the BH CRM rather than solely MiCAL. **The newly updated email address is** MDHHS-BH-CRM@michigan.gov. *Any emails that are sent to the former address (MDHHS-BHDDA-MiCAL@michigan.gov) will be routed to this new address.*

Questions or Comments

Community Mental Health Association of Michigan distributes this document to its' members.
To be added to the distribution list for this update - please contact MPCIP-support@mphi.org

MiCARE/Openbeds platform questions - contact Haley Winans, Specialist, LARA, WinansH@michigan.gov
988 or MiCAL questions, feedback, or complaints - contact us here.

Krista Hausermann, LMSW, CAADC
Crisis Services and Stabilization Section Manager,
Bureau of Specialty Behavioral Services,
Behavioral & Physical Health & Aging Services Administration
HausermannK@Michigan.gov

Time frame is April 19, 2021 to December 31, 2022 as indicated * MiCAL also includes CMHSP, First Responder, ER/ Hospital (ED) and 988 calls except as noted **

Metrics for MiCAL, December 2022

Offered 8496

Answered 7881

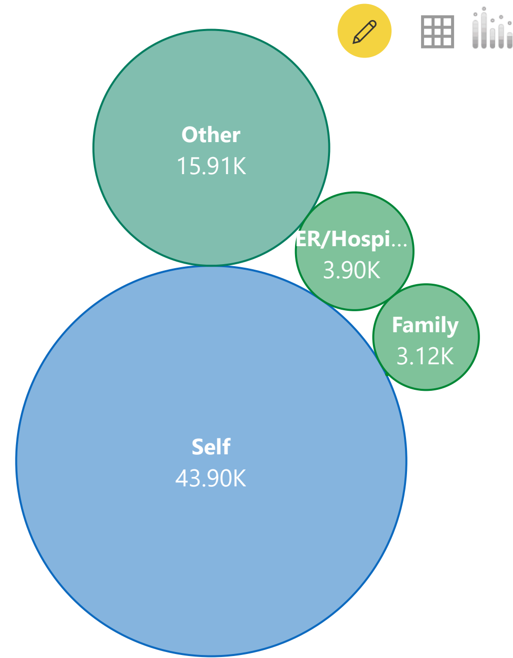
Answer Rate 93%

Avg. Speed of Answer (H:M:S) 00:00:16

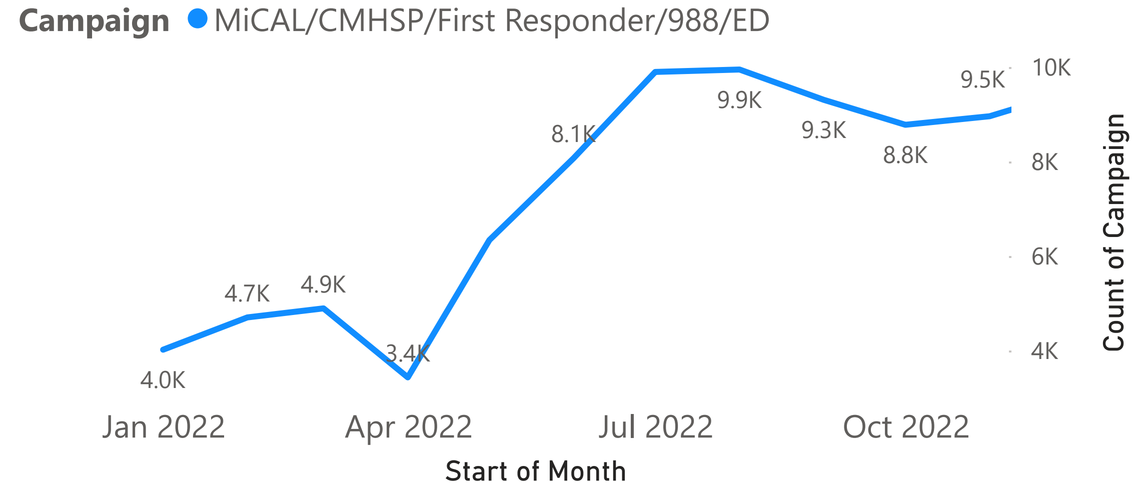
Avg. Talk Time 00:09:33

Goal (80% Answered in 30 Seconds) 91%

MiCAL Caller Type*

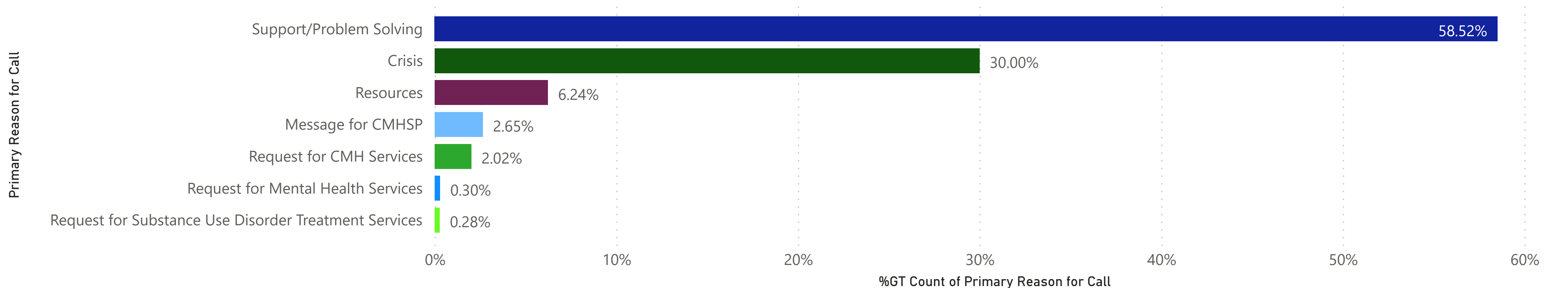


Call Volume Trends*



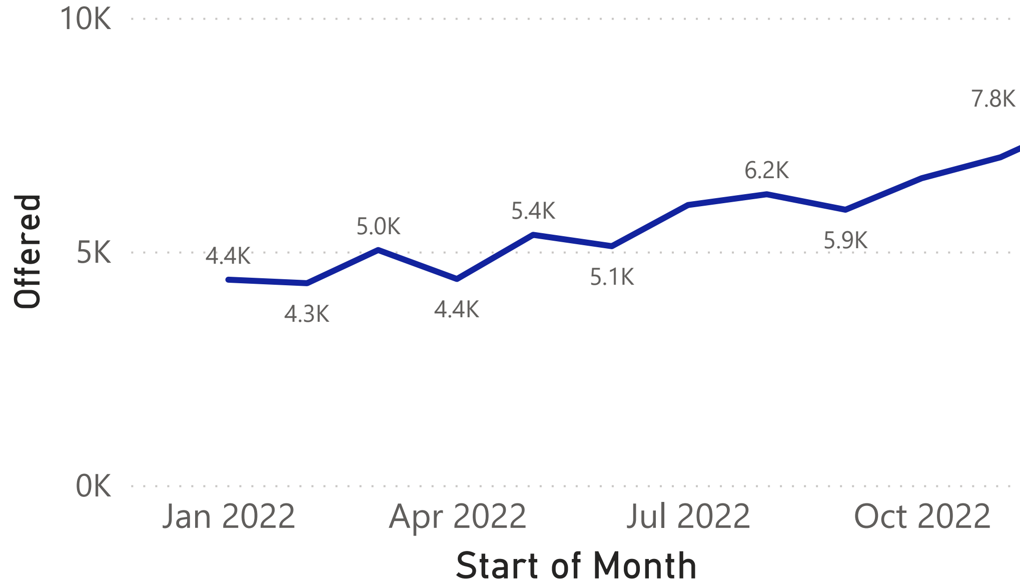
Campaign Name**	Inbound	Outbound	**Total**
988	44580		**44580**
MiCAL/CMHSP/First Responder/ED	53742	14007	**67749**

Reason for MiCAL Calls in Last 90 Days (from October 2, 2022 to December 31, 2022)

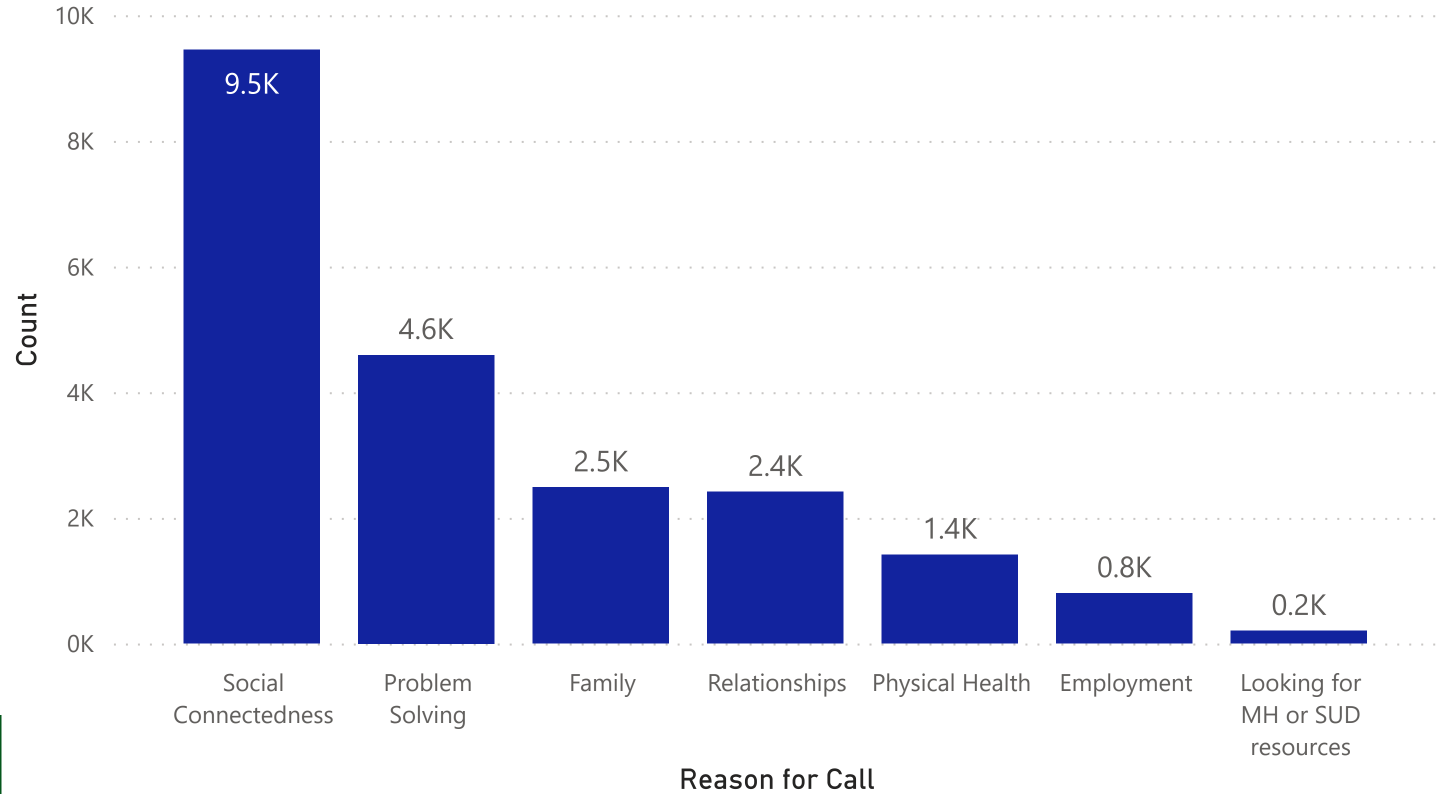


Michigan Warm Line Report - *Caller names and phone numbers are not connected to this data. Call reasons are documented anonymously.*

Call Volume Trends, January 1 to December 31, 2022



Frequency of Reason(s)* for Calls in Last 90 Days (October 2 to December 31, 2022)



*Warm Line Calls Can Be Documented with More Than 1 Reason

Call Volume, January 1, 2022 to December 31, 2022

Campaign Name	Offered
Peer Warm Line	68087

Call Volume, April 19, 2021 to December 31, 2022

Campaign Name	Offered
Peer Warm Line	99129

Metrics for Warm Line, December 2022

Avg. Time in Queue (H:M:S) 00:00:53

Avg. Talk Time 00:13:36

Service Delivery Transformation Section

February 2023 Update

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MDHHS Staff Update – Service Delivery Transformation Section

Service Delivery Transformation Section Overview

The Service Delivery Transformation Section is responsible for overarching strategic program policy development, implementation, and oversight for integrated health projects within Michigan's public behavioral health system. This includes behavioral health integration initiatives, Medicaid Health Homes, Certified Community Behavioral Health Clinics, SAMHSA integration cooperative agreements, and health integration technology initiatives to facilitate optimal care coordination and integration. Staff in this section collaborate with internal and external partners and provide training and technical support to the public behavioral health system and participants of integrated health projects. Lastly, this section focuses on quality-based payment for providers involved in behavioral health integration initiatives and oversees CCBHC Demonstration certification.

Our Team

Lindsey Naeyaert – Section Manager
naeyaertl@michigan.gov

- Leads programmatic, policy, and implementation of integrated health projects within section

Amy Kanouse – Behavioral Health Program Specialist
kanousea@michigan.gov

- CCBHC Demonstration
- Emergency Grants to Address Mental Health and Substance Use During COVID-19

Kelsey Schell – Health Home Analyst
schellk1@michigan.gov

- Opioid Health Home
- Substance Use Disorder Health Home

TBD – Behavioral Health Innovation Specialist

- Behavioral Health Home
- PIPBHC Grant
- Azara Integration

TBD – CCBHC Certification Specialist

- CCBHC Certification and Monitoring

TBD – CCBHC Analyst

- CCBHC Programmatic Support

Opioid Health Home

Opioid Health Home Overview

- Medicaid Health Homes are an optional State Plan Amendment under Section 1945 of the Social Security Act.
- Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration.
- Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.
- As of October 1, 2022, OHH services are available to eligible beneficiaries in 76 Michigan counties. Service areas include PIHP region 1, 2, 4, 5, 6, 7, 8, 9, and 10.

Current Activities

- As of February 1, 2023, 3,023 beneficiaries are enrolled in OHH services.
- With the OHH expansion, LE's have continued to expand OHH services with new Health Home Partners (HHPs). There are currently 38 Health Home Partners (HHP) contracted to provide services to OHH beneficiaries. Four HHPs are contracting with multiple LEs.
- MDHHS continues to collaborate with many state agencies to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Substance Use Disorder Health Home

Substance Use Disorder Health Home Overview

- The Substance Use Disorder Health Homes is an optional opportunity under the SUD Block Grant Supplemental.
- The Substance Use Disorder Health Homes is designed as a look a-like health home comprised of primary care and specialty behavioral health providers, with a similar structure to the current operational Opioid Health Home (OHH).
- With the same structure as the OHH, the Substance Use Disorder Health Home is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.

Current Activities

- Four PIHPs (2, 7, 8, 9) are using available funds to operate the Substance User Disorder Health Home with their SUD HH beneficiaries.
- Two (4, 6) PIHPs will be Substance User Disorder Health Home funds as a staffing grant to assist providers in meeting capacity to become an OHH partner within the next fiscal year.

Behavioral Health Home

Behavioral Health Home Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes provide comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness or serious emotional disturbance by attending to a beneficiary's complete health and social needs.
- Providers are required to utilize a multidisciplinary care team comprised of physical and behavioral health expertise to holistically serve enrolled beneficiaries.
- Behavioral Health Home services are available to beneficiaries in 42 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), 6 (Southeast Michigan), 7 (Wayne County), and 8 (Oakland County).

Current Activities

- As of February 1, 2023, there are 2,112 people enrolled:
    - Age range: 6-85 years old
    - Race: 25% African American, 69% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- Resources, including the BHH policy, directory, and handbook, are available on the Michigan Behavioral Health Home website. [Behavioral Health Home (michigan.gov)]
- MDHHS staff will be working to expand the BHH into PIHP Region 5, Mid-State Health Network. Anticipated start date is May 1, 2023.

Promoting Integration of Physical and Behavioral Health Care Grant

Promoting Integration of Physical and Behavioral Health Care (PIPBHC) Overview

- PIPBHC is a five-year Substance Abuse and Mental Health Services (SAMHSA) grant that seeks to improve the overall wellness and physical health status for adults with SMI or children with an SED. Integrated services must be provided between a community mental health center (CMH) and a federally qualified health center (FQHC).
- Grantees must promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental health and substance use disorders along with co-occurring physical health conditions and chronic diseases.
- MDHHS partnered with providers in three counties:
    - Barry County: Cherry Health and Barry County Community Mental Health to increase BH services
    - Saginaw County: Saginaw County Community Mental Health and Great Lakes Bay Health Centers
    - Shiawassee County: Shiawassee County Community Mental Health and Great Lakes Bay Health Centers to increase primary care

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.
- PIPBHC sites are focused on sustainability and the ways in which integrated care can continue after the end of the grant. The sites are also currently working on completing the annual PIPBHC Integration Self-Assessment Survey to determine how each agency views the current level of integration.

Certified Community Behavioral Health Clinic Demonstration

Certified Community Behavioral Health Clinic Demonstration Overview

- MI has been approved as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state by CMS. The demonstration launched in October 2021 with a planned implementation period of two years. The Safer Communities Act was signed with provisions for CCBHC Demonstration expansion, extending MI's demonstration until October 2027. 13 sites, including 10 CMHSPs and 3 non-profit behavioral health providers, are participating in the demonstration. The CCBHC model increases access to a comprehensive array of behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay.
- CCBHCs are required to provide nine core services: crisis mental health services, including 24/7 mobile crisis response; screening, assessment, and diagnosis, including risk assessment; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans.
- CCBHCs must adhere to a rigorous set of certification standards and meet requirements for staffing, governance, care coordination practice, integration of physical and behavioral health care, health technology, and quality metric reporting.
- The CCBHC funding structure, which utilizes a prospective payment system, reflects the actual anticipated costs of expanding service lines and serving a broader population. Individual PPS rates are set for each CCBHC clinic and will address historical financial barriers, supporting sustainability of the model. MDHHS will operationalize the payment via the current PIHP network.

Current Activities

- The CCBHC Demonstration wrapped up its first year. As of February 1, 2023, 53,664 Medicaid beneficiaries and 9,859 individuals without Medicaid are assigned in the WSA to the 13 demonstration CCBHC sites. The CCBHC team is working on finalizing Year 1 data, including determining daily visits and reviewing services delivered during the year. Preliminary data has identified 53,887 unique individuals receiving CCBHC services during FY22, 77% of whom were Medicaid beneficiaries. Approximately 30% served were children and young adults, age 0-21, and 70 were adults age 21+.
- MDHHS was awarded a two-year grant from the Michigan Health Endowment Fund to conduct an evaluation of the CCBHC Demonstration. MDHHS will partner with evaluators at the Center for Healthcare Research Transformation at the University of Michigan on the evaluation, which is intended to help measure the impact of

the demonstration- particularly efforts to expand access to behavioral health services for underserved populations. Work to develop a comprehensive evaluation plan will begin in early 2023.

- Training and technical assistance is ongoing. The February session of the CCBHC learning collaborative will focus on Zero Suicide initiatives. MDHHS is also sponsoring the training of two Community Health Workers (CHWs) at each CCBHC demonstration site in FY23 and has open spots remaining.
- The MDHHS CCBHC Implementation Team is working to finalize financial reporting requirements for the initial demonstration year and continuing to address additional operational issues that arise as the demonstration moves forward. Work is ongoing to validate reported numbers of daily visits and preliminary metrics.
- Certification site visits are being planned for Spring of 2023. Site visits are a requirement every two years to maintain certification as a CCBHC. MDHHS is awaiting guidance from SAMHSA in regard to final updates in the certification criteria implementation timeline.

MDHHS Staff Update – Service Delivery Transformation Section

- All three positions are on track to be filled by February 21st, 2023.

Questions or Comments

Lindsey Naeyaert, MPH
Service Delivery Transformation Section Manager
Behavioral and Physical Health and Aging Services Administration
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Program Policy Division PO Box 30809
Lansing MI 48909

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

February 14, 2023

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<City> <State> zipcode5-zipcode4

Dear Provider:

RE: Direct Care Worker Wage Increase

Pursuant to Public Act 166 of 2022, the Michigan Department of Health and Human Services (MDHHS) will implement a wage increase for direct care workers, to be included on an ongoing basis. This applies to the MDHHS programs and service codes listed below:

Program Name	Services	Related HCPCS Codes
MI Choice Waiver	Community Living Supports, Respite, Adult Day Health	H2015, H2016, S5150, S5151, S5100, S5101, S5102
MI Health Link	Expanded Community Living Supports, Personal Care, Respite, Adult Day Program	H2015, H2016, S5150, S5151, T1019, S5100, S5101, S5102
Behavioral Health	Community Living Supports Overnight Health and Safety Supports Personal Care Prevocational Services Respite Skill Building ABA Adaptive Behavior Treatment ABA Group Adaptive Behavior Treatment ABA Exposure Adaptive Treatment Crisis Residential Services Residential Services -SUD Residential Services – Co-occurring SUD/MH Withdrawal Management – SUD Supported Employment	97153, 97154, 0373T, H0043, H0019, H0010, H0012, H0014, H0018, H2014, H2015, H2016, T2027, T1020, T2015, S5151, T1005, H2023

The wage increase applies for services provided October 1, 2022 forward and is intended to cover a $2.35 per hour increase in direct care worker wages, along with an additional $0.29 per hour for agencies to cover their additional costs associated with implementing this increase. The increase can be utilized to cover direct care worker's indirect/administrative time (necessary time for the worker to complete associated direct care paperwork) and overtime. **The $2.35 per hour should be a base wage increase paid in addition to the worker's regular wage but cannot be less than the wage being received by, or the starting wage offered to, a qualifying direct care worker on March 1, 2020.** The $2.35 per hour payment must be applied entirely to direct care worker wages. The $2.35 and $0.29 per hour amounts may be implemented by an equivalent as divided per billing unit. One example of "an equivalent as divided per billing unit" is, for programs billing in 15-minute increments, the payment would be $0.5875 per 15-minute unit for the direct care worker, and $0.0725 per 15-minute unit for the additional agency cost.

Providers must retain and be able to submit documentation upon request that supports the distribution to direct care workers and that payments were made in accordance with the requirements in this letter.

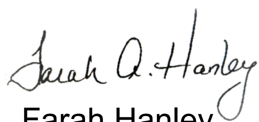
A direct care worker may choose to not receive the wage increase. This choice must be indicated in writing or electronically. This individual's employer must give back to the entity paying for services, as described in the table above, any funds allocated for this individual's wage increase.

Adult Foster Care homes and Homes For the Aged should follow guidance and reporting instructions provided on the MDHHS Coronavirus webpage at: https://www.michigan.gov/coronavirus/0,9753,7-406-98178_100722---,00.html under the Staffing tab and the "Direct Care Worker Resources" heading.

If you have questions, you can call Provider Support at 1-800-979-4662 or e-mail them at providersupport@michigan.gov.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Sincerely,



Farah Hanley
Chief Deputy Director for Health

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

MEMORANDUM

DATE: February 14, 2023

TO: PIHP and CMHSP CEOs and Medical Directors

FROM: Farah Hanley, Chief Deputy Director for Health

SUBJECT: MI-SMART Memo PIHP-CMHSP Leadership

The Michigan Department of Health and Human Services (MDHHS), the Michigan Health and Hospital Association (MHA), and staff from the Michigan Public Health Institute (MPHI) are excited to formally invite you to participate in the MI-SMART Medical Clearance Process. MI-SMART is part of the Michigan Psychiatric Care Improvement Project (MPCIP), which aims to improve Michigan psychiatric care - a multi-faceted complex issue - through collective impact.

Psychiatric patients are often at risk of being both under screened or over screened. The MI-SMART protocol enhances patient care by standardizing a thorough and comprehensive medical clearance process without subjecting patients to unnecessary testing. According to a pilot program study from Holland Hospital, they found that the MI-SMART Form decreased the length of stay for admitted patients by 9% and average charges per visit by 26% while also increasing Emergency Department efficiency. Similarly, Spectrum Health found that the length of stay in Emergency Department decreased.

Background Information

MDHHS, MHA, and MPHI convened a development and implementation Medical Clearance workgroup, which created the MI-SMART Form. Adapted from the MI SMART Form[1], this framework helps providers from behavioral health, including community mental health, emergency medicine, and inpatient psychiatry, work together to best serve patients' needs.

The workgroup was held pre-COVID-19 and has continued to convene since. The workgroup incorporated examples from two pilots in development of this form and protocol: 1) the Southeast Michigan Medical Clearance Pilot and 2) the Southwest Michigan SMART Form Pilot. Statewide feedback was solicited through presentations and facilitated discussions at various professional association events including those with the Community Mental Health Association of Michigan and the Michigan Psychological Association. In addition, a statewide survey was administered, and over 100 responses from a broad spectrum of organizations and consumers were received. Currently, 44% of Psychiatric hospitals - which encompass nearly half of Psychiatric Beds in the state of Michigan – accept the MI-SMART Form. In addition, 44% of Emergency Departments.

[1] Chi J. Nwaobiora. 2017. "The smart medical clearance protocol as a standardize clearance protocol for psychiatric patients in the emergency department", International Journal of Current Research, 9, (09), 5714057147.

and 32% of Michigan CMHSPs use and accept the MI-SMART Form. Other Michigan entities have expressed interest in joining the initiative and are preparing to launch by incorporating the MI-SMART form to ensure appropriate evaluation of stability for transfer. In this way, regardless of when a patient appears for screening, there are consistent practices for such screenings. Stakeholders that have incorporated this form have volunteered to do so, and the benefits of the implementation have resulted in positive feedback and the implementation. An up-to-date list of entities that have implemented MI-SMART is available online.

Below is a list of CMHSPs who have previously reported that they are accepting the MI-SMART Form in Michigan. If your CMSHP is not on the list and you are currently accepting the MI-SMART Form, please email MPCIP-support@mphi.org with any corrections. If your CMHSP is not on the list and you are NOT currently accepting the MI-SMART Form, please see the next section for requested steps.

- Allegan County CMH Services, dba OnPoint
- Barry County CMH Authority
- Bay Arenac Behavioral Health
- Community Mental Health for Central Michigan
- Detroit Wayne Mental Health Authority dba Detroit-Wayne Integrated Health Network
- Ionia County CMH dba The Right Door for Hope, Recovery and Wellness
- Kalamazoo CMH & Substance Abuse Services dba Integrated Services of Kalamazoo
- LifeWays
- Montcalm Center for Behavioral Health dba Montcalm Care Network
- Network180
- Newaygo County Mental Health Center
- Northern Lakes Community Mental Health
- Oakland Community Health Network
- Community Mental Health of Ottawa
- Van Buren Community Mental Health Authority
- West Michigan CMH System

Actions Requested:

Your commitment in the Medical Clearance Initiative is vital to helping people with behavioral health needs get quality medical screening at the Emergency Departments. In your crisis work, please inform all relevant parties at your organizations that this form will be a part of the psychiatric inpatient admission process. We request that you recognize and accept the MI-SMART form as proof of medical clearance for the placement of individuals into an inpatient hospital setting.

Below are the next steps that you will need to take to participate:

1. **Assign a MI-SMART lead at your facility**. This person should be familiar with your psychiatric preadmission screening and referral processes.

2. **Schedule and attend MI-SMART orientation for executive leadership and team leads for the psychiatric inpatient referral or acceptance process.** Please reach out to MPCIP-Support@mphi.org to set up a time to walk through the form with your team. If you are willing to participate in a joint orientation about MI-SMART with psychiatric hospitals and emergency departments, we ask that you let us know. We would be happy to facilitate a regional meeting to discuss the MI-SMART Form.

3. **After the orientation, please review MI-SMART with all staff members.** Use the Implementation Toolkit materials to train and prepare staff for the implementation of the MI-SMART Form.

4. **Confirm your facility's participation via email to the MPCIP Support Team.** After all team members are educated on the form and your facility is ready to actively accept MI-SMART, please email MPCIP-Support@mphi.org and they will contact local community partners and update their materials.

Please connect the MPCIP Medical Clearance Team at MPCIP-Support@mphi.org with a relevant staff member your organization who is willing to be the contact to help implement this initiative (for example - your hospital liaison, crisis team manager, etc.). If you have additional questions, there are a variety of supports available at: https://www.mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/ or you can contact MPCIP-Support@mphi.org.

We thank you for your partnership in this statewide rollout of the MI-SMART Medical Clearance Process!

FH/kh

THE MICHIGAN LEGISLATIVE COUNCIL

MICHIGAN OPIOID ADVISORY COMMISSION

DR. CARA POLAND, M.D., M.ED., CHAIR
COMMUNITY MENTAL HEALTH ASSOCIATION
FEBRUARY 7, 2023

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State-Local Collaboration
Community Outreach, Education & Engagemen

OAC

NATIONAL OPIOID SETTLEMENTS

National litigation involving the manufacturers, distributors and marketers of pharmaceutical opioids, has resulted in multiple, national settlements, commonly referred to as the "Opioid Settlements". Presently, Michigan is involved in eleven national lawsuits at various stages of litigation and settlement.

OAC

NATIONAL OPIOID SETTLEMENTS

Distributor Settlement

AmerisourceBergen, Cardinal Health, McKesson

Janssen

Johnson & Johnson

CVS

Walmart

Walgreens

Teva

Allergan

Mallinckrodt

Endo

Purdue

McKinsey & Co.

OAC

NATIONAL LANDSCAPE

OPIOID ADVISORY COMMISSIONS

States are in the process of implementing administrative structures to disburse an expected $50 billion awarded to states and localities from opioid-related lawsuits, which includes $26 billion awarded to 46 states as part of the National Opioid Settlement. These structures include strategies for engaging a wide variety of stakeholders on priorities for reducing opioid-related deaths and investing in SUD prevention, treatment, and recovery infrastructure.

National Academy of State Health Policy (NASHP)

Advise governing bodies on responsible use of state opioid settlement funds

Determine statewide needs, including service and funding gaps

Determine strategies for effective response activities

Provide data-driven recommendations to reduce disparities in service access

MICHIGAN'S

OPIOID ADVISORY COMMISSION

LEGISLATIVE BRANCH

LEGISLATIVE COUNCIL

COUNCIL AGENCIES

OPIOID ADVISORY COMMISSION (OAC)

OAC

MICHIGAN LEGISLATIVE COUNCIL
The Legislative Council is a bipartisan, bicameral body of legislators established in Article IV, Section 15 of the Constitution of Michigan. The Speaker of the House and the Senate Majority Leader each appoint six members of their chamber. At least two of each body must be members of the minority party. These leaders also appoint three alternates.
Legislative Services Bureau

LEGISLATIVE COUNCIL
AGENCIES
Opioid Advisory Commission (OAC)
State Drug Treatment Court Advisory Committee (SDTCAC)
Joint Committee on Administrative Rules (JCAR)
Legislative Corrections Ombudsman (LCO)
Legislative Services Bureau (LSB)
MI Commission on Uniform State Laws
Michigan Law Revision Commission
Michigan Veterans Facility Office
Michigan State Capitol Commission
MICHIGAN SENATE

LEGISLATIVE COUNCIL

STATE SENATORS

Senate Majority Leader Winnie Brinks (Chair)

Senator Sam Singh

Senator Jeremy Moss

Senator Sean McCann

Senator Roger Victory

Senator Ed McBroom

STATE REPRESENTATIVES

Speaker Joe Tate (Alternate Chair)

Representative Angela Witwer

Representative Laurie Pohutsky

Representative Abraham Aiyash

Representative Matt Hall

Representative Brian Posthumus

OAC

Act No. 84
Public Acts of 2022
Approved by the Governor
May 19, 2022
Filed with the Secretary of State
May 19, 2022
EFFECTIVE DATE: May 19, 2022

STATE OF MICHIGAN
101ST LEGISLATURE
REGULAR SESSION OF 2022

Introduced by Senator Huizenga

ENROLLED SENATE BILL No. 994

AN ACT to amend 1986 PA 268, entitled An act to create the legislative council; to prescribe its membership, powers, and duties; to create a legislative service bureau to provide staff services to the legislature and the council; to provide for operation of legislative parking facilities; to create funds; to provide for the expenditure of appropriated funds by legislative council agencies; to provide for the designation and authentication of certain electronic legal records as official; to authorize the sale of access to certain computerized data bases; to establish fees; to create the Michigan commission on uniform state laws; to create a law revision commission; to create a senate fiscal agency and a house fiscal agency; to create a commission on intergovernmental relations; to prescribe the powers and duties of certain state agencies and departments; to repeal certain acts and parts of acts; and to repeal certain parts of this act on specific dates, (MCL 4.1101 to 4.1901) by amending the title, as amended by 2018 PA 638, and by adding chapter 8A.

The People of the State of Michigan enact:

TITLE

An act to create the legislative council; to prescribe its membership, powers, and duties; to create a legislative service bureau to provide staff services to the legislature and the council; to provide for operation of legislative parking facilities; to create funds; to provide for the expenditure of appropriated funds by legislative council agencies; to provide for the designation and authentication of certain electronic legal records as official; to authorize the sale of access to certain computerized data bases; to establish fees; to create the Michigan commission on uniform state laws; to create a law revision commission; to create a senate fiscal agency and a house fiscal agency; to create a commission on intergovernmental relations; to create the opioid advisory commission and prescribe its powers and duties; to prescribe the powers and duties of certain state agencies and departments; to repeal certain acts and parts of acts; and to repeal certain parts of this act on specific dates.

CHAPTER 8A

OPIOID ADVISORY COMMISSION

Sec. 850. As used in this chapter:

(a) Michigan opioid healing and recovery fund means the Michigan opioid healing and recovery fund created in section 3 of the Michigan trust fund act, 2000 PA 489, MCL 12.253.

(b) Opioid advisory commission means the opioid advisory commission created in section 851.

(25)

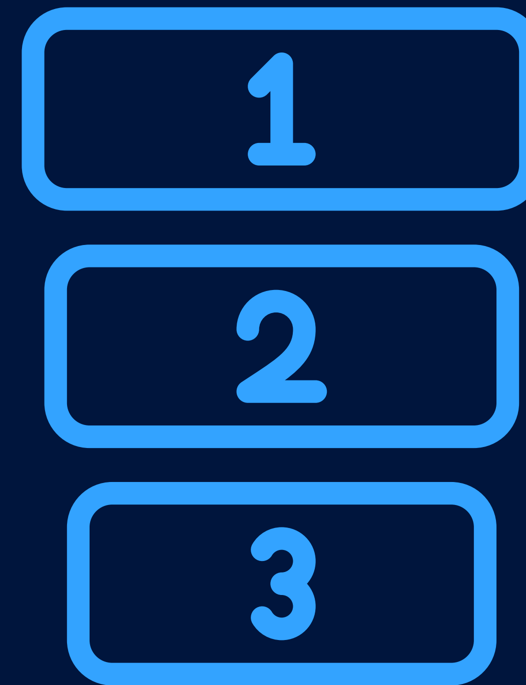
May 19, 2022

PUBLIC ACT 84 OF 2022 (SB 994)

OAC

PA 84 of 2022 (SB 994)

CHARGE OF THE OAC



REVIEW STRATEGIES

Review local, state and federal initiatives and activites related to education, prevention, treatment and services for individuals and families affected by SUD and co-occurring mental health conditions

ESTABLISH PRIORITIES

Establish priorites to address SUD and co-occurring mental health conditions; conduct statewide evidence-based needs assessment

RECOMMEND FUNDING

Recommend funding initiatives to the legislature; recommend funding for tasks, projects and initiatives that support the objectives of the commission

PA 84 of 2022 (SB 994)

CHARGE OF THE OAC

REPORT TO LEADERSHIP

Annual, written report to Governor, attorney general, senate majority leader, speaker of the house of representatives and chairs of the senate and house of representatives appropriations committees.

DEVELOP GOALS & RECOMMENDATIONS

Provide goals and recommendations around SUD and co-occurring mental health conditions, prevention, treatment, recovery and harm reduction efforts. Provide goals and recommendations for **reducing disparities** in access to programs, services, supports and resources.

RECOMMEND POLICY

If applicable, recommend additional legislation needed to accomplish the objectives of the commission.

OAC

OPIOID ADVISORY COMMISSION

STRATEGIC PRIORITIES

SUBSTANCE USE DISORDERS, MENTAL HEALTH CONDITIONS AND CO-OCCURRING DISORDERS

prevention Any strategy which helps educate, identify and prevent negative health or social outcomes from substance misuse, substance use disorders, mental health conditions or co-occurring disorders

treatment Any intervention intended to treat symptoms, improve functioning, and support positive health and social outcomes for individuals with substance use disorders, mental health conditions or co-occurring disorders

recovery Any non-clinical support which helps promote positive change and sustainable life outcomes for individuals with substance use disorders, mental health conditions or co-occurring disorders

harm reduction Any effort intended to help reduce the negative health impacts and social harms associated with substance use and substance overdose (overdose prevention)

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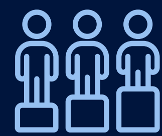
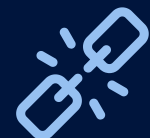
OPIOID ADVISORY COMMISSION

GUIDING PRINCIPLES



health equity

Ensuring that everyone has a fair and just opportunity to be as healthy as possible
Robert Wood Johnson Foundation

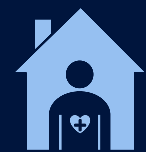


stigma change

Promotion of strategies to eliminate stigma associated with substance use disorders, mental health conditions and co-occurring disorders, by way of education, outreach, advocacy, engagement, training, collaboration and inclusion of voices with lived experience

cross-system collaboration

Development and maintenance of community partnerships across systems and sectors that enhance integrated care, advance health equity and reduce disparities in service access and delivery



whole-person care

Consideration of the whole person, including regard for the individual, their biology, life experiences, circumstances, and connections, to better understand adverse health impacts, better support individual health needs and better promote positive health outcomes

service innovation

Commitment to creative, novel and promising approaches that support health equity and meaningfully address substance use disorders, mental health conditions and co-occurring disorders

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MICHIGAN SETTLEMENT STRUCTURE
JANSSEN & DISTRIBUTORS

STATE SHARE **50%**

SUBDIVISION SHARE **50%**

MICHIGAN SUBDIVISIONS

- Counties
- Municipalities
- Townships

OAC

MICHIGAN
OPIOID SETTLEMENT
JANUARY 2023

Settlement	Estimated State Share	Payment Estimates To-Date	
McKinsey & Co.	$19,557,215.93	$17M	State Share
Janssen	$72,541,608.50	$54.6M	State Share
Distributors	$315,605,905.88	$27.6M	State Share

Estimated State Share Total FY 2023: **$99,312,183.77**

Mallinckrodt	PAYMENTS MAY OCCUR IN 2023; STATUS UNCONFIRMED
Allergen	STATE SIGN-ON, AWAITING FINALIZATION
Teva	STATE SIGN-ON, AWAITING FINALIZATION
CVS	STATE SIGN-ON, AWAITING FINALIZATION
Walgreens	AWAITING TRIAL FEBRUARY 2023
Walmart	STATE SIGN-ON, AWAITING FINALIZATION
Purdue	HAULTED: BANKRUPTCY PLAN, ON APPEAL
Endo	HAULTED: FILED FOR CHAPTER 11 BANKRUPTCY

JOHNS HOPKINS

BLOOMBERG SCHOOL OF PUBLIC HEALTH

PRINCIPLES FOR THE USE OF FUNDS FOR OPIOID LITIGATION

JOHNS HOPKINS
PRINCIPLES FOR THE USE OF FUNDS FOR OPIOID LITIGATION

PRINCIPLE 1

SPEND MONEY TO SAVE LIVES

PRINCIPLE 2

USE EVIDENCE TO GUIDE SPENDING

PRINCIPLE 3

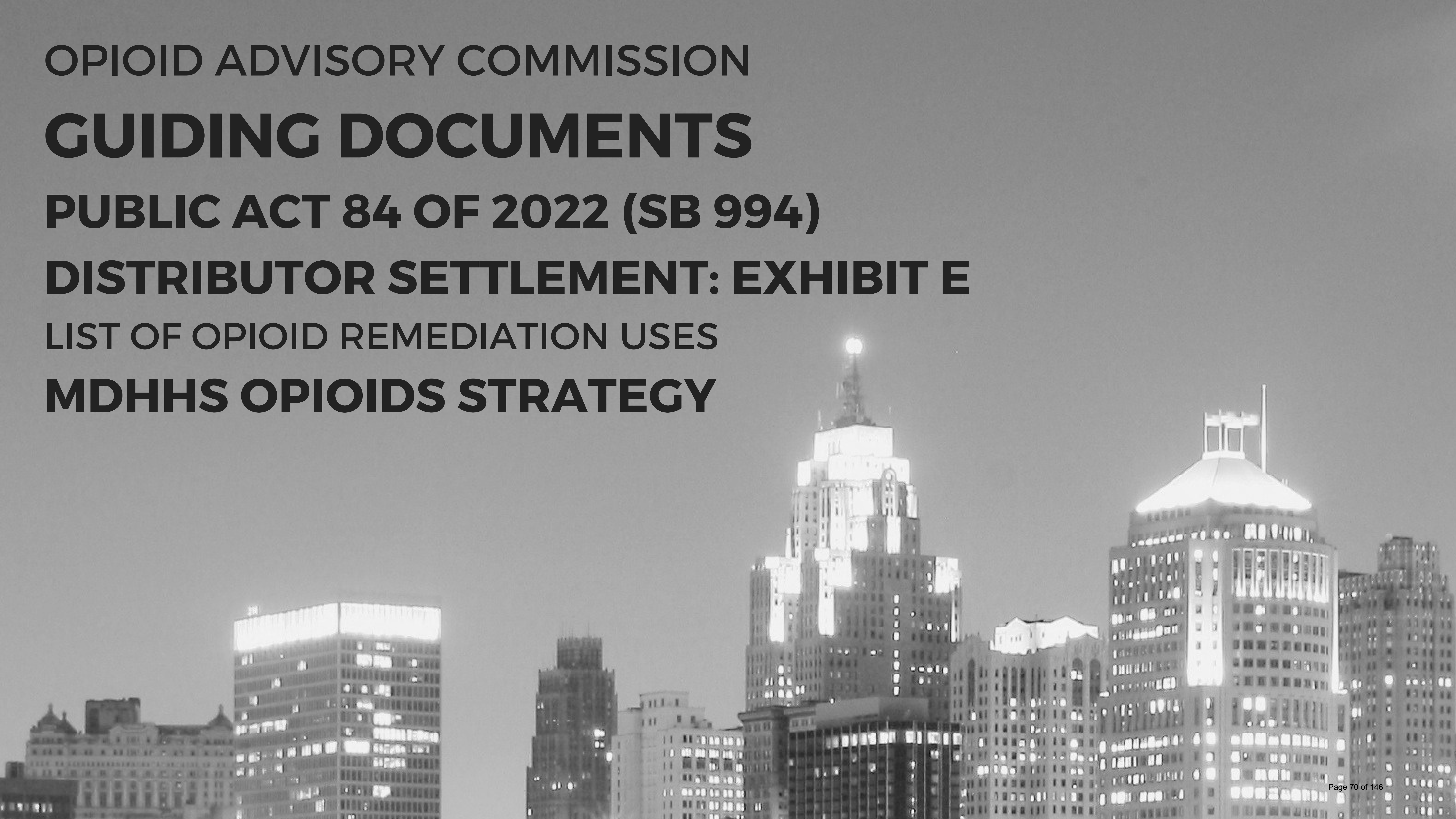
INVEST IN YOUTH PREVENTION

PRINCIPLE 4

FOCUS ON RACIAL EQUITY

PRINCIPLE 5

DEVELOP A FAIR AND TRANSPARENT PROCESS FOR DECIDING WHERE TO SPEND THE FUNDING


OPIOID ADVISORY COMMISSION
GUIDING DOCUMENTS
PUBLIC ACT 84 OF 2022 (SB 994)
DISTRIBUTOR SETTLEMENT: EXHIBIT E
LIST OF OPIOID REMEDIATION USES
MDHHS OPIOIDS STRATEGY

CROSS-DEPARTMENT COLLABORATION
Opioid Advisory Commission Legislative
State Departments Executive
State Court Administrative Office Judicial

STATE-LOCAL COLLABORATION
REPRESENTATIVE AGENCIES
Michigan Association of Counties (MAC)
Michigan Municipal League (MML)
PROVIDER NETWORKS
COMMUNITY COALITIONS
LOCAL GOVERNMENTS

THE MICHIGAN LEGISLATIVE COUNCIL

MICHIGAN OPIOID ADVISORY COMMISSION

OAC@LEGISLATURE.MI.GOV

DR. CARA POLAND, M.D., M.ED.
POLANDC2@MSU.EDU

January 31, 2023

To: CMH Board Members/Executive Directors (CMH & PIHP)/Management Staff (CMH & PIHP)/Provider Alliance Members

From: PAC Committee

Re: 2023 Annual PAC Campaign

This memorandum is being sent to all CMH boards, PIHPs and Provider Alliance members to announce and solicit participation in this year's CMH-PAC campaign. The CMH-PAC is a political action committee that helps support representatives and senators in leadership positions and those who champion the funding, legislation, and policy initiatives that help support and improve the provision of community-based mental health and substance use disorder services.

Your donations to the CMH PAC help support candidates who are supportive of our efforts at CMHA. The money that is raised for the CMH PAC helps raise awareness of our issues. While we are not able to match dollar for dollar the contributions of the larger interest groups your efforts go a long way and give CMHA a "seat at the table".

Last November's election certainly changed the landscape in Lansing for the foreseeable future – Democrats narrowly winning total control and a constitutional amendment changing term limits (allowing House members to stay for 12 years vs 6 years). **The demand for PAC dollars has never been higher, we receive fundraising requests almost daily.**

As you know, Sen. Shirkey is gone and SBs 597 & 598 failed to pass in lame duck, but the threat of privatization still remains. We have to remain vigilant and ready to fight potential threats, on flip side, we must be ready to push our own priorities through the new Legislature. We fully anticipate behavioral health being a part of the legislative dialog in the near future, it is critical we maintain an active presence – ***WE MUST BUILD OUR PAC FUND to a new level*** and support those key leaders who are willing to work with us.

In order to compete and stay relevant in Lansing we must increase our PAC contributions. For the past 8+ years we have raised roughly $4000 – $5000 a year. To put it in perspective the maximum contribution allowed by a PAC to a Michigan state senator during their 4-year term is $21,000 and the max for a House member in a 2-year term is $10,500.

As you know in 2021, we launched our new online capabilities, which makes it easier than ever to contribute to the CMH PAC. **We can now take credit card payments online by accessing the link below or scan the QR code on the back to use our secure online checkout function**.

https://cmham.org/public-policy/cmh-pac/

2023 CMH PAC CAMPAIGN
Details and Timeline

As always, our PAC goal is to have as many boards and members participate as possible. Typically, in past years we only had about 1/3 of our membership participate in the PAC campaign – **our goal is 100% member participation, we MUST increase our contributions.**

****NEW PAC FUNDRAISING GOAL****

Our new annual fundraising goal is $25,000 / year! We believe we can reach that goal if all of our membership participates – **we need 50 organizations (CMHs, PIHPs, and Provider Alliance members) to each contribute $500.** If you are a CMH and all of your board members donated 1 meeting per diem and the CEO contributed the same amount the $500 goal would be reached.

In past years as an incentive to increase participation we have been able to provide Tiger game suite tickets (12 tickets) donated by Muchmore Harrington Smalley and Associates that went into a drawing of all the eligible members – we will send out the date and time once it becomes available.

NEW – In order to qualify for the Tiger ticket drawing members must meet the new $500 goal contributions, which can come from the board members and/or staff.

The campaign is being announced early with the hope that more boards will have time to discuss its merits locally and increase the participation rate. The PAC Committee requests that CMH directors and board chairpersons announce and discuss the campaign over the next three months at their regular monthly meetings.

Again, we will have the details on the Tiger game later this year if it becomes available. In order to qualify for the special drawing members should expect to forward their campaign and donations to CMHA by late June / early July.

Again, you can pay online at the link below or scan the QR code to use our secure online checkout function or make checks payable to: CMH PAC ~ 426. S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please).

https://cmham.org/public-policy/cmh-pac/

If you have any questions regarding this year's campaign, please contact Robert Sheehan or Alan Bolter at CMHAM. Thank you for your participation.

Winter 2023 Public Policy Updates

Overview

* 2022 Election Recap
* 2022 Lame Duck Recap
* 102nd Legislature Begins
  * Key Committee Assignments
* 2023 State of the State
  * Democratic Legislative Priorities
* Budget Update
* CMHA Priorities
* Redesign Dangers

2022 Election Recap – Historic Shift in Power

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

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

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

2022 Lame Duck Recap

The November 8 election results had a direct impact on lame duck activities – wiped out any shot at a lengthy lame duck session.

* In total the House and Senate met for 3 days of legislative voting, ONLY 2 days for each chamber and ONLY 1 day where both chambers were voting on the same day.

* The legislature passed 55 bills during those 3 days, which was the second fewest bills during lame duck since Michigan went to a full-time legislature in the 1969-70 legislative session.

    * By comparison, the last lame duck session under former Gov. Rick Snyder saw a record 342 bills passed in 11 legislative session days.

2022 Lame Duck Recap – SB 597 & 598

Sen. Shirkey did attempt to pass a revised SB 597 & 598 out of senate on November 29.

- the bills would have moved foster care (only) over to a single managed care organization
- would have also restructured regional PIHP governance boards to consist of 1/3 CMH – 1/3 providers – 1/3 consumers/families.
- The bills also included the dual eligible population in this deal because the foster care population was "not enough" according to MAHP, however that language was stripped out before the vote.

The language in the revised bill was a deal reached by Sen. Shirkey & Rep. Whiteford.

Sen. Shirkey put the bills up for a vote in Senate after reaching a deal with the Senate Democratic leadership, in exchange for some democrat votes on SB 597 & 598 the Senate would pass a bill to change Michigan's presidential primary date up to February of 2024 (vs the March date).

In the end, both bills failed to pass – SB 597 failed on a 15-17 vote (4 senators were missing and 2 did not vote), SBs 598 failed on a 15-19 vote (4 senators were missing).

- 3 Democrats voted YES and 7 Republicans voted NO on 597
- 3 Democrats voted YES and 9 Republicans voted NO on SB 598
- **(YES democrats were Ananich, Hertel & Hollier)**
- **(NO republics were Bumstead, LaSata, MacDonald, Outman, Runestad, Theis, Zorn – Barrett & Johnson DNV on 597 and voted NO on 598)**

102nd Legislature Begins

- House and Senate members were sworn into office on January 11th
  - 52 new House members (56 total – 4 Senators are coming back to the House)
  - 14 new Senators (4 new Senators who did not serve in the House)

New leadership teams were elected by each legislative caucus:

House of Representatives

Democrat Caucus:

- Speaker of the House: Rep. Joe Tate (D-Detroit)
- Speaker Pro Tempore: Rep. Laurie Pohutsky (D-Livonia)
- Majority Floor Leader: Rep. Abraham Aiyash (D-Hamtramck)
- Caucus Chair: Rep. Amos O'Neal (D-Saginaw)

Republican Caucus:

- Minority Leader: Rep. Matt Hall (R-Comstock Township)
- Assistant Minority Leader: Rep. Andrew Beeler (R-Fort Gratiot)
- Minority Floor Leader: Rep. Bryan Posthumus (R-Cannon Township)
- Caucus Chair: Rep. Ken Borton (R-Gaylord)

Michigan Senate

Democrat Caucus:

- Senate Majority Leader: Sen. Winnie Brinks (D-Grand Rapids)
- President Pro Tempore: Sen. Jeremy Moss (D-Southfield)
- Majority Floor Leader: Sen. Sam Singh (D-East Lansing)
- Caucus Chair: Sen. Dayna Polehanki (D-Livonia)

Republican Caucus:

- Minority Leader: Sen. Aric Nesbitt (R-Lawton)
- Assistant Minority Leader: Sen. Rick Outman (R-Six Lakes)
- Minority Floor Leader: Sen. Dan Lauwers (R-Brockway)
- Caucus Chair: Kevin Daley (R-Lum)

Key Committee Assignments

The House and Senate recently announced their committee assignments for the 102nd Legislative Session. Below are the key committee assignments of interest, for a full list of committee assignments go to the links below:

https://house.mi.gov/Committees
https://committees.senate.michigan.gov/

Key Senate Committees (Democrats in **BOLD** / New Senator UNDERLINED)

Appropriations

Sen. Sarah ANTHONY (D-Lansing) (Chair), **Sen. Sean MCCANN (D-Kalamazoo)** (MVC), **Sen. Kristen MCDONALD RIVET (D-Bay City)**, **Sen. John CHERRY (D-Flint)**, **Sen. Rosemary BAYER (D-West Bloomfield)**, **Sen. Sylvia SANTANA (D-Detroit)**, **Sen. Sue SHINK (D-Northfield)**, **Sen. Jeff IRWIN (D-Ann Arbor)**, **Sen. Kevin HERTEL (D-St. Clair Shores)**, **Sen. Darrin CAMILLERI (D-Trenton)**, **Sen. Veronica KLINEFELT (D-Eastpointe)**, **Sen. Mallory MCMORROW (D-Royal Oak)**, **Sen. Mary CAVANAGH (D)**, Sen. Jon BUMSTEAD (R-Newaygo) (MinVC), Sen. Thomas ALBERT (R-Lowell), Sen. John DAMOOSE (R-Harbor Springs), Sen. Mark HUIZENGA (R-Walker), Sen. Rick OUTMAN (R-Six Lakes) and Sen. Lana THEIS (R-Brighton)

DHHS Budget Subcommittee

Sen. Sylvia SANTANA (D-Detroit) (Chair), **Sen. Kristen MCDONALD RIVET (D-Bay City)** (MVC), **Sen. Jeff IRWIN (D-Ann Arbor)**, **Sen. Mary CAVANAGH (D)**, **Sen. John CHERRY (D-Flint)**, **Sen. Darrin CAMILLERI (D-Trenton)**, **Sen. Rosemary BAYER (D-West Bloomfield)**, Sen. Rick OUTMAN (R-Six Lakes) (MinVC), Sen. Lana THEIS (R-Brighton), Sen. Mark HUIZENGA (R-Walker) and Sen. Roger HAUCK (R)

Key Committee Assignments

Senate Committees Cont.

Health Policy

Sen. **Kevin HERTEL (D-St. Clair Shores)** (Chair), **Sen.** **Sylvia SANTANA (D-Detroit)** (MVC), **Sen.** **Paul WOJNO (D-Warren)**, **Sen.** **John CHERRY (D-Flint)**, **Sen.** **Veronica KLINEFELT (D-Eastpointe)**, **Sen.** **Erika GEISS (D-Taylor)**, Sen. Michael WEBBER (R-Rochester Hills) (MinVC), Sen. Roger HAUCK (R), Sen. Mark HUIZENGA (R-Walker) and Sen. Jim RUNESTAD (R-White Lake)

Housing and Human Services

Sen. **Jeff IRWIN (D-Ann Arbor)** (Chair), **Sen.** **Sylvia SANTANA (D-Detroit)** (MVC), **Sen.** **Mary CAVANAGH (D)**, **Sen.** **Rosemary BAYER (D-West Bloomfield)**, **Sen.** **Sue SHINK (D-Northfield)**, **Sen.** **Stephanie CHANG (D-Detroit)**, **Sen.** **John CHERRY (D-Flint)**, **Sen.** **Erika GEISS (D-Taylor)**, Sen. Jonathon LINDSEY (R-Brooklyn) (MinVC), Sen. Michelle HOITENGA (R) and Sen. John DAMOOSE (R-Harbor Springs)

Key Committee Assignments

Key House Committees (Democrats in **BOLD** / New House Member UNDERLINED)

Appropriations

Rep. Angela WITWER (D-Delta Township) (Chair), **Rep. Amos ONEAL (D-Saginaw)** (MVC), **Rep. Natalie PRICE (D-Berkeley)**, **Rep. Alabas A. FARHAT (D)**, **Rep. Regina WEISS (D-Oak Park)**, **Rep. Jason MORGAN (D-Ann Arbor)**, **Rep. Felicia BRABEC (D-Pittsfield)**, **Rep. Rachel HOOD (D-Grand Rapids)**, **Rep. Julie BRIXIE (D-Meridian Township)**, **Rep. Jasper R. MARTUS (D-Flushing)**, **Rep. Phil SKAGGS (D-Grand Rapids)**, **Rep. Donovan MCKINNEY (D-Detroit)**, **Rep. Ranjeev PURI (D-Canton)**, **Rep. Christine MORSE (D-Texas Twp.)**, **Rep. Will SNYDER (D-Muskegon)**, **Rep. Samantha STECKLOFF (D-Farmington Hills)**, **Rep. Jimmie WILSON JR. (D-Ypsilanti)**, **Rep. Denise MENTZER (D-Mount Clemens)**, Rep. Sarah LIGHTNER (R-Springport) (MinVC), Rep. Ken BORTON (R-Gaylord), Rep. Phil GREEN (R-Millington), Rep. Andrew FINK (R-Hillsdale), Rep. Ann BOLLIN (R-Brighton Township), Rep. Timothy BESON (R-Kawkawlin), Rep. Bradley SLAGH (R-Zeeland), Rep. Tom KUHN (R-Troy), Rep. Nancy DEBOER (R-Holland), Rep. Donni STEELE (R-Orion Township), Rep. Bill G. SCHUETTE (R-Midland) and Rep. Cam CAVITT (R-Cheboygan)

DHHS Budget Subcommittee

Rep. Christine MORSE (D-Texas Twp.) (Chair), **Rep. Jasper R. MARTUS (D-Flushing)** (VC), **Rep. Felicia BRABEC (D-Pittsfield)**, **Rep. Rachel HOOD (D-Grand Rapids)**, **Rep. Phil SKAGGS (D-Grand Rapids)**, **Rep. Alabas A. FARHAT (D)**, **Rep. Amos ONEAL (D-Saginaw)**, **Rep. Natalie PRICE (D-Berkley)**, **Rep. Will SNYDER (D-Muskegon)**, **Rep. Ranjeev PURI (D-Canton)**, Rep. Phil GREEN (R-Millington) (MinVC), Rep. Ann BOLLIN (R-Brighton Township), Rep. Tom KUHN (R-Troy), Rep. Luke MEERMAN (R-Polkton Twp.), Rep. Donni STEELE (R-Orion Township)

Key Committee Assignments

House Committees Cont.

Health Policy

Rep. **Julie ROGERS (D-Kalamazoo)** (Chair), **Rep.** **Karen WHITSETT (D-Detroit)** (MVC), **Rep.** **Carrie A. RHEINGANS (D-Ann Arbor)**, **Rep.** **Reggie MILLER (D-Belleville)**, **Rep.** **John FITZGERALD (D-Wyoming)**, **Rep.** **Cynthia NEELEY (D-Flint)**, **Rep.** **Alabas A. FARHAT (D)**, **Rep.** **Jim HAADSMA (D-Battle Creek)**, **Rep.** **Brenda CARTER (D-Pontiac)**, **Rep.** **Carol GLANVILLE (D-Walker)**, **Rep.** **Jennifer CONLIN (D)**, **Rep.** **Betsy COFFIA (D-Traverse City)**, Rep. Curtis VANDERWALL (R-Ludington) (MinVC), Rep. Jaime THOMPSON (R-Brownstown), Rep. Mike MUELLER (R-Linden), Rep. Graham FILLER (R-DeWitt), Rep. John ROTH (R-Traverse City), Rep. Kathy SCHMALTZ (R-Jackson) and Rep. Greg VANWOERKOM (R-Norton Shores)

Behavioral Health Subcommittee within the Health Policy Committee

Rep. **Felicia BRABEC (D-Pittsfield)** (Chair), **Rep.** **Noah ARBIT (D-West Bloomfield)** (VC), **Rep.** **Carrie A. RHEINGANS (D-Ann Arbor)**, **Rep.** **Sharon MACDONELL (D-Troy)**, **Rep.** **Kimberly EDWARDS (D-Eastpointe)**, **Rep.** **Laurie POHUTSKY (D-Livonia)**, **Rep.** **Carol GLANVILLE (D-Walker)**, Rep. Kathy SCHMALTZ (R-Jackson) (MinVC), Rep. Mike HOADLEY (R-Au Gres), Rep. Alicia ST. GERMAINE (R-St. Clair Shores), and Rep. Jaime THOMPSON (R-Brownstown)

2023 State of the State

Governor Gretchen Whitmer delivered her fifth State of the State address at the Capitol in Lansing. This was the first time she has addressed the state in-person since the start of the coronavirus pandemic.

In her 2023 address, Governor Whitmer highlighted a number of different proposals:

* Roll back the retirement tax on our seniors, saving half a million households $1,000 a year. Seniors who served our communities, saved, and did everything right deserve to keep every dime of what they earned.

* Expand the Working Families Tax Credit, delivering at least $3,000 refunds to 700,000 families. That's hundreds of millions of dollars back in family budgets to help them pay rent, buy school supplies, and put nutritious meals on the table.

* Deliver preschool for all to save families an average of $10,000 a year and ensure all 110,000 4-year-olds in Michigan get a great start. Data shows that children who go to preschool are more likely to graduate, go to college, and get a good-paying job.

2023 State of the State

* To ensure more people can get good-paying, high-skill jobs let's take steps to lower the age for Michigan Reconnect, our program that currently offers anyone 25 and older a tuition-free associate's degree or skills training, from 25 to 21.
* Repeal the 1931 law banning abortion and other dangerous laws prohibiting people from accessing health care
* Expand the Elliott-Larsen Civil Rights Act so you can't be denied housing or employment because of who you are or how you identify.
* <u>Let's continue funding law enforcement with better training, oversight, and access to mental health resources.</u>
* To reduce violence in our communities, let's enact universal background checks, safe storage laws, and extreme risk protection orders, so we can make sure firearms are stored safely at home and kept out of the hands of those who might represent a danger to themselves or others.

Democratic Legislative Priorities

Legislation sponsored by Rep. **Angela Witwer** (D-Delta Twp.) and Sen. **Kevin Hertel** (D-St. Clair Shores) to repeal the retirement tax on Michigan seniors;

Legislation sponsored by Rep. **Nate Shannon** (D-Sterling Heights) and Sen. **Kristen McDonald Rivet** (D-Bay City) to enable workers to keep more of their hard-earned dollars through an increased Earned Income Tax Credit (EITC);

Legislation sponsored by Rep. **Jason Hoskins** (D-Southfield) and Sen. **Jeremy Moss** (D-Southfield) to expand Michigan's Elliott-Larsen Civil Rights Act to include anti-discrimination protections for sexual and gender identity;

Legislation sponsored by Rep. **Brenda Carter** (D-Pontiac) and Sen. **Veronica Klinefelt** (D-Eastpointe) to restore the state's prevailing wage law;

Legislation sponsored by Rep. **Regina Weiss** (D-Oak Park) and Sen. **Darrin Camilleri** (D-Trenton) to restore workers' rights by repealing the so-called "Right to Work" policy;

Legislation sponsored by Rep. **Laurie Pohutsky** (D-Livonia) and Sen. **Erika Geiss** (D-Taylor) to repeal Michigan's 1931 statute that criminalizes abortion care.

Budget Items

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

House Fiscal Agency
October 2014

Budget Update

January 13 – Revenue Estimating Conference

* State Budget Director projected the Michigan has a $9.2 billion surplus, including $5.8 billion in one-time money and $3.4 billion in ongoing funds.

Revenue

* Fiscal Agencies expect both the General Fund (GF) and School Aid Fund (SAF) to fall back this year
* The GF and SAF are estimated to fall by $2.6 billion in FY 23, but this remains well above pre-pandemic trends
  * This would leave the state with revenue $5.9 billion higher than it was pre-pandemic
* Economists predict modest growth in 2024
  * Expect to see further growth in 2025 after the economy recovers from the expected recession

Potential issues cutting into state budget

* 2015 road funding bill included a trigger that would cut the state income tax rate from 4.25% to 4.05%
  * Beginning with the 2021-22 fiscal year, a tax cut would be triggered when General Fund revenues increase at a greater rate than inflation.
  * $800 million cost

* Democratic priorities – EITC expansion & elimination of retirement taxes on pensions
  * $800 million cots

Budget Update

Potential issues cutting into state budget

Sb 7 – $1.1 billion supplemental appropriations package passed on January 26, 2023

* Among the largest items in the package are $200 million for a project to transform and upgrade a paper mill in the Upper Peninsula near Escanaba, $150 million for affordable housing, $150 million for the Strategic Outreach and Attraction Reserve fund and $100 million for community revitalization and placemaking grants.

February 8 – Governor's FY24 Executive Budget Presentation

Our Budget Priorities

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

* Continue the 5-year phase out of the local match draw down obligation as outlined in section 928 in appropriations boilerplate

* Closely monitor the impact of the unwinding of the Public Health Emergency (PHE) and its impact on Medicaid redeterminations & caseloads
  * Allow for real-time rate adjustments

CMHA Priorities

CMHA Priorities

ACCESS TO CARE

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

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

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

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

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

CMHA Priorities

WORKFORCE

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

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

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

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

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

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

CMHA Priorities

INPATIENT CARE

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

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

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

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

Redesign Dangers

Redesign Dangers

* Sen. Shirkey is gone – his bills did not pass
  * This redesign issue is NOT a republican only issue

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

  * The most common approach to privatization is done through the contacting/procurement process vs legislative changes

* **Health plan rebid**
  * MIHealthyLife (michigan.gov)
  * In fall 2023, MDHHS will ask Medicaid health plans for new contract proposals to provide health services to people enrolled in Medicaid.
  * Behavioral health will be included, but to what extent?

Redesign Dangers

- **MI Health Link (MHL) – Duals Initiative**
  - Last year MDHHS requested an extension from Centers for Medicare and Medicaid Services (CMS) for MI Health Link through at least 2025, as the current authority ends in December 2024
  - MDHHS is exploring the idea of converting the MHL into an Integrated Dual Eligibles Special Needs Plan by January 1, 2026.
    - MDHHS is exploring a transition to a highly or fully Integrated D-SNP, with the expectation of providing the greatest degree of continuity in the infrastructure and expectations for beneficiaries, providers, and health plans.
    - **Covered benefits:** The integrated D-SNPs will be required to cover all Medicaid benefits that are covered by MI Health Link. This includes, but is not limited to, physical healthcare, possibly behavioral healthcare, medications, LTSS, and care coordination. MDHHS is still determining how all of these services will be coordinated.

"As part of my own new generation, I was elected to the Ingham County Commission in 1974 at the age of 24. As the youngest and first woman to chair the Board, this began years of breaking barriers, blazing trails, and being the 'first' woman to reach historic milestones as an elected official, including the honor of being the first woman from Michigan elected to the U.S. Senate. But I have always believed it's not enough to be the 'first' unless there is a 'second' and a 'third."

U.S. Senator Debbie Stabenow on her groundbreaking career

CMHA

Contact Information

Community Mental Health Association of Michigan

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Northern Michigan Regional Entity

CONSULTATION DRAFT

FY22 Performance Bonus Incentive Pool (PBIP) Contractor-only and MHP/Contractor Joint Metrics Deliverables/Narratives Scoring

This communication serves as the consultation draft review response to your PIHP regarding the FY2022 performance bonus, contract section 8.4.2.
Scoring is based on Contractor-only and MHP/Contractor Joint Metrics deliverables.

TOTAL WITHHOLD	TOTAL WITHHOLD UNEARNED
$1,725,420.19	**$0**

CONTRACTOR-only Pay for Performance Measures (45% of total Withhold)

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.1 Identification of beneficiaries who may be eligible for services through the Veteran's Administration.	**$194,109.77**	**$0**	**25**	**25**
NARRATIVE REVIEW:				
Report fulfills stated purpose; however, does not give specific/detailed information/results of comparisons done between BHTEDS & Veteran Navigator Report. BHTEDS completion rates improved from last FY.				

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.2 Increased data sharing with other providers.	**$194,109.77**	**$0**	**25**	**25**
NARRATIVE REVIEW:				
NMRE stated that four of five CMHSPs have implemented outbound ADTs to MiHIN. MDHHS looks forward to an update on the remaining CMHSP in the FY23 narrative.				

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.3 Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence.	**$388,219.55**	**$0**	**50**	**50**

CONTRACTOR-only Pay for Performance Measures (25% of total Withhold)

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.4 Increased participation in patient-centered medical homes.	**$431,355.05**	**$0**	**100**	**100**
NARRATIVE REVIEW:				
MDHHS likes the idea of a 'one stop shop' to allow individuals to receive services in one place for multiple medical areas. Using 'huddles' during the pandemic was a great way to continue care, address any gaps between medical and behavioral health and to reduce a delay in services. An increase of 73% from last FY in peer-delivered services is outstanding! It is great to hear the collaboration between the two CMHSPs to make sure that members have seen their PCP within the last year.				

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
CONTRACTOR -only TOTAL	**$1,207,794.14**	**$0**	**200**	**200**

MHP/Contractor Joint Metrics (30% of total withhold)

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.1 Implementation of Joint Care Management Processes.	**$181,169.11**	**$0**	**35**	**35**

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.2.1 Follow-up after Hospitalization (FUH) within 30 days.	**$103,525.21**	**$0**	**20**	**20**

AGES	STANDARD	AET	BCC	HAR	MCL	MER	HAP MID	MOL	PRI	THC	UNI	UPP
6-20	70%	N/S	N/S	N/S	89	92	N/S	N/S	N/S	N/S	N/S	N/S
20-64	58%	N/S	N/S	N/S	79	76	N/S	70	N/S	N/S	71	N/S

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.2. 2 Follow-up after Hospitalization (FUH) within 30 days stratified by race/ethnicity.	**$103,525.21**	**$0**	**20**	**20**

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.3 Follow-up after (FUA) Emergency Department visit for Alcohol and Other Drug Dependency within 30 days stratified by race/ethnicity.	**$129,406.52**	**$0**	**25**	**25**

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
MHP/CONTRACTOR JOINT METRICS TOTAL	**$517,626.05**	**$0**	**100**	**100**

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

February 10, 2023

Mr. Eric Kurtz, CEO
Northern Michigan Regional Entity
1999 Walden Drive
Gaylord, MI 49735

Dear Mr. Kurtz:

MDHHS has completed a review of Northern Michigan Regional Entity's (NMRE) FY 2023 Risk Management Strategy. The components 1-5 of NMRE's Risk Management Strategy are in compliance with PIHP contract sections 4.I Internal Service Fund, 7.I Risk Corridor and the Policy and Practice guideline *Internal Service Fund Technical Requirement* at: www.michigan.gov/documents/mdhhs/Internal-Service-Fund-Technical-Requirement_704454_7.pdf and the MDHHS policy regarding risk management strategies as established in the Technical Advisory issued October 10, 2008.

Please revise Component 6 and resubmit by **February 24, 2023**. Component 6 seeks a brief description of the PIHP arrangement with its CMHSPs in sharing financing responsibility for Medicaid risk exposure. At this point the RMS is not considered approved.

After you receive notice that your revised RMS has been approved, if there are any anticipated changes to NMRE's FY 2023 Risk Management Strategy during the fiscal year, please submit a revised plan to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

Sincerely,

Jackie Sproat, MSW, Director
Division of Contracts and Quality Management
Bureau of Specialty Behavioral Health Services

cc: Jeff Wieferich, MDHHS
June White, MDHHS
Amanda Zabor, MDHHS
Ashley Seeley, MDHHS
Deanna Yockey, NMRE

Communication with Those Charged with Governance during Planning

February 7, 2023

To the Members of the Board
Northern Michigan Regional Entity
Gaylord, Michigan

We are engaged to audit the financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Northern Michigan Regional Entity (the PHIP) for the year ended September 30, 2022. Professional standards require that we provide you with the following information related to our audit.

We would also like to extend the opportunity for you to share with our firm any concerns you may have regarding the PHIP, whether they be in relation to controls over financial reporting, controls over assets, or issues regarding personnel, as well as an opportunity for you to ask any questions you may have regarding the audit.

Our Responsibilities under U.S. Generally Accepted Auditing Standards, *Government Auditing Standards*, and the Uniform Guidance

As stated in our engagement letter, our responsibility, as described by professional standards, is to express opinions about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

In planning and performing our audit, we will consider the PHIP's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinions on the financial statements and not to provide assurance on the internal control over financial reporting. We will also consider internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with the Uniform Guidance.

As part of obtaining reasonable assurance about whether the PHIP's financial statements are free of material misstatement, we will perform tests of its compliance with certain provisions of laws, regulations, contracts, and grants. However, providing an opinion on compliance with those provisions is not an objective of our audit. Also in accordance with the Uniform Guidance, we will examine, on a test basis, evidence about the PHIP's compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Compliance Supplement applicable to each of its major federal programs for the purpose of expressing an opinion on the PHIP's compliance with those requirements. While our audit will provide a reasonable basis for our opinion, it will not provide a legal determination on the PHIP's compliance with those requirements.

Our responsibility is to plan and perform the audit to obtain reasonable, but not absolute, assurance that the financial statements are free of material misstatement. We are responsible for communicating significant matters related to the audit that are, in our professional judgement, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures specifically to identify such matters.

Planned Scope, Timing of the Audit, Significant Risks, and Other

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent financial

ROSLUND, PRESTAGE & COMPANY, P.C.
525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN

reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity.

We will generally communicate our significant findings at the conclusion of the audit. However, some matters could be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

We have identified the following significant risks of material misstatement as part of our auditing planning:

- Management override of controls
- Improper revenue recognition due to fraud

To address these risks, we incorporate unpredictability into our audit procedures, emphasize the use of professional skepticism, and assign staff to the engagement with industry expertise.

Derek Miller is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it.

This information is intended solely for the use of those charged with governance and management of the PHIP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.
Certified Public Accountants

MICHIGAN MEDICAID & FEDERAL WAIVERS

ERIC KURTZ, CEO NMRE

WHAT IS MEDICAID?

- Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965 alongside Medicare.
- All states, the District of Columbia, and the U.S. territories have Medicaid programs designed to provide health coverage for **low-income people.**
- Although the Federal government establishes certain parameters for all states to follow, each state administers its Medicaid program differently, resulting in variations in Medicaid coverage across the country.
- In 1967, instead of Medicaid specifically targeting low-income individuals, coverage was expanded to not only for low-income adults, children, pregnant women and the elderly.,but also persons with disabilities.

MEDICAID CONTINUED

- Medicaid is administered by the state, according to federal requirements.
- The program is jointly funded by states and the federal government.
- The federal government portion is based on the Federal Medicaid Assistance Percentage (FMAP), which considers the per capita income for each state and compares it to the national average. This percentage cannot go below 50%.
- FMAP percentages also vary by the type of Medicaid program or population groups (Health Michigan is 90% federally funded as well as Health Home programs etc.).

MEDICAID CONTINUED

- Originally, most Medicaid services were funded by Medicaid State Plan, also known as State Plan Amendments (SPA), which identified a limited set of services paid on a Fee-for-Service (FFS) basis directly by the state.
- This is still the case for certain Medicaid beneficiary populations that are exempt from managed care enrollment or other Medicaid waiver programs.

SO, WHAT IS A MEDICAID WAIVER?

- Short version: Medicaid program waivers allow states, to waive certain sections of the Social Security Act with Health and Human Services Secretary approval.
- Longer story: Congress in the Omnibus Budget Reconciliation Act of 1981, introduced Medicaid program waivers specifically related to Freedom of Choice and Community-Based Waivers.
- These Waivers offer states additional targeted flexibility to test new approaches to service delivery.
- These waivers allowed States to use Medicaid funds to provide an array of non-medical services (excluding room and board) not otherwise covered by Medicaid, if those services allow recipients to receive care in community residential settings.

TYPES OF MEDICAID WAIVERS

- Although there are numerous variations with Medicaid waivers, but they basically fall under one of four categories:
  - Section 1915(b) Freedom of Choice Waivers
  - Section 1915(c) Home and Community-Based Service Waivers (HCBS)
  - Section 1915(i) HCBS waivers, like the 1915(c) but offered as part of the SPA to a broader population.
  - Section 1115 Demonstration Waivers.

SECTION 1915(B) FREEDOM OF CHOICE WAIVERS

- The Medicaid statute generally guarantees beneficiaries freedom of choice of providers, but Section 1915(b) waivers permit states to implement service delivery models (e.g., those involving managed care plans) that restrict choice of providers other than in emergency circumstances. States can also use Section 1915(b) to waive statewide requirements (e.g., to provide managed care in a limited geographic area) and comparability requirements (e.g., to provide enhanced benefits to managed care enrollees).
- This waiver is why we are all in this room today!

SECTION 1915(C)/(I) HOME AND COMMUNITY-BASED SERVICE WAIVERS (HCBS)

- Section 1915(c) waivers authorize states to provide HCBS as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with intellectual disabilities, and hospitals. The statute identifies services that may be considered HCBS, including case management, homemaker/home health aide, personal care, adult day programs, habilitation, and respite care services. The Secretary may also approve other services needed to avoid institutionalization.
- These are the waivers we need to learn more about today!

SECTION 1115 DEMONSTRATION WAIVERS

- Section 1115 of the Social Security Act gives broad authority to the Secretary to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives" of the programs. Under Section 1115 research and demonstration authority, the Secretary may waive certain provisions of the Medicaid (and CHIP) statutes related to state program design. Such projects are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state. This authority has also been used, however, to focus on specific services or populations, and to expand substance use disorder treatment benefits to provide residential treatment in institutions for mental diseases (IMD's).
- Another waiver that allows us to be in the room today!

SECTION 1915(C)/(I) HOME AND COMMUNITY-BASED SERVICE WAIVERS (HCBS) – A DEEPER DIVE

- Michigan currently operates (for our purposes) three different 1915(c) Waivers and now with a splash of 1915(i), which is essentially the same.
  - 1915(c) Habilitation Supports Waiver (HSW)
  - 1915(c) Children's Waiver Program (CWP)
  - 1915(c) Serious Emotionally Disturbed Waiver (SEDW)
  - 1915(i) Also a Home and Community-Based Supports Waiver

1915(C) HSW

- The HSW was one of Michigan’s first waiver programs.
  - As mentioned in the previous HSW slide, it was right on the heels of the Freedom of Choice Waivers, but specifically targeting individuals in leu of nursing home or institutional placement.
  - Requires specific enrollment targeted for those who would otherwise be in an institutional setting but choose to live in the community.
  - 8268 slots statewide. NMRE Region has 655 out of 689 slots filled
  - Enrolled beneficiaries provide an additional $$3,200 to $8,375 dollars per member/per month revenue for the CMHSP.
  - Provides approx. 43,000,000 in additional Medicaid revenue regionally.

1915(C) CWP AND SEDW PROGRAMS

- Both programs are based on a state enrollment model focused on the level of disability. need.
- State approves eligibility based on CMHSP assessment. "Can not deny assessment request"
- No additional financing;
- But allows families caring for disabled children to enroll the child as a "family of one" into the Medicaid program that waives family income limits.

1915(I) WAIVER PROGRAM

- Also falls under the HCBS rules
- Basically, a Waiver to pick up other populations not covered by 1915(c) Waivers.
- Requires eligibly enrollment, but less that the CWP and HSW.
- Provides a small set of expanded services outside of the SPA.
- These services were formally known as b(3) services under Michigan's previous 1915(b) Waiver.

THE END

?

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – FEBRUARY 8, 2023
VIA TEAMS

ATTENDEES:	**Vikki Butler, Connie Cadarette, Lauri Fischer, Ann Friend, Chip Johnston, Nancy Kearly, Allison Nicholson, Larry Patterson, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Carol Balousek**

REVIEW AGENDA & ADDITIONS
Ann asked to communications from MDHHS regarding an amendment to the Community Mental Health Services Programs 2023 Agreement and FY23 Fiscal Questionnaire to the meeting agenda. Lauri asked to add a discussion of HCBS non-compliant providers to the meeting agenda.

REVIEW PREVIOUS MEETING MINUTES
The January minutes were included in the materials packet for the meeting.

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE JANUARY 11, 2023 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY ANN FRIEND. MOTION APPROVED.

MONTHLY FINANCIALS
December 2022
- Net Position showed net surplus Medicaid and HMP of $3,517,563. Medicaid carry forward was reported as $16,367,583. The total Medicaid and HMP Current Year Surplus was reported as $19,885,146. Medicaid and HMP combined ISF was reported as $16,357,583; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $36,252,729.
- Traditional Medicaid showed $49,200,717 in revenue, and $46,777,769 in expenses, resulting in a net surplus of $2,422,948. Medicaid ISF was reported as $9,302,629 based on the interim FSR. Medicaid Savings was reported as $10,911,722.
- Healthy Michigan Plan showed $8,353,822 in revenue, and $7,259,207 in expenses, resulting in a net surplus of $1,094,615. HMP ISF was reported as $7,064,954 based on the interim FSR. HMP savings was reported as $5,455,861.
- Health Home showed $507,741 in revenue, and $372,597 in expenses, resulting in a net surplus of $135,144.
- SUD showed all funding source revenue of $7,102,768, and $5,851,495 in expenses, resulting in a net surplus of $1,251,273. Total PA2 funds were reported as $5,341,057.

MOTION BY LAURI FISCHER TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2022; SUPPORT BY ALLISON NICHOLSON. MOTION APPROVED.

EDIT UPDATE
The minutes from January 19th were included in the meeting materials.
- CLS and Music Therapy – Although these have historically been billed at the same time, MDHHS' policy states that billing two services, CLS and a clinical service, is not allowed to occur at the same time. The clinical service would be billed and not the CLS time.

DRAFT

- CLS and Other Services – It was asked whether CLS can be billed when clinical services are being provided in the consumer's home via telehealth. Currently, MDHHS policy is that this is not allowed; special exceptions may be considered for the waiver population in the future.
- Housing Support Benefit/CCBHC – It was determined that the housing service is allowed to be for CCBHC as it is a unique benefit under the 1915(i).
- Consideration for the Allowance of Biofeedback/Neurofeedback as an Allowable Modality for Therapy – Codes 90901, 90875, and 90876 will not be added at this time.
- Independent Facilitation and Wraparound – MDHHS will send a request for feedback to the EDIT group.
- Telemedicine Update – The PHE is currently scheduled to end on May 11, 2023; the final Telemedicine Policy will go into effect one day after the end of the PHE.
- EQI Update – The period 3 template was distributed at the end of December and is due to MDHHS by February 28th.
- COB Subgroup – The group continues to meet with the goal of collecting third party information payment for PIHP/CMHSP services.
- Update on the Status of Tiered Rate for Licensed Residential Services – The workgroup continues to meet monthly. Preparations for a Q3 FY24 pilot are being made by getting feedback on the needs assessment and the comparison rates factors for residential settings.
- Code Chart Changes Subgroup – The group continues to work through the code chart; the Appendix group is scheduled to meet in early February.
- Supported Employment/"Applicable Experience" Concern from NorthCare – The question of what constitutes "Applicable Experience" was raised. A revision to the language was proposed. This topic will be discussed further during the April meeting.
- Peer Services and Modifiers – Clarification was made that beginning with FY23 "WR" modifier refers to Certified Peer Recovery Coach and the "WS" modifier refers to Certified Peer Support Specialist. Retroactive changes are not needed. Milliman will be notified that Q1 may not include these changes. It was further clarified that the effective date of the MSA 22-01 memo was April 1, 2022.
- Code Chart and Provider Qualifications Chart Updates – A January 3, 2023 update has been posted online.

The next EDIT meeting is scheduled for April 20th at 10:00AM.

FSR
Deanna reminded the CMHSPs that the FSR is due to the NMRE February 14th for submission to the state by February 28th.

EQI UPDATE
Deanna reminded the CMHSPs that reports are due to the NMRE by February 14th.

Lauri referenced the EQI reporting instructions which state:

> ***Final Direct-Run Clinical Cost Center Summary (CMHSP and Dual CMHSP/PIHP Only)***
> *This tab is optional to complete in SFY 2022 but will be required in future years for all CMHSPs. It is meant to be copied and pasted directly from the Standard Cost Allocation Tool tab of the same name. IF the CMHSP is not utilizing the SCA*

tool, this tab should be filled out using the tool or methodology that the CMHSP is using to comply with MDHHS' SCA requirements.

Because this tab is optional for FY22 and CMHAM has not agreed to use to the use of anything related to MDHHS' SCA, the decision was made to not complete this for the period 3 submission.

Clarification was made that "behavioral health home (BHH) and opioid health home (OHH) service expenditures and administrative expenditures should be listed under the "Other Expenses" tab (and not included on the Service UNC tab) per the EQI reporting instructions.

Lauri inquired about the change to the "COB Summary" which splits direct-run and network expenditures into distinct sections. Erinn clarified that the provider COB does not flow into the reconciliation, but CMHSP direct does flow into the reconciliation.

HSW 101 TRAINING FEEDBACK & OPEN SLOTS

A regional HSW Training was held at the University Center in Gaylord on January 26th. Although none of the CFOs attended, feedback from staff was that it was very helpful.

Deanna reminded the CMHSPs that there are currently 37 open HSW slots. Packets may be submitted to NMRE Clinical Services Director, Bea Arsenov.

OTHER

Amendment to Community Mental Health Services Programs 2023 Agreement

Ann shared an email she received from the Grants Division of MDHHS' Bureau of Grants and Purchasing regarding an Amendment to the FY23 CMHSP Agreement, Part II, Statement of Work to add C6.3.2.1B, "Mediation in Mental Health Dispute Resolution." The other CMHSPs confirmed that they, too, received the email and advised her to follow the "Next Steps" provided in the email.

MDHHS Fiscal Questionnaire

Ann referred to an email from Crystal Carrothers dated January 17th requesting that CMHSPs complete a "Fiscal Questionnaire." The other Boards responded that they intend to submit the questionnaire to EGrAMS (and email to Crystal) by the February 10th due date.

HCBS Non-Compliant Providers

Lauri shared that Northern Lakes has one individual remaining in a setting found to be non-compliant with the HCBS Final Rule; she relayed the particulars of the situation to the group. It was noted that the provider intends to reapply after March 17th. Chip advised that Lauri contact Brian Martinus and/or Eric Kurtz to request that Jeff Wieferich be contacted to see about retaining the individual's Medicaid.

NEXT MEETING

The next meeting was scheduled for March 8th at 10:00AM.

DRAFT

Chief Executive Officer Report

February 2023

This report is intended to brief the NMRE Board of the CEO's activities since the last Board meeting. The activities outlined are not all inclusive of the CEO's functions and are intended to outline key events attended or accomplished by the CEO.

Jan 25: Attended and participated in NMRE Internal Operations Committee meeting.

Jan 26: Attended and presented at Regional HSW training.

Jan 27: Attended and participated in PIHP Contract Negotiations meeting.

Jan 30: Attended and participated in NLCMHA/Munson Crisis Workgroup.

Feb 2: Attended and participated in MDHHS/PIHP CEO meeting.

Feb 2: Attended and participated in NLCMHA/Munson Crisis Workgroup.

Feb 3: Attended and participated in CMHAM Rural Issues Workgroup.

Feb 7 & 8: Attended CMHAM Winter Conference.

Feb 13: Attended and participated in NLCMHA County Administrators Group.

Feb 16: Presented at North Country Board Retreat.

Feb 17: Attended and participated in NLCMHA/Munson Crisis Workgroup.

Feb 21: Plan to Chair NMRE Regional Operations Committee meeting.

December 2022

Finance Report

December 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	2,422,948	10,911,722	9,302,629
Healthy Michigan	1,094,615	5,455,861	7,064,954
	$ 3,517,563	$ 16,367,583	$ 16,367,583

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	384,104	1,073,382	(9,511)	1,571,909	79,749	540,425	(122,495)	$ 3,517,563
Medicaid Carry Forward								16,367,583
Total Med/HMP Current Year Surplus								$ 19,885,146
Medicaid & HMP Internal Service Fund								16,367,583
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 36,252,729

Northern Michigan Regional Entity

Funding Source Report - PIHP
Mental Health
October 1, 2022 through December 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 47,506,220	$ 1,578,954						$ 49,085,174
CMHSP Distributions	(46,109,710)		15,062,211	12,682,505	7,800,548	6,526,419	4,038,026	-
1st/3rd Party receipts			115,543	-	-	-	-	115,543
Net revenue	1,396,510	1,578,954	15,177,754	12,682,505	7,800,548	6,526,419	4,038,026	49,200,717
Expense								
PIHP Admin	610,106	13,921						624,026
PIHP SUD Admin		19,207						19,207
SUD Access Center		14,802						14,802
Insurance Provider Assessment	429,281	9,851						439,132
Hospital Rate Adjuster	-							-
Services		1,019,027	15,080,163	11,563,354	7,930,460	5,994,402	4,093,195	45,680,601
Total expense	1,039,387	1,076,808	15,080,163	11,563,354	7,930,460	5,994,402	4,093,195	46,777,769
Net Actual Surplus (Deficit)	$ 357,124	$ 502,146	$ 97,591	$ 1,119,151	$ (129,912)	$ 532,017	$ (55,169)	$ 2,422,948

Notes
Medicaid ISF - $9,302,629 - based on Interim FSR
Medicaid Savings - $10,911,722

Northern Michigan Regional Entity

Funding Source Report - PIHP
Mental Health
October 1, 2022 through December 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 5,132,019	$ 3,221,803						$ 8,353,822
CMHSP Distributions	(5,004,058)		1,823,869	1,512,639	620,671	630,636	416,243	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	127,961	3,221,803	1,823,869	1,512,639	620,671	630,636	416,243	8,353,822
Expense								
PIHP Admin	61,578	34,266						95,843
PIHP SUD Admin		47,278						47,278
SUD Access Center		36,436						36,436
Insurance Provider Assessment	39,403	24,248						63,651
Hospital Rate Adjuster	-							-
Services		2,508,339	1,930,971	1,059,881	411,010	622,228	483,569	7,015,998
Total expense	100,981	2,650,567	1,930,971	1,059,881	411,010	622,228	483,569	7,259,207
Net Surplus (Deficit)	$ 26,980	$ 571,236	$ (107,102)	$ 452,758	$ 209,661	$ 8,408	$ (67,326)	$ 1,094,615

Notes

HMP ISF - $7,064,954 - based on Interim FSR
HMP Savings - $5,455,861

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	**$ 384,104**	**$ 1,073,382**	**$ (9,511)**	**$ 1,571,909**	**$ 79,749**	**$ 540,425**	**$ (122,495)**	**$ 3,517,563**
Medicaid & HMP Carry Forward								**16,367,583**
Total Med/HMP Current Year Surplus								**$ 19,885,146**
Medicaid & HMP ISF - based on Interim FSR								**16,367,583**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 36,252,729**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2022 through December 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 149,401		132,667	48,434	15,794	31,235	130,210	$ 507,741
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	149,401	-	132,667	48,434	15,794	31,235	130,210	507,741
Expense								
PIHP Admin	4,895							4,895
BHH Admin	9,362							9,362
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	-		132,667	48,434	15,794	31,235	130,210	358,340
Total expense	14,257	-	132,667	48,434	15,794	31,235	130,210	372,597
Net Surplus (Deficit)	$ 135,144	$ -	$ -	$ -	$ -	$ -	$ -	$ 135,144

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2022 through December 31, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,578,954	$ 3,221,803	$ 1,115,309	$ 873,879	$ 312,823	$ 7,102,768
Expense						
Administration	33,128	81,544	28,525	57,978		201,174
OHH Admin			31,462	-		31,462
Access Center	14,802	36,436	-	8,422		59,660
Insurance Provider Assessment	9,851	24,248	-			34,099
Services:						
Treatment	1,019,027	2,508,339	877,431	579,778	312,823	5,297,398
Prevention	-	-	-	208,814	-	208,814
ARPA Grant	-	-	-	18,888	-	18,888
Total expense	1,076,808	2,650,567	937,418	873,880	312,823	5,851,495
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 502,146	$ 571,236	$ 177,891	$ (0)	$ -	$ 1,251,273

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of
Revenues, Expenses, and Unspent Funds
October 1, 2022 through December 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 47,506,220	$ 1,578,954	$ -	$ 49,085,174
Medicaid Savings	-	-	-	-
Healthy Michigan	5,132,019	3,221,803	-	8,353,822
Healthy Michigan Savings	-	-	-	-
Health Home	507,741	-	-	507,741
Opioid Health Home	-	1,115,309	-	1,115,309
Substance Use Disorder Block Grant	-	873,879	-	873,879
Public Act 2 (Liquor tax)	-	312,822	-	312,822
Affiliate local drawdown	148,704	-	-	148,704
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	-	-	-
Veteran Navigator Grant	26,726	-	-	26,726
SOR Grant Revenue	-	375,142	-	375,142
Gambling Grant Revenue	-	-	-	-
Other Revenue	960	-	2,025	2,985
Total operating revenue	53,322,370	7,477,909	2,025	60,802,304
Operating expenses				
General Administration	751,912	185,501	-	937,413
Prevention Administration	-	28,829	-	28,829
OHH Administration	-	31,462	-	31,462
BHH Administration	9,362	-	-	9,362
Insurance Provider Assessment	942,555	63,013	-	1,005,568
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	44,371,437	1,019,027	-	45,390,464
Healthy Michigan Services	4,489,536	2,508,339	-	6,997,875
Health Home Services	358,340	-	-	358,340
Opioid Health Home Services	-	877,431	-	877,431
Community Grant	-	579,778	-	579,778
Prevention	-	179,985	-	179,985
State Disability Assistance	-	-	-	-
ARPA Grant	-	18,888	-	18,888
Public Act 2 (Liquor tax)	-	312,823	-	312,823
Local PBIP	-	-	-	-
Local Match Drawdown	148,704	-	-	148,704
Miscellanous Grant	-	-	-	-
Veteran Navigator Grant	26,726	-	-	26,726
SOR Grant Expenses	-	375,141	-	375,141
Gambling Grant Expenses	-	-	-	-
Total operating expenses	51,098,572	6,180,217	-	57,278,789
CY Unspent funds	2,223,798	1,297,692	2,025	3,523,515
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	18,188,965	8,586,378	16,365,593	43,140,936
Unspent funds - ending	$ 20,412,763	$ 9,884,070	$ 16,367,618	$ 46,664,451

Northern Michigan Regional Entity

Statement of Net Position

December 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 41,795,273	$ 9,303,865	$ 16,367,618	$ 67,466,756
Accounts Receivable	2,356,711	1,660,058	-	4,016,769
Prepaids	65,928	-	-	65,928
Total current assets	44,217,912	10,963,923	16,367,618	71,549,453
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	44,217,912	10,963,923	16,367,618	71,549,453
Liabilities				
Current liabilities				
Accounts payable	23,567,726	1,079,853	-	24,647,579
Accrued liabilities	237,423	-	-	237,423
Unearned revenue	-	-	-	-
Total current liabilities	23,805,149	1,079,853	-	24,885,002
Unspent funds	$ 20,412,763	$ 9,884,070	$ 16,367,618	$ 46,664,451

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2022 through December 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 46,938,177	$ 47,506,220	$ 568,043	1.21%
Carryover	11,400,000	11,400,000	-	(11,400,000)	(1)
Healthy Michigan					
Capitation	19,683,372	4,920,843	5,132,019	211,176	4.29%
Carryover	5,100,000	5,100,000	-	(5,100,000)	(100.00%)
Health Home	1,451,268	362,817	507,741	144,924	39.94%
Affiliate local drawdown	594,816	148,704	148,704	-	0.00%
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	27,501	26,726	(775)	(2.82%)
Other Revenue	-	-	960	960	0.00%
Total operating revenue	227,426,695	68,898,042	53,322,370	(15,575,672)	(22.61%)
Operating expenses					
General Administration	3,591,836	895,314	751,912	143,402	16.02%
BHH Administration	-	-	9,362	(9,362)	0.00%
Insurance Provider Assessment	1,897,524	474,381	942,555	(468,174)	(98.69%)
Hospital Rate Adjuster	4,571,328	1,142,832	-	1,142,832	100.00%
Local PBIP	1,737,753	-	-	-	0.00%
Local Match Drawdown	594,816	148,704	148,704	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	22,929	26,726	(3,797)	(16.56%)
Payments to Affiliates:					
Medicaid Services	176,618,616	44,154,654	44,371,437	(216,783)	(0.49%)
Healthy Michigan Services	17,639,940	4,409,985	4,489,536	(79,551)	(1.80%)
Health Home Services	1,415,196	353,799	358,340	(4,541)	(1.28%)
Total operating expenses	208,177,013	51,602,598	51,098,572	504,026	0.98%
CY Unspent funds	$ 19,249,682	$ 17,295,444	2,223,798	$ (15,071,646)	
Transfers in			-		
Transfers out			-	51,098,572	
Unspent funds - beginning			18,188,965		
Unspent funds - ending			$ 20,412,763	2,223,798	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2022 through December 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 1,169,658	$ 1,578,954	$ 409,296	34.99%
Healthy Michigan	11,196,408	2,799,102	3,221,803	422,701	15.10%
Substance Use Disorder Block Grant	6,467,905	1,616,975	873,879	(743,096)	(45.96%)
Opioid Health Home	3,419,928	854,982	1,115,309	260,327	30.45%
Public Act 2 (Liquor tax)	1,533,979	-	312,822	312,822	0.00%
Miscellanous Grants	4,000	1,000	-	(1,000)	(100.00%)
SOR Grant	2,043,984	510,996	375,142	(135,854)	(26.59%)
Gambling Prevention Grant	200,000	50,000	-	(50,000)	(100.00%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	7,002,713	7,477,909	475,197	6.79%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	255,645	185,501	70,144	27.44%
Prevention Administration	118,428	29,607	28,829	778	2.63%
Insurance Provider Assessment	113,604	28,401	63,013	(34,612)	(121.87%)
Medicaid Services	3,931,560	982,890	1,019,027	(36,137)	(3.68%)
Healthy Michigan Services	10,226,004	2,556,501	2,508,339	48,162	1.88%
Community Grant	2,074,248	518,562	579,778	(61,216)	(11.80%)
Prevention	634,056	158,514	179,985	(21,471)	(13.55%)
State Disability Assistance	95,215	23,809	-	23,809	100.00%
ARPA Grant	-	-	18,888	(18,888)	0.00%
Opioid Health Home Admin	-	-	31,462	(31,462)	0.00%
Opioid Health Home Services	3,165,000	791,250	877,431	(86,181)	(10.89%)
Miscellanous Grants	4,000	1,000	-	1,000	100.00%
SOR Grant	2,043,984	510,996	375,141	135,855	26.59%
Gambling Prevention	200,000	50,000	-	50,000	100.00%
PA2	1,533,978	-	312,823	(312,823)	0.00%
Total operating expenses	25,222,653	5,907,175	6,180,217	(273,042)	(4.62%)
CY Unspent funds	$ 4,322,183	$ 1,095,538	1,297,692	$ 202,155	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			8,586,378		
Unspent funds - ending			$ 9,884,070		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2022 through December 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 480,453	$ 409,981	$ 70,472	14.67%
Fringes	666,212	158,406	136,790	21,616	13.65%
Contractual	683,308	170,829	110,865	59,964	35.10%
Board expenses	18,000	4,500	2,816	1,684	37.42%
Day of recovery	14,000	9,000	-	9,000	100.00%
Facilities	152,700	38,175	34,361	3,814	9.99%
Other	135,804	33,951	57,099	(23,148)	(68.18%)
Total General Admin	$ 3,591,836	$ 895,314	$ 751,912	$ 143,402	16.02%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2022 through December 31, 2022

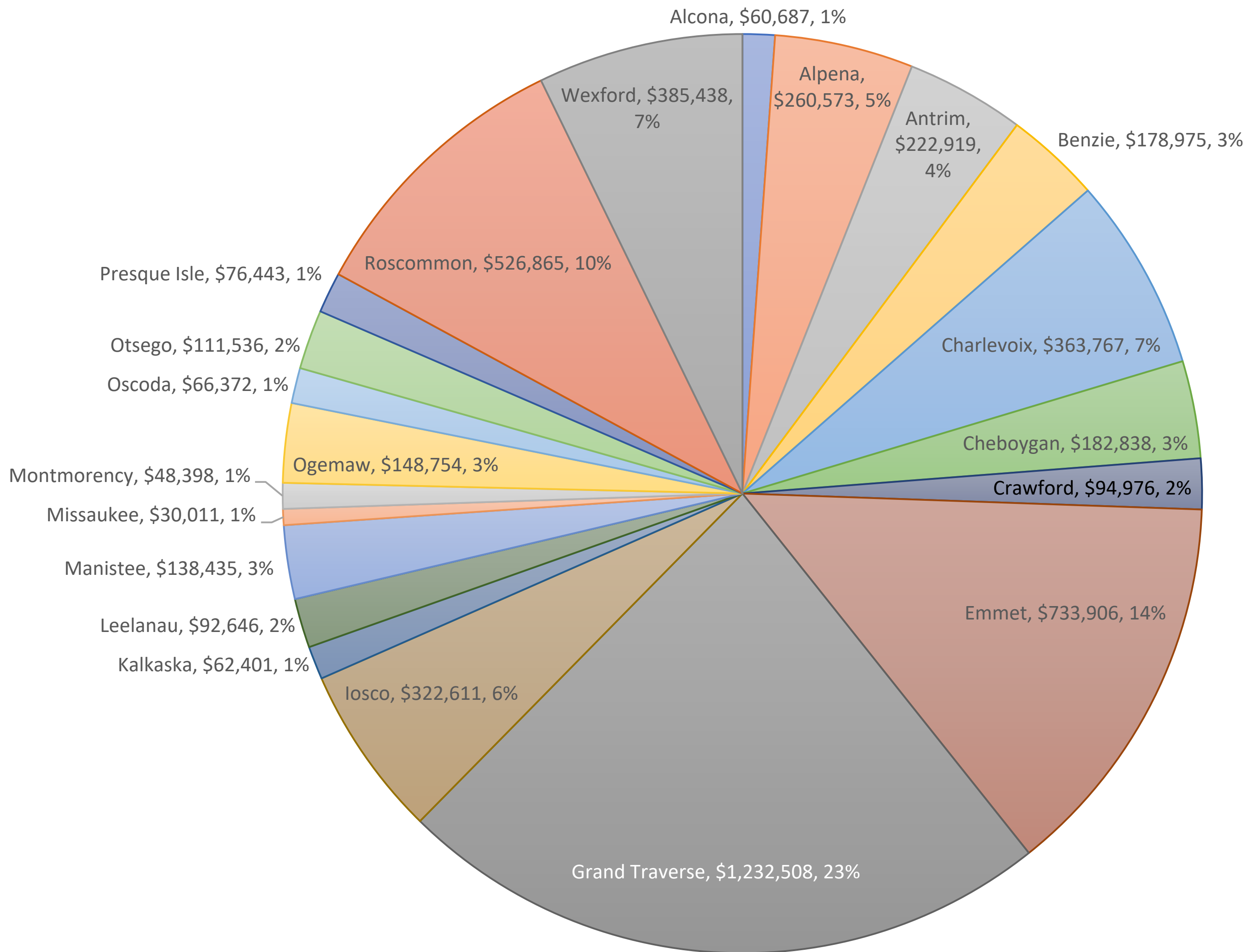
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 502,752	$ 125,688	$ 73,339	$ 52,349	41.65%
Fringes	145,464	36,366	19,019	17,347	47.70%
Access Salaries	220,620	55,155	44,472	10,683	19.37%
Access Fringes	67,140	16,785	15,188	1,597	9.51%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	18,750	28,561	(9,811)	(52.33%)
Board expenses	5,000	1,251	1,130	121	9.67%
Facilities	-	-	-	-	0.00%
Other	12,600	1,650	3,792	(2,142)	(129.82%)
Total operating expenses	$ 1,082,576	$ 255,645	$ 185,501	$ 70,144	27.44%

Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2022 through December 31, 2022

	Projected FY23 Activity				Actual FY23 Activity			
	Beginning Balance	FY23 Projected Revenue	FY23 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
						Actual Expenditures by County		
County								
Alcona	$ 59,376	$ 20,389	$ 4,410	$ 75,355	$ 3,048	1,736	$ -	$ 60,687
Alpena	263,254	69,040	45,317	286,976	10,701	13,382	-	260,573
Antrim	219,249	59,729	80,820	198,158	9,075	5,405	-	222,919
Benzie	173,705	52,923	14,857	211,771	8,217	2,947	-	178,975
Charlevoix	359,548	89,334	110,699	338,183	13,685	9,466	-	363,767
Cheboygan	191,247	74,954	138,728	127,472	11,422	19,830	-	182,838
Crawford	92,406	31,228	17,903	105,731	4,902	2,333	-	94,976
Emmet	716,610	155,245	115,175	756,679	24,999	7,703	-	733,906
Grand Traverse	1,282,987	406,430	1,234,676	454,741	61,007	111,485	-	1,232,508
Iosco	329,202	70,865	180,735	219,332	10,979	17,570	-	322,611
Kalkaska	74,226	31,700	83,823	22,103	5,320	17,145	-	62,401
Leelanau	102,658	56,613	117,817	41,454	8,508	18,520	-	92,646
Manistee	131,924	68,873	10,407	190,390	10,608	4,097	-	138,435
Missaukee	37,771	18,044	48,883	6,931	2,797	10,557	-	30,011
Montmorency	54,974	27,338	42,322	39,990	3,920	10,496	-	48,398
Ogemaw	154,130	50,286	142,919	61,497	8,557	13,933	-	148,754
Oscoda	65,061	20,039	36,568	48,532	2,701	1,390	-	66,372
Otsego	108,477	88,483	94,620	102,340	13,434	10,375	-	111,536
Presque Isle	75,221	22,256	5,450	92,027	3,367	2,145	-	76,443
Roscommon	524,550	74,697	72,090	527,157	11,202	8,887	-	526,865
Wexford	396,468	79,925	108,457	367,936	12,392	23,422	-	385,438
	5,413,044	1,568,386	2,706,676	4,274,754	240,837	312,824	-	5,341,057
PA2 Redirect								-
								5,341,057


PA2 Funds by County
Alcona, $60,687, 1%
Alpena, $260,573, 5%
Antrim, $222,919, 4%
Benzie, $178,975, 3%
Charlevoix, $363,767, 7%
Cheboygan, $182,838, 3%
Crawford, $94,976, 2%
Emmet, $733,906, 14%
Grand Traverse, $1,232,508, 23%
Iosco, $322,611, 6%
Kalkaska, $62,401, 1%
Leelanau, $92,646, 2%
Manistee, $138,435, 3%
Missaukee, $30,011, 1%
Montmorency, $48,398, 1%
Ogemaw, $148,754, 3%
Oscoda, $66,372, 1%
Otsego, $111,536, 2%
Presque Isle, $76,443, 1%
Roscommon, $526,865, 10%
Wexford, $385,438, 7%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2022 through December 31, 2022

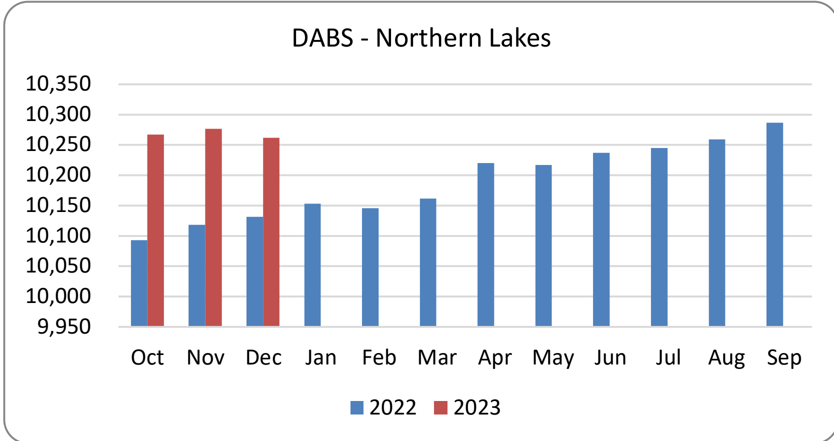
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	1,875	2,025	150	8.00%
Total operating revenue	7,500	1,875	2,025	150	8.00%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 1,875	2,025	$ 150	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,365,593		
Unspent funds - ending			$ 16,367,618		

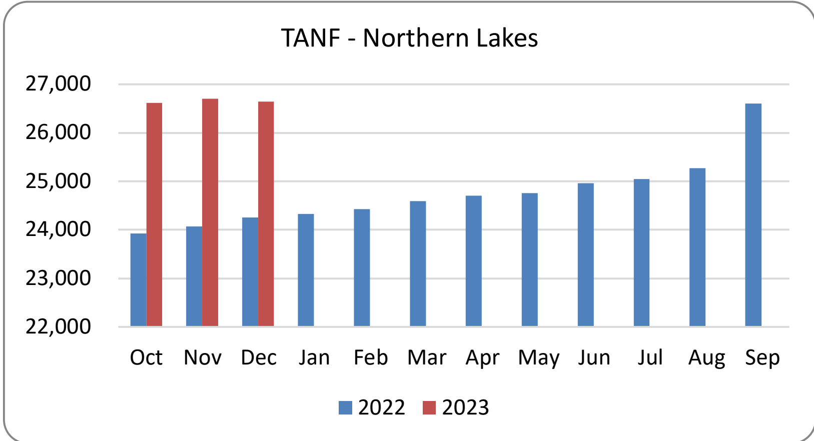
Northern Michigan Regional Entity

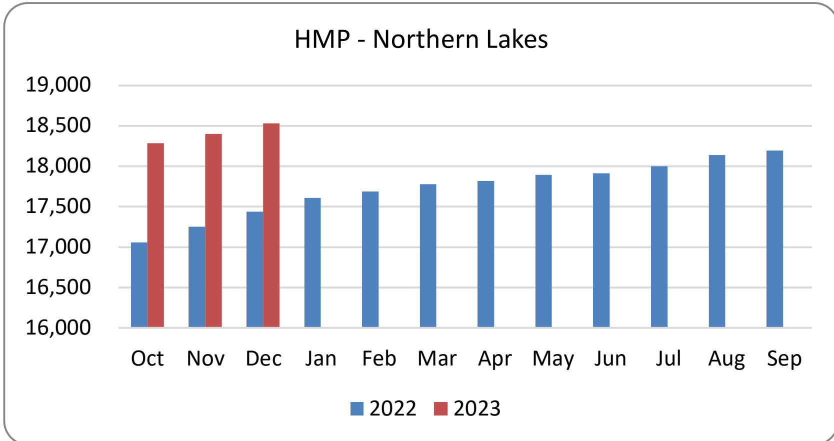
Narrative

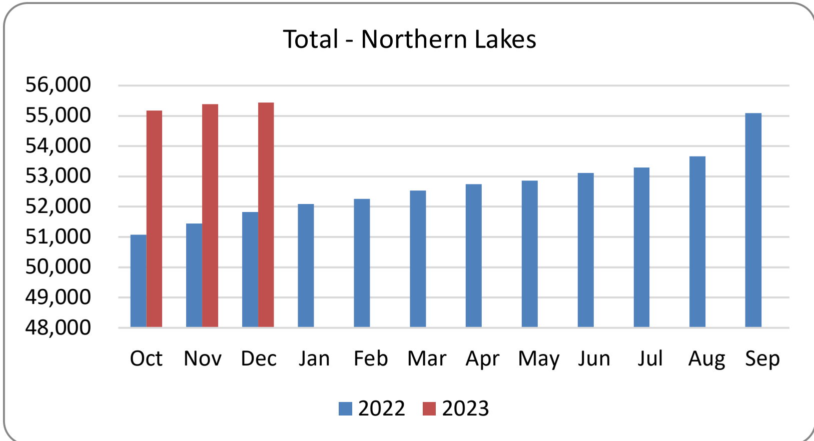
October 1, 2022 through December 31, 2022

Northern Lakes Eligible Trending - based on payment files







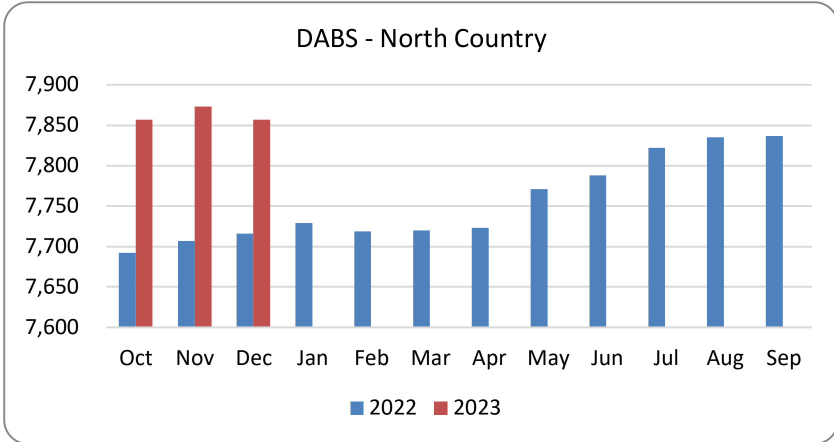


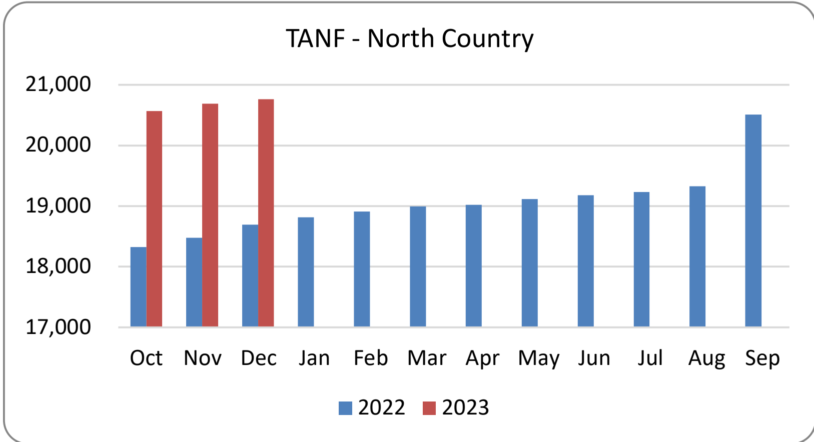
Northern Michigan Regional Entity

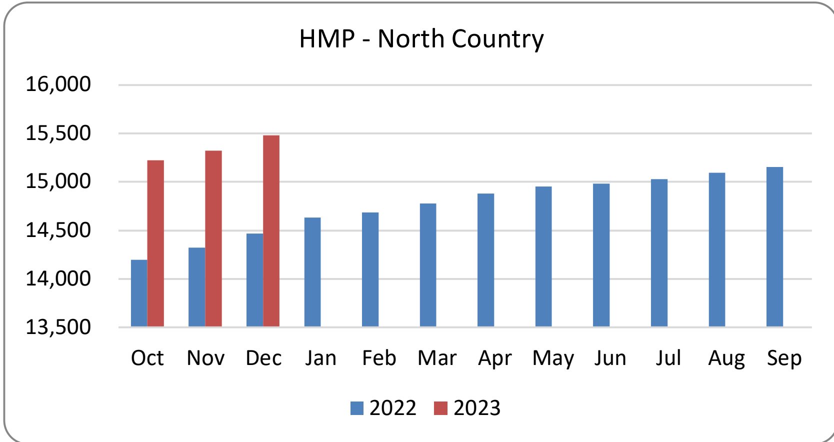
Narrative

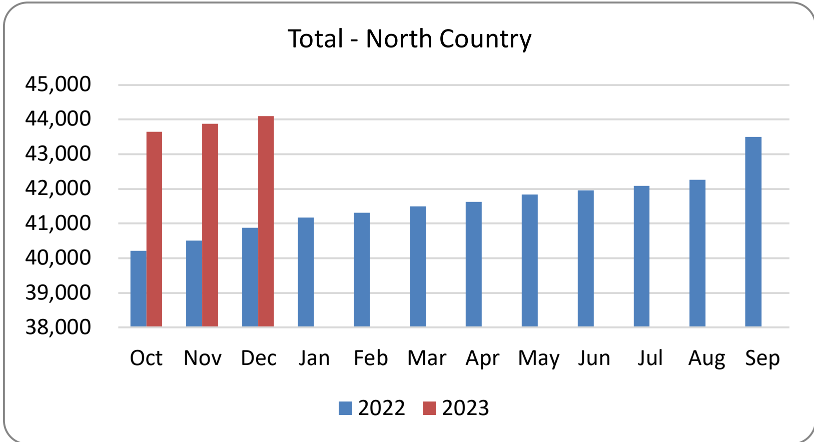
October 1, 2022 through December 31, 2022

North Country Eligible Trending - based on payment files







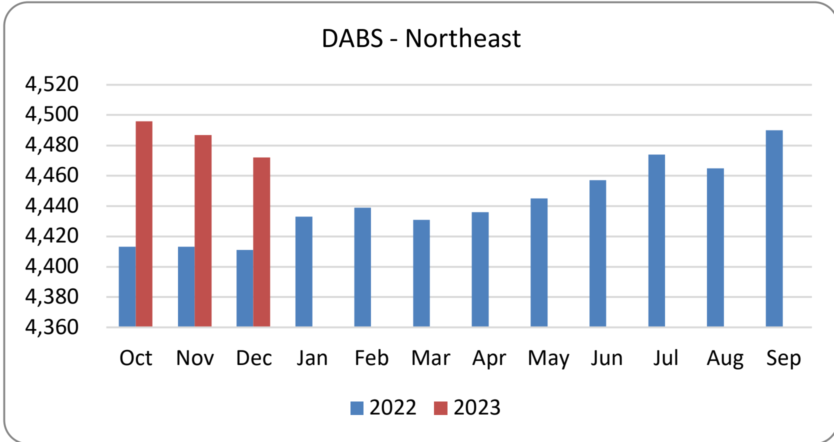


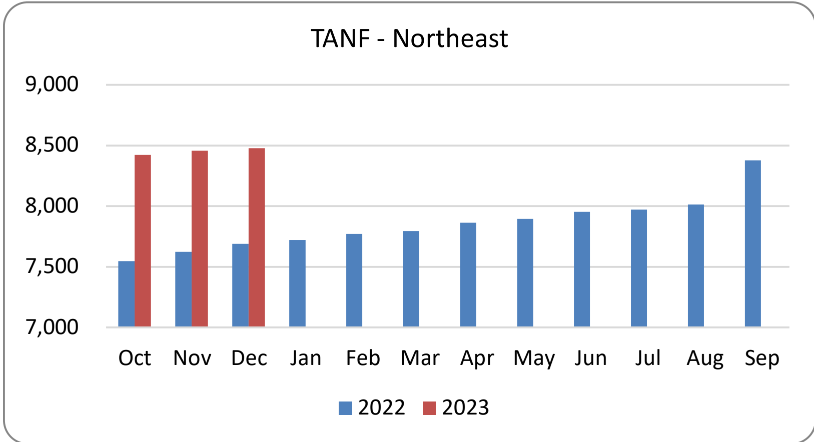
Northern Michigan Regional Entity

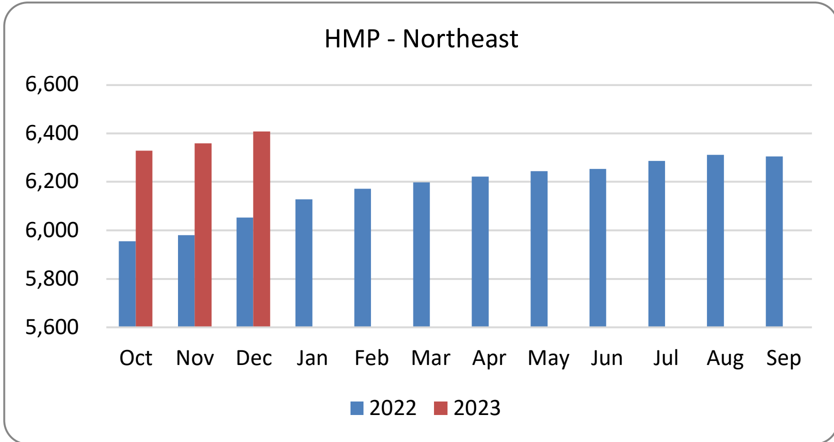
Narrative

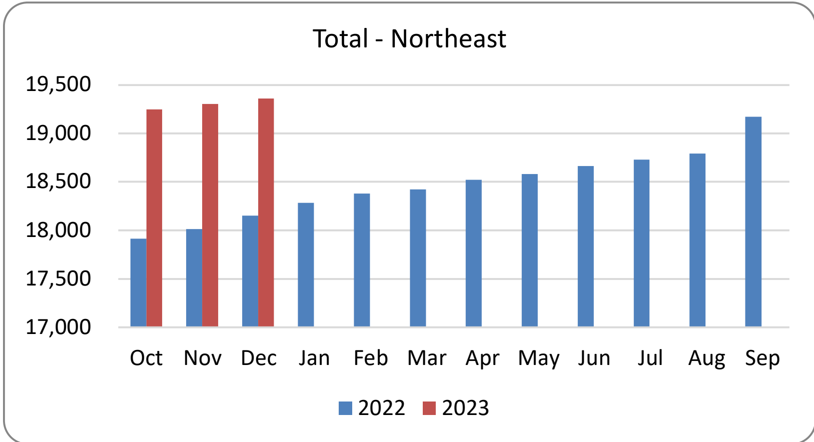
October 1, 2022 through December 31, 2022

Northeast Eligible Trending - based on payment files







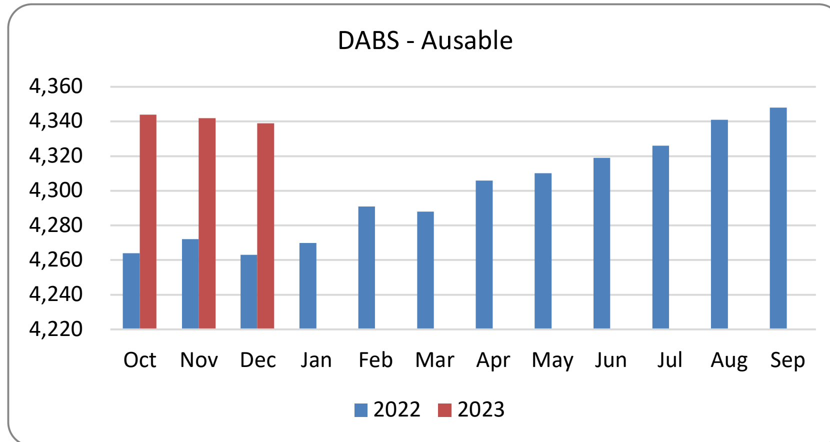


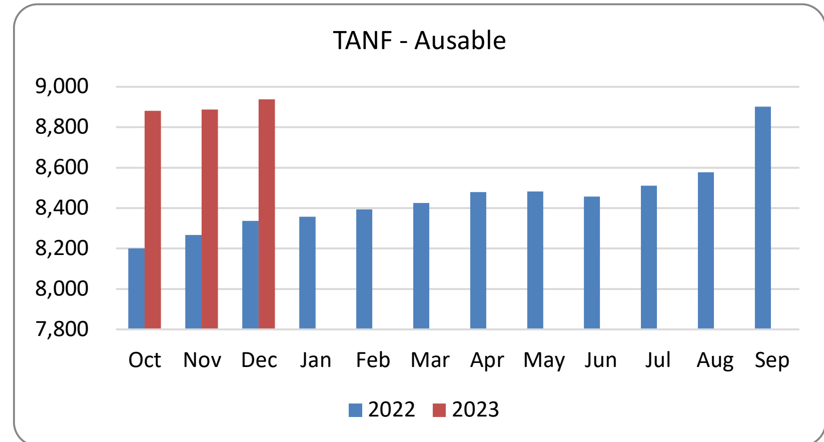
Northern Michigan Regional Entity

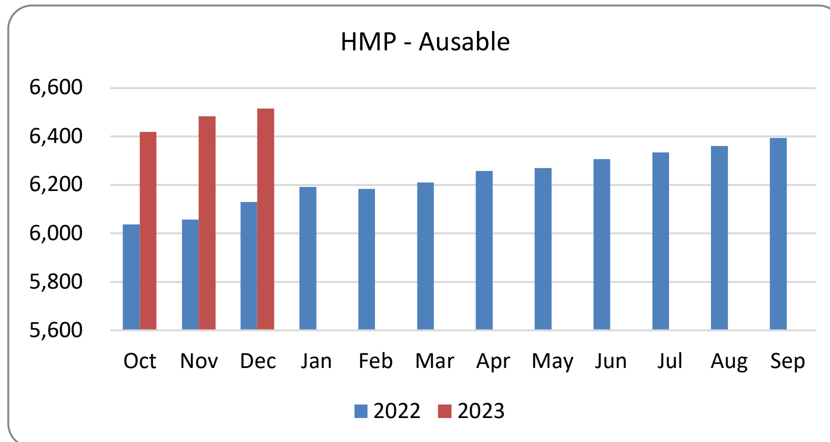
Narrative

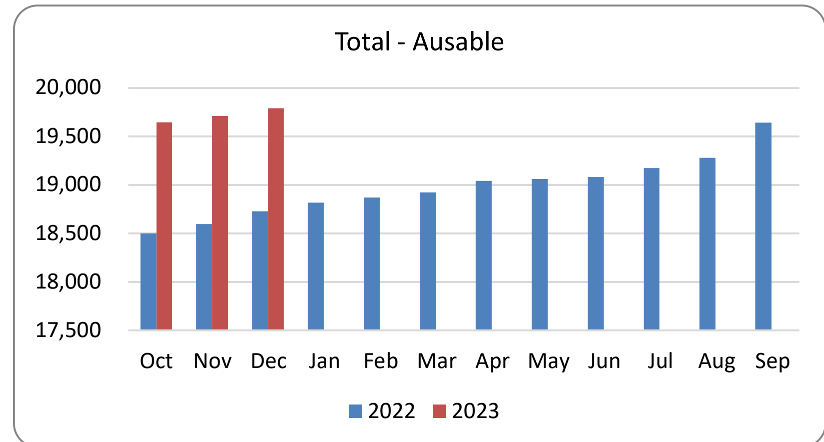
October 1, 2022 through December 31, 2022

Ausable Valley Eligibles Trending - based on payment files







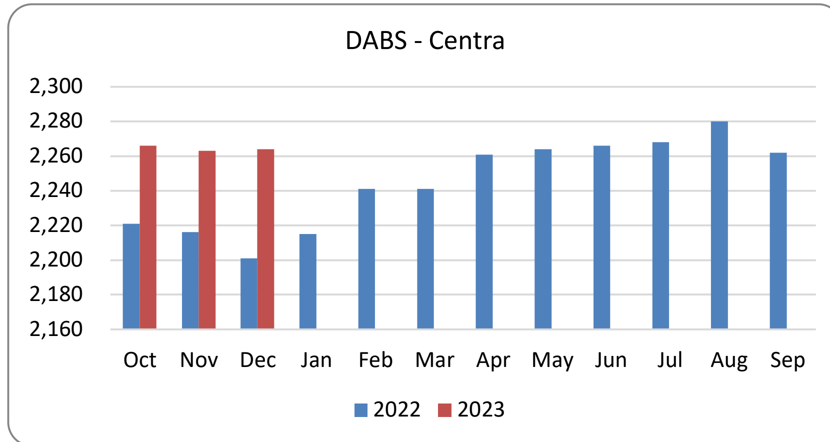


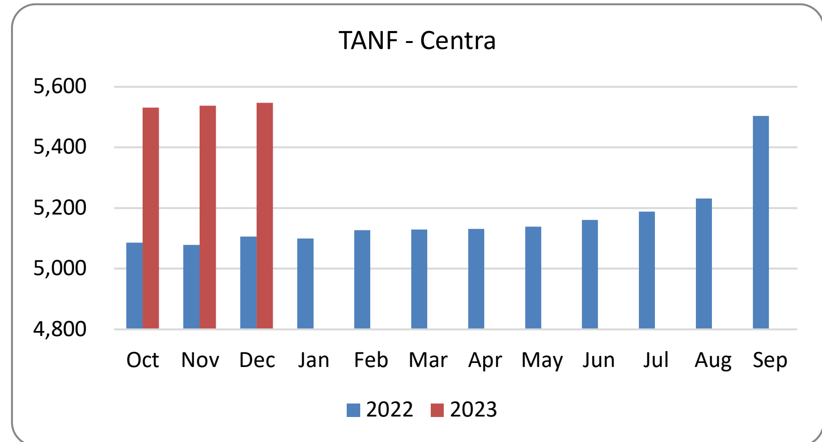
Northern Michigan Regional Entity

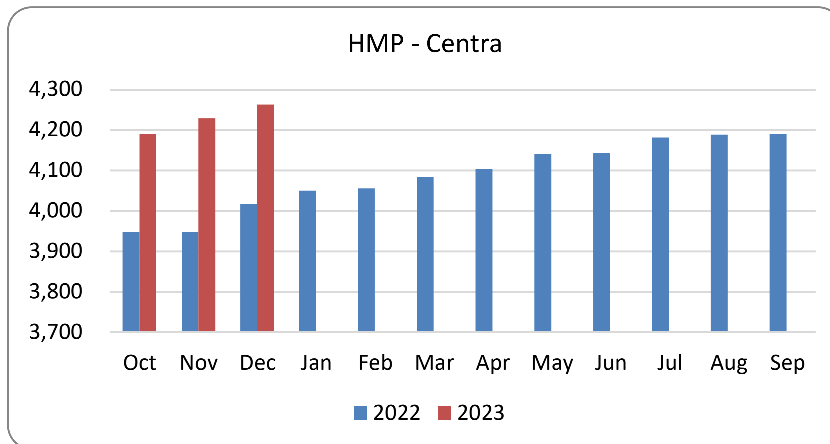
Narrative

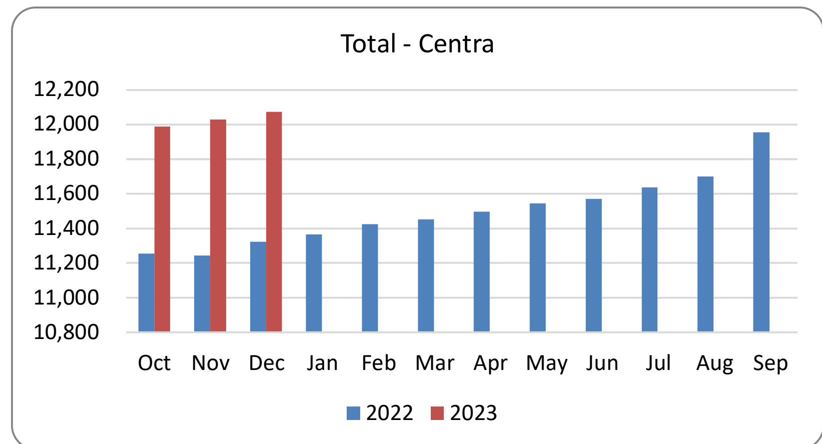
October 1, 2022 through December 31, 2022

Centra Wellness Eligibles Trending - based on payment files







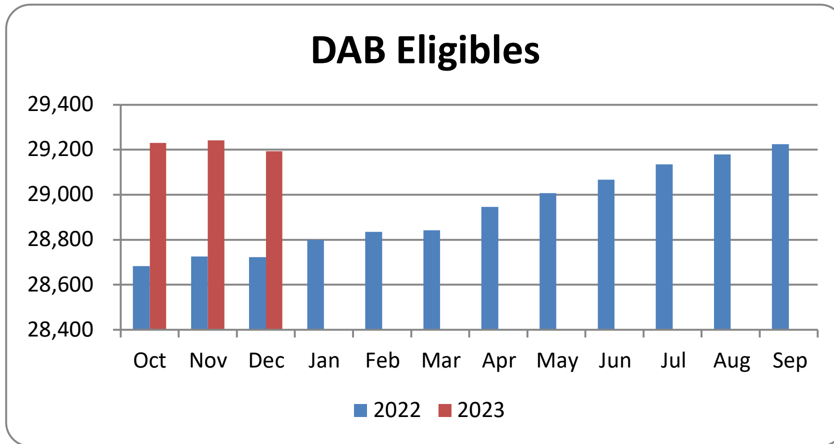


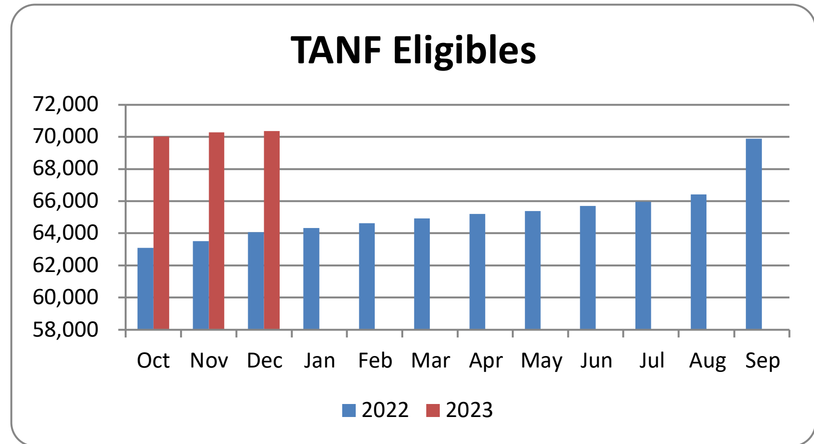
Northern Michigan Regional Entity

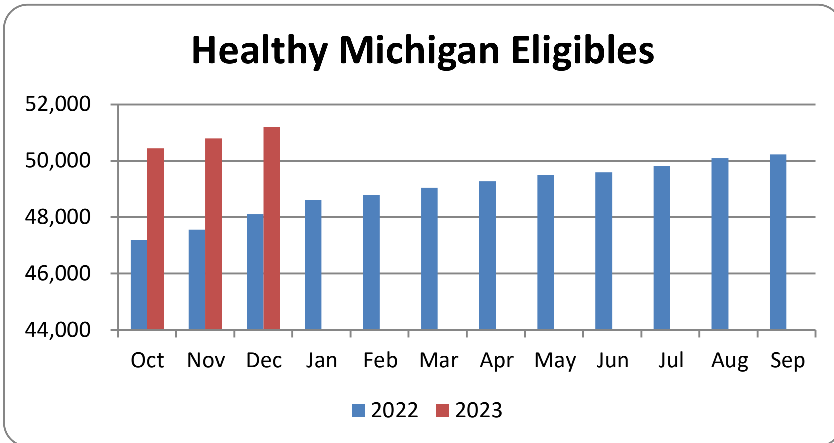
Narrative

October 1, 2022 through December 31, 2022

Regional Eligible Trending







Northern Michigan Regional Entity

Narrative

October 1, 2022 through December 31, 2022

Regional Revenue Trending