Northern Michigan Regional Entity

Board Meeting

May 25, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
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3.	Pledge of Allegiance	
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5.	Approval of Agenda	
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11.	New Business	
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12.	Old Business	
	b. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest	
13.	Presentation/Discussion	
	NMRE FY21 Financial Audit – Derek Miller, RPC	Pages 95 – 101
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – May 25, 2022 at 10:00 am	
16.	Adjourn	

Join Microsoft Teams Meeting

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – APRIL 27, 2022
GAYLORD BOARDROOM

ATTENDEES:	**Roger Frye, Ed Ginop, Gary Klacking, Terry Larson, Mary Marois, Gary Nowak, Jay O'Farrell, Justin Reed, Richard Schmidt, Karla Sherman, Don Smeltzer, Joe Stone, Don Tanner**
ABSENT:	**Christian Marcus**
NMRE/CMHSP STAFF:	**Joanie Blamer, Eugene Branigan, Christine Gebhard, Eric Kurtz, Diane Pelts, Brandon Rhue, Tricia Wurn, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Marie Fielder, Brandon, Hausbeck, Andrew Keller, Samantha Mishra, Carter Severs, Justin Severs, 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 Christian Marcus was absent from the meeting on this date; all NMRE Board Members were in attendance either in Gaylord or remotely.

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 requested.

MOTION BY ROGER FRYE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR APRIL 27, 2022 AS AMENDED; SUPPORT BY JOE STONE. MOTION CARRIED.

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

MOTION BY KARLA SHRMAN TO APPROVE THE MINUTES OF THE MARCH 23, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY MARY MAROIS. MOTION CARRIED.

CORRESPONDENCE
1) The minutes from the April 7, 2022 PIHP CEO meeting.
2) A letter to Eric Kurtz dated March 29, 2022 from Jackie Sproat reporting that the NMRE's FY22 Risk Management Strategy was determined to be in compliance.
3) MDHHS's Michigan Psychiatric Care Improvement Project (MPCIP) April 2022 Update.

4) Slides from the MDHHS Conflict-Free Access and Planing Workgroup's Update on State Reorganization presentation to PIHP CEOs dated April 7, 2022.
5) Slides from MDHHS Behavioral and Physical Health and Aging Services Administration Section 1513 Inpatient Tiered Rate Workgroup Update dated April 7, 2022.
6) Letter to Eric Kurtz dated April 7, 2022 from Belinda Hawks announcing the results from the March 22, 2022 State Opioid Response (SOR) grant virtual site visit; the NMRE was determined to be in compliance.
7) Correspondence announcing Southwest Michigan Behavioral Health's intent to Withdraw from MI Health Link Demonstration effective December 31, 2022.
8) Correspondence from Community Mental Health Association of Michigan's (CMHAM) titled, "Summary of Advocacy Efforts to Ensure the Strength and Survival of Michigan's Public Mental Health System in the Face of Legislative Threat" dated April 2022.
9) Announcement from Health and Human Services Office if the Assistant Secretary for Preparedness and Response extending the Federal Public Health Emergency to July 15, 2022.
10) Email correspondence from NMRE Provider Network Manager, Chris VanWagoner, announcing the NMRE's issuance of a Request for Proposals for American Rescue Plan Act (ARPA) grant funds to be used for identified substance use disorder prevention, treatment, and recovery support services.
11) Northern Michigan Regional Entity Q1 FY22 regional performance indicator report.
12) Flyer promoting the NMRE Day of Education scheduled for May 22, 2022 at Treetops Resort in Gaylord.
13) Draft minutes of the April 13, 2022 NMRE Regional Finance Committee meeting.

Mr. Kurtz underscored that the NMRE was found to be in compliance wih the State Opioid Response (SOR) audit.

Southwest Michigan Behavioral Health's intention to withdraw from the State's dual eligible demonstration effective January 1, 2023 was discussed.

Mr. Stone offered to meet with Mr. Kurtz about the Association's position in advocating for the PIHIPs (PIHP structure) in response to the system transformation bills.

Ms. Gebhard asked whether the NMRE Region is represented on the Conflict-Free Access and Planing Workgroup. Mr. Kurtz responded that the workgroup recently resurfaced with TBD Solutions involved; he was unclear about he current representation but agreed that Region 2 representation is needed.

ANNOUNCEMENTS

Let the record show that Ms. Marois announced that Joanie Blamer was named Northern Lakes Chief Executive Officer. Marie Fielder, candidate for State Representative for the 106th District, introduced herself to the Board.

PUBLIC COMMENTS

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

REPORTS

Executive Committee Report

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

CEOs Report
The NMRE CEO Monthly Report for April 2022 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to his presentation to the Emmet County Board of Commissioners on April 21st.

Financial Report
March 2022

- Net Position* showed net surplus Medicaid and HMP of $8,910,933. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $25,269,050. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $41,067,167.
- Traditional Medicaid showed $82,905,388 in revenue, and $73,350,750 in expenses, resulting in a net surplus of $9,554,638. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $12,890,175 in revenue, and $10,562,014 in expenses, resulting in a net surplus of $2,328,160. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $572,681 in revenue, and $426,233 in expenses, resulting in a net surplus of $146,448.
- SUD showed all funding source revenue of $9,977,841, and $7,987,460 in expenses, resulting in a net surplus of $1,990,381. Total PA2 funds were reported as $5,646,552.

Mr. Stone asked whether funds are available for major purchases (vehicles). Mr. Kurtz responded that it looks to be so; however he noted that purchases over $5K must be depreciated over 5 years. October 1, 2021 – March 31, 2022 revenue was reported as $1.9M above the same period in FY21.

MOTION BY GARY NOWK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR FEBRUARY 2022; SUPPORT BY ED GINOP. MOTION CARRIED.

Operations Committee Report
The draft minutes from April 19, 2022 were included in the materials for the meeting on this date. Mr. Kurtz spoke about the addition of a CFO "bench" and regional recruitment position to work with each CMHSP's HR department and create a centralized Job Bank on the NMRE website.

Mr. Tanner addressed the self-determination discussion that occurred during the April 19th Operations Committee meeting. Mr. Kurtz expressed that there was a breakdown in contract negotiations discussions. A joint PIHP/CFI workgroup worked with the Department to get the Self-Determination policy in place. In mid-December, during one of the Contract Amendment processes, the policy was agreed to; the Implementation Guide was placed on hold. Communication received from Department staff with MDHHS-PIHP Contract Amedment #4 included the Implementation Guide. Mr. Kurtz requested clarification and was informed that the self-determination policy was agreed to, but the Implementation guide has not been finalized (best practice). The workgroup that put the Implementation Guide together has been resurrected, to address issues raised (Brian Babbitt, North Country Chief Operating Officer/Compliance Officer sits on the workgroup). Ms. Blamer stressed that Finance (CFO) representation is also needed on the workgroup.

Ms. Marois asked for a summary of the CMHSPs' FY22 budget stabilizon/retention payments.

- Ms. Pelts reported that a COLA was given to AuSable Valley staff and two appreciation/retention payments are planned ((2 lump sum payments of $750 to coincide with holidays). Appreciation payments are not for provider staff; Providers must request stabilization payments.
- Ms. Gebhard reported that the North Country Board of Directors authorized up to $2M in retention payments; Providers have to apply. Additionally, North Country is looking at modifying its rate structure and is investigating offering health benefits to part-time staff.
- Ms. Sork reported that Northeast Michigan hasn't done anything yet for staff, but will likely do a percentage based retention payment toward the end of the year.
- Ms. Blamer reported that a 5% COLA was issued to staff on January 1st.
- Mr. Tanner reported that a 4% salary increase was implemented for Centra Wellness staff in April.

NMRE SUD Oversight Board Report
Let the record show that the next meeting of the Northern Michigan Regional Entity Substance Use Disorder Oversight Board is scheduled virtually for May 9, 2022 at 10:00AM.

NEW BUSINESS
NMRE Nominating Committee Report and Election of Officers
Let the record show that the NMRE Board Nominating Committee met virtually on April 25th to discuss the Election of Board Officers. Mr. Smeltzer reported that it was the recommendention of the Board Nominating Committee to reelect the current officers and maintain the current Members of the NMRE Executive Committee.

- Chair – Don Tanner
- Vice-Chair – Ed Ginop
- Secretary – Gary Nowak

Additional Members of the NMRE Board acting with the officers as the NMRE Executive Committee were stated as Mary Marois and Joe Stone.

Mr. Stone announced that he is moving out of the NMRE 21-county region in the near future; once he officially resigns from the NMRE Board, his position on the NMRE Executive Committee will be reassigned.

Let the record show that Mr. Tanner called three times for additional nominations; no additional nominations were declared.

MOTION BY JOE STONE TO APPROVE THE RECOMMENDATION OF THE NORTHERN MICHIGAN REGIONAL ENTITY NOMINATING COMMITTEE TO REAPPOINT THE CURRENT NORTHERN MICHIGAN REGIONAL ENTITY BOARD OFFICERS AND MEMBERS OF THE NORTHERN MICHIGAN REGIONAL ENTITY EXECUTIVE COMMITTEE FOR AN ADDITIONAL ONE-YEAR TERM; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Mid-Year COLA/Retention
Mr. Kurtz requested that the Board consider a midyear COLA for NMRE staff. A COLA of 2% would total $43,700; a COLA of 3% would total $66,000.

MOTION BY JOE STONE TO APPROVE A COST OF LIVING INCREASE TO NORTHERN MICHIGAN REGIONAL ENTITY STAFF AT THREE PERCENT (3%) FOR A TOTAL AMOUNT OF SIXTY-SIX THOUSAND DOLLARS ($66,000.00); SUPPORT BY MARY MAROIS. ROLL CALL VOTE.

"Yea" Votes: **R. Frye, E. Ginop, G. Klacking, T. Larson, M. Marois, G. Nowak, J. O'Farrell, J. Reed, R. Schmidt, K. Sherman, D. Smeltzer, J. Stone, D. Tanner**

"Nay" Votes: **Nil**

MOTION CARRIED.

OLD BUSINESS

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

Ms. Gebhard and Ms. Blamer attended the recent Northern Michigan Counties Meeting that also had Rep. Whiteford in attendance. Ms. Gebhard expressed that she feels our region is doing a good job of educating commissioners and representatives. Rep. Whiteford has offered nothing new but has expressed that she is open to additional changes. Ms. Gebhard feels Rep. Whiteford doesn't fully understand Managed Care or the current funding mechanism. She indicated that the latest substitution included some positive changes (much about self-determination.) A clear understanding of the rural exemption is lacking. It was noted that the proposed Administrative Services Organization (ASO) not a fiduciary.

PRESENTATION

Information Technology Security Assessment

Brandon Rhue was in attendance to present on the NMRE's independent IT Security Assessment. The NMRE received a security rating of 7.1, out of a possible 8.5 (83.5%).

Findings and Recommendations:

- ***Virus Protection*** – Antivirus protection was detected and up-to-date on each system.
- ***Classification*** – Strong passwords should be used at all levels, but should also increase in complexity as the device(s) becomes more critical to overall security.
- ***SpyWare*** – Antivirus and web filtering installations are working to reduce this security threat by blocking and detecting many SpyWare variants.
- ***External Exposure*** – No High or Critical vulnerabilities identified.
- ***System/Software Updates*** – 100% of reviewed workstations and servers are running supported versions of their operating systems.

A Periodic Security Assessment is scheduled for January 2023.

COMMENTS

Mr. Tanner called for any closing comments; none were expressed.

MEETING DATES

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on May 25, 2022.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:55AM.

PIHP CEO Meeting
May 5, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

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 Mental Health Authority)	Region 7
Anya Eliassen (Oakland Community Health Network)	Region 8
Dave Pankotai (Macomb County CMH Services)	Region 9

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie
Audrey Dick
Erin Emerson
Farah Hanley
Darrell Harden
Krista Hausermann
Belinda Hawks
Kristen Jordan
Leah Julian
Amy Kanouse
Brian Keisling
Phil Kurdunowicz
Kate Massey
Lindsay McLaughlin
Lindsey Naeyaert
Carrie Rheingans
Kelsey Schell
Brenda Stoneburner
Scott Wamsley
Keith White
Jeff Wieferich
Amanda Zabor

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

Evaluation Guidance for ASD Referrals

1. Phil Kurdunowicz reported that the misalignment between evaluation guidance and Medicaid policy is very specific to when a child has an identified need that may or may not be tied to autism spectrum disorder.
    a. The workgroup under the Autism Council has very specific suggestions that do not necessarily align with Medicaid policy.
    b. MDHHS is looking for input from the PIHPs.
2. The PIHPs reported that they had discussed the best process to provide that information for MDHHS.
    a. They suggested convening the PIHP Autism Leads in a short-term manner to gain their input.
    b. Phil Kurdunowicz stated that he has a meeting scheduled in May with the autism leads. He wanted to make sure that the Children's Bureau was connecting with the CEOs to raise the issue and build the relationship.
    c. The PIHPs said they appreciated being asked on the process.
        i. They also indicated it would be helpful if the Children's Bureau staff could send the questions about the evaluations to the autism spectrum disorder directors in advance.

HCBS Update

1. Belinda Hawks provided the HCBS update.
    a. Licensed residential work continues under a workgroup. They are currently scheduling provider interviews. The target interviewees include representatives of specialized residential services.
        i. MDHHS hopes to get these interviews scheduled for the summer and return the information to the workgroup going forward.
    b. Conflict-free access and planning meetings continue. These meetings are still in the inform phase. They are discussing concepts, other national models that could help inform the Michigan model, and then will be looking closely at what the current model in the state is. The inform phase also includes looking at how the self-assessment tool can help the workgroup better understand where to focus its efforts.
        i. The tool was released at the most recent meeting, and MDHHS requested volunteers to review the tool and provide feedback about it as a mechanism for understanding the current model.
    c. MDHHS has heard continued concern about provider network adequacy, particularly for some providers on heightened scrutiny. Specifically, those providers that have supported individuals with high needs who have restrictions in their settings due to said high needs.
        i. CMS has offered modifications that allow individualized restrictions. Providers are placed in heightened scrutiny status when the restrictions are setting-wide, and this leaves them potentially unable to receive Medicaid dollars.

ii. There are concerns that those providers might not overcome that heightened scrutiny status. MDHHS considered how best to support the PIHPs' work with those providers.
    1. MDHHS has called a meeting of the HCBS leads and PIHP CEOs to come together in June 2022 to bring those case-specific and provider-specific concerns to the discussion and come up with a support plan going forward.
    2. Midstate thanked MDHHS for this meeting.

d. MDHHS had collected concerns that the PIHPs and CMHs raised in calls back in February.
    i. One request was for the department to partner with the PIHPs/CMHs to consider flexibilities on provider qualifications and trainings.
    ii. MDHHS has been able to act on some of those concerns, though not all.
    iii. The department wants to request an ad hoc get together to discuss the concerns and proposed solutions.
    iv. MDHHS is meeting internally the week of May 8, 2022, to review and update the current spreadsheet with the initial response that MDHHS believes it can address, and then bring the PIHPs' and CMHs' voices to that conversation for discussion.
        1. Belinda Hawks requested the PIHPs bring any requested attendees to her attention through Cindy Gilpin, her administrative assistant.

e. A request came from the PIHPs previously to get MDHHS and the PIHPs aligned on the efforts for the External Quality Review (EQR) through the Health Services Advisory Group (HSAG) contract and site review process.
    i. MDHHS would like to address duplication or conflict if those issues exist.
    ii. MDHHS will talk it through and then invite the PIHPs to be a part of a discussion related to those raised concerns.
    iii. There had been an invitation from the PIHP Compliance Officers to MDHHS to have a representative in the compliance officer meetings going forward.

Public Health Emergency Unwind

1. Belinda Hawks shared that MDHHS was working with other programs to talk about the Public Health Emergency Unwind. There will be groups meeting to talk through communications to the providers. Webinars and a website will also be set up; the PIHPs should see invitations to participate in webinars.
2. Jeff Wieferich explained that MDHHS's request for the PIHPs during the Unwind would be to help MDHHS ensure that individuals currently receiving service through the PIHPs have updated addresses and current information.
    a. He asked that the PIHPs talk among their staff to determine what data the PIHPs would need to support this effort and inform enrollees of the restart of the redetermination process.

b. The PIHPs asked for clarification on how the unwind would proceed – would all beneficiaries be redetermined at once, or would it be rolling out during each individual's normal month?
    i. MDHHS responded that there would be more information soon, but the intent is to process renewals during the individual's eligibility month. For example, if the first month of the unwind were August 2022, they would process all individuals with an eligibility month of August first, then September, etc.

3. Erin Emerson shared that the current focus is getting the enrollees' addresses and contact information updated in MI Bridges. MDHHS does not want to send out redetermination packages to the wrong addresses and have individuals lose coverage because they did not receive the packet.

MPCIP & MI CAL Update

1. Krista Hausermann reported that all projects are moving ahead smoothly.
    a. She will provide a written update for June.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Erin Emmerson shared that she is watching the budget process and has noted that the budgets indicate interest in supporting these projects.
2. Erin Emmerson asked her team to provide the updates on their subject areas.
    a. Amy Kanouse reported on the CCBHCs. As of the week of May 1, 2022, there were over 30,000 Medicaid beneficiaries assigned to the CCBHCs, and 4400 without Medicaid assigned. All 13 demonstration sites have received full certification. That is more sites than in any other state participating in the demonstration.
    b. Lindsey Naeyaert reported on the Behavioral Health Homes; there so far were over 1100 individuals enrolled, ages 7 through 85. On May 1, 2022, the health homes expanded to three counties that included Livingston, Washtenaw, and Wayne. Two other regions (Lenawee and Monroe) will be joining in July 2022.
        i. Lindsey Naeyaert also shared that MDHHS would be hosting WSA training the week of May 8, 2022. There will also be limited-space Community Health Worker training for the regions with both behavioral and opioid health homes. It is a self-paced training through the Learning Management System. This will be offered starting in June.
    c. Lindsey Naeyaert shared that Promoting Integration of Primary and Behavioral Health Care (PIPBHC) is in year four of five. The work is now focusing on sustainability and how to continue services after the grant ends. MDHHS is working on site visit schedules to go over availability. Two counties are already seeing shared patient data, and MDHHS plans to bring in a third county, Barry County, to the integration as well.
    d. Kelsey Schell reported on the Opioid Health Homes. Over 2000 beneficiaries are now involved, and the Opioid Health Homes are now in 48 Michigan counties, and 7 of 10 PIHP

regions. There are beneficiaries with 35 different Health Home partners. Michigan is looking to expand the Opioid Health Home program statewide in FY 23. MDHHS has started communications with potential new PIHPs.

3. The PIHPs thanked the four for their leadership on these topics.

Information Request Processes from DHHS and Milliman

1. The PIHPs shared that they have received a lot of requests for data, and that it has been a struggle for their CFOs.
    a. The PIHPs would like to set up a meeting for the CFOs to be able to work with the department to set up a more efficient way to get the information MDHHS wants.
    b. MDHHS thanked the PIHPs for their feedback and agreed that MDHHS could improve at streamlining the data requests.
    c. The PIHPs want to help MDHHS get the information and data needed to make decisions, but they would like more efficiency. They want to make this process work better for everyone.

Opioid Settlement Roles and Responsibilities

1. The PIHPs repeated their request for a meeting with the CMHs and the Attorney General's office to discuss the roles and responsibilities of the PIHPs and CMHs in the opioid settlement process.
2. MDHHS reported that they had received confirmation from the Attorney General with a request that the PIHPs contact Matt Walker (WalkerM30@michigan.gov) so that they could work together directly to set up a time for a meeting.
    a. The PIHPs thanked MDHHS and said they would put together a poll among themselves to find a time so that Matt Walker is not juggling emails from 10 PIHPs at once.

PIHP Complex Care Management

1. The PIHPs wanted to follow up on a complex care management proposal they had submitted in May 2021.
    a. They re-raised the issue to Kate Massey and Farah Hanley in April.
    b. Both Farah Hanley and Kate Massey requested the PIHPs send that proposal to them.
    c. The PIHPs wanted it on record as delivered.
    d. The PIHPs will leave the timeline for addressing it to MDHHS, given the number of things happening at MDHHS.

Action Items

#	*Date Added*	*Action Item*	*Assigned To*	*Status*

COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN

APRIL REPORT

LAMBERT

CMHA – PR RESULTS SUMMARY

Summary of Work

PUBLIC RELATIONS

OVERVIEW

The key components of Lambert's integrated PR support include targeted media outreach, media relations, social media, creative support and strategic counsel.

All tactics are combined to focus on highlighting the need for continued support and funding for Michigan's public mental health system, and mental health resources CMHA and its partners provide Michigan residents.

- Developed **social media graphics and copy** for April
- Reviewed performance of **digital social media ads**
- Shared April **digital ads** with A. Bolter & R. Sheehan
- Monitored **Facebook comments** and developed responses
- Updated **social media tool kit** for local CMHA locations
- Managed **digital social media ads**
- Created **social media spotlight posts** to highlight advocacy participants
- Provided guidance on **opportunities** with IMG Media Group
- Provided guidance on **partnership opportunities** with Marx Layne
- Created **new ad graphics** for Gongwer and MIRS
- Contacted Gongwer and MIRS to **extend ads** through May
- Edited **Myths vs. Facts** infographic for A. Bolter
- Developed **pitch plan** for Mental Health Awareness Month in May
- **Ongoing communication** with R. Sheehan, A. Bolter regarding communication strategy
- **Monitored** for media coverage
- Prepared **March report**

Digital & Social

DIGITAL EFFORTS
OVERVIEW

INITIATIVES:
- In April, Lambert boosted select Facebook posts to further amplify the organic reach
- In April, Lambert also posted social media content organically to Facebook
- In May, Lambert will continue to boost select Facebook posts

FACEBOOK BOOSTED AD RESULTS
Impressions: 3,978

Engagements: 433

FACEBOOK TOTAL AD & ORGANIC RESULTS

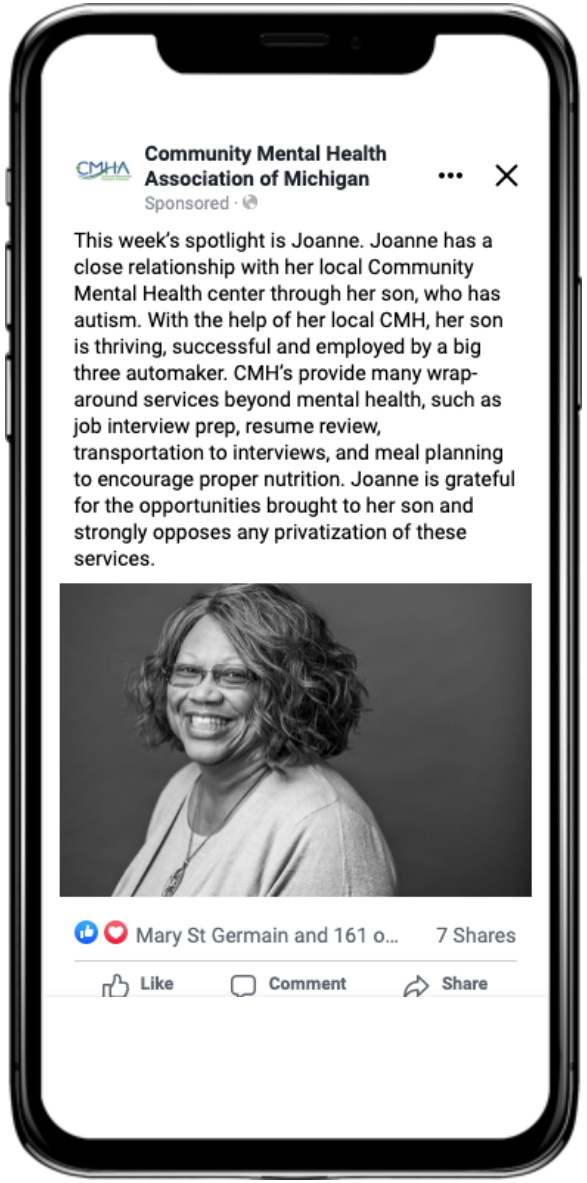
Page likes: 11 (4,687 total)

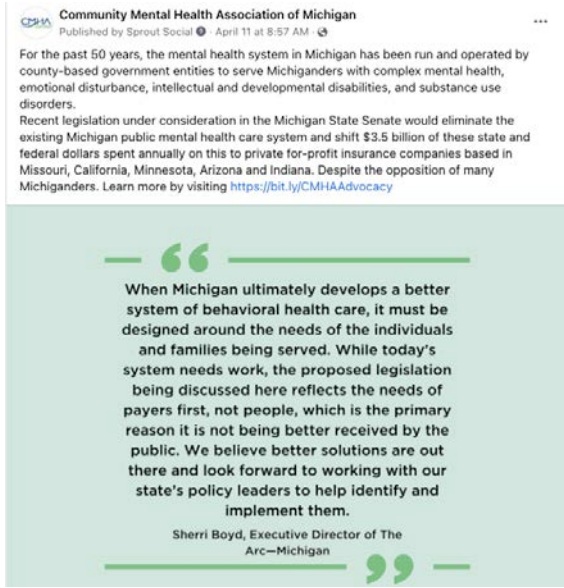
Impressions: 17,090

Engagements: 1,044

Post Link Clicks: 35

Video views: 169





Top Organic Post
Impressions: 2,153

Engagements: 234

Engagement Rate: 10.9%

A Look Ahead

MAY

- Manage **digital social media ads**
- Provide **social media graphics** for June
- Monitor **online Facebook comments**
- Review opportunities for additional **thought leadership pieces**
- Create **Myths vs Facts** booklet
- Monitor ad placements in Gongwer and MIRS
- **Continue pitching stories** to local and statewide media markets, including a Mental Health Awareness Month pitch
- Continue discussion on **Senator Shirkey's proposal** and PR strategy

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Reducing chaos during CMHA move by cancelling CMHA committee meetings during transition - June & July 2022
Date: Monday, May 9, 2022 9:08:16 AM
Importance: High

To: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons; CEOs of CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Reducing chaos during CMHA move by cancelling CMHA committee meetings during transition - June & July 2022

On behalf of CMHA and its staff, I want to thank you for your support, over the past several years, for our efforts to relocate the CMHA offices (and your support of many other bold initiatives). The **final outcomes of CMHA's relocation effort - leases as landlord and tenant - are far better than we had hoped**, providing us with **modern and professional offices and a very sound bottom line**. Thank you.

Reducing chaos during 2-month transition period: While this move is a strong step forward, the transition period – outlined below – created by this relocation leads to a considerable level of chaos and, to dampen that chaos, a change in the association's traditional committee meeting schedules.

Our lease with our tenants, Ingham County and the Ingham County Circuit Court (who will be leasing CMHA's entire building at 426 South Walnut), starts on June 1 and the lease for our new location starts on August 1. This leaves us with a 2-month gap without an office location. This gap was unavoidable in that the county needed a June 1 lease start so that they could renovate the building to be ready to hold court hearings this summer; with August 1 as our earliest move-in date at the new location due to renovation being done at our new location. These are not renovations in our offices, but in the lower level so that the Michigan Bankers Association staff can move to that lower level.

To reduce the chaos during this 2-month transition period, CMHA has developed a range of approaches: moving the copier (a key tool in our ramp up to the CMHA Summer Conference and a long list of trainings and events taking place during this transition period) to the new place in advance of June 1; installing wireless routers in the new location in advance of June 1; having CMHA staff work at home during the transition period and, for some who cannot work at home, CMHA has found them a place to work for those two months (thank you to the Mid-State Health Network for allowing us to use their space for two of our staff to work during this period); transferring mail delivery to CMHA's new location, at 507 South Grand, as of June 1, even though CMHA will not be in that location until August 1. The Michigan Bankers Association, our new landlord/partner, has agreed to sort and hold our mail for us to pick up.

In addition to these steps, the **CMHA Officers and leadership have determined that is wise to not hold CMHA committee meetings during two-month – June and July - transition period**: This set of cancellations, during this 2-month transition period, will dramatically reduce the chaos that CMHA will be experiencing during this 2-month "homeless" transition period. Note that CMHA has traditionally cancelled the July Steering Committee meeting, given the lack of agenda items. Additionally, the agendas for the June committee meetings are

light or empty.

With a strong June Board meeting at the Summer Conference, the CMHA Officers and leadership do not see this temporary break from summer committee meetings to be harmful to the association's operations nor sense of ownership by its members.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
426 South Walnut Street, Lansing MI 48933
517.374.6848 main
517.237.3142 direct
517.374.1053 fax
cmham.org

email correspondence

From: Monique Francis <MFrancis@cmham.org>
Sent: Monday, May 9, 2022 9:08 AM
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Reducing chaos during CMHA move by cancelling CMHA committee meetings during transition - June & July 2022

Importance: High

To: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons; CEOs of CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Reducing chaos during CMHA move by cancelling CMHA committee meetings during transition - June & July 2022

On behalf of CMHA and its staff, I want to thank you for your support, over the past several years, for our efforts to relocate the CMHA offices (and your support of many other bold initiatives). The **final outcomes of CMHA's relocation effort - leases as landlord and tenant - are far better than we had hoped**, providing us with **modern and professional offices and a very sound bottom line**. Thank you.

Reducing chaos during 2-month transition period: While this move is a strong step forward, the transition period – outlined below – created by this relocation leads to a considerable level of chaos and, to dampen that chaos, a change in the association's traditional committee meeting schedules.

Our lease with our tenants, Ingham County and the Ingham County Circuit Court (who will be leasing CMHA's entire building at 426 South Walnut), starts on June 1 and the lease for our new location starts on August 1. This leaves us with a 2-month gap without an office location. This gap was unavoidable in that the county needed a June 1 lease start so that they could renovate the building to be ready to hold court hearings this summer; with August 1 as our earliest move-in date at the new location due to renovation being done at our new location. These are not renovations in our offices, but in the lower level so that the Michigan Bankers Association staff can move to that lower level.

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email correspondence

From: Monique Francis <MFrancis@cmham.org>
Sent: Monday, May 9, 2022 3:08 PM
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Important Update regarding the upcoming CMHA 2022 Election of Officers
Attachments: Election Procedures Current 22.24.pdf; By-Laws (final).pdf; Slate of Officers Description 22.24.v.2.pdf; Roster22.24.pdf

Importance: High

Changes in CMHA Election Candidates

Attention CMHA Board of Directors, Executive Directors, Delegates and Board Chairpersons:

On April 22, 2022, you received all of the information pertaining to the upcoming CMHA Election of Officers. On the original ballot, the only candidate nominated for the Office of Treasurer was the incumbent, Randall Kamps, of Northern Lakes CMH (Northern Region). Randy has left the Northern Lakes Board, and that leaves the Association ballot with no candidate for Treasurer.

As we are well past the 45-day deadline for nominees to be submitted and vetted, and to ensure that the Association by-laws processes in place are followed, the election of Officers will go forward as planned on **June 6, 2022**, *with the office of Treasurer to be left unoccupied*. At the Regional Breakfast meetings on **June 8, 2022**, regions will be asked to *discuss, identify and nominate individuals for the office of Treasurer*, to be voted on during a Special Election, which will be scheduled for a future date. This will allow ample time for discussions, nominations, and review of nominee's background and views as in the regular election process.

The Nominating Committee will be included in the process for this Special Election in the same manner as they are for a regular election – reviewing all submissions, and identifying any potential conflicts that may arise, with a special ballot to be created with their assistance and guidance.

Attached are an updated version of the **Slate of Officers** (with Randy Kamps omitted) and **Roster** (also with Randy Kamps identified, but stricken) for your consideration. Please share this updated information with your full board ahead of the upcoming Summer Conference and Election.

If anyone has any questions about this unique set of circumstances, or needs any clarification, please feel free to reach out to me (mfrancis@cmham.org) or Bob Sheehan (rsheehan@cmham.org) at any time!

Thank you!~ 😊

Please be aware that I will be working from home Mondays, Wednesdays and Thursdays, and working in the CMHA Office on Tuesdays and Fridays. This schedule is subject to change according to meetings that may be held in the office. I am returning emails regularly, and can be reached on my cell phone on days that I am working remotely. My cell number is listed below in my signature.

INFORMATIONAL: Downtown I-496 will close for months in both directions – This may affect your route when coming to the CMHA Office – Click link below for information.
https://lansingcitypulse.com/stories/downtown-i-496-to-close-in-both-directions-for-six-months,19536

Monique Francis

Monique Francis, Board of Directors & Committee Clerk
Conference Exhibit Coordinator
Community Mental Health Association of Michigan
426 South Walnut Street, Lansing MI 48933
Direct Line: (517) 237-3145 Fax: (517) 374-1053
Cell: (517) 648-9258
cmham.org

"I'm trying to be totally awesome today,
But I'm exhausted from being totally awesome yesterday!"

From: Monique Francis
Sent: Friday, April 22, 2022 12:17 PM
To: Monique Francis (mfrancis@macmhb.org) <mfrancis@macmhb.org>
Cc: Robert Sheehan <rsheehan@cmham.org>; Alan Bolter <abolter@cmham.org>
Subject: CMHA 2022 Election of Officers Information
Importance: High

Community Mental Health Association of Michigan

April 22, 2022

MEMORANDUM

TO: Chairpersons
Delegates
Executive Directors
CMHA Board of Directors

FROM: Robert Sheehan, Chief Executive Officer

RE: **Election of Officers for 2022-2024**

This mailing is being sent to each board in compliance with the timelines established in the Association By-Laws for election materials. Attached you will find all of the information submitted by the deadline on the candidates nominated for each Association office. There is no action required of you at this time – this mailing is strictly informational and intended to begin the process of familiarizing you with the nominees for the Association's Election of Officers.

The Nominating Committee encourages the voting delegates of each board to read the enclosed information before casting your votes at the annual election of officers during the Member Assembly Meeting at the Annual Summer Conference, June 6, 2022, being held at the Grand Traverse Resort, Traverse City, Michigan.

In addition to the information on the candidates, the applicable sections of the By-laws, the final roster and the elections procedures are also attached to this mailing.

In approximately 2 weeks, Monique Francis will be reaching out to all CMH and PIHP Directors and Administrative Assistants to request Voting Delegates be assigned from your agency. Please watch for this email as we get closer to the Summer Conference!

Thank you,

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
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CMHA

Monique Francis

Community Mental Health Association of Michigan
2022 Elections
ROSTER

2022-2024 NOMINATING COMMITTEE: **(B) = Board Member (D) = Director**

Chairperson: *Ed Woods (LifeWays/MSHN)*

Central: Sharon Beals (Tuscola)
Metro: Linda Busch (Macomb)
Northern: Nena Sork (Northeast)
Southeast: Kay Randolph-Back (CEI)
U.P.: Jim Moore (Hiawatha)
Western: Todd Koopmans (Newaygo)

2022-2024 ROSTER OF NOMINEES

	President	1st VP	2nd VP	Treasurer	Secretary	Past President
Current Officers	Joseph Stone AuSable Valley *(Northern)*	Carl Rice, Jr. LifeWays *(Southeast)*	Craig Reiter Hiawatha *(UP)*	Randy Kamps Northern Lakes *(Northern)*	Cathy Kellerman Newaygo *(Western)*	William Davie Pathways *(UP)*
Eligible for re-election	**NO**	**YES**	**YES**	**YES**	**NO**	**N/A**
Central	Carl Rice, Jr (B) LifeWays *(Southeast)*	Craig Reiter (B) Hiawatha *(UP)*	Mary Babcock (B) Huron *(Central)*	~~Randall Kamps (B)~~*** ~~Northern Lks *(Northern)*~~	Wil Morris (D) Sanilac *(Central)*	Past President for 2022/2024 is Joseph Stone – AuSable *(Northern Region)* Nominations are not applicable for this position. The Past President position is included in the total number of officers from any given region. ***SEE NOTE AT BOTTOM OF PAGE.
Metro	Carl Rice, Jr (B) LifeWays *(Southeast)*	Angelo Glenn (B) Detroit Wayne *(Metro)*	~~Craig Reiter (B)~~*** ~~Hiawatha *(UP)*~~	~~Randall Kamps (B)~~*** ~~Northern Lks *(Northern)*~~	Lori Phillips (B) Macomb *(Metro)*	
Northern	Carl Rice, Jr (B) LifeWays *(Southeast)*	Craig Reiter (B) Hiawatha *(UP)*	Cathy Kellerman (B) Newaygo *(Western)*	~~Randall Kamps (B)~~*** ~~Northern Lks *(Northern)*~~	Sarah Boluyt (B) Newaygo *(Western)*	
Southeast	Carl Rice, Jr (B) LifeWays *(Southeast)*	Craig Reiter (B) Hiawatha *(UP)*	Cathy Kellerman (B) Newaygo *(Western)*	~~Randall Kamps (B)~~*** ~~Northern Lks *(Northern)*~~	John Clark (B) LifeWays *(Southeast)*	
U.P.	Carl Rice, Jr (B) LifeWays *(Southeast)*	Craig Reiter (B) Hiawatha *(UP)*	Cathy Kellerman (B) Newaygo *(Western)*	~~Randall Kamps (B)~~*** ~~Northern Lks *(Northern)*~~	Sarah Boluyt (B) Newaygo *(Western)*	
Western	Carl Rice, Jr (B) LifeWays *(Southeast)*	Craig Reiter (B) Hiawatha *(UP)*	Cathy Kellerman (B) Newaygo *(Western)*	~~Randall Kamps (B)~~*** ~~Northern Lks *(Northern)*~~	Sarah Boluyt (B) Newaygo *(Western)*	

Please Note:

- Officers to be elected will be president, first vice president, second vice president, treasurer and secretary.
- Our By-Laws mandate that the president and first vice president must be board members.
- The By-Laws also state that not more than two officers shall be from the same Association region.
  - The Past President for 22/24 (Joseph Stone) is from the Northern Region.

*** *Indicates Nominee was Ineligible, Declined Nomination, Withdrew, Did Not Get Reappointed to their Board, or Did Not Respond Prior to Deadline*

5/02/2022

2022-2024
Slate of Officers

Office of President

Carl Rice, Jr., LifeWays CMH

BACKGROUND:

Dr. Carl Rice, Jr. holds an Associate's degree in General Studies/Criminal Justice from Jackson College, a Bachelor's degree in Human Resources from Spring Arbor University, a Master's degree in Guidance & Counseling from Eastern Michigan University and a Doctorate in Theology from Andersonville Theological Seminary. Carl has a long history of service as a Jackson City Police Officer, a Mental Health Counselor, a Jackson College Special Populations Counselor, a Middle and High School Counselor, a Small Business Owner and County Commissioner. He serves on the LifeWays Board where he participates on several Committees, provides strong advocacy for our consumers and chair's the Mental Health In Schools committee. Working with partners from around the state, including CMHAM and many of its members, Carl helped to see that funding was received from the Michigan Department of Education to provide training on suicide intervention and prevention to all our 56 ISD's, making available to every school in Michigan this training. Carl previously served as the Chair of the Mid-State Health Network Substance Use Disorder Oversight Policy Board. Serving 1 year as 2nd Vice-President and 4 years as 1st Vice-President of the CMHAM, Carl has worked hard to address the concerns of people we serve, our membership, the Public Mental Health System and has provided leadership and teamwork on several committees, with other officers and the Association.

VIEWS:

Moving forward into the future, all of us should continue to make it clear to our Legislators, the MDHHS and the public that change is only necessary if it further enhances lives, while continuing to clarify the numerous services and value our public mental health system provides our local communities, and the inclusion of anyone who needs us. Are we perfect? No – however the publicly funded system is the most effective and efficient in helping people with mental health, substance use disorders, intellectual/developmental disabilities, crisis services, integration of care and more. We will continue seeking funding solutions and advocating for the funds that will help further our mission and vision. As President, I look for the CMHAM to continue advocating proactively and assertively and listen to input from our members. We will continue to interject a strong response as leaders and a team, with anyone who wants to push out the Public Mental Health System, which obviously includes private healthcare!

426 S. Walnut St.*Lansing, Michigan 48933*(517) 374-6848*Fax (517) 374-1053*www.cmham.org

Office of 1st Vice President

Angelo Glenn, Detroit Wayne Integrated Health Network

BACKGROUND:

Angelo graduated Cum Laude with an Associates of Arts Degree and a Certificate in Addiction Studies from Wayne County Community College. Mr. Glenn has served the citizens of Detroit and Wayne County since being appointed to the Board of Directors by the Wayne County Commission in 2013. He is the immediate past chair of the Substance Use Disorder Oversight Policy Board and remains as a board member. Angelo Glenn is the current Chairperson for the Detroit Wayne Integrated Health Network's (DWIHN) Board of Directors. Angelo worked for Mariner's Inn, a drug treatment facility in Detroit, for 15 years until May 2020. He served in several roles including the Substance Use Disorder Prevention Director where he helped young men with mental health issues, substance use disorders, and risk of becoming homeless. Mr. Glenn, after retirement, continues to assist young men and women to find employment opportunities while maintaining their recovery. He states his 'own story of drug addiction and recovery can be an inspiration for others.'

VIEWS:

Publicly funded mental health and substance use disorder services in Michigan are driven by regulations and requirements at the federal level which may or may not be advised by population/culturally relevant stakeholders' input. As an association, CMHAM members should reflect diverse board executive leadership to support an equitable decision-making process around policy formation for special populations' behavioral health services in our state. Developing an action plan that is inclusive and reflective of the voices of vulnerable populations such as adults and youth who have co-occurring mental health and substance use disorder is integral. As stated in my statement of intent, my dedication and passion is to be a voice in Detroit Wayne and across the state to ensure mental health and substance use disorder parity legislation related to this vulnerable population; in terms of the needs of these individuals and families who are impacted by their condition.

Craig Reiter, Hiawatha Behavioral Health

BACKGROUND:

Craig A. Reiter is a Schoolcraft County Commissioner, local web designer and farmer. Craig is a disabled veteran from the Navy. Born in 1958 in Detroit, Michigan; he is the son of a Detroit area middle school principle and special ed teacher. He graduated from Fraser High school in 1976, and then went on to graduate from Michigan Carrier Institute and R.E.T.S. electronic school. Craig was a Boiler Tech in the Navy before being injured; during his lengthy hospital stay he completed the credits towards an accounting degree. Craig has been active in the community all of his life. Starting in high school with Boy Scouts, sports, Jaycees and Junior Achievement. Craig has been active in his local community with being a Schoolcraft County Commissioner and board chair for 5 terms, Hiawatha Behavioral Health, CMHA served as Treasurer for 2 years, Michigan Association of Counties, EDC, EDA, CAA, Northcare SUD, PTO, Folk Fest, Hockey, County Fair, Chamber of Commerce, Boy and Girl Scouts, Humane Society, youth groups and local church's. Craig has been a resident of Schoolcraft County for the last 32 years. Father of 3 sons and 1 step daughter, he lives in Gulliver with his wife Barbara. Craig attends the St. Francis de Sales church in Manistique.

VIEWS:

With the 298 battle over, our public mental system is one again under attack. We are still fighting privatization of our CMH system here in Michigan, if that were to happen it would reduce the amount and quality of the care that the people we serve are receiving today. Now it would seem that Michigan's CMH is moving in a new direction with the talk about SIP's and the changing of our PIHP's. Now more than ever, we need our CMHA to be working hard for us. We need to stay in the talks and be engaged, work were we can to safeguard the system. We should also take this time to come up with better ways to serve our clients. If change is to come; we need to be on the forefront and part of the talks, with ideas that will bring about a better tomorrow for the people we serve today.

426 S. Walnut St.*Lansing, Michigan 48933*(517) 374-6848*Fax (517) 374-1053*www.cmham.org

Office of 2nd Vice President

Mary Babcock, Huron Behavioral Health

BACKGROUND:

Mary holds a BA in Business from the Northwood University. She has worked for 7 1/2 years for Huron Behavioral Health as Contract/Finance Manager. She is currently Vice Chair of the Board at Huron Behavioral Health, Chair of the Finance Committee and member of the Strategic Planning and Personnel Committees. She worked for 2 years in the communications Industry, serving on a number of Telephone Association committees and workgroups. She is also Huron County Commissioner, District 7, seeking her 3rd 2-year term. As County Commissioner she is Chair of the Finance Committee, Vice Chair of the Personnel Committee and a member of the Safety Committee.

VIEWS:

Mental health services in Michigan are under attack by some of the misguided legislature. As an association, we should be organizing our resources and activities to reflect this new reality. Working through our Association's strategic plan, specific priorities should include: 1) Working to strengthen partnerships with consumer and advocacy groups to: a) Work directly with federal administrative and legislative offices, and b) Pass mental health parity legislation at the state and federal level. 2) Working more proactively with MDCH representatives, hopefully in a partnership, to reduce non value-added federal and state administrative requirements. 3) Working with advocacy groups, the state and within the Association on general funding and funding equity issues. 4) Developing an action plan for our association and members related to the Governor's Mental Health Commission Report and the President's New Freedom Commission Report.

Cathy Kellerman, Newaygo County Mental Health Center

BACKGROUND:

My name is Catherine Kellerman and I currently hold the position of Secretary at CMHA. I have been nominated for the 2nd Vice President position this year and I would like to tell you a little about myself before asking you to vote for me. I have served on the Newaygo County Community Mental Health Board since 2007 and have been involved in several committees here at home base, and at CMHA since 2009 beginning with Member Services Committee. I am a retired teacher holding ME degree from Aquinas College in Grand Rapids. I first earned a BSW degree from Ferris State University, so you can see where my interests lie. I am married and have raised two young men, one of whom passed away four ago after 46 years of living with juvenile diabetes, Bipolar and Anxiety Disorders. Such has been my involvement with the Public Mental Health system. I fully understand the degree of assistance offered to those in need and vehemently support this system. My younger son recently underwent open heart surgery for a defective aortic valve he was diagnosed with at the age of three. He is now 39 and doing great post-surgery. He has also fought with depression for many years. I am a true believer in recovery for those with mental illness, and have seen first-hand how a bit of assistance, empathy, and caring leads to a full life of inclusion at many levels.

VIEWS:

Public Mental Health has come a long way from its beginnings and continues to grow and expand as we learn more about the area of the brain and behavioral health. We do not stand still. New developments occur constantly, and we move ahead with them to provide the best treatments and programs to help people with mental illness and/or developmental disabilities lead the fullest, most productive lives they can. We witness so many talents and contributions coming from some people who thought they had nothing to give. What a pleasure to see someone begin to shine and blossom. We have to keep fighting the good fight and not let anyone or any entity step in and take our place. Public Mental Health is 100% for the benefit of those with mental illness and/or developmental disabilities. We need to hold our place in this world of behavioral health and continue giving our best to those come to us for help. With continuing knowledge, developing treatments, advocacy and togetherness we can fight off any disturbance to our system. If you find me suitable, I would love to remain involved at the State Association level and continue to fight for Public Mental Health in every way I can, and would appreciate your vote of confidence. If you have any concerns or questions, feel free to contact me at balcat19@gmail.com. I would be happy to speak with you.

426 S. Walnut St.*Lansing, Michigan 48933*(517) 374-6848*Fax (517) 374-1053*www.cmham.org

Office of Secretary

Sarah Boluyt, Newaygo County Mental Health Center

BACKGROUND:

Sarah has been on the Newaygo County Mental Health Board of Directors for 10 years. She and her husband of 39 years have raised and homeschooled seven children on a farm near Sand Lake. Besides working on the farm and in the fields, she is the bookkeeper for Grant Christian School. She has also previously worked as a home health aide and performed many volunteer hours in the office at another Christian school. She has been and is currently involved in various committees in the community and church. She has also served on some of the Association committees.

VIEWS:

Although we have entered unprecedented times, it seems as though substance abuse, suicides, and other mental health conditions have greatly increased. With the increase in services, a concern is the availability of continued funding and enough personnel qualified to perform the services. I see continuing to integrate with healthcare systems important also as new technology continues to become available.

John Clark, LifeWays CMH

BACKGROUND:

John earned his BS in Business Administration from Central Michigan University, Post BA Teacher Certification from Spring Arbor University and an MA from Spring Arbor University in Educational Leadership. John holds a current State of Michigan Teaching Certificate but is retired after serving as both a Dean of Students / Principal and Business Education Instructor for Jackson Public Schools serving the at-risk student populations at Fourth Street Learning Center and T.A. Wilson Academy. John's business experience includes owning and operating several local businesses including Clark Distributing Company for 14 years where he was involved with Junior Achievement and a member of the Chamber of Commerce. John is currently the Treasurer of the Lifeways Board and member of the Executive Committee.

VIEWS:

Privatization of mental health services in Michigan is a threat to undermine the public mental health system developed over the last 58 years. SB 597 and 598 would transition community based mental health services to for-profit health insurers. It is the responsibility of the current community based providers to protect the mental health community's access to care and not allow it to be handed over to poor-performing high-overhead for-profit private insurance companies. Defeat of this bill is the number one priority.

Wil Morris, Sanilac County CMH

BACKGROUND:

Wil holds a BA in Psychology, an MA in Marriage and Family Psychology, with post graduate course work in School Psychology, Developmental Psychology, Educational Psychology and Statistics, all from Wayne State University. He is currently certified as a School Psychologist and licensed as an LLP. He has been a part of the behavioral health field since early childhood assisting his parents. He has worked for 21 years for two CMH boards (9 years for St. Clair CMH as clinician and supervisor, and currently for Sanilac CMH as CEO and previously as Clinical Director). Additionally, he has had the opportunity thru his career to hold many of the positions offered in the CMH system including direct care worker, respite worker, therapist, etc. He serves on a number of community committees in his home county of Sanilac County. He is also a member of the Association's Executive Committee, Member Services Committee and Contract and Legislative Committees.

VIEWS:

If there is one thing that the last 2 ½ years living with COVID has taught us, now is the time to find commonalities and the things that bring us together even though we live in a time when everyone seems to strive to drive us apart. It has always been my belief that we as a community/state need to work together to improve the services that we provide to every citizen in our community. It is both an exciting and terrifying time as we look to new initiatives, including CCBHCs, opioid health homes, behavioral health homes and other opportunities that will allow us to combat stigma and treat the whole person in a way we've never done in the past. At the same time, as a system, we face many challenges to how we operate and support our communities. I hope to support the Association in identifying opportunities that bring us as a system and a state closer together to meet the individuals we serve.

Lori Phillips, Macomb County CMH Services

BACKGROUND:

I currently serve on the board of CMH in Macomb County for over 4 years. I am a mother of an Autistic Adult who has received services. I worked for the Intermediate school district in Macomb and am presently retired. I serve as chair on two committees with Macomb County CMH. Persons with Mental Health issues have been an important part of my life and I want to continue to serve ALL. I am active in the Persons Served Advisory Group of CMHAM.

VIEWS:

For the future we must remain strong as a whole for the work to continue for persons served. We must protect local supports in our communities. We must continue the fight for positive changes to CMH and work with legislation that protects ALL, continue working with federal and state legislatures, and continue working with advocacy groups and MDHHS.

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CMHA Officer Election Procedures

1. The President shall appoint a parliamentarian to be available during the Member Assembly Meeting.
2. The President shall appoint two staff persons to serve as tellers and one delegate, not a candidate for office, from the Nominating Committee to supervise the counting of the votes.
3. There shall be no absentee or proxy voting.
4. All persons nominated for office by individual boards, and not selected as part of the regional slate, shall be nominated by April 1 of each year via the submission of the nominee(s)'s name to the Executive Secretary. The Executive Secretary will then include the nominee(s)'s name(s) on the ballot that contains the regional slate nominees and then reported to the Member Assembly.
5. Nominees, except for nominations from the floor, do not have to be present, at the Member Assembly, in order to be considered for an Association officer. Persons nominated from the floor must be present to be considered for an Association officer position.
6. Credentialing of delegates. Each delegate shall register in order to receive a voting card and ballots. Each delegate shall sign the central registry as well as his\her voting card.
7. There will be a single ballot containing all of the nominees for all of the Officer positions. Blank ballots shall be available in the same color as the original ballot for run-off elections.
8. Candidates for office shall be identified by a visible name tag and shall be introduced from the front of the room prior to each election at the Member Assembly meeting. Candidates shall be invited to submit additional information about themselves for inclusion in each delegate's meeting materials.
9. The candidate with the highest number of votes will be elected to the position for which he or she is a candidate, regardless of whether the candidate has the majority of the votes.
10. When the votes are counted, they shall be counted in the following order: President, First Vice-President, Second Vice-President, Treasurer, Secretary. If there is a tie vote and the need for a run-off the vote count will be halted, the run-off held, and vote count for the remaining officer positions resumed.
11. As the votes are being counted in the order outlined above, once two persons from the same region have been elected as officers, including the Immediate Past President, if a candidate receiving the greatest number of the votes for a subsequent officer position is from the same region as two of the already elected officers (including the Immediate Past President), that candidate shall be removed from the ballot.
    In such a case, if there is only one candidate for the position remaining on the ballot, that remaining candidate, as the only eligible candidate, shall be elected to the position.
    If there are two or more candidates for the position, remaining on the ballot, the candidate from the over-represented region is removed from the ballot and a new vote is held for that officer position, with the remaining candidates as the only candidates to be considered.
12. If, as a result of this process or for any other reason, there are no candidates eligible to be considered for this officer position, nominations will be taken from the floor. Any persons nominated from the floor must agree to serve if elected. The nominees from the floor must be present to be considered for an Association officer position.
13. Any promotional materials by a candidate will need to be copied and distributed by the candidate themselves and will not be included in the Association's conference materials or allowed at the conference registration area.

ARTICLE VI
OFFICERS

(A) Officers:

Officers of this Association shall be a President who shall be a CMHSP or PIHP board member, a First Vice-President who shall also be a CMHSP or PIHP board member, a Second Vice-President, a Treasurer, a Secretary and the immediate Past President, all of whom must be CMHSP or PIHP board members or Executive Directors of CMHSPs or PIHPs. Not more than two (2) officers shall be from the same Association region as designated in Article V (B) and (C).

(B) President:

The President shall preside at all meetings but may, at the President's discretion, arrange for presiding officers at any meetings. The President shall appoint the co-chairpersons of all Standing Committees and be a member thereof. The President may appoint ad hoc committees as needed. The President shall notify the membership of the committee appointments upon completion thereof. The President shall be Chairperson of the Personnel Committee. The President shall be chairperson of the Board of Directors and Steering Committee. The President shall perform such duties as are usually incumbent upon the office of President, or as may be authorized by resolution of the membership.

(C) Vice-Presidents:

1. In the absence of the President, the First Vice-President shall perform the duties of the President. Other duties of the Vice-Presidents will be at the discretion of the President
2. In the absence of the President and the First Vice-President, the Second Vice-President shall perform the duties of the President.

(D) Treasurer:

The Treasurer, in partnership with the Budget and Finance Committee, the Board of Directors, and the CEO shall assure that:

- all funds are received and disbursed or otherwise accounted for, that an accurate accounting of all financial transactions is maintained, and;
- an audit report of the association's financial operations is conducted and presented to the Board of Directors on an annual basis;
- that an annual budget is developed for review by the Budget and Finance Committee, the Board of Directors, and the Member Assembly
- that a periodic financial report is submitted for review by the Budget and Finance Committee and the Board of Directors.

The Treasurer shall serve as chairperson of the Budget and Finance Committee.

(E) Secretary:

The Secretary shall assure that minutes of the official proceedings are kept and shall be responsible for records and files of the Association and the Board of Directors. The Secretary shall assure that notices of all meetings will be sent to the membership of the Association and the Board of Directors. The Secretary shall perform such duties as are usually incumbent upon the office of Secretary or as may be prescribed by the President, the Board of Directors or the membership.

(F) Immediate Past President:

After completing their role as President, they will become Past President and maintain that role until the President fulfills their position. They will maintain a CMHA officers position with all rights and privileges therein.

(G) Election and Term of Office:

Officers shall be elected by a vote of the official delegates present and representing Member CMHSPs/PIHPs/"at large" Provider Representatives as defined by Article III (D) at the annual meeting of the Member Assembly designated for the election of officers and shall take office at the adjournment of the electoral conference, unless the election of the officer(s) is at a meeting resulting from the death or removal of an officer, constituting the need for a special election. In those instances, that officer shall assume office at the adjournment of that meeting. Officers shall serve one term or until their successors have been elected. A vacancy occurring in any office shall be filled by a majority vote of the Board of Directors. The candidate so elected shall serve the unexpired balance of the term. Officers may serve no more than two consecutive terms in the same office.

For all offices except President, a Board Member or Director (CMHSP or PIHP) can serve no more than four (4) consecutive terms as an Association officer, as elected by the membership, (excluding any time served when appointed to fill a vacancy by the Board of Directors and years served as immediate Past President).

For election to the office of President, a Board Member must serve in at least one other officer position but not more than 6 consecutive terms as an officer, including the position of President.

In addition, officers of the Association are prohibited from simultaneously serving as a co-chairperson of any Standing Committee.

Terms for Officers shall be defined as two (2) years.

(H) Election of Officers:

1. Nominations:

The President shall appoint the chair of the Nominating Committee. Each region shall designate one member to serve on the Committee. The Committee shall solicit from each CMHSP and PIHP suggestions for nominations for the officer positions beginning at least three months before the election. Nominations for office from individual CMHSPs and PIHPs shall be sent to the regional chairperson and to the Association office. All regions will consider nominations made by CMHSPs and PIHPs in their regions and recommend a roster of candidates to be nominated. Each region may nominate a candidate for each of the officer positions to be elected. The region shall send their roster of candidates to the Nominating Committee for submission to the membership. Persons may also be nominated for office by individual CMHSPs and PIHPs. If the individual has not been selected as part of the regional roster, they shall be reported to the membership.

2. Notice:

The Nominating Committee shall mail a slate listing all nominees together with biographical data to all members at least forty-five (45) days prior to the annual meeting of the Member Assembly designated for the election of Association officers and the slate shall be presented to the membership at that meeting.

3. Election:

Officers shall be elected in the following order: President, First Vice-President, Second Vice-President, Treasurer, Secretary. There shall be no absentee or proxy voting.

(I) Removal from Office:

An elected officer may be removed from his or her position for misfeasance or nonfeasance when a two-thirds (2/3) vote of a meeting of the Member Assembly indicates that it would be in the best interests of the Association to do so. The Board of Directors by majority vote may remove any elected officer who has accumulated three (3) unexcused absences at regular or special Board of Directors meetings, or meetings incumbent upon his or her official duties within the elected officer's term of office.

(J) In the event that a candidate for an Association officer position is the only candidate for the position and that person resigns from the Association Board of Directors after the nominations period for officer positions is closed but before the election of officers is held, the incumbent, holding the position at the time, retains that position for the next year until the next regularly scheduled election of officers. This process shall be followed regardless of election, term, or other conditions outlined in other section of the Association’s by-laws.

Community Mental Health Association of Michigan

FY23 Senate & House Budget Proposals

Specific Mental Health/Substance Abuse Services Line items

	FY'23 Exec Rec	FY'23 Senate	FY'23 House
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$2,975,480,500	$2,975,893,900	$2,810,590,500
-Medicaid Substance Abuse services	$82,657,700	$82,657,700	$85,421,900
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,705,200	$78,050,700	$79,705,200
-Health Homes Program	$61,337,400	$61,337,400	$61,337,400
-Autism services	$286,697,900	$286,697,900	$286,697,900
-Healthy MI Plan (Behavioral health)	$583,086,100	$583,086,100	$585,768,500
-CCBHC	$101,252,100	$101,252,100	$101,252,100
-Total Local Dollars	$15,285,600	$246,900	$10,190,500

Other Highlights of the FY23 Senate & House Budgets:

Senate Items of Interest

- Included $101.2 million for CCBHC – concurred with executive & House
- Included $61.3 million for Health Homes – concurred with executive recommendation
- Included Opioid Settlement Fund ($16 million Gross) – concurred with executive & House
- Local match drawn down phase out – $15 million GF (eliminates all but $247,000)
- Increase CMH guardianship rates ($5 million Gross and GF)

- Families Against Narcotics ($5 million Gross and GF)
- Michigan 2-1-1 Operational Increase ($2 million Gross and GF)
- Medicaid Reimbursement for community health workers ($28.3 million Gross, $10 m GF)

Senate New One Time

- Great Lakes Recovery Centers ($250,000)
- Northern MI Crisis Stabilization unit ($5 million Gross and GF)

Senate Boilerplate Changes

- The Senate removed language that appropriated $500,000 for an actuarial study to create a specialty Medicaid managed care health plan for children in foster care
- The Senate modified language to direct the expansion of behavioral health homes in Prepaid Inpatient Health Plan (PIHP) regions 6 and 7 and the expansion of SUD health homes in regions 6,7, and 10. The Senate added a quarterly report on the number of individuals being served by the health homes by PIHP region by site.
- Removes a SUD Detox Pilot @ St. Mary's in Livonia

Other Notes

- The Direct Care Worker wage increase is assumed to be continued as it is built into the baseline. Boilerplate language that was slightly altered in the Exec Rec was restored in Senate: (1) Requires the department to work with PIHPs and actuaries to include state minimum wage and federal wage increases that affect direct care staff when setting Medicaid rates. (2) States legislative intent that any increased Medicaid rate resulting from a minimum wage increase shall be passed through the direct care staff.
- Many of the new investments recommended by the Governor were not included, including $25 million proposed for behavioral health provider loan repayment
- Senate budget roughly $900 million less than the Governor's recommendation.

House Items of Interest

- Included $101.2 million for CCBHC – concurred with executive & Senate
- Included $61.3 million for Health Homes to increase the number of behavioral health homes from 37 to 42 and the number of opioid health homes from 40 to 49. **But House requires** funds be used to implement intellectual or developmental disability health home ($16.8 million Gross ($2.5 million GF/GP))
- Included Opioid Settlement Fund ($16 million Gross) – concurred with executive recommendation
- 2 – 5 % actuarial soundness adjustment for prepaid inpatient health plans (PIHPs)
- Local match drawn down phase out – $5 million GF (brings to year 3 of 5-year phase out)
- $1 million to provide supports for special education system navigation and to improve educational outcomes for youth in foster care who have a disability
- Construct a new Hawthorn Center for children and adolescents ($85 million GF/GP – one-time)
- Michigan Crisis and Access Line (MiCAL) funding to continue implementation of MiCAL statewide – a behavioral health crisis intervention and support call center and also provides primary coverage in

regions where a regional national suicide prevention 988 lifeline center does not provide coverage ($3 million Gross)

House One Time Funding

- House added funding for several one-time items to increase non-state Behavioral Health Facility Capacity ($178.6 million Gross):

    - Pine Rest pediatric behavioral health center ($50.0 million)
    - Detroit Wayne Integrated Health Network psychiatric campus ($45.0 million)
    - Establishing crisis stabilization units ($30.0 million)
    - U of M Medicine children's emergency psychiatry and day program for children and adults ($11.0 million)
    - Establishing psychiatric residential treatment facilities ($10.0 million)
    - Team Wellness adolescent behavioral wraparound health care program ($10.0 million)
    - Northern Michigan psychiatric inpatient ($5.0 million)
    - Bay County pediatric psychiatric inpatient ($5.0 million)
    - Kalamazoo or Berrien County pediatric psychiatric inpatient ($5.0 million)
    - War Memorial psychiatric inpatient ($3.6 million)
    - McLaren emergency psychiatric assessment, treatment, and healing (EmPATH) unit ($3.0 million) McLaren Greenlawn ($1.0 million)

- House also includes one-time funding for the following:

    - First responder mental health funding ($7.5 million SFRF)
    - Easterseals - autism comprehensive care center ($2.5 million)
    - Western Upper Peninsula CMHSP health professionals in schools ($1.0 million)
    - Altarum substance use disorder programing ($850,000)
    - Easterseals – Parent/Family stress programs ($500,000)
    - Great Lakes Recovery Center ($250,000)
    - Endeavor to Persevere – teen walk-in mental health ($50,000)
    - Mediation services ($40,000)
    - $100 placeholders for Jail Diversion Fund, Families Against Narcotics, and Salvation Army Safe Harbor ($300)

House Boilerplate Changes

(House budget added the following sections back into the budget – they were not included in the Governor's budget)

- Sec. 908. Uniform Community Mental Health Credentialing – States that contracts with PIHPs and CMHSPs must work toward implementing section 206b of the Mental Health Code on uniform community mental health services credentialing.

- Sec. 927. Uniform Behavioral Health Service Provider Audits – Requires DHHS to create a uniform community mental health services auditing process for CMHSPs and PIHPs, outlines auditing process requirements, and requires a report.

- Sec. 960. Autism Services Cost Containment – Requires DHHS to continue to cover all autism services that were covered on January 1, 2019; to restrain costs required DHHS to develop written guidance for

standardization; and requires 3-year reevaluations, unless a clinician recommended an earlier reevaluation, and require maintenance of statewide provider trainings, limits practitioners who can perform a diagnostic evaluation and requires evaluations performed by a master's level practitioner to be reviewed by a second practitioner, provide fidelity reviews and secondary approvals, and prohibit specific providers from providing both evaluation and treatment; requires a report.

- Sec. 970. Skill Building Assistance Services – Requires DHHS to maintain skill building assistance services policies in effect on October 1, 2018, and requires DHHS to continue to seek federal matching funds for skill building assistance services.

Other Notes

- The Direct Care Worker wage increase is assumed to be continued as it is built into the baseline. Boilerplate language – (Sec 231) House revises to require Medicaid managed care organizations of MI Choice, MI Health Link, and PIHPs to continue the direct care wage increase and to report quarterly to DHHS on direct care salaries paid, for DHHS to perform a market rate survey, and removes references to private child caring institutions, area agencies on aging, and long-term care (which is moved to new Sec. 1644).
- Many of the new investments recommended by the Governor were not included, including $25 million proposed for behavioral health provider loan repayment
- House budget roughly $500 million less than the Governor's recommendation.

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

CI. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

CII. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

email correspondence

From: Harrison, Julie (DHHS)
To: Eric Kurtz (NMRE); Carol Balousek (NMRE); Tema Pefok
Cc: Andrews, Debi (DHHS); Stoneburner, Brenda (DHHS)
Subject: FY2021 Performance Bonus Incentive Pool Award
Date: Thursday, March 17, 2022 3:23:39 PM
Importance: High

SENDING ON BEHALF OF DEBI ANDREWS

Final FY2021 Performance Bonus Incentive Pool Award.

This communication serves as the final notice to your PIHP regarding the FY2021 performance bonus, contract section 8.4.2. Scoring is based on PIHP/MHP Joint Metrics and PIHP-only deliverables. Total performance bonus earnings are shown in yellow below.
Payments will be made by April 30.

UPDATE-There will be two changes coming out to allow consistent and complete stratification of the data by race/ethnicity. Optum, the data warehouse vendor, will make an update in CC360 to the "H" and "Y" Ethnicity Code to Rollup to Race Hispanic. The update will be reflected in the "Race Rollup" column in the Export function. The change to CC360 is expected to be completed in April. In September 2022, Ethnicity will be added to the PIHP 834 file.

FY21 Total .75 Performance Bonus Incentive Pool

	Total $ Available (.75 withhold)	Total Withhold Unearned	Additional Performance Bonus Earned	Grand Total Earned
NMRE	$1,737,751.66	$0.00	$1,363,499.91	$3,101,251.57

PIHP/MHP Joint Metrics

Joint metrics with the MHPs included J.1 Implementation of Joint Care Management Processes, J.2 FUH Performance Measure, and J.3 FUA Performance Measure. The final Follow-up after Hospitalization for Mental Illness within 30 Days (FUH) for the 7/1/2020-06/30/2021 measurement period and Follow-up after ED visits for Alcohol and Other Drugs (FUA) were posted in CC360 in January 2022.

Points earned are displayed in the tables below.

J.1

Joint Care Management Processes (35 points)

	Joint care mgmt. processes Yes = 35, No = 0
NMRE	35

J.2

Follow-up after Hospitalization for Mental Illness within 30 days July 2020 -June 2021(20 points)

	Scored 6-20 Combos	Scored 6-20 Combos Meeting Standard	Scored 21-65 Combos	Scored 21-65 Combos Meeting Standard	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	**Score (maximum = 20)**
NMRE	2	2	4	4	6	3.33	6	**20**

Follow-up after Hospitalization for Mental Illness Disparity 2020.7-2021.6 (20 points)

	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	**Score (maximum = 20)**
NMRE	3	6.67	3	20

J.3

Follow-up after ED visits for Alcohol and Other Drugs Disparity (25 points)

	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	**Score (maximum = 25)**
NMRE	3	8.33	3	25

Joint metric results are represented below in dollar amounts.

PIHP Joint MHP Metric Score (100 points)

	Score	**Score Converted to Percentage**	**Joint Metric Total $ Available**	**Total Joint Metric Earned**
NMRE	100	100%	$ 521,325.50	$ 521,325.50

PIHP-only deliverables

PIHP-only deliverables included P.1 Quarterly Veteran Service Navigator data submissions; BHTEDS Data Quality Narrative Report, P.2 Admission Discharge and Transfer (ADT) submissions, and P.4 Narrative report on patient-centered medical home-like participation. Points earned along with dollar amounts are displayed in the table below.

PIHP-only Incentive Score (200 points)

	Total PIHP-only $ Available	P.4 PIHP-Only $ Earned	P.1 & P.2 Total PIHP-only $ Earned	Total PIHP-only $ Earned
NMRE	$1,216,426.16	$695,100.66	$521,325.50	$1,216,426.16

*PIHP-only Incentive header was incorrect on the 3/2/22 consultation draft and has been corrected as seen above.

Julie R. Harrison

Executive Secretary
Program Development, Consultation, and Contracts Division
Behavioral Health and Developmental Disabilities Administration
Michigan Department of Health and Human Services

Lansing, Michigan
Phone: 517-335-3768
Fax: 517-335-5376

MDHHS logo (2)

Northern Michigan Regional Entity

1999 WALDEN DRIVE ♦ GAYLORD, MI 49735 231.383.6123 ♦ OFC 989.448.7078 ♦ FAX NMRE.ORG

DATE: 5-3-22

TO: Amanda Zabor and Darrell Harden

FROM: Eric Kurtz, CEO Northern Michigan Regional Entity (NMRE)

RE: October 14, 2021 Memo Regarding Intensive Crisis Stabilization Services (ICSS) and POC

Dear Amanda,

As outlined in my email dated November 24, 2021, although apparently a Northeast MI CMHSP (NE) clinician stated that "clinicians take care of crisis for the individuals they serve" (which is generally a true statement), when issuing the annual ICSS report, the NMRE does not believe it or NE should be under a Plan of Correction (POC). As outlined in the 10-14-22 memo, the issue of contract non-compliance was related to the level of ICSS service utilization and that ICSS must be included in the array of Medicaid covered services. NE does in fact offer and provide ICSS mobile crisis services as requested (or needed), and in the November 24, 2021, email, I included material indicating NE was already meeting and doing the items outlined for the POC before it was even issued.

During our phone conversation, I also indicated that I understood the impetus for ICSS, but this service never really will be a highly utilized service in rural areas; it is very rare when two clinicians would be needed to respond to a crisis, especially when there are multiple crisis systems already in place to serve children in emergencies that should receive equal focus as opposed to this one Medicaid covered service (especially if the impetus is on both CMHSP non CMHSP clients).

Each CMHSP (in the state) is required to have a children's diagnostic treatment program as outlined in the Mental Health Code and certified by the Department. This program provides examination, evaluation, or facilitates treatment for minors including emergency services. CMHSP's are also required to provide 24-hour/seven-days-a week preadmission screening and crisis services and are available to respond to all crisis inquires (including children) on a 24-hour seven day a week basis. Depending on how the crisis program is organized, this service may include staff that meet the children's diagnostic and treatment program requirements or are available adjunct to the normal crisis program (in community or other). In addition, CMHSP's are also required to provide home based services as part of the Medicaid covered services array, which is reported as Homebased Services as opposed to Crisis Services if done by a member of the Homebased Services Team. It is also the expectation of the NMRE and NE that if qualified, any credentialed staff can do crisis services, provide crisis interventions as they may occur during their regular contacts. As it stands currently, NE has **five** different systems to address children's crisis services, including ICSS (mobile crisis).

Since we already have in place what was identified in the POC, we would respectfully request that we are not placed under a POC as NE does provide advertise ICSS as part of its service array as well as the other Children's crisis services outlined above for both CMHSP and non-CMHSP clients. We also provided the data for the time requested.

As we move forward, I would suggest that we look at all children's services and address whether there are issues with children services in that community as opposed to the ICSS utilization specifically. NE and I are always more than willing to discuss this further or to refine what we need to report under this POC and for how long. This is especially important since I have heard through the contract negotiation process that POC responses maybe part of contract bonus withholds in the near future. From the NMRE perspective, this means POC's need to be scrutinized much more carefully with clear expectations of the reporting expectations as we move forward.

Sincerely

Eric Kurtz
CEO NMRE

'Carter Kits' distributed to help responders work with those with autism

by Irelend Viscount

Thursday, April 28th 2022

NORTHERN MICHIGAN (WPBN/WGTU) -- The CDC reported in 2021 that 1 in 44 children in the United States is diagnosed on the autism spectrum.

It can be difficult to communicate with someone with a sensory disorder, especially during an emergency.

A Carter Kit sensory bag contains a weighted blanket, noise-canceling headphones, sunglasses, non-verbal cue cards and fidget toys.

“You can play with them,” Carter Severs said. “They help you with feeling calm.”

Carter was diagnosed with autism when he was 2-years old.

His dad Justin works for the Saginaw Township Police Department.

“One child that we interacted with, pretty much weekly, we would show up and we knew we had to go hands-on with the kid just to get them to go to the hospital,” Justin said. “I look back now, and I think, well, if we would have had tools like this, how could things have gone differently?”

“Responders needed a tool to be able to communicate with those who have sensory processing disorders,” Carter Kit’s President and Co-Founder Brandon Hauseeck said.

Around 2,000 Carter Kits are being distributed around northern Michigan.

“There is a need and to be able to add the training aspect that we're working on,” Justin said. Not only are you getting the bags but we're providing the training to how to use them.”

The training class here in Gaylord of about 15 first responders is only the beginning.

“The Carter Kits mission is to get these Carter Kits as widespread as we can not only for first responders, that's where we started,” Brandon said. “But all professionals, whether it's a school, whether it's a hospital, partner, kits can be used anywhere where you're trying to communicate with somebody.”

The northern Michigan regional entity used grant money to purchase these kits and get them in the hands of first responders and other organizations.

Currently, 29 states use Carter Kits.

Northern Michigan Mental Health Agencies Receive 'Carter Kits' for Children with Autism

Katie Birecki, Jacob Johnson

April 27, 2022

Five northern Michigan mental health agencies received 400 sensory kits to use with children with autism.

There called Carter Kits, named after seven-year-old Carter Severs from Frankenmuth, who has Autism Spectrum Disorder.

The kits include fidget toys, a 5 lbs weighted blanket, earmuffs and sunglasses to specifically help children with special needs calm down during a traumatic event.

There will be 1,600 more kits delivered to 21 northern Michigan counties.

"It keeps other kids calm and they can play with them," said Carter. "They help people stay relaxed."

Since starting Carter Kits in 2019, 1,800 kits have been used in across the U.S. in 29 states.

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00 – MAY 11, 2022
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Joanie Blamer, Connie Cadarette, Lauri Fischer, Ann Friend, Christine Gebhard, Chip Johnston, Eric Kurtz, Donna Nieman, Larry Patterson, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey**

REVIEW AGENDA & ADDITIONS
No additions to the meeting Agenda were requested.

REVIEW PRIOR MINUTES
The April minutes were included in the materials packet for the meeting

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE APRIL 13, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY LAURI FISCHER. MOTION APPROVED.

MONTHLY FINANCIALS
March 2022

- Net Position showed net surplus Medicaid and HMP of $8,248,294. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $24,606,411. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $40,964,528.
- Traditional Medicaid showed $99,621,062 in revenue, and $90,082,236 in expenses, resulting in a net surplus of $9,538,825. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $15,432,891 in revenue, and $13,157,185 in expenses, resulting in a net surplus of $2,275,707. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $734,211 in revenue, and $520,044 in expenses, resulting in a net surplus of $214,167.
- SUD showed all funding source revenue of $12,092,064, and $10,063,392 in expenses, resulting in a net surplus of $2,028,672. Total PA2 funds were reported as $5,814,770.

Deanna reported that the current surplus of $24.6M is higher that the surplus amount of $20M reported for the first six months of FY21. Carry forward for FY21 was $4.5M; the carry forward for FY22 was reported as $16M. Expenditures are also higher than this time last year, as is revenue. The Direct Care Wage surplus was estimated as $3,566,238.

Lauri indicated that Northern Lakes is seeing a migration of individuals from standard Medicaid to Program of All-Inclusive Care for the Elderly (PACE) Medicaid; she asked whether individuals on PACE Medicaid can be enrolled in the Behavioral Health Home. Eric responded that he doesn't think they can be enrolled as PACE is an all-inclusive program. Individuals with SMI should be advised to opt out of the PACE program.

Donna noted that that revenue trending is equal to or slightly below FY21, but eligible trending is higher in all categories; she questioned why they wouldn't trend the same or similar. Deanna responded that overall revenue is $1.9M higher than at the same time last year. It was also noted that FY22 saw a reduction in rates. An adjustment to the rates is expected for May – September to reflect the $2.35/hour DCW increase.

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2022; SUPPORT BY LAURI FISCHER. MOTION APPROVED.

EDIT UPDATE

Donna reported on the April 21st EDIT meeting.

1) MDHHS sent reports to PIHPs requesting Plans of Correction to address variances on the EQI. Tricia and Brandon met to review differences in rates (historical vs. actual); the Department has stated that it is more concerned with variances in units of which the NMRE had few (likely related to COB). Lauri requested that feedback from submissions sent to the PIHP be shared with the CMHSPs to inform future submissions; Tricia agreed to send the variance report but noted that it is not separated by Board.
2) The COB workgroup decided that for October 1, 2022 only FFS COBs will be reported.
3) The Code Chart Changes Subgroup in in the process of reviewing the mental health lines of the code chart.
4) The workgroup to develop tiered rates for inpatient psychiatric services is developing baselines for Tiers 1 – 4 for both pediatric and adult services.
5) The workgroup to develop tiered rates for licensed residential services is working on conducting key informant interviews from a variety of providers.
6) In Milliman's review of expenditures across billing providers in order to understand the variation in rates, the decision was made to use EIN numbers for atypical providers that do not have NPIs. It was noted that for providers that do not have EIN numbers, social security numbers would have to be used; this raised concerns among providers.
7) MDHHS has discretion to keep in place temporary policies (including the use of telehealth) after the PHE ends on July 15th.
8) Code Chart and Provider Qualifications Chart updates were made on March 31st and April 7th.
9) Lauri asked whether Transcranial Magnetic Stimulation (TMS) is an allowable service; the decision was made that this should be billed on the physical health side.

The next EDIT meeting is scheduled for July 21st

EQI UPDATE

Lauri reported that she reviewed the EQI and one thing that stood out prominently was that there is no "other expense" tab to record administration; therefore, EQI expenditures shown as Medicaid will not include administration. Erinn noted that some admin gets spread over services and will be in the report (delegated admin will not).

Tricia indicated she noticed a problem with the FY21 report some BHH codes ended up under "other GF" which she fixed on the reconciliation; the NMRE's Health Home row did not equal the CMHSPs' Health Home row.

HSW SLOT REPORT

Deanna forwarded an email update from Stewart Mills on May 9th. For May the region has 22 slots open; 12 packets are currently pending enrollment as they need updated information from the CMH. Additional packets were submitted and, if appropriate for the waiver, can be submitted this month. It is possible that all 22 slots will be filled in May to keep slot utilization at 100% while retaining 4 surplus packets on hand for enrollment for June.

Deanna thanked the Boards for their efforts toward getting the slots filled.

STANDARD COST ALLOCATION (SCA) STATUS

Eric reported that the Department is moving forward with the SCA, though he maintained that it should be brought through CFI. AuSable Valley and Northeast Michigan are drafting the EQI using the SCA. Donna reported that Centra Wellness and Northern Lakes are not. North Country received an extension.

REGIONAL CFO BENCH

Mr. Kurtz expressed that during the April 19th Operations Committee meeting the CEOs approved the hiring of a CFO bench position; this person would work for NMRE and provide assistance and expertise to the Boards when needed. The additional staff would allow the region to conduct more financial management and forecast projections.

LOCAL MATCH DUE TO NMRE

Deanna reported that one local match payment has been received from Centra Wellness. North Country, Northeast MI, and Northern Lakes agreed to send their payments. Chip commented that the legislature is cooperating; plans are moving forward to wipe out almost all of it in FY23.

NEXT MEETING

The next meeting was scheduled for June 8th at 10:00AM via Teams.

Chief Executive Officer Report

May 2022

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.

May 4: Attended and participated in PIHP CEO Meeting.

May 5: Attended and participated in PIHP/MDHHS CEO Meeting.

May 5: Met with NorthCare CEO regarding mutual needs and rural issues.

May 6: Met with West Michigan CMHSP regarding CCBHC crossover.

May 9: Met with GT County Administrator.

May 10: Met with North Country CEO regarding regional crisis home.

May 11: Attended and participated in NMRE Regional Finance Committee Meeting.

May 11: Met the Northern Lakes Staff regarding Grand Traverse County.

May 12: Presented at Northeast Michigan CMHS Board's annual planning session.

May 17: Chaired NMRE Operations Committee Meeting.

May 19: Attended CMHAM Improving Outcomes Conference.

May 20: Met with NMRE Medical Director.

Northern Michigan Regional Entity

March 2022 Finance Report

March 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	9,538,825	11,296,867	9,298,368
Healthy Michigan	2,275,707	5,061,250	7,059,749
	$ 11,814,532	$ 16,358,117	$ 16,358,117

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	29,083	1,477,979	1,838,390	2,628,805	732,021	1,074,659	467,356	$ 8,248,294
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 24,606,411
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 40,964,528

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through March 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)	$ 96,597,305	$ 2,331,754						$ 98,929,059
CMHSP Distributions	(93,429,187)		31,002,032	25,703,882	15,760,716	12,822,233	8,140,324	-
1st/3rd Party receipts			361,814	-	330,189	-	-	692,003
Net revenue	3,168,118	2,331,754	31,363,846	25,703,882	16,090,905	12,822,233	8,140,324	99,621,062
Expense								
PIHP Admin	1,307,050	26,066						1,333,115
PIHP SUD Admin		28,961						28,961
SUD Access Center		27,119						27,119
Insurance Provider Assessment	1,154,925	23,921						1,178,846
Hospital Rate Adjuster	688,072							688,072
Services		1,697,668	28,083,842	23,388,679	14,870,574	11,205,384	7,579,976	86,826,123
Total expense	3,150,047	1,803,735	28,083,842	23,388,679	14,870,574	11,205,384	7,579,976	90,082,236
Net Actual Surplus (Deficit)	$ 18,071	$ 528,019	$ 3,280,004	$ 2,315,203	$ 1,220,331	$ 1,616,849	$ 560,348	$ 9,538,825

Notes

Medicaid ISF - $9,298,368 - based on unaudited FSR
Medicaid Savings - $11,296,867

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through March 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 9,861,374	$ 5,569,241						$ 15,430,615
CMHSP Distributions	(9,128,325)		3,330,104	2,765,310	1,133,451	1,135,000	764,460	-
1st/3rd Party receipts			-	-	2,276	-	-	2,276
Net revenue	733,049	5,569,241	3,330,104	2,765,310	1,135,727	1,135,000	764,460	15,432,891
Expense								
PIHP Admin	125,061	62,026						187,087
PIHP SUD Admin		68,916						68,916
SUD Access Center		64,532						64,532
Insurance Provider Assessment	104,484	54,651						159,135
Hospital Rate Adjuster	492,492							492,492
Services		4,039,754	3,576,148	1,963,111	1,045,243	1,022,408	538,358	12,185,022
Total expense	722,037	4,289,879	3,576,148	1,963,111	1,045,243	1,022,408	538,358	13,157,185
Net Surplus (Deficit)	$ 11,012	$ 1,279,362	$ (246,044)	$ 802,199	$ 90,484	$ 112,592	$ 226,102	$ 2,275,707

Notes
HMP ISF - $7,059,749 - based on unaudited FSR
HMP Savings - $5,061,250

Direct Care Wage Estimated Surplus	**(329,402)**	**(1,195,571)**	**(488,597)**	**(578,794)**	**(654,782)**	**(319,093)**	**$ (3,566,238)**
Net Surplus (Deficit) MA/HMP/DCW	**$ 29,083**	**$ 1,477,979**	**$ 1,838,390**	**$ 2,628,805**	**$ 732,021**	**$ 1,074,659**	**$ 467,356**	**$ 8,248,294**
Medicaid & HMP Carry Forward								**16,358,117**
Total Med/HMP Current Year Surplus								$ 24,606,411
Medicaid & HMP ISF - based on unaudited FSR								**16,358,117**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 40,964,528**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through March 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 224,954		210,231	34,746	40,011	29,832	194,437	$ 734,211
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	224,954	-	210,231	34,746	40,011	29,832	194,437	734,211
Expense								
PIHP Admin	7,819							7,819
BHH Admin	-							-
Insurance Provider Assessment	2,968							2,968
Hospital Rate Adjuster								
Services	-		210,231	34,746	40,011	29,832	194,437	509,257
Total expense	10,787	-	210,231	34,746	40,011	29,832	194,437	520,044
Net Surplus (Deficit)	$ 214,167	$ -	$ -	$ -	$ -	$ -	$ -	$ 214,167

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through March 31, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 2,331,754	$ 5,569,241	$ 1,800,895	$ 1,331,695	$ 1,058,479	$ 12,092,064
Expense						
Administration	55,027	130,942	47,347	77,620		310,936
OHH Admin			57,777	-		57,777
Access Center	27,119	64,532	-	12,399		104,050
Insurance Provider Assessment	23,921	54,651	13,762			92,334
Services:						
Treatment	1,697,668	4,039,754	1,460,718	776,202	1,058,479	9,032,821
Prevention	-	-	-	465,474	-	465,474
State targeted response	-	-	-	-	-	-
Total expense	1,803,735	4,289,879	1,579,604	1,331,695	1,058,479	10,063,392
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 528,019	$ 1,279,362	$ 221,291	$ (0)	$ -	$ 2,028,672

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through March 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 96,597,305	$ 2,331,754	$ -	$ 98,929,059
Medicaid Savings	11,296,867	-	-	11,296,867
Healthy Michigan	9,861,374	5,569,241	-	15,430,615
Healthy Michigan Savings	5,061,250	-	-	5,061,250
Health Home	734,211	-	-	734,211
Opioid Health Home	-	1,800,895	-	1,800,895
Substance Use Disorder Block Grant	-	1,331,695	-	1,331,695
Public Act 2 (Liquor tax)	-	1,058,479	-	1,058,479
Affiliate local drawdown	449,800	-	-	449,800
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	21,087	-	21,087
Veteran Navigator Grant	52,767	-	-	52,767
SOR Grant Revenue	-	459,183	-	459,183
Gambling Grant Revenue	-	47,000	-	47,000
Other Revenue	-	-	3,681	3,681
Total operating revenue	124,053,574	12,619,334	3,681	136,676,589
Operating expenses				
General Administration	1,586,167	268,749	-	1,854,916
Prevention Administration	-	41,748	-	41,748
OHH Administration	-	57,777	-	57,777
BHH Administration	-	-	-	-
Insurance Provider Assessment	1,262,377	92,334	-	1,354,711
Hospital Rate Adjuster	1,180,564	-	-	1,180,564
Payments to Affiliates:				
Medicaid Services	84,436,452	1,697,668	-	86,134,120
Healthy Michigan Services	8,142,992	4,039,754	-	12,182,746
Health Home Services	509,257	-	-	509,257
Opioid Health Home Services	-	1,460,718	-	1,460,718
Community Grant	-	776,202	-	776,202
Prevention	-	423,726	-	423,726
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	1,058,479	-	1,058,479
Local PBIP	-	-	-	-
Local Match Drawdown	449,800	-	-	449,800
Miscellanous Grant	-	21,087	-	21,087
Veteran Navigator Grant	52,767	-	-	52,767
SOR Grant Expenses	-	459,183	-	459,183
Gambling Grant Expenses	-	47,000	-	47,000
Total operating expenses	97,620,376	10,444,425	-	108,064,801
CY Unspent funds	26,433,198	2,174,909	3,681	28,611,788
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,254,458	6,231,624	16,358,117	24,844,199
Unspent funds - ending	$ 28,687,656	$ 8,406,533	$ 16,361,798	$ 53,455,987

Northern Michigan Regional Entity

Statement of Net Position

March 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 9,271,650	$ 7,462,525	$ 16,361,798	$ 33,095,973
Accounts Receivable	37,165,136	2,264,873	-	39,430,009
Prepaids	65,491	-	-	65,491
Total current assets	46,502,277	9,727,398	16,361,798	72,591,473
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	46,502,277	9,727,398	16,361,798	72,591,473
Liabilities				
Current liabilities				
Accounts payable	17,555,288	1,258,420	-	18,813,708
Accrued liabilities	259,333	-	-	259,333
Unearned revenue	-	62,445	-	62,445
Total current liabilities	17,814,621	1,320,865	-	19,135,486
Unspent funds	$ 28,687,656	$ 8,406,533	$ 16,361,798	$ 53,455,987

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2021 through March 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 96,465,546	$ 96,597,305	$ 131,759	0.14%
Carryover	11,296,664	11,296,664	11,296,867	203	0
Healthy Michigan					
Capitation	20,566,272	10,283,136	9,861,374	(421,762)	(4.10%)
Carryover	5,061,832	5,061,832	5,061,250	(582)	(0.01%)
Health Home	506,772	253,386	734,211	480,825	189.76%
Affiliate local drawdown	1,204,388	602,194	449,800	(152,394)	(25.31%)
Performance Bonus Incentive	1,334,531	1,334,531	-	(1,334,531)	(100.00%)
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	55,002	52,767	(2,235)	(4.06%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	125,352,291	124,053,574	(1,298,717)	(1.04%)
Operating expenses					
General Administration	3,021,688	1,498,374	1,586,167	(87,793)	(5.86%)
BHH Administration	-	-	-	-	0.00%
Insurance Provider Assessment	1,645,387	822,694	1,262,377	(439,684)	(53.44%)
Hospital Rate Adjuster	4,001,228	2,000,612	1,180,564	820,048	40.99%
Local PBIP	1,334,531	-	-	-	0.00%
Local Match Drawdown	1,204,388	602,194	449,800	152,394	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	97,446	52,767	44,679	45.85%
Payments to Affiliates:					
Medicaid Services	173,402,120	86,701,060	84,436,452	2,264,608	2.61%
Healthy Michigan Services	15,233,944	7,616,972	8,142,992	(526,020)	(6.91%)
Health Home Services	456,768	228,384	509,257	(280,873)	(122.98%)
Total operating expenses	200,508,190	99,567,736	97,620,376	1,947,360	1.96%
CY Unspent funds	$ 32,503,361	$ 25,784,556	26,433,198	$ 648,643	
Transfers in			-		
Transfers out			-	97,620,376	
Unspent funds - beginning			2,254,458		
Unspent funds - ending			$ 28,687,656	26,433,198	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2021 through March 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 2,199,372	$ 2,331,754	$ 132,382	6.02%
Healthy Michigan	9,763,272	4,881,636	5,569,241	687,605	14.09%
Substance Use Disorder Block Grant	5,709,003	2,854,498	1,331,695	(1,522,803)	(53.35%)
Opioid Health Home	2,320,384	1,160,190	1,800,895	640,705	55.22%
Public Act 2 (Liquor tax)	1,533,979	-	1,058,479	1,058,479	0.00%
Miscellanous Grants	36,335	18,168	21,087	2,920	16.07%
SOR Grant	1,215,000	607,500	459,183	(148,317)	(24.41%)
Gambling Prevention Grant	200,000	100,000	47,000	(53,000)	(53.00%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	11,821,364	12,619,334	797,971	6.75%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	505,242	268,749	236,493	46.81%
Prevention Administration	90,144	45,072	41,748	3,324	7.37%
Insurance Provider Assessment	116,901	58,451	92,334	(33,884)	(57.97%)
Medicaid Services	3,387,649	1,693,825	1,697,668	(3,844)	(0.23%)
Healthy Michigan Services	7,453,459	3,726,730	4,039,754	(313,025)	(8.40%)
Community Grant	2,077,452	1,038,726	776,202	262,524	25.27%
Prevention	664,967	332,484	423,726	(91,243)	(27.44%)
State Disability Assistance	95,215	47,611	-	47,611	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	57,777	(57,777)	0.00%
Opioid Health Home Services	2,117,226	1,058,616	1,460,718	(402,102)	(37.98%)
Miscellanous Grants	36,335	18,168	21,087	(2,920)	(16.07%)
SOR Grant	1,215,000	607,500	459,183	148,317	24.41%
Gambling Prevention	200,000	100,000	47,000	53,000	53.00%
PA2	1,533,978	-	1,058,479	(1,058,479)	0.00%
Total operating expenses	20,058,810	9,232,422	10,444,425	(1,212,003)	(13.13%)
CY Unspent funds	$ 5,117,907	$ 2,588,941	2,174,909	$ (414,032)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,231,624		
Unspent funds - ending			$ 8,406,533		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2021 through March 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 864,534	$ 781,775	$ 82,759	9.57%
Fringes	549,516	260,286	257,982	2,304	0.89%
Contractual	433,304	216,654	431,217	(214,563)	(99.03%)
Board expenses	16,100	8,052	9,210	(1,158)	(14.38%)
Day of recovery	14,000	9,000	250	8,750	97.22%
Facilities	152,700	76,350	58,765	17,585	23.03%
Other	127,000	63,498	46,968	16,530	26.03%
Total General Admin	$ 3,021,688	$ 1,498,374	$ 1,586,167	$ (87,793)	(5.86%)

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2021 through March 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 241,104	$ 91,442	$ 149,662	62.07%
Fringes	166,800	83,400	24,264	59,136	70.91%
Access Salaries	194,484	97,242	79,537	17,705	18.21%
Access Fringes	57,588	28,794	24,513	4,281	14.87%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	49,998	42,780	7,218	14.44%
Board expenses	5,000	2,502	1,640	862	34.45%
Facilities	-	-	-	-	0.00%
Other	10,404	2,202	4,573	(2,371)	(107.67%)
Total operating expenses	$ 1,070,484	$ 505,242	$ 268,749	$ 236,493	46.81%

Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through March 31, 2022

County	Beginning Balance	FY22 Projected Revenue	Current Receipts	FY22 Approved Projects	County Specific Projects	Region Wide Projects by Population	Ending Balance
					Actual Expenditures by County		
Alcona	$ 83,635	$ 19,313	$ 0	$ 38,301	19,115	$ 888	$ 84,650
Alpena	315,554	66,080	-	160,005	57,846	2,440	281,915
Antrim	243,061	53,592	-	95,690	35,613	1,997	238,574
Benzie	144,391	49,804	-	27,891	8,466	1,507	176,277
Charlevoix	467,765	82,100	-	262,209	50,110	2,241	340,007
Cheboygan	280,756	68,778	-	176,925	83,512	2,175	258,296
Crawford	85,250	28,559	-	32,978	8,548	1,192	90,571
Emmet	754,134	145,253	-	278,987	76,656	2,846	699,902
Grand Traverse	1,615,220	376,032	-	909,582	294,305	7,872	1,383,847
Iosco	359,368	70,274	-	160,492	43,658	2,157	314,965
Kalkaska	73,813	33,023	-	42,665	18,277	1,512	83,961
Leelanau	131,774	48,924	-	97,254	44,831	1,857	130,132
Manistee	90,411	63,745	-	36,315	14,267	2,094	134,203
Missaukee	66,066	18,058	-	50,287	21,413	1,286	56,536
Montmorency	64,849	26,456	-	36,920	17,335	793	72,513
Ogemaw	164,571	54,659	-	80,483	35,643	1,799	176,189
Oscoda	76,895	17,086	-	43,817	14,700	711	65,575
Otsego	205,220	86,909	-	210,283	80,476	2,104	164,427
Presque Isle	102,301	20,617	-	47,065	21,595	1,097	98,545
Roscommon	488,633	75,491	-	63,178	19,632	2,049	522,626
Wexford	417,956	82,829	-	111,588	49,009	2,853	441,060
	6,231,626	1,487,584	0	2,962,916	1,015,006	43,471	5,814,770
PA2 Redirect							-
							5,814,770

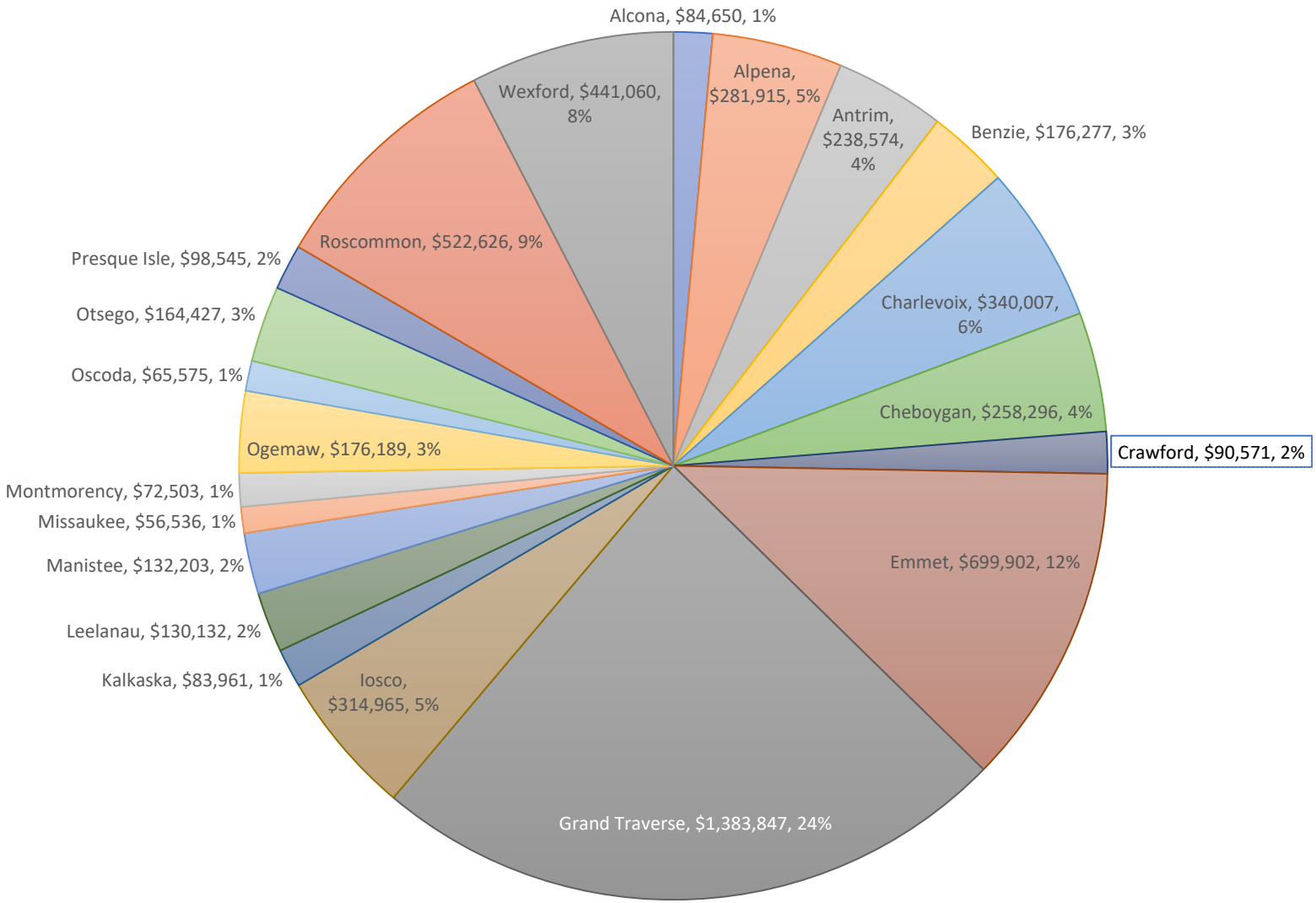
Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2021 through March 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	1,248	3,681	2,433	194.95%
Total operating revenue	2,501	1,248	3,681	2,433	194.95%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 1,248	3,681	$ 2,433	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,358,117		
Unspent funds - ending			$ 16,361,798		

PA2 Funds by County

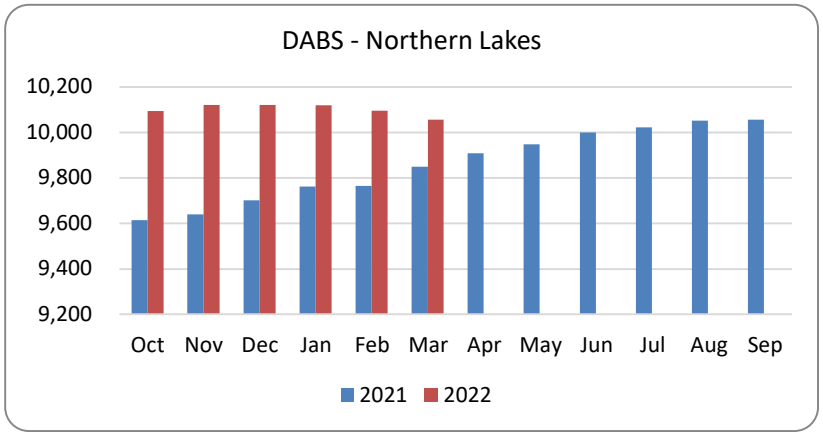


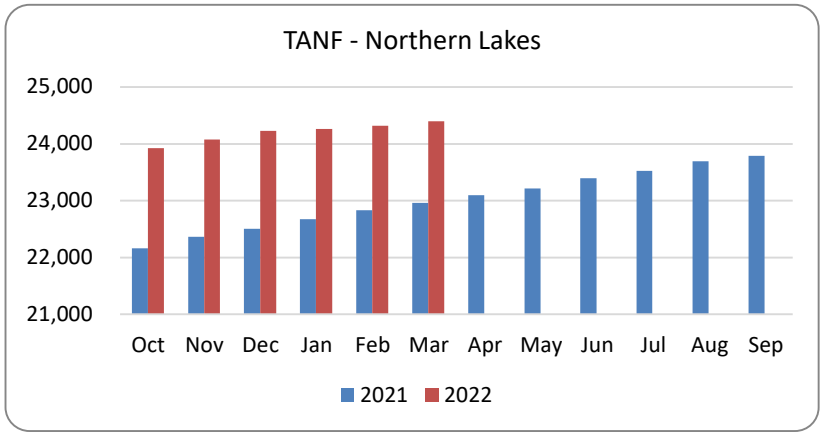
Northern Michigan Regional Entity

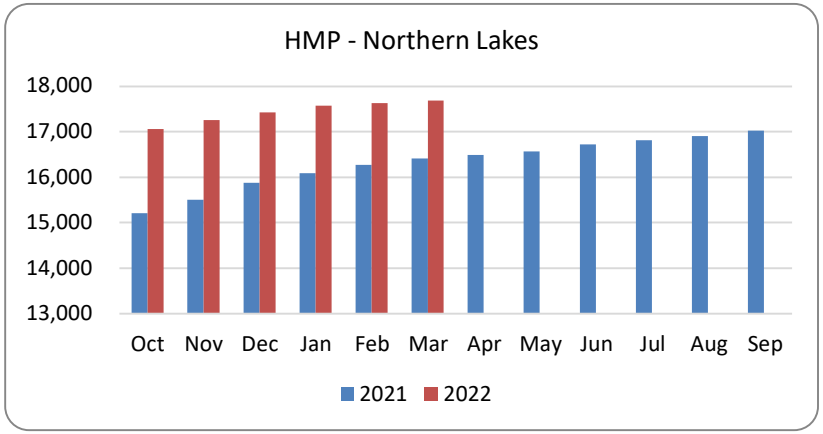
Narrative

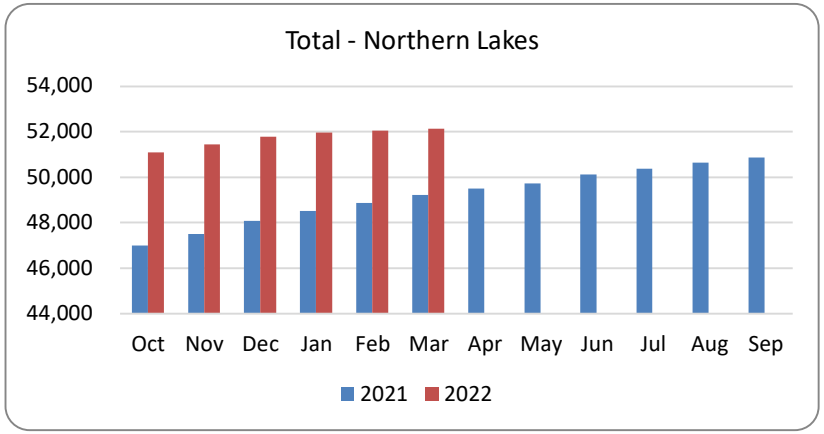
October 1, 2021 through March 31, 2022

Northern Lakes Eligible Trending - based on payment files







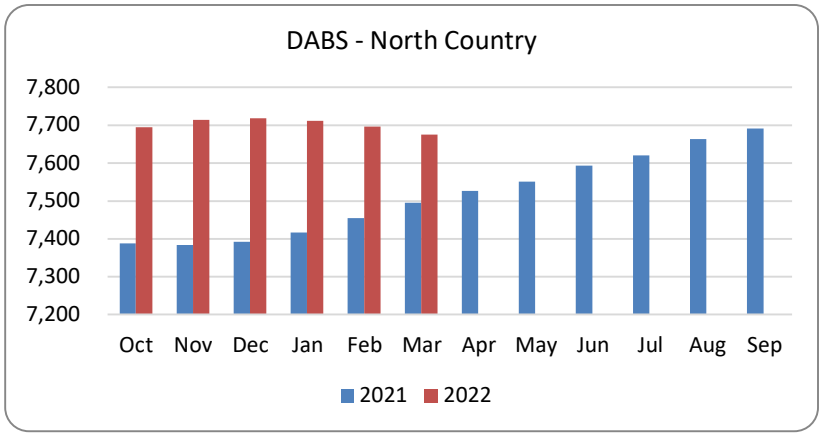


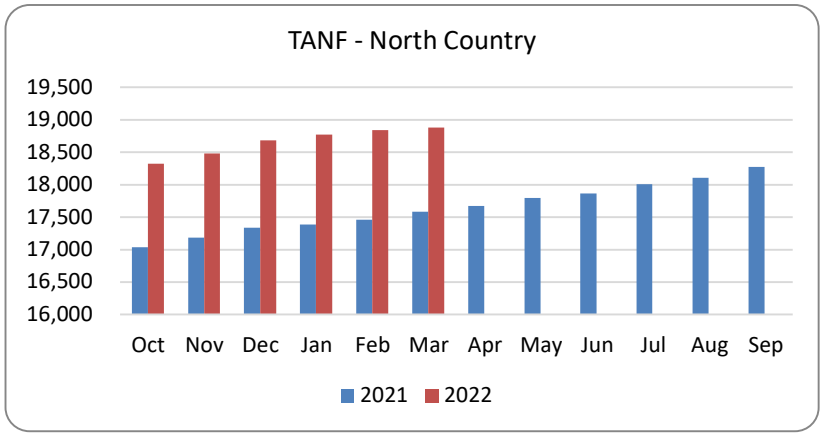
Northern Michigan Regional Entity

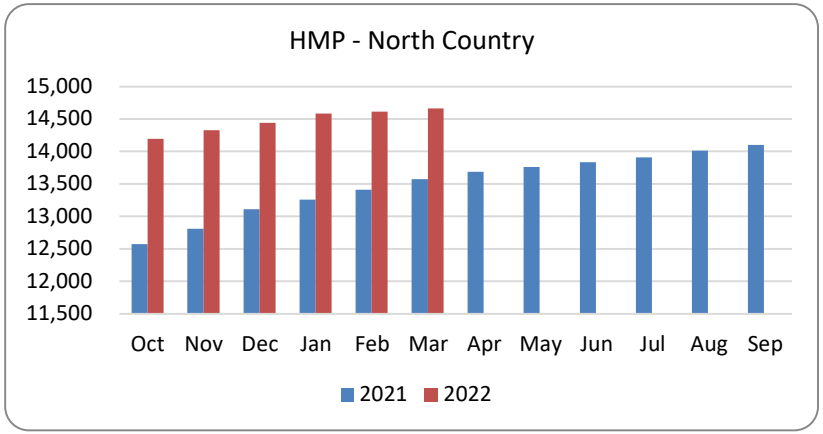
Narrative

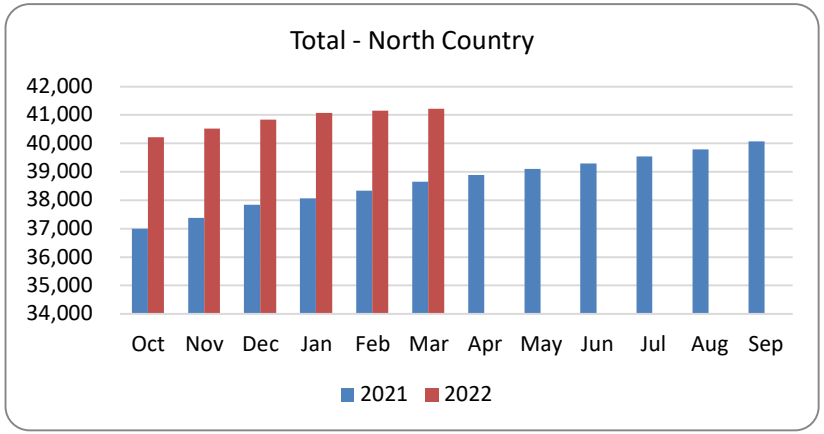
October 1, 2021 through March 31, 2022

North Country Eligible Trending - based on payment files







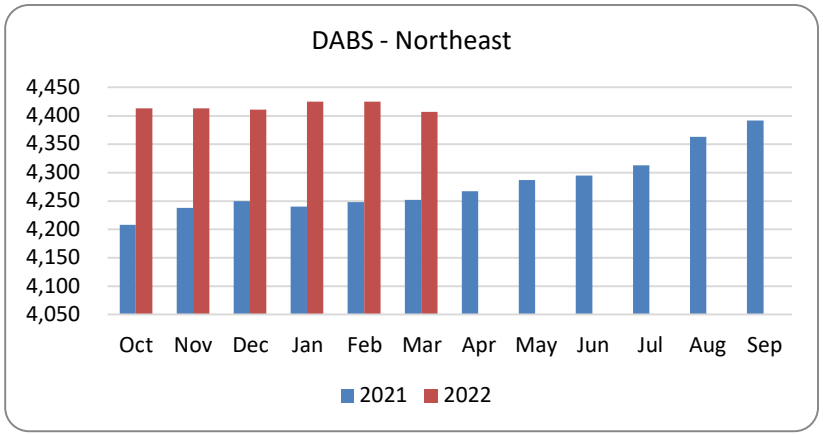


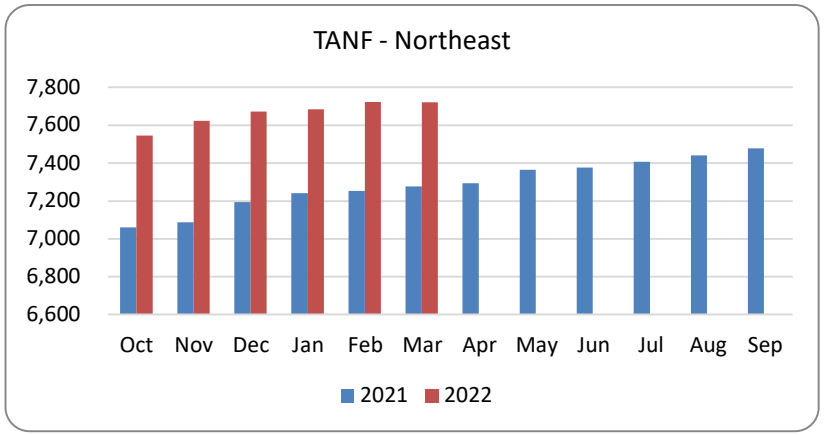
Northern Michigan Regional Entity

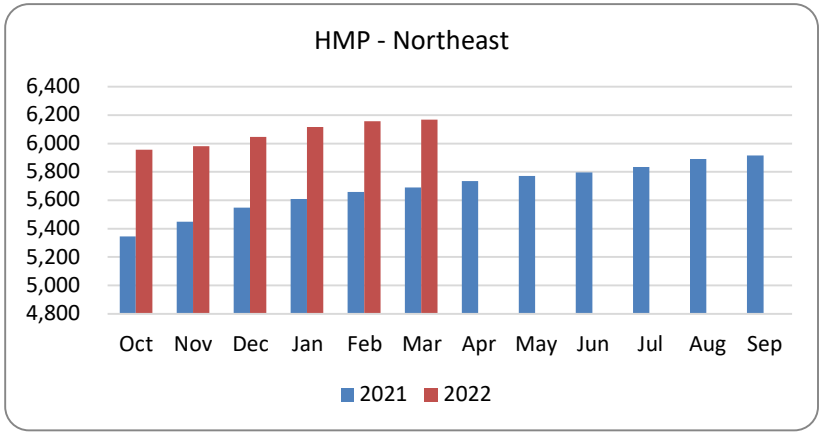
Narrative

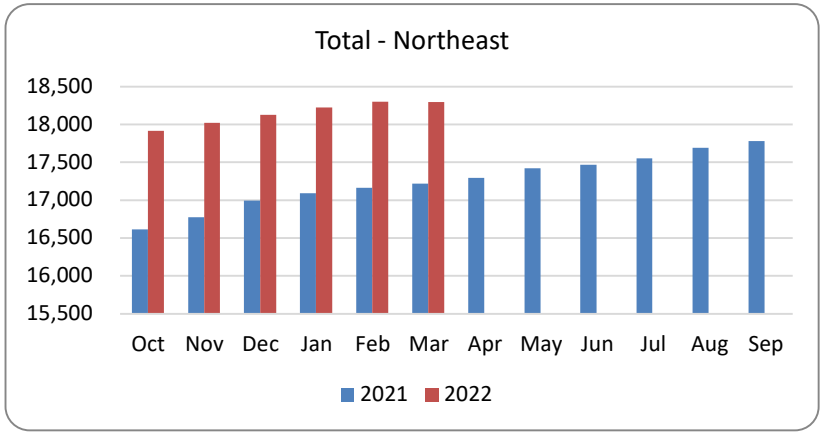
October 1, 2021 through March 31, 2022

Northeast Eligible Trending - based on payment files







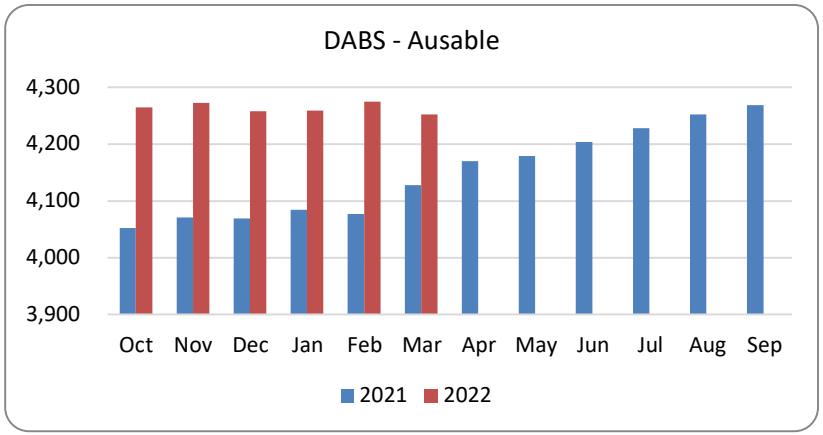


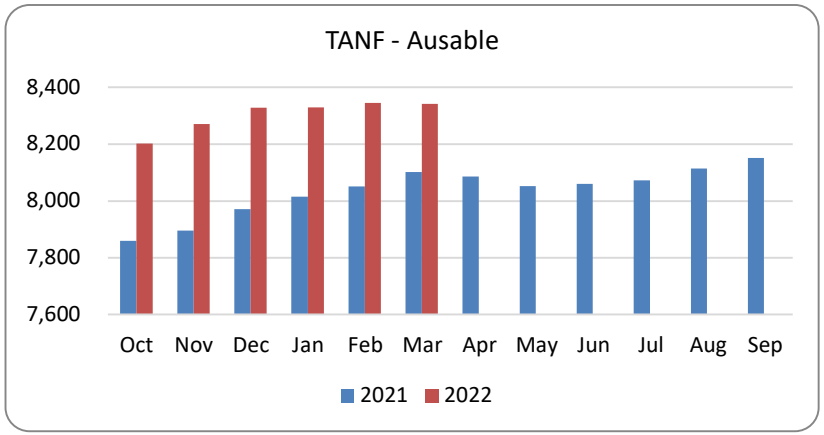
Northern Michigan Regional Entity

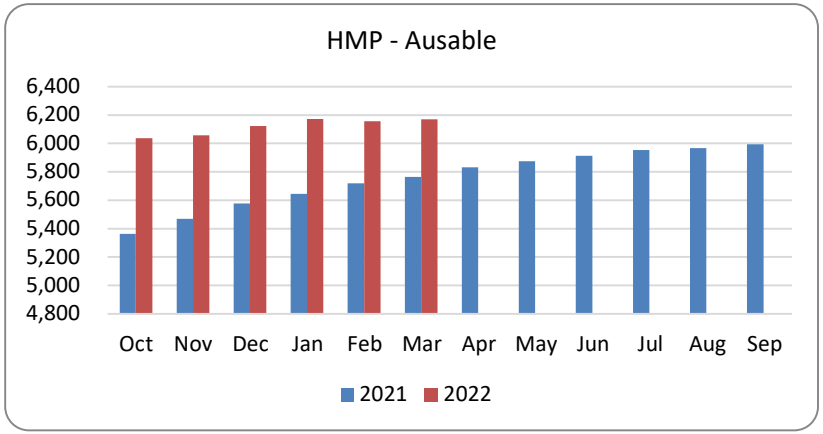
Narrative

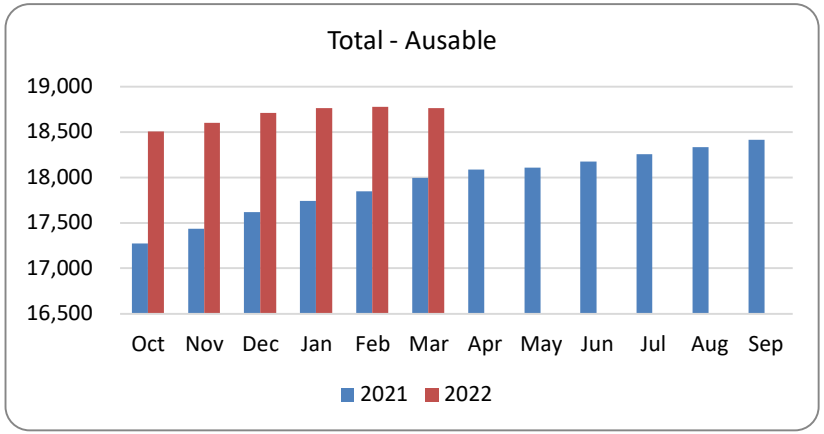
October 1, 2021 through March 31, 2022

Ausable Valley Eligibles Trending - based on payment files







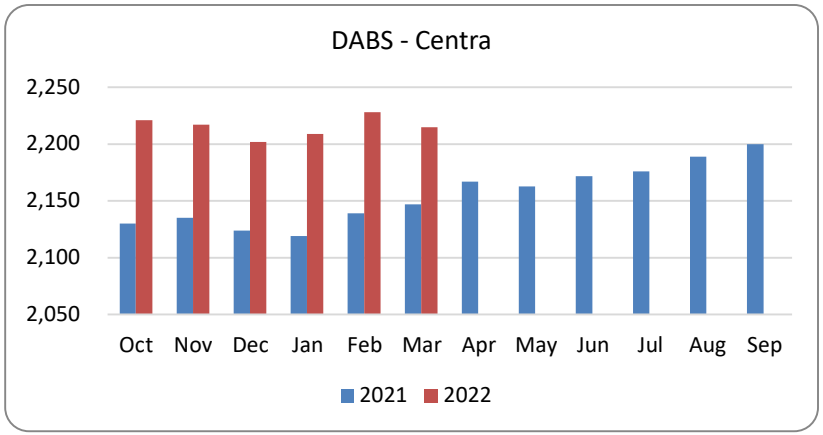


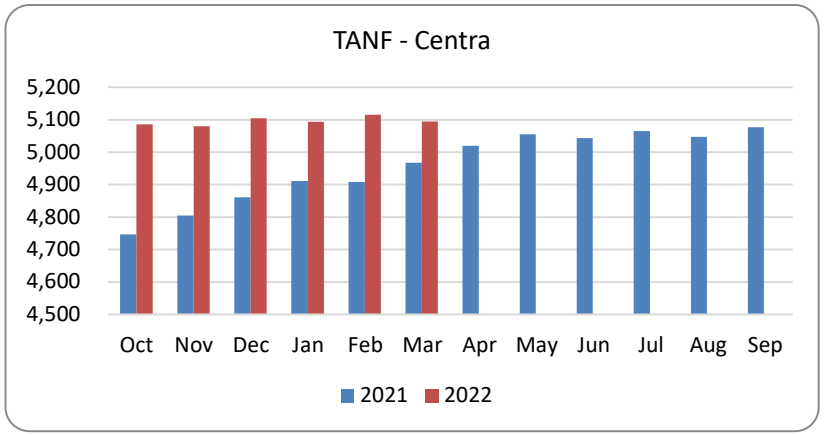
Northern Michigan Regional Entity

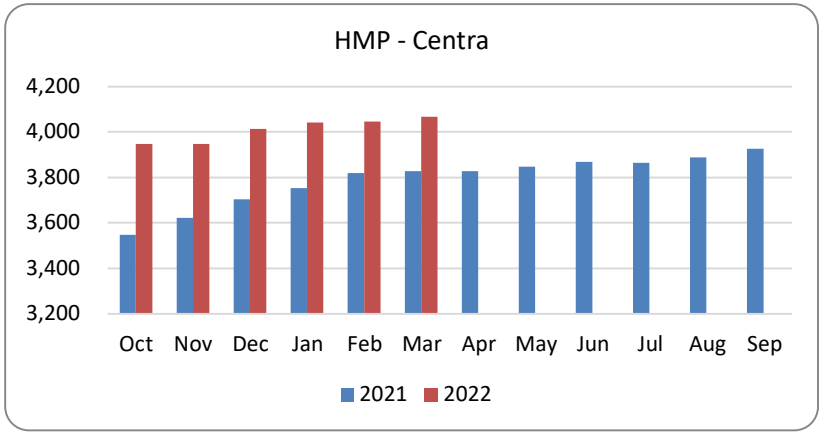
Narrative

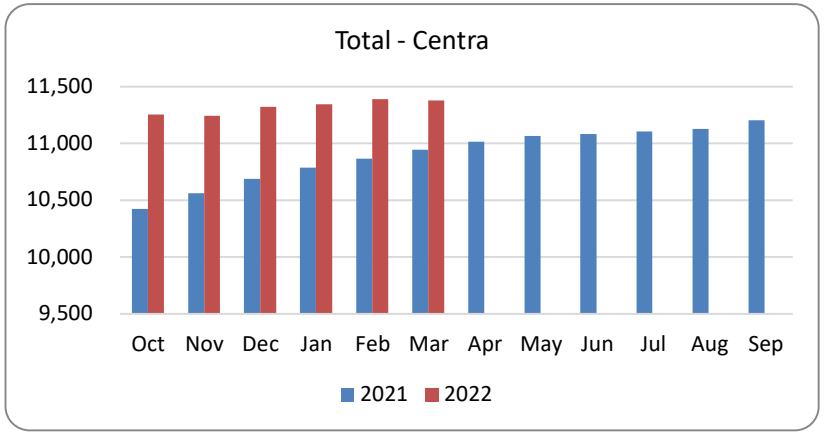
October 1, 2021 through March 31, 2022

Centra Wellness Eligibles Trending - based on payment files







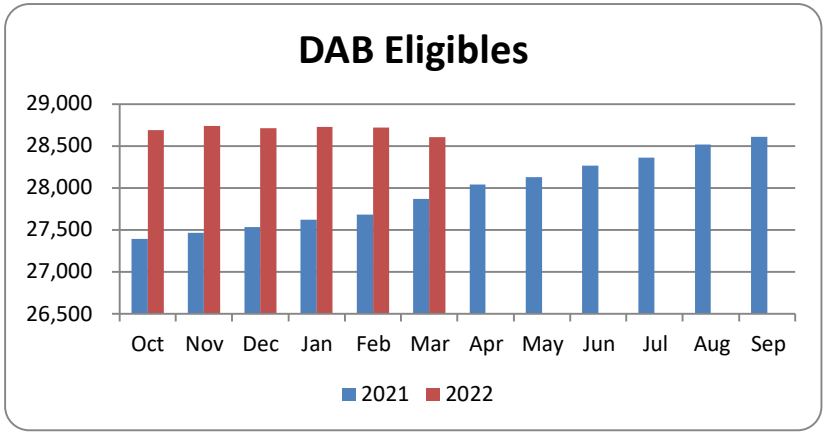


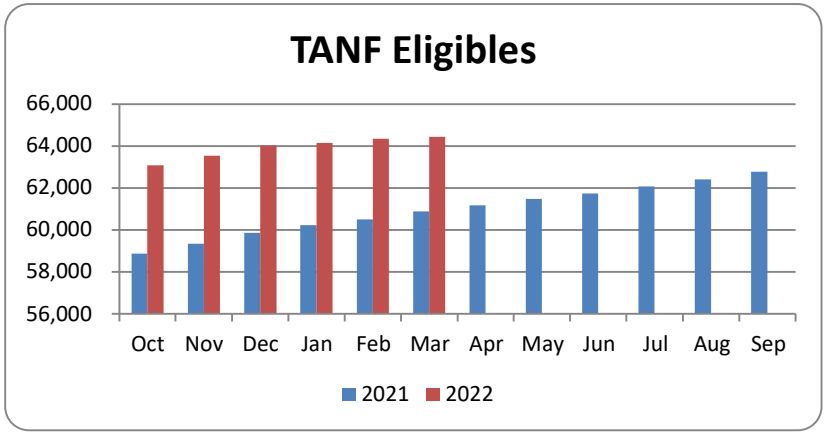
Northern Michigan Regional Entity

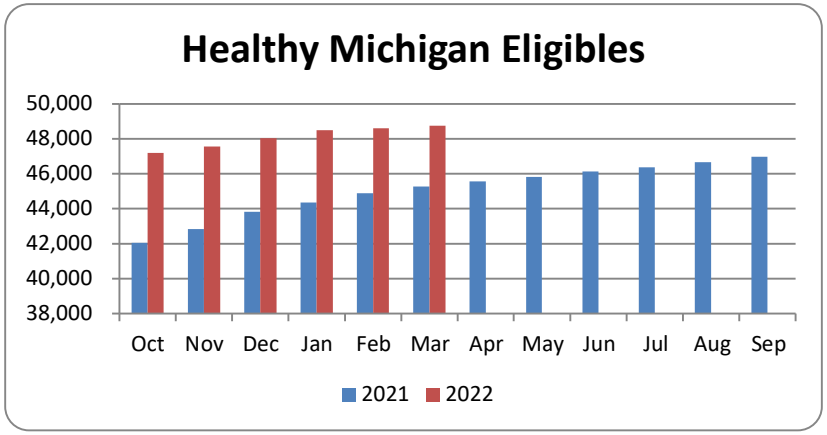
Narrative

October 1, 2021 through March 31, 2022

Regional Eligible Trending





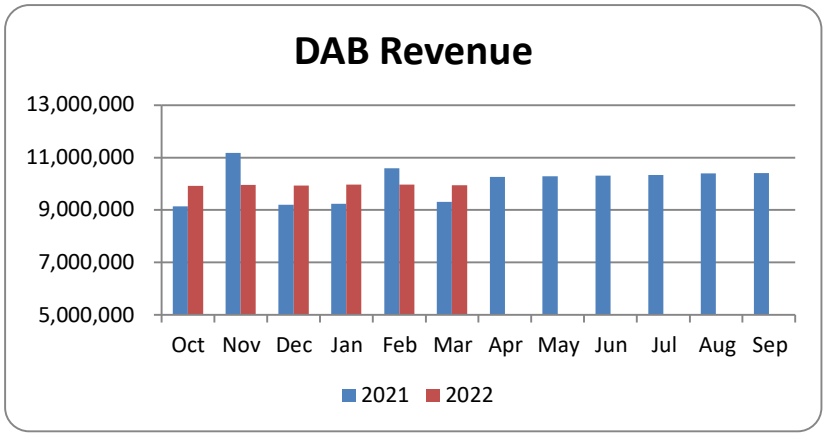


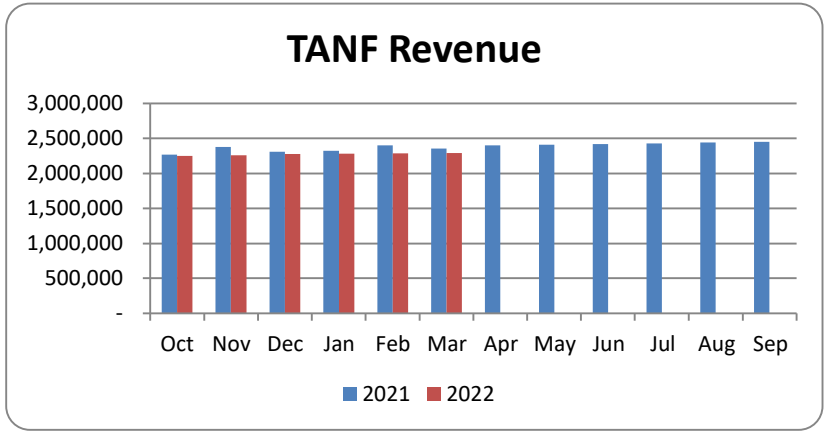
Northern Michigan Regional Entity

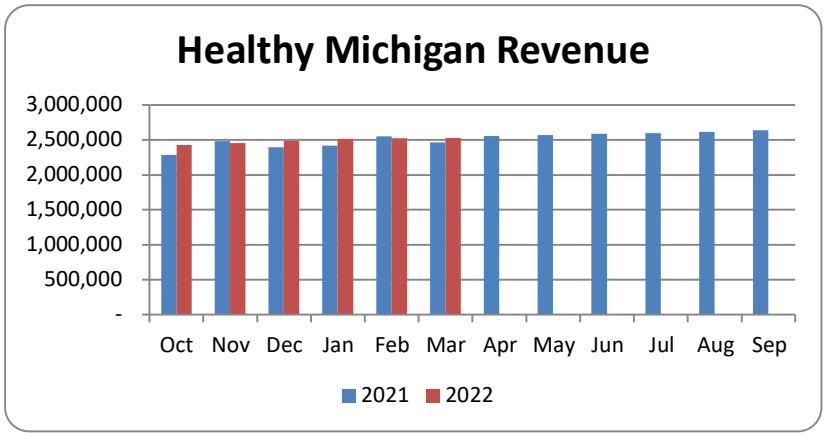
Narrative

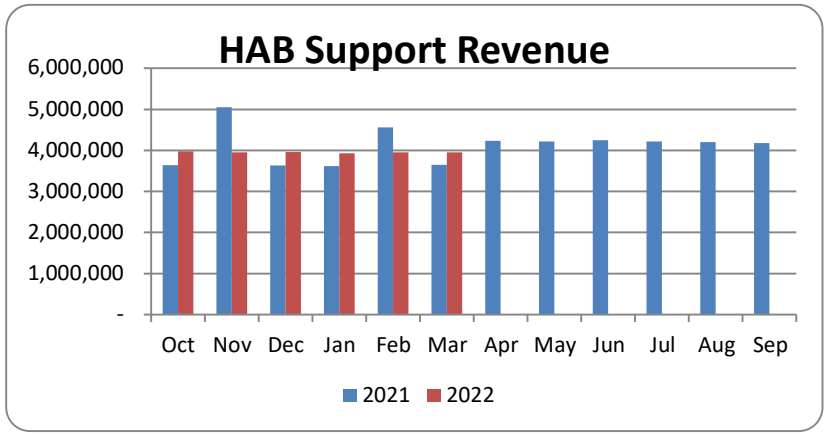
October 1, 2021 through March 31, 2022

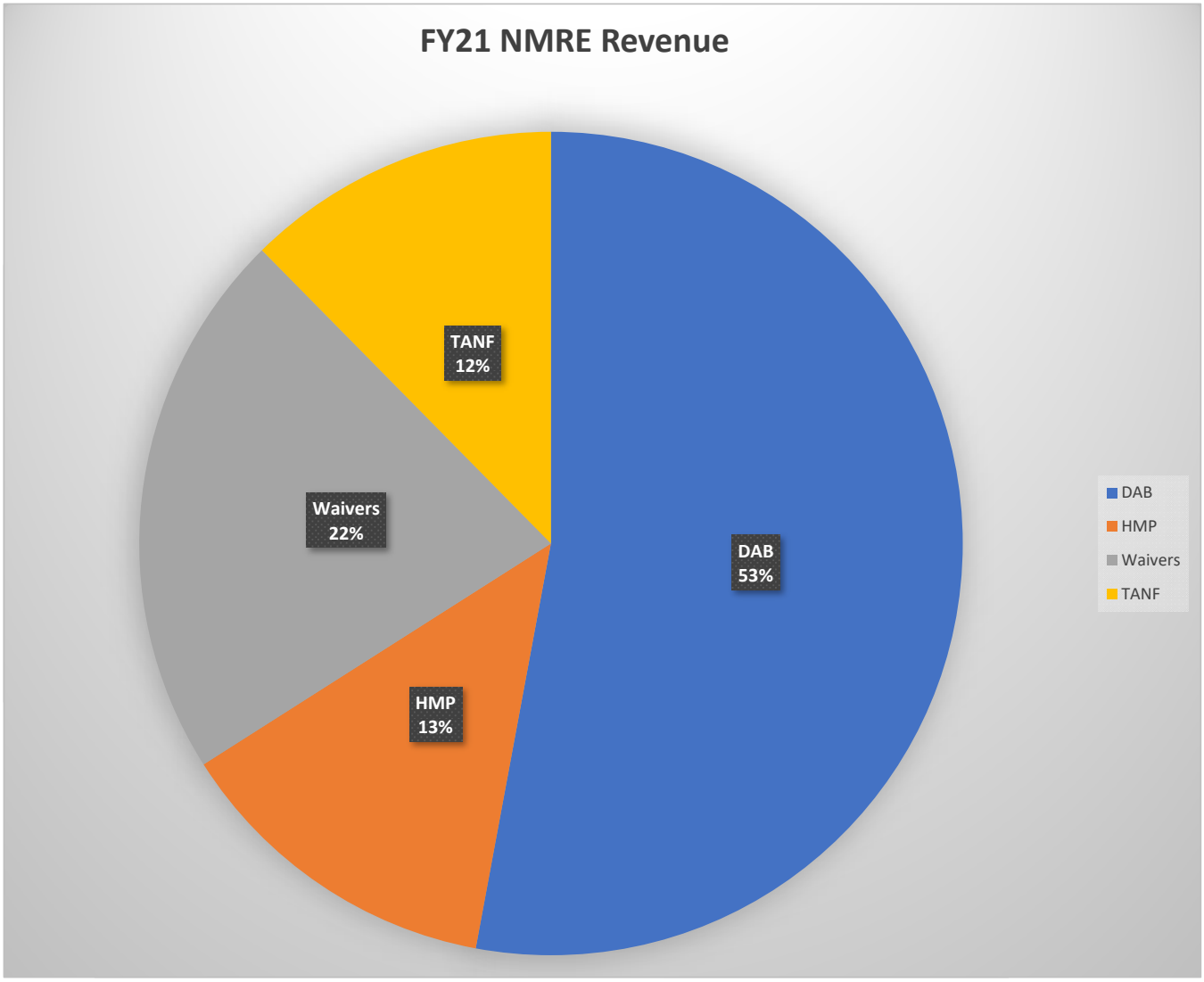
Regional Revenue Trending










FY21 NMRE Revenue
TANF 12%
Waivers 22%
DAB 53%
HMP 13%
DAB
HMP
Waivers
TANF

NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – MAY 17, 2022
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Brian Babbitt, Joanie Blamer, Mary Crittenden, Christine Gebhard, Chip Johnston, Eric Kurtz, Diane Pelts, Carol Balousek**
ABSENT:	**Nena Sork**

REVIEW AGENDA & ADDITIONS
Diane Pelts asked to add a discussion of regional Carter Kit training for EMS & Fire to the meeting Agenda.

APPROVAL OF PREVIOUS MINUTES
The minutes from April 19th were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE MINUTES OF THE APRIL 19, 2022 NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE MEETING; SUPPORT BY JOANIE BLAMER. MOTION APPROVE BY CONSENSUS.

FINANCE COMMITTEE & RELATED
March 2022 Financials

- Net Position showed net surplus Medicaid and HMP of $8,248,294. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $24,606,411. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $40,964,528.
- Traditional Medicaid showed $99,621,062 in revenue, and $90,082,236 in expenses, resulting in a net surplus of $9,538,825. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $15,432,891 in revenue, and $13,157,185 in expenses, resulting in a net surplus of $2,275,707. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $734,211 in revenue, and $520,044 in expenses, resulting in a net surplus of $214,167.
- SUD showed all funding source revenue of $12,092,064, and $10,063,392 in expenses, resulting in a net surplus of $2,028,672. Total PA2 funds were reported as $5,814,770.

Eric reported that October 1, 2021 – March 31, 2022 revenue was $1.9M above the same period in FY21. The Direct Care Wage surplus was estimated as $3,566,238. Ms. Gebhard noted that North Country CMHA is working on a new rate structure for its Provider Network resulting in a $2M expense. Medicaid redeterminations are likely to begin in September. Mr. Kurtz acknowledged a large migration from DAB to TANF over the past 2 years; work will need to be done to move as many individuals as possible back to DAB. NMRE IT Department will pull data.

MOTION BY CHIP JOHNSTON TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2022; SUPPORT BY JOANIE BLAMER. MOTION APPROVED BY CONSENSUS.

FY22 Budget Stabilization
This topic was not discussed at length but it was noted that provider stability payments can continue through the duration of the Public Health Emergency.

Performance Bonus Incentive
Mr. Kurtz reported that NMRE received the full $1.7M Performance Bonus Incentive Payment for FY21. NMRE was one of, or possibly the only, PIHP that met all the standards at 100%. According to the MDHHS-PIHP Contract, the remaining amount in the pool will be redistributed to regions that met the standards; therefore, NMRE will be awarded an additional $1.3M (which the CMHSPs can use as local funds). Mr. Kurtz expressed that he would like the NMRE to retain a portion as a cushion (supplement block grant). The Boards agreed that the NMRE can retain what it needs and distribute the reminder accordingly.

Regional CFO Bench
During the April Operations Committee meeting, the Boards supported the hiring of an NMRE staff to work with NMRE CFO, Deanna Yockey, to learn the financial system, conduct financial management and forecast projections, and ultimately act as a regional CFO "bench" to provide assistance and expertise in the event one of the Boards (or the NMRE) has a vacant CFO position. This topic was discussed during the May 11th Regional Finance Committee meeting and was met with some opposition among the CFOs. The committee discussed the benefits of this position, placing an emphasis on succession planning. The NMRE will move forward with developing a job description and posting the position; the ideal candidate will have CMHSP or PIHP CFO (or high level finance) experience.

SCA DHHS PIHP Contract Item 20
MDHHS has indicated to the PIHPs that it has posted 20 documents to the PIHP Contract folder, all of which it expects to enact without substantive changes. Included among the documents is the Standard Cost Allocation. Input is being gathered frm the PIHPs to inform a response. It has been suggested that the Asssociation conduct an analysis to identify issues with SCA, MLR,etc. Another suggestion was to pull together subject matter experts to meet with the Department to discuss financial reporting requirements.

<u>GRAND TRAVERSE COUNTY AND NORTHERN LAKES</u>
Grand Traverse County's movement to remove itself from the enabling agreement that created Northern Lakes CMHA was discussed at length. Mr. Kurtz has met with Grand Traverse County Administrator, Nate Alger and and County Board Chair, Rob Hentschel. Ms. Blamer has been holding conversations with a variety of stakeholders. No notice of intent to dissolve the enabling agreement with Northern Lakes has been sent and will not be until until an attorney and a consultant hired by the county have weighed in on the process. It was noted that the current enabling agreement could be revised or rewritten by the counties. Mr. Kurtz stressed that if the separation does move forward, NMRE will have to assert some measure of control to ensure that services are being delivered. A meeting of the Grand Traverse Board of Commissioners is scheduled for May 18th; a meeting of the Northern Lakes CMHA Board is scheduled for May 19th. More on this topic will follow in the weeks and months ahead.

ASD EVALUATION QUESTIONS

A discussion about the Evaluation Guidance for ASD Referrals took place during the May 5th PIHP CEOs meeting. Misalignment between evaluation guidance and Medicaid policy was reported (the Medicaid Manual requires a referral by a medical provider). Three questions were sent to the PIHPs for input prior to making any changes to the Medicaid Manual.

1) Should families be able to self-refer to the PIHP for an ASD evaluation, or should they be referred by a primary care provider?
2) Should Early On programs and school-based providers be able to refer children who had a positive screen for ASD to the PIHP for an ASD evaluation, or should the provider refer the child or youth to the primary care provider?
3) Should children and youth who had a positive screen for ASD have a full medical and physical evaluation prior to being referred to the PIHP for ASD evaluation?

The collective response from the Boards was to require a referreal by a primary care provider (care coordination). Mr. Kurtz agreed to send a response on behalf of the region.

CCBHC AND DESIGNATED COLLABORATING ORGANIZATION (DCO)

Mr. Johnston's May 16th email to Johah Cunningham at the National Association of County Behavioral Health & Developmental Disability Directors (NACBHD) regarding the minimum services that are required to be provided by a CCBHC was discussed. Apparently, the CCBHC does not require direct-provided services (though comprehensive behavioral health screening, assessment, and diagnosis, including risk assessments, person-centered and family-centered treatment planning, comprehensive outpatient mental health and substance use disorder services, and crisis behavioral health services were previously identified as services that can only be provided by the CCBHC directly.)

ICSS POC RESPONSE

Mr. Kurtz's memorandum dated May 3rd to Amanda Zebor and Darrell Harden (in which he asserts that Northeast Michigan CMHA should not be under a plan of Correction) was included in the meeting materials. Mr. Kurtz ecplained that a current issue highlights penalties in the MDHHS-PIHP contract for timely responses to Plan of Correction requests. This group will be kept informed of any response received from the Department.

REGIONAL CARTER KIT EMS & FIRE TRAINING

The need for a regional approach to rolling out the kits and arranging training in the region was identified. Currently both the CMHSPs and Carter Kits are scheduling trainings; this needs to be coordinated to avoid confusion. Primary contacts were named for each of the Boards:

- **AuSable Valley** - Diane Pelts
- **Centra Wellness Network** – Karen Goodman
- **North Country** – Christine Dillon
- **Northeast Michigan** – Mary Crittenden
- **Northern Lakes** – Stacey Kaminski

SELF-DETERMINATION

Brian Babbitt attended a meeting of the Self-Determination Workgroup prior to the meeting. He clarified that the Self-Determination Implementation Guide is not required (best practice); only the Policy has been approved. The workgroup agreed to look through the Implementation Guide for discrepancies and "overreach". One concern is that Compliance Training cannot be required. The workgroup is looking at the the stipulation that service cost must not be less than the

contracted, provider rate for the same service for the same level of need for that individual (wage vs. rate).

OTHER

- Ms. Gebhard asked about the current activities of the Quality Oversight and Compliance Committee (QOC) regarding Critical Incidents, Sentinel Events, Risk Events, and Behavior Treatment Review Committee data reporting. Mr. Kurtz responded that NMRE is required to have “meaningful discussions” about this data in order to comply with MDHHS/HSAG Compliance Examination requirements. The question of whether QOC is the best avenue to hold thes discussions was raised. Mr. Kurtz agreed to look into the matter.

- Ms. Pelts announced that AuSable Valley’s Triannual recipient rights audit resulted in full compliance.

- Ms. Gebhard asked abou the status of the CMHSP-NMRE Agreement. Mr. Kurtz responded that most comments from attorney Adam Falcone were supportive; no substantive changes were recommended. The Agreements may be distributed to the Boards for review and signing as early as June.

- Ms. Gebhard asked for a status update on when the CMHSPs will be expected to conduct SUD Assessments. Mr. Johnston responded that Centra Wellness is ready. It was noted that the CMHSPs are lacking resources for supervision for development plans; Mr. Kurtz indicated that the NMRE has two staff are able to provide MCBAB supervision.

NEXT MEETING

The next meeting was scheduled for June 21st at 9:30AM in Gaylord.

NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING
10:00AM – MAY 9, 2022
VIA TEAMS

VIRTUAL ATTENDEES:	**Carolyn Brummund (Alcona), Robert Adrian (Alpena), Tim Markey (Benzie), Robert Draves (Charlevoix), John Wallace (Cheboygan), Terry Newton (Emmet), Dave Freedman (Grand Traverse), Jay O'Farrell (Iosco), Greg McMorrow (Leelanau), Richard Schmidt (Manistee), Roger Frye (Montmorency), Ron Quackenbush (Ogemaw), Doug Johnson (Otsego), Terry Larson (Presque Isle), Tim Muckenthaler (Roscommon), Gary Taylor (Wexford)**
ABSENT:	**Melissa Zelenak (Antrim), David Comai (Kalkaska), Sherry Powers (Crawford), Chuck Varner (Oscoda)**
STAFF:	**Jodie Balhorn, Pamela Polom, Sara Sircely, Carol Balousek**
PUBLIC:	**Chip Cieslinski, Molly Harvey, Sue Winter**

CALL TO ORDER
Let the record show that Mr. Frye called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that David Comai, Sherry Powers, Chuck Varner, and Melissa Zelenak were absent for the meeting on this date; all remaining Substance Use Disorder Oversight Board Members attended virtually.

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

APPROVAL OF PAST MINUTES
The March 7, 2022 minutes were included in the materials for the meeting on this date.

MOTION BY CAROLYN BRUMMUND TO APPROVE THE MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD FOR MARCH 7, 2022; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

APPROVAL OF AGENDA
Let the record show that no additions or revisions to the meeting Agenda were proposed.

MOTION BY JOHN WALLACE TO APPROVE THE AGENDA FOR THE MAY 9, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD; SUPPORT BY RON QUACKENBUSH. MOTION CARRIED.

CORRESPONDENCE
Let the record show that there was no correspondence to discuss during the meeting on this date.

ANNOUNCEMENTS
Let the record show that no announcements were made during the meeting on this date.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST
Let the record show that Mr. Frye called for any conflicts of interest to any of the meeting agenda items; none were declared.

INFORMATIONAL REPORTS
Finance
February 2022 Monthly Report
SUD services through February 28, 2022 showed all funding source revenue of $9,977,841 and $7,987,460 in expenses, resulting in a net surplus of $1,990,381. Total PA2 funds were reported as $5,646,552. It was noted that additional columns were added to the report to show the anticipated FY22 revenue per county, County Specific Actual Expenditures by County, and Regionwide Projects Actual Expenditures by County (based on population).

Grant Update
Ms. Sircely reviewed the Grant Award Summary that was included in the meeting materials.

Gambling Grant	$	200,000.00
Michigan Youth Treatment Infrastructure Enhancement (MYTIE) Grant	$	17,838.00
Substance Abuse, Prevention, and Treatment Block Grant (SABG)	$	3,009,930.00
State Disability Assistance (SDA) Grant	$	95,215.00
State Opioid Response (SOR) 2 Grant	$	2,015,455.00
COVID SABG	$	1,388,858.00
American Rescue Plan Act (ARPA) SABG	$	579,060.00
TOTAL	**$**	**7,306,356.00**

RECOMMENDATION ITEMS
PA2 Fund Use Requests
1) Catholic Human Services – Cheboygan Substance Free Coalition/Cheboygan Youth Coalition

Cheboygan	$	23,366

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM CATHOLIC HUMAN SERVICES FOR CHEBOYGAN COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF TWENTY-THREE THOUSAND THREE HUNDERD SIXTY-SIX DOLLARS ($23,366.00) TO EXPAND THE CHEBOYGAN SUBSTANCE FREE COALITION TO INCLUDE THE CHEBOYGAN YOUTH COALITION; SUPPORT BY JOHN WALLACE. ROLL CALL VOTE.

"Yea" Votes: **R. Adrian, C. Brummund, R. Draves, D. Freedman, R. Frye, D. Johnson, T. Larson, T. Markey, G. McMorrow, T. Newton, J. O'Farrell, R. Quackenbush, R. Schmidt, G. Taylor**

"Nay" Votes: **Nil**

MOTION CARRIED.

PUBLIC COMMENT
As the NMRE SUD Oversight Board's representative for Grand Traverse County, Mr. Freedman announced that the Grand Traverse County Board of Commissioners has decided to split from Northern Lakes Community Mental Health Authority. Ms. Sircely responded that Eric Kurtz is meeting with Grand Traverse County Administrator, Nate Alger, and will stay on top of the matter.

Mr. McMorrow noted that he sits on the Northern Lakes CMHA Board of Directors and offered to discuss the topic with Mr. Freedman privately.

NEXT MEETING
The next meeting was scheduled for July 11, 2022 at 10:00AM.

ADJOURN
MOTION BY JOHN WALLACE TO ADJOURN THE MAY 9, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

Let the record show that Mr. Frye adjourned the meeting at 10:28AM.

PROGRAM BUDGET - COST DETAIL SCHEDULE

ATTACHMENT B.2

View at 100% or Larger MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES Page Of

Use WHOLE DOLLARS Only

PROGRAM	BUDGET PERIOD		DATE PREPARED
=IF('A1 Application'!A44="x","PREVENTION",(IF('A1 Applicatio	From:	To:	
Pulling Together Cheboygan Substance-Free Coalition,	4/1/2022	9/30/2022	4/1/2022
GRANTEE NAME	BUDGET AGREEMENT ☐ ORIG ☐ AMENDMENT		AMENDMENT #
Address / City State Zip			
1000 Hastings st. Traverse City, MI			

1. SALARY & WAGES: POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
	1. TOTAL SALARY & WAGES:		$ -

2. FRINGE BENEFITS: (limit of up to 25% of salary/wages - would need supporting documentation and provide Explanation) Composite Rate %

(Specify)

☐ FICA ☐ LIFE INS ☐ DENTAL INS
☐ UNEMP ☐ VISION ☐ WORK COMP
☐ HOSPI ☐ HEARING INS ☐ Tuition Remission (list
☐ RETIR ☐ OTHER:specify-

2. TOTAL FRINGE BENEFITS: $ -

3. TRAVEL: (Specify if category exceeds 10% of Total Expenditures)

CADCA Youth Mid-Year Training, 4H Life of the Straits, Weekend Youth Leadership Training $16,000

3. TOTAL TRAVEL: $ **16,000**

4. SUPPLIES & MATERIALS: (Specify if category exceeds 10% of Total Expenditures)

Youth Training Materials and Supplies, Marijuana Obstancle Course $4,000

4. TOTAL SUPPLIES & MATERIALS: $ **4,000**

5. CONTRACTUAL: (Subcontracts/Subrecipients)

Name	Address	Amount	

5. TOTAL CONTRACTUAL: $ -

6. EQUIPMENT: (Specify) Amount

6. TOTAL EQUIPMENT: $ -

7. OTHER EXPENSES: (Specify if category exceeds 10% of Total Expenditures) Amount

Communication:			
Space Cost:	CranHill Ranch Cost for (2 nights) Weekend Youth	$ 1,242	$1,242
Others (explain):			

7. TOTAL OTHER EXPENSES: $ **1,242**

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7) 8. TOTAL DIRECT EXPENDITURES: $ **21,242**

9. INDIRECT COST CALCULATIONS: (limit of 9%)

Rate #1 Base $ 21,242 x Rate 10.00% = $ 2,124

**** MUST submit a detailed (with amounts) explanation in Explanation tab*

9. TOTAL INDIRECT EXPENDITURES: $ **2,124**

10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9) $ **23,366**

AUTHORITY: P.A. 368 of 1978

COMPLETION: Is Voluntary, but is required as a condition of funding.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Northern Michigan Regional Entity

Substance Use Disorder Services

American Rescue Plan Act (ARPA) Block Grant

Projects and Responses to RFP:

Project	**Amount**	**Recommended for Contract**
Prevention Evidence Based Practice	$119,060	Health Department of Northwest Michigan *
Same Day Appointments for Detox, Residential or Methadone	$50,000	
SUD Health Home Maintenance	$10,000	
Telehealth Technology	$75,000	Catholic Human Services - $50,000 Bear River Health - $25,000 **
Recovery Community Organization	$150,000	Bear River Health - $81,970
Recovery Support Services	$75,000	***
Recovery Housing	$100,000	****

*Catholic Human Services also submitted a request for a media campaign but these funds are not able to be utilized for a media campaign

**Sacred Heart also applied for these funds. However, there are currently no NMRE funded clients in treatment services at the location applied for.

***Catholic Human Services applied for these funds however WSS will be utilized due to the request

****Billy Jane's Recovery House also applied however, SOR 2 funding will be utilized due to the request. Project Unity also applied for these funds but the requested activities are not allowable under the grant. Sacred Heart applied for these funds as well. The agency would like to establish a recovery home in Emmet or Cheboygan counties. However, there is no house currently.

Northern Michigan Regional Entity

Audit Presentation
May 25, 2022

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN 48801

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

Independent Auditor's Report

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

Report on the Financial Statements

We have audited the accompanying financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Northern Michigan Regional Entity (the Entity) as of and for the year ended September 30, 2021, and the related notes to the financial statements, which collectively comprise the Entity's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the Entity, as of September 30, 2021, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information
Accounting principles generally accepted in the United States of America require that the required supplementary information, as identified in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial

Northern Michigan Regional Entity
Statement of Net Position
September 30, 2021

	Enterprise Funds			Internal Service Fund	
	Mental Health Operating	Substance Use Disorder	Total Enterprise Funds	Medicaid Risk Reserve	Total Proprietary Funds
Assets					
Current assets					
Cash and cash equivalents	$ 6,583,689	$ 6,678,795	$ 13,262,484	$ 16,358,117	$ 29,620,601
Due from affiliates	27,942,772	-	27,942,772	-	27,942,772
Due from State of Michigan	3,201,356	1,050,386	4,251,742	-	4,251,742
Due from other governmental units	-	183,546	183,546	-	183,546
Prepaid expenses	90,791	-	90,791	-	90,791
Total current assets	37,818,608	7,912,727	45,731,335	16,358,117	62,089,452
			Prior year total assets		46,068,149
Liabilities					
Current liabilities					
Accounts payable	2,737,767	1,481,811	4,219,578	-	4,219,578
Accrued payroll and related liabilities	81,864	-	81,864	-	81,864
Due to affiliates	38,552	-	38,552	-	38,552
Due to State of Michigan	16,205,666	136,844	16,342,510	-	16,342,510
Unearned revenue	16,358,117	62,445	16,420,562	-	16,420,562
Compensated absences, due within one year	21,327	-	21,327	-	21,327
Total current liabilities	35,443,293	1,681,100	37,124,393	-	37,124,393
Noncurrent liabilities					
Compensated absences, due beyond one year	120,856	-	120,856	-	120,856
Total liabilities	35,564,149	1,681,100	37,245,249	-	37,245,249
			Prior year total liabilities		23,137,212
Net position					
Restricted for Substance use disorder	-	6,231,627	6,231,627	-	6,231,627
Restricted for Medicaid risk management	-	-	-	9,298,368	9,298,368
Restricted for Healthy Michigan risk management	-	-	-	7,059,749	7,059,749
Restricted for Performance Bonus Incentive Pool	1,737,752	-	1,737,752	-	1,737,752
Unrestricted	516,707	-	516,707	-	516,707
Total net position	$ 2,254,459	$ 6,231,627	$ 8,486,086	$ 16,358,117	$ 24,844,203
Prior year net position	1,293,901	6,840,164	8,134,065	14,796,872	22,930,937

The notes to the financial statements are an integral part of this statement.

Northern Michigan Regional Entity
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2021

	Enterprise Funds			Internal Service Fund	
	Mental Health Operating	Substance Use Disorder	Total Enterprise Funds	Medicaid Risk Reserve	Total Proprietary Funds
Operating revenues					
Medicaid	$ 177,079,844	$ 4,520,732	$ 181,600,576	$ -	$ 181,600,576
Healthy Michigan	16,293,529	10,297,788	26,591,317	-	26,591,317
Health Home	528,236	-	528,236	-	528,236
Opioid Health Home	-	2,283,904	2,283,904	-	2,283,904
State and federal grants	68,317	4,364,842	4,433,159	-	4,433,159
Local match from affiliates	1,204,388	-	1,204,388	-	1,204,388
Public Act 2 revenues	-	1,487,584	1,487,584	-	1,487,584
Performance incentive bonus pool	1,737,752	-	1,737,752	-	1,737,752
Total operating revenues	196,912,066	22,954,850	219,866,916	-	219,866,916
			Prior year total operating revenues		207,477,652
Operating expenses					
PIHP Administration	2,653,703	598,648	3,252,351	-	3,252,351
Hospital rate adjuster	3,977,820	-	3,977,820	-	3,977,820
Incentive payments	1,334,530	-	1,334,530	-	1,334,530
Local match payments	1,204,388	-	1,204,388	-	1,204,388
Taxes on services	1,643,380	118,907	1,762,287	-	1,762,287
Expenses for services					
Medicaid	170,214,536	3,607,771	173,822,307	-	173,822,307
Healthy Michigan	15,696,511	8,427,625	24,124,136	-	24,124,136
Health Home	518,679	-	518,679	-	518,679
Opioid Health Home	-	2,199,278	2,199,278	-	2,199,278
SUD Block Grant	-	4,157,172	4,157,172	-	4,157,172
Public Act 2	-	1,534,907	1,534,907	-	1,534,907
Grants	68,317	-	68,317	-	68,317
Total operating expenses	197,311,864	20,644,308	217,956,172	-	217,956,172
			Prior year total operating expenses		197,357,149
Operating income (loss)	(399,798)	2,310,542	1,910,744	-	1,910,744
Non-operating revenues					
Interest income	-	-	-	2,522	2,522
Total non-operating revenues	-	-	-	2,522	2,522
Income (loss) before transfers	(399,798)	2,310,542	1,910,744	2,522	1,913,266
Transfers					
Transfer in	2,919,079	-	2,919,079	1,558,723	4,477,802
Transfer out	(1,558,723)	(2,919,079)	(4,477,802)	-	(4,477,802)
Total transfers	1,360,356	(2,919,079)	(1,558,723)	1,558,723	-
Change in net position	960,558	(608,537)	352,021	1,561,245	1,913,266
			Prior year change in net position		10,137,977
Net position, beginning of year	1,293,901	6,840,164	8,134,065	14,796,872	22,930,937
Net position, end of year	$ 2,254,459	$ 6,231,627	$ 8,486,086	$ 16,358,117	$ 24,844,203

The notes to the financial statements are an integral part of this statement.

Forfeitures
Contributions are 100% vested immediately therefore there are no forfeitures of these contributions.

For the year ended September 30, employer contributions amounted to $232,079. Employee contributions amounted to $121,811. The outstanding liability to the plan at year-end was $8,217.

Defined Contribution Retirement Plan – 457

Plan Description
The Entity offers all employees a retirement plan created in accordance with the Internal Revenue Code, Section 457. The assets of the plan were held in trust for the exclusive benefit of the participants (employees) and their beneficiaries. ICMA acts as the custodian for the plan and holds the custodial account for the beneficiaries of this Section 457 plan.

The assets may not be diverted to any other use. ICMA are agents of the employer for purposes of providing direction to the custodian of the custodial account from time to time for the investment of the funds held in the account, transfer of assets to or from the account and all other matters. Plan balances and activities are not reflected in the Entity's financial statements.

Plan provisions are established or amended by Board resolution.

Eligibility
All full-time employees are eligible to participate upon employment (no waiting period).

Contributions
The Entity does not contribute to the plan. Employees may contribute up to the amount allowed by the IRS.

Normal Retirement Age & Vesting
Retirement age is not defined by the plan. Contributions are 100% vested immediately.

Forfeitures
Contributions are 100% vested immediately therefore there are no forfeitures of these contributions.

For the year ended September 30, employee contributions amounted to $39,797. The outstanding liability to the plan at year-end was $0.

NOTE 13 - OPERATING LEASES

The Entity has entered into various operating leases for the use of real and personal property. Operating leases do not give rise to property rights or lease obligations, and therefore, the results of the lease agreements are not reflected in the financial statements. Lease expense for the fiscal year was approximately $115,560.

The future minimum lease obligations as of September 30th, were as follows:

Year Ending September 30th	Amount
2022	117,678
2023	120,032
2024	10,019

NOTE 14 - RISK MANAGEMENT

MMRMA
The Entity is exposed to various risks of loss related to theft of, damage to, and destruction of assets; errors and omissions; injuries; and natural disasters. The Entity participated in the public entity risk pool – Michigan Municipal Risk Management Authority (MMRMA) for general liability, property and crime coverage.

MMRMA, a separate legal entity, is a self-insured association organized under the laws of the State of Michigan to

provide self-insurance protection against loss and risk management services to various Michigan governmental entities.

As a member of this pool, the Entity is responsible for paying all losses, including damages, loss adjustment expenses and defense costs, for each occurrence that falls within the member's self-insured retention. If a covered loss exceeds the Entity's limits, all further payments for such loss are the sole obligation of the Entity. If for any reason MMRMA's resources available to pay losses are depleted, the payment of all unpaid losses of the Entity is the sole obligation of the Entity. Settled claims have not exceeded the amount of coverage in any of the past three years.

The Entity's coverage limits are $15,000,000 for liability and $318,150 for buildings and personal property.

Medicaid Risk Reserve
The Entity covers the costs up to 105% of the annual Medicaid and Healthy Michigan contract. The Entity and MDHHS equally share the costs between 105% to 110% of the contract amounts. Costs in excess of 110% of the contract are covered entirely by MDHHS.

The Entity has established a Medicaid Risk Reserve Fund, in accordance with Michigan Department of Health and Human Services guidelines, to assist in managing risk under the terms of its contract with the MDHHS.

NOTE 15 – CONTINGENT LIABILITIES

Under the terms of various federal and state grants and regulatory requirements, the Entity is subject to periodic audits of its agreements, as well as a cost settlement process under the full management contract with the State. Such audits could lead to questioned costs and/or requests for reimbursement to the grantor or regulatory agencies. Cost settlement adjustments, if any, as a result of compliance audits are recorded in the year that the settlement is finalized. The amount of expenses which may be disallowed, if any, cannot be determined at this time, although the Entity expects such amounts, if any, to be immaterial.

NOTE 16 – ECONOMIC DEPENDENCE

The Entity receives over 95% of its revenues from the State of Michigan either directly or indirectly from MDHHS.

NOTE 17 – TRANSFERS

The Substance Use Disorder Fund transferred $2,919,079 to Mental Health Operating Fund the during the year for the purpose of covering future risk related to services provided to Medicaid and Healthy Michigan eligible consumers.

The Mental Health Operating Fund transferred $1,558,723 to the Medicaid Risk Reserve Fund during the year for the purpose of covering risk related to services provided to Medicaid and Healthy Michigan eligible consumers.

NOTE 18 - UPCOMING ACCOUNTING PRONOUNCEMENTS

GASB Statement No. 87*, Leases*, was issued by the GASB in June 2017 and will be effective for the Entity's fiscal year September 30, 2022. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities.

GASB Statement No. 96, *Subscription-based Information Technology Arrangements,* was issued by the GASB in May 2020 and will be effective for the Entity's fiscal year ending September 30, 2023. This Statement provides

guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users (governments). This Statement (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in Statement No. 87, *Leases,* as amended.