Northern Michigan Regional Entity

Board Meeting

December 7, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

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14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – January 25, 2023	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – OCTOBER 26, 2022
GAYLORD BOARDROOM

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

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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 Gary Klacking and Don Smeltzer were excused from the meeting on this date; all other NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

APPROVAL OF AGENDA
Let the record show that no changes to the meeting Agenda were requested.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR OCTOBER 26, 2022; SUPPORT BY MARY MAROIS. MOTION CARRIED.

APPROVAL OF PAST MINUTES
Let the record show that the September minutes of the NMRE Governing Board were included in the materials for the meeting on this date. Mr. Lawson will be added to the list of attendees and roll call voting.

MOTION BY KARLA SHERMAN TO APPROVE THE MINUTES OF THE SEPTEMBER 28, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS AS AMENDED; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

CORRESPONDENCE

1) The minutes from the October 6th PIHP CEO meeting.
2) Notes from the September 28th-29th CMHAM Directors Forum.
3) MDHHS Financial Liability for Mental Health Services rules filed with the Secretary of State on September 20, 2022.
4) Letter from Farah Hanley at MDHHS to Timothy Engelhardt at CMS dated September 30, 2022 regarding the state's transition plan to move its Medicare-Medicaid Plans into an Integrated Special Needs Plan (SNP) model by January 1, 2026 (with attached Plan).
5) Document titled, "Harm Reduction: A Consensus Statement of Support by Michigan's 10 Community Mental Health Entities (Prepaid Inpatient Health Plans)."
6) MDHHS Michigan Psychiatric Care Improvement Project (MPCIP) update dated October 2022.
7) MDHHS Michigan Integration Efforts: Service Delivery Transformation Update dated October 2022.
8) Memorandum from Jeffery Wieferich at MDHHS to PIHPs dated October 3, 2022 regarding Veteran Affairs (VA)/ Medicaid Service Requests.
9) Action Alert from CMHAM dated October 17th urging the public to reach out to legislators and the Governor requesting they not support a lame duck deal on Senate Bills 597 and 598.
10) Email correspondence from CMHAM clarifying the use of the state's MiCAL for after-hours services.
11) CMHAM document titled, "Exploring Partnership with Wakely for Actuarial Consultation" dated September 9, 2022.
12) CMHSM document titled, "Advancing Michigan's Mental Health System by Strengthening the Partnership between MDHHS and Michigan's Community Based Mental Health System" dated September 2022.
13) Email correspondence from CMHAM providing a summary of recent discussions with the CCBCHC team at MDHHS.
14) The NMRE Organizational Chart effective October 1, 2022.
15) The draft minutes from the October 12th NMRE Regional Finance Committee meeting.

Mr. Kurtz referred to the correspondence from Farah Hanley, Chief Deputy for Health, announcing the approval of a one-year extension to the MI Health Link (dual eligibles) pilot. He noted that a couple of PIHPs have requested to opt out, which has prompted the state to look to the future. There is a possibility that this population will be handed to the Medicaid Health Plans (along with the funding).

Mr. Kurtz next highlighted the memorandum from Jeffery Wieferich requiring that Veterans with Medicaid who meet medical necessity criteria for behavioral health services be served by the PIHPs/CMHSPs regardless of veteran status.

Mr. Kurtz drew the Board's attention to the Action Alert from CMHAM regarding SB 597 & 598 and HBs 4925 - 4928.

Mr. Kurtz informed the Board of CMHAM's intent to engage with Wakely actuarial firm to look at the legitimacy of what Milliman's activities (dueling actuaries). It was noted that the State MIChoice Waiver program uses Wakely.

Mr. Lawson asked what is meant by a "contract type candidate" as referenced in the Directors Forum minutes under "Changes in county commission make-up." Mr. Varner responded that he

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believes that the term refers to candidates who align with views similar to those in the 1994 Contract with America.

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

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

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

CEOs Report
The NMRE CEO Monthly Report for October 2022 was included in the materials for the meeting on this date. Mr. Kurtz noted that he attended a meeting of the Northern Lakes six county administrators on October 3rd; all six counties have signed Memorandum of Understanding (MOU) to revisit the enabling agreement that formed NLCMHA. Lakeview Consultants (Sarah Bannon) will be conducting listening sessions throughout the Northern Lakes region.

Ms. Dahlstrom asked whether a press release or letter to NLCMHA services recipients, contractors, and the public has been considered. Mr. Kurtz responded that a letter should originate with the counties; Nate Alger mentioned doing something similar recently. Brian Martinus will speak to the NLCMHA Board about issuing a communication to services recipients. Ms. Marois emphasized that Northern Lakes is appreciative of the support provided by Mr. Kurtz and the NMRE, stating that "it has made a huge difference."

Mr. Kurtz has spoken with Dr. Ibrahim and the staff at the North Shores Center about the status of the Gaylord Crisis Residential Unit (Alpine CRU). The building is on track for a January 1, 2023 opening. A lease has been signed and LARA has given an unofficial acknowledgement that licensing should go smoothly.

August 2022 Financial Report
- Net Position showed net surplus Medicaid and HMP of $12,475,178. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $28,833,295. 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 $45,191,412.
- Traditional Medicaid showed $186,405,461 in revenue, and $171,709,461 in expenses, resulting in a net surplus of $14,696,000. 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 $29,858,005 in revenue, and $25,540,724 in expenses, resulting in a net surplus of $4,317,281. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,359,717 in revenue, and $1,168,106 in expenses, resulting in a net surplus of $191,611.
- SUD showed all funding source revenue of $23,280,348, and $19,949,895 in expenses, resulting in a net surplus of $3,330,453. Total PA2 funds were reported as $5,326,234.

The direct care wage surplus was estimated at $5,326,234. A potential lapse of $10M for FY22 is anticipated (not including the DCW).

It was noted that the Public Health Emergency (PHE) scheduled to end on January 11th at which time Medicaid redeterminations will resume and revenue could (sharply) decrease. Ms. Dahlstrom asked whether CCBHC funding be pursued. Mr. Kurtz responded that CMHSPs are at full risk for the CCBHC service costs. He added that becoming certified for those entities that were not part of the original 14 could be up to a two-year process.

Mr. Lawson asked Ms. Yockey if she was able to determine the NMRE's overall percentage of administrative overhead per his request in September. Ms. Yockey responded that she calculated the NMRE's admin at approximately 2%. Mr. Kurtz noted that it is too low but due to the staffing crisis the NMRE is actively looking to fill some vacant positions.

Ms. Yockey was asked to explain the $1,026,665 deficit shown for Northeast Michigan on the Financial Summary page of the report. Ms. Yockey clarified that Northeast Michigan overspent its per member/per month payment in FY22. However, $15.6M of DCW is included in the NMRE's rates. Of that, only half is actually spent; the other half will be returned to the state.

Ms. Sherman asked how much of the surplus can be attributed to open positions; Mr. Kurtz replied that it is likely a significant amount.

Ms. Yockey turned attention to the Schedule of PA2 by county page of the financial report. The "FY22 Approved Projects" column shows approved funding; however, the "Current Receipts" shows how much has actually been billed. Currently, there is a difference of $2.3M which will be added to the $5.3M balance. Mr. O'Farrell shared that House Bill 5732 would allow the use of the counties' portion of liquor tax funds to be used for secondary road patrol.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR AUGUST 2022; SUPPORT BY CHUCK VARNER. MOTION CARRIED.

Operations Committee Report
The draft minutes from October 18, 2022 were included in the materials for the meeting on this date.

NMRE SUD Oversight Board Report
The next meeting of the Northern Michigan Regional Entity SUD Oversight Board is scheduled for 10:00AM on November 7, 2022 at the NMRE office in Gaylord.

NEW BUSINESS

Christine Gebhard Contract
Mr. Kurtz reached out to Christine Gebhard to determine whether she would be interested in taking on some projects on behalf of the region. Areas of focus were discussed as:

- Participation on the Northern Michigan CHIR
- General Advocacy
- Traverse City Crisis Services Unit
- Other as needed

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It was noted that Ms. Gebhard possesses strong relationships and historical knowledge that would benefit the region. Ms. Dahlstrom shared that good things are coming out of the CHIR; Action Teams have yielded very positive results.

Ms. Marcus asked about termination of the agreement. Mr. Kurtz responded that general terms for professional contracts state that either party may terminate the agreement for any reason by providing the other party with sixty days prior written notification.

MOTION BY MARY MAROIS TO CONTRACT WITH CHRISTINE GEBHARD FOR PROFESSIONAL SERVICES ON BEHALF OF THE NORTHERN MICHIGAN REGIONAL ENTITY AT A RATE OF ONE HUNDRED TWENTY-FIVE DOLLARS ($125.00) PER HOUR PLUS TRAVEL EXPENSES; MS. GEBHARD WILL BE REQUIRED TO PROVIDE MONTHLY EXPENDITURE REPORTS TO THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY KATE DAHLSTROM. ROLL CALL VOTE.

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

The final contract will be brought back to the Board in December.

OLD BUSINESS

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

The Action Alert from CMHAM dated October 17th and Alan Bolter's comments during the CMHAM Fall Conference were discussed. It is rumored that that Sen. Shirkey & Rep. Whiteford are drafting a compromise bill that would combine SBs 597 & 598 and HBs 4925 – 4928 in an attempt to get "something" done before the end of the year. It is speculated that a compromise bill could move all of the Medicaid children's services including autism and foster care over to private insurance companies and then the state would create one statewide entity to manage the other populations.

Grand Traverse County and Northern Lakes CMHA

Mr. Kurtz stated that he had nothing further to report on this topic; he will continue to keep the Board apprised of any developments.

PRESENTATION

Compliance and Quality Workplan Update

NMRE Compliance Officer, Tema Pefok, was in attendance to provide an update on the NMRE's Compliance and Quality Workplan.

Ms. Pefok reported that the Board that the NMRE is engaged in two regional Quality Improvement Initiatives in FY23:

1) Improve the percentage of individuals enrolled in the Behavioral Health Home program from 3.56% to 5%.
2) Decrease no-show/missed appointment rate for psychiatric services.

Ms. Pefok reviewed regional risk event, critical incident, sentinel event, and performance indicator data.

Ms. Pefok informed the Board that the NMRE implemented two additional regional committees in response to MDHHS/HSAG compliance reviews:
1) Behavior Treatment Plan Review Committee (BTPRC)
2) Utilization Review Committee

Mr. Tanner asked whether the Boards have explored out-of-state residential or inpatient placements. The mental health systems in Indiana, Ohio, and Wisconsin have been vetted through the Michigan Attorney General's office and approved for use by residents of Michigan. To date, the CMHSPs have not placed clients out-of-state.

Regarding no-show rates, the CMHSPs were asked if they provide appointment reminder calls; the CEOs responded yes, reminder calls and text messages are made prior to the scheduled appointments. The importance of peer engagement was emphasized. The NMRE will continue to track no-show rates for psychiatric services.

COMMENTS
Let the record show that there were no comments offered from Board Members, CMHSP CEOs, NMRE staff, or members of public at the close of the meeting on this date.

MEETING DATES
The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on December 7, 2022.

ADJOURN
Let the record show that Mr. Tanner adjourned the meeting at 12:00PM.

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PIHP CEO Meeting
November 3, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

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Ability to Pay

Direct Care Wage Increase

State Hospital Denials

Action Items

Attendees

Pre-paid Inpatient Health Plans (PIHP)

Dr. Timothy Kangas (Northcare Network)	Region 1
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
Dana Lasenby (Oakland Community Health Network)	Region 8
Dave Pankotai (Macomb County CMH Services)	Region 9
Jim Johnson	Region 10

Michigan Department of Health & Human Services (MDHHS)

Michael Baker
Kim Bastche-McKenzie
Lisa Collins
Alicia Cosgrove
Audrey Dick
Erin Emerson
Stacy Farrell
Farah Hanley
Darrell Harden
Krista Hausermann
Belinda Hawks
Lynn Hendges
Kristen Jordan
Leah Julian
Paula Kaiser VanDam
Brian Keisling
Phil Kurdunowicz
Lindsay McLaughlin
Dana Moore
Lindsey Naeyaert
Patricia Neitman
Ernest Papke
Ella Philander
Kelsey Schell
Angie Smith-Butterwick
Jeff Wieferich
Amanda Zabor

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

CC360 Homeless Vulnerability Level Tool

1. Lynn Hendges presented on the new Homeless Vulnerability Level Tool in CC360. This slide deck will be distributed to the group via email.
    a. The data comes directly from the Homeless Management Information system data and is matched with the Medicaid data.
    b. The tool tracks if a person is homeless, for how long they have been, and whether they are currently sheltered or unsheltered. These measures produce a rating of High, Medium, or Low.
    c. There are sharing agreements and protections in place in the system to ensure information is only shared when appropriate. No health-related information is shared via this tool.
2. Lynn Hendges sought feedback from the group.
    a. The PIHPs thanked her for the effort to create and inform them about the tool.

Children's Bureau Update

1. Patricia Neitman presented the update on the Office of the Advocate for Children, Youth, and Families. The slide deck has been distributed to the group via email.
2. A PIHP noted that there were three different pathways in which PIHPs might be contacted with concerns from MDHHS. They asked if those pathways for Children, Youth, and Families were largely the same as for adults.
    a. The PIHPs want to know the pathways the information may come from so that they can dedicate the correct unit for responding.
    b. Patricia Neitman responded that she might not be the best person to answer that question. She added that when they hear feedback from people in the community, they also encourage them to work through the customer service people at the local and regional level to work through their concerns first before asking MDHHS to get involved.
    c. A PIHP noted that they were very in favor of using the new MI CAL CRM to have one place to focus to find and address concerns.
        i. Patricia Neitman thanked them for the feedback. She added that the goal is to use the CRM as much as possible.
3. Lisa Collins presented on the MichiCANS assessment. This slide deck has been distributed to the group.
    a. Kim Batsche-McKenzie noted that the MichiCANS is an assessment, not a screening, and is a way to organize the information providers are already gathering. The MichiCANS elevates the top areas of both need and strength so the team can plan care around those.
    b. Lisa Collins added that MDHHS is creating a FAQ document. The draft version of this document has been distributed to the group via email.
    c. The PIHPs asked MDHHS to clarify if there would be a certification from CANS training, and for an estimate of the number of hours of training involved.
        i. Lisa Collins responded that training is expected to be between 6-8 hours.

ii. The PIHPs thanked her for the estimate and explained that they knew the planned training timeframe could change over time, but that a rough estimate allowed them to prepare for staff to take that training.
iii. The PIHPs noted that if there would be a certification required before involvement in CANS, that might involve a Medicaid update to the staff qualifications document. If so, the PIHPs would like to know about that as soon as possible.

4. Phil Kurdunowicz provided the update on the mobile crisis grants.
    a. When the mobile crisis grants were launched, it was with the intent to have multiple cohorts.
    b. The department is committed to operating this as a three-year grant, for as long as the minimum criteria are met.
    c. MDHHS hopes to see additional applicants in cohort two, and they were encouraged by the applications they saw in cohort one. MDHHS is providing feedback so cohort one can update their grant proposals.
    d. MDHHS hopes to make awards to cohort one by November 17, 2022.
    e. MDHHS intends to establish a learning community for mobile crisis units, specifically for children. The intent is to have a monthly meeting for grantees and a more open training session for all CMHs around best practices.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Lindsey Naeyaert shared her section is looking to fill three positions, two of which will be working with the Certified Community Behavioral Health Clinics (CCBHCs). The roles to be filled are:
    a. A CCBHC certification specialist.
    b. A CCBHC analyst position.
    c. A behavioral health innovation specialist.
2. Lindsey Naeyaert provided the Opioid Health Home update.
    a. Around 2700 beneficiaries are enrolled in the Opioid Health Home, and all the new regions are successfully enrolling additional beneficiaries.
    b. The Opioid Health Homes continue to collaborate with the women's specialty services grants to assist with additional care coordination services for pregnant and parenting people.
    c. MDHHS is looking to pursue a State Plan Amendment to expand the current Opioid Health Home in Region 2 to add alcohol use disorder and stimulant use disorder for Medicaid beneficiaries. MDHHS is targeting an implementation date of Q3 or Q4 for FY 2023.
    d. A PIHP asked if this was expected to be a step towards future statewide expansion.
        i. Lindsey Naeyaert responded that it would depend on how the implementation goes. If it goes well, that would be the eventual intent.
3. Lindsey Naeyaert provided the Behavioral Health Homes update.
    a. There are currently over 1800 people enrolled currently.
    b. MDHHS is working with Region 5 to expand behavioral health homes into the region.

c. MDHHS is also attempting to get approval on flexibility for some staffing requirements relating to LPNs and peer recovery coaches as part of the care team.
    i. These were recommendations from the health home partners and the PIHPs participating in the behavioral health homes.
4. Lindsey Naeyaert reported that for CCBHCs, MDHHS is still waiting for guidance from the United States Department of Health and Human Services to move forward with expansion.
    a. The team is thinking through the rough parameters of what an expansion might look like. Once those are developed, MDHHS will engage internal and external stakeholders.
    b. For Demonstration Year 2, MDHHS will be moving to a bi-monthly meeting schedule that will include both CCBHCs and PIHPs.
    c. MDHHS plans to update the handbook regularly, and will send out proposed changes for feedback in the format of a memo or update in alignment with PIHP contract language.
    d. MDHHS is finalizing the Demonstration Year 2 calendar.

HCBS Update

1. Belinda Hawks provided the HCBS update.
    a. Her division is moving to centralize its work under that platform as much as possible.
        i. The next iteration is to include the site review process for 1915(c) waivers under the CRM.
    b. She thanked the HCBS Leads for working with the HCBS team to implement the work.
    c. March 2023 is when the HCBS rule is fully active and implemented.
    d. MDHHS is looking at the state transition plan and public comment information. MDHHS is also working to create the final heightened scrutiny settings list to send to CMS for review and approval. MDHHS hopes to have this list in the next few weeks.
    e. She encourages all coordinators and leads to make sure their information in the waiver support application is up to date. This information is what MDHHS uses to communicate out and better understand the status of anyone enrolled in those waivers.
    f. She reported that MDHHS continues to have workgroup meetings on conflict-free access and planning.
        i. MDHHS has just conducted two listening sessions with some of the people served and their families and is putting those information packets together to bring back to the workgroup.
        ii. MDHHS hopes to hold additional listening sessions in January.
        iii. She will share the timeline as soon as it is developed.
2. Belinda Hawks shared highlights from the Residential Tiered Rate workgroup. The PowerPoint from the most recent meeting has been shared with the group via email.
    a. MDHHS conducted provider interviews over the summer, and MDHHS has a summary of the interviews.
    b. MDHHS wants to develop pilot program parameters in 2023.
    c. MDHHS hopes to implement the pilot in Q3 or Q4 of FY 2024.

d. Belinda Hawks shared that MDHHS is looking for feedback on what should be tested within the pilot, especially how quality within the pilot can be judged.

Public Health Emergency Unwind

1. Jeff Wieferich stated that MDHHS anticipates receiving advance notice of the upcoming end of the public health emergency by the end of the week of November 7, 2022.
    a. MDHHS is actively planning to be ready for it.
    b. Once MDHHS has confirmation that the end of the public health emergency is coming, there will be a flow of information from MDHHS to the PIHPs.
    c. In some of the communication coming out, what MDHHS usually refers to as a spenddown may be referred to as a deductible.

MPCIP & MI CAL Update

1. Krista Hausermann provided the MPCIP & MI CAL update.
    a. The bimonthly written update will be sent out in December.
2. For Crisis Stabilization Units (CSUs), she reminded the group that CSUs are a walk-in crisis receiving and stabilization center, not an inpatient setting. Most people are expected to be in and out of CSUs in several hours.
    a. Michigan has funded 7 CMHs to stand up CSUs through the Fiscal Year 2023 boilerplate.
    b. To get CSUs moving, MDHHS will begin with a CSU implementation pilot. The pilot will function like a community of practice. Communities and agencies ready to stand up a CSU will partner with MDHHS to develop best practices, recommendations, policies, and procedures around CSU implementation. By the end of the year, entities will be ready for certification and will have developed a handbook.
    c. MDHHS will be operating the pilot at the same time certification rules are moving through the administrative rules process.
    d. MDHHS expects to send out CSU readiness applications for the pilot. Several areas have already expressed interest.
    e. One requirement is that the area interested in developing a CSU have a contract with the PIHPs to provide SUD services around withdrawal management.
3. For stabilization guidance, she shared that MDHHS has received requests for clarification on the language.
    a. She will draft language into a document and request feedback from the PIHPs.
    b. This will take place in a special meeting so that staff can attend.
4. For MI CAL, Krista Hausermann reported meeting with all PIHPs and CMHSPs to institute coordinated care for when callers need more than phone support.
    a. Some CMHs have not yet entered all their information into the MI CAL CRM; MDHHS does need that information.
    b. MI CAL is staffing up to meet increased call volume. The target goal is to answer 95% of calls within 20 seconds.

5. A PIHP raised a concern that in some cases MDHHS has been working directly with the PIHPs' software vendor to engineer solutions to interoperability problems without engaging the PIHPs and CMHs. The PIHP was not sure if it was under Krista's purview but wanted to inform MDHHS.
    a. Krista Hausermann answered that if this was about the CRM, she absolutely wanted to know to make sure that it does not happen. If it is not the CRM, she will make sure the information gets to the correct person.
    b. The PIHP said they will try to trace back and find the instances for her to refer to.

New Methadone Reimbursement Rate

1. Jeff Wieferich elaborated on a message MDHHS had sent about the new reimbursement rate for H0020.
    a. It has come to MDHHS's attention that the PIHPs had not implemented the change to increase the rate for that code to $19. Funding was put into the capitation rates communicated as part of the process, but MDHHS has not heard back yet about what the PIHPs might need to implement it.
    b. Some MDHHS staff met with SUD directors and were concerned that many SUD directors did not know about the rate increase.
2. A PIHP explained that part of their confusion was that the directive came through boilerplate; the PIHPs are used to boilerplate instruction being directed at MDHHS, not PIHPs. The PIHPs were waiting for instruction.
    a. The PIHPs want guidance around what is expected to be in the bundle. There was a meeting, but the PIHPs felt that the meeting only explained what *could* be included, not what *was* to be included.
    b. The PIHPs requested a policy letter about what was included in the H0020 code when Milliman developed the Rate Certification Letter.
3. Another PIHP noted that the rate certification letter was received in mid-September, and that it was not a lot of time to turn it into a contract item when the contracts had already been let out for the year. There was timing issue, and the letter is still not attached to the PIHP contract.

Ability to Pay

1. The PIHPs requested an update on their prior request for MDHHS to consider consolidating into a single "ability to pay" schedule or fee schedule across all departments.
    a. Jeff Wieferich reported that there had been a meeting on November 2, 2022, to discuss it.
    b. MDHHS is moving in the direction of consolidating fee schedules; thus far they have not found anything that would prevent it. They are, however, checking on what block grants might require.
    c. MDHHS committed to providing an update on the follow-up.

Direct Care Wage Increase

1. Jeff Wieferich reported that the Direct Care Wage increase had come through on the budget this year at $2.35.
    a. MDHHS is informing the PIHPs verbally that this is part of the rates and is to be included in them; it is an increase for Direct Care Workers that will not be going away.
    b. MDHHS is meeting internally to dissect language and look at the previous guidance to make sure the PIHPs have what they need to put the increase into play.
    c. MDHHS is working on formal guidance such as an L-Letter.
    d. This increase will be treated like the previous wage increase, and there is no longer a cost settlement for FY 2023.
    e. MDHHS expects the PIHPs to push the wage increase out to the appropriate workers.
    f. Jeff Wieferich noted that this is not an increase on face-to-face time only, but rather a standard wage increase for direct care workers as individuals, regardless of how they need to bill their time.
2. The PIHPs expressed gratitude that this was built into the rates and not part of a cost settlement.
3. A PIHP expressed concern that in their region this would be using a lot of the Direct Care Wage Calculation revenue; they do not want to exceed the revenue allotted.
4. Another PIHP noted that the boilerplate has a lot of specifics and work built into it around reporting requirements and asked that MDHHS let the PIHPs know how that was to be handled.
    a. Jeff Wieferich answered that internal discussion was ongoing about what those reporting requirements meant and what would meet the criteria.

State Hospital Denials

1. Dave Pankotai asked for clarification on notices in cases of state hospitals denying individuals for care.
    a. The specific case that raised the question was an individual who had been accepted for Hawthorn Center at the outset, but then was later denied at the state level.
    b. He wanted to know who should issue the adverse action notification when the state hospitals and the medical officers at the PIHPs disagree on the appropriate level of care.
2. Farah Hanley requested that detail of the case and the PIHP's Chief Medical Officer's reasoning for their stance on the decision be sent to her, Jeff Wieferich, and Dr. Mellos.
3. A PIHP added that the PIHPs wanted to know in broader policy terms the roles and responsibilities relative to denials.
    a. The PIHPs understand that the state hospital is not a Medicaid benefit, but requirements for notice of adverse action apply in non-Medicaid situations as well. They want to know if the State Hospital Administration should be issuing the notice of adverse action, or if the notice is still a PIHP responsibility when the decision is made elsewhere.
    b. The PIHPs want to be sure to communicate appeal rights to beneficiaries properly.
    c. Another PIHP added that they also wondered where the second opinion would fall if the denial came from the state level, and who would make that determination.

Action Items

#	Date Added	Action Item	Assigned To	Status
1.	11/03/2022	Provide updates on the possibility of incorporating all departments' fee schedules into one.	MDHHS	

Michigan Integration Efforts

Service Delivery Transformation

November 2022 Update

Overview

Overview
MDHHS Integration Efforts include four key initiatives: Behavioral Health Homes (BHH), Opioid Health Homes (OHH), Certified Community Behavioral Health Clinics (CCBHC) and Promoting Integration of Primary and Behavioral Health Care (PIPBHC). Each initiative seeks to improve both behavioral and physical health outcomes by emphasizing care coordination, access, and comprehensive care. These programs specifically focus on adults and children with mental health and substance use disorder needs.

Goals

1. Increase access to behavioral health and physical health services.
2. Elevate the role of peer support specialists and community health workers.
3. Improve health outcomes for people who need mental health and/or substance use disorder services.
4. Improve care transitions between primary, specialty, and inpatient settings of care.

Opportunities for Improvement

1. Improve access to care for all individuals seeking behavioral health services (SMI, SUD, SED, mild to moderate).
2. Identify and attend to social determinants of health needs.
3. Improve care coordination between physical and behavioral health services.

Service Delivery Transformation Section

- Erin Emerson, Senior Policy Executive
- Lindsey Naeyaert, Section Manager
- Amy Kanouse, Behavioral Health Program Specialist
- Kelsey Schell, Health Home Analyst

Behavioral Health Homes (BHH)

Overview

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

Current Activities:

- As of November 1, 2022, there are 1,836 people enrolled:
    - Age range: 6-85 years old
    - Race: 25% African American, 69% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- Resources, including the BHH policy, directory, and handbook, are available on the Michigan Behavioral Health Home website. Behavioral Health Home (michigan.gov)
- MDHHS staff will be working to expand the BHH into PIHP Region 5, Mid-State Health Network. Anticipated start date is April 1, 2023.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Certified Community Behavioral Health Clinics (CCBHC)

Overview

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

Current Activities

- The CCBHC Demonstration wrapped up its first year. As of November 2, 2022, 46,069 Medicaid beneficiaries and 7,762 individuals without Medicaid are assigned in the WSA to the 13 demonstration CCBHC sites. Assignment has increased steadily since the start of the demonstration. Based on encounter data submitted as of October 3, 2022, there were 728,099 daily visits for CCBHC services delivered in DY1, including 688,956 (95%) to Medicaid beneficiaries and 39,143 (5%) to individuals without Medicaid.
- A training and technical assistance series will take place during DY2 with topics identified as areas of interest during DY1 Check In calls and outstanding certification requirements. MDHHS is also sponsoring the training of two Community Health Workers (CHWs) at each CCBHC demonstration site in FY23.
- The MDHHS CCBHC Implementation Team is working to finalize financial reporting requirements for the initial demonstration year and continuing to address additional operational issues that arise as the demonstration moves forward.

Questions or Comments

- Amy Kanouse (kanousea@michigan.gov)

Opioid Health Homes (OHH)

Overview

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

Current Activities

- As of November 1, 2022, 2,767 beneficiaries are enrolled in OHH services.
- With the OHH expansion, LE's have continued to expand OHH services with new Health Home Partners (HHPs). There are currently 38 HHPs contracted to provide services to OHH beneficiaries. Some HHPs are contracting with multiple LEs.
- MDHHS continues to collaborate with many state agencies to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

- Kelsey Schell (schellk1@michigan.gov)

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

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

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data

between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.

- Shiawassee and Saginaw counties are starting to see shared patient data in Azara DRVS. Both counties are moving to training and adoption. Barry County is working through data validation.
- PIPBHC sites are focused on sustainability and the ways in which integrated care can continue after the end of the grant. The sites are also currently working on completing the annual PIPBHC Integration Self-Assessment Survey to determine how each agency views the current level of integration.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 22-36

Distribution: Prepaid Inpatient Health Plans, Community Mental Health Services Programs

Issued: November 1, 2022

Subject: §1915(i) State Plan Home and Community-Based Services

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

Effective October 1, 2019, behavioral health community-based services that were previously authorized under the Managed Specialty Services & Supports §1915(b1)(b3) waivers moved authorities to the §1915(i) State Plan Home and Community-Based Services (HCBS) as directed by the Centers for Medicare & Medicaid Services (CMS). Effective, October 1, 2023, the §1915(i) State Plan Amendment will operate concurrently with the §1115 Behavioral Health Demonstration Waiver which establishes the provision of behavioral health community-based services through Michigan's managed care contract with the regional Prepaid Inpatient Health Plans (PIHPs). This bulletin outlines the transition of State Waiver Authority for HCBS into a §1915(i) State Plan benefit. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the MDHHS Medicaid Provider Manual, General Information section, for an overview of the mental health and developmental disabilities services and supports covered by Medicaid. The MDHHS Medicaid Provider Manual can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

I. General Information

HCBS provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups, such as people with intellectual or developmental disabilities, serious emotional disturbance and/or serious mental illnesses. CMS works with states to ensure and improve quality in Medicaid HCBS waiver programs.

II. Eligibility

The §1915(i) State Plan HCBS benefit is available to individual beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability who are currently residing in a HCBS setting and meet the needs-based criteria.

A. Needs-Based Criteria

1. Have a substantial functional limitation in one or more of the following areas of major life activity:

   (a) Self-care
   (b) Communication
   (c) Learning
   (d) Mobility
   (e) Self-direction
   (f) Capacity for independent living
   (g) Economic self-sufficiency; and

2. Without §1915(i) services, a beneficiary is at risk of not increasing or maintaining a sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, and/or community inclusion and participation.

NOTE: On October 1, 2023, the §1915(i) SPA will operate concurrently with the §1115 Behavioral Health Demonstration Waiver.

The PIHP provider network will perform the face-to-face assessments, compile required documentation, and submit findings to the MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA). BPHASA will make the determination of needs-based criteria through an independent evaluation and re-evaluation. The PIHPs must have a network of qualified providers responsible for conducting the assessment, including specific training in an individual's needs for HCBS.

These providers must meet one of the following qualifications:

- **Mental Health Professional:** An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (PA 368 of 1978, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (PA 368 of 1978, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (PA 368 of 1978, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the

public health code (PA 368 of 1978, MCL 333.16901 to 333.16915). **NOTE**: The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.

- **Qualified Intellectual Disability Professional (QIDP):** Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons with intellectual or developmental disabilities as part of that experience) or one year of experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.

- **Qualified Mental Health Professional (QMHP):** Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited-licensed marriage and family therapist, a licensed physician's assistant, or a human services professional with at least a bachelor's degree or higher in a human services field.

B. Independent Evaluations and Re-evaluations

For an independent evaluation/re-evaluation, BPHASA staff will apply the needs-based criteria to determine whether the individual in the targeted group is eligible for §1915(i) benefit services. The PIHP network will utilize standardized instruments to assist in identifying level of need (i.e., Level of Care Utilization System [LOCUS], Supports Intensity Scale [SIS], American Society of Addiction Medicine [ASAM], Global Appraisal of Individual Needs Initial [GAIN-I]), administer other face-to-face assessments related to the individual's functional abilities (i.e., Essential for Living [EFL], Assessment of Functional Living Skills [AFLS], administer other adaptive behavior/global functioning scales, etc.), and identify services and supports required to reach the expected outcomes of community inclusion and participation. The PIHP network will provide evidence to BPHASA for making the needs-based eligibility determination through a Waiver Support Application (WSA) portal.

BPHASA will conduct evaluations using standardized instruments that identify the individual meets all the eligibility requirements for §1915(i) service(s).

- For children and adolescents with Serious Emotional Disturbance (SED), standardized tools (i.e., the Preschool and Early Childhood Functional Assessment Scale [PECFAS], the Child Adolescent Functional Assessment Scale [CAFAS], etc.) are utilized.

- For children and adolescents with intellectual or developmental disability, standardized tools to identify functional abilities, adaptive behavior/global functioning, and level of support needs (i.e., Developmental Disabilities Children's Global Assessment Scale [DD-CGAS], Vineland, Supports Intensity Scale – Children's Version [SIS-C], etc.) are utilized.

- For adults with mental health and co-occurring mental health and substance use disorder related needs, LOCUS is applied. For adults with intellectual or developmental disability-related needs, Supports Intensity Scale – Adult Version [SIS-A] is used. For adults presenting with needs only involving substance use disorders, the GAIN-I core assessment is utilized as it directly supports the ASAM level of care criteria that this service system is based on.

Re-evaluation for eligibility is conducted annually. Formal review of the Individual Plan of Service (IPOS) will occur no less than annually with the beneficiary and any other person chosen to participate by the beneficiary or guardian. BPHASA will make determination of continuing eligibility based on evidence provided by the PIHP and an independent evaluation that the beneficiary still meets the needs-based criteria.

BPHASA staff must have a minimum of a bachelor's degree, preferably in a health or social services field. Staff are trained in the needs-based criteria outlined for these §1915(i) HCBS State Plan services and are able to evaluate documentation to determine whether each applicant meets these criteria. Staff will have access to State systems to verify that individuals are Medicaid eligible and currently residing in a HCBS setting.

C. Person-Centered Planning & Individual Plan of Service

For more detail, refer to the Home and Community Based Services Chapter of the MDHHS Medicaid Provider Manual under the Person-Centered Planning section.

The Michigan Mental Health Code establishes the right for all individuals to have an IPOS developed through a person-centered planning (PCP) process. The PIHP shall monitor quality of implementation of the PCP by its sub-contracted network of providers in accordance with the MDHHS Person-Centered Planning Practice Guidelines (Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Practice Guideline (michigan.gov)). The PIHP shall inform the beneficiary/guardian or authorized representative(s) of their rights to choose among providers for individual case management/supports coordination, including the option for self-direction. If the beneficiary/guardian or authorized representative(s) prefers an

independent facilitator to assist them, the PIHP Customer Services Unit maintains a list of PCP independent facilitators.

The Community Mental Health Services Program (CMHSP) or local contracted provider agency chosen by the beneficiary/guardian, under contract with the PIHP, is responsible for the development and implementation of the IPOS.

The case manager, supports coordinator, other qualified staff or independent facilitator that develops the IPOS is not a provider of any other §1915(i) SPA service for that individual. Qualified staff must be able to perform the following functions:

1. Planning and/or facilitating planning using the person-centered process. This function may be delegated to an independent facilitator chosen by the beneficiary/guardian or authorized representative(s).
2. Developing an IPOS using the PCP process, including revisions to the IPOS at the request of the beneficiary/guardian or authorized representative(s) or as changing circumstances may warrant.
3. Linking to, coordinating with, follow-up of, and advocacy with all medically necessary supports and services, including the Medicaid Health Plan, Medicaid Fee-for-Service (FFS), or other health care providers.
4. Monitoring of the §1915(i) services and other mental health services the beneficiary receives.
5. Brokering of providers of services/supports.
6. Assistance with access to entitlements and/or legal representation.

The strengths, needs, preferences, desires, abilities, interests, goals, and health status of the beneficiary are determined through pre-planning and the PCP process. Results from the independent assessment and any other medically necessary assessments by qualified providers, including but not limited to behavioral, psychosocial, speech, occupational and/or physical therapy, social/recreational, and physical and mental health care, are information used to inform the PCP process. The PCP process considers all life domains of the beneficiary, including emotional, psychological and behavioral health; health and welfare; education/needs; financial and other resources; cultural and spiritual needs; crisis and safety planning; housing and home; meaningful relationships and attachments; legal issues and planning; daily living; family; social, recreational and community inclusion; and other life domains as identified by the beneficiary/guardian or authorized representative(s), or assessors.

The IPOS is developed based on input from the beneficiary/guardian or authorized representative(s) and is informed by findings from all assessments. It includes the identification of outcomes based on the beneficiary's stated goals (if applicable), age, interests, desires and preferences; establishment of meaningful and measurable goals to achieve identified outcomes; determination of the amount, scope, and duration of all medically-necessary services for those supports and services provided through the public mental health system; identification of other services and supports the beneficiary, guardian or authorized representative(s) may require to which the public mental health system will assist with linking to the necessary resources. The IPOS

directs the provision of supports and services to be provided through the CMHSP in the amount, scope, and duration required to assist the beneficiary in achieving the identified outcomes.

For children, the concepts of PCP are incorporated into a family-driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators. The PCP process is an individualized, needs-driven, strengths-based process for children and their families or authorized representative(s). Consistent with Michigan's strong focus on a family-driven/youth-guided service planning process, all meetings are scheduled at times and locations convenient to the child and family or authorized representative(s). The family or authorized representative(s) of the minor child identify other people to participate in planning, such as extended family members, friends, neighbors and other health and supports professionals. The IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority.

The IPOS must address the health and welfare of the beneficiary. This may include coordination and oversight of any identified medical care needs to ensure health and safety, such as medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications or co-occurring medical conditions requiring care. The IPOS is a dynamic document that is revised based on changing needs, newly identified or developed strengths and/or the result of periodic reviews and/or assessments. The IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or their guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and their guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.

III. Coverage and Provider Qualifications

A. Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies include an item or set of items that enable the beneficiary to increase their ability to perform activities of daily living (ADL) with a greater degree of independence than without them and to perceive, control, or communicate with the environment in which they live. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the IPOS. All items must be ordered by a physician on a prescription as defined within the MDHHS Medicaid Provider Manual. An order is valid for one year from the date it was signed. Coverage includes:

- Items necessary for independent living (e.g., Lifeline, sensory integration equipment, electronic devices for emergencies/personal emergency response systems [PERS], etc.)
- Communication devices
- Special personal care items that accommodate the beneficiary's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of equipment and supply items
- Repairs to covered supplies and equipment that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of items, there must be documentation in the IPOS that the specialized equipment and supplies continue to be medically necessary. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Physician	Licensed as a Physician in the State of Michigan under section	Not applicable	Prescribed by a Licensed Physician within the scope of practice under Michigan law.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
	333.17001 of the public health code (PA 368 of 1978)		
Retail or medical supply stores	Not applicable	Not applicable	Items purchased must meet the specialized equipment and supplies service definition.

B. Vehicle Modification

Vehicle modifications include adaptations or alterations to an automobile or van that is the beneficiary's primary means of transportation in order to accommodate the special and medical needs of the beneficiary. These adaptations must be specified in the IPOS and enable the beneficiary to integrate more fully into the community and to ensure the health, welfare and safety of the beneficiary. All items must be ordered by a physician on a prescription as defined within the MDHHS Medicaid Provider Manual. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to a vehicles
- Assessments (by an appropriate health care professional) and specialized training needed in conjunction with the use of the adaptations, as well as alterations will be considered as part of the cost of the services.

Coverage excludes:

- The purchase or lease of a vehicle;
- Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the beneficiary;
- Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modification(s).

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. In order to cover repairs of vehicle modifications, there must be documentation in the IPOS that the alterations continue to be medically necessary. All applicable warranty and insurance coverages must be sought and denied before authorization is approved to pay for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the

PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code (PA 368 of 1978)	Not applicable	Prescribed by a Licensed Physician within the scope of practice under Michigan law.
Agency or business	Not applicable	Not applicable	Must meet the vehicle modification service definition, may be certified or licensed with the Michigan Department of Licensing and Regulatory Affairs (LARA) annually.

C. Enhanced Pharmacy Items

Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the IPOS. There must be documented evidence that the item is not available through Medicaid or other insurances and is the most cost-effective alternative to meet the beneficiary's need.

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First-aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:

- A history of aspiration pneumonia, or
- Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code (PA 368 of 1978)	Not applicable	Prescribed by a Licensed Physician within the scope of practice under Michigan law.
Retail or medical supply stores	N/A	N/A	Items purchased must meet the enhanced pharmacy service definition.

D. Environmental Modifications

Physical adaptations to the beneficiary's own home or apartment and/or workplace. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, the PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants) for assistance. It is expected that the CMHSP case manager/supports coordinator will assist the beneficiary in the pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab bars.
- Widening of doorways.
- Modification of bathroom facilities.

- Special floor, wall or window covering that will enable the beneficiary more independence or control over their environment and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception, under the fourth bullet point above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes.
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services.

The PIHP must ensure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must follow all

local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the property owner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to ensure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code (PA 368 of 1978)	Not applicable	Prescribed by a Licensed Physician within the scope of practice under Michigan law.
Agency or business	MCL 339.601 (1) MCL 339.601.2401 (1) MCL 339.601.2403 (3)	Licensed builder or licensed contractor	Must meet environmental modification service definition.

E. Family Support and Training

Family-focused services are provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a beneficiary with one of these disabilities. The services target the family members who are caring for and/or living with a beneficiary receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in their ability to achieve goals of:

- Performing ADL;
- Perceiving, controlling, or communicating with the environment in which the beneficiary lives; or
- Improving the beneficiary's inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's IPOS, along with the beneficiary's goal(s) that is being facilitated by this service.

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the beneficiary at home as specified in the IPOS.
- Counseling and peer support provided by a trained counselor or peer one-on-one or in a group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
- Family Psycho-Education (Substance Abuse and Mental Health Services Administration [SAMHSA] model – specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
- Parent-to-Parent Support - is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner who has or had a child with special mental health needs provides education, training, and support, and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents/family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (PA 368 of 1978, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (PA 368 of 1978, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (PA 368 of 1978, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (PA 368 of 1978, MCL 333.16901 to 333.16915). **NOTE:** The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.
Child Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; **or** an individual

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
			with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years of supervised experience in the examination, evaluation, and treatment of minors and their families; **or** an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.
Qualified Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant, or a human services professional with at least a bachelor's degree in a human services field.
Qualified Intellectual Disability Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
			student works directly with persons with intellectual or developmental disabilities as part of that experience) or one year of experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree in a human services field.
Parent Support Partner	None	None	Individual who: has lived experience as a parent/caregiver of a child with Serious Emotional Disturbance and Intellectual/Developmental Disability and is employed by the PIHP/CMHSP or its contracted providers and is trained in the Michigan Department of Health and Human Services approved curriculum and ongoing training model.

F. Fiscal Intermediary

Fiscal Intermediary services are defined as services that assist the beneficiary, or a representative identified in the beneficiary's IPOS, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling their individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Ensuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences and/or do not promote achievement of the goals contained in the beneficiary's IPOS so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide fiscal intermediary services to the beneficiary.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Entity/Organization or Individual Fiscal Agent	None	None	Must meet fiscal intermediary requirements. Entity/Organization or individual fiscal agent may not be the provider of other covered services for the individual for whom it is providing fiscal intermediary services.

G. Housing Assistance

Housing assistance enables beneficiaries to secure and/or maintain their own housing as set forth in the beneficiary's IPOS. Services must be provided in the home or a community setting and include the following components:

- Conducting a community integration assessment identifying the beneficiary's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the beneficiary, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).
- Assisting the beneficiary with finding and securing housing as needed. This may include arranging for or providing transportation.
- Assisting the beneficiary in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
- Developing an individualized community integration plan based upon the assessment as part of the overall Person-Centered Plan (PCP).
- Identify and establish short- and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.
- Participating in PCP meetings at re-determination and/or revision PCP meetings as needed.
- Providing supports and interventions per the PCP (individualized community integration portion).
- Supports to assist the beneficiary in communicating with the landlord and/or property manager regarding the beneficiary's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. This includes providing support/intervention for dispute resolution with the landlord/property manager.
- Housing assistance will provide supports to preserve the most independent living arrangement and/or assist the beneficiary in locating the most integrated option appropriate to the beneficiary.

Coverage excludes:

- Costs for room and board (i.e., rent, mortgage, motel/hotel stays, security deposit, etc.)
- Funding for ongoing housing costs (i.e., repairs, utility bills, insurance, taxes, appliances, etc.)

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
			otherwise authorized to engage in the practice of nursing under part 172 of the public health code (PA 368 of 1978, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (PA 368 of 1978, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (PA 368 of 1978, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (PA 368 of 1978, MCL 333.16901 to 333.16915). **NOTE:** The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.
Qualified Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst,

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
			registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited-licensed marriage and family therapist, a licensed physician's assistant or a human services professional with at least a bachelor's degree in a human services field.
Qualified Intellectual Disability Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons with intellectual or developmental disabilities as part of that experience) or one year of experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree in a human services field.

H. Respite Services

Respite services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports or other services of paid support or training staff should be used.

Decisions about the methods and amounts of respite should be decided during PCP. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care under the SED waiver as this is included in the bundled rate.

If an adult beneficiary living at home is receiving home help services and has hired their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the PCP team
- Licensed camp

- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family childcare home

Respite care may **not** be provided in:

- Day program settings, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), nursing homes, or hospitals

Respite care may not be provided by:

- Parent of a minor beneficiary receiving the service
- Spouse of the beneficiary served
- Beneficiary's guardian
- Unpaid primary caregiver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Direct Support Specialist	None	None	Individual with specialized training; is able to perform basic first-aid procedures; trained in the beneficiary's IPOS, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow IPOS requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

I. Skill-Building Assistance

Skill-building assistance consists of activities identified in the IPOS that assist a beneficiary to increase their self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services occur in community-based integrated settings and provide knowledge and specialized skill development and/or supports to achieve specific outcomes consistent with the beneficiary's identified goals with the purpose of furthering habilitation goals that will lead to greater opportunities of community independence, inclusion, participation, and productivity. Refer to the Home

and Community Based Services chapter of the MDHHS Medicaid Provider Manual for further details.

Services include:

- Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills.
- Activities that support an individual to attain and retain Individual Competitive Integrated Employment (ICIE) are time-limited and include work pathway services in the community in which a beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
- Developing and teaching skills that lead to ICIE including, but not limited to, ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety; and mobility training. May also provide learning and work experiences, including volunteering, where the beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in ICIE. Such employment related services are expected to occur over a defined period of time with specific employment-related goals and outcomes to be achieved, as determined by the beneficiary's IPOS.
- Participation in skill-building is not a required prerequisite for ICIE or receiving supported employment services.

Skill-building service components needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.).

If a beneficiary has a need for transportation to participate, maintain, or access the skill-building services, the same provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with the Medicaid non-emergency medical transportation policy outlined in the Non-Emergency Medical Transportation chapter of the MDHHS Medicaid Provider Manual.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Direct Support Professional	None	None	Individual with specialized training; is able to perform basic first-aid procedures; trained in the beneficiary's IPOS, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow IPOS requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

J. Community Living Supports

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.). Coverage includes assisting (that exceeds State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

- Meal preparation
- Laundry
- Routine, seasonal, and heavy household care and maintenance
- Activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- Shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under IDEA (e.g., Personal Care [assistance with ADLs in a certified specialized residential setting] and Home Help [assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, ADL and shopping]). If such assistance appears to be needed, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist them in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

CLS staff provide assistance, support and/or training with activities such as:

- Money management
- Non-medical care (not requiring nurse or physician intervention)
- Socialization and relationship building
- Transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
- Participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- Attendance at medical appointments
- Acquiring or procuring goods (other than those listed under shopping) and non-medical services
- Reminding, observing and/or monitoring of medication administration
- Observing and/or monitoring with preserving the health and safety of the beneficiary in order that they may reside or be supported in the most integrated, independent community setting

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through Medicaid FFS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the guardian of the beneficiary receiving CLS. CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed the allowable parameters. CLS may also be used for activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary's independence and integration into the community. This service provides skill development related to ADL, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Direct Support Professional	None	None	Individual with specialized training; is able to perform basic first-aid procedures; trained in the beneficiary's IPOS, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow IPOS requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

K. Supported/Integrated Employment

Supported/integrated employment services are services that are provided in a variety of community settings for the purposes of supporting beneficiaries in obtaining and sustaining ICIE. ICIE refers to full- or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work, and fully integrated with co-workers without disabilities. Supported employment services promote self-direction, are often customized, and are aimed to meet a beneficiary's personal and career goals and outcomes identified in the IPOS. Services may be provided continuously, intermittently, or on behalf of a beneficiary. Services may be delivered to promote community inclusion and competitive integrated employment.

Coverage includes:

- Job-related discovery, person-centered employment/career planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, asset development, and career advancement services career planning that supports an individual to make informed choices about ICIE or self-employment. The outcome of this service is sustained ICIE at or above the minimum wage in an integrated setting in the general workforce and in a job that meets personal and career goals as outlined in the beneficiary's IPOS.

Supported employment services include the following categories:

- Individual supported employment supports to attain or sustain paid employment at or above the minimum wage, and career development in an integrated, competitive setting in the general workforce in a job that meets personal and career goals.
- Self-employment refers to an individual-run business that nets the equivalent of a competitive wage, after reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings.
- Small group supported employment support are services and training activities, provided in typical business, industry and community settings for groups of two to six workers with disabilities, paying at least minimum wage that leads to ICIE. The purpose of funding for this service is to support sustained paid employment and work experience that leads to ICIE. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities. Small group supported employment must promote integration into the workplace and interaction between workers with disabilities and people who do not have disabilities. Participation in small group supported employment is not a required prerequisite for ICIE or receiving supported employment services.

Supported/integrated employment service components needed for each beneficiary are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under IDEA (20 U.S.C. 1401 et seq.).

If a beneficiary has a need for transportation to participate, maintain, or access the supported/integrated employment services, the same service provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with Medicaid non-emergency medical transportation policy outlined in the Non-Emergency Medical Transportation chapter of the MDHHS Medicaid Provider Manual.

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
Employment Specialist/Job Coach	None	None	Individual has completed specialized training; is able to perform basic first-aid procedures; is trained in the beneficiary's IPOS, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow IPOS requirements and beneficiary-specific

Provider Qualifications			
Provider Type	**License**	**Certification**	**Other Standard**
			emergency procedures, and to report on employment-related activities performed; and in good standing with the law.

Manual Maintenance

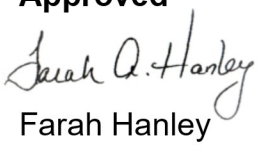
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

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

Approved



Farah Hanley
Chief Deputy Director for Health

Indicator 1a: Percentage of Children Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours -- 95% Standard

	Percentage	Number of Emergency Referrals for Children	Number Completed in Three Hours for Children
Detroit Wayne Mental Health Authority	98.91	733	725
Lakeshore Regional Entity	98.58	494	487
Macomb Co CMH Services	99.56	228	227
Mid-State Health Network	98.53	951	937
NorthCare Network	100.00	68	68
Northern MI Regional Entity	98.22	281	276
Oakland Co CMH Authority	96.64	268	259
Region 10	100.00	380	380
CMH Partnership of Southeast MI	99.25	134	133
Southwest MI Behavioral Health	98.77	244	241
Statewide Total	**98.85**	**3,781**	**3,733**

Indicator 1b: Percentage of Adults Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours -- 95% Standard

	Percentage	Number of Emergency Referrals for Adults	Number Completed in Three Hours for Adults
Detroit Wayne Mental Health Authority	97.83	2,765	2,705
Lakeshore Regional Entity	98.49	1,725	1,699
Macomb Co CMH Services	99.30	1,150	1,142
Mid-State Health Network	98.74	2,469	2,438
NorthCare Network	100.00	248	248
Northern MI Regional Entity	99.03	725	718
Oakland Co CMH Authority	92.63	1,208	1,119
Region 10	99.57	928	924
CMH Partnership of Southeast MI	98.78	572	565
Southwest MI Behavioral Health	99.42	867	862
Statewide Total	**98.38**	**12,657**	**12,420**

Indicator 2: The Percentage of New Persons During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	37.84	3,602	1,363
Lakeshore Regional Entity	59.50	1,210	720
Macomb Co CMH Services	10.70	1,327	142
Mid-State Health Network	61.24	4,221	2,585
NorthCare Network	57.75	639	369
Northern MI Regional Entity	57.72	1,282	740
Oakland Co CMH Authority	42.13	1,061	447
Region 10	46.86	1,818	852
CMH Partnership of Southeast MI	60.53	950	575
Southwest MI Behavioral Health	76.07	2,206	1,678
Statewide Total	**51.03**	**18,316**	**9,471**

Indicator 2a: The Percentage of New Children with Emotional Disturbance During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# MI Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	19.18	876	168
Lakeshore Regional Entity	62.95	475	299
Macomb Co CMH Services	5.04	377	19
Mid-State Health Network	63.92	1,369	875
NorthCare Network	61.71	222	137
Northern MI Regional Entity	58.64	411	241
Oakland Co CMH Authority	42.78	353	151
Region 10	50.80	502	255
CMH Partnership of Southeast MI	64.75	295	191
Southwest MI Behavioral Health	75.47	644	486
Statewide Total	**50.52**	**5,524**	**2,822**

Indicator 2b: The Percentage of New Adults with Mental Illness During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# MI Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	48.33	2,185	1,056
Lakeshore Regional Entity	56.39	571	322
Macomb Co CMH Services	12.24	817	100
Mid-State Health Network	60.10	2,489	1,496
NorthCare Network	56.30	373	210
Northern MI Regional Entity	55.70	754	420
Oakland Co CMH Authority	42.29	655	277
Region 10	44.46	1,001	445
CMH Partnership of Southeast MI	56.96	539	307
Southwest MI Behavioral Health	75.63	1,383	1,046
Statewide Total	**50.84**	**10,767**	**5,679**

Indicator 2c: The Percentage of New Children with Developmental Disabilities During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# DD Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	21.06	451	95
Lakeshore Regional Entity	75.32	77	58
Macomb Co CMH Services	10.98	82	9
Mid-State Health Network	55.29	255	141
NorthCare Network	36.84	19	7
Northern MI Regional Entity	68.67	83	57
Oakland Co CMH Authority	53.33	15	8
Region 10	48.48	231	112
CMH Partnership of Southeast MI	68.35	79	54
Southwest MI Behavioral Health	85.60	125	107
Statewide Total	**52.39**	**1,417**	**648**

Indicator 2d: The Percentage of New Adults with Developmental Disabilities During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# DD Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	48.89	90	44
Lakeshore Regional Entity	47.13	87	41
Macomb Co CMH Services	27.45	51	14
Mid-State Health Network	67.59	108	73
NorthCare Network	60.00	25	15
Northern MI Regional Entity	64.71	34	22
Oakland Co CMH Authority	28.95	38	11
Region 10	47.62	84	40
CMH Partnership of Southeast MI	62.16	37	23
Southwest MI Behavioral Health	72.22	54	39
Statewide Total	**52.67**	**608**	**322**

Indicator 2e: The Percentage of New Persons During the Quarter Receiving a Face-to-Face Service for Treatment or Supports Within 14 calendar days of a Non-emergency Request for Service for Persons with Substance Use Disorders

		Admissions			# of Persons Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request
	Percentage	# of Non-Urgent Admissions to a Licensed SUD Treatment Facility as reported in BH TEDS	# of Expired Requests Reported by the PIHP	Total	
Detroit Wayne Mental Health Authority	63.17	2,817	957	3,774	2,384
Lakeshore Regional Entity	68.60	1,261	223	1,484	1,018
Macomb Co CMH Services	82.63	1,297	102	1,399	1,156
Mid-State Health Network	76.05	2,802	409	3,211	2,442
NorthCare Network	74.05	555	104	659	488
Northern MI Regional Entity	71.05	1,036	104	1,140	810
Oakland Co CMH Authority	79.90	884	166	1,050	839
Region 10	64.54	1,699	515	2,214	1,429
CMH Partnership of Southeast MI	58.23	777	286	1,063	619
Southwest MI Behavioral Health	65.79	1,284	420	1,704	1,121
Statewide Total	**70.40**	**14,412**	**3,286**	**17,698**	**12,306**

Indicator 3: Percentage of New Persons During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# of Persons Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	84.66	2,621	2,219
Lakeshore Regional Entity	60.42	993	600
Macomb Co CMH Services	79.12	867	686
Mid-State Health Network	60.53	3,167	1,917
NorthCare Network	68.79	487	335
Northern MI Regional Entity	70.70	925	654
Oakland Co CMH Authority	99.66	882	879
Region 10	84.14	1,349	1,135
CMH Partnership of Southeast MI	75.39	711	536
Southwest MI Behavioral Health	59.22	1,817	1,076
Statewide Total	**74.26**	**13,819**	**10,037**

Indicator 3a: The Percentage of New Children with Emotional Disturbance During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	84.97	692	588
Lakeshore Regional Entity	54.77	451	247
Macomb Co CMH Services	75.43	232	175
Mid-State Health Network	56.03	1,119	627
NorthCare Network	69.10	178	123
Northern MI Regional Entity	70.36	307	216
Oakland Co CMH Authority	99.70	328	327
Region 10	89.82	393	353
CMH Partnership of Southeast MI	73.60	250	184
Southwest MI Behavioral Health	55.64	559	311
Statewide Total	**72.94**	**4,509**	**3,151**

Indicator 3b: The Percentage of New Adults with Mental Illness During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	83.57	1,576	1,317
Lakeshore Regional Entity	63.96	419	268
Macomb Co CMH Services	80.68	528	426
Mid-State Health Network	61.66	1,703	1,050
NorthCare Network	67.29	269	181
Northern MI Regional Entity	68.67	498	342
Oakland Co CMH Authority	99.60	505	503
Region 10	79.43	700	556
CMH Partnership of Southeast MI	72.40	366	265
Southwest MI Behavioral Health	62.06	1,078	669
Statewide Total	**73.93**	**7,642**	**5,577**

Indicator 3c: The Percentage of New Children with Developmental Disabilities During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# DD Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	91.48	270	247
Lakeshore Regional Entity	71.70	53	38
Macomb Co CMH Services	80.00	70	56
Mid-State Health Network	71.94	253	182
NorthCare Network	84.21	19	16
Northern MI Regional Entity	83.33	90	75
Oakland Co CMH Authority	100.00	16	16
Region 10	91.28	195	178
CMH Partnership of Southeast MI	90.77	65	59
Southwest MI Behavioral Health	50.39	129	65
Statewide Total	**81.51**	**1,160**	**932**

Indicator 3d: The Percentage of New Adults with Developmental Disabilities During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# DD Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	80.72	83	67
Lakeshore Regional Entity	67.14	70	47
Macomb Co CMH Services	78.38	37	29
Mid-State Health Network	63.04	92	58
NorthCare Network	71.43	21	15
Northern MI Regional Entity	70.00	30	21
Oakland Co CMH Authority	100.00	33	33
Region 10	78.69	61	48
CMH Partnership of Southeast MI	93.33	30	28
Southwest MI Behavioral Health	60.78	51	31
Statewide Total	**76.35**	**508**	**377**

Indicator 4a(1): The Percentage of Children Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days -- 95% Standard

	Percentage	# Children Discharged from Psychiatric Inpatient Unit	# Children Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	86.44	59	51
Lakeshore Regional Entity	89.06	64	57
Macomb Co CMH Services	33.75	80	27
Mid-State Health Network	96.30	108	104
NorthCare Network	100.00	19	19
Northern MI Regional Entity	100.00	43	43
Oakland Co CMH Authority	97.83	46	45
Region 10	97.73	88	86
CMH Partnership of Southeast MI	100.00	41	41
Southwest MI Behavioral Health	100.00	40	40
Statewide Total	**90.11**	**588**	**513**

Indicator 4a(2): The Percentage of Adults Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days -- 95% Standard

	Percentage	# Adults Discharged from Psychiatric Inpatient Unit	# Adults Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	96.81	565	547
Lakeshore Regional Entity	95.22	251	239
Macomb Co CMH Services	37.00	546	202
Mid-State Health Network	96.49	485	468
NorthCare Network	97.59	83	81
Northern MI Regional Entity	96.39	166	160
Oakland Co CMH Authority	88.14	253	223
Region 10	97.75	311	304
CMH Partnership of Southeast MI	98.69	153	151
Southwest MI Behavioral Health	94.47	235	222
Statewide Total	**89.86**	**3,048**	**2,597**

Indicator 4b: The Percent of Discharges from a Substance Abuse Detox Unit Who are Seen for Follow-up Care Within 7 Days -- 95% Standard

	Percentage	# SA Discharged from Substance Abuse Detox Unit	# SA Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	99.81	517	516
Lakeshore Regional Entity	99.04	104	103
Macomb Co CMH Services	92.65	272	252
Mid-State Health Network	97.16	176	171
NorthCare Network	100.00	4	4
Northern MI Regional Entity	93.65	126	118
Oakland Co CMH Authority	98.82	170	168
Region 10	98.46	65	64
CMH Partnership of Southeast MI	100.00	107	107
Southwest MI Behavioral Health	99.03	207	205
Statewide Total	**97.86**	**1,748**	**1,708**

Indicator 5: Percentage of Area Medicaid Recipients Having Received PIHP Managed Services

	Percentage	Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients
Detroit Wayne Mental Health Authority	6.10	48,994	802,808
Lakeshore Regional Entity	5.32	17,876	336,244
Macomb Co CMH Services	4.68	11,770	251,523
Mid-State Health Network	7.43	35,464	476,989
NorthCare Network	7.07	5,659	80,057
Northern MI Regional Entity	7.75	11,591	149,493
Oakland Co CMH Authority	7.17	16,627	231,831
Region 10	6.95	16,834	242,291
CMH Partnership of Southeast MI	6.25	9,567	153,042
Southwest MI Behavioral Health	6.62	17,022	257,200
Statewide Total	**6.53**	**191,404**	**2,981,478**

Indicator 6 (old #8): The Percent of Habilitation Supports Waiver (HSW) Enrollees in the Quarter Who Received at Least One HSW Service Each Month Other Than Supports Coordination

	Percentage	# of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	Total Number of HSW Enrollees
Detroit Wayne Mental Health Authority	93.21	920	987
Lakeshore Regional Entity	93.82	577	615
Macomb Co CMH Services	97.45	421	432
Mid-State Health Network	94.68	1,441	1,522
NorthCare Network	94.17	339	360
Northern MI Regional Entity	94.53	622	658
Oakland Co CMH Authority	95.39	787	825
Region 10	94.86	572	603
CMH Partnership of Southeast MI	90.23	628	696
Southwest MI Behavioral Health	91.43	640	700
Statewide Total	**93.98**	**6,947**	**7,398**

Indicator 10a (old #12a): The Percentage of Children Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit -- 15% or Less Standard

	Percentage	Number of Children Discharged from Inpatient Care	# Children Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	6.76	148	10
Lakeshore Regional Entity	4.71	85	4
Macomb Co CMH Services	5.19	77	4
Mid-State Health Network	2.68	149	4
NorthCare Network	4.35	23	1
Northern MI Regional Entity	10.00	60	6
Oakland Co CMH Authority	6.15	65	4
Region 10	9.45	127	12
CMH Partnership of Southeast MI	6.25	48	3
Southwest MI Behavioral Health	3.23	62	2
Statewide Total	**5.88**	**844**	**50**

Indicator 10b (old #12b): The Percentage of Adults Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit -- 15% or Less Standard

	Percentage	Number of Adults Discharged from Inpatient Care	# Adults Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	17.79	1,619	288
Lakeshore Regional Entity	11.17	376	42
Macomb Co CMH Services	17.50	583	102
Mid-State Health Network	8.87	846	75
NorthCare Network	13.00	100	13
Northern MI Regional Entity	9.28	237	22
Oakland Co CMH Authority	8.65	451	39
Region 10	9.75	523	51
CMH Partnership of Southeast MI	9.95	211	21
Southwest MI Behavioral Health	10.79	454	49
Statewide Total	**11.67**	**5,400**	**702**

email correspondence

From: Eric Kurtz (NMRE)
Sent: Wednesday, November 30, 2022 3:11 PM
To: Carol Balousek (NMRE)
Subject: FW: [EXTERNAL]Update on State Legislative Leadership Races

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From: Alan Bolter <ABolter@cmham.org>
Sent: Friday, November 18, 2022 8:27 AM
To: Alan Bolter <ABolter@cmham.org>
Cc: Robert Sheehan <rsheehan@cmham.org>
Subject: [EXTERNAL]Update on State Legislative Leadership Races

FYI – I wanted to pass this along from one of our lobby firms.

Good afternoon, Everyone,

We wanted to provide you with the Michigan State House and Senate Photo Directory for the upcoming 2023-2024 legislative session provided by Gongwer News Service. Both photo directories can be found here.

Additionally, the House and Senate have announced the full slate of leadership positions for their respective caucuses. The results are as follows:

Michigan House of Representatives
Democrat Caucus:

- Speaker of the House: Rep. Joe Tate (D-Detroit)
- Speaker Pro Tempore: Rep. Laurie Pohutsky (D-Livonia)
- Associate Speaker Pro Tem.: Rep. Carol Glanville (D-Walker)
- Associate Speaker Pro Tem.: Rep.-elect Kristian Grant (D-Grand Rapids)
- Majority Floor Leader: Rep. Abraham Aiyash (D-Hamtramck)
- Assistant Majority Floor Leader: Rep. Kara Hope (D-Holt)
- Assistant Majority Floor Leader: Rep.-elect Jimmie Wilson Jr. (D-Ypsilanti)
- Assistant Majority Floor Leader: Rep.-elect Betsy Coffia (D-Traverse City)
- Majority Whip: Rep. Ranjeev Puri (D-Canton)
- Deputy Whip: Rep.-elect Carrie Rheingans (D-Ann Arbor)
- Deputy Whip: Rep.-elect Alabas Farhat (D-Dearborn)
- Caucus Chair: Rep. Amos O'Neal (D-Saginaw)
- Caucus Vice Chair: Rep. Helena Scott (D-Detroit)
- Caucus Vice Chair: Rep. Brenda Carter (D-Pontiac)
- Caucus Vice Chair: Rep.-elect Jasper Martus (D-Flushing)

Republican Caucus:

- Minority Leader: Rep. Matt Hall (R-Comstock Township)
- Assistant Minority Leader: Rep. Andrew Beeler (R-Fort Gratiot)
- Minority Floor Leader: Rep. Bryan Posthumus (R-Cannon Township)
- Assistant Floor Leader: Rep. Graham Filler (R-DeWitt)
- Assistant Floor Leader: Rep. Andrew Fink (R-Hillsdale)

- Minority Whip: Rep. Sarah Lightner (R-Springport)
- Chief Deputy Whip: Rep. Mike Harris (R-Clarkston)
- Caucus Chair: Rep. Ken Borton (R-Gaylord)
- Caucus Vice Chair: Rep.-elect Jaime Greene (R-Richmond)

Michigan Senate

Democrat Caucus:

- Senate Majority Leader: Sen. Winnie Brinks (D-Grand Rapids)
- President Pro Tempore: Sen. Jeremy Moss (D-Southfield)
- Assistant Majority Leader: Sen.-elect Darrin Camilleri (D-Brownstown Township)
- Majority Floor Leader: Sen.-elect Sam Singh (D-East Lansing)
- Majority Whip: Sen. Mallory McMorrow (D-Royal Oak)
- Caucus Chair: Sen. Dayna Polehanki (D-Livonia)
- Caucus Policy & Steering Chair: Sen. Stephanie Chang (D-Detroit)
- Senate Appropriations Committee Chair: Sen.-elect Sarah Anthony (D-Lansing)

Republican Caucus:

- Minority Leader: Sen. Aric Nesbitt (R-Lawton)
- Assistant Minority Leader: Sen. Rick Outman (R-Six Lakes)
- Minority Floor Leader: Sen. Dan Lauwers (R-Brockway)
- Assistant Minority Floor Leader: Sen. Lana Theis (R-Brighton)
- Minority Whip: Sen. Roger Victory (R-Hudsonville)
- Caucus Chair: Kevin Daley (R-Lum)
- Assistant Minority Whip: Sen. Mark Huizenga (R-Walker)
- Assistant Caucus Chair: Sen. Jim Runestad (R-White Lake)
- Associate President Pro Tempore: Sen.-elect Joe Bellino (R-Monroe)

We will continue to keep you updated as more announcements are made. In the meantime, please do not hesitate to reach out to us with any questions.

Sincerely,

Your McCall Hamilton Team

McCALL HAMILTON
Advocacy & Public Affairs
Strong Legacy. Bold Future.

Community Mental Health Association of Michigan

Did You Know?

What is a PIHP?

PIHP is an acronym for Prepaid Inpatient Health Plan, a term in federal regulations from the Centers for Medicare & Medicaid Services (CMS).

Michigan's PIHPs partner with the Michigan Department of Health and Human Services (MDHHS) and the State's Community Mental Health Services Programs (CMHSPs), implementing the state vision and policy

Community Mental Health Association of Michigan

WHAT IS A PIHP?

1. Serves as the public health plan for a region through a shared-risk arrangement with the State of Michigan to manage the use of Medicaid dollars to serve the behavioral/mental health needs of Michiganders enrolled in Medicaid who live within the PIHPs region.

2. Serves adults with severe mental illness, youth with serious emotional disturbance, persons with intellectual & developmental disabilities or autism spectrum disorders under federal Medicaid managed care situations.

Community Mental Health Association of Michigan

WHAT IS A PIHP?

1. Carries out the functions of a private health plan but, as a public body, without taking profits.

2. Provides and manages the us and risk of Medicaid benefits to the state's Community Mental Health Service Providers, who use these dollars to provide and purchase the full range of community and home based mental health services and other providers.

Community Mental Health Association of Michigan

WHAT IS A PIHP?

1. Provides and manages the use and risk of over $100 million annually in federal mental health and substance abuse block grant funds, earmarked for substance use disorder services, to public and private providers in the region.

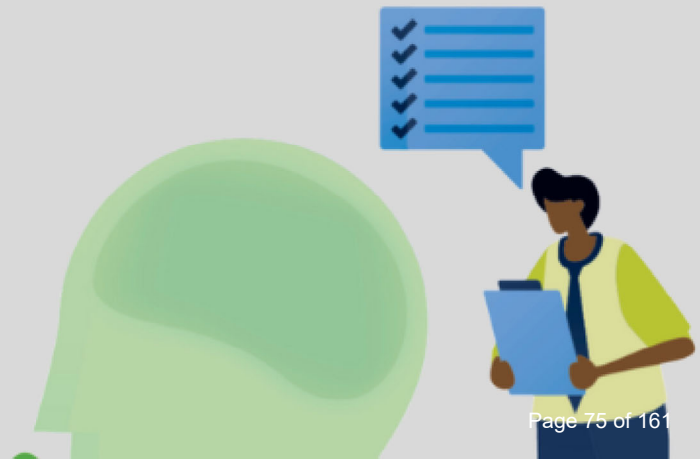
2. Receives the Medicaid funds that it manages, not through a fee-for-service, but through capitated statements (a given payment for each Medicaid enrollee living in the PIHP region)

Community Mental Health Association of Michigan

WHAT DO PIHPs DO?

1. PIHPs are responsible for enrollee rights and protections for Medicaid-eligible persons and have a proven record of adherence to regulations and, more importantly, to beneficiary protections.

2. PIHPs assure the availability and accessibility of all Medicaid services and have a proven record of adherence to regulations and, more importantly, to beneficiary services.



Community Mental Health Association of Michigan

WHAT DO PIHPs DO?

1. PIHPs are designated Community Mental Health Entities in regional statutory substance use disorder prevention and treatment planning roles and will provide essential functions and expertise in the successful implementation of the Opioid Settlement across Michigan.

2. PIHPs significantly prevent, detect, and reduce Medicaid fraud, waste, and abuse. Each has robust compliance programs with ongoing activity supporting the proper use of taxpayer dollars.

Community Mental Health Association of Michigan

WHAT DO PIHPs DO?

1. PIHPs are directed through an MDHHS agreement and are actively overseen and monitored by MDHHS and its contractors. Including but not limited to regular audits of PIHPs, broad and frequent data reporting to MDHHS, and annual reviews of managed care regulation, performance measure validation, and performance improvement projects by a federally required External Quality Review Organization, Health Services Advisory Group.

Community Mental Health Association of Michigan

FINANCIAL VALUE OF PIHPs

PIHPs cushion the state from financial risk as they are responsible for the first 5% of cost overruns and half of the second 5%. As governmental agencies, they do not earn a profit, do not distribute excess revenue to other parties, and invest any savings back into the public behavioral health system and the communities they serve.

Community Mental Health Association of Michigan

PROGRAMMATIC EXPERTISE OF PIHPs

PIHPs provide oversight and education to ensure that county-based organizations' financial strategies and fiduciary responsibility comply with applicable processes and maintain transparent accountability. PIHPs serve as state-designated Community Mental Health Entities with broad statutory roles in policy, planning and programs for substance abuse treatment and prevention.

They offer deep and broad integrated care services, leadership, and results. They work with Medicaid plans, hospitals and health systems, physician groups, and others to identify complex cases for care coordination for better health outcomes and reductions in avoidable physical health services.

Community Mental Health Association of Michigan

QUALITY VALUE OF PIHPs

PIHPs offer unparalleled access for persons served. PIHPs regularly meet or exceed the access and responsiveness metrics in the Michigan Mission Based Performance Indicator System while remaining public entities where the consumer's voice is at the highest levels, including their public board meetings.

Northern Michigan Regional Entity

Member Newsletter

Fall 2022

If you have something you would like to contribute to the next Consumer Newsletter, please contact Member Services at 833.285.0050

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Just because no one else can heal or do your inner work for you

doesn't mean you can, should, or need to do it alone.

What is the NMRE?

The Michigan Department of Health and Human Services contracts with ten organizations in the state to manage behavioral health, intellectual and developmental disabilities, and substance use disorder services for people enrolled in Medicaid and Healthy Michigan. These organizations are called Prepaid Inpatient Health Plans (PIHPs).

The Northern Michigan Regional Entity (NMRE) is the PIHP for 21 counties in northern lower Michigan. This means that the NMRE manages the Medicaid funding for AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health Authority, Northeast Michigan Community Mental Health Authority, Northern Lakes Community Mental Health Authority, and 18 substance use disorder (SUD) services providers.

In addition to making sure that services are available within the region, the NMRE must ensure that quality care is given to individuals served. Each CMH, and the NMRE, monitors the services and providers available in the region. It is important that individuals receive the right care, at the right place, at the right time.

The Consumer Newsletter is a way for the NMRE to share important information with individuals served, their families, and the community. It is also a way for individuals to share their experiences, successes, challenges, and strategies. Topic suggestions and content submissions may be sent to the NMRE by emailing customerservices@nmre.org or calling 833.285.0050, or by contacting the local Community Mental Health Services Provider and asking to speak with a Customer Services Representative.

- AuSable Valley serves Iosco, Ogemaw, and Oscoda Counties.
  Customer Services: 844.841.5627
- Centra Wellness Network serves Benzie and Manistee Counties.
  Customer Services: 877.398.2013
- North Country serves Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego Counties.
  Customer Services: 877.470.3195
- Northeast Michigan serves Alcona, Alpena, Montmorency, and Presque Isle Counties.
  Customer Services: 800.968.1964
- Northern Lakes serves Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford Counties.
  Customer Services: 800.337.8598

Health Home Services

Within the NMRE region, individuals who meet certain requirements have the ability to be enrolled in a health home. A health home is not a building; it is a model of care that is available to individuals who have a qualifying health condition, who live within the NMRE region, and meet Medicaid eligibility.

Health homes provide care coordination services to address an individual's health care needs.

The Behavioral Health Home (BHH) is available to individuals who have a qualifying mental illness. This program is coordinated through the five regional Community Mental Health Services Providers (CMHSP): AuSable Valley CMHA, Centra Wellness Network, North Country CMHA, Northeast Michigan CMHA, and Northern Lakes CMHA.

Some of the CMHs refer to their BHH programs by other names: Northern Lakes' BHH is known as Comprehensive Health Assistance Team (CHAT), North Country's BHH is known as Holistic Approach to Coordinated Healthcare (HATCH), and AuSable Valley's BHH is known as Partnership Aimed at Total Health (PATH). There are currently 400 individuals enrolled in the BHH in the NMRE region.

The Opioid Health Home (OHH) is available to individuals with an opioid use disorder (OUD). This program is coordinated through Medication Assisted Treatment (MAT), Substance Use Disorder (SUD), CMH, and physical health services providers across the 21-county region including:

- Addiction Treatment Services
- Alcona Health Center
- Bear River Health
- Best Medical Services
- Centra Wellness Network
- Catholic Human Services
- Grand Traverse Women's Health Services
- Harbor Hall
- MidMichigan Health Services
- Northern Michigan Substance Abuse Services
- Thunder Bay Community Health Services
- Traverse Health Clinic

There are currently 1,024 individuals enrolled in the OHH in the NMRE region.

The Alcohol Health Home (AHH) is available to individuals with an alcohol use disorder. This program is coordinated through Addiction Treatment Services in Traverse City, Catholic Human Services, MidMichigan Health Services in Houghton Lake, and Harbor Hall in Petoskey. There are currently 48 individuals enrolled in the AHH in the NMRE region.

To learn more about health homes programs and eligibility criteria, please contact the NMRE Access Center at 800-834-3393.

Carter Kits

The NMRE Board of Directors recently approved the purchase of 2,000 Carter Kits Sensory Bags.

Carter Kits were created in Michigan and contain clinically proven items known to comfort and appropriately focus children who are on the autism spectrum, as well as many other children who occasionally find themselves overwhelmed or impacted by traumatic events.

It can be difficult to communicate with someone with a sensory disorder, especially during an emergency. Carter Kits were designed to help first responders when they arrive at a scene and find a child or adult experiencing a crisis, anxiety, or learning challenges. Each Sensory Bag contains a weighted blanket, sunglasses, noise reducing earmuffs, fidget toys, sunglasses, and non-verbal cue cards.

The NMRE and its five Community Mental Health Services Programs have distributed Carter Kits to law enforcement, fire stations, EMS, and many other organizations including schools, and emergency departments throughout the 21-county region. In addition, community trainings have occurred to educate the public about how to use Carter Kits to calm distressed individuals.

The NMRE was able to utilize grant funding to purchase the kits. Carter Kits is a nonprofit organization.

Know Your Rights

If you are a recipient of public behavioral health services, you have the right to:

Get a copy of your paper or electronic record

- You may ask to view or receive an electronic or paper copy of your record and other available health information about you.
- A copy or a summary of your health information will be provided to you, usually within 30 days of your request.

Correct your paper or electronic medical record

- You may ask NMRE to correct health information that you believe is incorrect or incomplete.
- A request may be denied, but a proper explanation in writing within 60 days will be provided to you.

Request confidential communication

- You may request NMRE to contact you in a specific way, such as home, alternate phone number, or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit the information we share

- You may ask NMRE not to use or share certain health information for treatment, payment, or operations. We are not required to agree to your request and may only say "no" if it affects your care.
- If a service is paid in full or a health care item is paid out-of-pocket, you may request that information will not be shared for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared your information

- You may ask for a list (accounting of disclosure) of the times we have shared your health information for six years prior to the date you ask, who we have shared it with, and why.
- All the disclosures except for those about treatment, payment, health care operations and certain other disclosures, such as any you requested us to make, will be included.
- NMRE will provide one accounting disclosure per year for free.

Get a copy of the privacy notice

- A paper copy of the privacy notice may be requested at any time, even if you have agreed to receive the notice electronically.
- NMRE will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- NMRE will make sure the person has this authority and can act for you before any action is taken.

File a complaint if you believe your privacy rights have been violated

- NMRE values your feedback. Complaints can be made if you feel we have violated your rights by contacting the Compliance hotline at:

  NMRE Compliance/Privacy Officer
  1999 Walden Drive
  Gaylord, MI 49735
  Phone: 231.330.2040 or 1.866.789.5774
  Email: compliancesupport@nmre.org

File a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by Sending a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, D.C. 20201
Call 1.877.696.6775
You may also visit:
www.hhs.gov/hipaa/filing-a-complaint/index.html

The NMRE will not retaliate against you for filing a complaint.

Have you Heard?

A new Crisis Residential Unit is under construction in the NMRE region. Alpine CRU is scheduled to open in Gaylord in early 2023.

Unwinding the Public Health Emergency

In January 2020 the US Department of Health and Human Services declared a Public Health Emergency (PHE) as a result of the COVID-19 pandemic.

During the federal PHE, many changes were made to the Medicaid program's eligibility to prevent individuals from losing their healthcare coverage. As a result, individuals with Medicaid and Healthy Michigan Plan (HMP) remained covered during the federal PHE, so they wouldn't have to worry about their health and wellbeing during such a challenging time.

Unless it is extended further, the PHE is currently set to expire in April 2023. Michigan will then restart Medicaid eligibility renewals. Before this happens, individuals with Medicaid and HMP will receive an alert letter with guidance on how to prepare.

Beneficiary alert letters will be mailed the month before the federal Public Health Emergency is set to end. These letters will inform individuals about the end of the PHE and describe the renewal process.

Eligibility renewal packets will be due 30 days after the packet is mailed. The due date is printed on the eligibility renewal packet. Packets should be returned by the due date to ensure that Medicaid and HMP coverage will continue without any gaps.

Community Mental Health workers will assist you with completing your renewal packet. It is important to make sure that that your contact information is up to date (address, phone number, email, etc.) and that any changes to your household income have been reported to ensure a smooth process.

Quick Facts About Mental Health

Mental Health America

- 1 in 5 American adults will have a diagnosable mental health condition in any given year.
- 46% percent of Americans will meet the criteria for a diagnosable mental health condition sometime in their life; half of those people will develop conditions by the age of 14.
- 50 million US adults have a diagnosed mental illness.
- 19 million US Adults have had a Substance Use Disorder in the past year.
- 1 million youth under age of 18 have had a Substance Use Disorder in the Past Year.
- 21 million US Adults have a diagnosis of Major Depression.
- 3.7 million youth age 12-17 have a diagnosis of Major Depression.
- 2.5 million youth age 12-17 have a diagnosis of Severe Depression.
- Major depression is one of the most common mental illnesses.
- 42.5 million US adults have a diagnosis of Anxiety Disorder.
- Anxiety disorders are among the most common mental illnesses in America.
- 3.3 million US adults have a diagnosis of Bipolar Disorder.
- An estimated 2.5 percent of US adults will experience bipolar disorder at some time in their lives.
- 12 million US adults have a diagnosis of Post-Traumatic Stress Disorder.
- 1.5 million US adults have a diagnosis of Schizophrenia.
- 11.4 million US adults have reported having suicidal thoughts.
- Suicide rates are highest among adults age 45-64.
- 27 million of adults with mental illness have never received treatment.
- 2.17 million youth age 12-17 with depression have never received treatment.

SUD Prevention Coalition Highlights

Drug Free Northern Michigan Coalition Alliance

Throughout the NMRE's 21-county service area, a number of substance use prevention coalitions are educating the public about the risks of alcohol, vaping, marijuana, drug, tobacco, and gambling misuse.

The Grand Traverse Drug Free Coalition has distributed Naloxone Safety Kits throughout the community. Naloxone Safety Kits are placed in prominent locations in public areas and contain the lifesaving opioid overdose reversal drug Naloxone (Narcan).

The Live Well Kalkaksa Substance Free Coalition provided Adverse Childhood Experiences (ACEs) training to local law enforcement. ACEs training provides a link between childhood trauma and adult illnesses, chronic diseases, and behavioral issues, including substance use. In a post training evaluation, the majority of the officers who took the training reporting knowing little to nothing about the connection between brain trauma and substance use. At the completion of the training, most reported increased knowledge about the subject and believed they would use what they had learned in their work.

The Ogemaw County Drug Free Coalition is working with MyMichigan Medical Center in West Branch to expand its Medication Assisted Treatment (MAT) and peer recovery programs. MAT is the use of medications, in combination with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of substance use disorders. West Branch has had a active peer-to-peer recovery network, but MAT is a new program that the facility is excited to embrace.

Other coalitions in the region are focusing their efforts on prevention media campaigns to address prescription opioid use avoidance, safe medication disposal, coping with COVID in a healthy way, and anti-vaping. Additional activities include prescription drug takeback events and lock-box distribution, Narcan training and distribution, community presentations, messaging to create a more trauma-informed community and decrease sigma, and community surveys to gain insight into local substance use issues.

If you see one of the region's prevention coalitions promoting its message at a local community event, please stop by and say "hello". Their work is important to the health of our communities.

Liquor Tax Funding

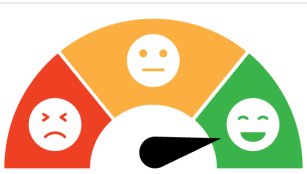
Did you know that half of the revenue collected on taxes from the purchase of liquor in the NMRE 21-county region comes back to the NMRE to be used for substance use prevention, treatment, and recovery support services?

Each year the NMRE Substance Use Disorder Oversight Board and Governing Board approve the use of millions of dollars in "liquor tax funds" for initiatives such as recovery housing, jail services, peer recovery coaching, media campaigns, coalition activities, recovery supports, and education and training. By law, the funds must be spent in the county from which they originated.

The NMRE receives payments from each of its 21 counties three times per year. NMRE staff track liquor tax funds monthly. To access the funds, an application needs to be completed to be considered. NMRE staff review all applications before they are sent to the Board for approval. Only licensed SUD providers may apply to use liquor tax funds.

Annually, the NMRE identifies specific areas of focus for liquor tax funds and closely monitors projects to be sure that this resource is being used effectively.

Why Are Satisfaction Surveys So Important?



Satisfaction surveys are one of the best ways that the NMRE can hear directly from the community and persons served about their views and concerns. Your feedback helps inform NMRE's efforts to build meaningful patient/provider relationships, establish effective and constructive communication, and develop care journeys that are grounded in empathy and compassion.

In April 2022, the NMRE surveyed individuals receiving mental health services from a Community Mental health Services Program, with a total of 620 individuals responding. Here are some of the results:

- 99.02% of respondents answered either "Strongly Agree" or "Agree" to the statement, "Staff treats me with dignity and respect."
- 97.20% of respondents answered either "Strongly Agree" or "Agree" to the statement, "Appointment times are convenient for me."
- 97.18% of respondents answered either "Strongly Agree" or "Agree" to the statement, "I feel comfortable asking questions about my services."
- 98.34% of respondents answered either "Strongly Agree" or "Agree" to the statement, "Staff explained information about my services in a way I can understand."

Areas of improvement were identified as:

- 11% of respondents reported not knowing who to call if they needed help when the CMH was not open.
- 20% of respondents reported not knowing how to file an appeal.
- 11% of respondents reported not being spoken to about smoking, alcohol, or drug use.
- 13% of respondents reported not being spoken to about the side effects of their medication.
- 13% of respondents reported being unaware that they signed a Release of Information for coordination of care purposes.

The NMRE is challenged with low participation in satisfaction surveys. We encourage you to let your voices be heard by completing a survey whenever there is an opportunity. Your feedback is used to improve the services you receive.

Home and Community-Based Services Rule

The Home and Community-Based Services rule is designed to improve the quality of services for individuals receiving HCBS. It addresses several sections of Medicaid law that allow states to use Medicaid funds to pay for home and community-based services (HCBS).

Under the HCBS rule, individuals receiving services through HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting allowable.

In 2018, as part of the HCBS transition process, the Michigan Department of Health and Human Services began site reviews of all home and community-based settings for compliance with the rule.

What happens when my service provider does not meet the HCBS settings final rule?

Certain service providers have received information from MDHHS that their facility is not compliant with the HCBS rule; therefore, certain consumers may have to transition from the facility. If you or your loved one has been impacted by this decision, please contact your case manager or your CMHSP right away for next steps.

The NMRE and the CMHSPs are focused on providing information to beneficiaries, family members, and other stakeholders to make this process less painful.

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – NOVEMBER 9, 2022
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Connie Cadarette, Richard Carpenter, Lauri Fischer, Ann Friend, Chip Johnston, Nancy Kearly, Eric Kurtz, Donna Nieman, Larry Patterson, Brandon Rhue, Nena Sork, Erinn Trask, Deanna Yockey, Tricia Wurn, Carol Balousek**

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

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

MOTION BY ERINN TRASK TO APPROVE THE MINUTES OF THE OCTOBER 12, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY LAURI FISCHER. MOTION APPROVED.

MONTHLY FINANCIALS
September 2022

- Net Position showed net surplus Medicaid and HMP of $11,331,599. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $27,689,716. 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 $44,047,833.
- Traditional Medicaid showed $203,038,742 in revenue, and $188,520,205 in expenses, resulting in a net surplus of $14,518,537. Medicaid ISF was reported as $9,298,368 based on the final FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $32,507,098 in revenue, and $28,551,560 in expenses, resulting in a net surplus of $3,945,538. HMP ISF was reported as $7,059,749 based on the final FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,507,126 in revenue, and $1,283,632 in expenses, resulting in a net surplus of $223,494.
- SUD showed all funding source revenue of $25,668,256, and $22,503,103 in expenses, resulting in a net surplus of $3,165,153. Total PA2 funds were reported as $5,511,715.

The direct care wage surplus was estimated at $7,132,476. Total DCW revenue was reported as $15.3M. Final quarter PA2 payments were received totaling approximately $1.5M.

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR SEPTEMBER 2022; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

DRAFT

EDIT UPDATE

The minutes from October 20th were included in the meeting materials; discussion topics included:

- CFI reported to the Department about communication issues; the CMHSPs would like direct communication with EDIT. The EDIT charter was reviewed, and regions were instructed to review communication processes.
- Clarification was provided regarding the use of the 97153 and 97154 codes: 97153 is billed for anyone providing the treatment protocol for an individual; 97154 is billed for anyone providing the treatment protocol for a group.
- The question of whether there is a plan to add housing assistance as a billable code under the CCBHC was raised. Under CCBHC housing support is under care coordination umbrella and not billable. A CCBHC Team Member will be invited to the January EDIT meeting. Eric explained that the 1115(i) was supposed to include Permanent supportive housing as part of the bundled payment model. Donna shared a "Housing Assistance" document with the committee.
- A request to allow case management to overlap with the SIS assessment was denied.
- The transition from the CAFAS to the CANS was reviewed. PCE is working to integrate the CANS into the EHR.
- A request to allow overlap of case management and music therapy was discussed; this will be investigated and brought back in January.
- A request to consider the allowance of biofeedback/neurofeedback as an allowable modality for therapy was discussed; this will be investigated and brought back in January.
- The Federal PHE is expected to end on January 11, 2023. If not extended again, the new Telemedicine policy will go into effect on January 12, 2023. It was noted that a 60-day notice should be received by November 11th.
- The next EQI meeting is scheduled for November 10th; Tricia would like to join the committee. Deanna will reach out to Kathy Haines to make the request.
- The Improving Outcomes Conference in December will include a presentation on Supported Employment modifiers.
- The question of what services fall under crisis intervention H2011 code was raised; this topic will be brought back in January.

Eric noted that he sits on the Residential Tiered Rates Workgroup; however, meeting times conflict with the NMRE Operations Committee monthly meetings. He asked for a volunteer to represent the region in his place. Lauri expressed interest. The next meeting is scheduled for December 20th. Chip voiced strong opposition to the project. (Kent/Oakland favor it).

The next EDIT meeting is scheduled for January 19, 2023.

EQI UPDATE

The Period 3 template will be released November 10th. Tricia thanked the Boards for getting her their data timely. Tricia reminded the group that monthly HSW detail is uploaded to ShareFile which includes Medicaid IDs, retractions, and payments.

HSW OPEN SLOTS

Deanna reported that the region currently has 17 open waiver slots. The CMHSPs were encouraged to submit packets.

AUDIT SCHEDULES

FY22 audit schedules were shared as follows:

- **AuSable Valley**: Jan 30th – 31st
- **Centra Wellness:** January 3rd – 4th
- **North Country:** December 19th – 20th
- **Northeast Michigan:** 2nd week in January
- **Northern Lakes:** January 9th – 10th
- **NMRE:** February 8th – 9th

SCA METHODOLOGY & DELEGATION GRID

The MDHHS Standard Cost Allocations instructions version 1.1 and the Delegation Grid developed by regional PIHP CFOs were included in the meeting materials; Eric is working on a regional version of the delegation grid.

Richard explained that there were major Managed Care Rule changes in 2016. The starting point is to get the PIHPs on the same page to inform the Department. Richard stated that consensus is needed regarding, 1) what PIHP managed care functions can be delegated, 2) what PIHP managed care functions must be delegated, and 3) what PIHP managed care functions may or may not be delegated to the CMHSPs. Eric noted that some areas are direct service codes.

Eric commented that the SCA is prescriptive about non-encounterable costs. Richard added that non-encounterable and managed care are not interchangeable terms; he advised using the term e "allocable costs." It was noted that the Department and Milliman don't understand some of the costing principles; "Managed care only" are relatively limited cost centers at the CMH level.

Chip expressed that the delegation grid is not accurate regarding claims. Richard confirmed that claims adjudication is spelled out in CFR.

Reference was made to the decision by Adam Falcone of Feldesman, Tucker, Leifer, and Fidell legal firm regarding service/encounter costs for CMHSPs. According to the memorandum:

"MDHHS's proposal would be inconsistent with federal Medicaid managed care regulations. Contracting with direct care providers to render services does not transform a CMHSP into a subcontractor or result in a CMHSP performing managed care functions when it supports and oversees the direct care providers. Consequently, MDHHS should only exclude costs from calculating service/encounter costs when those costs arise from a CMHSP performing specific managed care functions that have been delegated by the PIHP to the CMHSP."

The regional PIHP CFO group will continue to review and complete the delegation grid.

OTHER

Lauri asked whether it is known why TANF eligibility numbers jumped from August to September. Deanna didn't have an answer but agreed to look into it and report back.

Deanna reminded the Boards that FSRs were due to the NMRE on November 8th; if they have not been submitted, please do so as soon as possible.

NEXT MEETING

The next meeting was scheduled for December 14th at 10:00AM.

DRAFT

Chief Executive Officer Report

November 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.

Nov 1: Attended and participated in PIHP CEO Meeting.

Nov 2: Attended and participated in NMRE Internal Operations Committee Meeting.

Nov 3: Attended and participated in Meeting with Munson Executives regarding crisis services.

Nov 3: Partially attended and participated in PIHP/MDHHS CEO Meeting.

Nov 7: Attended and participated in SUD Oversight Board Meeting.

Nov 7: Attended and participated in NLCMHA County Admin Meeting.

Nov 9: Attended NMRE Regional Finance Committee Meeting.

Nov 17: Attended and participated in NMRE Internal Operations Committee.

Nov 22: Attended and participated in potential SUD clinic in West Branch.

Nov 22: Attended and participated in Arc, CMHA and MHAM advocacy discussion.

Nov 23: Attended and participated in CMHA Self Determination Meeting.

Nov 28: Attended and participated in NMRE Internal Operations Committee Meeting.

Nov 30: Attended and participated in MDHHS PIHP CEO Meeting.

September 2022

Interim Finance Report

September 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	14,518,537	11,296,867	9,298,368
Healthy Michigan	3,945,538	5,061,250	7,059,749
	$ 18,464,075	$ 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	1,233,039	2,245,418	3,518,065	3,649,302	(1,295,277)	1,554,898	426,155	$ 11,331,599
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 27,689,716
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 44,047,833

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2021 through September 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 197,686,148	$ 4,755,998						$ 202,442,146
CMHSP Distributions	(190,026,285)		63,042,814	52,175,747	31,993,176	26,232,370	16,582,178	-
1st/3rd Party receipts			478,301	-	118,295	-	-	596,596
Net revenue	7,659,863	4,755,998	63,521,115	52,175,747	32,111,471	26,232,370	16,582,178	203,038,742
Expense								
PIHP Admin	2,384,344	50,108						2,434,451
PIHP SUD Admin		65,088						65,088
SUD Access Center		60,479						60,479
Insurance Provider Assessment	1,581,270	32,186						1,613,456
Hospital Rate Adjuster	2,548,084							2,548,084
Services		3,741,906	57,279,129	48,716,191	32,957,435	23,279,233	15,824,752	181,798,646
Total expense	6,513,698	3,949,767	57,279,129	48,716,191	32,957,435	23,279,233	15,824,752	188,520,205
Net Actual Surplus (Deficit)	$ 1,146,165	$ 806,231	$ 6,241,986	$ 3,459,556	$ (845,964)	$ 2,953,137	$ 757,426	$ 14,518,537

Notes

Medicaid ISF - $9,298,368 - based on Final FSR

Medicaid Savings - $11,296,867

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through September 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 21,054,148	$ 11,446,386						$ 32,500,534
CMHSP Distributions	(18,738,221)		6,819,759	5,690,429	2,327,067	2,327,745	1,573,221	-
1st/3rd Party receipts			-	-	6,564	-	-	6,564
Net revenue	2,315,927	11,446,386	6,819,759	5,690,429	2,333,631	2,327,745	1,573,221	32,507,098
Expense								
PIHP Admin	227,433	118,613						346,046
PIHP SUD Admin		154,076						154,076
SUD Access Center		143,165						143,165
Insurance Provider Assessment	141,916	74,787						216,703
Hospital Rate Adjuster	1,859,704							1,859,704
Services		8,857,754	7,152,539	4,523,489	1,625,357	2,416,421	1,266,306	25,841,866
Total expense	2,229,053	9,348,395	7,152,539	4,523,489	1,625,357	2,416,421	1,266,306	28,561,560
Net Surplus (Deficit)	$ 86,874	$ 2,097,991	$ (332,780)	$ 1,166,940	$ 708,274	$ (88,676)	$ 306,915	$ 3,945,538

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

Direct Care Wage Estimated Surplus		(658,804)	(2,391,142)	(977,193)	(1,157,587)	(1,309,564)	(638,187)	$ (7,132,476)
Net Surplus (Deficit) MA/HMP/DCW	$ 1,233,039	$ 2,245,418	$ 3,518,065	$ 3,649,302	$ (1,295,277)	$ 1,554,898	$ 426,155	$ 11,331,599
Medicaid & HMP Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 27,689,716
Medicaid & HMP ISF - based on unaudited FSR								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 44,047,833

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through September 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 255,987		494,135	146,531	96,342	72,016	442,114	$ 1,507,126
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	255,987	-	494,135	146,531	96,342	72,016	442,114	1,507,126
Expense								
PIHP Admin	16,754							16,754
BHH Admin	9,902							9,902
Insurance Provider Assessment	5,837							5,837
Hospital Rate Adjuster								
Services	0		494,135	146,531	96,342	72,016	442,114	1,251,139
Total expense	32,493	-	494,135	146,531	96,342	72,016	442,114	1,283,632
Net Surplus (Deficit)	$ 223,494	$ -	$ -	$ -	$ -	$ -	$ -	$ 223,494

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2021 through September 30, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 4,755,998	$ 11,446,386	$ 3,823,624	$ 3,369,636	$ 2,272,612	$ 25,668,256
Expense						
Administration	115,196	272,689	102,043	190,118		680,047
OHH Admin			124,495	-		124,495
Access Center	60,479	143,165	-	30,728		234,373
Insurance Provider Assessment	32,186	74,787	21,499			128,472
Services:						
Treatment	3,741,906	8,857,754	3,314,653	1,901,181	2,272,612	20,088,106
Prevention	-	-	-	1,060,192	-	1,060,192
ARPA Grant	-	-	-	187,418	-	187,418
Total expense	3,949,767	9,348,395	3,562,690	3,369,637	2,272,612	22,503,103
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 806,231	$ 2,097,991	$ 260,934	$ (1)	$ -	$ 3,165,153

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through September 30, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 197,686,148	$ 4,755,998	$ -	$ 202,442,146
Medicaid Savings	11,296,867	-	-	11,296,867
Healthy Michigan	21,054,148	11,446,386	-	32,500,534
Healthy Michigan Savings	5,061,250	-	-	5,061,250
Health Home	1,507,126	-	-	1,507,126
Opioid Health Home	-	3,823,624	-	3,823,624
Substance Use Disorder Block Grant	-	3,369,636	-	3,369,636
Public Act 2 (Liquor tax)	-	2,272,612	-	2,272,612
Affiliate local drawdown	899,600	-	-	899,600
Performance Incentive Bonus	1,363,500	-	-	1,363,500
Miscellanous Grant Revenue	-	21,087	-	21,087
Veteran Navigator Grant	99,798	-	-	99,798
SOR Grant Revenue	-	1,413,548	-	1,413,548
Gambling Grant Revenue	-	186,050	-	186,050
Other Revenue	960	-	7,476	8,436
Total operating revenue	238,969,397	27,288,941	7,476	266,265,814
Operating expenses				
General Administration	2,912,425	630,525	-	3,542,950
Prevention Administration	-	89,882	-	89,882
OHH Administration	-	124,495	-	124,495
BHH Administration	9,902	-	-	9,902
Insurance Provider Assessment	1,729,023	128,472	-	1,857,495
Hospital Rate Adjuster	4,407,788	-	-	4,407,788
Payments to Affiliates:				
Medicaid Services	177,460,144	3,741,906	-	181,202,050
Healthy Michigan Services	16,977,548	8,857,754	-	25,835,302
Health Home Services	1,251,139	-	-	1,251,139
Opioid Health Home Services	-	3,314,653	-	3,314,653
Community Grant	-	1,901,181	-	1,901,181
Prevention	-	970,310	-	970,310
State Disability Assistance	-	-	-	-
ARPA Grant	-	187,418	-	187,418
Public Act 2 (Liquor tax)	-	2,272,612	-	2,272,612
Local PBIP	2,801,252	-	-	2,801,252
Local Match Drawdown	899,600	-	-	899,600
Miscellanous Grant	-	21,087	-	21,087
Veteran Navigator Grant	99,797	-	-	99,797
SOR Grant Expenses	-	1,413,547	-	1,413,547
Gambling Grant Expenses	-	186,050	-	186,050
Total operating expenses	208,548,618	23,839,892	-	232,388,510
CY Unspent funds	30,420,779	3,449,049	7,476	33,877,304
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,254,458	6,231,624	16,358,117	24,844,199
Unspent funds - ending	$ 32,675,237	$ 9,680,673	$ 16,365,593	$ 58,721,503

Northern Michigan Regional Entity

Statement of Net Position

September 30, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 42,602,414	$ 8,820,681	$ 16,365,593	$ 67,788,688
Accounts Receivable	15,410,744	2,523,302	-	17,934,046
Prepaids	74,818	-	-	74,818
Total current assets	58,087,976	11,343,983	16,365,593	85,797,552
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	58,087,976	11,343,983	16,365,593	85,797,552
Liabilities				
Current liabilities				
Accounts payable	25,236,586	1,663,310	-	26,899,896
Accrued liabilities	176,153	-	-	176,153
Unearned revenue	-	-	-	-
Total current liabilities	25,412,739	1,663,310	-	27,076,049
Unspent funds	$ 32,675,237	$ 9,680,673	$ 16,365,593	$ 58,721,503

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2021 through September 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 192,931,092	$ 197,686,148	$ 4,755,056	2.46%
Carryover	11,296,664	11,296,664	11,296,867	203	0
Healthy Michigan					
Capitation	20,566,272	20,566,272	21,054,148	487,876	2.37%
Carryover	5,061,832	5,061,832	5,061,250	(582)	(0.01%)
Health Home	506,772	506,772	1,507,126	1,000,354	197.40%
Affiliate local drawdown	1,204,388	1,204,388	899,600	(304,788)	(25.31%)
Performance Bonus Incentive	1,334,531	1,334,531	1,363,500	28,969	2.17%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	110,000	99,798	(10,202)	(9.27%)
Other Revenue	-	-	960	960	0.00%
Total operating revenue	233,011,551	233,011,551	238,969,397	5,957,846	2.56%
Operating expenses					
General Administration	3,021,688	2,992,744	2,912,425	80,319	2.68%
BHH Administration	-	-	9,902	(9,902)	0.00%
Insurance Provider Assessment	1,645,387	1,645,387	1,729,023	(83,636)	(5.08%)
Hospital Rate Adjuster	4,001,228	4,001,228	4,407,788	(406,560)	(10.16%)
Local PBIP	1,334,531	-	2,801,252	(2,801,252)	0.00%
Local Match Drawdown	1,204,388	1,204,388	899,600	304,788	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	194,888	99,797	95,091	48.79%
Payments to Affiliates:					
Medicaid Services	173,402,120	173,402,120	177,460,144	(4,058,024)	(2.34%)
Healthy Michigan Services	15,233,944	15,233,944	16,977,548	(1,743,604)	(11.45%)
Health Home Services	456,768	456,768	1,251,139	(794,371)	(173.91%)
Total operating expenses	200,508,190	199,131,467	208,548,618	(9,417,151)	(4.73%)
CY Unspent funds	$ 32,503,361	$ 33,880,084	30,420,779	$ (3,459,305)	
Transfers in			-		
Transfers out			-	208,548,618	
Unspent funds - beginning			2,254,458		
Unspent funds - ending			$ 32,675,237	30,420,779	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2021 through September 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 4,398,744	$ 4,755,998	$ 357,254	8.12%
Healthy Michigan	9,763,272	9,763,272	11,446,386	1,683,114	17.24%
Substance Use Disorder Block Grant	5,709,003	5,709,003	3,369,636	(2,339,367)	(40.98%)
Opioid Health Home	2,320,384	2,320,384	3,823,624	1,503,240	64.78%
Public Act 2 (Liquor tax)	1,533,979	1,533,979	2,272,612	738,633	48.15%
Miscellanous Grants	36,335	36,335	21,087	(15,248)	(41.97%)
SOR Grant	1,215,000	1,215,000	1,413,548	198,548	16.34%
Gambling Prevention Grant	200,000	200,000	186,050	(13,950)	(6.97%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	25,176,717	27,288,941	2,112,224	8.39%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	1,010,484	630,525	379,959	37.60%
Prevention Administration	90,144	90,144	89,882	262	0.29%
Insurance Provider Assessment	116,901	116,901	128,472	(11,571)	(9.90%)
Medicaid Services	3,387,649	3,387,649	3,741,906	(354,257)	(10.46%)
Healthy Michigan Services	7,453,459	7,453,459	8,857,754	(1,404,295)	(18.84%)
Community Grant	2,077,452	2,077,452	1,901,181	176,271	8.48%
Prevention	664,967	664,967	970,310	(305,343)	(45.92%)
State Disability Assistance	95,215	95,215	-	95,215	100.00%
ARPA Grant	-	-	187,418	(187,418)	0.00%
Opioid Health Home Admin	-	-	124,495	(124,495)	0.00%
Opioid Health Home Services	2,117,226	2,117,226	3,314,653	(1,197,427)	(56.56%)
Miscellanous Grants	36,335	36,335	21,087	15,248	41.97%
SOR Grant	1,215,000	1,215,000	1,413,547	(198,547)	(16.34%)
Gambling Prevention	200,000	200,000	186,050	13,950	6.97%
PA2	1,533,978	1,533,978	2,272,612	(738,634)	(48.15%)
Total operating expenses	20,058,810	19,998,810	23,839,892	(3,841,082)	(19.21%)
CY Unspent funds	$ 5,117,907	$ 5,177,907	3,449,049	$ (1,728,858)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,231,624		
Unspent funds - ending			$ 9,680,673		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2021 through September 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 1,729,068	$ 1,548,168	$ 180,900	10.46%
Fringes	549,516	520,572	501,387	19,185	3.69%
Contractual	433,304	433,304	601,913	(168,609)	(38.91%)
Board expenses	16,100	16,100	19,338	(3,238)	(20.11%)
Day of recovery	14,000	14,000	4,917	9,083	64.88%
Facilities	152,700	152,700	135,651	17,049	11.17%
Other	127,000	127,000	101,051	25,949	20.43%
Total General Admin	$ 3,021,688	$ 2,992,744	$ 2,912,425	$ 80,319	2.68%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2021 through September 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 482,208	$ 229,240	$ 252,968	52.46%
Fringes	166,800	166,800	59,902	106,898	64.09%
Access Salaries	194,484	194,484	181,091	13,393	6.89%
Access Fringes	57,588	57,588	53,282	4,306	7.48%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	100,000	91,349	8,651	8.65%
Board expenses	5,000	5,000	4,240	760	15.20%
Facilities	-	-	-	-	0.00%
Other	10,404	4,404	11,421	(7,017)	(159.33%)
Total operating expenses	$ 1,070,484	$ 1,010,484	$ 630,525	$ 379,959	37.60%

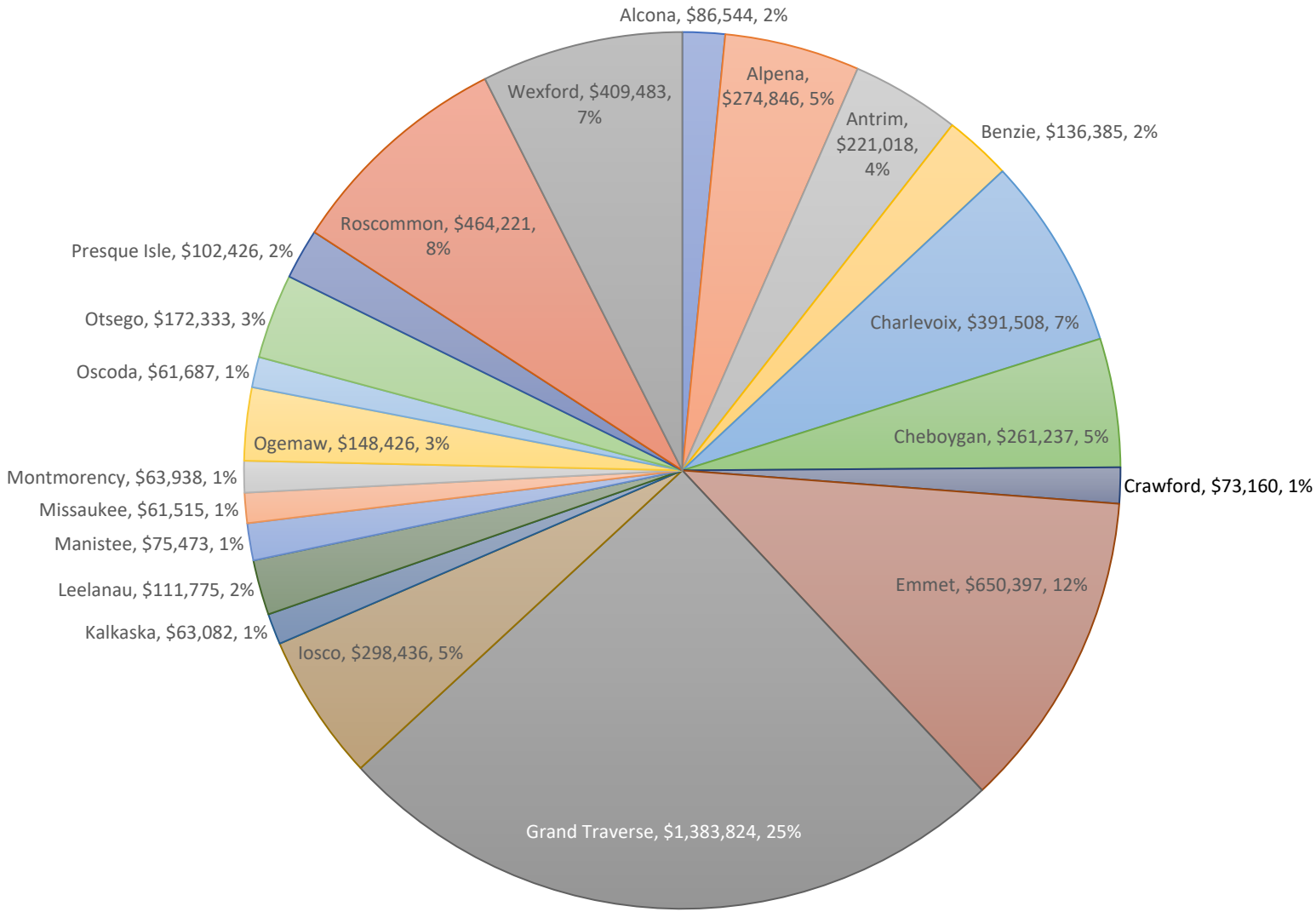
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through September 30, 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	$ 19,260	$ 38,301	40,268	$ 888	$ 86,544
Alpena	315,554	66,080	65,235	160,005	116,011	2,440	274,846
Antrim	243,061	53,592	54,992	95,690	73,049	1,997	221,018
Benzie	144,391	49,804	51,000	27,891	19,574	1,507	136,385
Charlevoix	467,765	82,100	84,999	262,209	186,609	2,241	391,508
Cheboygan	280,756	68,778	71,908	176,925	158,361	2,175	261,237
Crawford	85,250	28,559	31,195	32,978	22,331	1,192	73,160
Emmet	754,134	145,253	157,175	278,987	184,326	2,846	650,397
Grand Traverse	1,615,220	376,032	383,335	909,582	677,616	7,872	1,383,824
Iosco	359,368	70,274	69,753	160,492	96,882	2,157	298,436
Kalkaska	73,813	33,023	33,605	42,665	31,004	1,512	63,082
Leelanau	131,774	48,924	52,996	97,254	79,471	1,857	111,775
Manistee	90,411	63,745	67,391	36,315	22,928	2,094	75,473
Missaukee	66,066	18,058	17,775	50,287	44,167	1,286	61,515
Montmorency	64,849	26,456	25,952	36,920	34,712	793	63,938
Ogemaw	164,571	54,659	50,933	80,483	58,813	1,799	148,426
Oscoda	76,895	17,086	17,185	43,817	27,996	711	61,687
Otsego	205,220	86,909	86,927	210,283	175,309	2,104	172,333
Presque Isle	102,301	20,617	20,148	47,065	45,624	1,097	102,426
Roscommon	488,633	75,491	73,418	63,178	34,645	2,049	464,221
Wexford	417,956	82,829	82,014	111,588	99,446	2,853	409,483
	6,231,626	1,487,584	1,517,189	2,962,916	2,229,139	43,471	5,511,715
PA2 Redirect							-
							5,511,715

PA2 Funds by County



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2021 through September 30, 2022

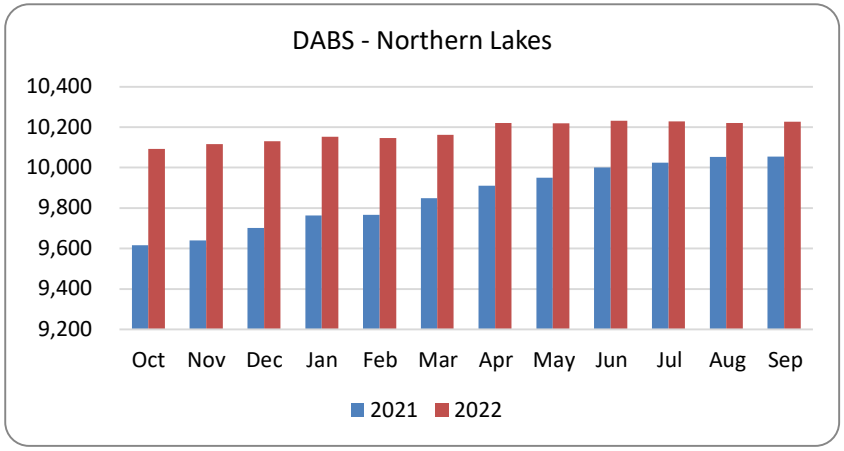
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	2,501	7,476	4,975	198.92%
Total operating revenue	2,501	2,501	7,476	4,975	198.92%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 2,501	7,476	$ 4,975	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,358,117		
Unspent funds - ending			$ 16,365,593		

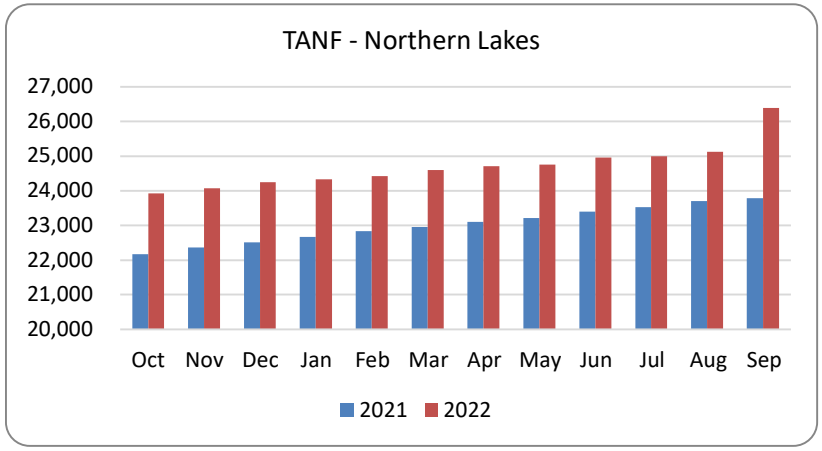
Northern Michigan Regional Entity

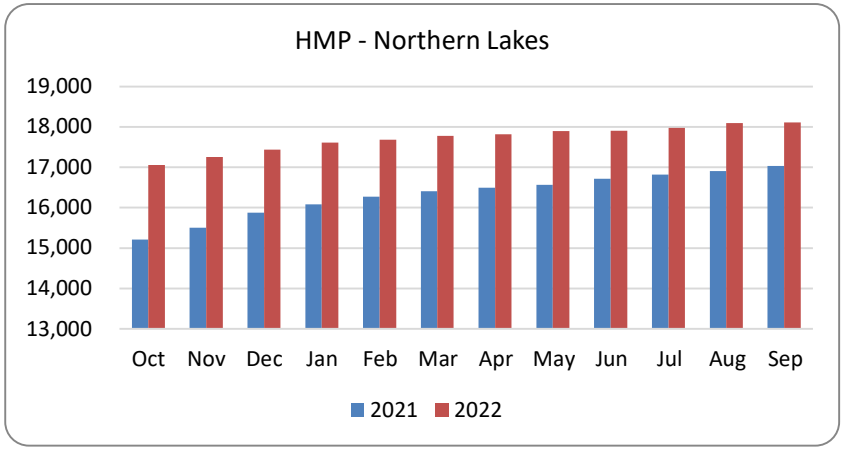
Narrative

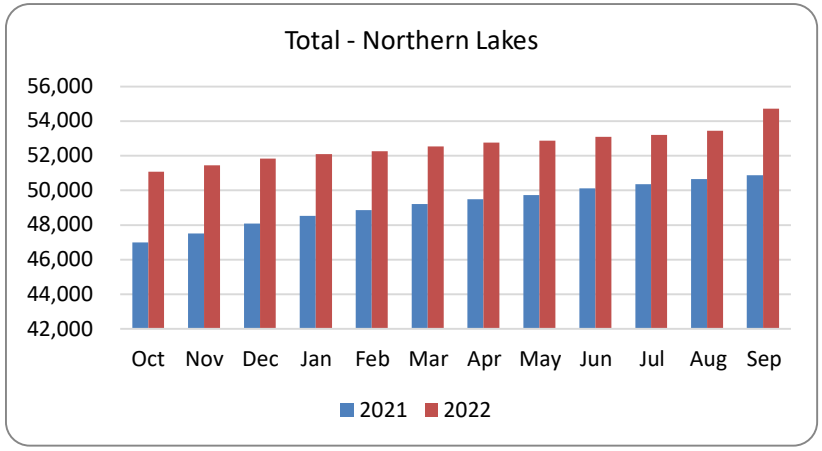
October 1, 2021 through September 30, 2022

Northern Lakes Eligible Trending - based on payment files







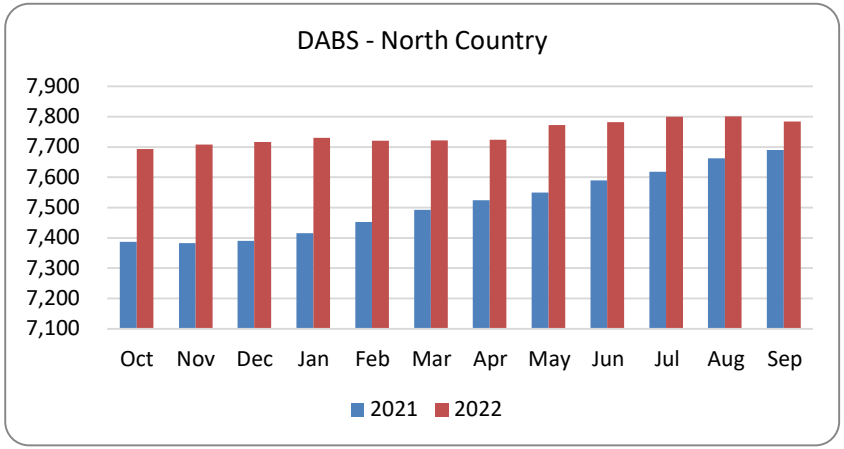


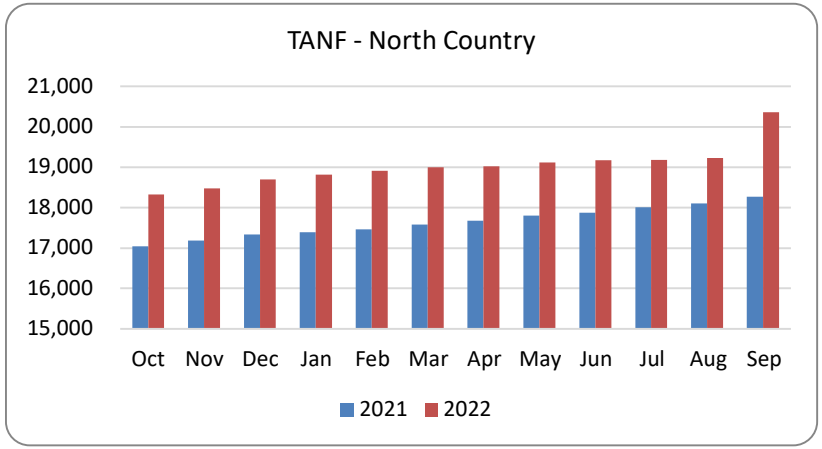
Northern Michigan Regional Entity

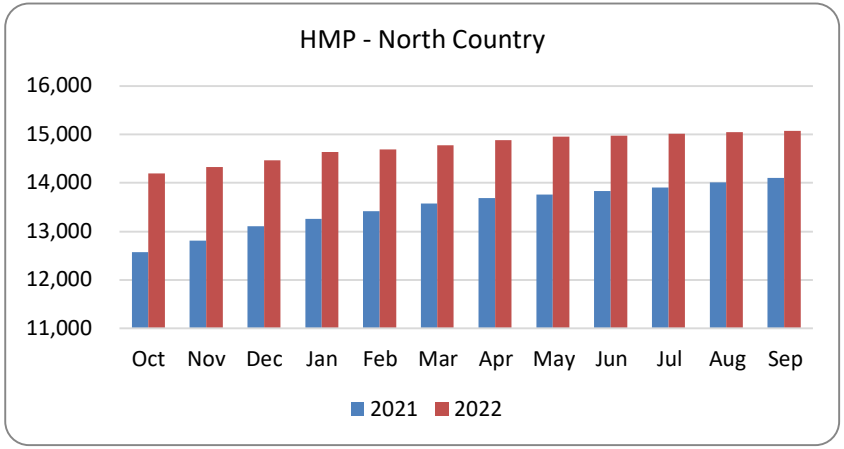
Narrative

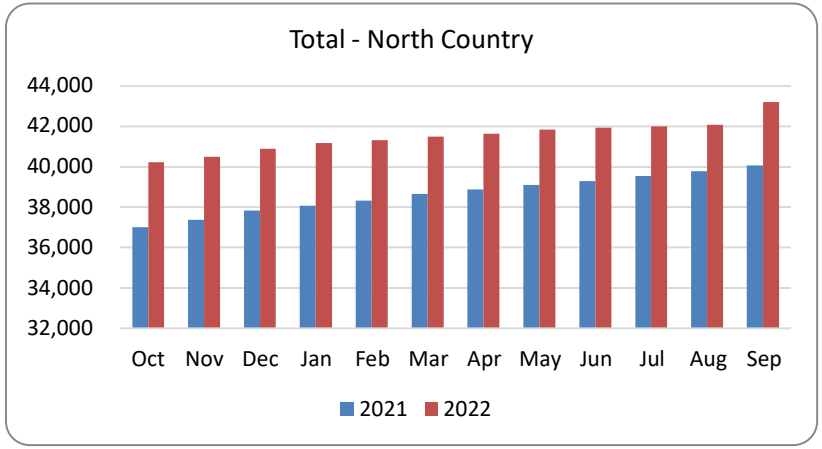
October 1, 2021 through September 30, 2022

North Country Eligible Trending - based on payment files







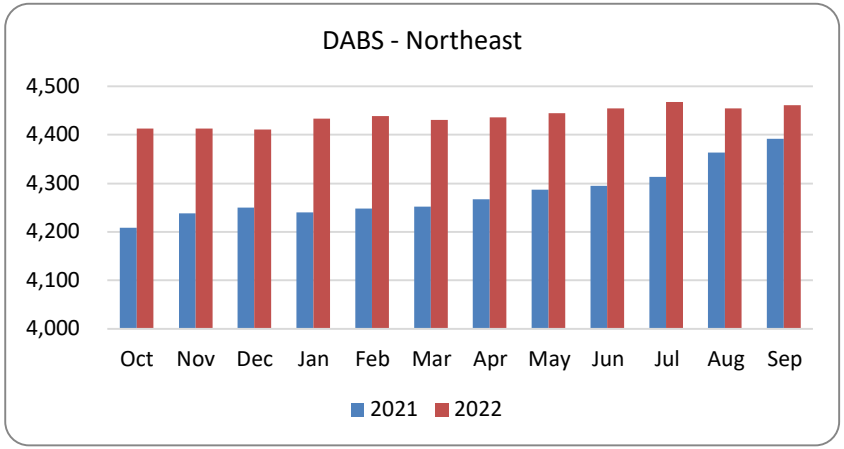


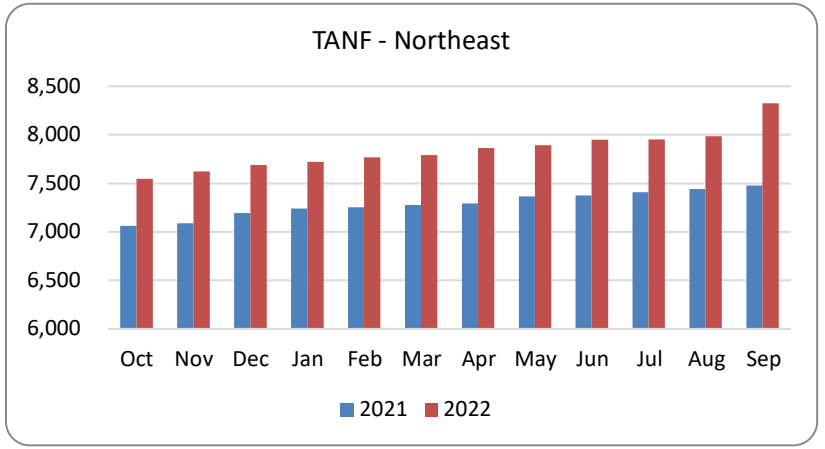
Northern Michigan Regional Entity

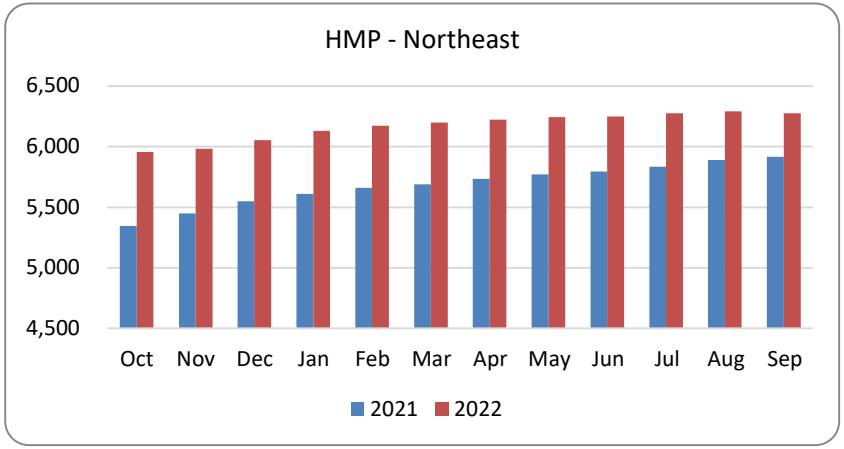
Narrative

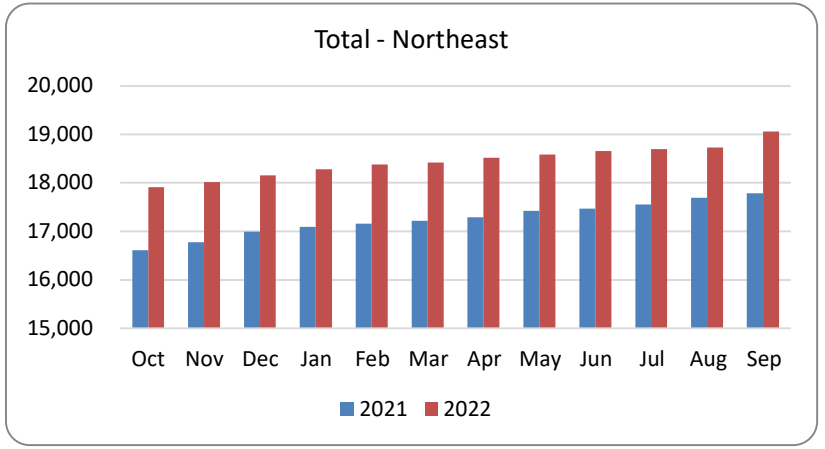
October 1, 2021 through September 30, 2022

Northeast Eligible Trending - based on payment files







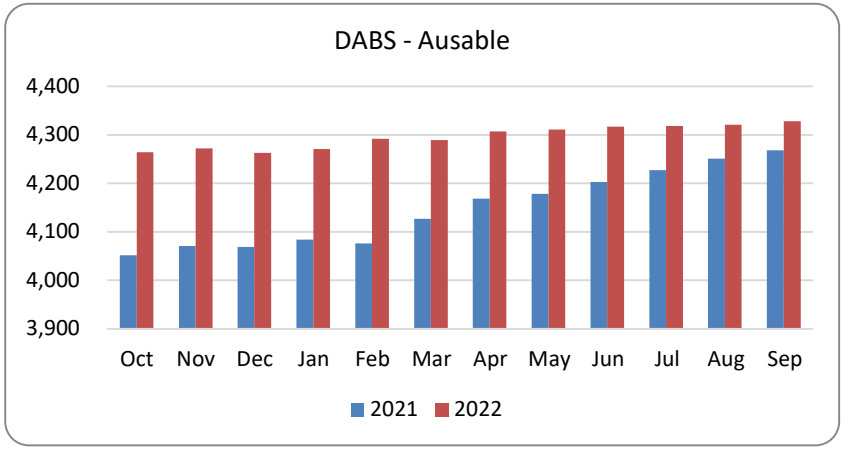


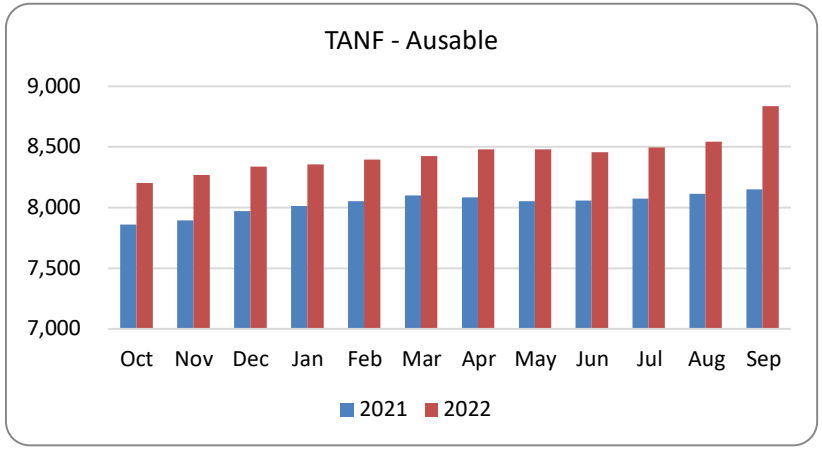
Northern Michigan Regional Entity

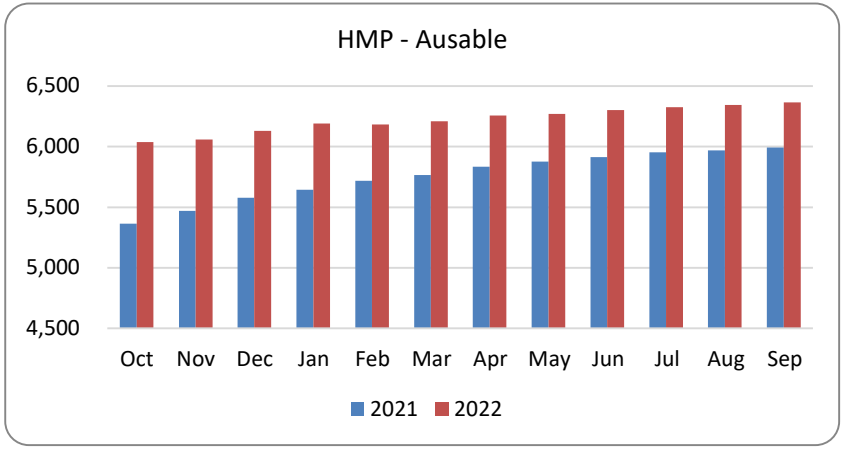
Narrative

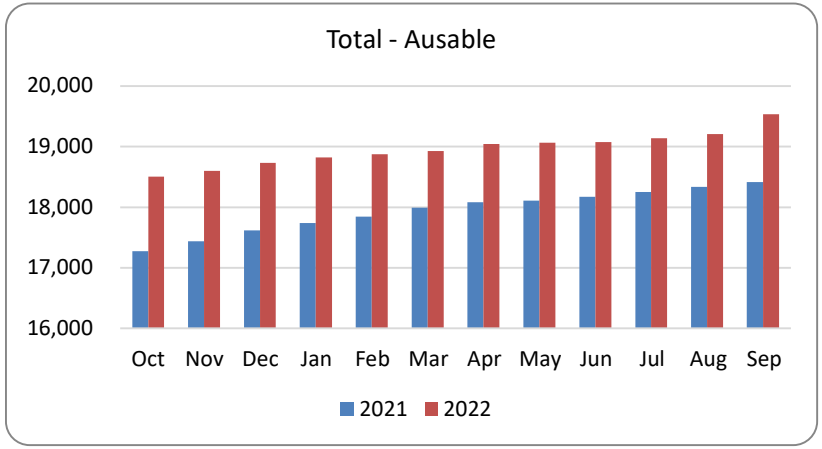
October 1, 2021 through September 30, 2022

Ausable Valley Eligibles Trending - based on payment files







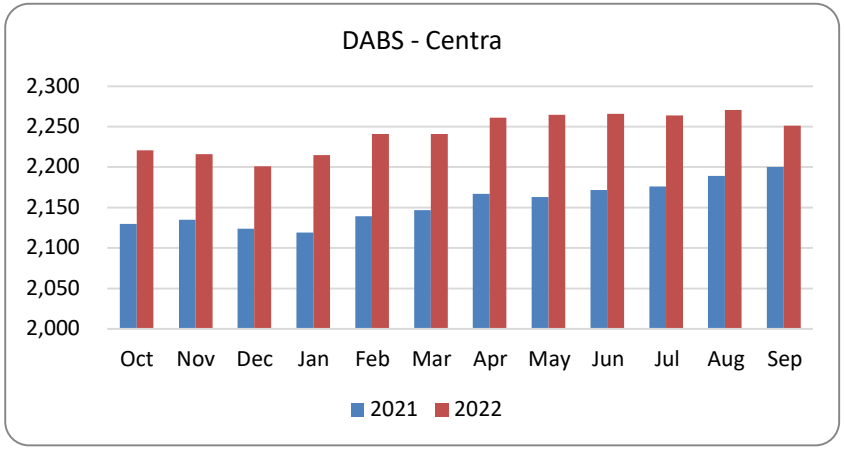


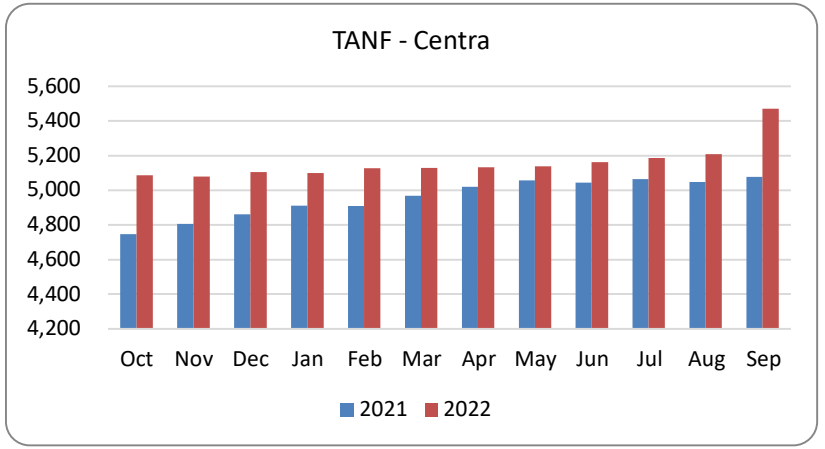
Northern Michigan Regional Entity

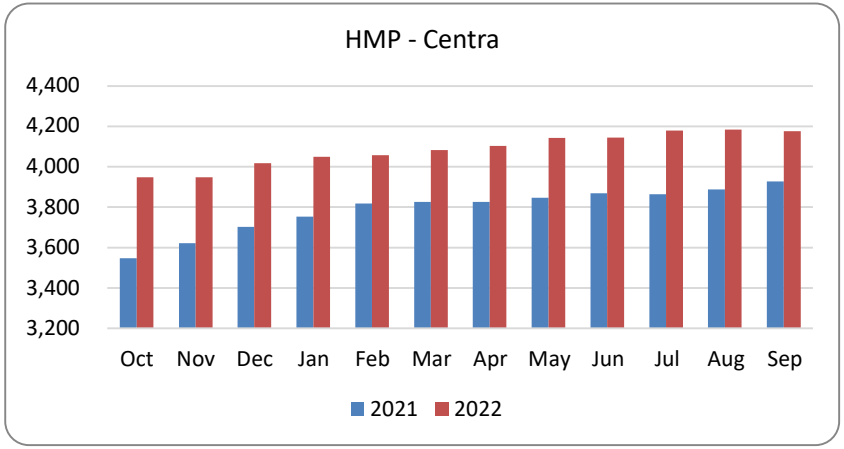
Narrative

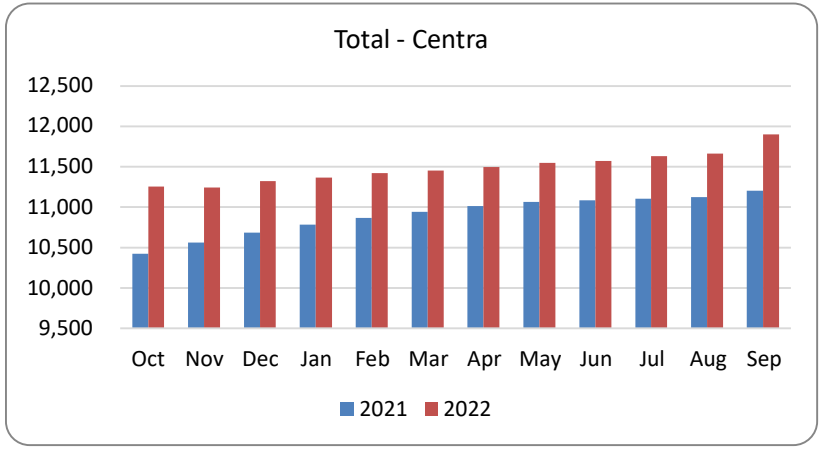
October 1, 2021 through September 30, 2022

Centra Wellness Eligibles Trending - based on payment files







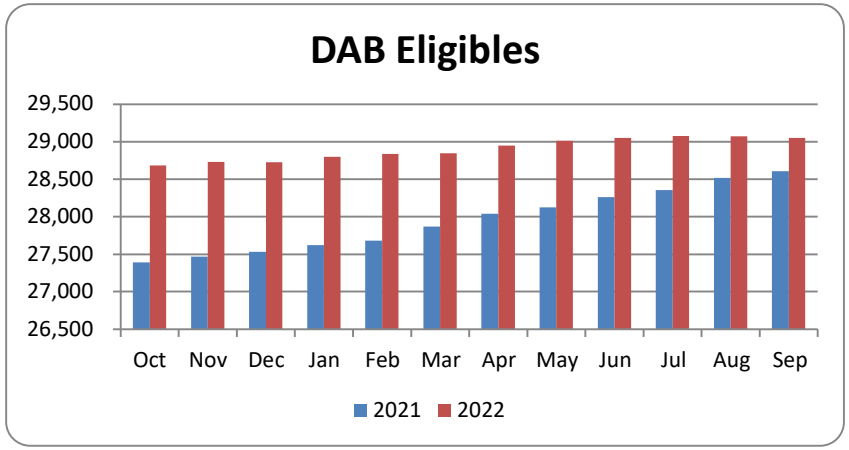


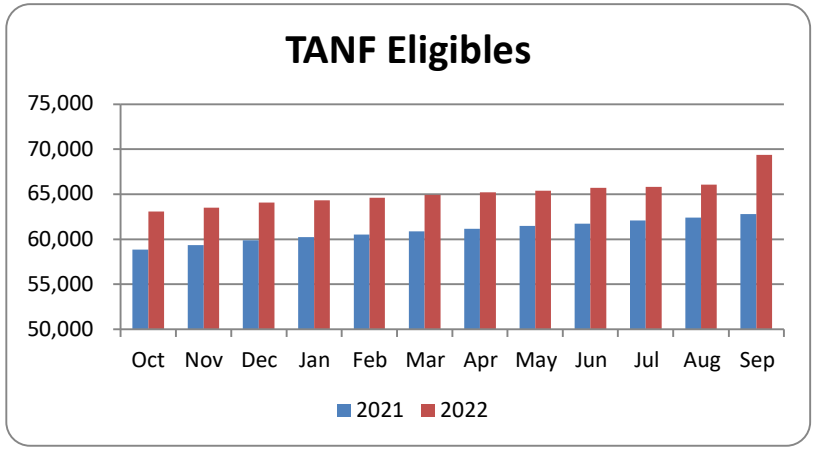
Northern Michigan Regional Entity

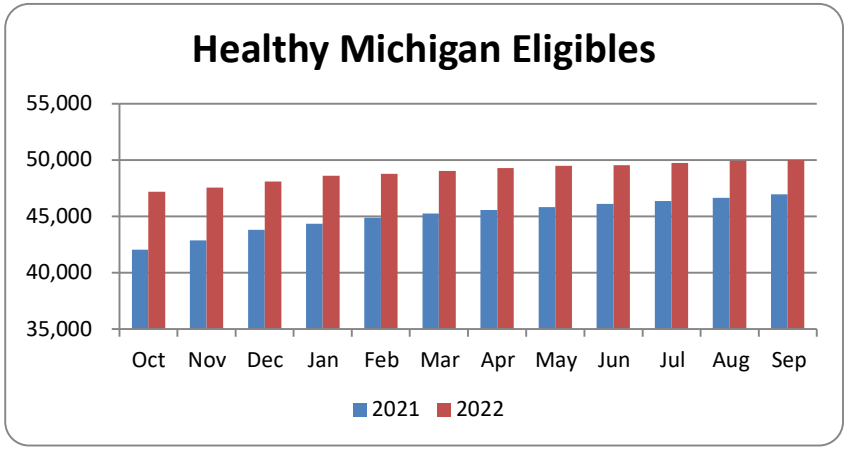
Narrative

October 1, 2021 through September 30, 2022

Regional Eligible Trending





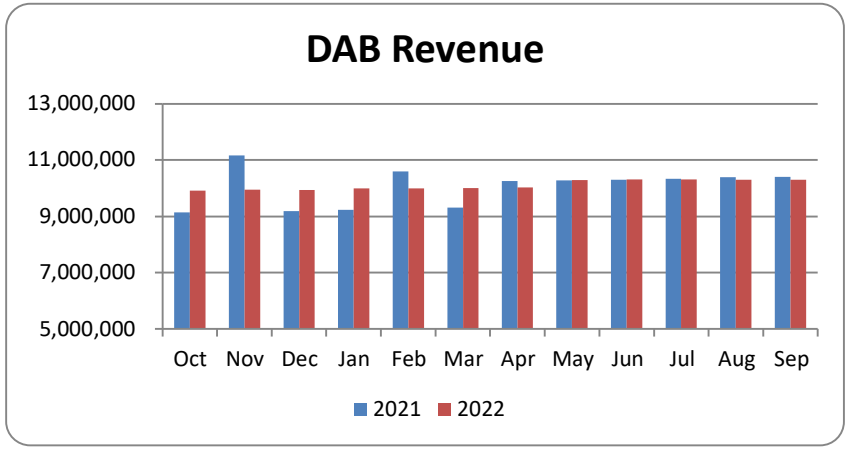


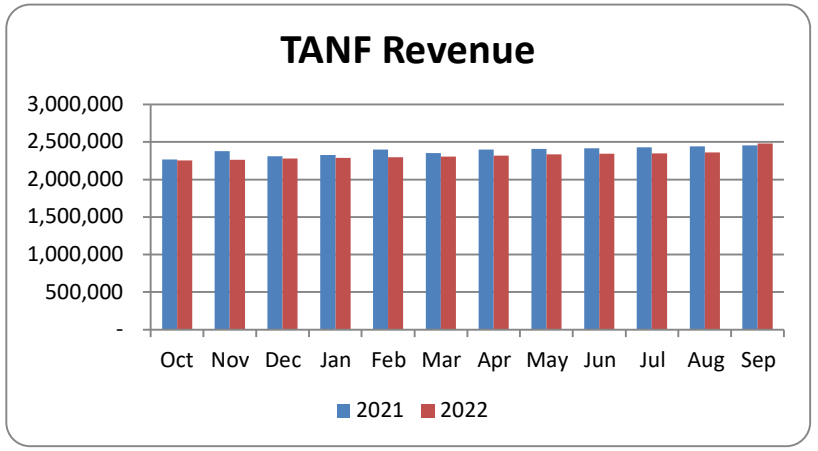
Northern Michigan Regional Entity

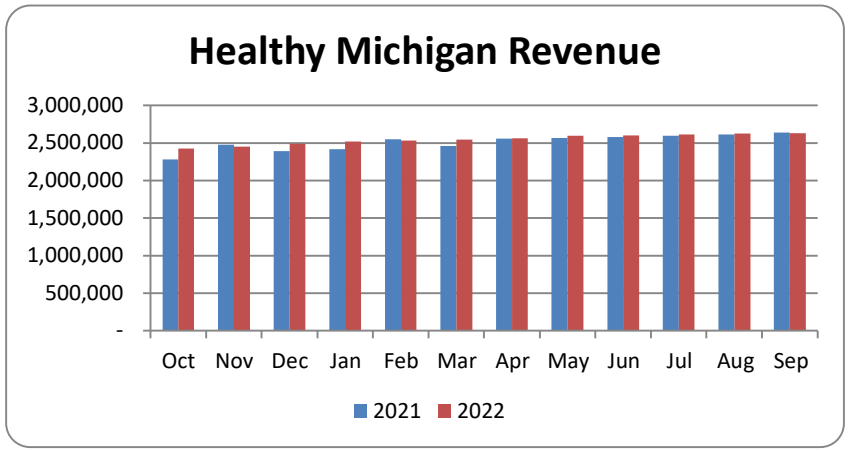
Narrative

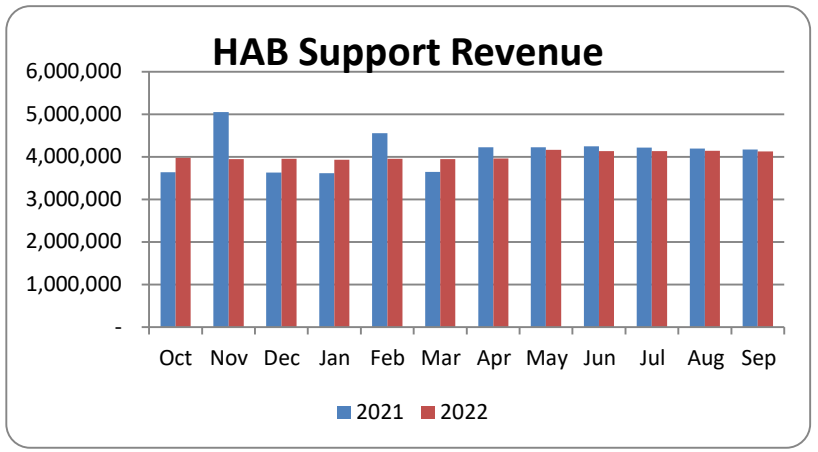
October 1, 2021 through September 30, 2022

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING
10:00AM – NOVEMBER 7, 2022
GAYLORD CONFERENCE ROOM

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

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

ROLL CALL
Let the record show that Robert Adrian, and Melissa Zelenak were excused from the meeting on this date, David Comai was absent, and all remaining Substance Use Disorder Oversight 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.

APPROVAL OF PAST MINUTES
The September minutes were included in the materials for the meeting on this date.

MOTION BY GARY NOWAK TO APPROVE THE MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD FOR SEPTEMBER 12, 2022; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

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

MOTION BY BOB DRAVES TO APPROVE THE AGENDA FOR THE NOVEMBER 7, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

DRAFT

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 Ms. Brummund called for any conflicts of interest to any of the meeting agenda items; none were declared.

INFORMATIONAL REPORTS

Admissions

The admissions report through September 30, 2022 was included in the materials for the meeting on this date. Overall admissions were down 4.2% from FY21. The data showed that outpatient was the highest level of treatment admissions at 49%, and alcohol was the most prevalent primary substance at 54% (heroin was second at 16%). Ms. Sircely noted that methamphetamine use is rising throughout the region reported as 15% vs. 12.7% in FY21.

Finance

August 2022 Monthly Report
SUD services through August 31, 2022 showed all funding source revenue of $23,280,348 and $19,949,895 in expenses, resulting in a net surplus of $3,330,453. Total PA2 funds were reported as $5,326,234.

RECOMMENDATION ITEMS

FY23 Liquor Tax Request Recommendations

A summary of the liquor tax requests that will be presented for review and approval on this date, including NMRE staff recommendations, was included in the meeting materials.

PA2 Fund Use Requests

1) Munson Medical Center Behavioral Health Services – Recovery Coach Patient Engagement within Healthcare Practices

   Grand Traverse $ 173,817

   The recommendation by NMRE was to approve for one year. The NMRE will work with Munson to get peer recovery coach services into billed services within the year. A potential 50% reduction may be warranted due to county fund balances; if funds are available, the full amount will be paid.

2) Health Department of Northwest Michigan – Syringe Exchange Program

   Antrim $ 5,000.00

   The recommendation by NMRE was to approve.

3) AuSable Valley Community Mental Health Authority (AVCMHA) – Peer Recovery Coach Program

DRAFT

Iosco		$	71,400.82
Ogemaw		$	59,536.62
Oscoda		$	23,515.56
	Total	**$**	**$154,453.00**

The recommendation by NMRE was to approve for one year. The NMRE will work with AVCMHA to get peer recovery coach services into billed services within the year.

4) AuSable Valley Community Mental Health Authority (AVCMHA) – Jail Services

Iosco		$	29,201.72
Ogemaw		$	24,757.98
Oscoda		$	9,522.30
	Total	**$**	**$63,482.00**

The recommendation by NMRE was to approve.

5) 217 Recovery – 217 Recovery Community Center

Antrim		$	20,060.88
Benzie		*$*	*15,135.23*
Charlevoix		$	22,512.94
Crawford		$	11,977.79
Emmet		$	28,588.39
Grand Traverse		$	79,071.31
Kalkaska		$	15,187.77
Leelanau		$	18,652.69
Manistee		*$*	*21,038.43*
Missaukee		$	12,917.44
Otsego		$	21,134.03
Roscommon		$	20,580.23
Wexford		$	28,659.87
	Total	**$**	**315,517.00**

The recommendation by NMRE was to approve; however, grant funding will be sought to reduce the amount of PA2.

A potential 50% reduction for Grand Traverse County and a 25% reduction for Kalkaska and Leelanau Counties may be warranted due to county fund balances; if funds are available, the full amount will be paid.

Mr. Larson noted that the counties listed are all on the west side of the state; he asked whether there has been any interest on the east side. Ms. Sircely responded that if the initial project is successful, an expansion is possible in the future. Mr. Schmidt voiced that Benzie and Manistee Counties have opted out of the project. Residents of those counties will either be ineligible to participate in the Community Center or the $36K will be absorbed by the other counties.

DRAFT

6) Bay Area Substance Education Services (BASES) – Jail Services

Charlevoix $ 20,000.00

The recommendation by NMRE was to approve.

MOTION BY JAY O'FARRELL TO APPROVE THE FISCAL YEAR 2023 LIQUOR TAX REQUESTS REVIEWED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD ON NOVEMBER 7, 2022 IN THE AMOUNT OF SEVEN HUNDRED THIRTY-TWO THOUSAND TWO HUNDRED SIXTY-NINE DOLLARS ($732,269.00); SUPPORT BY TERRY NEWTON. ROLL CALL VOTE.

"Yea" Votes: **C. Brummund, B. Draves, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Markey, T. Muckenthaler, J. O'Farrell, T. Newton, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace**

"Nay" Votes: **Nil**

MOTION CARRIED.

PROPOSED FY23 MEETING SCHEDULE

A change to the FY23 meeting schedule approved in September was requested. The NMRE will be closed on January 2, 2023; January 9, 2023 was proposed as the new meeting date.

MOTION BY RICHARD SCHMIDT TO APPROVE AMENDING THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING SCHEDULE FOR FISCAL YEAR 2023 BY MOVING THE JANUARY 2, 2023 MEETING TO JANUARY 9, 2023; SUPPORT BY BOB DRAVES. MOTION CARRIED.

The revised FY23 meeting schedule will be posted to the Northern Michigan Regional Entity - Northern Michigan Regional Entity (nmre.org).

PUBLIC COMMENT

Board

Mr. Freedman asked whether it would be perceived as a conflict of interest if he volunteered at the 217 Recovery Community Center in some capacity; Mr. Kurtz responded that he would not be financially enhanced, so there would be no conflict.

NEXT MEETING

The next meeting was scheduled for January 9, 2022 at 10:00AM.

ADJOURN

Let the record show that Ms. Brummund adjourned the meeting at 10:34AM.

DRAFT

PIHP Contract Change Order #7

Item 1:

NEW:

Schedule A, Statement of Work Section 1. General Requirements, F. Covered Services, 1. General letter d. is hereby deleted and replaced in its entirety with the following:

d. The Contractor will be responsible for the Reciprocity Standards policy which can be found on the MDHHS Policies & Practice Guidelines website, https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

OLD:

Contractor Reciprocity Standards The Contractor will be responsible for the Reciprocity Standards policy which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.htmFinancial Management System

Item 2:

NEW

Section 1. General Requirements, L. Grievance and Appeals Process for Beneficiaries, 1. Grievance and Appeals Policies and Procedures, letter b. is hereby deleted and replaced in its entirety with the following:

b. Contractor must have written policies and procedures governing the resolution of Grievances and Appeals; A beneficiary, or a third party acting on behalf of a beneficiary, may file a Grievance or Appeal, orally or in writing, on any aspect of Covered services as specified in the definitions of Grievance and Appeal

OLD:

b. Contractor must have written policies and procedures governing the resolution of Grievances and Appeals; An beneficiary, or a third party acting on behalf of an beneficiary, may file a Grievance or Appeal, orally or in writing, on any aspect of Covered services as specified in the definitions of Grievance and Appeal. Unless a beneficiary requests an expedited resolution, an oral appeal must be followed by a written, signed appeal

Item 3

NEW:

Section 1. General Requirements, N. Provider Services, 10. substance use disorder (SUD) Services, letter a, item iv. is hereby deleted and replaced in its entirety with the following:

iv. On request from MDHHS or LARA, subject to applicable regulations, collect and transfer data and financial information from local programs to the LARA.

OLD:

iv. Collect and transfer data and financial information from local programs to the LARA.

Item 4

NEW:

Section 1. General Requirements, R. Program Integrity is hereby deleted and replaced in its entirety with the following:

R. Program Integrity The State, MDHHS-Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Contractor and all subcontracted entities.

1. General:

a. To the extent consistent with applicable Federal and State law, including, but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the Contractor must disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.

b. The Contractor must have administrative and management arrangements or procedures for compliance with 42 CFR 438.608. Such arrangements or procedures must identify program integrity compliance activities that will be delegated and how the Contractor will monitor those activities.

c. The Contractor must provide prompt notification to the State, MDHHS BPHASA when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including, changes in the beneficiary's residence and the death of a beneficiary.

d. The Contractor that makes or receives annual payments under this Contract of at least $5,000,000 to a Provider, must make provision for written policies for all employees of the entity, and of any contractor or agent of the entity, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

e. The Contractor must require all contracted Providers that make or receive annual payments under this Contract of at least $5,000,000 to agree to comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

f. The Contractor must have a program integrity compliance program as defined in 42 CFR 438.608. The program integrity compliance program must include the following:

i. Written policies and procedures that describe the Contractor's commitment to comply with Federal and State fraud, waste and abuse standards enforced through well-publicized disciplinary guidelines.

ii. The designation of a Compliance Officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the

senior management or Board of Directors, with effective lines of communication to the Contractor's employees.

iii. A system for training and education for the Compliance Officer, the Contractor's senior management, and the Contractor's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this Contract. While the compliance officer may provide training to Contractor employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer to himself/herself.

iv. Provisions for internal monitoring and auditing of compliance risks. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities). Acceptable audit methodology examples include:

a. Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
b. Beneficiary interviews to confirm services rendered.
c. Provider self-audit protocols.
d. The frequency and quantity of audits performed should be dependent on the number of fraud, waste, and abuse complaints received, as well as high risk activities identified through data mining and analysis of paid claims.

v. Provisions for the Contractor's prompt response to detected offenses and for the development of corrective action plans. "Prompt Response" is defined in this Contract as action taken within 15 business days of receipt and identification by the Contractor of the information regarding a potential compliance problem.

g. Dissemination of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste, or abuse by subcontractors of Contractor to both the Contractor and the MDHHS-OIG. Dissemination of this information must be made to all Contractor subcontractors and members annually. The Contractor must indicate that reporting of fraud, waste or abuse may be made anonymously.

2. Biannual meetings will be held between MDHHS-OIG and all Contractor Compliance Officers to train and discuss fraud, waste, and abuse.

3. Subcontracted Entities

a. The Contractor must include program integrity compliance provisions and guidelines in all contracts with subcontracted entities.
b. If program integrity compliance activities are delegated to subcontractors, the subcontract must contain the following:

i. Designation of a compliance officer
ii. Submission to the Contractor of quarterly reports detailing program integrity compliance activities

iii. Assistance and guidance by the Contractor with audits and investigations, upon request of the subcontracted entity

iv. Provisions for routine internal monitoring of program integrity compliance activities

v. Prompt Response to potential offenses and implementation of corrective action plans

vi. Prompt reporting of fraud, waste, and abuse to the Contractor vii. Implementation of training procedures regarding fraud, waste, and abuse for the subcontracted entities' employees at all levels.

c. Annually, the Contractor must submit a list of subcontracted entities using the template created by MDHHS-OIG.

i. The Contractor must maintain a list that contains all facility locations where services are provided, or business is conducted. This list must contain Billing Provider NPI numbers assigned to the entity, what services the entity is subcontracted to provide, and Provider email address(es).

4. Investigations

a. The Contractor must investigate program integrity compliance complaints to determine whether a potential credible allegation of fraud exists. If a potential credible allegation of fraud exists, the Contractor must refer the matter to MDHHS-OIG (see Reporting of Fraud, Waste, or Abuse) and pause any recoupment/recovery in connection with the potential credible allegation of fraud until receiving further instruction from MDHHS-OIG.

b. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the Contractor must cooperate fully in any investigation or prosecution by any duly authorized government agency, including but not limited to: MDHHS-OIG or the Department of Attorney General, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to schedule interviews with designated Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to the investigation or prosecution.

i. Contractor must maintain written policies and procedures pertaining to cooperation in investigations or prosecutions.

5. Reporting Fraud, Waste, or Abuse

a. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e., Contractor, employee, subcontracted entity, provider, or member), the Contractor must perform a preliminary investigation. Upon completion of the preliminary investigation, if the Contractor determines a potential credible allegation of fraud exists, and an overpayment of $5,000 or greater is identified (cases under this amount shall not be referred to OIG), the Contractor must promptly refer the matter to MDHHS-OIG. These referrals must be made using the Contractor fraud referral template and be shared with MDHHS-OIG via secure File Transfer Process (sFTP) using the Contractor's applicable MDHHS-OIG sFTP area. After reporting a potential credible allegation of fraud, the Contractor shall not take any of the following actions unless otherwise instructed by OIG:

i. Contact the subject of the referral about any matters related to the referral.

ii. Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; or

iii. Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.

iv. If the State makes a recovery from an investigation and/or corresponding legal action where the Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to Contractor.

b. The Contractor must report all suspicion of waste or abuse on the Quarterly Submission described in Section R.7. Quarterly Submissions below.

c. Questions regarding whether suspicions should be classified as fraud, waste or abuse should be presented to MDHHS-OIG for clarification prior to making the referral.

d. Documents containing protected health information or protected personal information must be submitted in a manner that is compliant with applicable Federal and State privacy rules and regulations, including but not limited to HIPAA.

6. Overpayments

The Contractor must report overpayments due to fraud, waste, or abuse to MDHHS-OIG.

a. If the Contractor identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the Contractor refers the findings to MDHHS-OIG and waits for further instruction from MDHHS-OIG prior to recovering the overpayment.

b. If the Contractor identifies an overpayment involving waste or abuse prior to identification by MDHHS- OIG, the Contractor must void or correct applicable encounters, should recover the overpayment, and must report the overpayment on its quarterly submission (see Section R.7. Quarterly Submissions below).

c. If a Network Provider identifies an overpayment, they must agree to:

i. Notify the Contractor, in writing, of the reason for the overpayment and the date the overpayment was identified.

ii. Return the overpayment to the Contractor within 60 calendar days of the date the overpayment was identified.

d. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

7. Quarterly Submissions

a. The Contractor must provide information on program integrity compliance activities performed quarterly using the template provided by the MDHHS-OIG. Program integrity compliance activities include, but are not limited to:

i. Tips/grievances received

ii. Data mining and analysis of paid claims, including audits performed based on the results

iii. Audits performed

iv. Overpayments collected

v. Identification and investigation of fraud, waste, and abuse (as these terms are defined in the "Definitions" section of this contract

vi. Corrective action plans implemented

vii. Provider dis-enrollments

viii. Contract terminations

b. All program integrity activities performed each quarter must be reported to OIG according to the following schedule:

i. Activities performed January through March must be reported by May 15; activities performed April through June must be reported by August 15; activities performed July through September

must be reported by November 15; and activities performed October through December must be reported by February 15

c. The Contractor must provide MDHHS-OIG with documentation to support that these program integrity compliance activities were performed by its subcontractors in its quarterly submission to the MDHHS-OIG.

d. The Contractor must include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by the Contractor during the course of its program integrity activities. It is understood that identified overpayment recoveries may span multiple reporting periods. This report also includes a list of the individual encounters corrected. To ensure accuracy of reported adjustments, Contractor must:

i. Purchase at minimum one (1) license for MDHHS-OIG's case management software. This license will be utilized to upload report submissions to the case management system and to check the completeness and accuracy of report submissions.

ii. For medical equipment, supplies, or prescription provided, adjust any encounter for an enrollee to zero dollars paid. If the encounter with a dollar amount cannot be adjusted to zero dollars paid, then the encounters with dollars paid must be voided and resubmitted with zero dollars paid.

iii. Specify if overpayment amounts were determined via sample and extrapolation or claimbased review. In instances where extrapolation occurs, Contractor may elect to correct claims, and thus encounters, as they see fit.

iv. Specify encounters unavailable for adjustment in CHAMPS due to the encounter aging out or any other issue.

a. These encounters must be identified by the Contractor and reported to MDHHS-OIG. MDHHS-OIG will record a gross adjustment to be taken out of the Contractor's next capitation payment.

v. Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.

8. MDHHS-OIG Sanctions

When MDHHS-OIG sanctions (suspends and/or terminates from the Medicaid Program) providers, including for a credible allegation of fraud under 42 CFR § 455.23, the Contractor must, at minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. The Contractor may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, the Contractor may elect to do the same.

9. MDHHS-OIG Onsite Reviews

a. MDHHS-OIG may conduct onsite reviews of Contractor and/or its subcontracted entities.

b. To the extent consistent with applicable law, including, but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the Contractor is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

10. Contractor Ownership and Control Interest

a. A Contractor may not knowingly have a relationship of the type described in paragraph (c) of this section with the following:

i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR §2.101, of a person described in paragraph (a)(i) of this section.

b. A Contractor may not knowingly have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

c. The relationships described in paragraph (a) of this section, are as follows:

i. A director, officer, or partner of the Contractor.

ii. A subcontractor of the Contractor, as governed by 42 CFR §438.230.

iii. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.

iv. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the State.

d. The Contractor must comply with the Federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104-106. In addition, the Contractor must ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided under the Medicaid agreement require compliance with 42 CFR §455.104-106. Pursuant to 42 CFR §455.104: the State will review ownership and control disclosures submitted by the Contractor and any of the Contractor's Subcontractors.

OLD:

Nearly a complete rewrite.

Item 5

NEW

5. Section 8. Payment Terms, B. State Funding, 9. Premium Pay Hourly Wage Increase for Direct Care Workers (DCW) is hereby deleted and replaced in its entirety with the following:

9. Premium Pay Hourly Wage Increase for Direct Care Workers (DCW)

a. A premium pay hourly wage increase for direct care workers is in effect from October 1, 2020, through September 30, 2023. Rate increases are in effect for contract time periods for hours billed as follows:

i. October 1, 2020 – February 28, 2021: A $2.00 per hour increase in direct care worker wages, plus an additional $0.24 per hour increase to cover additional provider agency costs associated with implementing the wage increase.

ii. March 1, 2021 - September 30, 2021: A $2.25 per hour increase in direct care worker wages, plus an additional $0.27 per hour increase to cover additional provider agency costs associated with implementing the wage increase.

iii. October 1, 2021 – September 30, 2022: A $2.35 per hour increase in direct care worker wages, plus an additional $0.29 per hour increase to cover additional provider agency costs associated with implementing the wage increase.

iv. October 1, 2022 – September 30, 2023: A $2.35 per hour increase in direct care worker wages, plus an additional $0.29 per hour increase to cover additional provider agency costs associated with implementing the wage increase.

b. The Contractor must implement the hourly wage increase, referred to as Premium Pay, provisions of MSA L letters specific to the premium pay increase. The L letters are located at: https://www.michigan.gov/mdhhs/doingbusiness/providers/providers/medicaid/communicationtraining/173142. MDHHS will provide increased capitation rates during the Premium Pay period to cover the actual cost of mandatory premium pay increases. The Contractor must disperse these funds to eligible contracted providers employing individuals that qualify for the increase.

c. Providers of the following services are eligible for the DCW wage increase:

- Community Living Supports (HCPCS Codes H2015, H2016)
- Overnight Health and Safety Supports (HCPCS Code T2027)
- Personal Care (HCPCS Code T1020)
- Prevocational Services (HCPCS Code T2015)
- Respite (HCPCS Codes S5151, T1005)
- Skill Building (HCPCS Code H2014)
- ABA Adaptive Behavior Treatment (HCPCS Code 97153)
- ABA Group Adaptive Behavior Treatment (HCPCS Code 97154)
- ABA Exposure Adaptive Treatment (HCPCS Code 0373T)

- Crisis Residential Services (HCPCS Code H0018)
- Residential Services –SUD (HCPCS Codes H0018, H0019)
- Residential Services – Co-occurring SUD/MH (HCPCS Codes H0018, H0019)
- Withdrawal Management – SUD (HCPCS Codes H0010, H0012, H0014)
- Supported Employment (HCPCS Code H2023)

d. The Contractor is to ensure to the greatest extent possible that the full amount for funds appropriated for a direct care worker wage increase, except for costs incurred by the employer, including payroll taxes, resulting from the increase to direct care worker wages, is provided to direct care workers through sustained increased wages.

e. DCW wage increase funding will be a component of monthly capitation payments made to the Contractor. The Contractor will pay the increase to eligible providers that employ eligible individuals on an as-invoiced basis, through increased contracted rates for eligible services, or other means approved by the MDHHS.

f. The Contractor is responsible for maintaining a record of DCW wage increase payments and is subject to the risk corridor cost settlement procedures outlined in Schedule A Subsection 7 Risk Corridor of this contract.

g. All wage increase payments are subject to audit and potential recoupment. Providers should retain documentation that demonstrates the distribution of payments to eligible staff.

h. The Contractor will ensure to the greatest extent possible that all employees, agents, and subcontractors of the Contractor, if any, comply with all of the foregoing as well as tracking and annual reporting per legislative and MDHHS requirements.

OLD

None

Item 6

NEW

Section 8. Payment Terms, D. Contractor Performance Bonus, 1. Withhold Arrangements, letter b. is hereby deleted and replaced in its entirety with the following:

b. Performance Bonus Incentive Pool (PBIP)

i. Withhold and Metrics The State will withhold 0.75% of BHMA, BHMA-MHP, BHHMP, BHHMP-MHP, HSW-MC, CWP-MC, and SEDW-MC payments for the purpose of establishing a PBIP. Distribution of funds from the PBIP is contingent on the Contractor's results from the joint metrics, the narrative report, and the Contractor-only metrics available on the MDHHS reporting requirements website located at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

ii. Assessment and Distribution PBIP funding awarded to the Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system. The 0.75% PBIP withhold will be distributed as follows:

a. Contractor-only Pay for Performance Measure(s): 45%

b. Contractor Narrative Reports: 25%

c. MHP/Contractor Joint Metrics: 30%

d. The State will distribute earned funds by April 30 of each year.

OLD

b. Performance Bonus Incentive Pool (PBIP)

i. Withhold and Metrics The State will withhold 0.75% of BHMA, BHMA-MHP, BHHMP, BHHMP-MHP, HSW-MC, CWP-MC, and SEDW-MC payments for the purpose of establishing a PBIP. Distribution of funds from the PBIP is contingent on the Contractor's results from the joint metrics, the narrative report, and the Contractor-only metrics referenced below.

ii. Assessment and Distribution

PBIP funding awarded to the Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system. The 0.75% PBIP withhold will be distributed as follows:

a. Contractor-only Pay for Performance Measure(s): 30%

b. Contractor Narrative Reports: 40%

c. MHP/Contractor Joint Metrics: 30%

d. The State will distribute earned funds by April 30 of each year.

Schedule E Financial Reporting Requirements Update

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CONTRACTOR AGREEMENT FOR CONSULTATION SERVICES

THIS AGREEMENT, made and entered into this 1st day of November by and between the Northern Michigan Regional (hereinafter referred to as the "Purchaser), whose administrative offices are located 1999 Walden Drive Gaylord, MI 497735 and Christine Gebhard, whose administrative offices are located at 618 Mitchell St, Petoskey MI 49770 (hereinafter referred to as the "Contractor").

WITNESSETH:

WHEREAS, AuSable Valley Community Mental Health, Manistee-Benzie Community Mental Health (a.k.a. Centra Wellness Network), North Country Community Mental Health, Northeast Michigan Community Mental Health, and Northern Lakes Community Mental Health have jointly created a regional entity known as the Northern Michigan Regional Entity (NMRE), as provided in Sec. 204b of the Michigan Mental Health Code, and

WHEREAS, the NMRE, upon successful submission of the Michigan Department of Health and Human Services (MDHHS) Application for Participation in 2013, has entered into a contract with the MDHHS as the specialty Medicaid Prepaid Inpatient Health Plan for the counties of Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon and Wexford, and

WHEREAS, the Payor, is in need of professional consulting and advocacy services representing the regional entity known as the NMRE.

WHEREAS, as applicable, the Contractor has been presented to the Payor as being licensed, qualified, and willing to provide such services as required by the Payor and under the terms and conditions set forth herein,

NOW, THEREFORE, in consideration of the above and in consideration of the mutual covenants hereinafter contained, IT IS HEREBY AGREED by the Purchaser and the Contractor as follows:

1. The purpose of this Agreement is to set forth the terms and conditions whereby the Purchaser will direct Contractor's consulting services with regards to general advocacy efforts, attendance at community collaborative's including but not limited to efforts related to the Northern Michigan Community Health Innovation Region (CHIR), Mental Health Parity and the development of regional community crisis services including efforts related to establishing Crisis Stabilization Units and/or advocacy for increased psychiatric bed capacity within the NMRE Region.

2. This Agreement shall commence on the 1st day of November 2022 and shall continue until the 30th day of September 2023.

3. Nothing in this Agreement shall be construed as requiring either the Purchaser or the Contractor to extend or renew this Agreement or to enter into any subsequent agreements.

4. Notwithstanding any other provisions in this Agreement to the contrary, either the Purchaser or the Contractor may terminate this Agreement for any reason by providing the other party

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with THIRTY (30) days prior written notification. Any material breach of this Agreement may result in either party's immediate termination of this Agreement, with said termination effective as of the date of delivery of written notification to the other party. Any termination of this Agreement shall not relieve either party of the obligations incurred prior to the effective date of such termination.

5. This Agreement is entered into pursuant to the authority granted to the Purchaser under the Mental Health Code and its PIHP Medicaid Subcontract with the state. This Agreement is in accordance with the rules, regulations, and standards (hereinafter referred to as the "MDHHS Rules") of the MDHHS adopted and promulgated in accordance with the Mental Health Code. This Agreement is in accordance with requirements of the Balanced Budget Act of 1997 (BBA), as amended, and said BBA final rules, regulations, and standards and applicable State and Federal laws shall govern the expenditure of funds and provisions of services hereunder and govern in any area not specifically covered by this Agreement.

6. This Agreement is contingent upon the Purchaser's receipt of sufficient Federal, State and local funds, upon the terms of such funding as appropriated, authorized and amended, upon continuation of such funding.

7. It is expressly understood and agreed by the Contractor that this agreement is subject to the terms and conditions of the Purchaser's MDHHS/CMHSP Master contact for Medicaid Funds. The provisions of this Agreement shall take precedence over said Master Contracts unless a conflict exists between the Agreement and the provisions of a said Master Contract. In the event that any provision of this Agreement is in conflict with the terms and conditions of a Master Contract, the provisions of the said Master Contract shall prevail. However, a conflict shall not be deemed to exist where this agreement:

a. contains additional provisions and additional terms and conditions not set forth in a said master Contract with the MDHHS:

b. restates provisions of a Master Contract with the MDHHS.

8. The Purchaser hereby agrees that its staff, at the direction of its Chief Executive Officer aka Executive Director (hereinafter referred to as the "Purchaser's CEO"), shall provide the Contractor with such information as the Contractor may need to perform the services required under this Agreement.

9. Under this Agreement, the Contractor shall provide certain contractual administrative support services defined in the attached document labeled "Attachment A" which is incorporated by reference into this Agreement and made a part hereof. All contractual services hereunder must be authorized by the Purchaser's CEO or said CEO's designated representative.

The Contractor shall provide qualified, trained, and competent staff (its employees and/or contractors) to perform the administrative support services required under this Agreement. The deadlines for final results of services and applicable schedules of services of the Purchaser, as authorized by the Purchaser are CEO or the CEO's designated representative. The Contractor shall exercise independent control over its services rendered hereunder, including the manner or methods of services, service duties or tasks, and the service procedures thereof. The

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Purchaser shall evaluate, on a current and/or retrospective basis, the appropriateness, quality, and timeliness of services performed by the Contractor and the Contractors compliance with service standards required hereunder.

10. For the period that this Agreement is in effect, the Contractor shall be paid contractually by the Purchaser for the Contractor's services rendered hereunder, as specified and delineated in the attached document labeled "Attachment B" which is incorporated by reference into this Agreement and made a part hereof.

The Contractor agrees to provide a billing statement (using a format acceptable to the Purchaser) for each month in which Purchaser authorized services are performed pursuant to this Agreement. Each billing statement shall be submitted by the Contractor to the Purchaser within thirty (30) days following the completion of each month that said services were performed by the Contractor under this Agreement. Payments from the Purchaser for service performed hereunder shall be made within thirty (30) days following the Contractor's submittal of complete and accurate billings and service documentation/verification. The Contractor shall maintain payroll records and other time keeping records sufficient to document the provision of service required hereunder. The Contractor's submittal of a billing statement hereunder for any service fees constitutes its verification that the services have been completed, as authorized.

11. This Agreement shall be construed according to the laws of the State of Michigan. The Contractor shall adhere to all applicable federal, state, and local laws, ordinances, rules and regulations while rendering contractual services pursuant to this Agreement.

12. Each of the parties hereto shall not violate any applicable federal, state, and local laws, ordinances, rules, and regulations prohibiting discrimination. Breach of this section shall be regarded as a material breach of this Agreement and may result in immediate termination of this Agreement by the nonbreaching party.

13. To the extent that the Health Insurance Portability and Accountability Act (HIPAA) is pertinent to the services that the Purchaser purchases and the Contractor provides under this Agreement, the Contractor ensures that it is in compliance with the HIPAA requirements. The parties hereto shall strictly comply with all Recipient Rights provisions of the Mental Health Code and the MDHHS Rules. Each of the parties hereto and its officers, employees, servants, and agents shall comply with all applicable Federal and State laws, rules and regulations, including the Mental Health Code and the MDHHS Rules, on confidentiality with regards to disclosure of any materials and/or information provided pursuant to this Agreement.

14. Upon termination of this Agreement, the Contractor shall return to the Purchaser all documents, tapes, correspondence, files, papers or other property of any kind of the Purchaser that the Contractor, its officer, employees, and agents may have in their possession or control.

15. It is expressly understood and agreed that the employees, servants and agents of either of the parties to this Agreement shall not be deemed to be and shall not hold themselves out as the employees, servants or agents of the other party. Each of the parties to this Agreement shall be responsible for withholding and payment of all income and social security taxes to the proper Federal, State, and local governments for the employees. The employees of each of the parties

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hereto shall not be entitled to any fringe benefits otherwise provided by the other party to its employees, such as, but not limited to, health and accident insurance, life insurance, paid vacation leave, paid sick leave, and longevity. Each of the parties hereto shall carry workers compensation and unemployment compensation coverage for its employees, as required by law.

16. Each party to this Agreement must seek its own legal representative and bear its own costs, including judgments, in any litigation which may arise from the performance of this Agreement. It is specifically understood and agreed that neither party will indemnify the other party in such litigation. Nothing herein shall be construed as a waiver of any public or governmental immunity granted to the Purchaser or the Contractor as provided by the applicable statutes and/or court decisions.

17. It is specifically understood and agreed that neither party shall provide insurance coverage for the other party pursuant to this Agreement.

18. No failure or delay on the part of any of the parties to this Agreement in exercising any right, power or privilege hereunder shall operate as a waiver thereof, nor shall a single or partial exercise of any right, power or privilege preclude any other or further exercise of any other right, power or privilege.

19. The Contractor shall not assign, subcontract or otherwise transfer its duties and/or obligations under this Agreement without the prior written approval of the Purchaser.

20. Modifications, amendments, or waivers of any provision of this Agreement may be made only with the written mutual consent of the Purchaser and the Contractor.

21. This Agreement and the additional and supplementary documents incorporated herein by specific reference contain all the terms and conditions agreed upon by the parties hereto. No other agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either of the parties hereto.

22. If any provision of this Agreement is found to be in conflict with Federal or State law, that provision will be subordinate to the law. The other provisions of this Agreement shall not be affected thereby, except where the invalidity of the provision would result in the illegality and/or unenforceability of this Agreement.

23. The persons signing this Agreement on behalf of the parties hereto certify by said signature that they are duly authorized to sign this Agreement on behalf of said parties and that this Agreement has been authorized by said parties.

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IN WITNESS WHEREOF, the parties hereto have fully executed this Agreement on the day and the year first above written.

PAYOR: Northern Michigan Regional Entity

DocuSigned by:
BY: Eric Kurtz, NMRE Chief Executive Officer 11/18/2022
0243CD9A77214B3...

Eric Kurtz, CEO Date

CONTRACTOR: Christine Gebhard

DocuSigned by:
BY: Christine Gebhard 11/13/2022
447D1E12A25C49E...

Christine Gebhard Date

DocuSign Envelope ID: 9F1E3B63-313C-4E7A-80FD-BB6E30F59F53

ATTACHMENT A

It is expressly understood and agreed by the parties hereto that the Contractor's consultation services, as the specific administrative support service required by the Purchaser hereunder, to be provided for subsequent reimbursement from the Purchaser per valid invoice under this Agreement shall include the following:

The Purchaser will direct Contractor's consulting services with regards to general advocacy efforts, attendance at community collaborative's including but not limited to efforts related to the Northern Michigan Community Health Innovation Region (CHIR), Mental Health Parity and the development of regional community crisis services including efforts related to establishing Crisis Stabilization Units and/or advocacy for increased psychiatric bed capacity within the NMRE Region.

It is expressly understood that the Contractor cannot litigate, sue, or appear in any court on the Payor's behalf.

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ATTACHMENT B

The purchaser shall make contractual payments at the rate of ONE HUNDRED AND TWENTY FIVE DOLLARS ($125.00) per hour (unit) plus mileage at the federally established mileage rate and other expenses as approved by the Purchaser CEO. to the Contractor in accordance with the requirements of the Mental Health Code, the MDHHS Rules, the MDHHS/CMHSP Master Contract for General Funds, the MDHHS/PIHP Master Contract for Medicaid Funds, and applicable State and Federal laws, including Medicaid regulations.

The total amount of contractual payments from the Purchaser to the Contractor for all Purchaser-authorized services rendered by the Contractor during the term of this Agreement shall not exceed THIRTY THOUSAND DOLLARS AND NO CENTS ($30,000).

The Detroit News

OPINION *This piece expresses the views of its author(s), separate from those of this publication.*

Murphy: Don't outsource state's mental health care | Opinion

As a sheriff, I know there is absolutely no question that our communities are safer when each of us is healthy, supported and cared for.

Michael J. Murphy

Published 11:01 p.m. ET Oct. 29, 2022

Those in law enforcement who understand the relationship between health and safety can clearly recognize that the potential for over 320,000 Michigan residents to lose access to their mental health care is dangerous.

Nevertheless, the Legislature is considering bills that would privatize our state's strong public mental health system. In doing so, policymakers are tempting a scenario in which thousands of Michigan residents could lose access to the high-quality, cost-effective and affordable mental health care they need.

As a sheriff, I know there is absolutely no question that our communities are safer when each of us is healthy, supported and cared for. Amid a national mental health crisis exacerbated by the pandemic, these bills, SB 597 and SB 598, reflect a perilous misunderstanding of how to best support those living with mental illness.

While the benefits these bills will bring to Michigan taxpayers are uncertain at best, the threat they pose to our communities is crystal clear.

These bills could jeopardize access to vital care for those who need it for the sake of private shareholders who may never step foot in the state of Michigan. They would hand over the existing system to inexperienced, high-cost, for-profit, private companies.

These bills are wholeheartedly opposed by the Michigan Sheriffs' Association, among others who recognize that "the private sector can be a partner in this endeavor," but it "cannot be the owner" without destroying the community partnerships created by the public sector.

Currently, the network of Clubhouses across Michigan, each of which employs the clubhouse model of care pioneered by Fountain House, serves thousands of people living with serious mental illness in 30 different counties. These bills would devastate clubhouses' ability to serve each of those people, endangering the care, stability and necessary sense of community for those who need it most.

But the harm caused by these bills may go far beyond mental health services, impacting Medicaid services across the board. They would effectively eliminate local accountability and oversight of health services that over 2 million Michigan residents rely on. The ripple effect from these bills could touch every facet of our community and should raise alarm among us all, regardless of whether we currently live with mental illness or personally rely on Medicaid services.

Shifting to higher-cost, less efficient, for-profit administration of this system could cause Michigan to lose its single point of access for people in need, and for law enforcement responding to mental health crisis situations. Further, these bills could cause Michigan residents to lose the safety net for people who have inadequate private insurance coverage.

Each person in our state who lives with mental illness deserves to continue receiving the exceptional care they've come to rely upon. But, under these bills, accessing and affording that care could become more difficult, if not impossible, for those most in need.

Michael J. Murphy is Livingston County's sheriff.

From: Info CMHAM
To: Carol Balousek (NMRE)
Subject: [EXTERNAL]ACTION ALERT - Tell Legislators NO Lame Duck Deals on SBs 597 & 598
Date: Monday, October 24, 2022 12:04:33 PM

Community Mental Health Assocation of Michigan

Call to Action

Rumors have been swirling around Lansing for the past several weeks that Sen. Shirkey & Rep. Whiteford have been drafting a compromise bill that would combine SBs 597 & 598 along with HBs 4925 – 4928 in an attempt to get "something" done before the end of the year. Most of the talk around a compromise bill has been to move all of the Medicaid kids services including autism and foster care over to private insurance companies and then the state would create 1 statewide entity to manage the other populations (essentially going from 10 PIHPs to 1 PHIP or ASO). CMHA and our allies have not been part of the discussions with Sen. Shirkey and Rep. Whiteford, those discussions have been behind closed doors so can only speculate on the content of such a proposal, but we do know that both sides have had multiple conversations and meetings.

With the November 8 General Election and the lame duck legislative session fast approaching we want to make sure that policy makers still know we are out here, and we are watching. After the election on November 8, there are only 11 more scheduled session days left in the calendar year. We certainly do not want termed out legislators passing a half-baked idea as they are walking out the door just for the sake of doing "something".

We believe any compromise bill between Sen. Shirkey and Rep. Whiteford will be equally as bad as the current version of SBs 597 & 598, which would still privatize Medicaid mental health services by giving them financial control and oversight or decision making to for-profit insurance companies.

REQUEST FOR ACTION: **We are asking you to reach out to your legislators (House & Senate) and the Governor and URGE them to not support a LAME DUCK deal on SBs 597 & 598. Stakeholders have not been part of the recent or meaningful discussions and the Legislature should not be making changes of this magnitude with so few legislative days left. This approach is nothing more than a health plan money grab, these bills will not improve care for Michigan's most vulnerable citizens, and it will give control to entities who have not proven they can do the job – this is BAD public policy.**

Please feel free to customize your response as you see fit

We also need you **to ask that the members of your Board of Directors, your staff, and your community partners make those same contacts – SIMPLY FORWARD THIS EMAIL TO THEM**. This will not be the last action alert we send out before the end of the year. It is critical that lawmakers hear from us before the critical November 8 election and know this is an issue that is important to the voters in their districts.

Thank you in advance for your support and tireless advocacy on this important topic.

Click the link below to log in and send your message:
https://www.votervoice.net/BroadcastLinks/Y-AMUB5_SHBQTsngrEI1ew

Click here to unsubscribe from this mailing list.

email correspondence

From: Eric Kurtz (NMRE)
Sent: Wednesday, November 30, 2022 2:46 PM
To: Carol Balousek (NMRE)
Subject: FW: [EXTERNAL]Another SB 597 & 598 Update
Attachments: SB 597 (S-6).pdf; SB 598 (S-8).pdf

From: Alan Bolter <ABolter@cmham.org>
Sent: Wednesday, November 30, 2022 12:17 PM
To: Alan Bolter <ABolter@cmham.org>
Cc: Robert Sheehan <rsheehan@cmham.org>
Subject: [EXTERNAL]Another SB 597 & 598 Update

Two updates

1. Attached are the revised bills that were voted down by the Senate last night.

2. As we know, there is a strong desire by the administration to better serve the mental health needs of children in the foster care and child care institution (CCI) system – please see the below press release from MDHHS and the language which was included in today's MIRS report:

   The substitute limited the Medicaid population impacted by the integration of physical and mental health services under an HMO umbrella to only foster children. The Department of Health and Human Services officials were OK with the bill because they saw it as a noteworthy reform they could take before the federal judge who is overseeing Michigan's foster care system.

DHHS leadership has agreed to get together with CMHA and our members to outline a plan for fostering access to the state's public mental health system for foster care and CCI kids in very near future.

From: Michigan Department of Health and Human Services <MDHHS@govsubscriptions.michigan.gov>
Sent: Wednesday, November 30, 2022 7:57 AM
To: Christin Nohner <christin@mccallhamilton.com>
Subject: FOR IMMEDIATE RELEASE: MDHHS enhances work with providers to meet behavioral health needs of children in foster care, juvenile justice systems; New contracts focusing on youth dealing with mental health crises will provide more innovative care

FOR IMMEDIATE RELEASE: Nov. 30, 2022

MEDIA CONTACT: Bob Wheaton, 517-241-2112, WheatonB@michigan.gov

MDHHS enhances work with providers to meet behavioral health needs of children in foster care, juvenile justice systems

New contracts focusing on youth dealing with mental health crises will provide more innovative care

LANSING, Mich. – Children in the state foster care and juvenile justice systems experiencing a behavioral health crisis will have expanded access to services under a new effort by the Michigan Department of Health and Human Services (MDHHS).

MDHHS is asking congregate care providers to submit plans for placement in their facilities to address the needs of youth who must access mental health stabilization programs – meaning services to stabilize and treat youth dealing with serious mental health concerns, like suicidal thoughts.

“This is an important step forward to ensure that children in the foster care and juvenile justice systems who need mental health stabilization have a place to go to be treated,” said Demetrius Starling, executive director of the department’s Children’s Services Agency. “To do that, we are asking our child-caring institutions to provide the behavioral health treatment youth need before they transition to homes with their parents, relatives or foster families.”

The department has issued a statewide request for proposals for new child-caring institution contracts and will begin implementing the new contracts in summer 2023.

MDHHS has contracts with 31 child-caring institutions to provide 800 beds, however, due to nationwide staffing shortages and other factors, these facilities provide fewer than 500 beds. The changes are expected to improve access to behavioral health services that youth in care need.

“Members of the Michigan Federation for Children and Families believe a strong partnership with the Michigan Department of Health and Human Services is critical in expanding and providing equitable access to the full array of behavioral health services that best serve young people and their families,” said Janet Reynolds Snyder, executive director of the statewide association of private nonprofit community-based child and family-serving organizations that partner with MDHHS.

The idea of the new contract model is to encourage greater innovation in caring for the unique needs of children in the state's foster care and juvenile justice systems.

This effort is part of a multi-faceted approach by MDHHS to address a national need for expanded behavioral health services for youth. The demand is coupled with a nationwide staffing shortage that makes it difficult to provide needed services, which MDHHS is also addressing.

MDHHS contracts with child-caring institutions to provide specialized treatment to youth in foster care or the juvenile justice system. In recent years it has been challenging in Michigan and nationally to find foster care and juvenile justice placements – especially residential therapeutic treatment beds.

"As a family court judge, I am encouraged that the department has recognized the greatest unmet health need of children and teens in the foster care system is their mental and behavioral health and is addressing the issue," said Marquette County Probate Court Judge Cheryl L. Hill. "The new contracting model should allow for targeted results to meet the individual mental health needs of the youth and hopefully allow courts to reunify families sooner. While there are other issues to tackle in the overall child welfare system, this is a good step in the right direction to solving the crisis in care issues we face."

MDHHS has already taken action to address the challenge, including bipartisan support of legislation signed by Gov. Gretchen Whitmer to:

- Increase rates paid to the facilities.
- Increase funding for specialized programs.
- Put in place temporary wage increases for staff working in the facilities during the COVID-19 pandemic.
- Issue lump sum payment awards to help offset pandemic-related expenses and lost revenue.

MDHHS also has:

- Restructured the department to ensure behavioral health services are supported across community-based, residential and school locations, as well as other settings. The changes will benefit people of all ages, with addressing the needs of children and their families a top priority. This includes creation of the Bureau of Children's Coordinated Health Policy and Supports.
- Created a Health Care and Human Services Workforce Steering Committee that is involved in multiple efforts to recruit more behavioral health workers to address shortages.
- Created the Division of Child Safety and Program Compliance to assist and provide additional oversight of contracted agencies providing congregate care or place children in foster care homes or facilities.

To earn state contracts, facilities must demonstrate through the request for proposal process that they can meet the specialized needs of children.

Other goals of the new process are to clearly define expectations and increase contract oversight effectiveness

To ensure contracted facilities are included in this reform, the department solicited input through provider surveys, in addition to hosting focus groups to hear from providers on the proposed reforms. The department used this feedback to help refine goals for reform

Agencies that would like to submit a proposal should go to the “Child Caring Institution – Therapeutic Short-Term Treatment Program” Bid Number 230000000402 at www.michigan.gov/SIGMAVSS after registering on that website. For assistance with registration or navigating the site, contact the Office of Financial Management at 517-284-0540 or 888-734-9749 and press “1” on the automated menu, or email SIGMA-Vendor@michigan.gov. Vendors who intend to submit a proposal and have questions should contact the solicitation manager, Mary Ostrowski, at 517-249-0438 or ostrowskim@michigan.gov.

# # #

- Child-Caring Institutions Press Release.pdf

Become a foster parent through Michigan Department of Health & Human Services foster care program.

Questions? Contact Us

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STAY CONNECTED:

This email was sent to christin@mccallhamilton.com using GovDelivery Communications Cloud on behalf of: Michigan Dept of Health & Human Services · 235 S. Grand Ave W. · Lansing, MI 48909 ·

SUBSTITUTE FOR

SENATE BILL NO. 597

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

by amending section 109f (MCL 400.109f), as amended by 2017 PA 224.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 109f. (1) The department shall support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance use disorder. Medicaid-covered specialty services and supports, **except for those services and supports for children in foster care**, ~~—~~shall be managed and delivered by specialty prepaid health plans chosen by the department. The specialty services and supports shall be carved out from the basic Medicaid health care benefits package.

(2) Specialty prepaid health plans are Medicaid managed care organizations as described in section 1903(m)(1)(A) of title XIX, 42 USC 1396b, and are responsible for providing defined inpatient services, outpatient hospital services, physician services, other specified Medicaid state plan services, and additional services approved by the Centers for Medicare and Medicaid Services under section 1915(b)(3) of title XIX, 42 USC 1396n.

(3) This section does not apply to a pilot project authorized under section 298(3) of article X of 2017 PA 107.

SUBSTITUTE FOR

SENATE BILL NO. 598

A bill to amend 1974 PA 258, entitled

"Mental health code,"

by amending sections 116, 204b, 752, and 754 (MCL 330.1116, 330.1204b, 330.1752, and 330.1754), section 116 as amended by 1998 PA 67, section 204b as added by 2002 PA 594, section 752 as amended by 1995 PA 290, and section 754 as amended by 2006 PA 604.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 116. (1) Consistent with section 51 of article IV of the state constitution of 1963, which declares that the health of the people of the state is a matter of primary public concern, and as required by section 8 of article VIII of the state constitution of 1963, which declares that services for the care, treatment, education, or rehabilitation of those who are seriously mentally

disabled shall always be fostered and supported, the department shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state. To this end, the department ~~shall have~~ **has** the general powers and duties described in this section.

(2) The department shall do all of the following:

(a) Direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance. The department shall give priority to the following services:

(*i*) Services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability.

(*ii*) Services for individuals with serious mental illness, serious emotional disturbance, or developmental disability who are in urgent or emergency situations.

(b) Administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state. In the administration of chapter 2, ~~it shall be~~ the **department's** objective ~~of the department~~ **is** to shift primary responsibility for the direct delivery of public mental health services, **except public mental health services for children in foster care**, from the state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.

(c) Engage in planning for the purpose of identifying, assessing, and enunciating the mental health needs of the state.

(d) Submit to the members of the house and senate standing committees and appropriation subcommittees with legislative oversight of mental health matters an annual report summarizing its assessment of the mental health needs of the state and incorporating information received from community mental health services programs under section 226. The report ~~shall~~ **must** include an estimate of the cost of meeting all identified needs. Additional information shall be made available to the legislature upon request.

(e) Endeavor to develop and establish arrangements and procedures for the effective coordination and integration of all public mental health services, and for effective cooperation between public and nonpublic services, for the purpose of providing a unified system of statewide mental health care.

(f) Review and evaluate the relevance, quality, effectiveness, and efficiency of mental health services being provided by the department and ~~assure~~ **ensure** the review and evaluation of mental health services provided by community mental health services programs. The department shall establish and implement a structured system to provide data necessary for the reviews and evaluations.

(g) Implement those provisions of law under which it is responsible for the licensing or certification of mental health facilities or services.

(h) Establish standards of training and experience for executive directors of community mental health services programs.

(i) Support research activities.

(j) Support evaluation and quality improvement activities.

(k) Support training, consultation, and technical assistance regarding mental health programs and services and appropriate

prevention and mental health promotion activities, including those that are culturally sensitive, to employees of the department, community mental health services programs, and other nonprofit agencies providing mental health services under contract with community mental health services programs.

(*l*) Support multicultural services.

(3) The department may do all of the following:

(a) Direct services to individuals who have mental disorders that meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental health disorders published by the American ~~psychiatric association~~ **Psychiatric Association** and approved by the department and to the prevention of mental disability and the promotion of mental health. Resources that have been specifically appropriated for services to individuals with dementia, alcoholism, or substance ~~abuse,~~ **use disorder**, or for the prevention of mental disability and the promotion of mental health shall be utilized for those specific purposes.

(b) Provide, on a residential or nonresidential basis, any type of patient or client service, including, but not limited to, prevention, diagnosis, treatment, care, education, training, and rehabilitation.

(c) Operate mental health programs or facilities directly or through contractual arrangement.

(d) Institute pilot projects considered appropriate by the director to test new models and concepts in service delivery or mental health administration. Pilot projects may include, but need not be limited to, both of the following:

(*i*) Issuance of a voucher to a recipient of public mental

health services in accordance with the recipient's individual plan of services and guidelines developed by the department.

(*ii*) Establishment of revolving loans to assist recipients of public mental health services to acquire or maintain affordable housing. Funding under this subparagraph shall only be provided through an agreement with a nonprofit fiduciary in accordance with guidelines and procedures developed by the department related to the use, issuance, and accountability of revolving loans used for recipient housing.

(e) Enter into an agreement, contract, or arrangement with any individual or public or nonpublic entity that is necessary or appropriate to fulfill those duties or exercise those powers that have by statute been given to the department.

(f) Accept gifts, grants, bequests, and other donations for use in performing its functions. Any money or property accepted ~~shall~~ **must** be used as directed by its donor and in accordance with law and the rules and procedures of the department.

(g) ~~The department has~~ **Use** any other power necessary or appropriate to fulfill those duties and exercise those powers that have been given to the department by law and that are not otherwise prohibited by law.

Sec. 204b. (1) A combination of community mental health organizations or authorities may establish a regional entity by adopting bylaws that satisfy the requirements of this section. A community mental health agency may combine with a community mental health organization or authority to establish a regional entity if the board of commissioners of the county or counties represented by the community mental health agency adopts bylaws that satisfy the requirements of this section. All of the following ~~shall~~ **must** be

stated in the bylaws establishing the regional entity:

(a) The purpose and power to be exercised by the regional entity to carry out the provisions of this act, including the manner by which the purpose shall be accomplished or the power shall be exercised.

(b) The manner in which a community mental health services program will participate in governing the regional entity, including, but not limited to, all of the following:

(*i*) Whether a community mental health services program that subsequently participates in the regional entity may participate in governing activities.

(*ii*) The circumstances under which a participating community mental health services program may withdraw from the regional entity and the notice required for that withdrawal.

(*iii*) The process for designating the regional entity's officers and the method of selecting the officers. This process ~~shall include~~ **includes** appointing a fiscal officer who shall receive, deposit, invest, and disburse the regional entity's funds in the manner authorized by the bylaws or the regional entity's governing body. A fiscal officer may hold another office or other employment with the regional entity or a participating community mental health services program.

(c) The manner in which the regional entity's assets and liabilities shall be allocated to each participating community mental health services program, including, at a minimum, all of the following:

(*i*) The manner for equitably providing for, obtaining, and allocating revenues derived from a federal or state grant or loan, a gift, bequest, grant, or loan from a private source, or an

insurance payment or service fee.

(*ii*) The method or formula for equitably allocating and financing the regional entity's capital and operating costs, payments to reserve funds authorized by law, and payments of principal and interest on obligations.

(*iii*) The method for allocating any of the regional entity's other assets.

(*iv*) The manner in which, after the completion of its purpose as specified in the regional entity's bylaws, any surplus funds shall be returned to the participating community mental health services programs.

(d) The manner in which a participating community mental health services program's special fund account created under section 226a shall be allocated.

(e) A process providing for strict accountability of all funds and the manner in which reports, including an annual independent audit of all the regional entity's receipts and disbursements, shall be prepared and presented.

(f) The manner in which the regional entity shall enter into contracts including a contract involving the acquisition, ownership, custody, operation, maintenance, lease, or sale of real or personal property and the disposition, division, or distribution of property acquired through the execution of the contract.

(g) The manner for adjudicating a dispute or disagreement among participating community mental health services programs.

(h) The effect of a participating community mental health ~~service~~ **services** program's failure to pay its designated share of the regional entity's costs and expenses, and the rights of the other participating community mental health services programs as a

result of that failure.

(i) The process and vote required to amend the bylaws.

(j) Any other necessary and proper matter agreed to by the participating community mental health services programs.

(2) Except as otherwise stated in the bylaws, a regional entity has all of the following powers:

(a) The power, privilege, or authority that the participating community mental health services programs share in common and may exercise separately under this act, whether or not that power, privilege, or authority is specified in the bylaws establishing the regional entity.

(b) The power to contract with the state to serve as the ~~medicaid~~ **Medicaid** specialty service prepaid health plan for the designated service areas of the participating community mental health services programs.

(c) The power to accept funds, grants, gifts, or services from the federal government or a federal agency, the state or a state department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the regional entity, and from a private or civic source.

(d) The power to enter into a contract with a participating community mental health ~~service~~ **services** program for any service to be performed for, by, or from the participating community mental health services program.

(e) The power to create a risk pool and take other action as necessary to reduce the risk that a participating community mental health services program otherwise bears individually.

(3) A regional entity established under this section is a

public governmental entity separate from the county, authority, or organization that establishes it.

(4) Beginning not later than 6 months after the effective date of the amendatory act that added this subsection, a regional entity board must be composed of the following:

(a) Members who are 18 years of age or older.

(b) No more than 1/3 members who are community health services program providers or county commissioners who represent the community mental health services program provider's county.

(c) At least 1/3 members who are behavioral health providers or agencies that are nongovernmental entities and who are not community mental health services program providers.

(d) At least 1/3 members who are members of the general public of which at least 2 members are primary consumers or recipients of behavioral health services or their family members.

(5) ~~(4)~~ All the privileges and immunity from liability and exemptions from laws, ordinances, and rules provided under section 205(3)(b) to county community mental health ~~service~~ **services** programs and their board members, officers, and administrators, and county elected officials and employees of county government are retained by a regional entity created under this section and the regional entity's board members, officers, agents, and employees.

(6) ~~(5)~~ A regional entity ~~shall~~ **must** provide an annual report of its activities to each participating community mental health services program.

(7) ~~(6)~~ The regional entity's bylaws ~~shall~~ **must** be filed with the clerk of each county in which a participating community mental health services program is located and with the secretary of state, before the bylaws take effect.

(8) ~~(7)~~ If a regional entity assumes the duties of a participating community mental health services program or contracts with a private individual or entity to assume the duties of a participating community mental health services program, the regional entity ~~shall~~ **must** comply with all of the following:

(a) The manner of employing, compensating, transferring, or discharging necessary personnel is subject to the provisions of the applicable civil service and merit systems and the following restrictions:

(*i*) An employee of a regional entity is a public employee.

(*ii*) A regional entity and its employees are subject to 1947 PA 336, MCL 423.201 to 423.217.

(b) At the time a regional entity is established under this section, the employees of the participating community mental health services program who are transferred to the regional entity and appointed as employees ~~shall~~ retain all the rights and benefits for 1 year. If at the time a regional entity is established under this section a participating community mental health services program ceases to operate, the employees of the participating community mental health services program shall be transferred to the regional entity and appointed as employees who ~~shall~~ retain all the rights and benefits for 1 year. An employee of the regional entity shall not, by reason of the transfer, be placed in a worse position for a period of 1 year with respect to worker's compensation, pension, seniority, wages, sick leave, vacation, health and welfare insurance, or another benefit that the employee had as an employee of the participating community mental health services program. A transferred employee's accrued benefits or credits ~~shall~~ **are** not ~~be~~ diminished by reason of the transfer.

(c) If a participating community mental health services program was the designated employer or participated in the development of a collective bargaining agreement, the regional entity assumes and is bound by the existing collective bargaining agreement. Establishing a regional entity does not adversely affect existing rights or obligations contained in the existing collective bargaining agreement. For the purposes of this subsection, "participation in the development of a collective bargaining agreement" means that a representative of the participating community mental health services program actively participated in bargaining sessions with the employer representative and union or was consulted during the bargaining process.

Sec. 752. (1) The department, each community mental health services program, each licensed hospital, and each service provider under contract with the department, a community mental health services program, or a licensed hospital ~~shall~~ **must** establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights. The policies and procedures ~~shall~~ **must** provide a mechanism for prompt reporting, review, investigation, and resolution of apparent or suspected violations of the rights guaranteed by this chapter, ~~shall~~ **must** be consistent with this chapter and chapter 7a, and ~~shall~~ **must** be designed to protect recipients from, and prevent repetition of, violations of rights guaranteed by this chapter and chapter 7a. The policies and procedures ~~shall~~ **must** include, at a minimum, all of the following:

(a) Complaint and appeal processes.

(b) Consent to treatment and services.

(c) Sterilization, contraception, and abortion.

(d) Fingerprinting, photographing, audiotaping, and use of 1-way glass.

(e) Abuse and neglect, including detailed categories of type and severity.

(f) Confidentiality and disclosure.

(g) Treatment by spiritual means.

(h) Qualifications and training for recipient rights staff.

(i) Change in type of treatment.

(j) Medication procedures.

(k) Use of psychotropic drugs.

(*l*) Use of restraint.

(m) Right to be treated with dignity and respect.

(n) Least restrictive setting.

(o) Services suited to condition.

(p) Policies and procedures that address all of the following matters with respect to residents:

(*i*) Right to entertainment material, information, and news.

(*ii*) Comprehensive examinations.

(*iii*) Property and funds.

(*iv*) Freedom of movement.

(*v*) Resident labor.

(*vi*) Communication and visits.

(*vii*) Use of seclusion.

(2) All policies and procedures required by this section shall be established ~~within 12 months after the effective date of the amendatory act that added section 753.~~**by March 28, 1997.**

(3) The department must enforce the provisions of the policies and procedures listed in subsection (1)(a) to (p) and ensure that appropriate remedial action is taken to resolve any violations of

the policies and procedures listed in subsection (1)(a) to (p).

Sec. 754. (1) The department shall establish a state office of recipient rights subordinate only to the director.

(2) The department shall ensure all of the following:

(a) The process for funding the state office of recipient rights includes a review of the funding by the state recipient rights advisory committee.

(b) The state office of recipient rights will be protected from pressures that could interfere with the impartial, even-handed, and thorough performance of its duties.

(c) The state office of recipient rights will have unimpeded access to all of the following:

(*i*) All programs and services operated by or under contract with the department except where other recipient rights systems authorized by this act exist.

(*ii*) All staff employed by or under contract with the department.

(*iii*) All evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.

(d) Staff of the state office of recipient rights receive training each year in recipient rights protection.

(e) Each contract between the department and a provider requires both of the following:

(*i*) That the provider and his or her employees receive annual training in recipient rights protection.

(*ii*) That recipients will be protected from rights violations while they are receiving services under the contract.

(f) Technical assistance and training in recipient rights protection are available to all community mental health services

programs and other mental health service providers subject to this act.

(3) The department ~~shall endeavor to~~ **must** ensure all of the following:

(a) The state office of recipient rights has sufficient staff and other resources necessary to perform the duties described in this section.

(b) Complainants, staff of the state office of recipient rights, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities.

(c) Appropriate remedial action is ~~taken to resolve violations of~~ **enforced with an entity that violates recipient** rights and ~~notify~~ the complainants **are notified** of substantiated violations, **with the remediations that were taken**, in a manner that does not violate employee rights.

(4) After consulting with the state recipient rights advisory committee, the department director shall select a director of the state office of recipient rights who has the education, training, and experience to fulfill the responsibilities of the office. The department director shall not replace or dismiss the director of the state office of recipient rights without first consulting the state recipient rights advisory committee. The director of the state office of recipient rights ~~shall have~~ **has** no direct service responsibility. The director of the state office of recipient rights ~~shall report~~ **reports** directly and solely to the department director. The department director shall not delegate his or her responsibility under this subsection.

(5) The state office of recipient rights may do all of the

following:

(a) Investigate apparent or suspected violations of the rights guaranteed by this chapter.

(b) Resolve disputes relating to violations.

(c) Act on behalf of recipients to obtain appropriate remedies for any apparent violations.

(d) Apply for and receive grants, gifts, and bequests to effectuate any purpose of this chapter.

(6) The state office of recipient rights shall do all of the following:

(a) Ensure that recipients, parents of minor recipients, and guardians or other legal representatives have access to summaries of the rights guaranteed by this chapter and chapter 7a and are notified of those rights in an understandable manner, both at the time services are requested and periodically during the time services are provided to the recipient.

(b) Ensure that the telephone number and address of the office of recipient rights and the names of rights officers are conspicuously posted in all service sites.

(c) Maintain a record system for all reports of apparent or suspected rights violations received, including a mechanism for logging in all complaints and a mechanism for secure storage of all investigative documents and evidence.

(d) Initiate actions that are appropriate and necessary to safeguard and protect rights guaranteed by this chapter to recipients of services provided directly by the department or by its contract providers other than community mental health services programs.

(e) Receive reports of apparent or suspected violations of

rights guaranteed by this chapter. The state office of recipient rights shall refer reports of apparent or suspected rights violations to the recipient rights office of the appropriate provider to be addressed by the provider's internal rights protection mechanisms. The state office shall intervene as necessary to act on behalf of recipients in situations in which the director of the department considers the rights protection system of the provider to be out of compliance with this act and rules promulgated under this act.

(f) Upon request, advise recipients of the process by which a rights complaint or appeal may be made and assist recipients in preparing written rights complaints and appeals.

(g) Advise recipients that there are advocacy organizations available to assist recipients in preparing written rights complaints and appeals and offer to refer recipients to those organizations.

(h) Upon receipt of a complaint, advise the complainant of the complaint process, appeal process, and mediation option.

(i) Ensure that each service site operated by the department or by a provider under contract with the department, other than a community mental health services program, is visited by recipient rights staff with the frequency necessary for protection of rights but in no case less than annually.

(j) Ensure that all individuals employed by the department receive department-approved training related to recipient rights protection before or within 30 days after being employed.

(k) Ensure that all reports of apparent or suspected violations of rights within state facilities or programs operated by providers under contract with the department other than

community mental health services programs are investigated in accordance with section 778 and that those reports that do not warrant investigation are recorded in accordance with subdivision (c).

(*l*) Review semiannual statistical rights data submitted by community mental health services programs and licensed hospitals to determine trends and patterns in the protection of recipient rights in the public mental health system and provide a summary of the data to community mental health services programs and to the director of the department.

(m) Serve as consultant to the director in matters related to recipient rights.

(n) At least quarterly, provide summary complaint data consistent with the annual report required in subdivision (o), together with a summary of remedial action taken on substantiated complaints, to the department and the state recipient rights advisory committee.

(o) Submit to the department director and to the committees and subcommittees of the legislature with legislative oversight of mental health matters, for availability to the public, an annual report on the current status of recipient rights for the state. The report shall be submitted not later than March 31 of each year for the preceding fiscal year. The annual report shall include, at a minimum, all of the following:

(*i*) Summary data by type or category regarding the rights of recipients receiving services from the department including the number of complaints received by each state facility and other state-operated placement agency, the number of reports filed, and the number of reports investigated.

(*ii*) The number of substantiated rights violations by category and by state facility.

(*iii*) The remedial actions taken on substantiated rights violations by category and by state facility.

(*iv*) Training received by staff of the state office of recipient rights.

(*v*) Training provided by the state office of recipient rights to staff of contract providers.

(*vi*) Outcomes of assessments of the recipient rights system of each community mental health services program.

(*vii*) Identification of patterns and trends in rights protection in the public mental health system in this state.

(*viii*) Review of budgetary issues including staffing and financial resources.

(*ix*) Summary of the results of any consumer satisfaction surveys conducted.

(*x*) Recommendations to the department.

(p) Provide education and training to its recipient rights advisory committee and its recipient rights appeals committee.