Northern Michigan Regional Entity

Board Meeting

June 28, 2023

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – May 24, 2023	Pages 2 – 6
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8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Did not meet	
	c. CEO's Report – June 2023	Page 53
	d. Financial Report – April 2023	Pages 54 – 75
	c. Operations Committee Report – June 20th meeting	Pages 76 – 80
	e. NMRE SUD Oversight Board Report – The next meeting is July 10th	
11.	New Business	
	a. Expanded Agreement with Roslund Prestage & Company, PC	
12.	Old Business	
	a. Grand Traverse County and Northern Lakes	Pages 81 – 82
13.	Presentation/Discussion	
	NMRE Quality Assurance and Performance Program Update	Pages 83 – 153
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – July 26, 2023 at 10:00AM	
16.	Adjourn	

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – MAY 24, 2023
GAYLORD BOARDROOM

ATTENDEES:	**Tom Bratton, Ed Ginop, Eric Lawson, Greg McMorrow, Michael Newman, Gary Nowak, Jay O'Farrell, Ruth Pilon, Richard Schmidt, Don Smeltzer, Don Tanner, Chuck Varner**
ABSENT:	**Gary Klacking, Terry Larson, Karla Sherman**
NMRE/CMHSP STAFF:	**Brian Babbitt, Chip Johnston, Eric Kurtz, Brian Martinus, Trish Otremba, Brandon Rhue, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Kate Dahlstrom, Dave Freedman, Trevor Kapp, Derek Miller, Sue Winter**

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

ROLL CALL
Let the record show that Gary Klacking, Terry Larson, and Karla Sherman were excused from the meeting on this date; all other NMRE Board Members were in attendance.

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 the election of NMRE Board Officers and a proposal for consulting services from Capitol Affairs, Inc. were added under New Business.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR MAY 24, 2023 AS AMENDED; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

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

MOTION BY JAY O'FARRELL TO APPROVE THE MINUTES OF THE APRIL 26, 2023 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY GARY NOWAK. MOTION CARRIED.

CORRESPONDENCE

1) The minutes from the April 4, 2023PIHP CEO meeting.
2) The minutes from the May 4, 2023 MDHHS PIHP CEO meeting.
3) The minutes from the April 26 – 27, 2023 CMHAM Directors Forum.
4) Communication from MDHHS dated April 26, 2023 announcing the soft launch of the Michigan Child and Adolescent Needs and Strengths (MichiCANS) tool in Quarter 2 of FY24.
5) Memorandum from Lindsay McLaughlin at MDHHS dated May 15, 2023 to PIHP and CMHSP Executive Directors regarding the Impact of the End of the Public Health Emergency on MSA 20-58 (which allowed PIHPs and CMHAPS to ensure the provision of essential services while protecting the health and wellness of beneficiaries and providers throughout the COVID Public Health Emergency).
6) Letter dated May 12, 2023 from Farah Hanley at MDHHS providing clarification on Medicaid policy related to the reimbursement of services for children with Intellectual/Developmental Disabilities (including children with Autism Spectrum Disorder) who reside in Child Caring Institutions.
7) Legal opinion from attorney Adam Falcone of Feldesman, Tucker, Leifer, and Fidell to Bob Sheehan at CMHAM dated May 9, 2023 regarding Conflict-Free Access and Planning.
8) Announcement of Meghan Groen as Senior Deputy Director of the MDHHS Behavioral and Physical Health and Aging Services Administration.
9) Announcement of Jeff Wieferich as the Senior Executive of the State Psychiatric Hospitals/Centers effective June 11, 2023.
10) May 4, 2023 Traverse City Record Eagle article by Patti Brandt Burgess titled, "Mental Health Services Take Giant Leap Forward."
11) Flyer from MDHHS announcing stakeholder meetings to gather feedback on direct care and behavioral health workforce challenges.
12) The draft minutes of the May 10, 2023 regional Finance Committee meeting.

Mr. Kurtz drew attention to the legal opinion from Adam Falcone related to conflict free access and planning (CFA&P). Mr. Falcone asserted that MDHHS demonstrated an "arbitrary reversal" of position related to CFA&P. Mr. Falcone further stated that for MDHHS to reverse its position on this issue, it would require, at a minimum, that MDHHS explain what motivated is change of position and offer stakeholders the opportunity to comment on this stance. CMHA intends to pursue its advocacy against the state's CFA&P proposals.

Mr. Kurtz next noted the staff changes at MDHHS with Meghan Groen named Senior Deputy Director of the MDHHS Behavioral and Physical Health and Aging Services Administration and Jeff Wieferich moving to the position of Senior Executive of the State Psychiatric Hospitals/Centers.

Mr. Lawson asked why there are two separate PIHP CEO meetings. Mr. Kurtz clarified that an initial meeting is held monthly among the ten PIHP CEOs which is followed by a second meeting with PIHP CEOs and MDHHS staff.

ANNOUNCEMENTS

Let the record show that new NMRE Board Members Tom Bratton, Greg McMorrow, and Ruth Pilon (representing Northern Lakes Community Mental Health Authority) were introduced to the group.

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

Kate Dahlstrom shared that she enjoyed serving on the NMRE Board and was disappointed to not be reappointed. She stated that she was removed from all Northern Lakes CMHA committees during the May18th Board meeting. Ms. Dahlstrom expressed the hope that the NMRE Board be open to efforts to enhance youth services in the region.

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

CEO Report
The NMRE CEO Monthly Report for May 2023 was included in the materials for the meeting on this date. Mr. Kurtz highlighted his participation in the NMRE Substance Use Disorder (SUD) Day of Recovery Education on May 8th and the Northeast Michigan CMHA Strategic Planning Session on May 11th.

March 2023 Financial Report
- Net Position showed net surplus Medicaid and HMP of $4,206,198. Budget stabilization was reported as $16,369,542. The total Medicaid and HMP Current Year Surplus was reported as $20,575,740. Medicaid and HMP combined ISF was reported as $16,369,542; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $36,945,282.
- Traditional Medicaid showed $98,795,368 in revenue, and $96,778,094 in expenses, resulting in a net surplus of $2,017,274. Medicaid ISF was reported as $9,306,578 based on the current FSR. Medicaid Savings was reported as $7,742,649.
- Healthy Michigan Plan showed $17,405,142 in revenue, and $15,216,218 in expenses, resulting in a net surplus of $2,188,924. HMP ISF was reported as $7,062,964 based on the current FSR. HMP savings was reported as $8,626,893.
- Health Home showed $1,109,075 in revenue, and $927,510 in expenses, resulting in a net surplus of $181,565.
- SUD showed all funding source revenue of $14,692,732, and $12,821,233 in expenses, resulting in a net surplus of $1,871,499. Total PA2 funds were reported as $4,852,460.

Ms. Yockey noted that current revenue is running $2M over projections. The NMRE will likely close the current fiscal year with a fully funded ISF and a sizable lapse. The decrease in eligibles (due to redeterminations) may be offset by a potential rate increase for FY24.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2023; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

Operations Committee Report
The minutes from May 16, 2023 were included in the materials for the meeting on this date. Mr. Kurtz shared that a regional Pediatric Behavioral Health Summit is being planned with AuSable Valley and can include attendees from the Upper Peninsula on October 4th at Treetops Resort.

It was noted that, during a recent meeting of the Michigan Association of Counties (MAC) Health and Human Services Committee meeting, a rural exemption was passed and will be presented to the full board. The rural exemption asks MDHHS to look at natural resources in the community before enacting policies. The goal is for the rural exemption request to be presented to the Michigan legislature.

NMRE SUD Oversight Board Report
Let the record show that the next SUD Oversight Board meeting is scheduled for July 10, 2023 at 10:00AM.

NEW BUSINESS

House Bills 4576 and 4577 of 2023
House Bills 4576 and 4577 have been introduced by Curt Vanderwall. The bills aim to update the mental health code regarding the transition from specialty prepaid inpatient health plans (PIHP) to specialty integration plans (SIP).

Election of NMRE Officers
The election of NMRE Board Officers was added to the agenda for the meeting on this date. It was reported that all current officers were eligible for an additional term.

MOTION BY GARY NOWAK TO REAPPOINT THE CURRENT NORTHERN MICHIGAN REGIONAL ENTITY BOARD OFFICERS AND APPOINT JAY O'FARRELL AND RUTH PILON TO THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD EXECUTIVE COMMITTEE FOR THE TERM OF ONE YEAR; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

- NMRE Board Chair – Don Tanner
- NMRE Board Vice-Chair – Ed Ginop
- NMRE Board Secretary – Gary Nowak
- Additional Board Executive Committee Members – Jay O'Farrell and Ruth Pilon

Proposal for Consulting Services from Capitol Affairs, Inc.
A proposal from Capitol Affairs, Inc. for consulting services was distributed during the meeting on this date.

MOTION BY GARY NOWAK TO APPROVE THE PROPOSAL FROM CAPITOL AFFAIRS, INC. FOR THE PROVISION OF CONSULTING SERVICES TO THE NORTHERN MICHIGAN REGIONAL ENTITY AT A TOTAL COST OF THIRTY-SIX THOUSAND DOLLARS ($36,000.00) FOR A PERIOD OF ONE YEAR TO BEGIN ON JUNE 1, 2023; SUPPORT BY ERIC LAWSON. ROLL CALL VOTE.

"Yea" Votes:	T. Bratton, E. Ginop, E. Lawson, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, R. Schmidt, D. Smeltzer, D. Tanner, C. Varner
"Nay" Votes:	Nil

OLD BUSINESS

Grand Traverse County and Northern Lakes CMHA
The Enabling Agreement passed (unanimously) through all six counties and will be filed with the County Clerks. Mr. Martinus acknowledged the work of Northern Lakes CMHA staff throughout the process; he stressed that staff have remained focused on NLCMHA's mission.

PRESENTATION

NMRE FY22 Financial Audit

Derek Miller and Trevor Kapp from Roslund, Prestage & Company were in attendance via Teams to present the results of the NMRE's FY22 Financial Audit. Mr. Miller provided the following opinion:

> *We have audited the accompanying financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Northern Michigan Regional Entity (the Entity), as of and for the year ended September 30, 2022, and the related notes to the financial statements, which collectively comprise the Entity's basic financial statements as listed in the table of contents.*
>
> *In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the Entity, as of September 30, 2022, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.*

Mr. Miller thanked the NMRE Team for their work and assistance in completing the audit.

MOTION BY RICHARD SCHMIDT TO ACCEPT THE NORTHERN MICHIGAN REGIONAL ENTITY FISCAL YEAR 2022 FINANCIAL AUDIT REPORT BY ROSLUND, PRESTAGE & COMPANY; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

COMMENTS

Board Members

Mr. Schmidt announced that during the last meeting of the Michigan Association of Counties (MAC), Jay O'Farrell was elected to its Board of Directors.

Staff/CMHSP CEOs

- Ms. Yockey introduced NMRE Financial Analyst, Tricia Wurn, and NMRE Finance Specialist, Pamela Polom and thanked them for their work on the FY22 financial audit.

- Mr. Johnston referenced his "Red Book" presentation given during the recent CMHAM Improving Outcomes Conference. He has also given this presentation to staff in the UP and has offered the presentation to the regional CMHSPs and the NMRE.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on June 28, 2023.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:05AM.

Community Mental Health Association of Michigan

Concerns and recommendations: MDHHS-proposed Conflict-Free Access and Planning options

May 2023

In March 2023, the MDHHS Conflict-Free Access and Planning (CFAP) Workgroup met to review a number of CFAP options proposed by MDHHS to ensure compliance with the federal CFAP requirements. These options raised a number of concerns for the members of the Community Mental Health Association of Michigan (CMHA) – concerns around the threat that these options hold for persons served and to the integrity of Michigan's public mental health system. These concerns and recommendations for action are outlined below.

Summary of concerns and recommendations

Concerns:

1. The structural separation of access and planning from service delivery, proposed by MDHHS, **makes an already complex system more complex for persons served** and creates an **artificial access barrier to persons seeking services and weakens continuity and coordination/integration of care**.

The comments of persons served, obtained during the MDHHS listening sessions underscore the **concerns of persons served around the complexity and loss of continuity of care that will occur as a result of the Department's proposed system restructuring**. These comments are provided in the body of this document.

3. **MDHHS has developed, with CMS approval, an innovative set of sound conflict-mitigation approaches – not cited in the MDHHS proposed options - that reflect the unique nature of Michigan's system. These approaches are reflected in Michigan's HCBS plan amendment** with the relevant sections of that amendment included in the endnotes to this document.

The **legal opinion** of the firm of Feldesman Tucker (one of the nation's leading Medicaid managed care law firms) **underscores this point**.

2.The options outlined **dismantle Michigan's comprehensive risk-sharing public safety net system** when a range of **other conflict mitigation tools exist**. The Department's options are in conflict with the **core characteristics of Michigan's community mental health system** – statutorily defined public safety net role; financed through a shared-risk Medicaid capitation payment system; **with mandated roles of CMHSPs including access, clinical plan development, and network management.**

Recommendation:

1. **Build upon and strengthen the wide range of conflict mitigation processes and tools currently existing in Michigan's system and described in Michigan's HCBS plan amendment – jointly with the members of the MDHHS CFAP Workgroup, the state's major advocacy groups, CMHSP/PIHP leadership, and CMHA**.

Concerns

Concern 1: These options make an already complex system more complex for persons served and create an **artificial access barrier to persons seeking services and weakens continuity and coordination/integration of care:** The structural separation of access and planning from service delivery, as proposed in all of the options outlined by MDHHS, places another barrier in the path of persons seeking mental health services and harms continuity and coordination of care. The discontinuity between access, service and supports planning, and service delivery makes an already complex system more so.

In fact, the comments received by MDHHS during the **listening sessions with persons served underscore their concern that the structural separation, proposed by MDHHS, hampers continuity of care**:

- "I think [Separating access/planning from direct service] could be problematic due to a person having to repeat providing their info… A positive could be reducing conflict between accessing services and then those for the planning such as supports coordination"
- "Having to go from here, to here, to here to do it when being in a place where I need help would be a lot. It's a lot to ask one person to go through."
- "The concern is the challenge is managing [different organizations] that need to be in alignment with one another. The management now is already a concern. Does this make it worse
- "…if no communication or miscommunication this will be hard because it will be left to person with disabilities to relay info."
- "[I have] mixed feelings. [It is] Protecting people getting these services, but I can get frantic going places to places."
- "Between the point of access and referral, things get dropped and lost."
- "It feels like the game it goes through several people and it is not the same in the end after it has moved through all the steps."

Concern 2: Dismantles Michigan's comprehensive risk-sharing public safety net system when a range of other conflict mitigation tools exist – all of which could be strengthened: While a range of structural and procedural conflict-mitigation approaches exist, the Conflict-Free Access and Planning (CFAP) options proposed by MDHHS are centered on unnecessary and cumbersome structural mitigation, rather than strengthening the existing conflict-mitigation approaches. [i]

The proposed structural mitigation approaches dismantle the core components of the state's CMHSPs and violate state law and the Medicaid waivers undergirding Michigan's public mental health system.

In fact, Michigan's HCBS plan amendment (in the Conflict of Interest Standards section) [ii] and the TBD 2022 Safeguards in Conflict-Free Service Planning report outline the **wide array of conflict mitigation processes and tools**, which exist in Michigan's system, that, **if strengthened would form a sound conflict free access and planning system**.

The **legal opinion** of the firm of Feldesman Tucker (one of the nation's leading Medicaid managed care law firms) **underscore this point**. That legal opinion can be found here.

The analysis below outlines the case against structural mitigation and proposes a range of procedural mitigation approaches that MDHHS had, up until this point, integrated into its HCBS state plan.

Concern 3: The core characteristics of Michigan's community mental health system call for conflict-mitigation approaches that reflect these dimensions, unlike those applied to private, fee-for-service provider networks.

A. The MDHHS proposed structural approaches to prevent private gain – relevant for states with private Community Mental Health or Medicaid provider systems **- are not relevant to Michigan's CMHSP system, given its public nature, statutory obligations, and waiver defined identity as Comprehensive Specialty Services Networks (CSSN)**. [iii]

B. CMHSPs are local governmental units, paid on a sub-capitated basis and, as such, do not gain financially from receiving clients through the access, person-centered planning, and casemanagement processes. In fact, these funds are provided, on **a shared-risk arrangement with the State of Michigan**, through the state's PIHPs (acting as Regional Entities created by the state's CMHSPs or as stand-alone PIHPs who are also CMHSPs), to the state's CMHSPs. **As a result, gains and losses by this system are shared by the State of Michigan.** Additionally, **annual cost settlement with the State of Michigan, and the oversight by local elected officials,** required of the state's CMHSPs, mitigate against gain due to access and planning functions.

C. The access and person-centered planning roles of CMHSPs, as local units of government, **are core requirements of Michigan's CMHSP system under Michigan's Mental Health Code and Medicaid waiver**, unlike CMHSPs in many other states, making the development of a Michigan-tailored CFAP approach essential - calling for a procedural rather than structural separation of duties. The procedural protections that are implemented should build upon and strengthen Michigan's system has a 60-year history of integrating the access, assessment PCP development, and provider roles. **The PCP process, required offering of independent PCP facilitation, required choice of provider, and the requirement to offer Self-Determination/Self-Directed Budget arrangements form a core set of methods to mitigate against conflict of interest.**

D: **CMHSPs, which are CCBHCs, are required to operate access and person-centered/service planning functions** – thus underscoring the need for a procedural rather than structure separation of duties.

The CCBHC design, being employed across the country, is patterned after Michigan's CMHSP system – with the same broad and integrated Comprehensive Specialty Services Network (CSSN) structure that is at the core of Michigan's public mental health system.

E. In all of the models proposed by MDHHS, provider network management and payments to these network providers move from the CMHSPs to the state's PIHPs – in violation of Michigan's Mental Health Code, CCBHC requirements, and the community's longstanding expectation and reliance on the CMHSPs to have the full range of behavioral health and intellectual/developmental disability services. CCBHCs are required to directly hold DCO contracts as their CCBHC provider network.

F. The MDHHS CFAP models do not fit Michigan's CMHSP and PIHP system given that **these models are drawn from states that are unlike Michigan's system** in many key dimensions. **Those differences should drive discussions and negotiations between MDHHS and CMS:**

- These states do not have a CMHSP system that is governmental, funded with capitated Medicaid dollars, with a statutorily and waiver defined identity as a Comprehensive Specialty Services Network (CSSN) – traits that are core to Michigan's system.
- These states have a very limited number of persons receiving HCBS services – typically only those persons certified to be on habilitative, SED, or similar waivers – whereas Michigan has wisely expanded the use of HCBS services to a large and diverse number of Medicaid beneficiaries.
- These states have direct contracts from the state to these providers, many of which are private non-profits and private for-profits, for whom self-referral and authorization-related private gain concerns often lead to structural mitigation models – unlike Michigan's local government CMHSP system.

Concerns over process

The announcement, in March 2023, to the MDHHS Conflict-Free Access and Planning (CFAP) Workgroup, of the CFAP options proposed by MDHHS to ensure compliance with the federal CFAP requirements, were met with deep concern by the representatives of the state's Community Mental Health Services Programs (CMHSPs) and Medicaid Prepaid Inpatient Health Plans (PIHPs) – concerns that they expressed during this March meeting of the workgroup.

Many of the CMHSP and PIHP staff on that workgroup indicated, during that meeting and since, that these models do not align with much of the workgroup's past discussions nor draw from the concepts and workable options proposed by the CMHSP and PIHP members of the workgroup. These workgroup members indicated that, throughout the life of the workgroup and again during this March 2023 discussion of these options, **their views have not been heard** and that the options that they have proposed to ensure Conflict-Free Access and Planning while building upon and strengthening Michigan's public mental health system **were not seriously considered.**

These members were surprised at the design options presented by MDHHS and expressed deep concerns regarding these options – seeing all of these options as violating the core roles, integrity, and definition of Michigan's Community Mental Health system, as captured in statutes, regulation, and contract.

Additionally, the **views of those persons served who participated in the CFAP listening sessions**, especially those around continuity of care, do not appear to be reflected in the options proposed by MDHHS.

Recommendations for Action

Recommended action: MDHHS should **build upon and strengthen the existing conflict-mitigation structures and processes as outlined in Michigan's HCBS plan amendment,** jointly with the members of the MDHHS CFAP Workgroup, the state's major advocacy groups, CMHSP/PIHP leadership, and CMHA, rather than pursue the proposed complex and cumbersome structural mitigation approaches to meeting the federal CFAP requirements.

The existing structural and procedural mitigation approaches which would form the foundation for any revised approaches, are outlined in **Michigan's HCBS plan amendment** (in the Conflict of Interest Standards section) [iv] and the TBD Solutions report.

[i] Procedural mitigation approaches are allowed by CMS as per the following section of the federal HCBS regulations. **Such approaches recognize that, as outlined in state law and the state's Medicaid waivers, the state's CMHSPs, as the sub-capitated Medicaid Comprehensive Specialty Services Network (CSSN), are the only bodies that can develop and approve the individual plan of service and will be, at times, also a HCBS provider:**

42 CFR 441.301(c)(1)(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that **the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS**. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process

[ii] Existing sound structural and procedural mitigation approaches, which would form the foundation for any revised approaches, **are outlined in Michigan's 1915(i) State plan HCBS State plan (Attachment 3.1–i.2)** the relevant sections of which are highlighted below:

> The right of every individual receiving public mental health services in Michigan to the development of an individual plan of services and supports using the person-centered planning process is established by law in Chapter 7 of the Michigan Mental Health Code. Through the MDHHS/PIHP contract, MDHHS delegates the responsibility for the authorization of the service plan to the PIHPs.
>
> The PIHPs delegate the responsibilities of plan development to CMHSP supports coordinator or other qualified staff chosen by the individual or family. These individuals responsible for the IPOS are not providers of any HCBS for that individual and are not the same people responsible for the independent HCBS needs assessment. The CMHSPs authorize the implementation of service through a separate service provider entity. The development of the IPOS through the person-centered planning (PCP) process is led by the beneficiary with the involvement of allies chosen by the beneficiary to ensure that the service plan development is conducted in the best interests of the beneficiary. The beneficiary has the option of choosing an independent facilitator (not employed by or affiliated with the PIHP) to facilitate the planning process. In addition, the PIHP, through its Customer Services Handbook and the one-on-one involvement of a supports coordinator, supports coordinator assistant, or independent supports broker are required to provide full information and disclosure to beneficiaries about the array of services and supports available and the choice of providers.
>
> The beneficiary has the option to choose his or her supports coordinator employed by a PIHP subcontractor or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network) or select a supports coordinator assistant or independent supports broker. This range of flexible options enables the beneficiary to identify who he or she wants to assist with service plan development that meets the beneficiaries'
> interests and needs. Person-centered planning is one of the areas that QMP Site Review Team addresses during biennial reviews of each PIHP.
>
> The MDHHS/BHDDA has several safeguards in place to assure that the independent assessment, independent eligibility evaluation, development of the Individual Plan of Service (IPOS), and delivery of 1915(i) services by the PIHP provider network are free from conflict of interest through the following:
>
> > 1) The mandated separation required in the MDHHS/PIHP contract that assures the assessor(s) of eligibility will not make final determinations about the amount, scope and duration of 1915i services;
> >
> > 2) The MDHHS/PIHP contract assures the provider responsible for the independent HCBS needs assessment are separate from the case manager/supports coordinator providers responsible for the development of the IPOS;

3) All Medicaid beneficiaries are supported in exercising their right to free choice of providers and are provided information about the full range of 1915(i) services, not just the services furnished by the entity that is responsible for the person-centered service plan development.

All beneficiaries are advised about the Medicaid Fair Hearing process in the Customer Services Handbook that is provided by the PIHP to the individual at the onset of services, at least annually at the person-centered planning meeting and upon request of the individual at any time. The Medicaid Fair Hearings process is available to the individual to appeal decisions made related to 1915(i) services.

This may include beneficiaries who believe they were incorrectly determined ineligible for 1915(i) services; beneficiaries who believe the amount, scope, and duration of services determined through the person-centered planning process is inadequate to meet their needs; and if 1915(i) services are reduced, suspended or terminated. Adequate Notice of Medicaid Fair Hearing rights is provided at the time the person-centered plan of service is developed and Advanced Notice of Medicaid Fair Hearing rights is provided prior to any reduction, elimination, suspension or termination of services;

4) The results of the individual needs assessment, including any other historical assessment or evaluation results, may be used as part of the information utilized in developing the individual plan of services (IPOS). Oversight/coordination of the IPOS is done by a case manager or supports coordinator or other qualified staff chosen by the individual or family, is not a provider of any other service for that individual, and is not the professional/entity that completes the individual needs assessment/authorization for eligibility or services;

5) The PIHP performs the utilization management managed care function to authorize the amount, scope and duration of 1915i services. PIHP utilization management staff are completely separate from the sub-contracted staff and entities performing evaluation, assessment, planning, and delivery of 1915i services;

[iii] **A. CMHSPs as comprehensive service providers as defined by statute (Michigan Mental Health Code)**: Michigan's CMHSPs have been designed, with that design imbedded in state law, as comprehensive mental/behavioral health services providers. This role is underscored by the Michigan Mental Health Code requirement (Code language provided below) that outlines the comprehensive service array that CMHSPs must provide **whether provided directly or via contract with another provider**.

330.1206 Community mental health services program; purpose; services.

Sec. 206.
(1) The purpose of a community mental health services program **shall be to provide a comprehensive array of mental health services** appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:

(a) **Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service** that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.
(b) **Identification, assessment, and diagnosis** to determine the specific needs of the recipient and to develop an individual plan of services.
(c) **Planning, linking, coordinating, follow-up, and monitoring** to assist the recipient in gaining access to services.
(d) **Specialized mental health recipient training, treatment, and support**, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.
(e) Recipient rights services.
(f) Mental health advocacy.
(g) **Prevention activities** that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.
(h) **Any other service approved by the department**.

All of the work of the CMHSP in fulfilling this role, including staff credentialling, contract management, quality improvement, claims payment, customer services and recipient rights, is **related to the CMHSP role as a comprehensive services provider as it has been for decades long prior to the advent of managed care in Michigan's Medicaid program.**

B. CMHSPs as Comprehensive Specialty Services Networks (CSSN) receiving capitated payments: Michigan's managed behavioral health Medicaid program is built on a structure that designates Michigan's CMHSPs as comprehensive providers receiving sub-capitation payments.

Since the 1998 implementation of the Michigan Medicaid Managed Specialty Supports and Services Program and subsequent federal waiver authorities, CMHSPs were designated as Comprehensive Specialty Services Networks (CSSNs) and are expected to create and maintain Provider Specialty Services Networks (PSSNs). This has been the state's expectations for all CMHSPs and is the very foundation for Michigan's unique managed care "carve-out" sole source contractual arrangement with the public community mental health system.

These roles are outlined in a number of foundational documents of Michigan's behavioral health Medicaid program, excerpts of which are provided below:
Michigan Department of Community Health; Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans; Final Version; September 2000

> … CMHSPs in the affiliation would be eligible for a special provider designation – that of **"Comprehensive Specialty Service Network" (CSSN)** – that affords them special consideration in the provider network and qualifies them to receive a sub-capitation from the PHP or hub-CMHSP.

Michigan Department of Community Health; Specialty Pre-Paid Health Plan 2002 application for participation; January 2002

> Sub-capitation: An applicant **may sub-capitate for shared risk with affiliates** or established risk-sharing entities.

[iv] Ibid

Service Delivery Transformation Section

June 2023 Update

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Service Delivery Transformation Section Overview

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

Our Team

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Opioid Health Home

Opioid Health Home Overview

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

Current Activities

- As of June 2, 2023, 3,523 beneficiaries are enrolled in OHH services.
- Resources including the OHH policy, directory, and handbook, are available on the Michigan Opioid Health Home website Opioid Health Home (michigan.gov)
- With the OHH expansion in October 2022, LE's have continued to expand OHH services with new Health Home Partners (HHPs). There are currently 38 Health Home Partners (HHP) contracted to provide services to OHH beneficiaries. Four HHPs are contracting with multiple LEs.
- MDHHS continues to collaborate with many state agencies to ensure OHH beneficiaries have comprehensive support services to aid in their recovery journey.

Substance Use Disorder Health Home

Substance Use Disorder Health Home Overview

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

Current Activities

- Three PIHP regions (2, 7, and 8) are using available funds to operate the Substance Use Disorder Health Home.
- Two PIHP regions (4 and 6) will use Substance Use Disorder Health Home funds as a staffing grant to assist providers in meeting capacity to become an OHH partner within the next fiscal year.

Behavioral Health Home

Behavioral Health Home Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes provide comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness or serious emotional disturbance by attending to a beneficiary's complete health and social needs.
- Providers are required to utilize a multidisciplinary care team comprised of physical and behavioral health expertise to holistically serve enrolled beneficiaries.
- Behavioral Health Home services are available to beneficiaries in 42 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), 5 (Mid-State), 6 (Southeast Michigan), 7 (Wayne County), and 8 (Oakland County).

Current Activities

- As of June 2, 2023, there are 2,562 people enrolled:
    - Age range: 6-86 years old
    - Race: 25% African American, 70% 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)

Promoting Integration of Physical and Behavioral Health Care Grant

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

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

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.

- PIPBHC sites are focused on sustainability and the ways in which integrated care can continue after the end of the grant.

Certified Community Behavioral Health Clinic Demonstration

Certified Community Behavioral Health Clinic Demonstration Overview

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

Current Activities

- CCBHCs reported providing 817,251 daily visits to Medicaid beneficiaries during FY22 and 70,143 visits to individuals without Medicaid coverage. Services were provided to 62,626 unique individuals. Approximately 30% served were children and young adults, age 0-21, and 70% were adults age 21+. As of May 31, 2023, 62,141 Medicaid beneficiaries and 11,537 non-Medicaid individuals are assigned in the WSA to the 13 demonstration CCBHC sites.
- PIHPs and CCBHCs have requested Beneficiary level detail reports relating to DY1 quality bonus payment performance rates and distribution of payment is anticipated to be dispersed end of June 2023.
- MDHHS continues to partner with evaluators at the Center for Healthcare Research Transformation at the University of Michigan on formulating an evaluation, which is intended to help measure the impact of the demonstration- particularly efforts to expand access to behavioral health services for underserved populations. Work to develop a comprehensive evaluation plan will begin in early 2023.
- Training and technical assistance is ongoing. An Integrated Health Summit to include BHH, OHH and CCBHC is planned at the end of August. MDHHS is also sponsoring the training of two Community Health Workers (CHWs) at each CCBHC demonstration site in FY23 and has open spots remaining.

- MDHHS has announced the new SAMSHA criteria will be required to be implemented for demonstration sites by October 1, 2024.
- MDHHS has implemented an internal steering committee to help develop expectations for future CCBHC expansion. The committee has completed the five proposed planning sessions and a plan to implement work groups moving forward is being discussed. A process for collecting external feedback is under development.
- A survey, completed on May 5, 2023, was used to measure the ability and interest of potential CCBHC expansion sites meeting the criteria to enter the demonstration effective October 1, 2023. MDHHS identified 19 providers eligible to apply for CCBHC certification due July 1, 2023. The survey results and eligibility to apply have been communicated with potential sites and perspective PIHPs as well as with the existing CCBHCs and external partners. TA sessions begin June 5, 2023, and continue throughout the month, topics include Finance/Actuarial and biweekly Programmatic support.
- SAMHSA released new grant funding opportunities for clinics with a deadline to submit requests by May 22, 2023. Clinics without previous CCBHC experience could apply for CCBHC Planning, Development, and Implementation grants and existing grant recipients or demonstration sites could apply for CCBHC Improvement and Advancement grants. MDHHS provided 27 letters of support to prospective sites to assist in obtaining their requested grant funding.

Questions or Comments

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Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 23-39

Distribution: Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), State Psychiatric Hospitals

Issued: May 30, 2023

Subject: Psychiatric Residential Treatment Facilities (PRTF)

Effective: July 1, 2023

Programs Affected: Medicaid, Healthy Michigan Plan, MI Choice

This purpose of this policy is to establish a Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual chapter specific to Psychiatric Residential Treatment Facility (PRTF) service providers.

SECTION 1 – General Information

This chapter applies to PRTF service providers. According to the Centers for Medicare & Medicaid Services (CMS), a PRTF is any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient psych under 21 benefit. PRTFs provide services under the direction of a physician. According to CMS, A PRTF provides comprehensive mental health treatment to children and adolescents (youth) who, due to mental illness, substance abuse, or severe emotional disturbance, need treatment that can most effectively be provided in a residential treatment facility. All other ambulatory care resources available in the community must have been identified, and if not accessed, determined not to meet the immediate treatment needs of the youth. PRTF programs are designed to offer a short term, intense, focused mental health treatment program to promote a successful return of the youth to the community. Specific outcomes of the mental health services include the youth returning to the family or to another less restrictive community living situation as soon as clinically possible and when treatment in a PRTF is no longer medically necessary. The residential treatment facility is expected to work actively with the family, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment designed to meet the individual needs of the youth including those identified with emotional and behavioral issues.

SECTION 2 – Common Terms

Behavior Treatment Plan (BTP) A behavior treatment plan, where needed, is developed through the person-centered planning process that involves the beneficiary. The person-centered planning process should determine whether a comprehensive assessment should be done to rule out any physical or environmental cause for the behavior. Any behavior treatment plan that proposes aversive, restrictive, or intrusive techniques, or psycho-active medications for behavior control purposes and where the target behavior is not due to an active

substantiated psychotic process, must be reviewed and approved by a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist and one of whom shall be a licensed physician/psychiatrist. The psychologist or physician must be present during the review and approval process. At least one of the committee members shall not be the developer or implementer of the behavior treatment plan. The approved behavioral plan shall be based on a comprehensive assessment of the behavioral needs of the beneficiary. Any proposed aversive, intrusive, or restrictive technique not supported in current peer-reviewed psychological/psychiatric literature must be reviewed and approved by the Michigan Department of Health and Human Services (MDHHS) prior to implementing.

PRTF Certification – (CMS Certification of Need [CoN]) – As defined by CMS, CoN for services involves an assessment of medical necessity of this level of care. The CoN must be made by an independent team that includes a physician who has competence in diagnosis and treatment of mental illnesses, preferably child psychiatry, and has knowledge of the child's situation. For emergency situations, the CoN must be made within 14 days of admission.

Individualized Plan of Service (IPOS) - The document that identifies the needs and goals of the individual beneficiary and the medical necessity, amount, duration, and scope of the services and supports to be provided. For beneficiaries receiving mental health or developmental disabilities services, the individual plan of services must be developed through a person-centered planning process. In the case of minors with developmental disabilities, serious emotional disturbance or mental illness, the child and his family are the focus of service planning, and family members are an integral part of the planning process.

Person Centered Planning - A process for planning and supporting the individual (and family for children) receiving services that builds upon the individual's (and families for children) capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. (MHC 330.1700[g]) - See also: MDHHS Person-Centered Planning Practice Guideline.

Psychiatric Residential Treatment Facility (PRTF) – A non-hospital facility with a provider agreement with Michigan Medicaid to provide the inpatient services benefit, consistent with CMS and MDHHS standards, to Medicaid-eligible individuals under the age of 21 years.

Section 3 - Provider Certification Criteria

Per state law, PRTFs must meet certain requirements to participate. Those entities requesting enrollment as a PRTF provider must meet the requirements and selection criteria to be eligible to provide PRTF services as reimbursed by the Michigan Medicaid program. The requirements include, but may not be limited to:

(a) Compliance with 42 CFR Part 441.151-441.182.
(b) Compliance with all applicable federal, state, and local emergency preparedness requirements as outlined in 42 CFR 441.184.
(c) Licensed as a CCI by Division of Child Welfare Licensing, Michigan Department of Health and Human Services.

(d) For those facilities serving individuals aged 18 and over, licensed as Adult Foster Care by Michigan Department of Licensing and Regulatory Affairs.
(e) Certification by MDHHS.
(f) Accreditation by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, or Council on Accreditation of Services for Families and Children.
(g) Enrollment in the Community Health Automated Medicaid Processing System (CHAMPS).

SECTION 4 – Eligibility

Medicaid-enrolled children and youth whose intensity of behavioral health needs necessitates an inpatient level of treatment without the need for the safety, security, and monitoring of an inpatient psychiatric hospital will be eligible for services in a PRTF.

Eligibility requirements are:

- Under the age of 21 upon admission. Services may continue until the youth meets criteria for discharge or reaches 22 years of age, whichever comes first. If the individual turns 22 while in a PRTF, payment ends the day prior to the 22nd birthday.
- Establishment of medical necessity through comprehensive evaluation and assessment, and the Child and Adolescent Needs Assessment. Clinical documentation and justification indicate treatment level is inpatient and cannot be provided through home and community-based services.
- Have a primary mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.
- Have a severe functional impairment.
- Evidence of difficulty functioning safely and successfully in the community, school, or home due to their mental health needs and functional impairment.
- Require an inpatient level of psychiatric treatment which is beyond the reasonable duration of an acute care hospital to improve the youth's condition or prevent further regression without necessitating the safety, security, and monitoring of an inpatient hospital.

SECTION 5 – Service Authorization

MDHHS will manage certification and enrollment of PRTF providers, issue payment for services to Medicaid beneficiaries served, and monitor the quality and performance of the PRTF providers. The MDHHS will, when appropriate, authorize admissions to PRTF services, particularly when the individual is currently in a state operated inpatient facility.

The Prepaid Inpatient Health Plan (PIHP) is responsible for managing Medicaid mental health services for all Medicaid beneficiaries residing within the service area covered by the PIHP. This includes the responsibility for timely screening, referral, and certification of requests for admission to, PRTF services, defined as follows:

- Screening means the PIHP has been notified of the youth and has been provided enough information to support a referral to a PRTF based on the admission criteria

established below. The screening may be provided on-site, face-to-face by PIHP personnel, the telephone, or via a video conferencing platform.
- Certification means that the PIHP has screened the youth and has documented that the services requested seem appropriate. Telephone screening must be followed up by the written certification.
- All PRTF service authorizations will be made by MDHHS. The PIHP should make referrals when appropriate and will be actively involved in treatment planning/monitoring meetings, discharge planning and transition to the community.

PIHP Responsibilities

- Receive and process requests for PRTF admissions when coming from individuals not currently in a state hospital.
- Review to determine that all admission requests/referrals for individuals not currently in a state hospital meet medical necessity criteria and are complete and justified.
- Work with the local MDHHS office to determine Medicaid eligibility and secure enrollment for individuals who meet PRTF eligibility criteria but who are not currently a Medicaid beneficiary. (Refer to the Beneficiary Eligibility chapter of the MDHHS Medicaid Provider Manual for more information).
- Provision of notice regarding rights to a second opinion in the case of denials.
- If coverage of a PRTF is not appropriate, provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider such as a Community Mental Health Services Program (CMHSP) or State of Michigan Hospital and ensuring PRTF communication with the family and, as applicable, custodial agency.
- Facilitate coordination with the primary care physician.
- Planning in conjunction with the youth, family, custodial agency (as applicable), PRTF and CMHSP and, if necessary, state hospital personnel, for the beneficiary's after-care services.

Referring Provider Responsibilities

The requesting provider/entity making the referral must do the following to request PRTF admission for a beneficiary:
- Coordinate with the PIHP to complete the Eligibility for Admission form (to be created).
- Child and family team meeting with all involved parties must be completed prior to making a formal referral for PRTF care to clearly identify:
  - Child's needs that can't currently be met in the community
  - The expected living situation for the youth after discharge from the PRTF
  - The child and family team members
  - CMHSP services which will be active during child's stay focused on building aftercare support networks in child's home and the community
- IPOS specifying PRTF service and concurrent community-based services
- Updated diagnostic assessment completed by an appropriately credentialled professional.

PRTF Responsibilities

The PRTF must submit a child's IPOS to MDHHS and the PIHP/CMHSP no later than 10 calendar days after admission. The IPOS should include a tentative discharge plan and a request for anticipated dates beyond the initial 30 days. The IPOS must meet the following criteria:

- Must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's and member's family situation and reflects the need for inpatient psychiatric care.
- Must include an integrated program of therapies, activities and experiences designed to meet treatment goals.
- May include other services that are provided under arrangement by licensed professionals who are not part of the treatment team as well as educational services, recreation and socialization, and family engagement and visitation.
- Must include discharge plans for aftercare services and coordination to ensure continuity of care with the child's family, school, and community upon discharge.
- The PRTF provider will enter all admissions and discharges into CHAMPS.

5.1 Admissions

Request for PRTF admissions will be submitted by PIHP/CMHSPs or other qualifying providers/entities, to MDHHS for authorization. State inpatient facilities will submit request for PRTF admissions to MDHHS. Requesting/referring providers will use the PRTF Eligibility for Admission Form (to be created).

- The MDHHS will make authorization and approval decisions for PRTF services according to guidelines established by MDHHS cited in 4.2 below. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the contracting entity and MDHHS. MDHHS will monitor and audit all enrollments as necessary and appropriate.
- While MDHHS is paying for PRTF services, MDHHS will review and approve/deny authorization for PRTF services according to guidelines established by MDHHS cited in 4.2 below. All admission and continuing stay responsibilities and procedures must be conducted in accordance medical necessity and need criteria and will be communicated to the PIHP.

5.2 PRTF Admission Guidelines

Michigan PRTFs must adhere to the following admission guidelines:

- Admission and the first five days of treatment are authorized by the MDHHS with the PRTF Eligibility for Admission Form (to be created); continued admission beyond the first five days must follow Continued Stay Authorization Requirements
- Certification of need for care: A physician, physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law, must verify a member's need

for continued stay at an inpatient hospital level of care. The initial certification, meeting the requirements stated below, consists of the admitting provider's written order and plan of care documented in the medical record.
- Information about general appeals procedures is described in the MDHHS PIHP Contract.
- A provider's signature is required on the IPOS for initial admissions and continued stay reviews to certify and/or recertify the need for care at a PRTF.
- PRTF must have appropriate medical clearance documented in the individual's record.

Certification of Need

A Certification of Need for PRTF must be completed by a referring provider with an independent, multi-disciplinary treatment team and submitted to MDHHS for review and approval. The treatment team, as specified below must certify that:

- Ambulatory care resources available in the community do not meet the treatment needs of the individual.
- Proper treatment of the individual's psychiatric condition required services on an inpatient basis under the direction of a physician, and
- The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

The certification specified satisfies the utilization control requirement for physician certification.

Team certifying need for services must include:

- A Physician, competent in diagnosis and treatment of mental illness, preferably in child psychiatry, psychologist, physician assistant or psychiatric nurse practitioner and knowledgeable of the individual's situation.
- For emergency admissions, the certification must be made by the team responsible for the plan of care within 14 days of admission.

5.3 Appeals

MDHHS will make authorization and approval decisions for PRTF services according to guidelines established by MDHHS and appearing in this chapter. If a youth or their legal representative disagrees with a decision related to admission authorization/approval or approved days of care, they may request a reconsideration and second opinion from MDHHS. If MDHHS's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing after receiving notice that MDHHS is, after appeal, upholding an Adverse Benefit Determination, or when MDHHS fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in federal regulation (42 CFR 438.408. 42 CFR 438.408[f][1][i]).

5.4 Continued Stay Authorization Requirements

MDHHS must review the IPOS every 30 days to determine continued medical necessity for treatment and to authorize an additional 30 days of treatment. This includes verification that a child continues to meet criteria for PRTF services and requires continued PRTF services. It also requires an assurance that the child and family is making progress towards treatment goals, discharge, and successful transition into a home and community-based setting. Specifically, the following is required for continued stay authorization:

- The PRTF must submit an updated IPOS before the 30th day of the last authorized date of service.
- The PRTF must submit an updated authorization request when the IPOS changes.
- The PRTF must submit an updated IPOS when the provider does any of the following:
  - Requests additional days beyond the initial 30 days of treatment.
  - Adds or changes arranged services to the IPOS that require authorization.
  - Adds or changes concurrent services to the IPOS as part of the discharge plan.
  - Adds or changes therapeutic leave days.

SECTION 6 - Discharge Planning

Discharge planning must begin at the onset of treatment in the inpatient unit. Comprehensive discharge planning is essential for individuals to successfully function in their community. Discharge Planning will include the youth and family, the treatment team and the PIHP. The following criteria must be met:

- Development of a transitional process specific to the youth for discharge to a less restrictive or family-based setting.
- IPOS that includes discharge plans for aftercare services and coordination to ensure continuity of care with the recipient's family, school, and community upon discharge, including referrals for treatment, opportunities for home visits, and inclusion of community-based treatment providers in team meetings.
- IPOS that includes a tentative discharge plan and a request for anticipated dates beyond the initial 30 days.

SECTION 7 - Provider Requirements

7.1 Environment of Care Provisions

A PRTF must provide a 24/7 structured therapeutic environment with individualized and intensive treatment based as delineated by a beneficiary's IPOS. A PRTF must:

1) Secure appropriately credentialed or trained staff. Positions must include, but are not limited to:
   a) Medical Director who is an MD or a DO and Board Certified or Board Eligible
   b) Direct Care Staff (required 24/7)
   c) Registered Nurses
   d) Psychiatrists

e) Pediatrician, or a Family Physician, or an Internist
f) Behavior Analysts
g) Social Workers
h) Occupational or Recreational Therapists
i) Necessary staff to ensure quality nutrition and well-balanced food that meets the dietary requirements of the youth; housekeeping and maintenance staff; and administrative and business personnel to ensure all necessary reporting, documentation, communication, oversight, financial accountability, transportation, information technology, and emergency preparedness functions.

2) Other services that are required on an as-needed basis include but are not limited to:
   a) Psychological testing
   b) Speech therapy
   c) Physical therapy
3) Initiate meetings with potential placements identified by MDHHS or the PIHP if the youth will not be returning to their own home upon discharge from the PRTF.
4) Provide individual treatment and therapeutic interventions daily.
5) Provide crisis response and de-escalation training and support to staff and limit seclusion and restraint to physical management techniques only. Require debriefing with Medical Director and treatment team after a restraint.
6) Provide educational services for youth within the community in coordination with the local school district. (Collaborate with the youth's local school district on amending IEP, hospitalized services – resource Providing Homebound and Hospitalized Educational Services for Michigan Public School Pupils
7) Ensure that transportation is provided to address behavioral health, medical health, and educational services, and for services intended to accomplish goals of the youth's PCP IPOS.
8) Work with the beneficiary's treatment team to develop a behavioral treatment plan (BTP), if appropriate.
9) Propose and develop a transitional process specific to the beneficiary for discharge to a less restrictive or family-based setting. Develop a parent/guardian training plan into the plan of care.
10) Meet with the beneficiary weekly to assess, plan, and deliver services. These meetings must include, but are not necessarily limited to:
    a) The beneficiary.
    b) The beneficiary's aftercare family/guardian.
    c) The beneficiary's PRTF treatment team.
    d) The CMHSP primary caseworker or clinician.
    e) The beneficiary's child welfare worker or juvenile justice probation officer (if appropriate).
11) Maintain the following related to care of a beneficiary:
    a) Individualized services based on input from the beneficiary and their family.
    b) Treatment at the program is beneficiary-guided and family-driven with the beneficiary voice incorporated.
    c) Staff are trained in cultural competency and the treatment environment supports diversity and equity.

d) Treatment that is strength and resiliency-based and trauma-responsive with a focus on skill building and supporting the youth and family to meet their needs in their own home and community.
e) Comprehensive care that provides for family engagement with partnerships to support sustained, successful outcomes for the beneficiary with their families and the community following treatment.
f) Standardized behavioral approaches to prevent predictable and continuing behaviors that place the beneficiaries or others at risk of harm.
g) Treatment plans and interventions that can be integrated into the beneficiary's natural environment and based on real world approaches.
h) Collect and report on data regarding measures to assess outcomes and improve treatment, care, and services. Data must include but is not limited to youth and family satisfaction, length of stay, active treatment, and restrictive interventions. Data must be reported at least quarterly, and more frequently if required by MDHHS based on identified need or developing trends.
i) Ensure metabolic monitoring for youth on psychotropic medications.
j) Ensure and actively monitor for appropriate use of psychotropic medications, including attention to reducing polypharmacy use and reducing the use of psychotropic medications to treat sleep disturbances.

12) Abide by any additional terms and conditions of the RFP and the completed contract with MDHHS.

7.2 Reimbursement

Established rates are per diem and include all services provided to the beneficiary by the PRTF provider. Rates are tiered to reflect the severity of the treatment services and staffing ratios. Adjustments to the tiered rate authorized will be based on the youth's needs as determined in regular treatment planning and review meetings. Specific criteria and processes for review are found in the program specific operating procedures.

The per diem rate includes, but may not be limited to:

1) Personal care and community living supports.
2) Psychiatry.
3) Group and individual behavioral health therapy.
4) Case management.
5) Behavior treatment plan development, implementation, and monitoring.
6) Room and board.
7) All transportation services. This includes transportation to accomplish PRTF treatment goals, education, and non-emergency non-ambulance medical transportation.

Billing and reimbursement for professional or institutional services not rendered within the context of a beneficiary's treatment goals within a PRTF (e.g., physician, vision, or dental services) must be billed according to requirements of the MDHHS Medicaid Provider Manual. (Refer to the applicable chapter for more information.) Professional or institutional services required by a beneficiary are covered by Medicaid if they are billed and provided in accordance with the MDHHS Medicaid Provider Manual and requisite policy.

7.3 Education and Training of Staff [1]

The facility must require staff to have ongoing education, training, and education activities in the required areas outlined below. The facility must identify and provide for the training needs of staff based upon their responsibilities to include direct care staff as well as administrative, clerical, and housekeeping staff. The facility must review documentation in staff files to verify that the training is occurring and provide MDHHS with an annual report.

- Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations.
- The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations.
- The safe use of physical restraint (mechanical and chemical restraint not allowed) and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.
- Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.
- Trainings must be conducted by individuals who are qualified by education, training, and experience.
- Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
- Staff must be trained and demonstrate competency before participating in an emergency safety intervention.
- Staff must demonstrate their competencies as specified in 42 CFR 483.376(b) on an annual basis.
- The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training; and
- All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency.

SECTION 8 - Coverage for Out of State Services

When feasible, the beneficiary will receive services in the geographically closest PRTF to the individual's home community. There may be instances when a PIHP/MDHHS is responsible for a youth that has been admitted to a PRTF out-of-state. In these cases, MDHHS is responsible, in consultation with the PIHP, for authorizing admission and/or continuing stay. MDHHS will contract with, and issue payment to the out of state provider.

Out-of-state PRTF services will be covered in the same manner as EPSDT benefits, consistent with the MDHHS Medicaid Provider Manual.

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_n_prtf.pdf

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments to Kristen Jordan at JordanK4@michigan.gov.

Please include "Psychiatric Residential Treatment Facilities" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

Manual Maintenance

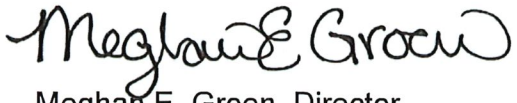
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

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 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

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

Approved



Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

Community Mental Health Association of Michigan

Sample of efforts, by CMHA member organizations, to address Michigan's behavioral health workforce shortage

June 2023

Below is a sample of some of the work that member organizations of the Community Mental Health Association of Michigan (CMHA) – the state's Community Mental Health Services Programs (CMHSPs), public Prepaid Inpatient Health Plans (PIHPs), and providers in the networks of the state's CMHSPs and PIHPs – have designed and implemented to address, in their local communities, the deep and prolonged behavioral health workforce shortage. This sample represents the information, in their own words and format, submitted by a diverse set of CMHA members in response to a call for the summaries of these efforts.

AuSable Valley Community Mental Health Authority

- Intern program:
    - We know that interns tend to become employees after their internship is completed. In order to attract more interns, we have started a program of compensating both interns as well as the supervisors that take on the interns. This is for both MSWs and BSWs. We also provide licensure supervision as a benefit of employment.
    - The important thing is that all interns leaving the agency feel good about the internship they had with us. They will then promote us to other students or people they know in the field. This in turn builds a positive reputation for the agency. It also gives people in the field a solid foundation to start from.

    In order for this to be a good experience we need to:

    - Spend a few months to train, onboard and allow them to shadow before giving them independent work. Don't overload them, they are here for a learning experience, not free labor.
    - Keep caseloads low throughout the internship (10 to 12) so they can learn and not be so frazzled they miss their learning piece.
    - Offer solid, weekly supervision. This is key. So many graduates today do not realize the importance of supervision (we see this in the new hires). Supervision is where the student and new staff build their foundation for future work. So much can be learned in those first few years that a clinician carries with them through life. If you have supervision that isn't that good, it turns out staff that aren't that good at what they do. Most new therapists do not realize how important supervision is early on. They don't know what they don't know. This goes back to the very basics.
    - Partnerships with SVSU, Spring Arbor, MSU, possibly Wayne State and U of M
    - Have attended field placement days to share program, information, and brochures
- Wellness days
    - Three days (outside of normal PTO); to be used in full day increments; cannot be aligned with a holiday; do not carryover; no notice is required; "Just Because Days"
- New wage scale
    - Implemented a 12-step wage grid, market and region competitive, 2% increase between steps
- Employee Engagement Committee

    - Responsible for internal inclusion/appreciation/recognition
- PTO Donation Program
    - Another way staff can help their colleagues
- Volunteer shift sign-up
    - Staff outside of community CLS can voluntarily sign up for shift work to assist during times of PTO and will be compensated at an enhanced rate (share the load). This has helped gain a greater understanding and appreciation of other roles in the agency and community.
- Billboards (static and electronic)
    - Advertisement throughout the state for urgently needed positions
- Radio spots
- Hybrid work schedules
    - Remote/on-site
- Employee referral Program ($150, $250, $750)
- Dedicated Emergency Services Team
    - In the past all clinical staff were required to be on the ES team on a rotating basis; exit interview data showed that the requirement to be on call for crises was the #1 reason for clinical staff leaving
    - The agency piloted a dedicated ES Team, working to people's strengths instead of forcing their anxiety; staff not on the team are still allowed to volunteer and are paid the ES stipend when they are on the schedule
    - This has been very successful
- Expanding Telehealth for OPT services

Barry County Community Mental Health Authority

- Adjusted BCCMHA pay scale
- Provided longevity payments
- Provided enrichment/development opportunities such as Guided Meditation with Catherine Schmidt, owner of The Yoga Zen
- Provided flexible work schedules – allowing a combination of work from home and in office
- Created an on call system where BCCMHA perform after hrs. on call for one week at a time but do not perform their "day jobs" during that week.
- Provided a 4 day work week opportunity for staff
- Foster working relationships with colleges to reignite internship programs

Community Mental Health for Central Michigan

- Engaged with local colleges/universities to strengthen talent pipeline through internships and education to students on the community mental health system
- Provided staff with flexibles schedules and hybrid work options
- Engaged staff in the recruitment process with implementation of employee referral program
- Provided sign-on incentives for difficult-to-fill positions
- Added two floating holiday's to time off package
- Developed alternative pay arrangement for extended vacancies to recruit and retain staff
- Updated longevity compensation program to begin after completion of trial period of employment
- Enhanced benefit program with the following:
    - Paid Family Leave Program
    - Tuition Reimbursement

- Fitness Reimbursement
- Dental and Vision Buy-Up Plans
- Employer Contributions to H.S.A.

Community Mental Health of Clinton, Eaton, and Ingham Counties

Compensation:

- Retention Payment
  - Implemented in December 2021.
- One to One Vacation Buyout
  - Implemented in December 2021.
- Expanded Student Debt Relief 2022
  - Expanded in FY21 and continued for FY22 and FY23.
  - Awards $2,000 payment directly to student loan lenders for eligible employees to reduce student loan debt.
- Wage Increase provided a 5% raise for all salary schedules effective April 1, 2022
  - This included an early implementation of the planned FY23 3% increase plus an additional 2%
- Phase 1 External Wage and Compensation Study on hardest to fill positions- Master's Level Clinical Positions and Nursing. (Mental Health Therapist, Developmental Disabilities Clinicians, Vocational Clinicians, Behavioral Psychologists, and all Nursing positions)
  - This was completed April 1, 2022.
- Phase 2 External Wage and Compensation Study.
  - Positions surveyed included Client Services Specialists and Developmental Disability Specialists, Psychologist PHY Certified (AMHS), Occupational Therapist, Speech and Language Pathologist, Administrative Officers, Administrative Supervisors, Administrative Managers, Administrative Coordinators, HR Specialists, Payroll and Benefits Specialist, Systems Technician, Systems Engineer, Software Developer, Business Analysts
  - This was completed in September, 2022

Other Recruitment and Retention Efforts

- Added a Campus Liaison Position to Human Resources Specialist Staff to increase our presence and recruitment efforts on college campuses both in Michigan and other states. This resulted in doubling the number of student interns in 1 year from 25 students to 50 students. As a result of increasing internships we have hired 11 recent graduates in Spring 2023 to fill open positions.
- Diversity Advisory Council Initiatives-Ongoing. Here are some examples of recent initiatives:
  - 21 Day Challenge and Dialogue Sessions
  - Mentoring Program
  - Pronoun Training
  - Working on developing Employee Resource Groups and Book Clubs
- MSU Scholars Cohort planning launched in MSU Summer and Fall Semesters 2022
  - Sponsorship of a cohort of nine Bachelors level Clinical Staff in obtaining a Masters of Social Work Degree with agreement to work for 3 years post graduate.
  - In FY23 we will evaluate if we can start another cohort for FY24. If so, planning will begin in Fall 2023.
- Media Campaign-Completed spring-summer 2022
  - Human Resources and WILX TV joined forces in launching a campaign called "Work at CMHA-CEI and Make a Difference".

    - Comprised familiar faces of our current employees telling their story of working at CMHA-CEI.
    - Commercials, Digital Ads, and Billboards were featured.
    - These efforts drove additional traffic to our job site to view postings
- Resumption of Manager Adaptive Leadership Training and other Manager Training Supports
    - Adaptive Leadership Training for all new managers was held in June, 2022
    - Human Resources Manager Training Topics resumed in spring and summer.
    - Adaptive Design Training to be held in May 24-25, 2023
- Employee Referral Payment Opportunity Launched-August 2022
    - Initiated in August, any full or part-time CMHA-CEI employee who refers an individual to Human Resources for a Mental Health Therapist, Developmental Disabilities Clinician or Behavioral Psychologist to work in a full or part time position within a Clinical Program, may be eligible for up to a $2,000.00 referral fee.
- Promotion of federal and state tuition reimbursement or other workforce enhancement opportunities
    - Ongoing identification, promotion, or application for opportunities available to eligible staff working in public behavioral health settings from state and federal sources.

Community Mental Health of Ottawa County

One of the ways we are trying to close the behavioral health workforce gap in the West Michigan area is with a new certificate program for Direct Support Professions through Grand Rapids Community College. The long term goal of this program is to elevate the profession to be similar to a CNA with livable wages to go along with it. The development of the DSP Certificate Program was a collaborative effort between four of our larger residential providers in Ottawa County; MOKA, Heritage Homes, Benjamin's Hope, and Harbor House, CMHOC and GRCC. The program held its "pilot" session starting in the first of the year and registration for the ongoing program is happening now. The attached picture is of the first graduating class. For most of the graduates it was their first exposure to college level courses and you could see and hear the pride in their accomplishment. Such a cool thing and hopefully one of the successful ways that will help to attract more people to the field in the future. While developing the curriculum we were aware of the IMPART Alliance Train-the Trainer (T3) certificate program and we do not believe the GRCC certificate program and T3 conflict at all – just different avenues to achieve the same goal. Some people might want to go the route of a college certificate – some may not.

I've included the link to the program below.
https://learning.grcc.edu/eCS/CourseListing.aspx?master_id=2777&master_version&course_area=CEGH&course_number=216&course_subtitle=00&fbclid=IwAR0xY7ZuJLVQI-gid6crk8iDpnqj1Lfb4KNRaYjXqFw4jF1CvU1TQ5hoOyM

HealthWest

- **Retention Stipends**

  A $1,000 retention stipend will be paid to all staff who were employed on or after 10/1/2022 after six months of continued employment during the fiscal year. Payment to staff who were employed on 10/1/2022, will automatically be paid in April of 2023. Staff hired after 10/1/2022 will automatically be paid the month following their six-month anniversary date.
- **Youth Services and Corrections Services Masters Level Clinician Incentives**

A $1,000 retention stipend for Masters Level Clinicians who works in Youth Services and Corrections Services will automatically be paid quarterly for staff employed at the end of the quarter, for a maximum of two quarters.

- **Committee Chair and Co-Chair Incentives**
  Employees who volunteer for Chair and Co-Chair position on HealthWest Official Committees will be paid a $1,000 stipend upon completion of six months of service on the committee.
- **On-Call Incentive Stipends**
  Employees who work two or more on-call shifts in a quarter will receive a $300.00 bonus. This is tracked by payroll and will automatically be paid after the end of each quarter.
  - 1st Quarter –10/1/2022-12/31/2022 (Payment in January 2023)
  - 2nd Quarter –1/1/2023 –3/31/2023 (Payment in April 2023)
  - 3rd Quarter –4/1/2023–6/30/2023 (Payment in July of 2023)
  - 4th Quarter –7/1/2023 –9/30/2023 (Payment in October 2023)
- **Employee Referral Bonus**
  HealthWest offers a referral bonus for staff who refer individuals for HealthWest employment. Staff members who refer a candidate for employment will be given a $200 one-time payment upon hiring of that individual and another $200 payment if the individual successfully pass their probationary period
  Staff referrals can be identified by the new hire, but staff are also invited to submit an Employee Referral Form (below) to report who you referred to HealthWest and HR will track your referral for payment.
- **Credential Stipends**
  HealthWest will provide a $1,000 credential stipend to staff members who have or who earn credentials valuable to the organization, such as licensure and certifications. Staff are required to use the credential for one-year before payment will be made. Applications will be submitted to the Chief Executive Officer for approval prior to payment.
- **Assertive Community Treatment (ACT) Retention Stipends**
  Staff who are hired for the Assertive Community Treatment Program (ACT) between October 1, 2022, and September 30, 2023, will receive a $2000 sign-on bonus. In addition, for the Fiscal Year 2023, ACT staff will receive a $300 on-call incentive for each month they work at least four on-call shifts, a monthly retention bonus of $117.21 per month, paid after six months of work ($703.28 per six month period) and upon completion of ACT 101 and/or ACT 201 training.
- **CALM App**
  HealthWest is providing staff a Calm Premium Subscription, which includes access to hundreds of meditations, sleep stories, soundscapes, music and more. Whether you have 30 seconds or 30 minutes, Calm content is made to suit your schedule and needs.
- **Professional Development Dollars**
  All HealthWest staff have access to up to $300 per year for professional development and growth, including conferences, training, seminars, and other similar opportunities. These funds are available for any training, learning or development opportunity.
- **Education Assistance (Tuition Reimbursement)**
  All employees are eligible to receive reimbursement for qualified expenses if they complete college level courses with a grade of C or better, up to a maximum of $5,000 per calendar year. Eligible expenses include tuition, fees, books and supplies. Please see Policy 02-029, Education Assistance Policy. Employees are eligible for education assistance for courses they have started and completed during employment. Classes taken prior to employment start date are not eligible. Employees may be reimbursed only for eligible expenses that they personally pay out-of-pocket

and are not paid by financial aid, such as scholarships, grants and/or tuition forgiveness and discounts. Student Loans are not considered financial aid for purposes of this program.

Huron Behavioral Health

We have been supporting current bachelor's level staff to return to school to obtain their master's degree in social work by offering 3 hours of paid time per week as well as a flexible work schedule and the ability to complete their internships within our agency. They are able to do their internship in a master's level capacity/program within HBH. We have had numerous staff take advantage of this and graduate with their master's degree.

We also take a lot of interns and this has typically worked out very well for us as we have been able to hire them on post-graduation both bachelor's and master's level interns.

We now offer a $3,000 sign on bonus for any of our master's level positions to help incentivize and we have recently increased our pay scale for our master's level clinicians to get closer to being competitive with the local school as this is where we lose most of our master's level staff.

We also offer a hybrid work environment where staff are able to get permission to work from home some of the time as well as a flexible work schedule such as requesting to work 4 days per week, 10 hours each day. These are all with approval and oversight but this has been very popular.

LifeWays Community Mental Health

- Revamped the wage scale to ensure we align with other Michigan organizations.
- Created a career ladder by separating out clinician/therapist positions with clinician/therapist I, II, III positions which offer pay grade jump when full licensure is obtained, and then again when CAADC/CAADC + Full Licensure is obtained.
- Award a step increase when preferred education/certification/licensure is met.
- Created a "Provisional" clinical category on clinical positions such as therapist/clinician.
- Implemented an online Applicant Tracking System.
- Attend Job Fairs.
- Post sponsored Indeed Ads to reach a broader audience.
- Pay for other paid job boards.
- Provide free Licensure supervision.
- Broadened our posting sites.
- Host Interns.
- Offer Guest Lecturing to classes informing them of LifeWays.
- Implemented Vitality Academy - addressing educational gaps for brief solution-focused interventions.
- Implemented Licensing links - licensing exam prep courses in partnership with People & Culture (HR Dept).

Lincoln Behavioral Services

Has increased its efforts over the past few years to address the workforce shortage and attract and retain staff. LBS has increased the number of student placements and has increased the number of schools that we partner with across multiple disciplines (family medicine residents, RNs, social workers, counselors, psychiatric residents, PA and NP students and volunteers from local high schools). LBS has also applied for and participated in many loan forgiveness programs

(MI Kids Now, STAR, NHSC provider, qualification as a HPSA area). LBS shortened the work day to an 8 hour work day, with a 1 hour paid lunch, developed a program for staff to have 1 work from home day per pay period to focus on trainings and paperwork, has kept employee benefits cost low (with increasing rates, LBS did not require employees to increase their contribution), additional Holiday was added, formed an employee DEIB group, added an EAP at no cost to employees, opened an employee fitness and wellness center and provided raises and retention bonuses to staff.

Network180

For CLS have been giving an additional $2/hour above Direct Care Wage (Overall cost estimate of $5 million). Have given hiring bonuses to providers to attract MSWs into the system as well as retention bonuses (most recent did not include retention funds). Contract with Real Life Services for a "relief" pool that provides staff to fill in as needed (targets individuals who are at highest risk in an unlicensed setting). Rate increases to providers were not significant (cost-of-living). Have had providers with significant deficits and have provided funds to assisting with solvency. Brought ACT in house.

Onpoint

Providers were given an increase from 2 to 10 percent. Internal staffing – COLA retroactive to April, 2022. New hires are getting insurance on the day of hire and fully funding the HSA.

Saint Clair County Community Mental Health Services

All staff

- Emphasis on work-life balance with many hybrid/remote positions available
- 37.5 full-time work week
- Increase from 2 to 4 personal days per year available out of sick bank
- Retention payments given to staff in addition to cost-of-living adjustments yearly
- Tuition support for CMH nurses working toward becoming Nurse Practitioners
- 100% Tuition reimbursement for continuing education towards MSW
- Internship opportunities available, including evening hours and weekends
- Child care through Tri-share for income eligible staff
- Increase to 13 Paid Holidays per year
- Up to an 8% employer match on 457B

Clinician-based

- Hiring Bonus of $3500 ($1750 in first paycheck, and $1750 at completion of six month probation)
- Free CEU opportunities
- Free evidence based training
- Free on-site Clinical Supervision to support licensing requirements
- Increased vacation time to 17 days per year (Five days after six month probation, and twelve days at one-year anniversary)
- LLMSW positions start at 3 year level of the Union Salary Schedule, $66,668/year
- Fully licensed LMSW positions start at 3 year level of the Union Salary Schedule, $68,657/year

*We have diversified our recruiting efforts on Handshake, LinkedIn, Facebook, ZipRecruiter, and SC EDA Hot Jobs in addition to hiring new grads before they receive their limited license in

response to the MDHHS Bulletin Number MMP 23-02 issued on January 5, 2023 allowing us to do so.*

Tuscola Behavioral Health Systems

- We participate in various Thumb Community Health Partnership (TCHP) workgroups. Focus areas have been HR workforce planning/activities meetings and employer led collaborative meetings. Initiatives have focused on developing and increasing our workforce; such as, offering nursing and social work apprenticeships (to keep individuals in the thumb area) and another objective is to increase educational opportunities related to health and human services for the thumb. There are events where guest speakers talk with 9th and 10th graders at high schools and technology centers in the thumb to focus on youth pursuing careers in behavioral health. We also speak with students on campus and have been developing those partnerships with universities and colleges about our needs. Increase the number of internships and job shadow opportunities so we are able to develop those relationships with schools and universities in order to TCHP is addressing how individuals could complete degrees in this area since community colleges have closed and travel/distance being a barrier. d increasing the number of internships and job shadow opportunities so we are able to develop those relationships with schools and universities in order to build the pipeline.
- Offering opportunities for employee development, training and conferences.
- Our pension program has waived the hours requirement for retirees through 2027 to help with the workforce shortage.
- Numerous recruitment and retention strategies have been implemented to recruit, invest and retain our current workforce as we struggle to find skilled/qualified workers.

West Michigan Community Mental Health System

- Implement a FY-long strategic goal focus that is focused on workplace experience …. Building a culture where all team members are energized, engaged, and equipped to do their best work for the people we serve. There are a number of projects and deliverables tied to this strategic goal focus.
- Pilot alternative work schedules for staff which also meet consumer and organizational needs.
- Allow a hybrid work schedule for those staff positions where that makes sense to meet consumer and organizational needs.
- Utilize MDHHS ARPA grant dollars to support staff recruitment and retention – most recently we've applied for and received dollars specific to recruiting and retaining ACT and Crisis staff.
- Enhance organizational communication -- lean huddles, monthly newsletters, every 2-week all-team meetings.
- Implement the CE-CERT supervision model (to better support all staff) with appropriate supervisory staff.
- Enhance our new hire orientation process.
- Encourage and support professional development of all staff.
- Ensure our workplace is welcoming to all – enhance our DEI work.
- Increase our staff referral bonus and staff tuition reimbursement.
- Focus on leadership development (continued work with our leadership consultant).
- Flexible (as appropriate) about the credentials required to fill vacant positions.
- Enhance employee engagement activities – all staff picnic, themed casual Fridays, logo wear availability, face-to-face team building activities, holiday party, Cheers for Peers, etc.
- Expand our staff recruitment efforts (i.e., internship opportunities, job fairs, university fairs, radio ads, social media campaigns, etc.)

- Participate in NHSC and other loan forgiveness programs, daycare repayment options, etc.
- Complete market study to ensure appropriate placement of positions on pay grades and ensure economic wage increases align better with COLA, pricing index and inflation rates.
- Include staff retention payments as option in compensation package.
- Ensure market-competitive benefits (i.e., health insurance, HSA, dental, vision, FSA, etc.)
- Add “wellness day” to staff PTO bank.
- Add additional holiday to staff paid holidays.
- Implement lean principles across the organization to support improved communication, efficiency, and effectiveness and reduce waste/duplication, etc.

Community Mental Health Association of Michigan

Proposal for rural-oriented public mental health policies and practices in Michigan

May 2023

Summary

This paper identifies the need for a concerted and permanent set of actions to ensure that policies and practices, binding upon and used by the state's public mental health system, are flexible enough to ensure that the needs of Michigan's rural and frontier communities and regions are met.

Background

Michigan's communities are extremely diverse along a number of dimensions. One of those dimensions – the theme of this paper - centers around the diversity across Michigan's urban (large and small), suburban, rural, and frontier communities. The rural vs urban diversity (simplified to this two-segment framework for ease in communication and analysis) is reflected in the very different strengths, cultures, approaches, relationships, and challenges of these community types.

Understanding this rural vs urban diversity is key when designing and implementing policies that guide and practices that are used by the state's public mental health system. [1]

Failing to reflect, in policy and practice, the unique qualities (strengths, cultures, approaches, relationships, and challenges) of Michigan's rural and frontier communities and regions, and the public mental health system serving them, results in ineffective or inefficient (or, at times, impossible to meet) mandates and approaches to serving the mental health needs of these communities and regions.

Central to efforts to meet the needs of rural communities is the recognition that approaches to meet the needs of rural communities cannot be simply rural derivatives from urban models. Rather, the approaches to meet the needs of rural communities must be developed by those living and working in those communities and reflect the unique qualities (strengths, cultures, approaches, relationships, and challenges) of Michigan's rural and frontier communities and regions, and the public mental health system serving them.

Aims of this initiative

1. To ensure that state statutes, policies, and practices meet the unique qualities (strengths, cultures, approaches, relationships, and challenges) of Michigan's rural and frontier communities and regions, and the public mental health system serving them.

2. To develop and implement a set of dialogue, information-sharing, and input/influence venues and methods to ensure that state statutes, policies, and practices meet the unique qualities (strengths, cultures, approaches, relationships, and challenges) of Michigan's rural and frontier communities and regions, and the public mental health system serving them.

[1] The terms "mental health" and "behavioral health" are used interchangeably in this paper and refer (for simplicity in communication) to a system that serves the need of persons with mental health illness, children and adolescents with emotional disturbance, persons with intellectual/developmental disabilities, and/or persons with substance use disorders.

Issues unique, in kind or degree, to rural and frontier communities and mental health organizations who serve them and recommendations to address them.

A. Lack of rural/frontier-specific guidance in policy and practice development and adoption: Needed is a venue or method, supported by MDHHS, to obtain the views and guidance of behavioral health leaders from rural and frontier communities on a range of topics:

Recommended action:

1. MDHHS to form a **Rural/Frontier Advisory Group** to review and provide to guidance on MDHHS proposed evidence-based or promising practices, proposed policies, and other initiatives.

2. Require that Medicaid policies and waivers, all behavioral health policies, and MDHHS contract (CMHSP and PIHP) proposals be reviewed by the Rural/Frontier Advisory Group, and comments from this group received, prior to the public comment period and prior to promulgation of the final policy.

3. **Require that the Office of Rural Development** within the Michigan Department of Agriculture and Rural Development seek the views of the Rural/Frontier Advisory Group in efforts to foster rural development.

4. MDHHS to form an **Office of Rural Health Affairs** to ensure a rural/frontier perspective on a range of health care issues, policies, and practices, including behavioral health.

B. Behavioral health workforce shortage: Rural CMHs, PIHPs, and providers have long experienced uniquely high vacancy and turnover rates. It is key to note that this workforce has existed long before the recent pandemic.

Recommended:

1. Develop a **student stipend program** available to persons while they are enrolled graduate degrees in clinical disciplines needed by rural/frontier CMHs and providers in the networks of these CMHs, in exchange for the person's commitment to work at the CMH and/or provider in the CMH network for a number of years.

2. Provide funding, to rural/frontier CMHs and the providers in their networks, to provide **signing bonuses** to attract staff.

C. Lack of MDHHS-endorsed rural/frontier centered or tailored clinical models: Too often clinical models are based on serving communities with moderate to high population density, with public transportation, and with urban/suburban cultural views of behavioral health.

Recommended action:

1. MDHHS, with guidance from rural/frontier mental health leaders, to **revise the following** to ensure flexibility in the clinical models allowed and/or required to carry out the clinical/service delivery purposes of the modalities listed above (and others), to allow for the tailoring of these service delivery/clinical models to meet the needs of rural/frontier communities:

- Michigan Medicaid Provider Manual

- Michigan's Medicaid State Plan and relevant Medicaid waivers
- MDHHS-CMHSP and MDHHS-PIHP contracts

2. MDHHS, in partnership with **rural/frontier persons served and mental health leaders** and the **Rural/Frontier Advisory Group**, develop, identify, and endorse **evidence based and promising practices designed around rural/frontier needs**.

3. MDHHS, in partnership with rural/frontier persons served and mental health leaders, to **tailor to meet the needs of rural and frontier communities, a range of mental health clinical models, designed for urban/suburban communities**, Examples include:

- ACT teams
- Psychosocial Rehabilitation units (clubhouses)
- Consumer-run drop in centers
- Mobile crisis teams
- Crisis Stabilization Units
- Adult and Children's Crisis Residential Settings

Proposed approach, by CMHA, to further the development and implementation of these methods

1. Form a Rural and Frontier Caucus, within CMHA, to:
   - Further refine this document and its purpose
   - Serve to continually identify and make recommendations to address rural issues.
   - Provide regular updates to the CMHA Board of Directors

2. Submit to and discuss with the leadership of MDHHS, the recommendations in this document

3. Ally with other health and human services providers serving rural and frontier communities and regions in Michigan to advocate for the adoption of these recommendations by MDHHS. Potential allies include:

Local allies:
   - Local Sheriffs
   - Local courts
   - Local DNR offices
   - Local EMS offices
   - Community foundations
   - UPCAP

State association allies:
   - Michigan Association of Counties and local counties
   - Four major statewide advocacy groups (NAMI, Arc, MHAM, ACMH)
   - Michigan Health and Hospital Association and its staff working to support the work of Critical Care Hospitals (rural hospitals)
   - Michigan Center for Rural Health at Michigan State University
   - Michigan Sheriffs Association
   - Rural Health Equity Group

4. Identify and enlist the support of Michigan legislators representing rural and frontier communities in the advocacy effort around the adoption of these recommendations by MDHHS

email correspondence

From:	Robert Sheehan
To:	Megan Rooney; dan mckinney (dmckinney@hbhcmh.org); Diane Pelts (AV); Nena Sork (NEM); Chip Johnston (CWN); Eric Kurtz (NMRE); Matt Maskart
Cc:	Alan Bolter
Subject:	CMHA Board approves Rural caucus recommendations
Date:	Friday, June 16, 2023 12:32:33 PM
Attachments:	image001.png Proposal for rural-centered public mental health policies & practices - 5.23.pdf

Initial group of rural members of CMHA Rural Caucus,

As you may know, the CMHA Board of Directors, during its meeting last week, unanimously approved the action steps recommended by this group. That set of recommendations is attached.

I want to express our appreciation for your work on this issue. Your thinking clearly resonated with the full CMHA Board.

PROPOSED NEXT STEPS: **By Friday, June 23**, please review the draft list of next steps, below, and let us know of any changes you want in this game plan.

1. CMHA sends the approved set of recommendations, attached, to all of the state's CMHSPs and PIHPs.
2. Invite, to a meeting, all of the CMHSPs and PIHPs that serve rural communities and regions.
   We could really use your guidance here: Should we invite all of the state's CMHSPs and PIHPs, allowing them to self-select as to whether they serve rural or frontier communities or should we invite those CMHSPs and PIHPs that CMHA sees as serving rural or frontier communities?
3. At this meeting, we would:
   A. CMHA (with all/any of you adding to the discussion/explanation) would walk through these recommendations so that all are aware of these recommendations, their purpose, and the context of this project – especially in light of the fact that only this small group of us are familiar with this document.
   B. Determine, jointly with the participants in this meeting, which recommendations/steps should be pursued first.
   C. Determine if a regular meeting schedule for this group, to keep the pursuit of these recommendations on track.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
507 South Grand Avenue
Lansing, MI 48933
(Note new address)
517.374.6848 main
517.237.3142 direct

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

June 1, 2023

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

Dear Mr. Kurtz:

Thank you for the documents submitted via email on May 25, 2023, and revised documents submitted today, June 1, 2023, requesting approval for Adult Crisis Residential Services in your region. Staff of the Behavioral and Physical Health and Aging Services Administration, Community Practices and Service Innovations Section has reviewed your request in relationship to the requirements in the Medicaid Provider Manual.

Based on the description of the programs, they appear to meet the necessary criteria outlined in the Medicaid Provider Manual and you are approved to provide Adult Crisis Residential Services as of June 1, 2023. This approval is for the following site:

North Hope Crisis
844 Indian Trail Blvd.
Traverse City, MI 49686

Sincerely,

Jeffery L. Wieferich MA, LLP
Director
Bureau of Specialty Behavioral Health Services
Behavioral and Physical Health and Aging Services Administration

c: Deb Mock
Brian Martinus
Belinda Hawks
Brenda Stoneburner
Jackie Wood

https://upnorthlive.com/news/local/for-those-struggling-with-their-mental-health-hope-is-here

For those struggling with their mental health, Hope is here

by Marc Schollett

Wed, June 21st 2023, 7:01 PM EDT

For those struggling with their mental health, Hope is here (UpNorthLive News)

GRAND TRAVERSE COUNTY, Mich., (WPBN/WGTU) -- After years of talk about the need and possible solutions, there's some action to address a mental health treatment need in northern Michigan.

And on Wednesday, there's a new $5 million commitment to care.

"This is the first one in Traverse City, it opened June 14," said Brain Martinus, the interim CEO of Northern Lakes Community Mental Health.

And not a day too soon according to Brian Martinus, with Northern Lakes Community Mental Health.

"One of the distinct needs within northern Michigan is the placement of people that need psychiatric inpatient," Martinus said.

To most people, North Hope is just a red house tucked into a Traverse City neighborhood.

To Northern Lakes, it's partner **Hope Network** and to patients, it's so much more.

"We're able to give them the care that they need," Martinus said.

6 beds inside for patients 21 and older to get the urgent care they need.

"Mental health services, decompression if they're having anxiety, suicidal ideation, they get stabilized, and they get help," Martinus said.

But the benefit of having a place like this now, may not be limited to the patient.

"It gives us an option not to put them in the ER at Munson," Martinus said.

Which reduces the strain on the ER for everyone.

This is up and running today. But Northern Lakes, Munson, and mental health advocates are looking farther down the road and even larger in scale.

"Many of you know access to behavioral health services has always been an issue, but the impacts of the pandemic over the last 3 years have really exacerbated that issue," said Laura Glenn, the chief operating officer at Munson Healthcare.

Grand Traverse County Commissioners voted unanimously to authorize Northern Lakes, Munson and community partners to spend $5 million in ARPA funds to launch the development of the Grand Traverse Center for Mental Wellness to be housed in this building on Munson’s campus – mental health, substance abuse disorder, and crisis services.

"This is not one organization alone who's going to make this happen, it really is going to require us coming together to achieve our vision," Glenn said. "And we are fully committed to seeing this through."

Steps, smaller and bigger to address a challenge.

Steps, not a solution.

"I wouldn't say problem solved. I would say this is just a steppingstone, because there is a vast need within the community," Martinus said.

While the Northern Hope Home is up and running right now, much work still needs to be done before the facility with Munson will be. There's a goal to have it operational by the end of 2024.

Nomination Narrative for Hal Madden Award

June 21, 2023

The Northern Region (AV, CW, NC, NE, NL), PIHP 2, would like to nominate Joe Stone for the Hal Madden award. Joe has worked tirelessly for more than 25 years within the CMH system. He has taken on various roles of leadership on the local, regional and State levels and has been a champion for the public behavioral health system in Michigan.

Joe was officially appointed to the AuSable Valley Community Mental Health Authority Board in March of 1999. He became Chair of the Building Committee in May of the same year, bringing his expertise from his full-time job as the Building Official in Montmorency County. When Joe came to AuSable Valley CMHA in 1999, the Agency's budget at that time was $9,695,377. When Joe retired in August of 2022, 23 years later, and left the AV Board, the budget had increased to $27,013,833! In April of 2006, Joe was elected as Vice-Chair of the AV Board and in April of 2012, he became Board Chair. AV has only had three Executive Directors, and Joe has worked with all three and has certainly seen a lot of change! Over the years, Joe has served on the Executive and Finance Committee, Recipient Rights Advisory and Appeals Committees, Building (now known as Facilities) Committee, Personnel (now known as Human Resources) Committee, and Program Committee at AuSable Valley. Joe was on the NMRE Board since it started meeting to prepare for the AFP in April 2013. He was the first Chair of the Northern Michigan Regional Entity Board, serving a three-year term from 2014-2017, and then remained a member until August 2022.

Currently, Joe serves as Past President of the CMHAM Board of Directors. He served as President from 2017-2022, and Vice President from 2015-2017. Joe was also appointed to the Lt. Governor's workgroup on boilerplate language for Section 298.

Joe was an Oscoda County Commissioner for 14 years and the Chairman for 12 years. During that time, he served on many Boards and Committees, including District Health, Road Commission, Planning and Zoning, and Emergency Management. Joe has been a very active member of the Community helping on many community betterment projects. He was instrumental in helping to start Lydia's Gate, a woman's homeless shelter in Oscoda County, and assisting with the building of a new facility for His Love Family Resources, a Pregnancy Resource Center. Joe graduated from the Flint Police Academy and became a Sheriff's Deputy. He retired as the Building Official for Montmorency County in late 2022.

Beyond being a very successful Board Member and community contributor, Joe was an equally successful high school football Coach (25 years). He took over a struggling program, never had a losing season in his tenure, and played in a State Championship Game. Joe also is an avid hunter and fisherman. To say that Joe's community reach and effect have been profound would be a significant understatement.

When Joe was President of the Community Mental Health Association, he was quoted as saying: “It’s so enlightening to see the dedicated, professional, hard-working people we have in our system. I hope to be able to lead us into our next challenges, which seem to change day by day. I believe we need to be quick to adapt to the changes before us; things are moving so fast in the Mental Health field that the ones dragging their feet are going to be left behind. We cannot fail; our Consumers depend on us to be the champions for them. I hope I can use my experience to help lead our association into the next phase of this transition.” Personally, from my time with Joe as my Board Chair at AuSable Valley, that was a continual theme for him…what more can we do for our consumers?

In summary, I don’t think the word retirement is actually in Joe’s vocabulary! Not soon after Joe left northern Michigan to relocate to the west side of the state, he was appointed as a Board Member for Network 180 where we know he will continue to make a difference, just like he has up until now.

NMRE Board Member Terms

Terms are for 3 years

CMHSP	Board Member	Appointment Date	Renewal Date
AuSable Valley	Gary Klacking	Reappointed 3/29/19	3/28/22
	Jay O'Farrell	Reappointed 3/24/20	3/23/23
	Chuck Varner	Appointed 9/1/22	9/30/25
Centra Wellness	Richard Schmidt	Appointed 4/23/13	
	Don Smeltzer	Appointed 5/14/20	5/13/23
	Don Tanner	Appointed 4/23/13	
North Country	Ed Ginop	Reappointed 4/20/23	4/19/26
	Michael Newman	Appointed 1/30/23	1/29/26
	Karla Sherman	Reappointed 4/20/23	4/19/26
Northeast Michigan	Terry Larson	Reappointed 4/14/22	4/13/25
	Eric Lawson	Appointed 9/8/22	9/7/25
	Gary Nowak	Reappointed 3/9/23	3/8/26
Northern Lakes	Tom Bratton	Appointed 5/18/23	5/17/26
	Greg McMorrow	Appointed 5/18/23	5/17/26
	Ruth Pilon	Appointed 5/18/23	5/17/26

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – JUNE 14, 2023
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Connie Cadarette, Lauri Fischer, Ann Friend, Chip Johnston, Nancy Kearly, Eric Kurtz, Allison Nicholson, Brandon Rhue, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

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

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE MAY 10, 2023 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY LAURI FISCHER. MOTION APPROVED.

MONTHLY FINANCIALS
April 2023

- Net Position showed net surplus Medicaid and HMP of $5,332,150. Budget stabilization was reported as $16,369,542. The total Medicaid and HMP Current Year Surplus was reported as $21,701,692. Medicaid and HMP combined ISF was reported as $16,369,542; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $38,071,234.
- Traditional Medicaid showed $115,760,019 in revenue, and $112,701,515 in expenses, resulting in a net surplus of $3,058,504. Medicaid ISF was reported as $9,306,578 based on the current FSR. Medicaid Savings was reported as $7,742,649.
- Healthy Michigan Plan showed $20,757,795 in revenue, and $18,484,149 in expenses, resulting in a net surplus of $2,273,646. HMP ISF was reported as $7,062,964 based on the current FSR. HMP savings was reported as $8,626,893.
- Health Home showed $1,297,430 in revenue, and $1,118,296 in expenses, resulting in a net surplus of $179,134.
- SUD showed all funding source revenue of $17,249,548, and $15,106,237 in expenses, resulting in a net surplus of $2,143,311. Total PA2 funds were reported as $5,227,061.

Deanna noted that the net surplus continues to grow. A lapse is expected for FY23. The 5-month recoupment process will reduce the Health Home surplus. The revised rates for May – September reduced monthly revenue by $116K ($580K total).

MOTION BY LAURI FISCHER TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR APRIL 2023; SUPPORT BY ANN FRIEND. MOTION APPROVED.

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

FSR
Deanna indicated that the NMRE is nearing the end of the Compliance Audit. During a recent FSR meeting with the State, it was announced that an Interim FSR will be due August 15th.

EQI UPDATE
The May 11th EQI Workgroup minutes were included in the meeting materials. The next EQI is due September 30th for October 2022 through May 2023.

HSW OPEN SLOTS
Deanna reported that there are over 30 open slots in the region. Each slot is equivalent to $5,000 in monthly revenue. Deanna referenced the "Regional Revenue Trending" page of the April Financial report which shows that HAB revenue has dipped in FY23.

MID-YEAR REPORT
The mid-year report was submitted by the May 31st due date. Two Boards provided actual numbers; data was trended through FY23 for the other three Boards.

FY24 BUDGET
Deanna reiterated the $580K loss in revenue for May – September. Eligibles and revenue are expected to drop due to Medicaid redeterminations, but the full effect may not be known until FY24.

Lauri noted that the 1010 report can be used to target reenrollment. Brandon added that the NMRE IT team is working on utilizing the formula to project future months. The entire population should be available by redetermination month. All the Boards are using similar processes to get individuals reenrolled.

Lauri asked whether any of the Boards are seeing a significant swing in insurance coverage in their PCE systems the past month from HMP to Medicaid. She is expecting a 1.2% swing from Medicaid to HMP which amounts to approximately $600K. None of the other Boards reported similar findings.

Lauri asked whether any of the other Boards are increasing contract rates for CLS beginning October 1st. Erin responded that AuSable Valley is evaluating increases on a case-by-case basis. Connie noted that the same is true for Northeast Michigan. The decision was made to discuss this topic further during the July meeting.

Clarification was made that the DCW is currently embedded in the rates and cost settled. Bob Sheehan spoke about a potential additional increase ($0.65 - $1.50) during the Improving Outcomes conference in May; this is making its way through the legislature.

NEXT MEETING
The next meeting was scheduled for July 12th at 10:00AM.

Chief Executive Officer Report

June 2023

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

May 18: Attended and participated in OIG Draft Referral Process.

May 22: Attended and participated in Rural Development Meeting.

May 23: Attended and participated in CMHAM Advocate Meeting.

May 25: Attended and participated in PIHP Rate Setting Meeting.

May 26: Attended and participated in PIHP Contract Negotiations Meeting.

May 26: Attended and participated in Rural Mental Health Caucus.

May 30: Attended and participated in NLCMHA Internal Crisis Center Meeting.

May 31: Attended and participated in GT County Crisis Services Meeting.

June 1: Attended and participated in MDHHS/PIHP CEO Meeting.

June 1: Attended and participated in Regional Business Intelligence Meeting.

June 2: Attended MDHHS meeting regarding NMRE contract issues.

June 2: Attended MDHHS meeting regarding NMRE contract issues related to NLCMHA.

June 5: Attended and participated in North Country Stepping Up Strategy.

June 14: Attended and participated in Regional Finance Committee Meeting.

June 14: Chaired NMRE Internal Operations Committee Meeting.

June 19: Attended and participated in NMRE all staff Red Book Training (Thanks Chip).

June 20: Chaired NMRE Regional Operations Committee Meeting.

June 23: Plan to attend PIHP Contract Negotiations Meeting.

April 2023 Finance Report

April 2023 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	3,058,504	7,742,649	9,306,578
Healthy Michigan	2,273,646	8,626,893	7,062,964
	$ 5,332,150	$ 16,369,542	$ 16,369,542

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	809,366	1,859,634	(704,185)	1,970,201	(233,626)	1,858,755	(227,996)	$ 5,332,150
Budget Stabilization Full Year		1,878,908	4,919,342	4,095,691	2,272,462	1,955,236	1,247,903	16,369,542
Total Med/HMP Current Year Surplus	809,366	3,738,542	4,215,157	6,065,892	2,038,836	3,813,991	1,019,907	$ 21,701,692
Medicaid & HMP Internal Service Fund								16,369,542
Total Medicaid & HMP Net Surplus								$ 38,071,234

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2022 through April 30, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 111,800,894	$ 3,698,844						$ 115,499,738
CMHSP Distributions	(107,565,085)		35,178,332	29,608,132	18,190,775	15,189,503	9,398,344	-
1st/3rd Party receipts			260,281	-	-	-	-	260,281
Net revenue	4,235,809	3,698,844	35,438,613	29,608,132	18,190,775	15,189,503	9,398,344	115,760,019
Expense								
PIHP Admin	1,412,030	37,527						1,449,557
PIHP SUD Admin		46,480						46,480
SUD Access Center		26,493						26,493
Insurance Provider Assessment	999,355	24,035						1,023,390
Hospital Rate Adjuster	1,078,000							1,078,000
Services		2,823,853	35,712,106	28,417,945	18,834,059	13,636,233	9,653,399	109,077,595
Total expense	3,489,385	2,958,388	35,712,106	28,417,945	18,834,059	13,636,233	9,653,399	112,701,515
Net Actual Surplus (Deficit)	$ 746,424	$ 740,456	$ (273,493)	$ 1,190,187	$ (643,284)	$ 1,553,270	$ (255,055)	$ 3,058,504

Notes

Medicaid ISF - $9,306,578 - based on current FSR

Medicaid Savings - $7,742,649

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2022 through April 30, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 13,124,379	$ 7,633,416						$ 20,757,795
CMHSP Distributions	(11,883,080)		4,324,041	3,600,055	1,476,785	1,491,624	990,575	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	1,241,299	7,633,416	4,324,041	3,600,055	1,476,785	1,491,624	990,575	20,757,795
Expense								
PIHP Admin	143,411	82,600						226,011
PIHP SUD Admin		102,307						102,307
SUD Access Center		58,314						58,314
Insurance Provider Assessment	94,313	55,459						149,772
Hospital Rate Adjuster	940,632							940,632
Services		6,215,558	4,754,734	2,820,040	1,067,126	1,186,139	963,516	17,007,113
Total expense	1,178,356	6,514,238	4,754,734	2,820,040	1,067,126	1,186,139	963,516	18,484,149
Net Surplus (Deficit)	$ 62,943	$ 1,119,178	$ (430,693)	$ 780,015	$ 409,659	$ 305,485	$ 27,059	$ 2,273,646

Notes
HMP ISF - $7,062,964 - based on current FSR
HMP Savings - $8,626,893

Net Surplus (Deficit) MA/HMP	**$ 809,366**	**$ 1,859,634**	**$ (704,185)**	**$ 1,970,201**	**$ (233,626)**	**$ 1,858,755**	**$ (227,996)**	**$ 5,332,150**
Medicaid Carry Forward								**16,369,542**
Total Med/HMP Current Year Surplus								$ 21,701,692
Medicaid & HMP ISF - based on current FSR								**16,369,542**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 38,071,234**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2022 through April 30, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 263,823		375,538	185,312	63,526	97,921	311,310	$ 1,297,430
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	263,823	-	375,538	185,312	63,526	97,921	311,310	1,297,430
Expense								
PIHP Admin	14,365							14,365
BHH Admin	22,943							22,943
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	47,381		375,538	185,312	63,526	97,921	311,310	1,080,988
Total expense	84,689	-	375,538	185,312	63,526	97,921	311,310	1,118,296
Net Surplus (Deficit)	$ 179,134	$ -	$ -	$ -	$ -	$ -	$ -	$ 179,134

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2022 through April 30, 2023

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 3,698,844	$ 7,633,416	$ 2,521,472	$ 2,400,412	$ 995,404	$ 17,249,548
Expense						
Administration	84,007	184,907	62,639	154,458		486,011
OHH Admin			69,580	-		69,580
Access Center	26,493	58,314	-	14,491		99,298
Insurance Provider Assessment	24,035	55,459	-			79,494
Services:						
Treatment	2,823,853	6,215,558	2,105,576	1,544,582	995,404	13,684,973
Prevention	-	-	-	622,318	-	622,318
ARPA Grant	-	-	-	64,563	-	64,563
Total expense	2,958,388	6,514,238	2,237,795	2,400,412	995,404	15,106,237
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 740,456	$ 1,119,178	$ 283,677	$ (0)	$ -	$ 2,143,311

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2022 through April 30, 2023

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 111,800,894	$ 3,698,844	$ -	$ 115,499,738
Medicaid Savings	7,742,649	-	-	7,742,649
Healthy Michigan	13,124,379	7,633,416	-	20,757,795
Healthy Michigan Savings	8,626,893	-	-	8,626,893
Health Home	1,297,430	-	-	1,297,430
Opioid Health Home	-	2,521,472	-	2,521,472
Substance Use Disorder Block Grant	-	2,400,412	-	2,400,412
Public Act 2 (Liquor tax)	-	995,403	-	995,403
Affiliate local drawdown	297,408	-	-	297,408
Performance Incentive Bonus	626,931	-	-	626,931
Miscellanous Grant Revenue	-	2,668	-	2,668
Veteran Navigator Grant	58,068	-	-	58,068
SOR Grant Revenue	-	921,225	-	921,225
Gambling Grant Revenue	-	25,864	-	25,864
Other Revenue	960	-	4,675	5,635
Total operating revenue	143,575,612	18,199,304	4,675	161,779,591
Operating expenses				
General Administration	1,760,132	394,984	-	2,155,116
Prevention Administration	-	67,443	-	67,443
OHH Administration	-	69,580	-	69,580
BHH Administration	22,943	-	-	22,943
Insurance Provider Assessment	1,093,668	79,494	-	1,173,162
Hospital Rate Adjuster	2,018,632	-	-	2,018,632
Payments to Affiliates:				
Medicaid Services	105,838,333	2,823,853	-	108,662,186
Healthy Michigan Services	10,766,991	6,215,558	-	16,982,549
Health Home Services	1,080,988	-	-	1,080,988
Opioid Health Home Services	-	2,105,576	-	2,105,576
Community Grant	-	1,544,582	-	1,544,582
Prevention	-	554,875	-	554,875
State Disability Assistance	-	-	-	-
ARPA Grant	-	64,563	-	64,563
Public Act 2 (Liquor tax)	-	995,404	-	995,404
Local PBIP	2,184,506	-	-	2,184,506
Local Match Drawdown	297,408	-	-	297,408
Miscellanous Grant	-	2,668	-	2,668
Veteran Navigator Grant	58,068	-	-	58,068
SOR Grant Expenses	-	921,225	-	921,225
Gambling Grant Expenses	-	25,864	-	25,864
Total operating expenses	125,121,669	15,865,669	-	140,987,338
CY Unspent funds	18,453,943	2,333,635	4,675	20,792,253
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,602,594	5,413,045	16,369,542	24,385,181
Unspent funds - ending	$ 21,056,537	$ 7,746,680	$ 16,374,217	$ 45,177,434

Northern Michigan Regional Entity

Statement of Net Position

April 30, 2023

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 45,773,399	$ 6,378,632	$ 16,374,217	$ 68,526,248
Accounts Receivable	18,750,074	2,986,867	-	21,736,941
Prepaids	65,928	-	-	65,928
Total current assets	64,589,401	9,365,499	16,374,217	90,329,117
Noncurrent Assets				
Capital assets	125,002	-	-	125,002
Total Assets	64,714,403	9,365,499	16,374,217	90,454,119
Liabilities				
Current liabilities				
Accounts payable	43,465,942	1,618,819	-	45,084,761
Accrued liabilities	191,924	-	-	191,924
Unearned revenue	-	-	-	-
Total current liabilities	43,657,866	1,618,819	-	45,276,685
Unspent funds	$ 21,056,537	$ 7,746,680	$ 16,374,217	$ 45,177,434

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2022 through April 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 109,522,413	$ 111,800,894	$ 2,278,481	2.08%
Carryover	11,400,000	11,400,000	7,742,649	(3,657,351)	(0)
Healthy Michigan					
Capitation	19,683,372	11,481,967	13,124,379	1,642,412	14.30%
Carryover	5,100,000	5,100,000	8,626,893	3,526,893	69.15%
Health Home	1,451,268	846,573	1,297,430	450,857	53.26%
Affiliate local drawdown	594,816	297,408	297,408	-	0.00%
Performance Bonus Incentive	1,334,531	1,334,531	626,931	(707,600)	(53.02%)
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	64,169	58,068	(6,101)	(9.51%)
Other Revenue	-	-	960	960	0.00%
Total operating revenue	227,426,695	140,047,061	143,575,612	3,528,551	2.52%
Operating expenses					
General Administration	3,591,836	2,077,066	1,760,132	316,934	15.26%
BHH Administration	-	-	22,943	(22,943)	0.00%
Insurance Provider Assessment	1,897,524	1,106,889	1,093,668	13,221	1.19%
Hospital Rate Adjuster	4,571,328	2,666,608	2,018,632	647,976	24.30%
Local PBIP	1,737,753	-	2,184,506	(2,184,506)	0.00%
Local Match Drawdown	594,816	297,408	297,408	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	53,501	58,068	(4,567)	(8.54%)
Payments to Affiliates:					
Medicaid Services	176,618,616	103,027,526	105,838,333	(2,810,807)	(2.73%)
Healthy Michigan Services	17,639,940	10,289,965	10,766,991	(477,026)	(4.64%)
Health Home Services	1,415,196	825,531	1,080,988	(255,457)	(30.94%)
Total operating expenses	208,177,013	120,344,494	125,121,669	(4,777,175)	(3.97%)
CY Unspent funds	$ 19,249,682	$ 19,702,567	18,453,943	$ (1,248,624)	
Transfers in			-		
Transfers out			-	125,121,669	
Unspent funds - beginning			2,602,594		
Unspent funds - ending			$ 21,056,537	18,453,943	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2022 through April 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 2,729,202	$ 3,698,844	$ 969,642	35.53%
Healthy Michigan	11,196,408	6,531,238	7,633,416	1,102,178	16.88%
Substance Use Disorder Block Grant	6,467,905	3,772,943	2,400,412	(1,372,531)	(36.38%)
Opioid Health Home	3,419,928	1,994,958	2,521,472	526,514	26.39%
Public Act 2 (Liquor tax)	1,533,979	511,326	995,403	484,077	94.67%
Miscellanous Grants	4,000	2,333	2,668	335	14.34%
SOR Grant	2,043,984	1,192,324	921,225	(271,099)	(22.74%)
Gambling Prevention Grant	200,000	116,667	25,864	(90,803)	(77.83%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	16,850,991	18,199,304	1,348,313	8.00%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	596,505	394,984	201,521	33.78%
Prevention Administration	118,428	69,083	67,443	1,640	2.37%
Insurance Provider Assessment	113,604	66,269	79,494	(13,225)	(19.96%)
Medicaid Services	3,931,560	2,293,410	2,823,853	(530,443)	(23.13%)
Healthy Michigan Services	10,226,004	5,965,169	6,215,558	(250,389)	(4.20%)
Community Grant	2,074,248	1,209,978	1,544,582	(334,604)	(27.65%)
Prevention	634,056	369,866	554,875	(185,009)	(50.02%)
State Disability Assistance	95,215	55,545	-	55,545	100.00%
ARPA Grant	-	-	64,563	(64,563)	0.00%
Opioid Health Home Admin	-	-	69,580	(69,580)	0.00%
Opioid Health Home Services	3,165,000	1,846,250	2,105,576	(259,326)	(14.05%)
Miscellanous Grants	4,000	2,333	2,668	(335)	(14.34%)
SOR Grant	2,043,984	1,192,324	921,225	271,099	22.74%
Gambling Prevention	200,000	116,667	25,864	90,803	77.83%
PA2	1,533,978	511,326	995,404	(484,078)	(94.67%)
Total operating expenses	25,222,653	14,294,725	15,865,669	(1,570,944)	(10.99%)
CY Unspent funds	$ 4,322,183	$ 2,556,266	2,333,635	$ (222,631)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			5,413,045		
Unspent funds - ending			$ 7,746,680		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2022 through April 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 1,121,057	$ 970,897	$ 150,160	13.39%
Fringes	666,212	369,614	333,315	36,299	9.82%
Contractual	683,308	398,601	266,502	132,099	33.14%
Board expenses	18,000	10,500	9,050	1,450	13.81%
Day of recovery	14,000	9,000	1,192	7,808	86.76%
Facilities	152,700	89,075	81,557	7,518	8.44%
Other	135,804	79,219	97,619	(18,400)	(23.23%)
Total General Admin	$ 3,591,836	$ 2,077,066	$ 1,760,132	$ 316,934	15.26%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2022 through April 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 502,752	$ 293,272	$ 171,882	$ 121,390	41.39%
Fringes	145,464	84,854	45,674	39,180	46.17%
Access Salaries	220,620	128,695	71,003	57,692	44.83%
Access Fringes	67,140	39,165	28,295	10,870	27.75%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	43,750	66,208	(22,458)	(51.33%)
Board expenses	5,000	2,919	3,070	(151)	(5.17%)
Day of Recover	-	-	692	(692)	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	3,850	8,160	(4,310)	(111.95%)
Total operating expenses	$ 1,082,576	$ 596,505	$ 394,984	$ 201,521	33.78%

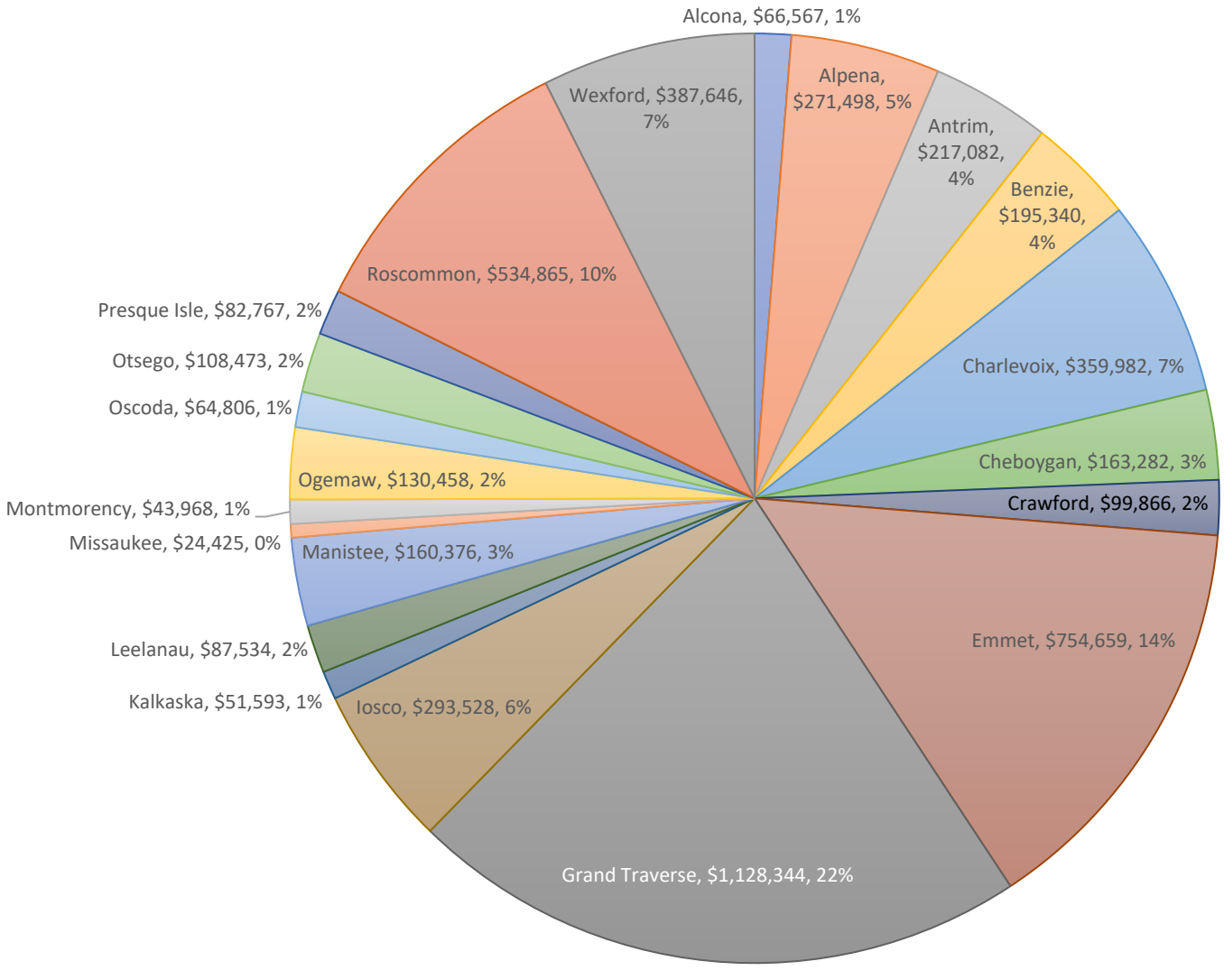
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2022 through April 30, 2023

	Projected FY23 Activity				Actual FY23 Activity			
	Beginning Balance	FY23 Projected Revenue	FY23 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 59,376	$ 20,389	$ 4,410	$ 75,355	$ 10,242	3,051	$ -	$ 66,567
Alpena	263,254	69,040	45,317	286,976	35,963	27,718	-	271,498
Antrim	219,249	59,729	80,820	198,158	30,499	32,667	-	217,082
Benzie	173,705	52,923	14,857	211,771	27,616	5,982	-	195,340
Charlevoix	359,548	89,334	110,699	338,183	45,993	45,559	-	359,982
Cheboygan	191,247	74,954	138,728	127,472	38,386	66,351	-	163,282
Crawford	92,406	31,228	17,903	105,731	16,476	9,016	-	99,866
Emmet	716,610	155,245	115,175	756,679	84,017	45,968	-	754,659
Grand Traverse	1,282,987	406,430	1,248,209	441,208	205,034	359,677	-	1,128,344
Iosco	329,202	70,865	180,735	219,332	36,897	72,571	-	293,528
Kalkaska	74,226	31,700	83,823	22,103	17,878	40,510	-	51,593
Leelanau	102,658	56,613	117,817	41,454	28,594	43,718	-	87,534
Manistee	131,924	68,873	10,407	190,390	35,651	7,199	-	160,376
Missaukee	37,771	18,044	48,883	6,931	9,401	22,747	-	24,425
Montmorency	54,974	27,338	42,322	39,990	13,175	24,182	-	43,968
Ogemaw	154,130	50,286	142,919	61,497	28,758	52,430	-	130,458
Oscoda	65,061	20,039	36,568	48,532	9,077	9,332	-	64,806
Otsego	108,477	88,483	94,620	102,340	45,150	45,154	-	108,473
Presque Isle	75,221	22,256	5,450	92,027	11,315	3,770	-	82,767
Roscommon	524,550	74,697	72,090	527,157	37,648	27,333	-	534,865
Wexford	396,468	79,925	108,457	367,936	41,646	50,468	-	387,646
	5,413,044	1,568,386	2,720,209	4,261,221	809,417	995,400	-	5,227,061
PA2 Redirect								-
								5,227,061

PA2 Funds by County



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2022 through April 30, 2023

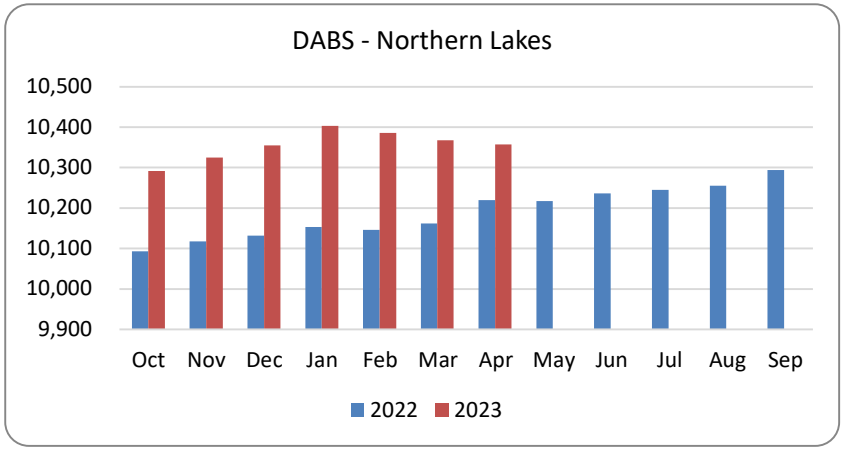
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	4,375	4,675	300	6.86%
Total operating revenue	7,500	4,375	4,675	300	6.86%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 4,375	4,675	$ 300	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,369,542		
Unspent funds - ending			$ 16,374,217		

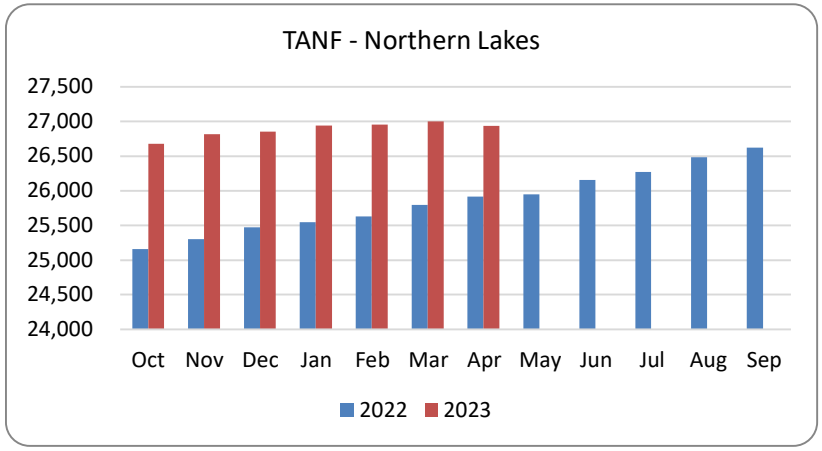
Northern Michigan Regional Entity

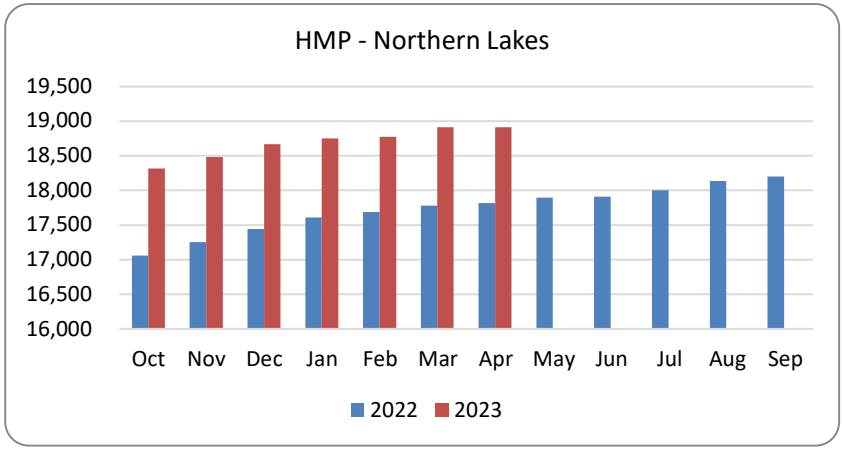
Narrative

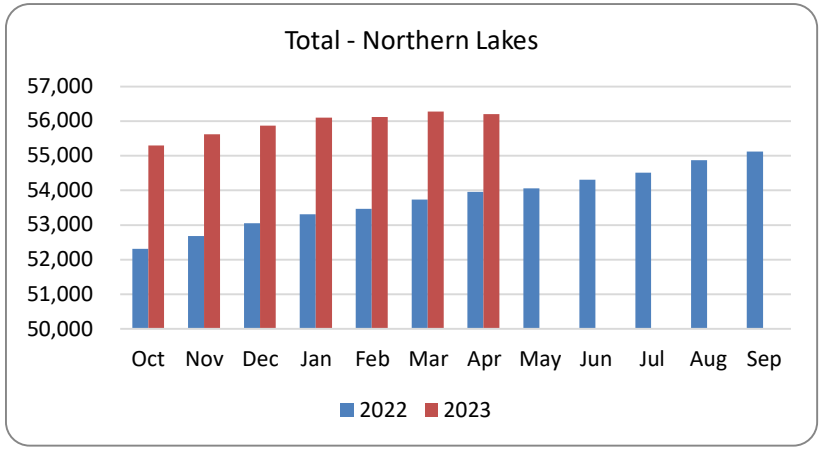
October 1, 2022 through April 30, 2023

Northern Lakes Eligible Members Trending - based on payment files







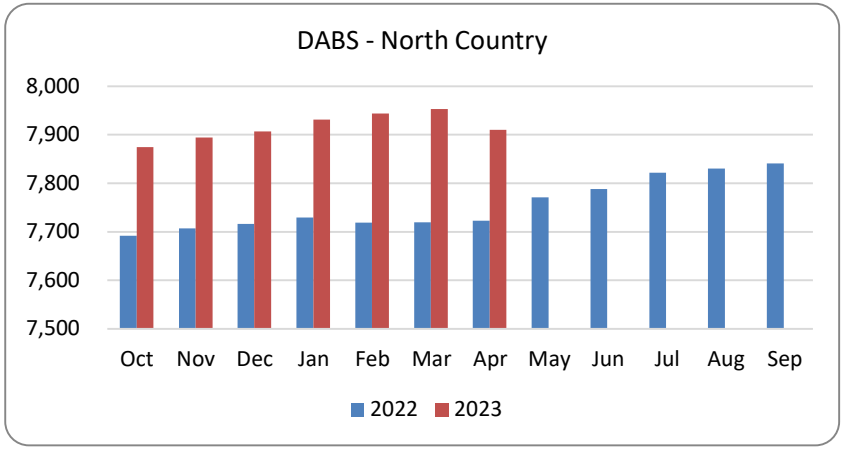


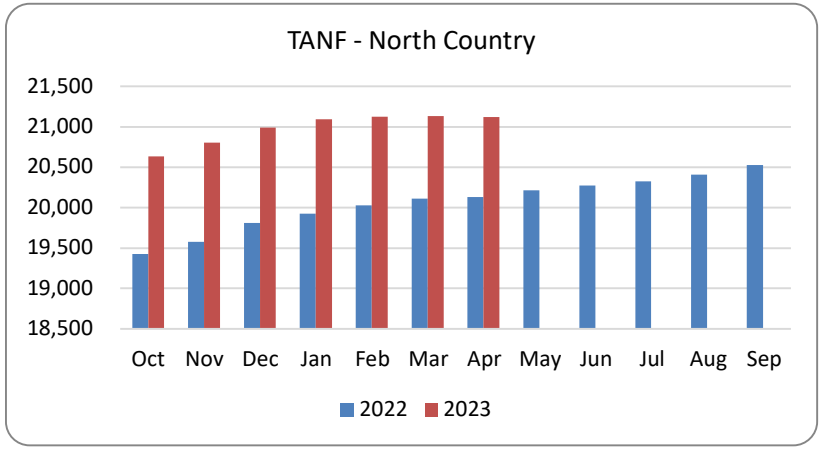
Northern Michigan Regional Entity

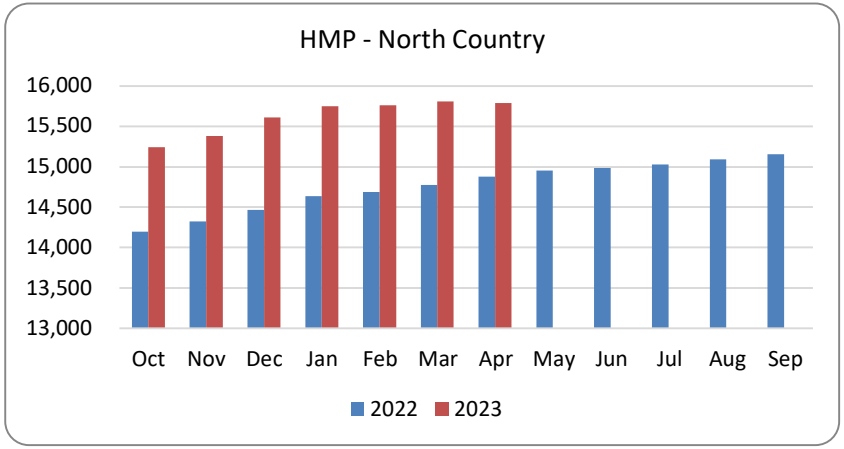
Narrative

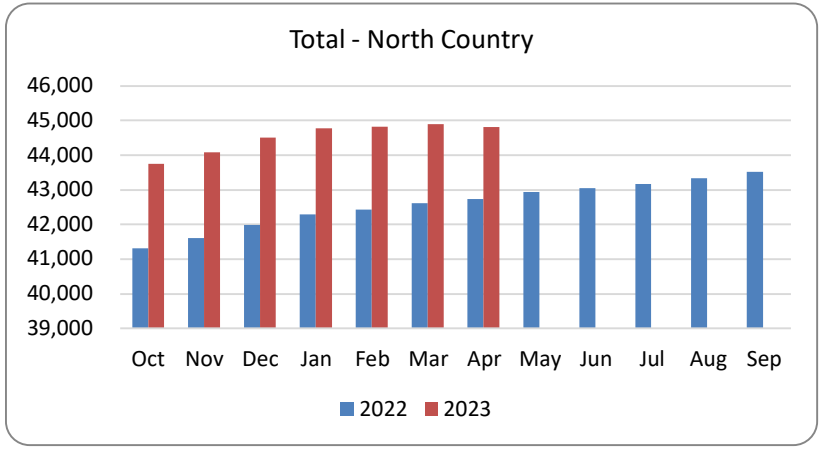
October 1, 2022 through April 30, 2023

North Country Eligible Members Trending - based on payment files







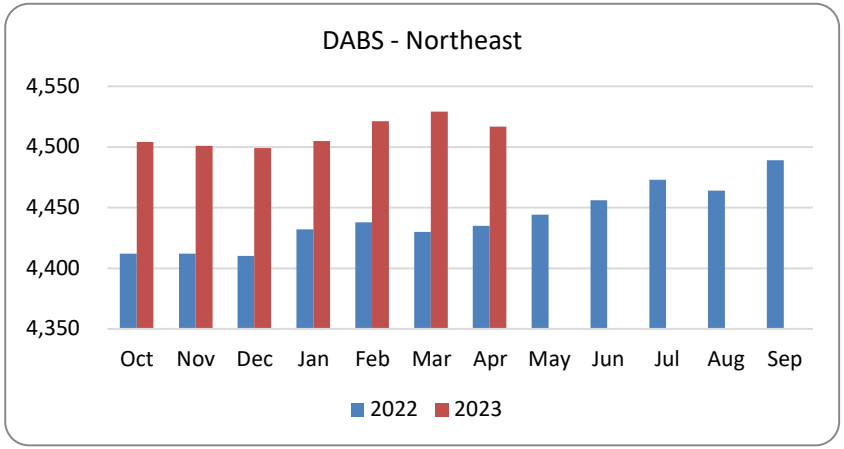


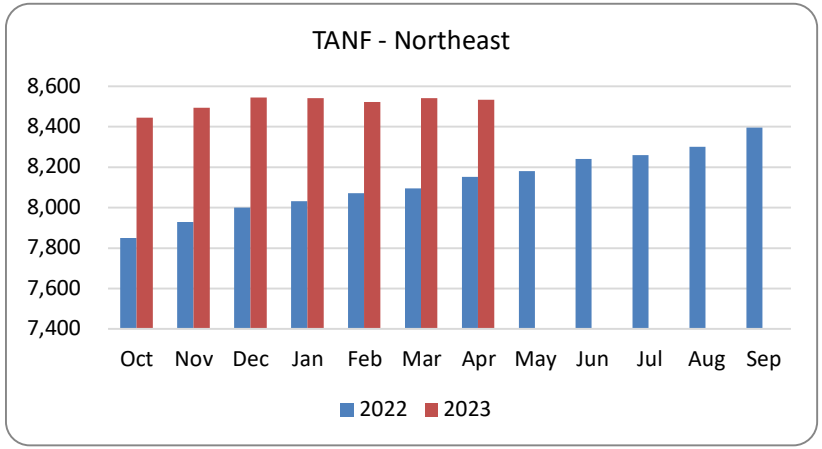
Northern Michigan Regional Entity

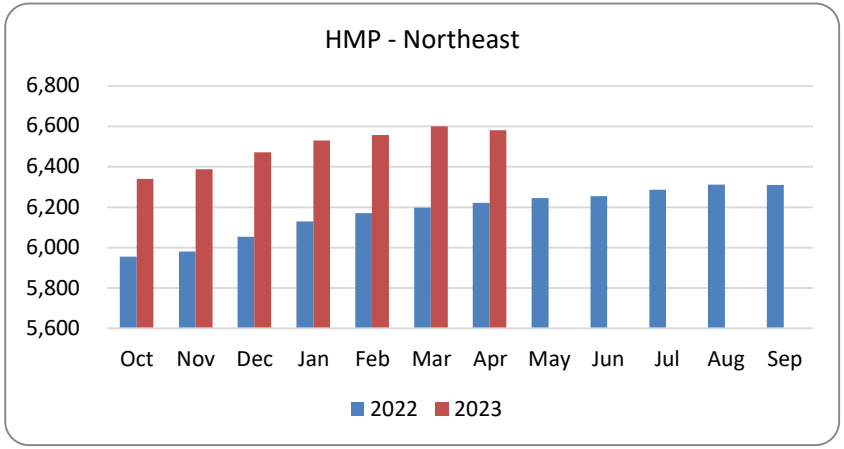
Narrative

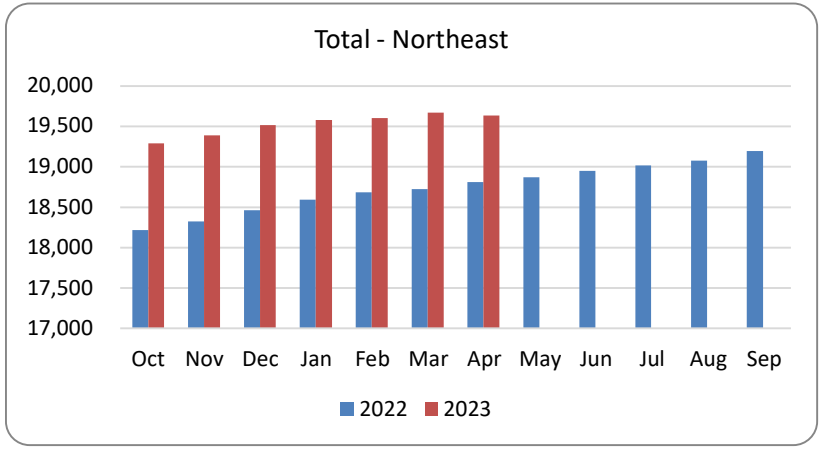
October 1, 2022 through April 30, 2023

Northeast Eligible Members Trending - based on payment files







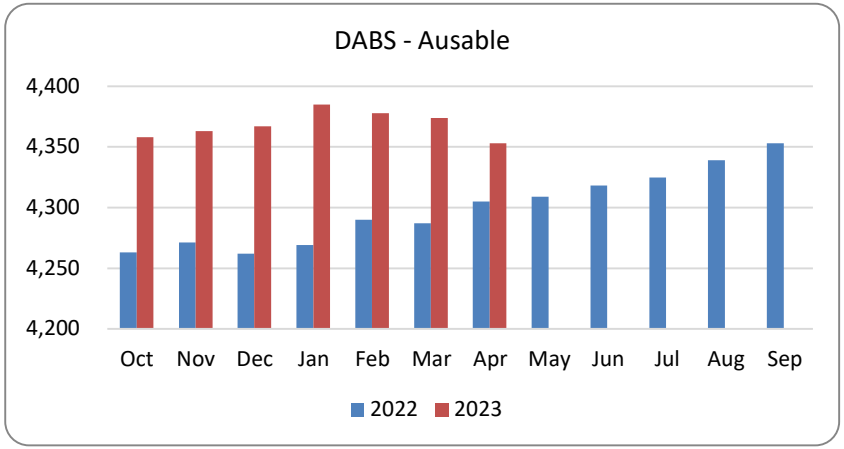


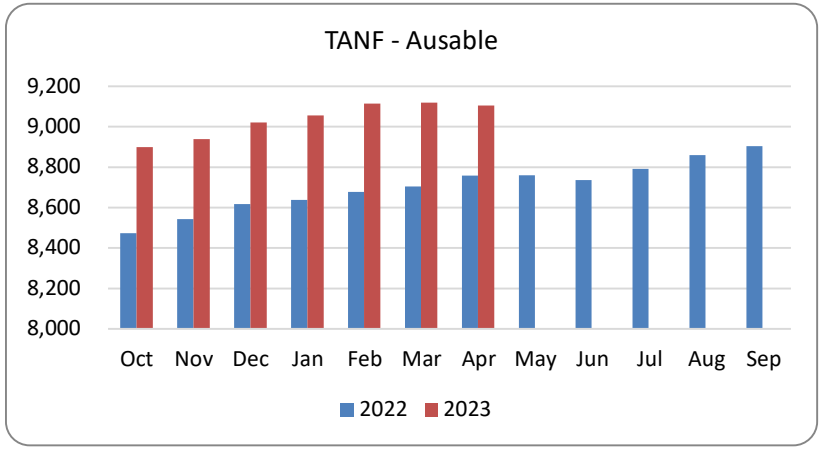
Northern Michigan Regional Entity

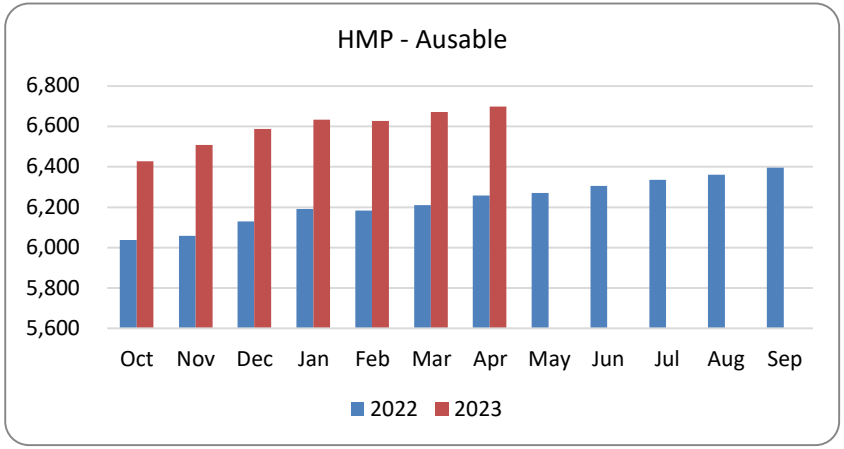
Narrative

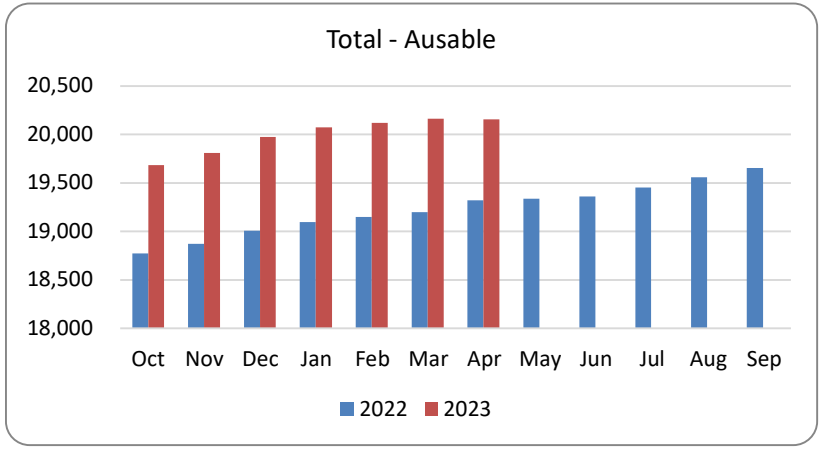
October 1, 2022 through April 30, 2023

Ausable Valley Eligible Members Trending - based on payment files







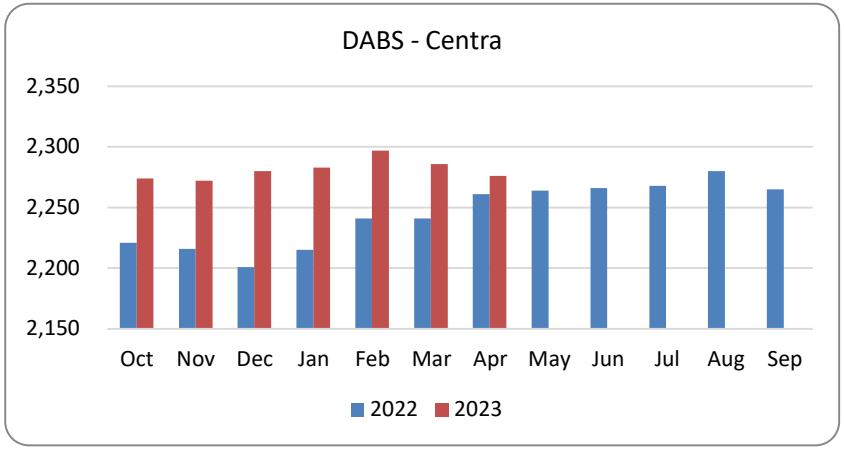


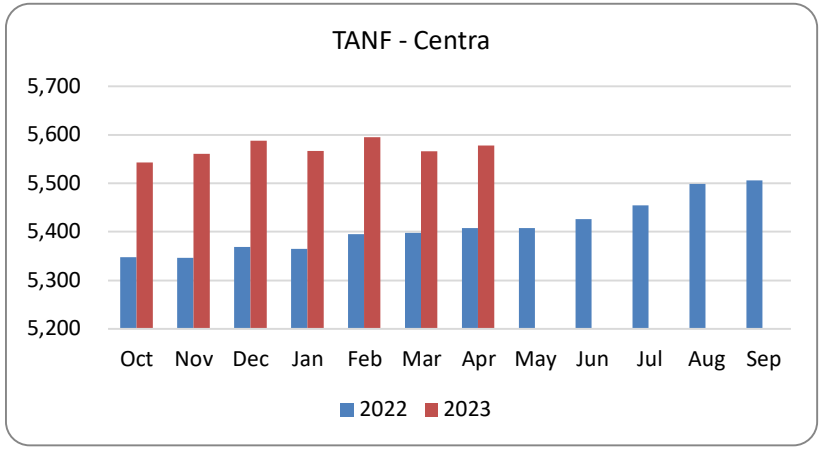
Northern Michigan Regional Entity

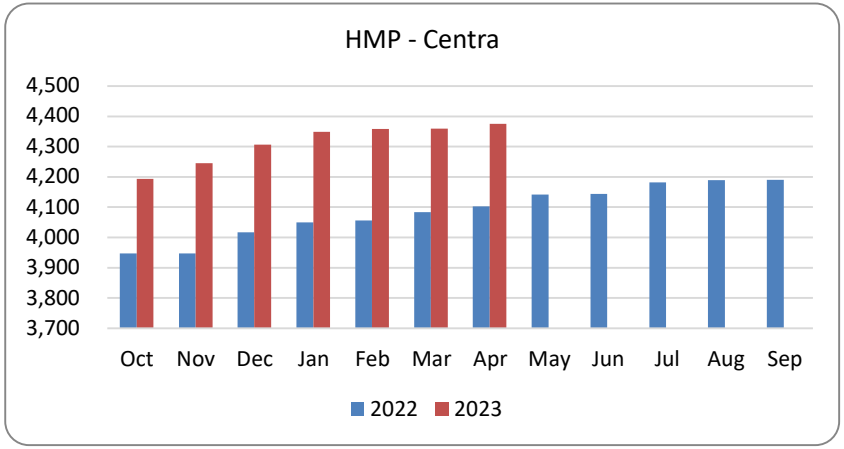
Narrative

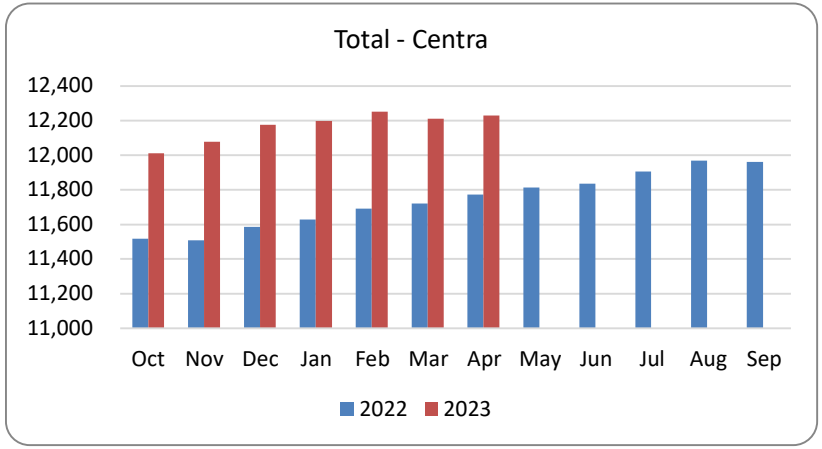
October 1, 2022 through April 30, 2023

Centra Wellness Eligible Members Trending - based on payment files







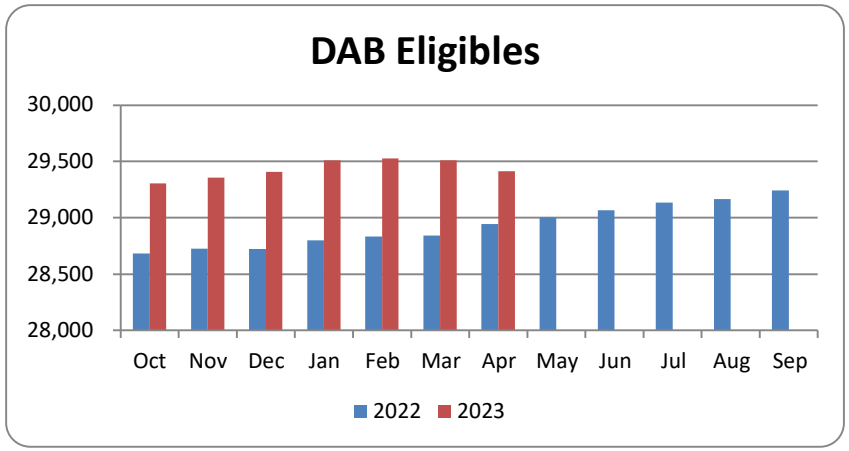


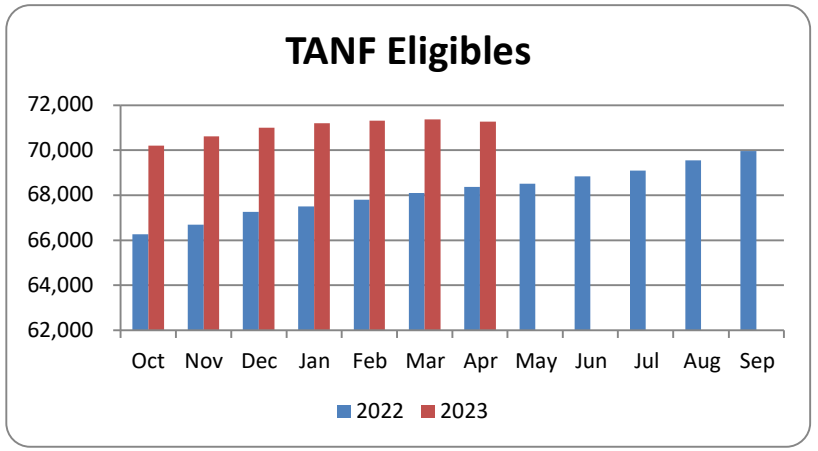
Northern Michigan Regional Entity

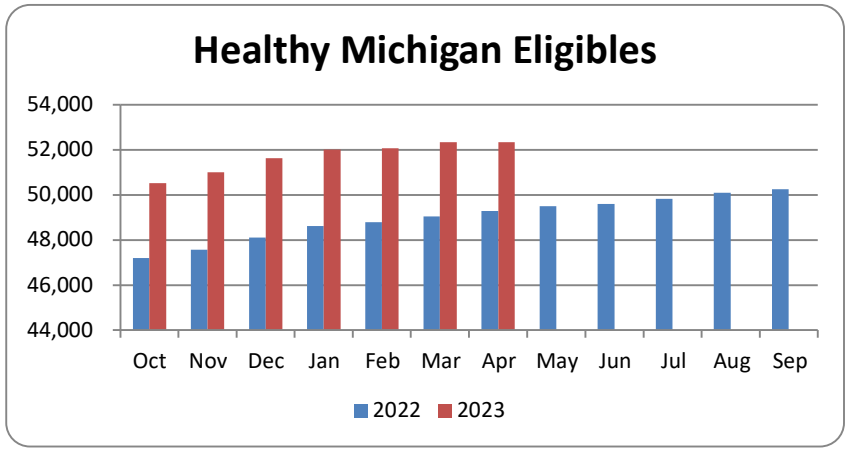
Narrative

October 1, 2022 through April 30, 2023

Regional Eligible Trending





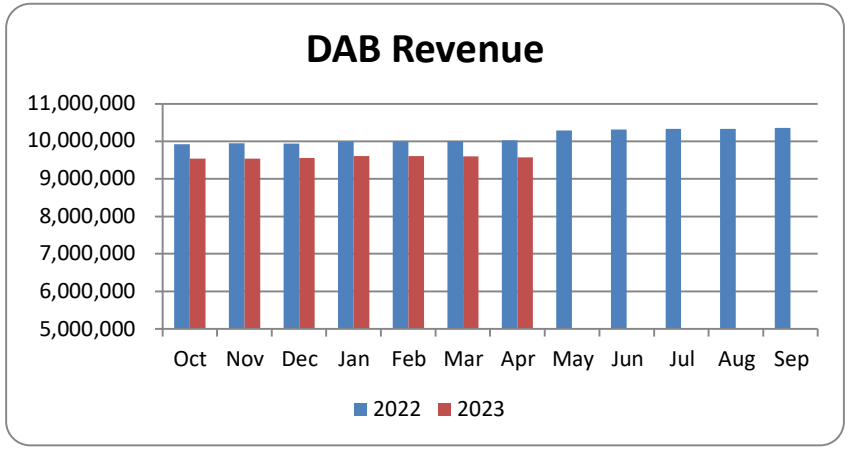


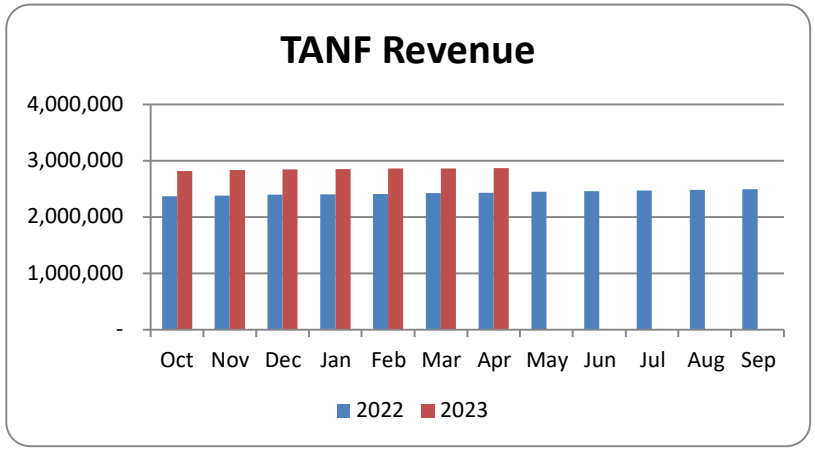
Northern Michigan Regional Entity

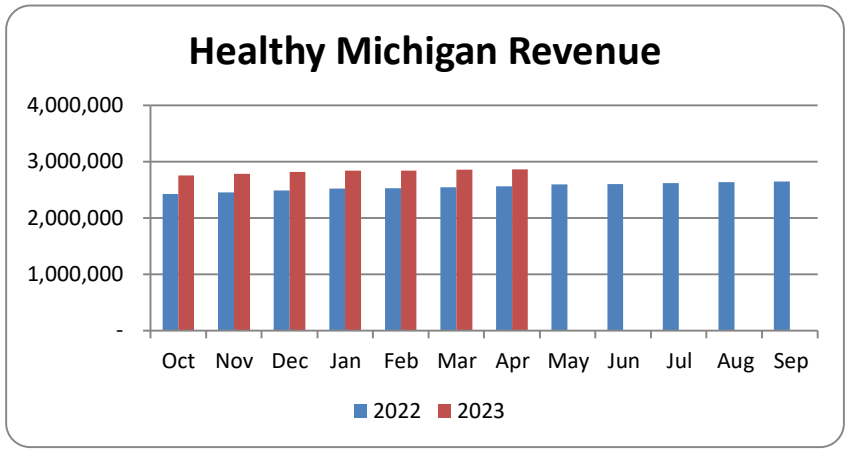
Narrative

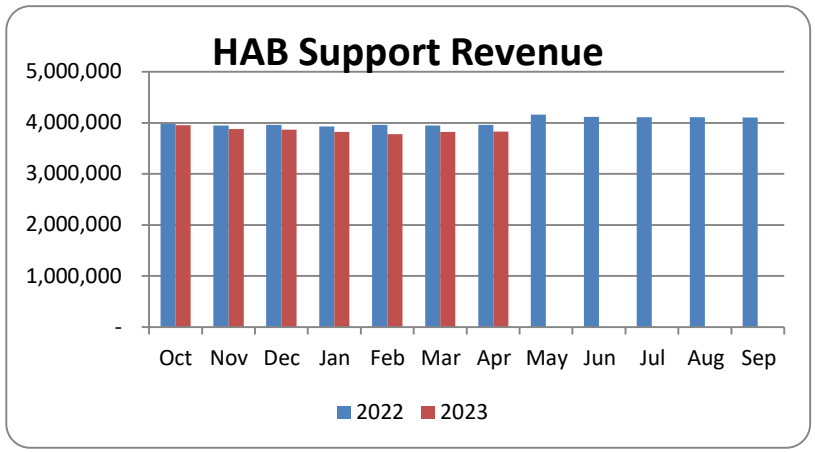
October 1, 2022 through April 30, 2023

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – JUNE 20, 2023
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Brian Babbitt, Chip Johnston, Eric Kurtz, Diane Pelts Nena Sork, Carol Balousek**
ABSENT:	**Brian Martinus**
GUEST:	**Chris Cooke**

REVIEW OF AGENDA AND ADDITIONS

Ms. Sork requested that a discussion about potential stability payments to AFC homes be added to the meeting agenda.

CHRIS COOKE REGARDING PSYCHIATRIC INPATIENT

Attorney Chris Cooke (Secrest Wardle) was invited to the meeting to discuss the recent trend of youth being denied inpatient hospitalization resulting in situations that put the youth and/or the community at risk. Ms. Sork spoke about the incident that involved a youth from Alpena who was recently charged in connection with an attempted kidnapping. She referred to these youth as at risk to the community and to themselves because hospital admissions are being denied. There is great concern that it is just a matter of time before there is a very adverse outcome, leaving CMHSPs in a bad position. The NMRE would like to take proactive measures.

Mr. Johnston noted that a 1985 map showed 6 children's hospitals in the state; currently there is 1 (Hawthorne Center) which is being reduced to 33 beds during the construction of a new facility (there will be an additional 20 children's beds in 2026 when construction is complete). Ms. Sork added that kids who have been court ordered for inpatient psychiatric hospitalization can't even get into Hawthorne; some are removed from the waiting list without notice. There are zero children's psychiatric hospital beds in the NMRE 21-county region. The State has reached out to the NMRE to inquire about what is being done to increase capacity; the creation of children's inpatient psychiatric beds does not fall within the NMRE's purview. Northeast Michigan has offered to pay 1:1 staffing at an enhanced rate to try to get kids in the hospital.

The Boards reviewed their data regarding wait times for hospital placements.

The CEOs would like Mr. Cooke to compose a "legal letter" on behalf of the region. Mr. Cooke suggested compiling data in the form of a memorandum. A regional list of concerns will be compiled as soon as possible. Mr. Johnston suggested gathering input from the court system as well. Mr. Cooke asked about the possibility of pulling historical admissions data, which Mr. Kurtz agreed to do.

APPROVAL OF PREVIOUS MINUTES

The minutes from May 16th were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE MINUTES OF THE MAY 16, 2023 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY NENA SORK. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

April 2023

- Net Position showed net surplus Medicaid and HMP of $5,332,150. Budget stabilization was reported as $16,369,542. The total Medicaid and HMP Current Year Surplus was reported as $21,701,692. Medicaid and HMP combined ISF was reported as $16,369,542; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $38,071,234.
- Traditional Medicaid showed $115,760,019 in revenue, and $112,701,515 in expenses, resulting in a net surplus of $3,058,504. Medicaid ISF was reported as $9,306,578 based on the current FSR. Medicaid Savings was reported as $7,742,649.
- Healthy Michigan Plan showed $20,757,795 in revenue, and $18,484,149 in expenses, resulting in a net surplus of $2,273,646. HMP ISF was reported as $7,062,964 based on the current FSR. HMP savings was reported as $8,626,893.
- Health Home showed $1,297,430 in revenue, and $1,118,296 in expenses, resulting in a net surplus of $179,134.
- SUD showed all funding source revenue of $17,249,548, and $15,106,237 in expenses, resulting in a net surplus of $2,143,311. Total PA2 funds were reported as $5,227,061.

Mr. Kurtz noted that the net surplus continues to grow. A lapse is expected for FY23. The 5-month recoupment process will reduce the Health Home surplus. The revised rates for May – September reduced monthly revenue by $116K ($580K total).

MOTION BY BRIAN BABBITT TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR APRIL 2023; SUPPORT BY NENA SORK. MOTION APPROVED.

FY24 Budget Stabilization/Revenue

Eligibles and revenue are expected to drop due to Medicaid redeterminations, but the full effect may not be known until FY24. For planning purposes, the CMHSPs were advised to budget consistent with FY23.

REGIONAL TRAINING

Mr. Martinus is working to bring Dave Bartley to the region to address mental illness and suicide prevention. AuSable Valley is coordinating a regional Pediatric Behavioral Health Summit on October 4th at Treetops Resort.

The Operations Committee had previously discussed hiring a regional training specialist, possibly pairing with NorthCare Network. The thought was to offer trainings in the northern region that had previously only been offered through CMHAM. The CEOs agreed to discuss the

topic with their staff and report back regarding the level of interest. It was noted that a Back-up CFO/accountant for the regions CMHSP's had also been suggested.

BUILDING SECURITY AND SAFETY PLANS

Ms. Pelts asked the other CEOs what security measures they have in place at their facilities to protect staff. Mr. Babbitt responded that North Country offices are equipped with emergency buttons and AlertMedia software is used to push emergency messages out to staff. North Country is looking at mobile emergency buttons which are tied to cell phones and can be connected to law enforcement. Ms. Sork indicated that similar "reasonable measures" are in place at Northeast Michigan. She noted that requests for bullet proof glass and storage lockers were denied. It was noted that "Weapons Free Zone" signs are posted at all facilities.

CFAP BOARD RESOLUTION

Examples of Board resolutions letters opposing the conflict free access and planning models proposed by MDHHS were included in the meeting materials. Instead of a Board resolution, North Country opted to send a letter of opposition to Elizabeth Hertel, Farah Hanley, local legislators, and the Governor.

FY24 MDHHS PLANS OF CORRECTION

The final report of the Childrens Waiver Program (CWP), Habilitation Supports Waiver (HSW), and Serious Emotional Disturbances Waiver (SEDW) audit was shared with the CMHSPs. Numerous repeat citations were noted, for which remediation will be required. Mr. Kurtz explained that repeat citations may be brought to the attention of MDHHS contract staff and could lead to a withhold of FY24 revenue.

BENEFITS TO WORK COACH

Mr. Johnston asked about the possibility of securing a Benefits-to-Work Coach for the region to assist consumers with maintaining their benefits while in supportive employment (possibly shared with NorthCare). Mr. Kurtz directed him to Joe Longcor, Supported Employment Specialist, with the state's Behavioral and Physical Health and Aging Services Administration. Ms. Sork also indicated that Northeast Michigan has a staff employed that Centra Wellness may utilize.

ALPINE CRU

Mr. Babbitt reported that he spoke with Dr. Ibrahim and Jill LeBourdais on June 16th. They indicated that they are open to the NMRE pre-paying for beds. AuSable valley is also meeting with Dr. Ibrahim later on this date. Mr. Babbitt had requested a copy of the Alpine CRU budget. The NMRE will likely create a separate agreement to cost settle with the facility.

BUSINESS INTELLIGENCE TEAM CHARTER

Brandon Rhue joined the meeting to review the Business Intelligence & Technology Team Charter. The Charter and draft minutes from June 1st were included in the meeting materials. The committee was convened at the request of the Operations Committee to discuss collaborative efforts around data reporting and PCE enhancements (including a backlog of enhancement requests at PCE).

MOTION BY CHIP JOHNSTON TO APPROVE THE REGIONAL BUSINESS INTELLIGENCE AND TECHNOLOGY TEAM CHARTER; SUPPORT BY BRAIN BABBITT. MOTION CARRIED.

GRAND TRAVERSE COUNTY AND NORTHERN LAKES

Mr. Kurtz sent a memorandum to Ben Townsend (NLCMHA Board Chair) and Tom Bratton (NLCMHA Search Committee Chair) on June 5th requesting that they delay the CEO search until the bylaws have been reviewed/revised and NMRE continues its contractual oversight obligation by conducting a targeted services and financial audit including a deeper review of grant sustainability and some delegated function reviews.

PINE REST RATE REQUEST

A rate increase from Pine Rest for FY24 was included in the meeting materials.

Pine Rest

	FY23 Rate	Proposed FY23 Rate	% Increase
Adult and Older Adult Unit	$1,182	$1,240	4.9%
Adolescent Unit	$1,228	$1,314	7%
Partial Hospitalization	$528	$554	4.6%
ECT Inpatient	$805	$845	4.9%
ECT Outpatient	$1,040	$1,092	0.05%

MOTION BY CHIP JOHNSTON TO APPROVE THE FISCAL YEAR 2024 RATE REQUEST FROM PINE REST CHRISTIAN MENTAL HEALTH SERVICES AS PRESENTED AND REVIEWED ON THIS DATE; SUPPORT BY BRIAN BABBITT. MOTION CARRIED.

OTHER

(i)SPA Enrollment

Current regional (i)SPA enrollment numbers were shared for informational purposes. Enrollment must be completed by October 1st.

	Point in Time Enrollment 6/15/23	PIHP Projections March 2023	% of Completed Enrollments 6/15/23
AuSable Valley	180	190	95%
Centa Wellness	2	250	1%
North Country	228	460	50%
Northeast Michigan	20	430	5%
Northern Lakes	266	470	57%
Total	**696**	**1800**	**39%**

FY23 Stability Payments to AFCs

Ms. Sork asked whether the Boards intend to provide stability payment to AFC homes for the current year. Mr. Johnston responded that Centra Wellness will not, as an RFP and salary study were both conducted for FY23. Mr. Babbitt has asked staff to look at ways to provide "value-based incentives." Ms. Sork asked to be informed if any stability payments are offered to AFC providers.

CMHAM Rural Caucus/Bob Sheehan Request

It was noted that the CMHAM Board of Directors unanimously approved the action steps recommended by the Rural Caucus. CMHAM requested that Rural Caucus members weigh in on the proposed next steps by June 23rd. Clarification was made that the action steps are intended for CMHSPs and PIHPs serving rural and frontier communities, though the method used to define these areas has not been settled. Matt Maskart, CEO of Pathways Community Mental Health, suggested using the US Department of Agriculture Frontier and Remote (FAR) Levels as a guide.

NEXT MEETING

The next meeting was scheduled for 9:30AM on July 18th in Gaylord.

Northern Michigan Regional Entity

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

June 5, 2023

Hi Ben and thanks for the email update.

Sonya was out on and off most of last week, but I can help as I have been through a few of these in my past. I also saw Tom's email regarding the salary ranges, which we provided for the last search committee, and we can reproduce those. I also had names of at least two search firms that I was ready to provide to the last Search Committee. As part of the NMRE's contractual oversight, we will assist with an RFP and help Tom and the Committee to ensure independent integrity in the process. Most good search firms will do some, or most of this as well. Tom and I talked a little after the NMRE Board meeting and, like you, we want this to go as easily as possible.

With that said, I must indicate on the NMRE's behalf that starting the CEO search seems a little premature. Although, we/I am thrilled the Enabling Agreement is signed, it was in our minds, the first step in the NMRE Contractual Oversight process (which included appointing an Interim NLCMHA CEO). From an NMRE perspective, the focus now changes to ensuring NLCMHA has some stability in leadership and can manage its contractual service obligations and delegated functions. I also recall that the Enabling Agreement committee made some suggestions regarding the NLCMHA Bylaws including requiring a 2/3 or super majority vote by the "full" Board before making an offer to a CEO candidate, among other suggestions. I fully understand that the Bylaws are under the purview of the NLCMHA Board, but I want to hold true to the agreements we discussed with the county administrators and commissioners, and, at a minimum, this be done prior to starting any search. I am also concerned that this will start another round of staff posturing related to the new CEO search, as opposed to maintaining the momentum currently in place.

As some of your Board Members may or may not be aware, after the previous notice of Grand Traverse County's vote to remove itself from the from the 2003 Enabling Agreement that created the Northern Lakes Community Mental Health Authority (NLCMHA) and the clear lack of governance and consistent leadership within NLCMHA, the NMRE Board invoked enhanced contractual oversight on 8-9-22. This was done to assure NLCMHA remains viable and that services to NLCMHA beneficiaries were not interrupted due to these issues. This also came with additional attention brought on by MDHHS requiring biweekly updates regarding NLCMHA's ability to manage these contractual functions as well as approximately six (or more) contractual plans of correction regarding consumer complaints, their status, and the steps NMRE is taking to ensure these issues are resolved.

Additionally, I have been asked and have been providing regular updates to the NMRE Board Chair since the contractual oversight was put in place. In these discussions, and as referenced in the 8-9-22 Enhanced Contractual Oversight memo, the NMRE is planning to do a deeper dive into certain NLCMHA operations beyond the regular site review. The NMRE Board is expecting a review of operations, which will include service capacity and efficiency, past Human Resources operations, the effect of other NLCMHA business lines, any outstanding legal complaints/settlements, and the sustainability plans of numerous NLCMHA grants that have been requested over the past several years.

Again, acknowledging the progress that has been made with the NLCMHA Enabling Agreement and to date with NLCMHA, the NMRE Board respectfully asks that as part of the ongoing Enhanced Contractual Oversight that the NMRE appointed CEO remains in place until these activities are accomplished or till a mutually agreed upon date can be reached in the future.

If you have any questions, please feel free to contact me or reach out to Carol Balousek who can contact Don Tanner, the NMRE Board Chair, if you have any questions.

Sincerely,

Eric Kurtz
NMRE CEO

Don Tanner
NMRE Board Chair

Quality Assessment and Performance Improvement Program Description, Program Evaluation FY2022, and Program Workplan FY 2023

Approved By	Date
Compliance and Quality Committee (QOC)	January 3, 2023
Internal Operations Committee (OOC)	January 11, 2023
Board of Directors	January 25, 2023

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FY23 QAPIP Program WORKPLAN

INTRODUCTION

The Northern Michigan Regional Entity (NMRE) is the Medicaid specialty prepaid inpatient health plan (PIHP) for the five Community Mental Health Services Programs (CMHSPs) serving the northern lower peninsula of Michigan. The member Boards are: AuSable Valley Community Mental Health Authority (AVCMH) serving Iosco, Ogemaw, and Oscoda counties, Centra Wellness Network (CWN) serving Benzie and Manistee counties, North Country Community Mental Health Authority (NCCMH) serving Antrim, Charlevoix, Cheboygab, Emmet, Kalkaska, and Otsego counties, Northeast Michigan Community Mental Health Authority (NEMCMH) serving Alcona, Alpena, Montmorency, and Presque Isle counties, and Northern Lakes Community Mental Health Authority (NLCMH) serving Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford Counties. The managed care activities are the responsibility of the NMRE.

AUTHORITY

The Quality Assessment and Performance Improvement Program (QAPIP) is reviewed and approved on an annual basis by the NMRE Governing Board. Through this process, the Governing Board gives authority for the implementation of the plan and all its components. This authority is essential to the effective execution of the plan.

Consistent with the structure of the NMRE and the governance structure of its Board of Directors, this authority is discharged through the Chief Executive Officer (CEO) of the NMRE. In turn, the CEO discharges authority through the Compliance Director.

DEFINITIONS

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or their representative (also "Member" or "Consumer").

Community Mental Health Services Program (CMHSP): For the purposes of this document, a CMHSP member is one of the following: AuSable Velley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health Authority, Northeast Michigan Community Mental Health Authority, or Northern Lakes Community Mental Health Authority.

Michigan Department of Health and Human Services (MDHHS): A principal department of state of Michigan, headquartered in Lansing, that provides public assistance, child and family welfare services, and oversees health policy and management.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services pursuant to the Specialty Supports and Services Contract between the State of Michigan and the NMRE, it's member CMHSPs, and/or its Substance Use Disorder (SUD) Provider Panel.

Northern Michigan Regional Entity (NMRE): One of 10 prepaid inpatient health plans (PIHPS) in the state of Michigan. The NMRE covers Region 2, the twenty-one counties at the tip of Michigan's lower peninsula (Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, and Wexford).

NMRE Internal Operations Committee (IOC): An NMRE internal committee comprised of key leadership staff.

NMRE Operations Committee (Ops): An NMRE regional committee comprised of the top-level executive staff (CEO/Executive Director) of the NMRE and its five member CMHSPs.

NMRE Quality and Compliance Oversight Committee (QOC): A regional quality improvement committee, comprised of NMRE staff and quality and compliance leaders from the five member CMHSPs. Additional members may be appointed, as appropriate, including members from the NMRE SUD Provider Panel and service recipients (primary or secondary).

Prepaid Inpatient Health Plan (PIHP): The ten organizations in Michigan responsible for managing Medicaid services related to behavioral health, intellectual/developmental disabilities, and substance use disorders.

Quality Assessment and Performance Improvement Program (QAPIP): A data driven and proactive approach to quality improvement. The QAPIP is used to ensure services are meeting quality and performance standards.

MISSION & VISION

Mission

Develop and implement sustainable, managed care structures to efficiently support, enhance, and deliver publicly funded behavioral health and substance use disorder services.

Vision

A healthier regional community living and working together.

PURPOSE

As the PIHP for the twenty-one county region, the NMRE's mission guides quality improvement activities. The QAPIP is intended to serve several functions, including but not limited to.

- Serve as the quality improvement structure for the managed care activities of the NMRE as the PIHP for the twenty-one county area.
- Provide oversight of the CMHSPs' quality improvement structures and ensure coordination with PIHP activities, as appropriate.
- Provide leadership and coordination for the PIHP Performance Improvement Projects (PIPs).

- Coordinate with the regional Compliance Coordinator and Regional Compliance Committee for verification of Medicaid claims submitted.
- Describe how these functions will be executed within the NMRE's organizational structure.

This written plan describes how these functions will be accomplished. It also describes the organizational structure and responsibilities relative to these functions.

GOVERNANCE

The NMRE has a fully operational QAPIP that meets the conditions specified in its Specialty Supports and Services Contract with the State.

The NMRE Governing Board/Board of Directors reviews and approves the QAPIP on an annual basis. Through this process, the Governing Board gives authority for the implementation of the QAPIP and all its components. The Governing Board receives routine updates on the QAPIP, as well as a year-end effectiveness review.

STRUCTURE

1. Provider/Beneficiary Involvement
   The involvement of provider and beneficiary representatives is essential to the effectiveness of the QAPIP; this involvement is sought, encouraged, and supported at several levels including:

   a. The NMRE Governing Board includes beneficiaries as members.
   b. The NMRE Consumer Advisory Panel (Regional Entity Partners) provides input on various managed care activities.
   c. The regional Quality and Compliance Oversight Committee (QOC) is comprised of staff from the NMRE and its member CMHSPs.
   d. Each member CMHSP operates a Consumer Advisory Committee and includes beneficiary representatives on its Governing Board and on various committees.

2. NMRE Internal Operations Committee
   The NMRE Internal Operations Committee (IOC) has the central responsibility for the implementation of the QAPIP. Committee membership consists of key NMRE staff including but not limited to:

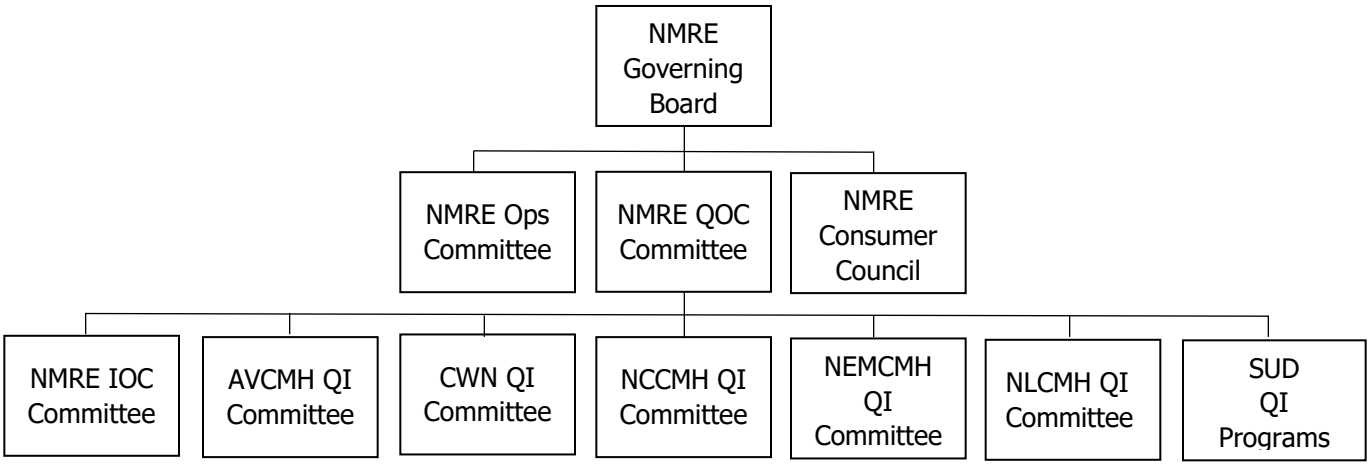
   a. Chief Executive Officer
   b. Chief Information Officer/Operations Director
   c. Chief Financial Officer
   d. Compliance Director
   e. Clinical Services Director
   f. Human Ressources Director

3. NMRE Quality and Compliance Oversight Committee
   The regional Quality and Compliance Oversight Committee (QOC) has the responsibility for ensuring that network providers have appropriate quality improvement structures and activities necessary to meet federal and state requirements. This group provides the primary link between the quality improvement structures of network providers and the NMRE. To create this link, the CEO of each member CMHSP appoints representatives to serve as members of the committee.

4. CMHSP Quality Improvement Committees
   Each member CMHSP has a Quality Improvement process to address quality issues within its operations that meets the requirements of MDHHS and the NMRE.

5. Accountability
   Because one of the tenants of quality improvement and a key element of a successful team is accountability, the success of the NMRE's QAPIP is dependent on the success of its parts. Employees and/or agents of the NMRE and its network providers will be accountable to beneficiaries, coworkers, various committees, and their primary employer for the quality and integrity of their work.

   The following table displays the reporting accountability of the various components of the quality improvement system.



RESPONSIBILITIES

Each of the components of the QAPIP structure have specific responsibilities. These various tasks, when taken in whole, ensure that the NMRE and its network providers are administering

quality services, effectively managing and protecting available resources, protecting the rights of beneficiaries, and identifying opportunities to improve.

1. NMRE Quality and Compliance Oversight Committee (QOC)
   The NMRE regional QOC acts as the NMRE's primary connection to the quality improvement activities of its network providers. This committee, the Regional Customer Services Committee, and the regional Consumer Advisory Committee (Regional Entity Partners) are the vehicles from which the NMRE receives beneficiary input.

2. NMRE Internal Operations Committee (IOC)
   The NMRE IOC has the lead role within the NMRE in implementing the QAPIP, beginning with the quality, effectiveness, and efficiency of the managed are activities.

3. Compliance Director
   The NMRE Compliance Director is a senior staff person responsible for the implementation of the NMRE's QAPIP. On an annual basis, the Compliance Director works with various committees to conduct an effectiveness review of the QAPIP and the previous fiscal year's workplan. The effectiveness review includes an analysis to determine whether members experienced any improvement in their quality of healthcare and services due to the QAPIP. The effectiveness review is shared with the NMRE Governing Board, network providers, and upon request, to members and MDHHS. The effectiveness review is used to inform the following year's QAPIP and Workplan.

4. Member CMHSP Quality Improvement Committees
   Each member CMHSP will maintain an appropriate quality improvement program that meets the requirements of federal regulations and national accreditation. Each CMHSP submits summary reports of quality improvement activities, minutes of Quality Improvement Committee meetings, and Quality Improvement Plans to the NMRE. The NMRE monitors all quality improvement program activities to ensure they are consistent with the standards and requirements of managed care, as specified in federal regulations and the NMRE's Specialty Supports and Services Contract with the State.

   Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations (SUD Provider Panel). No managed care functions are delegated to SUD providers. To ensure adequate representation of SUD service in the NMRE's quality improvement activities, the NMRE SUD Grant and Treatment Manager is an integral member of various committees.

The components of the QAPIP Structure are intended to ensure compliance with the following required activities:

1. **Claims Verification**
   The verification of Medicaid claims is required both by federal regulations and the Specialty Supports and Services Contract with the State. The primary responsibility for this activity, as specified in the NMRE Medicaid Encounter Verification Policy and Procedure is assigned to the Compliance Director.

The NMRE has established a consistent methodology for the validation of Medicaid encounters submitted within its provider network to ensure compliance with federal and state regulations in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program, the Medicaid Services Verification-Technical requirements.

Scores that fall below 95% accuracy for each quarterly review will require a plan of correction from the provider. The plan of correction template will be emailed along with the final MEV report. The provider will identify remediation strategies for the NMRE to review. Once approved, the NMRE will monitor the actions specified within the plan of correction. Services that are found to be invalid will be voided for payment with Medicaid funds; proof will be sent to the NMRE Compliance Director within 3 days of the finding or the end of review period. For SUD services, proof of retractions will be provided by a reconsideration report, sent within 2 weeks of the final report. A provider may appeal findings, in writing, to the NMRE Compliance Director, who will seek consultation and render a decision within 2 weeks from receiving the appeal.

If there is suspicion of fraud and/or abuse, the NMRE Compliance Officer will notify the NMRE Chief Executive Officer (CEO) and the Provider's CEO/Executive Director of the alleged issue. The NMRE CEO will report the suspicion to the Health Services Office of the Inspector General (HSOIG) as required by the NMRE's Specialty Supports and Services Contract with the State. No attempt to further investigate or resolve the issue(s) will be made by the NMRE or the provider once the issue has been reported to the HSOIG.

2. Practice Guidelines

The NMRE supports the use of practice guidelines that are evidence-based and widely accepted. The NMRE's practice guidelines are comprised of the American Psychiatric Association (APA) practice guidelines, other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), MDHHS practice guidelines, and region-specific practice guidelines.
The APA practice guidelines provide evidence-based recommendations for the assessment and treatment of psychiatric disorders and are intended to assist in clinical decision making by presenting systematically developed patient care strategies in a standardized format.

a. Clinical Practice Guidelines created or made available by the American Psychiatric Associationhttps://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines

b. MDHHS Practice Guidelines (https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines)

c. Region Specific Practice Guidelines

The process of developing, reviewing, adopting, and disseminating practice guidelines as specified in the NMRE Practice Guidelines Policy and Procedure is assigned to the NMRE Provider Network Manager. The NMRE IOC has the responsibility for ensuring that the policy and procedure is implemented appropriately. Practice Guidelines are posted on the NMRE website: Northern Michigan Regional Entity - Northern Michigan Regional Entity (nmre.org).

3. Events Reporting and Notification

The NMRE complies with its Specialty Supports and Services Contract with the State and the Event Notification/ Reporting System by providing clear guidance for the reporting and reviewing of critical incidents, sentinel events, risk events, and deaths of beneficiaries. The NMRE will analyze this data quarterly to identify improvement opportunities.

Quarterly, the NMRE collects, aggregates, and analyzes events data through the Quality and Compliance committee (QOC). The findings of this data are then reported to NMRE's Internal Operations Committee and the Board.

a. Sentinel Events: A sentinel event is a type of critical incident that is an "unexpected occurrence" involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). A sentinel event does **not** include a death attributed to natural causes. Investigation of a sentinel event will be conducted by a staff with the appropriate credentials to review the event; for example, a sentinel event involving a death or serious medical condition will involve a physician or nurse.

To be a sentinel event, the incident must have occurred to a beneficiary in a reportable population and determined, through investigation, to be a sentinel event. Except for arrests/conviction and serious challenging behavior, each incident should be reviewed to determine if it meets sentinel event criteria.

i. Unexpected Death: The death of a beneficiary that is not the result of natural causes. An unexpected death includes any death that results from suicide, homicide, an undiagnosed condition, accident, or where it appears suspicious for possible abuse and/or neglect.

ii. Serious Physical Injury: Serious damage suffered by a beneficiary that a physician or nurse determines caused, or could have caused, the death of the beneficiary, the impairment of his/her bodily functions, loss of limb, or permanent disfigurement. An injury caused by actual or suspected abuse or accident must be treated at a medical facility. The treating medical facility must be noted on the incident report.

iii. Emotional Harm: Impaired psychological functioning, growth, or development that is significant in nature as evidenced by observable physical symptomatology, as determined by a mental health professional or psychiatrist.

iv. Death by Natural Causes: The death of a beneficiary that occurred as the result of a disease process from which death is an anticipated outcome. A death by natural causes is **not** a sentinel event.

v. Physical Illness Requiring Hospital Admission: The unexpected hospitalization of a beneficiary for a previously unknown or undiagnosed illness. A planned surgery, whether outpatient or inpatient, is **not** considered an unexpected occurrence and, therefore, not included in reporting under this definition. A hospital admission for

an illness directly related to a beneficiary's chronic or underlying illness is also **not** reported as a sentinel event.

vi. Serious Challenging Behavior: A behavior that results in significant (over $100) property damage, an attempt at self-inflicted harm or harm to others, or an unauthorized leave of absence. A serious challenging behavior includes behaviors not previously addressed in a Behavior Treatment Plan.

vii. Medication Error: The delivery of medication to a beneficiary that is the wrong medication, wrong dosage, or double dosage, or failure to deliver medication that resulted in death or serious injury or the risk thereof. An instance where a beneficiary refused medication is **not** a medication error.

viii. Arrest/Conviction: Any arrest or conviction of a beneficiary who is in a reportable population at the time of the arrest or conviction. An arrest or conviction will be reported as a sentinel event [through the MDHHS Michigan Crisis and Access Line (MiCAL)] but does not require a root cause analysis.

b. Substance Use Disorder (SUD) Sentinel Event Reporting: Specific sentinel events that occurred to beneficiaries who were living in a 24-hour specialized residential substance abuse treatment settings at the time of the event are required to be reported to MDHHS. The specific categories are:

i. Death

ii. Accident that requires an emergency room visit and/or hospital admission

iii. Physical illness that required a hospital admission

iv. Arrest or conviction

v. Serious Challenging Behavior

vi. Medication error

c. Risk Events: An event that puts a beneficiary who is in a reportable population at risk of harm is categorized as a "risk event." A risk event is reported for internal analysis to determine what actions are needed to remediate the problem or situation and to prevent reoccurrence.

i. Harm to Self: An action taken by a beneficiary that causes them physical harm that requires emergency medical treatment or hospitalization (e.g., pica, head banging, self-mutilation, biting, suicide attempt).

ii. Harm to Others: An action taken by a beneficiary that causes physical harm to an individual(s) (family, friend, staff, peer, public, etc.) that requires emergency medical treatment or hospitalization of the injured person(s).

iii. Police Call: A call to police by a staff of a specialized residential setting, or general (AFC) residential home, or other provider agency requesting assistance with a beneficiary during a behavioral crisis, regardless of whether contacting law enforcement is addressed in a Behavior Treatment Plan.

iv. Emergency Use of Physical Management: The of physical management by a trained staff in response to a behavioral crisis.

v. Physical Management: A technique used as an emergency intervention to restrict the movement of a beneficiary by continued direct physical contact despite their resistance, to prevent them from physically harming themselves or someone else. "Physical management" does not include briefly holding a beneficiary to comfort them or demonstrate affection or holding their hand.

vi. Unscheduled Hospitalizations: Two or more unscheduled admissions of a beneficiary to a medical hospital within a 12-month period not due to planned surgery or the natural course of a chronic illness. The use of an emergency room or emergency department is **not** considered a hospital admission.

d. Critical Incidents: The NMRE requires all network providers (both CMHSPs and SUD providers) to report critical incidents to the NMRE monthly. Critical incidents include:

i. Suicide

ii. Non-suicide death

iii. Death of unknown cause

iv. MAT medication error

v. SUD medication error

vi. Seriously challenging behavior

Any unexpected death of a beneficiary who, at the time of their death, was receiving specialty supports and services will be reviewed. The review will include:

i. Confirmation of beneficiary's death (e.g., coroner's reports and/or death certificate)

ii. Involvement of medical personnel in the mortality review

iii. Documentation of the mortality review process, findings, and recommendations

iv. Use of mortality information to review quality of care

v. Aggregate mortality data to identify possible trends over time

The review will be a "formal process" and include areas of clinical risk. The review team will include individuals with appropriate credentials to review the scope of care, individuals who were not involved in the treatment of the beneficiary, and any additional individuals who may contribute to a thorough review process.

e. Root-Cause Analysis (RCA): A root cause analysis is a process for identifying the basic or causal factors that underlie variations in performance, including the occurrence or possible occurrence of a sentinel event or other serious event. A root cause analysis should result in an action plan designed to reduce or attempt to reduce future incidents. Within three (3) days of a critical incident, network provider staff will determine whether it meets sentinel event standards; if it does meet that standard network provider staff will initiate a root cause analysis within two (2) days of the determination. A request for

additional information, such as a coroner's report or death certificate, constitutes the start of a root cause analysis.

f. Unexpected Death Reporting: All unexpected deaths of Medicaid beneficiaries who, at the time of their death, were receiving specialty supports and services will be reviewed in accordance with the NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting Policy and Procedure and the NMRE's Specialty Supports and Services Contract with the State. This reporting will include suicide, non-suicide death, homicide, undiagnosed conditions, accidental death, suspicious death, or abuse/neglect.

The NMRE and/or the network provider will immediately report to MDHHS:

i. Any death of a beneficiary who was discharged from a State Facility within 12 months preceding the date of death

ii. Any death that occurs as the result of suspected NMRE or network provider staff action or inaction, or

iii. Any death that is the subject of a Recipient Rights, licensing, or police investigation.

The report will be submitted electronically within 24 hours of either the death or the responsible network provider staff's receipt of the death notification, or the responsible network provider staff's receipt of notification that a Recipient Rights, licensing, and/or police investigation has commenced to the NMRE Compliance Director. The report will include:

i. Name of beneficiary

ii. Beneficiary ID Number (Medicaid or Healthy Michigan Plan)

iii. Consumer ID (CONID) if there is no beneficiary ID number

iv. Date, time, and place of death (if a licensed foster care facility, include the license #)

v. Preliminary cause of death

vi. Contact person's name and email address

In addition, the network provider will submit a written report of its review/analysis of the death to the NMRE within 45 days from the month in which the death occurred. The NMRE will notify MDHHS within 60 days after the month in which the death occurred.

The primary responsibility for the review of sentinel events, critical incidents, and risk events falls to NMRE network providers and residential treatment providers. The NMRE IOC and QOC will analyze data sent by network providers quarterly to identify trends and implement plans of correction, as appropriate, to reduce the potential for future events. These reviews will be completed in accordance with MDHHS definitions and reporting requirements and the NMRE's Critical Incident, Risk Events, Sentinel Events and Death Reporting policy.

4. Credentialing and Recredentialing

The NMRE will ensure that anyone rendering services to beneficiaries is appropriately credentialed within the state and is qualified to perform the services by having met all applicable licensing, scope of practice, contractual, and Medicaid provider requirements.

The NMRE will monitor its Network Providers so that appropriately qualified and competent staff provide covered and authorized services. Credentialing and recredentialing will be based upon specific license, education, training, experience, and competence. The provider's level of competence and professional ethics will be of the highest order, and will continuously meet or exceed the qualifications, standards, and requirements.

a. The NMRE will:

    i. Be responsible for oversight of credentialing and recredentialing decisions; and

    ii. Terminate the credentialing of a provider when appropriate.

b. The NMRE will ensure that the credentialing and recredentialing processes do not discriminate against:

    i. A behavioral health care provider, solely based on license, registration, or certification; and

    ii. A behavioral health care provider who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

c. The NMRE will ensure the following:

    i. The provision of high quality and cost-effective mental health and substance use disorder (SUD) services to consumers.

    ii. Consumer access to a timely, geographically convenient, and specialized array of mental health and substance use disorder treatment and support services.

    iii. Licensed Independent Providers (LIPs) meet and/or exceed the accreditation and regulatory standards for practicing and delivering services independently.

    iv. The decision to enter a contractual relationship with any LIP credentialed by the NMRE under this policy is left to each CMHSP based on the needs of its Board and community.

    The NMRE credentials organizational providers. Each network provider completes its own credentialing of staff. The NMRE ensures that credentialing is completed in a manner consistent with the NMRE Credentialing Policy and Procedure, MDHHS Credentialing and Recredentialing document dated May 24, 2003, and the NMRE's Specialty Supports and Services Contract with the State.

d. Provider Monitoring: The NMRE monitors its network providers at least annually, including the five member CMHSPs, the SUD Provider Panel, and other contracted providers, as needed. Monitoring includes a review of delegated functions, services and supports provisions, and compliance with administrative requirements including credentialing and staff training. As appropriate, targeted monitoring activities for people

identified as "vulnerable" are also conducted. When a network provider is found to be out of compliance with contract requirements, appropriate corrective action is required.

e. Reporting: Each of the NMRE's Network Provider's is responsible for reporting any conduct by a member of its staff or provider network that results in suspension or termination from the provider network to the NMRE; in turn, the NMRE will report the conduct to the appropriate authorities (i.e., the Michigan Department of Health and Human Services, the provider's regulatory Board or agency, the Attorney General's Office) and any other Federal and State entities as specified in the NMRE's Specialty Supports and Services Contract with the State. Additionally, NMRE will notify MDHHS regarding any disclosures of criminal offense as found in sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil monetary penalties or assessments imposed under section 1128A of the Act.

f. Coordination with Network Provider Structures: The NMRE recognizes that quality improvement is best addressed by the individuals involved in the systems to be improved. As such, those best equipped to improve the various functions of the NMRE's provider network are those within the provider organizations. The NMRE supports the existing quality improvement structures of its network providers though the NMRE retains the responsibility for ensuring that federal and state regulatory requirements and the quality improvement provisions of the NMRE's Specialty Supports and Services Contract with the State are met.

5. Utilization Management

The NMRE will ensure access to public behavioral health services in the region in accordance with its contract with MDHHS and relevant Michigan Medicaid Provider Manual (MMPM) and Michigan Mental Health Code (MMHC) requirements. The NMRE supports the use of practice guidelines that are evidence-based and widely accepted to provide these services. The NMRE's practice guidelines are comprised of the American Psychiatric Association (APA) practice guidelines, other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), MDHHS practice guidelines, and region-specific practice guidelines.

Consistent with the Balanced Budget Act (BBA) and MDHHS contract requirements, the NMRE, in collaboration with the CMHSPs and contracted provider entities, will implement mechanisms to detect over- and under-utilization of services. These mechanisms will include but are not limited to:

- Develop, monitor, and track additional key performance indicators to detect patterns or trends.
- Specific studies of certain sets of services based on established factors or criteria. These may include services with high risk, high cost, ASAM levels of care, etc.
- Ares with significant variation in utilization patterns.
- Conduct data-driven analysis of regional utilization patterns
- Require corrective action when necessary.

The NMRE has a Utilization Management Plan that identifies:

a. Strategies for validating beneficiary eligibility criteria.

b. Strategies for evaluating medical necessity and service authorization decisions.

c. Mechanisms to identify the correct under- and over-utilization of services.

d. Procedures to conduct prospective, concurrent, and retrospective authorization reviews.

Collaboratively, NMRE and CMHSP designated staff are responsible to:

a. Provide oversight to ensure that each CMHSP has policies and procedures that comply with State and federal requirements related to UM.

b. Develop, monitor and track key performance indicators to include identification of over/under utilization patterns and/or deviation from expected results across the region.

c. Engage in studies of specific populations or sets of services based on identified factors or criteria. These may include populations or services with high risk, high costs, the presence of negative outliers or outcomes, or the presence of significant variances in utilization patterns.

d. Act as the representative for the region on any Utilization Management initiatives across the state.

6. Long-Term Services and Supports

The NMRE has mechanisms in place to ensure quality and appropriate care is provided to individuals receiving Long-Term Services and Supports.

"Long term services and supports (LTSS)" means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).

The following services are noted as LTSS services per the 1115 Pathway to Integration Waiver: Respite, Community Living Supports (CLS), Private Duty Nursing (PDN), Supported/Integrated Employment, Out of Home Non-Vocational Habilitation, Goods and Services, Environmental Modifications, Supports Coordination, Enhanced Pharmacy, Personal Emergency Response System (PERS), Community Transition Services, Enhanced Medical Equipment and Supplies, Family Training, Specialty Therapies (Music, Art, Message), Children Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services, Fiscal Intermediary Services, and Prevocational Services.

The NMRE will ensure that Long-Term Services and Supports (LTSS) are provided in accordance with 42 CFR §438.208(c)(1)(2) to persons with disabilities who need additional support due to:

a. Advancing age; or

b. Physical, cognitive, developmental, or chronic health conditions; or

c. Other functional limitations that restrict their abilities to care for themselves; and

d. Receive care in home and community-based settings or facilities such as nursing homes.

The NMRE's site review tool and consumer satisfaction survey include items monitoring the appropriateness of care for members receiving these services.

7. Performance Indicators

MDHHS has established performance indicators for CMHSPs and PIHPs. These indicators are drawn from the Michigan Mission Based Performance Indicator System (MMBPIS) in the areas of access, efficiency, timeliness, and outcomes. Each member CMHSP and the SUD Provider Panel reports relevant performance indicator data to the NMRE.

A standardized PI Export/Import is used in each CMHSP system to compile the data into RECON (the NMRE's EMR/PCE system). The NMRE IOC and QOC monitor these data quarterly and over time. When a standard is not met for two consecutive quarters, the NMRE requests a corrective action plan from the provider. This information includes persons served by NMRE providers for mental health, intellectual/developmental disability, and substance use conditions. The QOC reviews and monitors the NMRE's performance in this area.

The QOC reviews the trends in service delivery and health outcomes over time. This review includes whether there have been improvements or barriers impacting the quality of care and services to members. These reports are also shared quarterly with the NMRE's Governing Board and other stakeholders.

8. Member Satisfaction

The NMRE QOC, Customer Services Committee, and SUD Providers are responsible for ensuring that surveys are administered to beneficiaries to measure their degree of satisfaction with services, including those for mental health, intellectual/developmental disabilities, and substance use disorders, including long-term supports and services. Surveys are conducted in a way that results can be measured over time. The NMRE investigates areas of dissatisfaction when the data indicates a systemic concern with a particular provider. Survey findings are shared with the NMRE Governing Board, the NMRE regional Consumer Advisory Committee (Regional Entity Partners), network providers, and the public via the NMRE website.

9. Performance Improvement Projects (PIPs)

In accordance with federal regulations and the NMRE's Specialty Supports and Services Contract with the State, the NMRE conducts at least two Performance Improvement Projects (PIPs) each year. The MDHHS mandates the topic of one of the two PIPs. The NMRE regional QOC selects the topic for the additional PIP(s). The PIP study topics include clinical and non-clinical aspects of care. Prior to selecting the PIP topics, the NMRE's Internal Operations Committee, in collaboration with the Quality Operations Committee, identified areas of concern that could be addressed through a meaningful PIP.

For the fiscal year 2023, the NMRE is conducting three PIPS:

a. Increase the percentage of individuals enrolled in the Opioid Health Home (OHH) services.
b. Increase the percentage of individuals enrolled in the Behavioral Health Home (BHH) services.
c. Impact of telehealth on no show/missed appointments.

The PIHP utilizes the plan, do, study, act model to improve the quality of services. The NMRE QOC reviews PIP data at least quarterly. The NMRE Compliance Director reports on the PIPs in accordance with the timeline established by MDHHS.

10. Analysis of Behavior Treatment Data

The NMRE believes in protecting and promoting the dignity and respect of all individuals receiving public mental health services. Therefore, the NMRE has developed a policy that provides protection for individuals receiving services, promotes the use of least restrictive optimally effective treatment, assists staff by acting as a consultative resource committee, and ensures that the BTPRCs at the CMHSPs comply with the MDHHS Technical requirement for Behavior Treatment Plans.

At least quarterly, the NMRE regional Behavior Treatment Plan Review Committee (BTPRC) reviews and analyzes data from network providers in which intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis to identify trends and any subsequent action that needs to be taken to reduce the potential for future events. Data includes the number of interventions and the length of time the interventions were used per individual. The NMRE adheres to the provisions outlined in the MDHHS Technical Requirement for Behavior Treatment Plans dated July 29, 2020, and the NMRE's Specialty Supports and Services Contract with the State.

Approval Signature

NMRE Chief Executive Officer

2/8/23

Date

A. Performance Improvement Projects (PIPs)

1. Increase the percentage of individuals enrolled in Opioid Health Home (OHH) services.

Enrollment Process:

The Michigan OHH used a two-pronged enrollment approach where the Lead Entities (LEs) enrolled eligible members, using the MDHHS-determined, CMS-approved criteria. The LEs assigned enrolled members to one of the LEs contracted Health Home Providers (HHPs).

The OHH provides comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. For enrolled beneficiaries, the OHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. The model also elevates the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, a beneficiary's complete health and social needs are attended to. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

Sampling is not being used for this PIP because the entire eligible population will be used.

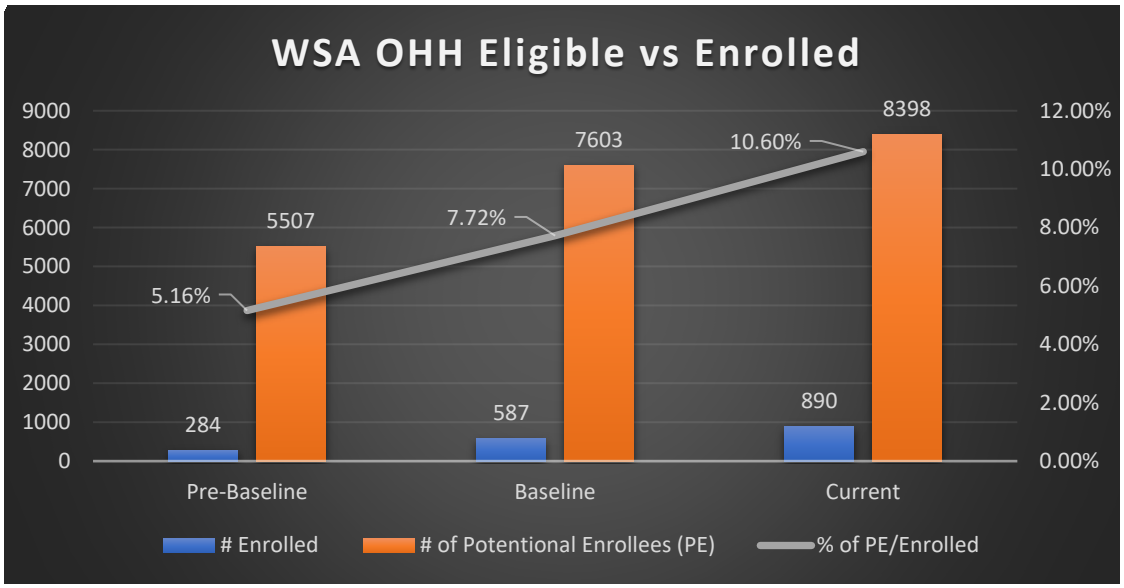
Eligible beneficiaries must reside within the NMRE's 21-county region, and must be enrolled in Medicaid, Healthy Michigan Plan (HMP), Freedom to Work, Healthy Kids Expansion, or MIChild and have a diagnosis of Opioid Use Disorder.

Goals

a. Increase access to Medication Assisted Treatment (MAT) and integrated behavioral, primary, and recovery-centered services for beneficiaries with Opioid Use Disorder
b. Decrease opioid overdose deaths.
c. Decrease opioid-related hospitalizations.
d. Increase utilization of peer recovery coaches.
e. Improve the "intangibles" of health status (e.g., the social determinants of health).

Initial Data

Time Period	Running Date	# Enrolled	# of Potential Enrollees (PE)	% of PE/Enrolled
Pre-Baseline	<= 9/30/2020	284	5,507	5.16%
Baseline	<= 9/30/2021	587	7,603	7.72%
Current	<= 9/30/2022	890	8,398	10.60%



Based on the data, the was a 0.8 percent increase in the OHH enrollment rate. The increase reflected a slight improvement in enrollment.

Positive interventions

a. Provider Network expansion: There was an increase in the provider network which led to a subsequent increase in enrollment.

b. Current providers increased participation resulting in an increase in enrollment. Some of the things that providers did differently were identified as:

   i. Hired more staff. Providers hired more staff in critical areas such as care coordinators to help maintain and expand enrollment.

   ii. Became more engaged in the process by attending meetings with the NMRE and investing more in the program.

c. The NMRE did the following to increase enrollment:

   i. Provided monthly meetings with providers. These monthly meetings helped to keep providers more engaged and motivated

   ii. Monthly meetings provided opportunities for additional education to providers.

Challenges

The major challenges were related to staffing capacity.

a. Staffing inconsistency due to high turnover
b. When providers lost critical staff, they were almost starting over because they had to either slow down or put a halt on new enrollment, hire new staff, and train new staff before they could get back on track.
c. Providers were unable to manage the overhead burden involved with this process given the ongoing staff shortage.

Systems challenges

a. Staff Stability
    i. Providers may have been doing very well then, suddenly, they lost a key staff member.
    ii. Staff were being stretched very thin and were required to cover a wide area of responsibilities.
    iii. Given the shortage in staffing, it was difficult to dedicate a staff to keep the client engaged and stay enrolled.
b. No show issues.
    i. Clients often didn't have a reliable source of transportation or didn't have transportation at all.

Other Concerns

a. Redeterminations – With the PHE coming to an end and the redetermination process starting up again, some beneficiaries will lose coverage, and this will negatively impact enrollment. The NMRE will monitor closely.
b. Some steps that the NMRE is taking to prepare:
    i. Alerting providers about the upcoming redeterminations and what that will mean for the provider and the beneficiaries.
    ii. When NMRE staff finds out that a beneficiary's address is incorrect in the WAS, they will alert the provider to make sure they have an accurate address, so communications are not going to the wrong place or person.
    iii. Encouraging providers to check beneficiary addresses to make sure they are updated in the system.
    iv. Showing providers how to run reports in the WAS to see and track redetermination due dates to be prepared for reenrollment and/or disenrollment.

v. Encouraging providers to have dedicated staff so they can have consistent enrollment.

How to measure success

Some of the ways that can be used to evaluate the success of this improvement project are:

a. Improved quality of life for individuals served.

b. Decreased Recidivism – re-hospitalization of individuals served.

c. Increased employment status for individuals served. In 2019 it was 33.9%, 2020 46.8% and 2021 52.8%

Systemic success factors

a. Fewer provider issues overall.

b. Better understanding of the OHH program by providers:

   i. Improved billing

   ii. Better care plans

Clinical Success Factors

a. Nurses at the CMHSPs saved lives because of this program; beneficiaries were referred to this program and their health outcomes improved.

b. Less use of the emergency rooms because clients were able to go to the CMHSPs for emergency services instead of going to the emergency room. Nurses at some CMHSPs were able to administer NARCAN treatments to beneficiaries in the parking lot, instead of calling 911.

c. There was improved collaboration to identify and connect beneficiaries with services.

d. Chronic conditions were kept under control by proper care coordination. This helped keep beneficiaries out of the ER because of better care management.

e. Cancer and other life-threatening illnesses were diagnosed sooner rather than later. This provided the opportunity of early intervention.

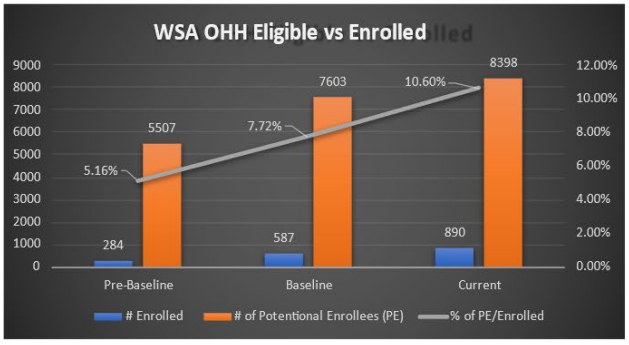
OHH PIP Data

Data as of November 17, 2022

OHH Breakout June 2, 2023

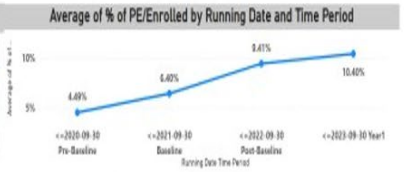
WSA OHH Eligible vs Enrolled

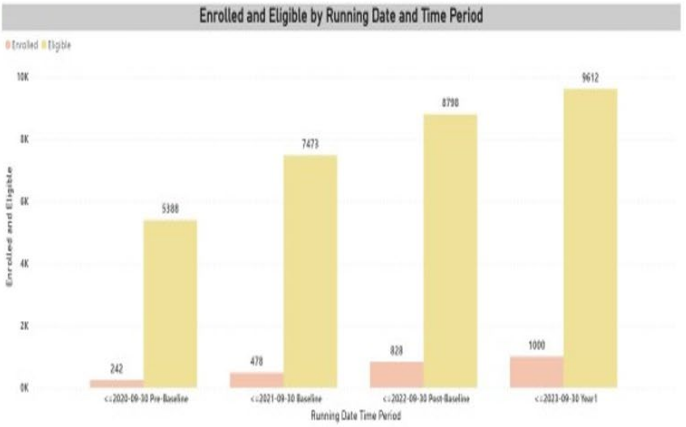
# Enrolled	# of Potentional Enrollees (PE)	% of PE/Enrolled	
284	5507	5.16%	
587	7603	7.72%	
890	8398	10.60%	



WSA OHH Breakout: Eligible versus Enrolled

Time Period	Running Date	Enrolled	Eligible	% of PE/Enrolled
Pre-Baseline	<=2020-09-30	242	5388	4.49%
Baseline	<=2021-09-30	478	7473	6.40%
Post-Baseline	<=2022-09-30	828	8798	9.41%
Year1	<=2023-09-30	1000	9612	10.40%





2. **Behavioral Health Home (BHH) – Improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 3.56% to 5% by the end of FY2023.**

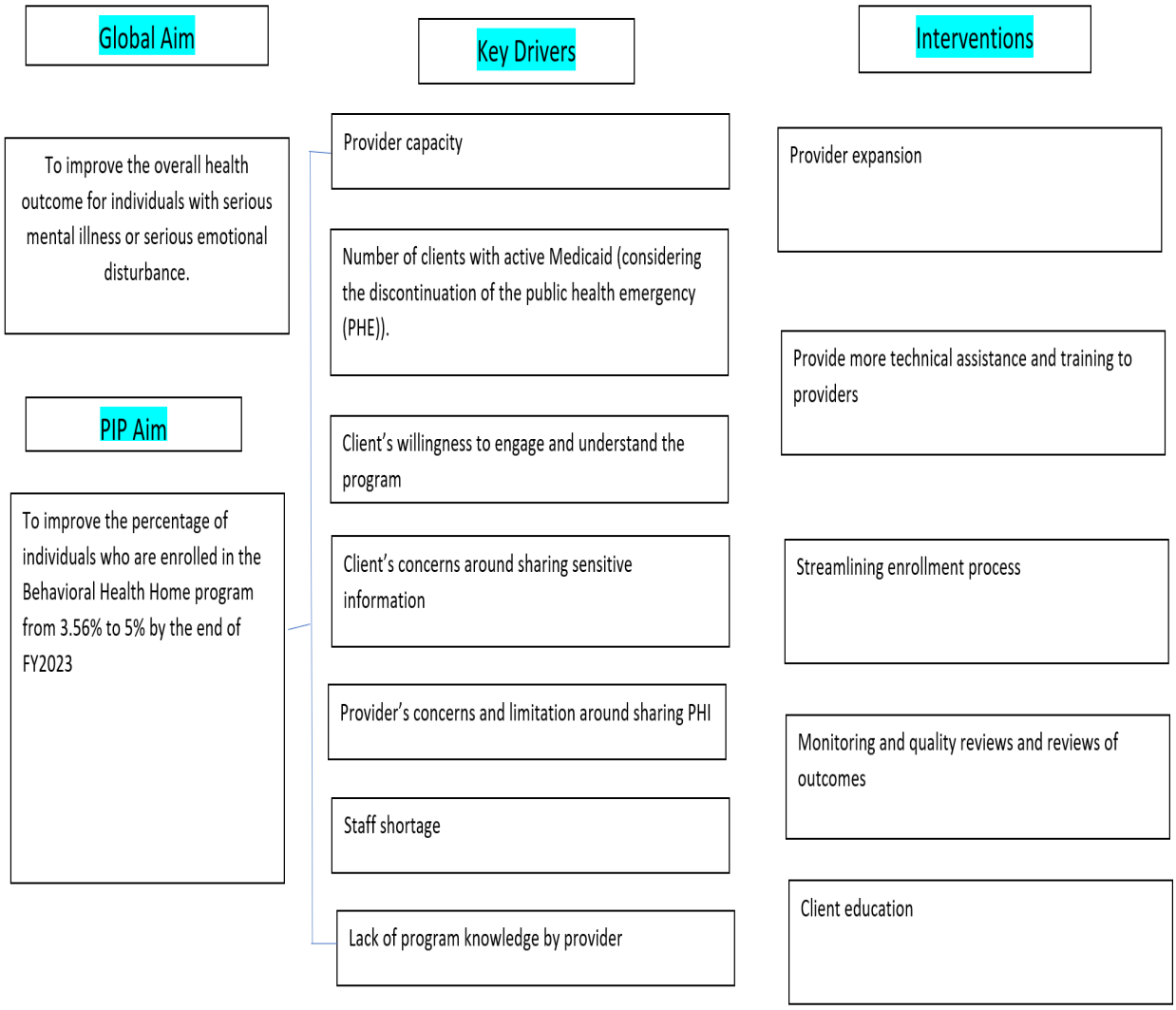
   Goals

   a. Improve care management for beneficiaries with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED).

   b. Improve care coordination between physical and behavioral services.

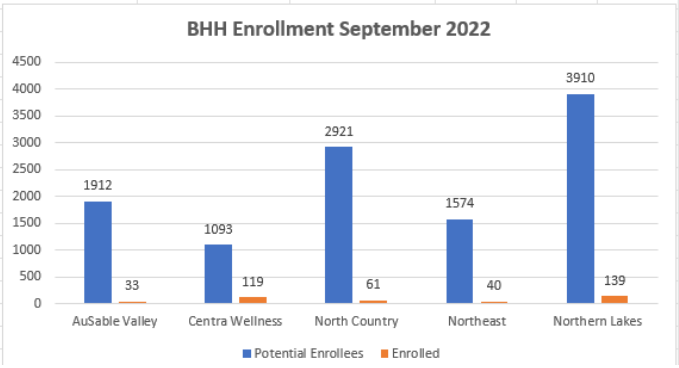
   c. Improve care transitions between primary care, specialty services and inpatient settings.

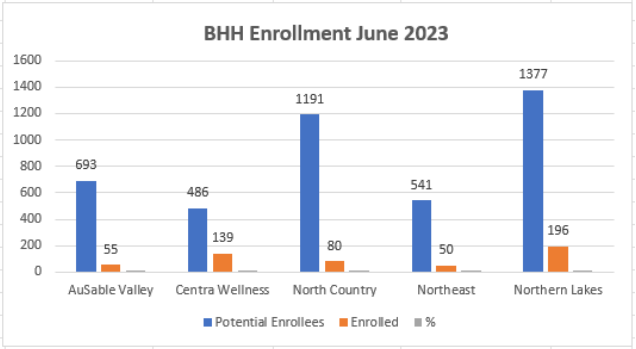
Key Driver Diagram for Behavior Health Home



BHH Enrollment September 2022			
	Potential Enrollees	Enrolled	%
AuSable Valley	1912	33	1.73%
Centra Wellness	1093	119	10.89%
North Country	2921	61	2.09%
Northeast	1574	40	2.54%
Northern Lakes	3910	139	3.55%
	11410	**392**	**3.44%**

BHH Enrollment June 2023			
	Potential Enrollee	Enrolled	%
AuSable Valley	693	55	7.94%
Centra Wellness	486	139	28.60%
North Country	1191	80	6.72%
Northeast	541	50	9.24%
Northern Lakes	1377	196	14.23%
	4288	**520**	**12.13%**



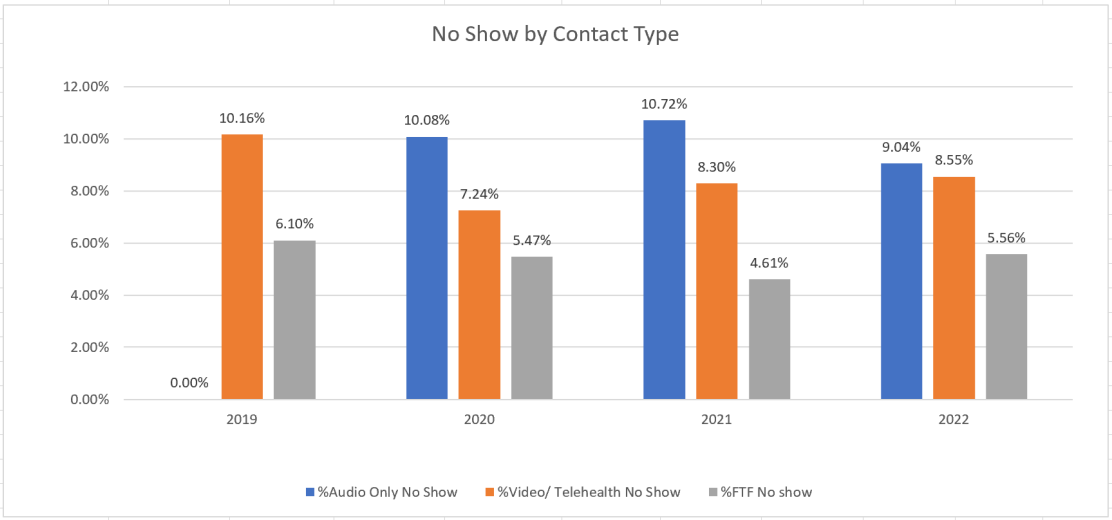


*** It should be noted that in 2022 the data was pulled for all eligible beneficiaries in the region. However, it was determined that the data would be more meaningful if it only reflected eligible beneficiaries served by each CMHSP. This explains the drop in potential enrollees from September 2022 to June 2023.

3. Decrease no-show/missed appointment rate for psychiatric services.

Region Wide No-Show Data

	Total Appointments Scheduled	Total No Show	%Total No Show	Audio Only Scheduled	Audio Only No Show	%Audio Only No Show	Video/ Telehealth Scheduled	Video/ Telehealth No Show	%Video/ Telehealth No Show	FTF Scheduled	FTF No Show	%FTF No show
2019	225018	12562	**5.58%**	1	0	**0.00%**	9544	970	**10.16%**	189718	11570	**6.10%**
2020	229678	17083	**7.44%**	90485	9120	**10.08%**	22052	1597	**7.24%**	116071	6351	**5.47%**
2021	235344	17050	**7.24%**	82605	8854	**10.72%**	32134	2666	**8.30%**	119595	5519	**4.61%**
2022	194798	12533	**6.43%**	26889	2432	**9.04%**	23456	2005	**8.55%**	145362	8081	**5.56%**



Next Steps

a. Discussion on challenges from various Boards.

b. Boards sharing successes.

c. Review common goals.

B. Site Reviews

1. HSAG Compliance Review

The FY 2022 compliance review was the second year of the three-year cycle of compliance reviews that commenced in FY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance review for Michigan PIHPs consists of 13 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first six standards in Year One (FY 2021), and a review of the remaining seven standards in Year

Two (FY 2022). In Year Three (FY 2023), a comprehensive review was conducted on each element scored as *Not Met* during the FY 2021 and FY 2022 compliance reviews. The standards that were reviewed in FY22 are comparable to the standards reviewed in 2019. Although the FY22 standards were much more elaborate, there was still an 8% increase in 2022 compared to the outcomes from 2019. The practice guidelines had the lowest score, and some process changes were put in place to mitigate this situation. There was significant improvement in the Confidentiality standard and additional processes were implemented to maintain this standard.

The FY 2021 compliance review CAP was approved, and the CAP implementation is in progress. The FY 2022 CAP was submitted and accepted.

2019 HSAG Compliance Review

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	5	3	0	63%
Standard II—Quality Measurement and Improvement	8	4	4	0	50%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	9	7	0	56%
Standard VIII—Members' Rights and Protections	13	11	2	0	85%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	6	4	0	60%
Total	82	57	25	0	70%

2022 HSAG Compliance Review

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	75%
Standard VIII—Confidentiality[1]	11	11	10	1	0	91%
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	84%
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	80%
Standard XI—Practice Guidelines	7	7	4	3	0	57%
Standard XII—Health Information Systems	12	11	9	2	1	82%
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	21	9	0	70%
Total	119	118	92	26	1	78%

2. NMRE Site Review

The NMRE conducts regional CMH site reviews biannually; year one is a full review and year two is a review of the Corrective Action Plan (CAP) implementation. Fiscal year 2022 was a full review year for the NMRE's site review. The NMRE requested random sample of evidence from the CMHSPs. It was a Hybrid review where part was a deck review and NMRE staff went on site for separate piece.

Results Summary					
TOOL	OVERALL SCORE				
	AVCMHA	CWN	NCCMHA	NEMCMHA	NLCMHA
DMC	100%	99.4%	99.7%	97.9%	97.6%
Program Specific	97.37%	97.9%	97.4%	92.6%	95.8
Clinical Records	97.85%	98.2%	97.4%	96.6%	95.0%
Training			88.5%	85.4%	92.0%

Site Review Observations:

a. Most of the missing documentation; trainings were from 2020.

b. Most of the missing documents; trainings were from AFC Homes.

c. Unable to see a clear or separate training between the various specialties such as customer service, cultural competency, etc.

d. Some Boards did not have a training grid which would have made it easier to identify the various roles and trainings.

e. National Practitioner Databank (NPDB) checks were not incorporated in the initial verifications of clinical staff.

f. The CMHSPs are currently working on the CAPs for the FY2022 site review.

3. MDHHS Review

The NMRE team worked with the CMHSPs and MDHHS to complete the initial 2022 (c) Waiver (HSW, CWP, SEDW) review; this review occurs every other year. There were no outstanding trends among the five CMHSPs reviewed; however, there was a need for a technical assistance call with the five CMHSPs to clarify certain areas.

4. SUD Program Review

The NMRE conducts SUD Providers site reviews biannually; year one is a full review and year two is a review of the Corrective Action Plan (CAP) implementation. The 2022 compliance review for SUD providers was a CAP review of the 2021 full review. This year the NMRE requested evidence of CAPs that were activated as a result of the 2021 NMRE site review. The SUD providers in the region were found to be substantially compliant with the CAPs.

C. Satisfaction Surveys

The NMRE will ensure that Network Providers have established policies and procedures that comply with regulations regarding member experience. Providers must conduct, at least annually, the regional consumer satisfaction survey in a way that is representative of all the individuals served including those receiving long term care (LTSS) such as case management, support coordination, etc.

The MI and I/DD survey was updated to include areas specific to individuals receiving LTSS. The NMRE Customer Services Specialist followed up on all negative comments or responses that were less than favorable.

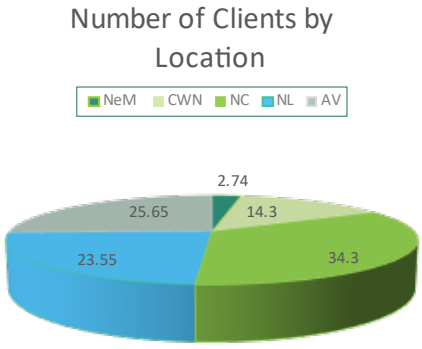
The NMRE used survey monkey to collect these data, and later aggregate and analyze the data. The results were reviewed with the Internal Operations Committee, QOC, and the NMRE Board. The results were also shared with the provider network and REP committees and placed on the NMRE.org website.

1. The following satisfaction surveys were completed:
    a. SUD Residential
    b. MH Outpatient
    c. Detox
    d. Methadone
2. The NMRE Customer Services Specialist and Compliance Director:
    a. Reviewed the surveys for trends and identified areas for improvement.
    b. Identified underperforming providers and reached out to them to implement a CAP and provide technical assistance.
    c. Followed up with the CAP through to completion.
3. Survey results were disseminated/communicated as follows:
    a. Shared with the individual providers.
    b. Shared and discussed during the SUD Director's meeting.
    c. Shared and discussed during the Compliance and Quality Committee meeting.
    d. Shared with the Board of Directors.
4. The following challenges to the survey process were identified:
    a. Low participation
    b. Lack of communication between staff and administration resulting in low participation.
    c. Not all clients returned to inpatient services.
    d. Completed surveys were not returned timely.

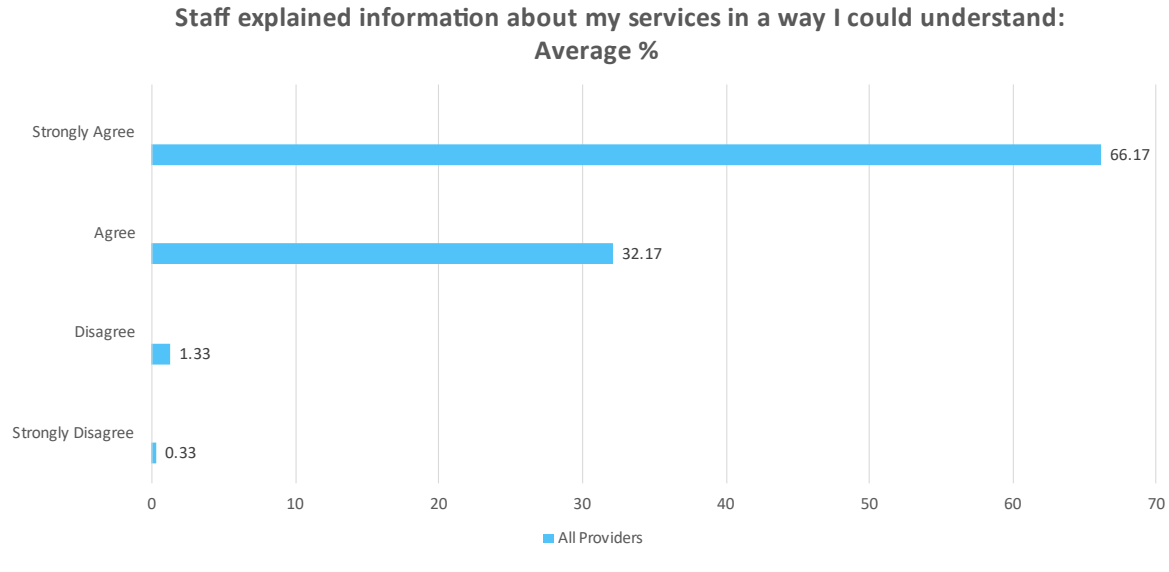
A few highlights from the survey as follows:

Mental Health Outpatient

- Total Responses: 620



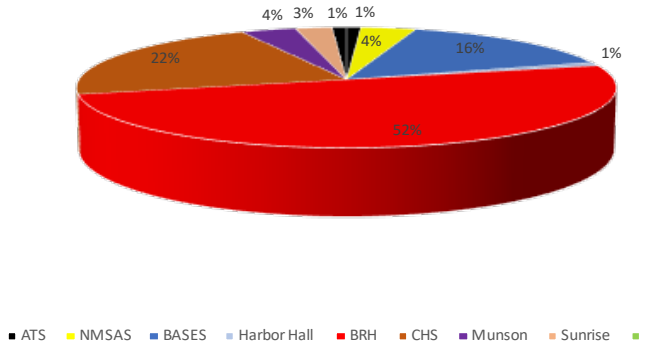
Location	# of Clients Completing Survey
Northeast Michigan CMH	17
Centra Wellness Network	87
North Country CMH	211
Northern Lakes CMH	146
AuSable Valley CMH	159



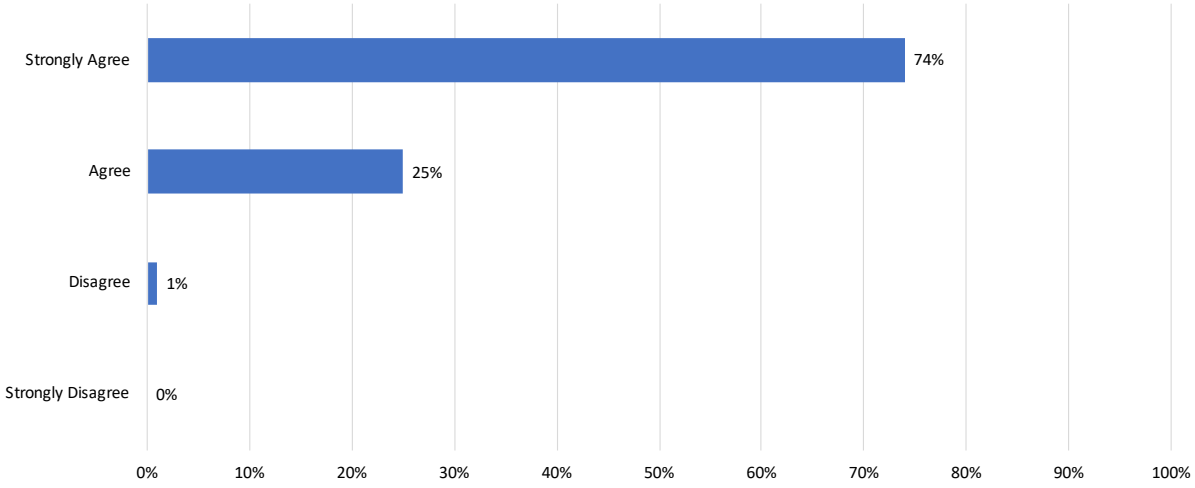
SUD Outpatient Survey

Responses : 238

Location	# of Clients
Addiction Treatment Service	3
Bear River Health	120
Sunrise Center	6
Catholic Human Services	52
Munson	9
Harbor Hall	1
BASES	37
NMSAS	9
GRACE Center	1



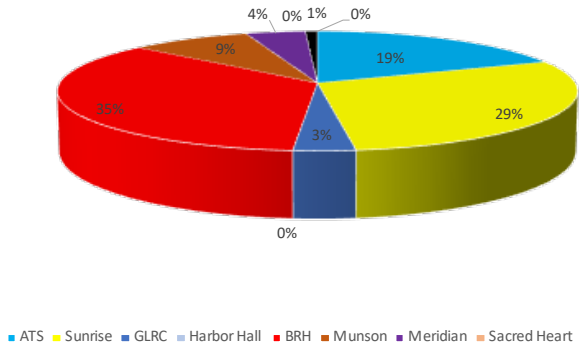
Services were provided quickly after I contacted the program.



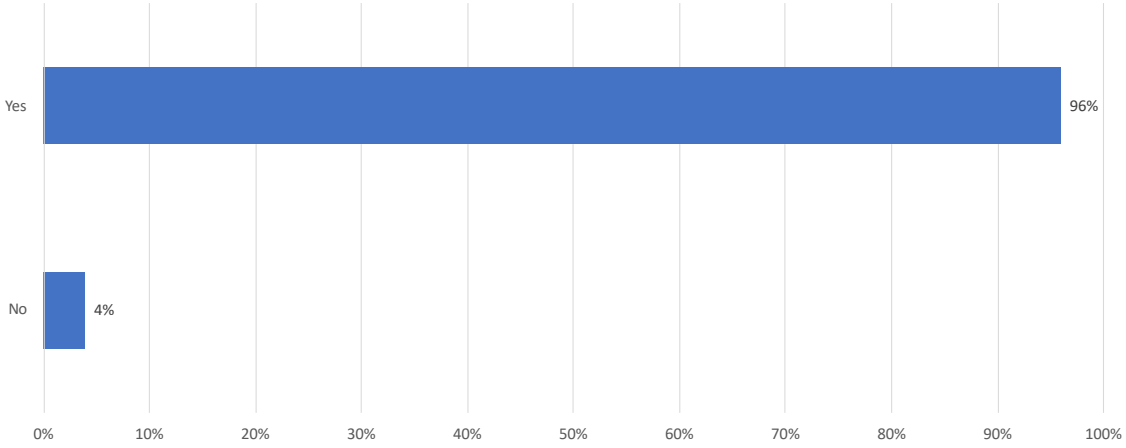
SUD Residential Survey

Residential Responses: 117

Location	# of Clients
Addiction Treatment Service	22
Bear River Health	41
Sunrise Center	34
Great Lakes Recovery Center	4
Munson	10
Harbor Hall	0
Meridian	5
Sacred Heart	0
Ten Sixteen	1
Dot Caring	0



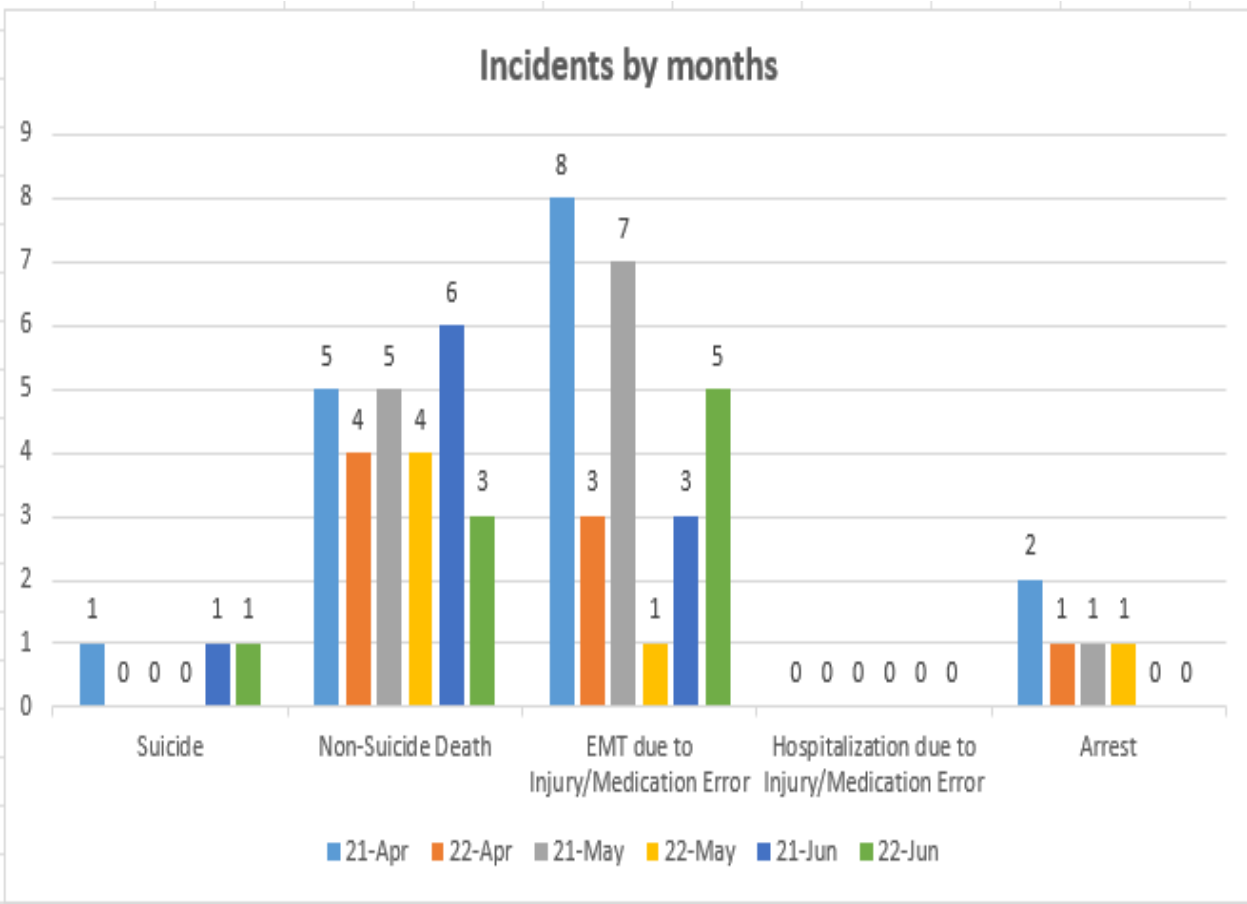
I am involved in my treatment planning.

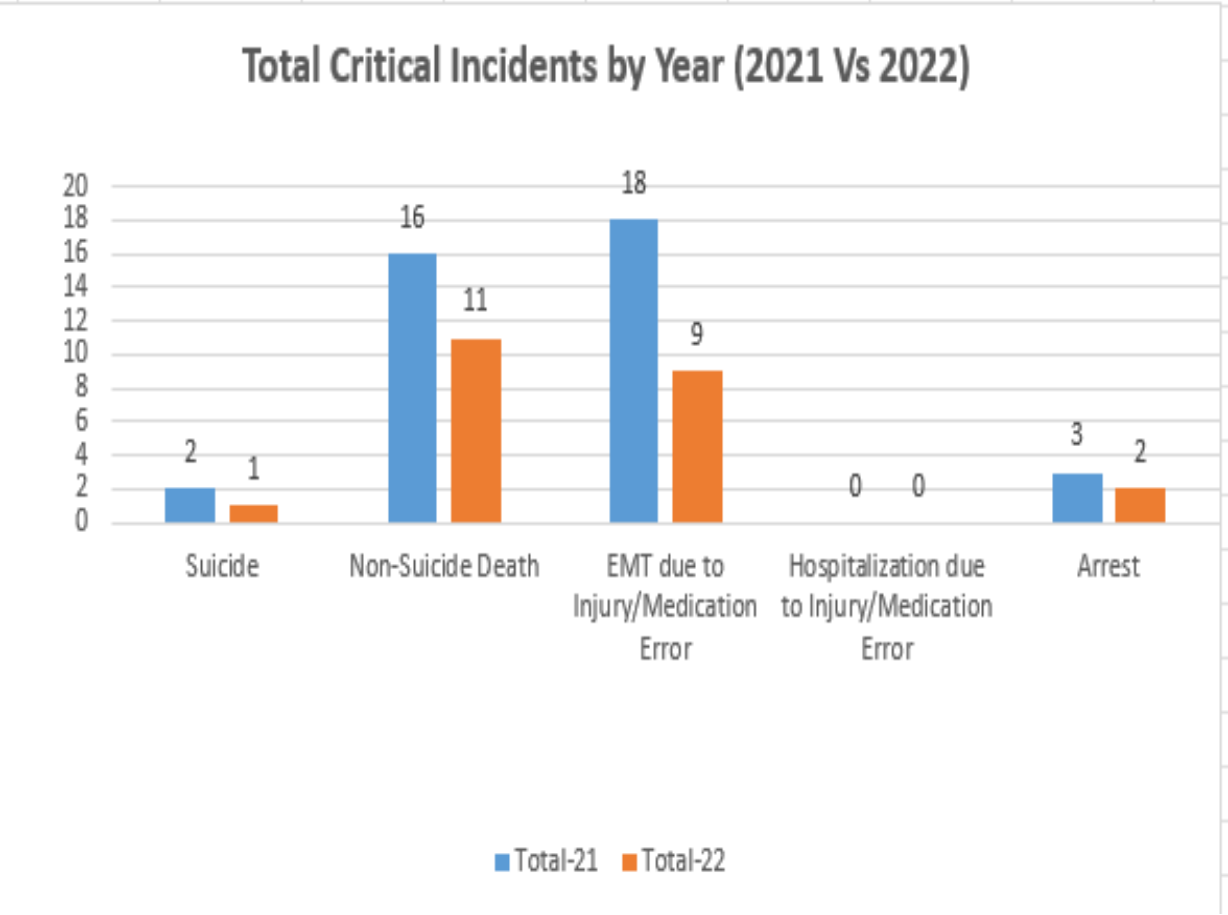


D. Events Data

1. Critical Incidents

Critical Incidents data were broken down by months and by year. March of 2022 had the highest number of incidents reported, however, there were no trends identified around this occurrence. Non—suicide death was the highest category in 2022. It was determined that the impact of COVID was the major cause of the increase in reported deaths. EMT due to injury/Medication error came second. This came as no surprise because Region 2 continues to experience a significant level of staff shortage and high turnover. Overall, there was a total of 106 critical incidents reported in 2022, a 29% decrease from 2021.

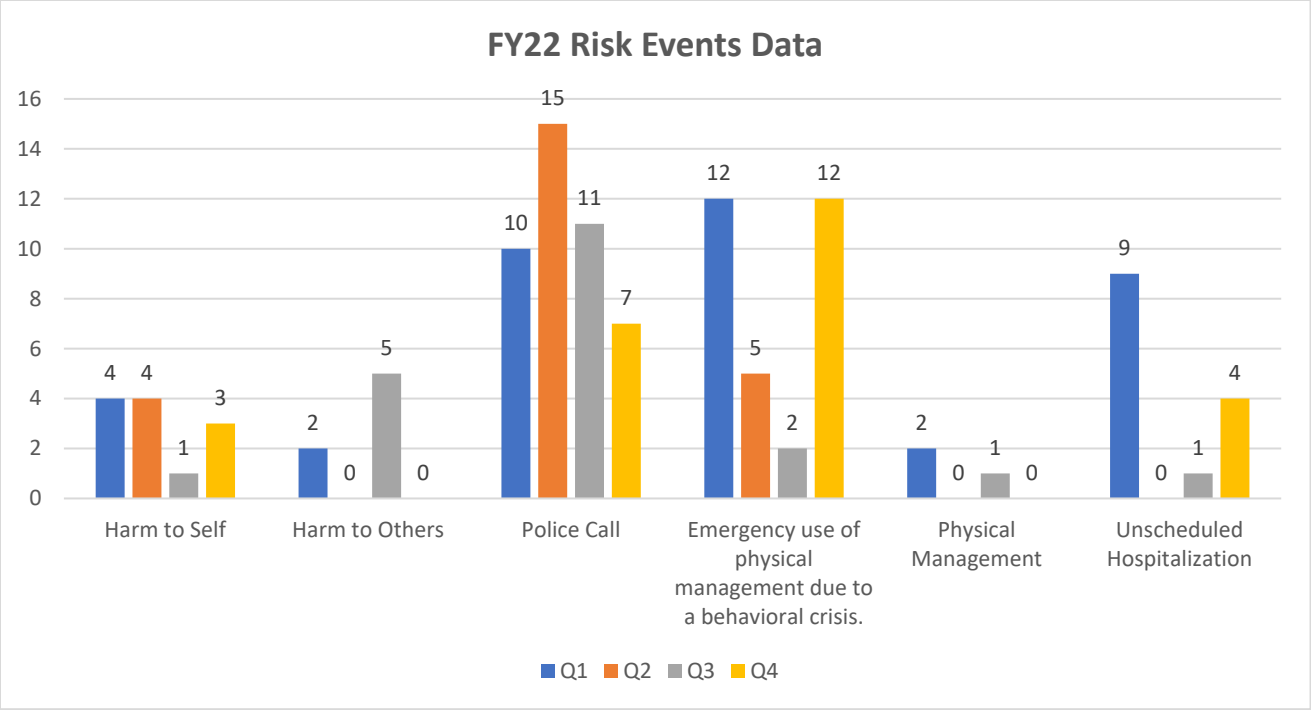




2. Risk Events Data

Risk events data were reviewed by quarter as opposed to FY2021 vs. 2022 because 2022 was the first year with full data. Police calls remained consistently high due to increasing cases with chronic behavioral issues with either less staffing or insufficiently trained staff due to the staff shortage and staff turnover in the region. Emergency use of physical management due to behavioral crisis came in second. This was again attributed to the high staff turnover and staff shortage which didn't allow staff to be properly trained before they fully assumed their duties.

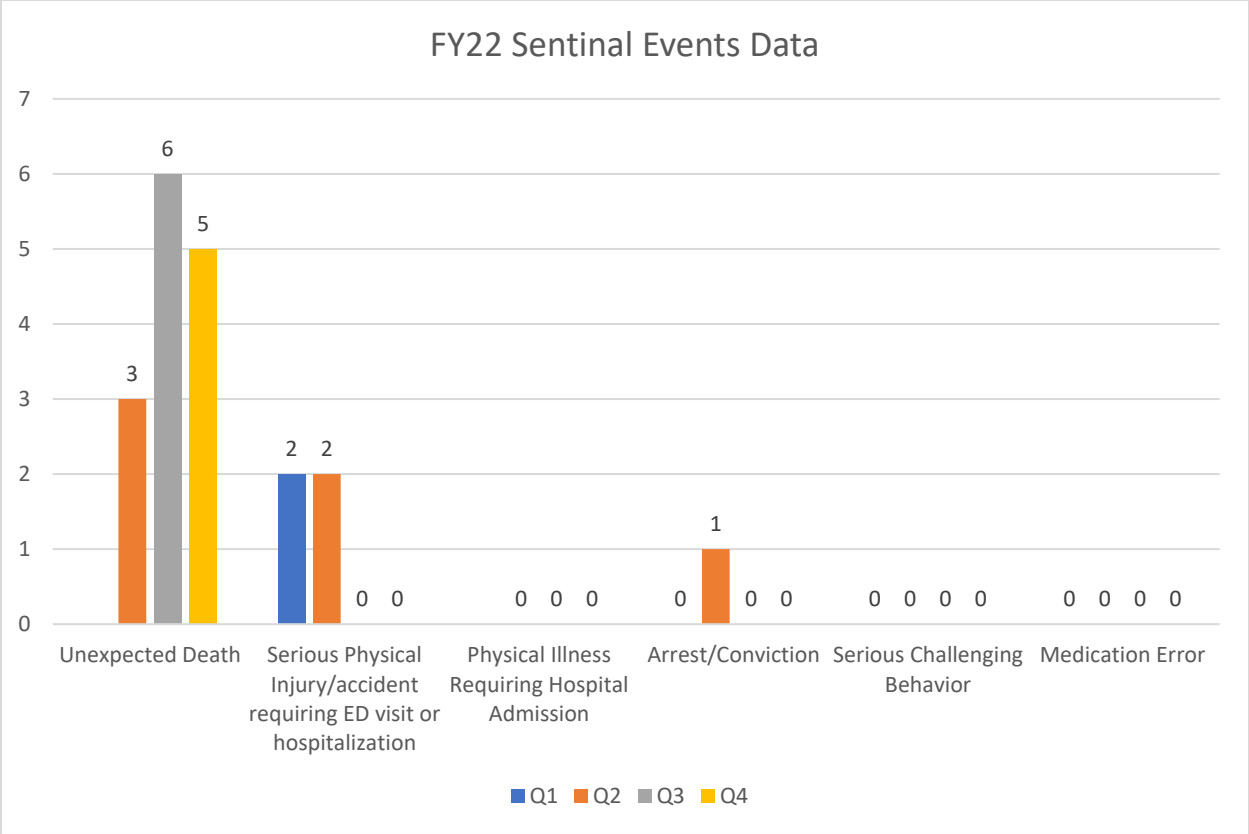
Event Type	Q1	Q2	Q3	Q4
Harm to Self	4	4	1	3
Harm to Others	2	0	5	0
Police Call	10	15	11	7
Emergency Use of Physical Management Due to a Behavioral Crisis	12	5	2	12
Physical management	2	0	1	0
Unscheduled Hospitalization	9	0	1	4



3. Sentinel Events Data

Sentinel events data were reviewed by quarter as opposed to FY2021 vs. 2022 because 2022 was the first year with full data. Suicidal death was the highest sentinel event reported; unfortunately, there was no identified trend. The cause of death and location varied; however, a need for enhanced crisis planning and the ongoing use of crisis plans was detected. It was also observed that there was an increase in substance use disorders and lack of training to properly identify SUD and high-risk individuals. Some of the CMHSPs created an SUD committee to address this need. Motivational Interviewing training was also being pursued.

Event Type	Q1	Q2	Q3	Q4
Unexpected Death		3	6	5
Serious Physical Injury/Accident Requiring ED Visit or Hospitalization	2	2	0	0
Physical Illness Requiring Hospital Admission		0	0	0
Arrest/Conviction	0	1	0	0
Serious Challenging Behavior	0	0	0	0
Medication Error	0	0	0	0



For critical incidents that were classified as a sentinel events, the NMRE had two business days to commence root cause analyses of the events. This was a challenge, however, because the information was not usually being passed on from the provider to the NMRE.

Reminders were provided during various regional committee meetings to make sure that information is being passed on to the NMRE appropriately. The initial sentinel event reporting form requires the CMHSPs and other providers to report sentinel events to the NMRE within 24 hours. The NMRE also implemented a Root Cause Analysis (RCA) form. The RCA must commence within two days of confirming that a sentinel event occurred and must be completed and submitted to the NMRE within 45 days unless an extension is requested. Extensions requests must be properly documented. The NMRE continued to provide reminders to the CMHSPs and the SUD providers. The NMRE will monitor the CMHSPs to make sure they are also providing similar trainings to their provides.

E. Performance Indicators

The Michigan Department of Health and Human Services (MDHHS) requires that the NMRE complies with certain quality measures as they relate to access to care, efficiency, and outcomes. The MDHHS established measures known as the Michigan Mission Based Performance Indicator System (MMBPIS).

The NMRE is required to share this data with MDHHS quarterly. This data is usually referred to as performance indicators and it is broken down by the various indicators in tables. The NMRE's goal for 2023 was to meet and exceed the MMBPIS measures.

Performance indicator data was shared with all the PIHPs and the Substance Use Disorder (SUD) Directors for review and feedback. During QOC and at the SUD Directors meetings, this data was presented and the opportunity for meaningful discussions was provided. During these meetings, the NMRE highlighted areas of success and areas with deficiencies were discussed.

It was discovered that there were certain situations when a client went back into the hospital prior to 7 days after discharge, the system did not pick up the exception consistently. This required a manual adjustment which was not usually completed consistently by all the Boards. It was also revealed that hospitals sometimes do not schedule the follow-up visit before a client leaves that hospital. Once the client leaves the hospital, it is sometimes difficult to reach them prior to the 7-day window. The CMHSPs worked with the hospitals to mitigate this situation.

For SUD access to care, due to the staffing shortage, it was sometimes not possible to have schedule an intake appointment within seven days. SUD providers continued to explore other options, such as telehealth to be able to bridge this gap.

The NMRE did not have the capability to obtain the value for table 2b – Timeliness/first request. As a result, the NMRE looked at expired requests and focused on ways to reduce that number.

Prior to the exceptions being removed from table2 2 and 3, the NMRE consistently scored values over 95%. With the exceptions in place, the percentages dropped. The NMRE routinely monitors statewide data on these indicators.

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# < 3 Hours	% < 3 Hours
Children	180	179	99.44%
Adults	770	761	98.83%
Total	**950**	**940**	**98.95%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	# In 14 Days	% In 14 Days
MIC	353	195	55.24%
MIA	910	498	54.73%
DDC	77	59	76.62%
DDA	33	20	60.61%
Total	**1,373**	**772**	**56.23%**

Table 2b – Access – Timeliness/First Request - Substance Use Disorder

Population	Admissions	Expired	# In 14 Days	% In 14 Days
SA	Calculated	217	Calculated	%

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	# In 14 Days	% In 14 Days
MIC	229	162	70.74%
MIA	515	330	64.08%
DDC	70	52	75.71%
DDA	22	14	63.64%
Total	**836**	**559**	**66.87%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	# 7 Days	% 7 Days
Children	59	14	45	45	100%
Adults	228	80	148	145	97.97%
Total	**287**	**94**	**193**	**190**	**98.45%**

Table 4b – Access – Continuity of Care - Substance Use Disorder

Population	# Discharges	Exceptions	Net Discharges	# 7 Days	% 7 Days
SA	255	102	153	145	94.77%

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	# Readmit in 30 Days	% Readmit in 30 Days
Children	59	0	59	4	6.78%
Adults	228	1	227	26	14.45%
Total	**287**	**1**	**286**	**30**	**10.49%**

F. Medicaid Encounter Verification

1. Medicaid Encounter Verification (MEV)

MEV audits of providers were conducted quarterly. This process allowed the NMRE to ensure that all claims for services were properly documented and that services were provided prior to payment. This audit was completed quarterly, and the results were shared with the providers. If an audited sample yielded less than 95% accuracy, a Plan of Correction was

required. If an audited population fell below 90% accuracy during a 12-month period, a stratified sample was pulled, and a plan of correction was required.

- CMHSP Direct Provided Services Population (5 Providers Total)
  40 Services per year, 10 per Quarter
- CMHSP Subcontractors Provided Services Population (5 Providers Total)
  40 Services per year, 10 per Quarter
- SUD Provider Population (1 Provider Total)
  60 Services per year, 15 per Quarter
- Financially Significant Population (3 SUD, 0 CMHSP)
  40 Services per year, 10 per Quarter

Any single provider that accounted for more than 10% of the total MH or SUD budgets accordingly.

- Stratified Population-if review yielded less than 90% accuracy

The MEV audit of the five (5) CMHSP yielded the following findings. For details on the population of providers, see sampling methodology above.

a. Five providers were audited (CMH Contracted Services and CMH Direct Services).

b. $146,890.56 dollars were audited, with $146,509.64 dollars validated.

c. 400 encounters were audited and 198 were valid.

d. $380.92 dollars were invalid.

e. 99.5% of encounters were compliant.

The MEV audit of ten (10) Substance Use Disorder Providers yielded the following findings. For details on the population of providers, see sampling methodology above.

a. A total of ten providers were audited.

b. $58,837.10 dollars were audited, with $5,890.72 dollars validated.

c. 180 encounters were audited and 153 were valid.

d. $2,946.38 dollars were invalid.

e. 85% of encounters were compliant.

The Medicaid Encounter Verification Audit for FY 2022 resulted in a few plans of correction which were due to the NMRE 30 days after the final MEV report was received by the providers. It was noted that several providers struggled with the following issues:

- Staffing shortage, especially with the SUD providers. As a result of this, staff were stretched too thin which caused them to miss certain aspects of the job.

- High turnover also played a major factor. When staff left, they took the knowledge they had gained with them; new staff needed to be trained all over again. During the training period, certain processes were missed as new staff getting on board.

Grand totals for the NMRE's FY 2022 MEV audit yielded the following findings. For details on the population of providers, see sampling methodology above.

a. 15 Providers in total were audited.
b. $205,727.66 dollars were audited, with $202,400.36 dollars validated resulting in a compliance rate of 95%.
c. 580 encounters were audited, with 551 encounters validated.
d. $3,327.03 dollars and 29 encounters were found to be invalid.

Persistent challenges such as the pandemic, high staff turnover, and staff shortage, caused a 1% decrease in MEV results in 2022 compared to 2021.

2. Prevention Program.

The NMRE contracted with four prevention providers to deliver evidence-based programs with fidelity standards as well as other services to prevent youth drinking, marijuana misuse, drug misuse, and youth tobacco sales within the 21-county region. The annual audit involveed a random sample method that included program monitoring, staff verifications, and Michigan Prevention Data System (MPDS) verifications and was conducted through site visits (if applicable), desk review, and concluded with an exit interview. The Prevention Monitoring tool broke down each section in detail to compile the results, as shown below.

Provider	Program Monitoring	Staff	MPDS	Synar Complete	Total	Records Audited
Catholic Human Services	90%	100%	73%		81%	19
Centra Wellness	59%	100%	86%		82%	13
District Health Dept #10	100%	100%	100%		100%	10
Health Dept of NW MI	98%	100%	100%		99%	14
District Health Dept #2						
NMRE Grand Total	**87%**	**100%**	**90%**		**91%**	**56**

Definitions/Explanations*

Program Monitoring- Review assessments, meeting minutes, publication samples/approvals, Prevention Plans, Cultural Competency, and reporting

Staff Verification- Credentials, background checks, and trainings

MPDS- Direct services are entered into this state system within 30 days of service. Contracted providers deliver supporting documentation that this activity occurred as billed.

Synar checks- In accordance with the Federal Youth Tobacco Act, the NMRE Contracts with Designated Youth Tobacco Use Representative (DYTUR) to ensure retailers do not sell tobacco or Electronic Nicotine Delivery Systems (ENDS) to underage persons.

G. Utilization Management (UM) Committee

A Regional Utilization Management (UM) Committee was formed in 2022. The purpose of this committee was to provide oversight and perform utilization management functions to control costs and minimize risk while assuring quality care. The NMRE UM Plan established a framework for oversight and guidance of the Medicaid program by ensuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services. Individuals and or entities that conduct utilization management activities must sign an attestation stating that compensation cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

The committee accomplished the following:

1. Reviewed the current UM processes for all the CMHSPs and SUD services providers.
2. Discussed authorization decision making processes to make sure that services are not being denied unnecessarily.
3. Other areas reviewed included:
    a. Service denials
    b. Telehealth
    c. Out-of-state placements
    d. Respite program
    e. 14-day compliance
    f. Intake and first services

H. Behavior Treatment Plan Review Committee (BTRC)

A regional Behavior Treatment Plan Review (BTPR) Committee was formed in 2022. The committee quarterly reviewed and analyzed data from the CMHSPs' Behavior Treatment Review Committees where intrusive or restrictive techniques were approved for use with beneficiaries and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that were approved during person-centered planning by the beneficiary or his/her guardian, were permitted to be used with beneficiaries. Data included the number of interventions and length of time the interventions were used per person.

In FY22, the committee accomplished the following:

1. Developed and approved the Behavior Treatment Review Committee (BTRC) Policy.

2. Reviewed and approved the BTRC data collection template.
3. Reviewed BTRC data from all five CMHSPs.

Once the data was reviewed, it was evident that more training was required. Some reports missed important details such as the length of time of the interventions. Additional training was provided to improve this process.

I. Credentialing and recredentialing

Exclusion/sanctions verifications

a. The NMRE completed exclusion checks for all NMRE employees, contractors, contracted entities/providers, and Board Members upon hire,prior extending a contract, and monthly thereafter.

b. The NMRE completed monthly checks for SUD Providers.

The databases that were searched included:

- MI_SPL – Michigan Medicaid List of Sanctioned Providers
- OIG – Office of Inspector General – List of Excluded Individuals/Entities
- OIG_Most_Wanted – Office of Inspector General – Most Wanted Fugitives
- SAM System for Award Management: Excluded Parties
- SDN – Office of Foreign Assets Control – Specially Designated Nationals
- NPDB – National Practioner Data Bank

J. Network Adequacy

The NMRE's anticipated monthly enrollment of Medicaid beneficiaries was approximately 180,444. Of the total Medicaid beneficiaries, children made up 31.9%, or 57,737 enrollees (Table 1: Enrollment).

Table 1. Enrollment

Funding	Age Group	Eligible Recipients (2020)	Eligible Recipients (2021)	Eligible Recipients (2022)
MC (excluding HMP)	At or Over 18	40,345	48,066	63,575
MC (excluding HMP)	Under	40,911	42,146	57,737
MC (excluding HMP)	Total	81,256	90,212	121,312
HMP	At or Over 18	36,896	50,301	59,132
HMP	Under	0	86	0

HMP	Total	36,896	50,387	59,132
Combined At or Over 18	At or Over 18	77,241	98,367	122,707
Combined Under 18	Under	40,911	42,232	57,737
Combined Total	Total	118,152	140,599	180,444

Based on the latest network adequacy report, the decline in ACT services ended in 2020; an increase of 7.3% wad observed in 2021, though 2023 again saw a decrease of 3% to 362 enrollees. (Table 2: ACT)

Table 2: ACT

Fiscal Year	Service Received	# of Enrolled Individuals
2018	ACT	362
2019	ACT	344
2020	ACT	328
2021	ACT	352
2022	ACT	342

Psychosocial Rehabilitation (Clubhouse) decreased slightly for the second year in a row. (Table 3: Clubhouse)

Table 3: Clubhouse

Fiscal Year	Service Received	# of Enrolled Individuals
2018	Clubhouse	380
2019	Clubhouse	372
2020	Clubhouse	369
2021	Clubhouse	333
2022	Clubhouse	314

Home-Based services increased steadily from FY 2018 – 2021, then saw a decrease of 31% in FY 2022. (Table 4: Home-Based)

Table 4: Home-Based

Fiscal Year	Service Received	# of Enrolled Individuals
2018	Home-Based Services	316
2019	Home-Based Services	358
2020	Home-Based Services	395
2021	Home-Based Services	434
2022	Home-Based Services	317

Wraparound services have remained relatively unchanged from FY 2018 through FY 2022. (Table 5: Wraparound)

Table 5: Wraparound

Fiscal Year	Service Received	People
2018	Wraparound	107
2019	Wraparound	124
2020	Wraparound	123
2021	Wraparound	127
2022	Wraparound	126

The NMRE region maintained 23 Children's Home-based full-time equivalents (FTEs) and 8.5 Children's Wraparound FTEs. CMHSP-specific data was reported as follows:

- AuSable Valley Community Mental Health: 2 Home-based FTEs, 3 Wraparound FTEs
- Centra Wellness Network: 2 Home-based FTEs, 1 Wraparound FTEs
- Northeast Michigan Community Mental Health: 3.5 Home-based FTEs, 1 Wraparound FTE
- North Country Community Mental Health: 6 Home-based FTEs, 1.5 Wraparound FTEs
- Northern Lakes Community Mental Health: 10 Home-based FTEs, 3 Wraparound FTEs

The NMRE met all the state identified standards of network adequacy for adult and child populations with the exception of Opioid Treatment Programs (OTP), which is very close to being met. The NMRE added a fourth OTP setting on April 1, 2022, in St. Ignace, Michigan to assist regional enrollees in obtaining this service in the northern portion of the region.

The NMRE and the member CMHSPs utilized single case agreements for enrollees in need of services that were not be available at the network adequacy standards; the NMRE utilized single case agreements when necessary for OPTs to ensure that services were conducted in accordance with PIHP and MDHHS policies and state, federal, and Medicaid regulations.

The NMRE's five CMHSPs contracted with a total of 44 adult crisis residential beds and 24 pediatric crisis residential beds (Note: COFR agreements completed as necessary). CMHSP-specific data was reported as follows:

- AuSable Valley Community Mental Health: 14 adult CRU beds, 24 pediatric CRU beds
- Centra Wellness Network: 24 adult CRU beds
- Northeast Michigan Community Mental Health: 14 adult CRU beds, 18 pediatric CRU beds
- North Country Community Mental Health: 12 adult CRU beds, 24 pediatric CRU beds
- Northern Lakes Community Mental Health: 44 adult CRU beds, 24 pediatric CRU beds

The NMRE used Power BI to build reporting structures to measure mileage and drive time from its CMSHPs to contracted inpatient psychiatric locations and Substance Use Disorder Providers by ASAM level, and continued this methodology for the CMHSPs' full array of service locations in FY 2023. The NMRE used the data reported in Power BI to project the time/distance requirements stated in its Specialty Supports and Services Contract with the State by rural distance standards. In addition, the NMRE used the data to provide adequacy reporting for the following enrollee-to-provider ratios:

Adult Services

- Assertive Community Treatment teams
- Psychosocial rehabilitation (Clubhouses)
- Opioid Treatment Programs (OTP)
- Crisis residential beds

Pediatric Services

- Home-Based regional FTEs
- Wraparound regional FTEs
- Crisis residential beds

CONCLUSION

The NMRE's QAPIP Report was reviewed and updated with input from various stakeholders and approved by the Governing Board. The NMRE's Board of Directors, the Operations Committee, the Internal Operations Committee (IOC) and the Compliance and Quality Oversight Committee (QOC) were responsible for the evaluation of the effectiveness of the QAPIP. The Annual Effectiveness Review included analyses of whether there have been improvements in the quality of healthcare and services for recipients due to quality assessment and improvement activities and interventions carried out by the NMRE. The analysis considered trends in service delivery and health outcomes over time and included the monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP was provided to network providers and to recipients upon request. The annual analysis was provided to the MDHHS no later than February 28, 2023.

The NMRE's QAPIP Report provided a summary of the accomplishments and highlights from the previous Fiscal Year as well as key information to determine whether current systems and processes provided desired outcomes. This report was shared with the NMRE Board of Directors, Provider Network, Regional Consumer Council, and other interested stakeholders.

The NMRE posted this document on its website at https://www.nmre.org. Copies of this document were made available to stakeholders upon request.

FY23 QAPIP Program WORKPLAN

Goal #1

The NMRE will conduct Performance Improvement Projects (PIPs) that achieve ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction.

Objective #1

The NMRE Quality and Compliance Oversight Committee (QOC) will continue to collect data, conduct ongoing analysis, and coordinate with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program through September 30, 2023. The NMRE will collect data and conduct analysis in preparation for Measurement 1 to show evidence of enrollment improvement from the baseline by September 30, 2024.

Objective #2

The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 3.56% to 5% by September 30, 2024.

Objective #3

The NMRE QOC will collect data and conduct analysis for no-show/missed psychiatric appointments with a goal of decreasing the regional no-show/missed appointment rate for psychiatric services by the end of FY2024.

Goal #2

The NMRE QOC, as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. The QOC will also work on improving the data quality and timeliness in reporting events.

Objective #1

The NMRE will provide training to providers on the type of data to collect, the population involved in this data collection, and timeliness in reporting. The expectation is that these providers will continue to train and remind their staff about this process.

Objective #2

The NMRE will update the incident reporting policy and will review the changes with network providers so they can also review the changes with their staff; this is intended to reduce underreporting.

Objective #3

The NMRE will continue to collect events data quarterly, analyze trends, and implement necessary interventions.

Objective #4
The NMRE will ensure that a root cause analysis (RCA) is completed and reviewed by the quality team to ensure that proper corrective action plans were implemented.

Objective #5
Annually, the NMRE will check to see if interventions are improving patient safety. This will be done by reviewing the data submitted which will include the number of events.

Goal #3
The NMRE will conduct quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract whit the State. Assessment results will be used to improve services, processes, and communication.

Objective #1
The NMRE will incorporate consumers receiving long-term supports or services (LTSS) (e.g., persons receiving case management, respite services or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

Objective #2
The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction.

Objective #3
The NMRE will conduct separate Substance Use Disorder (SUD) surveys, including Withdrawal Management/Detox and Methadone surveys, to identify specific member experiences.

Objective #4
The NMRE will identify and provide possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

Objective #5
The NMRE will outline systemic action steps to follow-up on the findings from survey results on an ongoing basis.

Objective #6
The NMRE will share survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), network providers, Board of Directors, the Regional Consumer Council (Regional Entity Partners), and post copy to the NMRE.org website.

Goal #4

The NMRE will monitor its network providers at least annually.

Objective #1

The NMRE will conduct site review annually for all contracted service providers by 9/30/2023.

Objective #2

The NMRE will monitor and follow-up on corrective action plans to ensure Corrective Action Plans (CAPs) are being implemented as stated by network providers.

Objective #3

The NMRE QOC will receive regular updates from providers regarding the progress of their Quality Improvement Workplans and CAPs.

Objective #4

The NMRE will perform quarterly audits to verify Medicaid claims/encounters submitted within the provider network. This will include verifying data elements from individual claims/encounters to ensure proper codes are used and proper documentation is in place.

Goal #5

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

Objective #1

The NMRE will monitor that only techniques permitted by the MSHHS Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the members or their guardians have been used with members through its annual site reviews by 9/30/2023.

Objective #2

The NMRE regional BTRC will be tasked with reviewing data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the members or their guardians have been used.

Objective #3

The NMRE regional BTRC will monitor behavior treatment data quarterly, including the numbers of interventions and length of time the interventions were used per person.

Objective #4

The NMRE regional BTRC will review analyses of data from each CMHSP behavior treatment committee review process quarterly.

Objective #5
The NMRE QOC will review meeting minutes from the BTRC quarterly to assure that its reviews of data are accurate and complete.

Goal #6

The NMRE will establish regional HEDIS measures to demonstrate the effectiveness of improvements in the quality of health care and services for members as a result of the NMRE quality assessment and improvement activities and interventions carried out by the NMRE provider network. In addition, the NMRE will include other performance measures as established by MDHHS in areas of access to care, efficacy, and outcome.

Objective #1
The NMRE will provide HEDIS measure reports to the NMRE QOC on a regular basis.

Objective #2
The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool to receive full payment.

- Follow-up after hospitalization (FUH) for mental illness within 30 days.
- Follow-up after (FUA) emergency department visit for Alcohol and Other Drug Dependence.

Objective #3
The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool to receive full payment with the CMHSPs and identify interventions to improve these outcomes.

Objective #4
The NMRE OOC will continue to monitor the impact of the changes with FUH and FUA data. FUH and FUH are being calculated using the unaltered HEDIS specifications; this means that certain service coded that applied to these measures will no longer qualify.

Objective #5
The NMRE QOC will work provider network to maintain the performance measures that are already at 95% and above. This will also work at improving the measures that are under-performing especially with tables two (2) and three (3) where the exceptions were removed.

Objective #6
The NMRE and QOC will review performance measure data at least quarterly to identify areas for improvement and implement measures to improve.

Goal #7

The NMRE will meet and maintain the performance standards as set by the MDHHS and the PIHP contract with the state.

Objective #1
The NMRE will continue to meet all MDHHS MMPBIS and a 95% rate or higher for indicators 1, 4a, and 4b. The PIHP will also find ways to capture percentage for indicator 10 and be sure to maintain less than 15% for that standard.

Objective #2
The NMRE will continue to monitor the CMHSPs to ensure they are maintaining at least 95% for indicators 1, 4a, and 4b and als ensure they are staying below 15% for indicator 10.

Objective #3
The NMRE will require a corrective action from CMHSPs and providers for each indicator not met to quarters in a roll.

Goal #8

The NMRE will identify an external vendor to conduct Medicaid Encounter Verifications. (MEV) for the region. However, the NMRE will continue to pull the sample data.

Objective #1
The NMRE will identify a vendor that is suitable for this task, possibly a vendor that is already conducting similar tasks for other PIHPS.

Objective #2
The NMRE will inform the providers including the CMHSPs about the change in this process and the new vendor.

Objective #3
The NMRE will develop and implement timelines as to how and when this transition will occur.

Objective #4
The NMRE will invite the vendor to the SUD provider meeting and to QOC to introduce them and also have them explain their process and allow for questions and clarifications.

Objective #4
The NMRE will collaborate with providers and CMHSPs to make data available for the audit.

Goal #9

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

Objective #1
QAPIP activities will be reviewed and evaluated by QOC.

Objective #2

The QAPIP update report will be shared with the Governing Board quarterly.

Objective #3
QAPIP activities will be shared with consumers through the regional Consumer Council (Regional Entity partners) and other stakeholders through committees and posting to the NMRE.org website.

Goal #10
The NMRE and its network providers will implement a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and Michigan Department of Health and Human Services (MDHHS). The NMRE will also develop and adopt additional regional practice guidelines.

Objective #1
The NMRE, in collaboration with its network providers, will review and adopt practice guidelines established by APA and MDHHS.

Objective #2
The NMRE, in collaboration with its network providers and stakeholders, will develop and adopt additional regional practice guidelines as they relate to the services provided pursuant to the NMRE's Specialty Supports and Services Contract with the State.

Objective #3
The NMRE will disseminate adopted practice guidelines to all affected providers, members, and potential members as needed.

Objective #4
The NMRE will publish adopted practice guidelines on the NMRE.org website to be accessible to all interested stakeholders.

Goal #11
The NMRE will update Sub-contractual Relationships and Delegation Agreements to include the recommendation from HSAG during the compliance review.

Objective #1
The NMRE will ensure that in future agreements there is specific language around "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later".

Goal #12
The NMRE will update its credentialing and recredentialing standards to align with its Specialty Supports and Services Contract with the State and federal regulations.

Objective #1
The NMRE will update its annual monitoring tools, as applicable, to ensure evidence is collected in policy, procedure, and practice regarding its delegation review of member

concerns, grievances, appeal information, or quality issues during periods of individual practitioner recredentialing.

Objective #2
Because the CMHSPs have recently taken over running all staff in a monthly third-party exclusion check, the NMRE will annually and periodically ensure that the CMHSPs processes for exclusions checks are maintained each month and verify their processes for validation of the reports.

Objective #3
The NMRE will create a new monitoring tool specific to organizational credentialing and recredentialing using the HSAG tool as an example. The NMRE will ensure all standards in the MDHHS Credentialing and Recredentialing Guidelines are reviewed. The NMRE will further ensure that evidence of credentialing decision and accreditation or ongoing quality assessment, and timeframes, are reviewed.

Objective #4
The NMRE will host a series of Credentialing Roundtables for the region with the intention of educating staff that do the actual individual credentialing. This will allow the NMRE to drive a series of interactive meetings that allow the CMHSPs to discuss their processes as a group and review the following in an organized manner:

a. The NMRE's Specialty Supports and Services contract with the State's credentialing and recredentialing standards (including timeline and all credentialing application requirements),

b. HSAG's monitoring tool requirements,

c. NMRE's monitoring tool requirements,

d. CAP document and noted deficiencies,

e. MDHHS credentialing report requirements, and

f. Localized CMHSP practices that are responsible for deficiencies and recommended changes for "best practice."

Goal #13
The NMRE will transition substance use disorder (SUD) exclusion check activities from the NMRE to the SUD Providers. (The NMRE will continue to run exclusion checks for the SUD providers until the transition is complete.)

Objective #1
Review Exclusion Check policy with SUD providers and update, if necessary.

Objective #2
Share the Exclusion Checks Policy with providers and receive feedback to make sure everyone is on the same page.

Objective #3
Provide necessary information and assistance to ensure a smooth transition.

Goal #14

The NMRE will continue to develop standardized utilization management protocols & functions across the region to identify areas of underutilization and overutilization of services. This will ensure access to public behavioral health services in the region in accordance with its contract with MDHHS and relevant Michigan Medicaid Provider Manual (MMPM) and Michigan Mental Health Code (MMHC) requirements.

Objective # 1
Develop, monitor, and track additional key performance indicators to detect patterns or trends.

Objective # 2
Research and engage in specific studies of various services based on established factors or criteria as it applies to the region.

Objective # 3
Conduct additional analysis on areas with significant variation in utilization patterns to identify root causes and opportunities for improvement.

Objective # 4
Incorporate LTSS into the UM plan.

NMRE Board Compliance and QAPIP Program Update

JUNE 28, 2023

1

Objectives

1. QAPIP Document Update
2. PIP (OHH and BHH) Update
3. MH & IDD Satisfaction

2

QAPIP Document Update

1. Claims Verification
2. Practice Guidelines
3. Events Reporting and Notification
4. Credentialing and Recredentialing
5. Long Term Services and Support (LTSS)
6. Member Satisfaction
7. Workplan

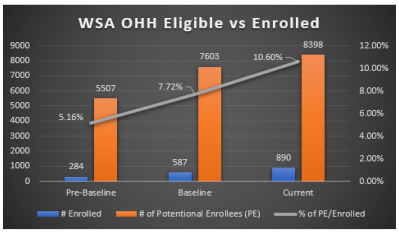
3

Opioid Health Home (OHH) PIP Update

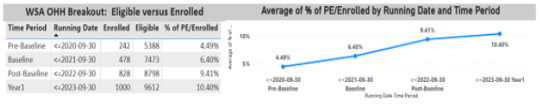
Data as of November 17, 2022

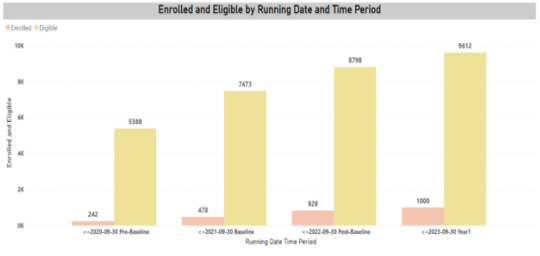
WSA OHH Eligible vs Enrolled

Time Period	Running Date	# Enrolled	# of Potentional Enrollees (PE)	% of PE/Enrolled
Pre-Baseline	<= '2020-09-30'	284	5507	5.16%
Baseline	<= '2021-09-30'	587	7603	7.72%
Current	<= '2022-09-30'	890	8398	10.60%



Data as of June 8, 2023





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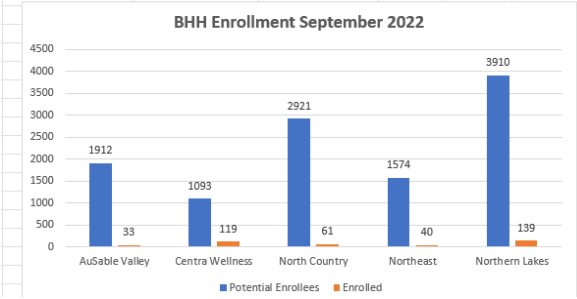
Behavioral Health Home (BHH) PIP Update

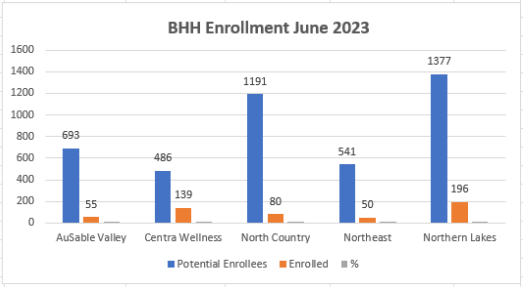
BHH Enrollment September 2022

	Potential Enrollees	Enrolled	%
AuSable Valley	1912	33	1.73%
Centra Wellness	1093	119	10.89%
North Country	2921	61	2.09%
Northeast	1574	40	2.54%
Northern Lakes	3910	139	3.55%
	11410	**392**	**3.44%**

BHH Enrollment June 2023

	Potential Enrollee	Enrolled	%
AuSable Valley	693	55	7.94%
Centra Wellness	486	139	28.60%
North Country	1191	80	6.72%
Northeast	541	50	9.24%
Northern Lakes	1377	196	14.23%
	4288	**520**	**12.13%**





5

Interventions

1. Streamline enrollment process.
2. Provide client education.
3. Provider Network expansion.
4. Provide more monthly meetings with providers.
5. Encourage current providers to increased participation.

6

Intervention Outcomes

Systemic Success Factors:

- Fewer provider operations issues
- Better understanding of the program
- Consumers are more willing to participate in the program
- Increased unemployment rate from 33.9% in 2019 to 52.8% in 2022

Clinical Success Factors:

- Fewer emergency room visits as consumers can proactively access services.
- Better care coordination and chronic conditions are kept under control.
- Early diagnosis and early intervention for life threatening illness.
- Though specific data has not been collected, there has been a decrease in re-hospitalizations.

7

Concerns/Challenges

1. Staff shortage

2. No show/missed appointments

Redetermination

8

Northern Michigan Regional Entity

Mental Health Services Survey

ALL PROVIDERS

MAY 2023

9

Objectives

Receive feedback on how providers are meeting the needs of their clients

Identify opportunities for quality and performance improvement activities

Access the client's perspective about;

Quality of care
Access to care
Interpersonal relationships
Service delivery
Service environment

10

Methodology

*21 Questions

*Clients receiving Outpatient, Medical Services, ACT, Peer Support Services, Clubhouse, Long Term Support Services (CLS, Case Management, Self Direction, Family Training, Supported Employment) funded in whole or in part by NMRE

*Survey period: May 1 – May 31, 2023

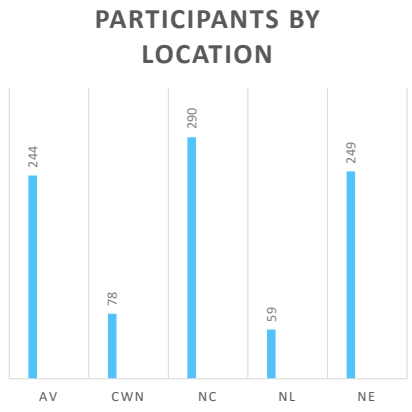
Available in paper or electronic format

11

Participation

- Total Responses: 920
- Total Served: 16,045
- Participation Rate: 6%

Location	# of Clients Completing Survey
AuSable Valley CMH	244
Centra Wellness Network	78
North Country CMH	290
Northern Lakes CMH	59
Northeast Michigan CMH	249



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Data Collection Challenges

- Lack of continued effort to encourage participation
- Ineffective survey administration due to lack of communication between staff and management
- Surveys not returned to NMRE by clients or staff in a timely manner

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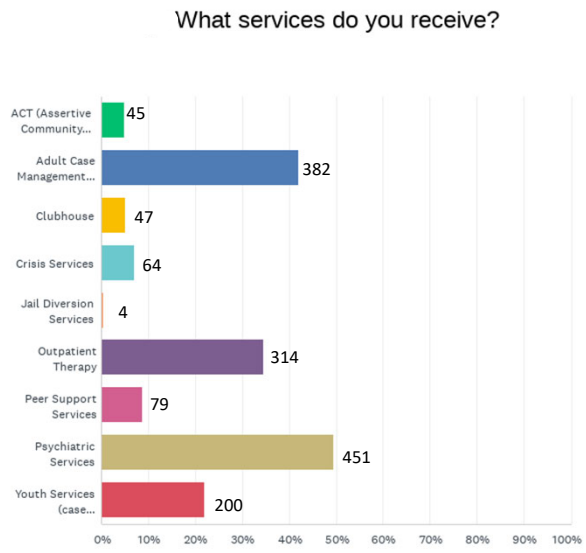
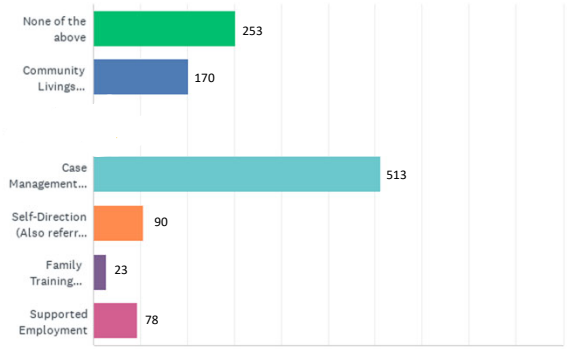


14

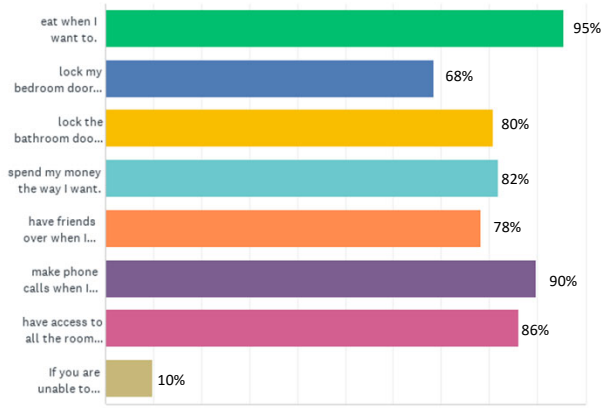
Please check any of the following Long Term Supports and Services you have received.



* LTSS for reporting

15

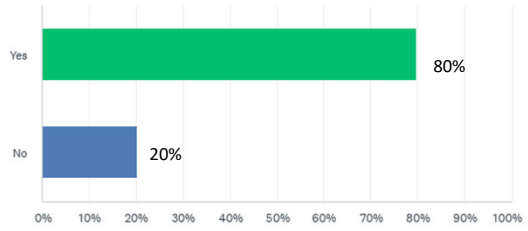
At home, I have the ability to (check all that apply):



*HCBS Rules

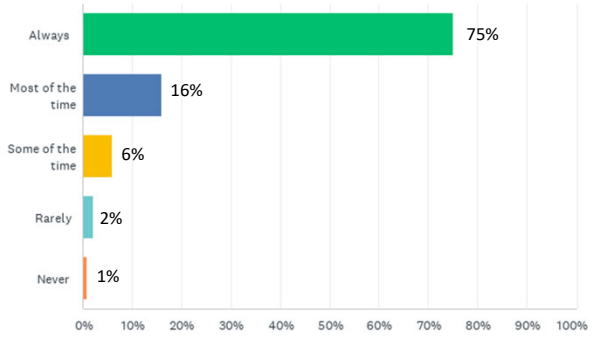
16

Somebody talked to me about sharing my health information with other people involved in my care.



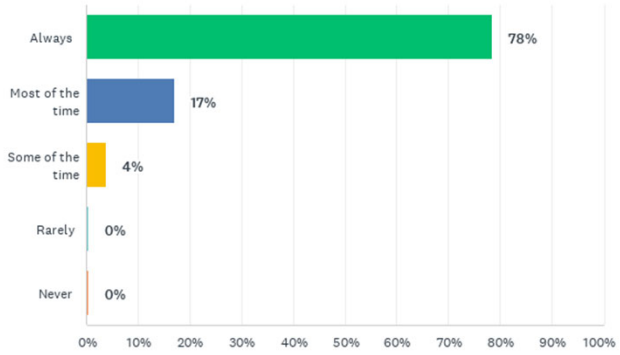
17

I feel comfortable asking questions about my services or asking for other services I want.



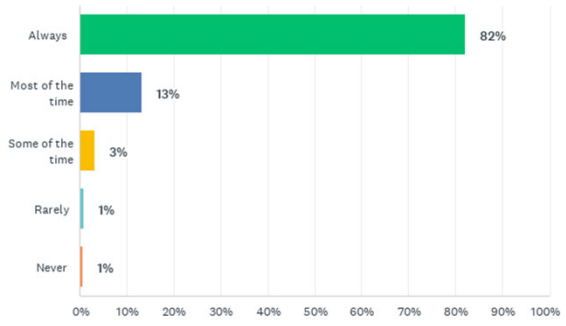
18

Staff explain information about my services to me in a way that I can understand.



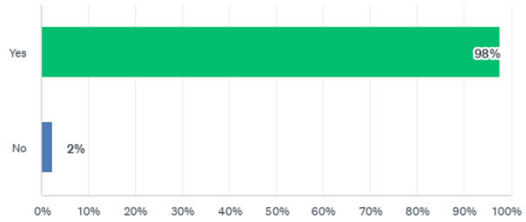
19

I am involved in my health care decisions and the development of my treatment plan.



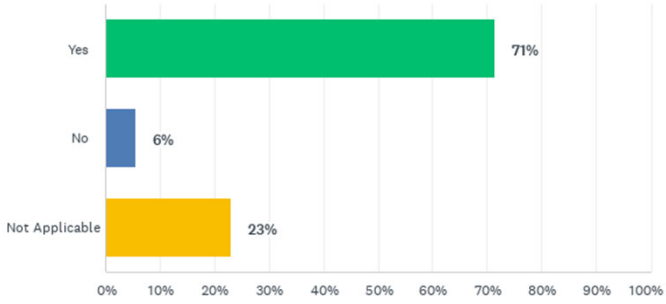
20

I know who to call when I need help, or I am in crisis.



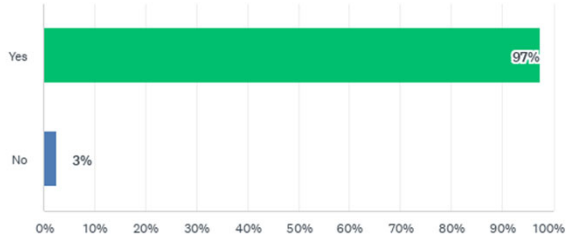
21

Someone has talked with me about the side effects of any medication prescribed to me through CMH and explained the results of any lab tests ordered by CMH.



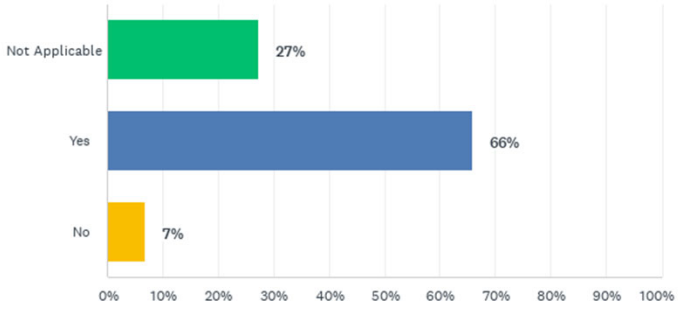
22

Appointment times are convenient for me.



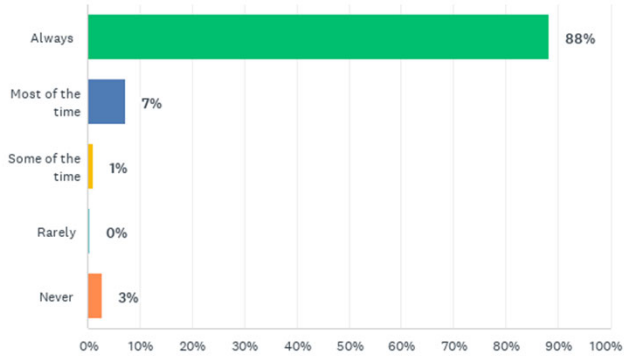
23

Access to services via telephone or video (telemedicine/telehealth) has improved my care.



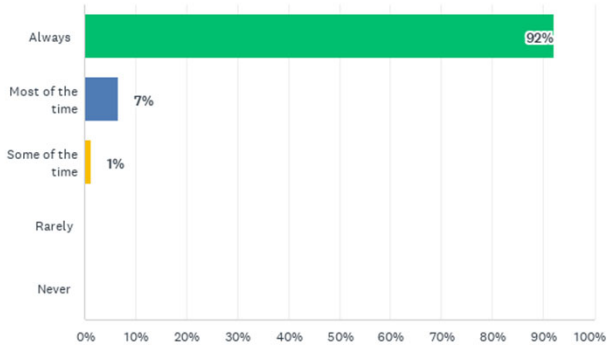
24

I feel staff is sensitive to my cultural/ethnic background or gender identity.



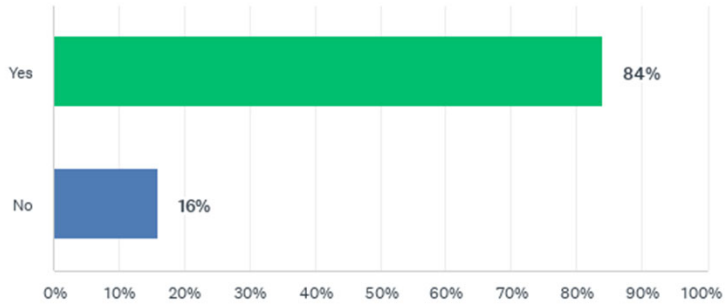
25

Staff treat me with dignity and respect.



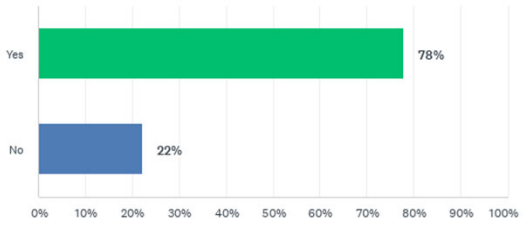
26

I know how to file a complaint or grievance, if I want to.



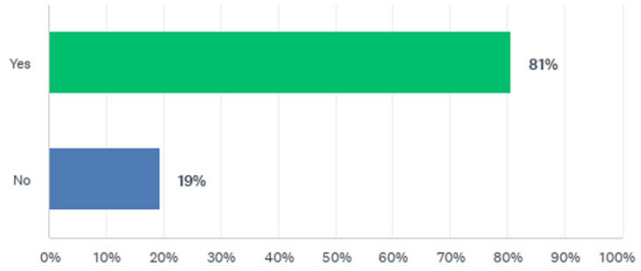
27

I know how to file an appeal if I don't agree with a denial of a service I requested or I don't agree with a change to my services.



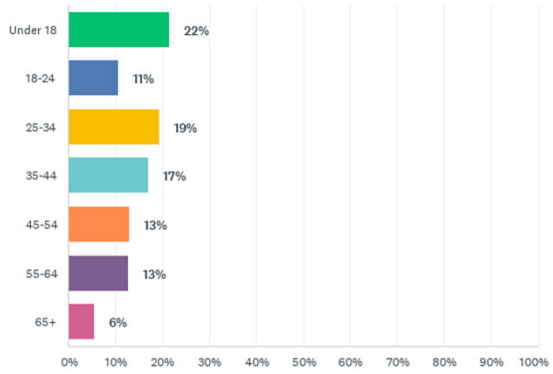
28

I have been given information about mediation services and I know how to request mediation if I want to.



29

What is your age



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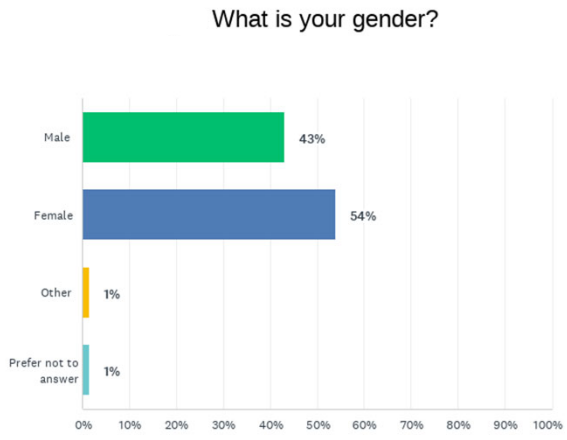

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Performance Comparison FY22 v. FY23

In FY22, NMRE served 15,731 recipients with 4% (620) of recipients participating in the survey, compared to 16,045 people served in FY23, and 6% (920) of recipients participating in the survey. There was a 2% increase in participation.

95% said they felt staff were sensitive to their cultural and ethnic background and gender identity, compared to 97% in FY22. There was a 2% decrease in staff sensitivity over the past year.

99% said staff treat them with dignity and respect, the same number from FY22. There has been no change over the past year.

96% said they are involved in the development of their treatment plan, compared to 98% in FY22. There was a 2% decrease in person centered planning over the past year.

32

16% do not know how to file a grievance, compared to 19% in FY22. Grievance knowledge has increased by 3% over the past year.

22% do not know how to file an appeal, compared to 20% in FY22. Appeal knowledge has decreased by 2% over the past year.

19% are not aware of mediation services

*no data for FY22

25% are not always comfortable asking questions about their services or requesting new services, compared to 34% in FY22. The ease at which recipients feel comfortable asking about services has increased by 9% over the past year.

20% were not informed about sharing of health information , compared to 23% in FY22. The knowledge about sharing health information has increased by 3% over the past year.

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Recommendations

Recipients have the right to file appeals of an Adverse Benefit Determination. Review the Appeal process with all staff to ensure compliance.

Recipients have the right to file grievances if they are unhappy. Review the grievance process with all staff to ensure compliance.

Recipients have the right to mediation services, which is a good alternative to appeals or grievances. Recipients must be given information about mediation. Review mediation services with staff to endure compliance.

Recipients should feel comfortable enough to ask questions about their services or request new services. Make sure staff are approachable and can answer any questions recipients may have.

Staff must make sure notice of privacy/confidential information paperwork is procured, and that the client understands that they are giving permission for their health care team to coordinate their care. It is vital that we normalize open lines of communication between behavioral and medical health providers.

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Overview

98% of recipients are involved in their healthcare decisions and the development of their treatment plan.

95% of recipients feel that staff explain information in a way they can understand

99 % of recipients feel that they are treated with dignity and respect.

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ACTION TAKEN

Responses that included possible Recipient Rights violations were reported to the corresponding CMH. Particularly, the high number of individuals who didn't know how to file a grievance.

The HCBS written responses which included noncompliance by licensed specialized residential homes were reported and opened as investigations with the CMHSP in question.

Responses regarding licensed general Adult Foster Care Homes and the noncompliance of HCBS were reported to LARA.

Based on individual CMHSP responses, extra training has been recommended. For example, 34% of respondents at a specific CMHSP did not know how to file an appeal. Quality and Compliance was notified, and staff training recommended.

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