Northern Michigan Regional Entity

Board Meeting

March 23, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
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 – February 23, 2022	Pages 2 – 5
7.	Correspondence	Pages 6 – 56
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – No Report	
	c. CEO's Report – March 2022	Page 57
	d. Financial Report – January 2022	Pages 58 – 79
	c. Operations Committee Report – March 15, 2022	Pages 80 – 83
	e. NMRE SUD Oversight Board Report – March 7, 2022	Pages 84 – 87
11.	New Business	
	a. Liquor Tax Requests – budgets are posted on Northern Michigan Regional Entity - Northern Michigan Regional Entity (nmre.org)	
	b. MDHHS Behavioral Health Reorganization	Pages 88 – 104
12.	Old Business	
	b. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest	Pages 105 – 109
13.	Presentation/Discussion	
	Carter Kits Presentation and Approval Request	Pages 110 – 115
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – April 27, 2022	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – FEBRUARY 23, 2022
GAYLORD BOARDROOM

ATTENDEES:	**Roger Frye, Ed Ginop, Christian Marcus, Gary Nowak, Justin Reed, Don Smeltzer, Joe Stone, Don Tanner**
VIRTUAL ATTENDEES:	**Gary Klacking (West Branch), Terry Larson (Rogers City), Mary Marois (Destin, FL), Jay O'Farrell (Whittemore), Richard Schmidt (Kaleva), Karla Sherman (LaJolla, CA)**
ABSENT:	**Randy Kamps**
NMRE/CMHSP STAFF:	**Joanie Blamer, Christine Gebhard, Chip Johnston, Eric Kurtz, Tema Pefok, Brandon Rhue, Sara Sircely, Nena Sork, Teresa Tokarczyk, Deanna Yockey, Carol Balousek**
PUBLIC:	**Nichole Flickema, Jackie Guzman, Donna Hardies, Sue Winter**

Note: At 10:00AM there was not a quorum present to proceed with the Board meeting. The decision was made to begin with the "Presentation" portion of the Agenda and then determine whether a quorum was present.

PRESENTATION
Substance Use Disorder Prevention Coalition Updates
Donna Hardies (Catholic Human Services) and Nichole Flickema (Health Department of Northwest Michigan) were in attendance virtually to provide updates on the current activities of Prevention Coalitions operating within the NMRE region.

CALL TO ORDER
Let the record show that Chairman Don Tanner called the meeting to order at 10:30AM as a quorum was present in Gaylord.

ROLL CALL
Let the record show that Randy Kamps was excused from the meeting on this date; all other Board Members were in attendance either in Gaylord or remotely.

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

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

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

MOTION BY JOE STONE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR FEBRUARY 23, 2022 AS AMENDED; SUPPORT BY GARY NOWAK. MOTION CARRIED.

APPROVAL OF PAST MINUTES

Let the record show that the January minutes of the NMRE Governing Board were included in the materials for the meeting on this date.

MOTION BY ROGER FRYE TO APPROVE THE MINUTES OF THE JANUARY 26, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY GARY NOWAK. MOTION CARRIED.

CORRESPONDENCE

1) The minutes from the February 3, 2022 PIHP CEO meeting.
2) Press release from Michigan Attorney General Dana Nessel's Office giving an opinion on Meeting Attendance Accommodations Required under ADA.
3) MDHHS's Michigan Integration Efforts February 2022 Update.
4) MDHHS's Michigan Psychiatric Care Improvement Project (MPCIP) February 2022 Update.
5) MDHHS's Region 2 MiCAL Rollout Timeline.
6) CMHAM February 2022 Social Media campaign to combat Senate Bills 597 & 598.
7) Email correspondence from CMHAM dated February 7, 2022 regarding hacking of recent CMHAM meetings.
8) Email correspondence from Alan Bolter at CMHAM providing an overview of the Governor"s FY23 Budget Recommendation in Senate Appropriations Subcommittee.
9) Email correspondence from CMHAM dated February 16, 2022 providing Guidance related to demand for financial data by Milliman and MDHHS: View of Provider Alliance leadership and CMHA.
10) Draft minutes of the February 9, 2022 NMRE Regional Finance Committee meeting.

Mr. Kurtz drew attention to the MiCAL rollout timeline and discussion during the February 15th Operations Committee meeting; NMRE is scheduled to "go live" with the MiCAL 988 National Suicide Prevention Lifeline (NSPL) on March 31, 2022. Mr. Kurtz also brought attention to correspondence from Jacque Wilson, Chair CMHA Provider Alliance and Robert Sheehan, CMHAM CEO to PIHP/CMHSP CEOs and Provider Alliance Members outlining guidance related to the demand for financial data by Milliman and MDHHS (provider salary and wage survey, provider expense survey, Standard Cost Allocation).

Mr. Marcus referenced the "Strategic Behavioral Health Integration and Coordination Initiatives" section of the February 3rd PIHP CEO meeting minutes regarding the expansion of Health Homes in the state and the implementation of a SUD Health Home in the NMRE region; he asked what the potential impact on funding could be. Mr. Kurtz indicated that there would not be an impact and responded that PIHPs are funded by enrollee; Health Homes are 90% Federally funded (BHH for 8 quarters, OHH for 10 quarters).

ANNOUNCEMENTS

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

PUBLIC COMMENTS

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

REPORTS

Executive Committee Report

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

CEOs Report
The NMRE CEO Monthly Report for February 2022 was included in the materials for the meeting on this date.

Financial Report
December 2021

- Traditional Medicaid showed $49,360,242 in revenue, and $42,879,230 in expenses, resulting in a net surplus of $6,481,012. Medicaid ISF was reported as $9,298,750 based on the interim FSR. Medicaid Savings was reported as $11,296,664.
- Healthy Michigan Plan showed $7,385,336 in revenue, and $5,489,748 in expenses, resulting in a net surplus of $1,895,589. HMP ISF was reported as $7,059,746 based on the interim FSR. HMP savings was reported as $5,061,832.
- Net Position* showed net surplus Medicaid and HMP of $8,376,601. Medicaid carry forward was reported as $16,358,496. The total Medicaid and HMP Current Year Surplus was reported as $22,572,877. Medicaid and HMP combined ISF was reported as $16,358,496; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $38,931,373.
- Health Home showed $287,798 in revenue, and $236,739 in expenses, resulting in a net surplus of $51,059.
- SUD showed all funding source revenue of $5,864,110, and $4,562,086 in expenses, resulting in a net surplus of $1,302,024. Total PA2 funds were reported as $5,752,223.

The Direct Care Wage Surplus was reported as $2,162,220. Ms. Yockey reported that the first of three PA2 payments for FY22 is expected in April. Ms. Gebhard that a column showing the amount of PA2 funds allocated and the projected revenue by county be added to the report, which Ms. Yockey agreed to provide beginning with the January 2022 report.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2021; SUPPORT BY JOE STONE. MOTION CARRIED.

Operations Committee Report
The minutes from February 15, 2022 were included in the materials for the meeting on this date. A discussion of salary caps, longevity pay, and salary structures for PIHP and CMHSP staff occurred; the importance of retaining seasoned staff was emphasized.

NMRE SUD Oversight Board Report
Let the record show that the next meeting of the NMRE Substance Use Disorder Oversight Board is scheduled for March 7, 2022 at 10:00AM in the Gaylord Conference Room.

NEW BUSINESS
Bear River Health (BRH)
Mr. Kurtz shared that on February 9, 2022, he was notified by the CMH Partnership of Southeast Michigan (Region 6 PIHP) that BRH had received a (payroll) tax levy and that all payments from Southeast Michigan needed to be made to the IRS; subsequently, Network 180 (Kent County) and Community Mental Health of Ottawa County also contacted Mr. Kurtz about the communication.

Mr. Kurtz met with BRH staff on February 11th to discuss the issue. A letter dated February 11th from Dan Hartman, BRH Executive Director and email correspondence from Jackie Guzman, BRH Financial Director were included in the materials for the meeting on this date. Mr. Kurtz

reported that he was notified of the release of the levy from the IRS on February 22, 2022; the issue appears to be resolved though Mr. Kurtz noted more information is needed to assure this is not an ongoing concern.

PIHP Representative on the CMHAM Board of Directors
Correspondence from CMHAM about PIHP representation on its Board of Directors was included in the materials for the meeting on this date. Interested NMRE Board Members were instructed to contact Mr. Kurtz.

Performance Bonus
Email correspondence from MDHHS dated January 28, 2022 was included in the materials for the meeting on this date. The NMRE earned full points in both the PIHP/MHP joint metrics and PIHP-only deliverable for a total bonus payment of $1,737,751.66 which will be passed to the Boards as local dollars.

Lambert Public Relations
Mr. Kurtz informed the Board that he is overall unimpressed by the work Lambert PR has done for the NMRE to date; he is considering going in a different direction.

OLD BUSINESS
Senate Bills 597 & 598/House Bills 4925 – 4929 – The Latest
A summary of the Mental Health Listening Tour by Michigan House Democrats titled, "Enhancing our Community Mental Health System" was included in the materials for the meeting on this date. Mr. Johnston expressed his feeling that meetings with the Northern Michigan Counties Association have been extremely effective; Mr. Tanner agreed. Ms. Gebhard referenced a report authored by Rep. Brabec (55th House District); Rep. Brabec is working closely with Rep. Whiteford on making alterations to her bills based on feedback from the listening tour.

The possibilities of a rural exception and/or PIHP/CMHSP financial risk arrangement were discussed.

COMMENTS
Board
- Mr. Russell commented about a discussion that occurred during the February meeting of the Northern Lakes CMHA Board of Directors; the public (Record Eagle) appears to be blaming the CMH for AFCs closing in Grant Traverse County.
- Mr. Tanner advised everyone to watch their secure data streams during globally volatile times.

Staff/CMHSP CEOs
- Mr. Johnston expressed that he has had a variety of interactions with CMHSPs in the UP recently; he stressed the need to stay out of "southern Michigan issues" for the benefit of individuals served.
- Board Members were invited to stay to attend the CMHAM Northern Region meeting at 1:00PM.

MEETING DATES
The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on March 23, 2022.

ADJOURN
Let the record show that Mr. Tanner adjourned the meeting at 11:32AM.

CHI²

Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

Healthcare Integration and Coordination – 2021/2022 Update: Survey of Initiatives of Michigan's Public Mental Health System

February 2022

Center for Healthcare Integration and Innovation
Community Mental Health Association of Michigan

Center for Healthcare Integration and Innovation

Community Mental Health Association of Michigan

Healthcare Integration and Coordination – 2021/2022 Update: Survey of Initiatives of Michigan's Public Mental Health System

February 2022

I. Abstract

This study serves as an annual follow-up to previous studies conducted in 2016 to present. In November 2020, the Community Mental Health Association of Michigan's (CMHA) Center for Healthcare Integration and Innovation conducted a study of the healthcare integration initiatives led by Michigan's Community Mental Health Services Programs (CMH), the state's public Prepaid Inpatient Health Plans (PIHP), and providers within the CMH system. The study examined varying efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical healthcare services. Results showed that more than 451 healthcare integration efforts, led by these public sector parties, were in operation throughout Michigan. The CMHs, PIHP, and providers involved in healthcare integration, often pursue a number of efforts simultaneously, with each organization that responded to the survey reporting an average of over 20 healthcare integration initiatives. Of this number, work around physical health-informed behavioral health and intellectual/developmental disability (BHIDD) services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts.

II. History and Background

The responsibility for the management, design, and operation of Michigan's public behavioral healthcare and intellectual/developmental disability services system (BHIDD), has historically been the responsibility of the Community Mental Health Services Programs (CMHSP), the public Prepaid Inpatient Health Plans (PIHP) that were formed and governed by the CMHSP, the provider networks managed by these two sets of public bodies, and the Michigan Department of Health and Human Services (MDHHS). MDHHS funds this system, Michigan's public mental health system, with state General Fund dollars and Medicaid funding, the latter provided through a monthly shared risk arrangement with the State of Michigan in the form of capitation

payments (per Medicaid-eligible). [12] The public BHIDD system (CMHSPs, PIHP, and providers) have historically taken a whole-person orientation to service delivery, working to address a range of human needs in addition to behavioral health and intellectual disability needs, as well as a range of social determinants of health. This whole-person orientation is grounded in the person-centered, community-based, and recovery-oriented philosophies guiding the system. Over the past several years, CMHSPs, PIHP, and providers have focused increasingly on integrating the BHIDD services that they provide with primary care and other physical healthcare services. This practice has:

- Increased access for BHIDD consumers to primary care services
- Improved access to BHIDD services to persons seen in primary care settings but without ready access to the full array of BHIDD services
- Improved prevention and intervention to reduce serious physical illnesses
- Improved overall health status of consumers[3]

Because the CMHSP/PIHP/provider system views the health of the consumer and the broader population as its top priorities, the full spectrum of health-related needs of the people served needs to be considered and addressed.

While, anecdotally, the CMH Association of Michigan knew that a large number of diverse integration efforts were in operation across the state, led by CMHSPs, PIHP, and providers within the CMHSP networks in Michigan, no formal cataloging of those efforts had been completed. In 2016, the initial study conducted by the Community Mental Health Association of Michigan (CMHA) Center for Healthcare Integration and Innovation identified a vast array of integration efforts across the state. The Center for Healthcare Integration and Innovation conducted the second annual study in 2017 to capture a picture of the advancement, breadth, and depth of these initiatives. The current study, conducted late 2020, aims to update the data collected in the previous years, given the rapid and continual development of these initiatives by Michigan's public mental health system.

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[1] Throughout this document, the term "public mental health system" will be used to describe Michigan's Community Mental Health Services Programs (CMHSP), the public Prepaid Inpatient Health Plans (PIHP) that were formed and governed by the CMHSP, and the provider networks managed by these two sets of public bodies

[2] Michigan Department of Health and Human Services. Welcome to Behavioral Health and Developmental Disabilities Administration. Retrieved from http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941-146590--,00.html. Accessed February, 2022.

[3] SAMHSA-HRSA Center for Integrated Health Solutions. SAMHSA PBHCI Program. Retrieved from http://www.integration.samhsa.gov/about-us/pbhci. Accessed February, 2022.

III. Methods

In November 2021, CMHA issued an electronic survey to its member agency directors and CEOs, in order to gather information regarding the healthcare integration efforts of Michigan's CMHs, PIHP, and providers. The survey included questions surrounding current healthcare integration activities and services. **Twenty** CMHA member organizations responded, representing a variety of organizational types and settings. This study will continue to be replicated on an annual basis to continue tracking the work being done by the state's CMHs, PIHP, and provider system to foster integrated care. The range of healthcare integration and coordination methods, around which information on activity within the system were sought, is outlined in Attachment A.

IV. Findings and Analysis

This study resulted in a number of key findings:

A. The state's CMH, PIHP, and provider system has **long recognized that the integration and coordination of healthcare services are key tools to improving the health of persons with BHIDD needs**, making services more effective and accessible while working to lower the overall cost of healthcare and related human services to the communities served by these BHIDD systems.

B. The **variety of healthcare integration initiatives** designed and implemented by the state's CMH, PIHP, and provider system is broad, representing dozens of approaches to fostering integration and coordination of care. The range of healthcare integration approaches are captured in Attachment A.

C. **Safety net behavioral and physical healthcare providers are working together to provide vital services through integrated care models.** The current study is the first to examine healthcare integration efforts among Michigan's public physical and behavioral healthcare systems. The study found that the CMH, PIHP, and provider system is involved in over **43** efforts state-wide to coordinate and integrate care with federally funded Community Health Centers (FQHCs). These efforts include active referral networks, co-location, care coordination, collaborative treatment planning, data sharing, efforts to identify and address needs of high/super-utilizers, and joint workforce education and training initiatives.

D. **Three specific types of integration, with considerable complexity, stood out, in addition to a handful of other notable findings**. This 2021 study identified **451** healthcare integration efforts occurring across the state, with the potential for more to come. While there were many different methods of integration implemented by the public system, three of those efforts stood out, given their organizational, clinical, technical, and relational complexity. Those efforts were physical health informed BHIDD services, co-location, and identification of super-

utilizers. These three methods of integration are discussed below, with the frequency of responses summarized in Attachment B.

1. <u>Physical Health Informed BHIDD Services</u>: Integrating physical health needs and goals into BHIDD services improves outcomes and proves the most effective approach to caring for people with multiple healthcare needs. This study found **71** total initiatives regarding physical health informed BHIDD services.

a. <u>Identification of Patients Without a Primary Care Provider</u>: 20 sites (100%) reported processes in place to identify patients without a primary care provider and/or patients who have not engaged a primary care provider in the past year. Having a regular primary care provider (i.e., family physician or nurse practitioner) is crucial for obtaining compressive, continuous, accessible, and timely healthcare. A primary care provider allows for coordination among other parts of the healthcare system. Research suggests patients who have a primary care provider benefit from improved care coordination and chronic disease management. They receive more preventative care, are less likely to use emergency services, and have better health outcomes overall.

<u>Facilitating Communication between BHIDD provider and primary care providers (Fostering Integration)</u>: 17 sites (85%) reported efforts aimed at fostering communication efforts between BHIDD sites and primary care providers. These efforts included communication via case manager, supports coordinators, care managers and similar intensive coordination. Coordinating with primary care providers increases the likelihood of positive outcomes for patients, strengthens coordination and improves quality of care.

b. <u>Health Screening</u>: 16 sites (80%) reported utilization of health screenings. These screenings consist of items designed to identify risk factors for undiagnosed acute or chronic care issues integrated throughout traditional behavioral health assessments. Untreated chronic disease is a major factor in the increased cost of care for people with behavioral health issues or substance use disorders. The implementation of health screening processes allows providers in primary care and other healthcare settings to assess the severity of health issues and identify the appropriate level of treatment.

2. <u>High/Super-Utilizer Initiatives</u>: A significant segment of the integration initiatives identified in this study are those efforts that address the needs of the high/super-utilizer population. High/super-utilizers are individuals with very high healthcare service utilization patterns, often across disciplines and sectors. These same people often demonstrate high levels of utilization of human services outside of traditional healthcare domains, such as: public safety, housing supports, judiciary, and child welfare. The study found **100** joint efforts between CMHs, PIHP, providers, and primary care practices,

hospitals, and Medicaid Health Plans to address the needs among this population in order to effectively utilize healthcare resources.

a. 17 sites (85%) reported active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access.

b. 16 sites (80%) reported joint efforts with Medicaid Health Plans to address the needs of high/super-utilizers.

c. 16 sites (80%) reported use of hands-on complex case/care management to persons with complex needs.

d. 14 sites (70%) reported active use of data (Care Connect 360 or other data analytics) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care.

e. 14 sites (70%) reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources.

3. Co-location Initiatives: This study identified **64** total efforts to co-locate physical and BHIDD services within the same physical space. The most common method of co-location was psychiatric consultation, telephonic, video, or face-to-face, provided by BHIDD party to a primary care site, with **13 sites (65%)** reporting this method of integration. **12 sites (60%)** reported BHIDD staff in hospital emergency departments, or creating regular protocol that BHIDD staff provide crisis screening in emergency departments. **10 co-location efforts (50%)** across the state involve a FQHC.

Other notable findings:

19 sites (95%) reported an active and frequent referral network.

19 sites (95%) reported providing healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, or exercise courses.

18 sites (90%) reported receiving Admission, Discharge, and Transfer (ADT) data from hospitals and emergency departments.

18 sites (90%) reported providing system navigation guidance to consumers (by BHIDD party or in partnership with healthcare provider or health plan)

18 sites (90%) reported workforce training on healthcare integration and health literacy.

10 sites (50%) reported

V. Conclusion

These findings demonstrate significant gains that continue to be made in Michigan to integrate and coordinate healthcare efforts across BHIDD and physical health systems. Through the integration and coordination of healthcare services, CMHs, PIHP, and providers are working to improve the health of persons with BHIDD needs while controlling the overall cost of their healthcare. This study identified **451** healthcare integration initiatives led by CMHs, PIHPs, and BHIDD providers across the state of Michigan, of which **227** were those involving: physical health informed BHIDD services, active referral networks, or efforts to address the needs of the high/super-utilizer population.

As this series of studies represents the first of its kind to catalogue the healthcare integration efforts of the state of Michigan's CMH, PIHP, and provider network, the study will continue to be replicated in the future to track the emergence of new efforts and the changes in the integration services identified in this study.

The Center for Healthcare Integration and Innovation (CHI^2) is the research and analysis office within the Community Mental Health Association of Michigan (CMHAM). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHA) is the state association representing Michigan's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.

Attachment A

Healthcare Integration and Coordination approaches sought via Center for Healthcare Integration and Innovation survey (November 2021 study; February 2022 report)

Active referral network

- Formal referral agreements between BHIDD party and primary care provider
- System navigation guidance to consumers (by BHIDD party or in partnership with healthcare provider or health plan)
- Active and frequent referral relationship
- Community Health Centers (FQHCs) are included in referral network

Co-location related efforts

- BHIDD staff co-located in primary care practice (may be team-based care or less intense partnership)
- Primary care provider co-located in a BHIDD site (may be team-based care or less intense partnership)
- BHIDD staff co-located at hospital emergency department or BHIDD staff go to the emergency department as a regular protocol to provide crisis screening or inpatient admission pre-screening
- Psychiatric consultation, telephonic, video, or face-to-face provided, by BHIDD party, to primary care site
- Physical health laboratory or lab pick-up at BHIDD site
- Co-funded positions
- Loaning positions from or to BHIDD party
- Co-location efforts involve a Community Health Center (FQHC)

Physical health informed BHIDD services

- Health screening, including identification of risk factors for undiagnosed, acute, or chronic care issues integrated within the behavioral health assessment process
- Identification of patients without a primary care provider and/or who have not engaged primary care provider in past year and active referral to such care
- Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator, care manager, nurse care manager, or similar intensive coordination)
- Use of data by the BHIDD party, including health dashboards and standardized tools to target interventions (often to high utilizers and others) to improve population health
- BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical healthcare needs

Services/supports/treatment plan and Electronic Health Record (EHR)

- Single care plan reflecting BHIDD services and supports and physical health treatment
- Shared or linked BHIDD and primary care electronic health records
- ADT (Admission, Discharge, and Transfer) data by hospitals and emergency departments with BHIDD party
- Use of portals with primary care and hospital systems as a normal part of workflow to direct treatment
- Integration of primary care coordination measures (MDHHS, HEDIS, or others) into EHR and staff workflows (e.g., physical and behavioral health medication reconciliation)
- Collaborative treatment planning and/or data sharing with Community Health Centers (FQHCs)

High/super-utilizers

- Active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access
- Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care
- Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resources
- Joint effort with hospitals (including emergency departments) to address the needs of high/super-utilizers of healthcare resources
- Joint effort with Medicaid Health plans to address the needs of high/super-utilizers of healthcare resources
- Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of healthcare resources
- Use of hands-on complex case/care management to persons with complex needs

Workforce education and training

- Joint educational and networking efforts for BHIDD providers and primary care providers
- BHIDD workforce trained on healthcare integration and health literacy
- BHIDD party provides/facilitates training for primary care workforce on BHIDD issues
- Community Health Centers (FQHCs) are included in training and education efforts

Consumer/patient empowerment and access

- Healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, exercise courses

- Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site
- Movement to integrate SAMSHA wellness and recovery principles into BHIDD services
- Use of collaborative/concurrent documentation to improve healthcare delivery transparency and consumer health literacy and efficient workflow for staff, reducing time onsite for consumers
- Use of same-day/next-day access and just in time prescribing approaches to reduce no-shows and enhance access to services

Attachment B

1. **Physical health-informed BHIDD services**

Health screening, including identification of risk factors for undiagnosed, acute, or chronic care issues integrated within the behavioral health assessment process	16
Identification of patients without a primary care provider and/or who have not engaged primary care provider in past year and active referral to such care	20
Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator, care manager, nurse care manager, or similar intensive coordination)	17
Use of data by the BHIDD party, including health dashboards and standardized tools to target interventions (often to high utilizers and others) to improve population health	17
BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical healthcare needs	12

2. **High/super-utilizers**

Active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access	17
Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care	14
Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resources	14
Joint effort with hospitals (including emergency departments) to address the	13

needs of high/super-utilizers of healthcare resources	
Joint effort with Medicaid Health Plans to address the needs of high/super-utilizers of healthcare resources	16
Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of health care resources	10
Use of hands-on complex case/care management to persons with complex needs	16

3. Co-location initiatives

BHIDD staff co-located in primary care practice (may be term-based care or less intense partnership)	7
Primary care provider co-located in a BHIDD site (may be term-based care or less intense partnership)	6
BHIDD staff co-located at hospital emergency department or BHIDD staff go to the emergency department as regular protocol to provide crisis screening or inpatient admission pre-screening	12
Psychiatric consultation, telephonic, video, or face-to-face, provided by BHIDD party to primary care site	13
Pharmacy co-located in CHIDD site	4
Physical health laboratory or lab pick-up at BHIDD site	4
Co-funded positions	6
Loaning positions from or to BHIDD party	2

MDHHS: FY23 Budget Executive Recommendation

State Hospital Administration

March 9, 2022

George Mellos, MD, Senior Deputy Director, State Hospital Administration
Farah A. Hanley, Senior Deputy Director, Financial Operations Administration

Michigan's Public State Hospitals

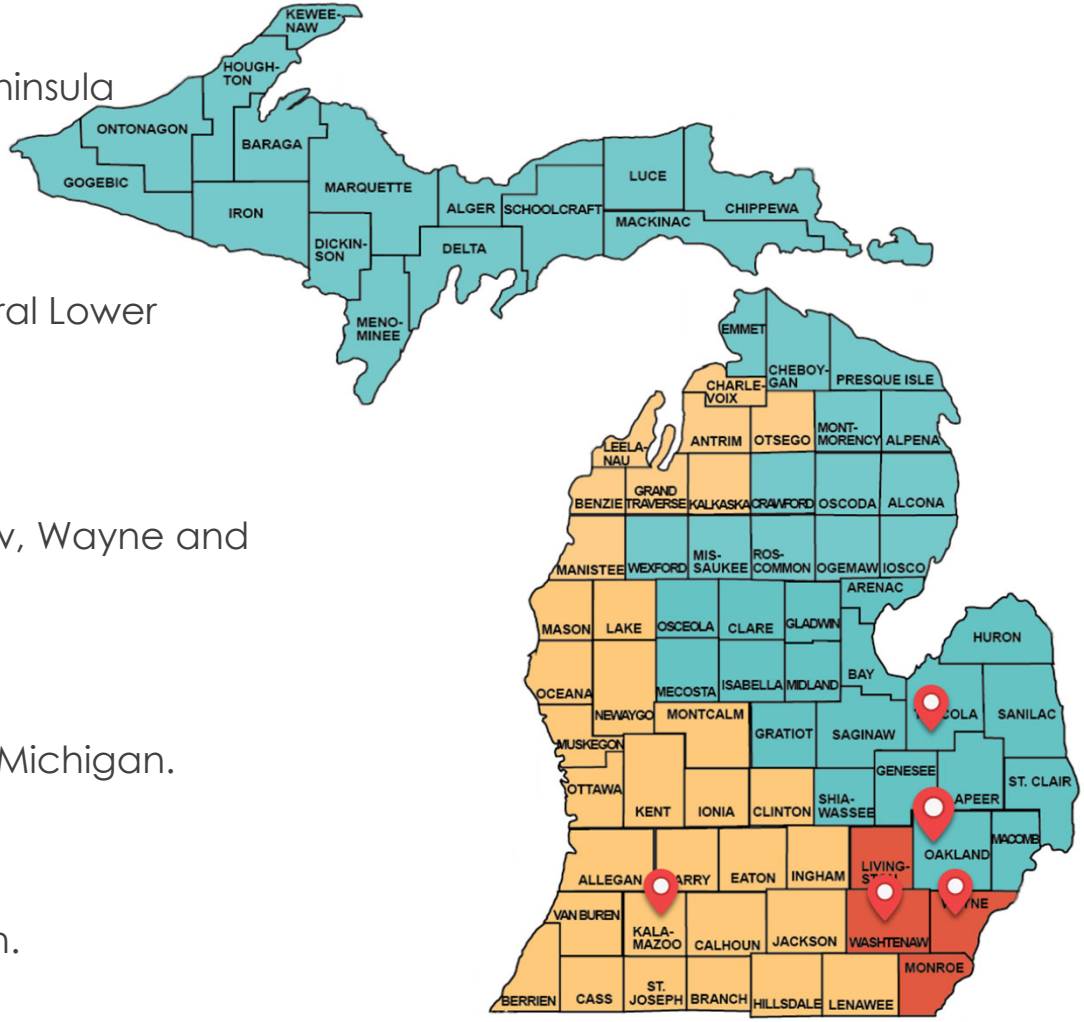
Caro Center
- CY 2021 average census: 102 patients
- Serves adult patients residing in the Upper Peninsula and northeast Lower Peninsula.

Kalamazoo Psychiatric Hospital
- CY 2021 average census: 155 patients
- Serves adult patients in western and the central Lower Peninsula.

Walter Reuther Psychiatric Hospital (Westland)
- CY 2021 average census: 168 patients
- Serves adult patients in Livingston, Washtenaw, Wayne and Monroe counties.

Hawthorn Center (Northville)
- CY 2021 average census: 49 patients
- Serves children & adolescent patients across Michigan.

Center for Forensic Psychiatry (Saline)
- CY 2021 average census: 224 patients
- Serves adult forensic patients across Michigan.

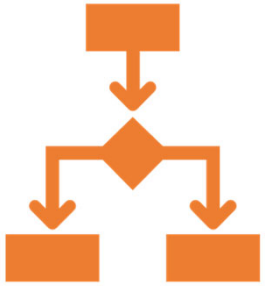



FY 2022
State Hospital Administration
Accomplishments, Progress, and Challenges

FY 2022 Strategic Accomplishments

Development and implementation of a **community transition program** for adults consistent with Section 962 of Public Act 67 (2019)

Expansion of **higher educational opportunities** and relationships in state hospitals.



State Hospital Administration **Throughput Outcomes**.

MDHHS

FY 2022 Progress: Caro Center

- September 2020 - **site work commenced**.
- December 2021 - **building enclosure**.
- Project on pace for **spring 2023** opening.
- Patient capacity -**100 beds**.
- Approximately **114,000 square feet**.
- Physical plant encompassing **27 acres**.
- Construction/design team has been successful in **forecasting supply chain issues** and **remains on schedule and under budget.**

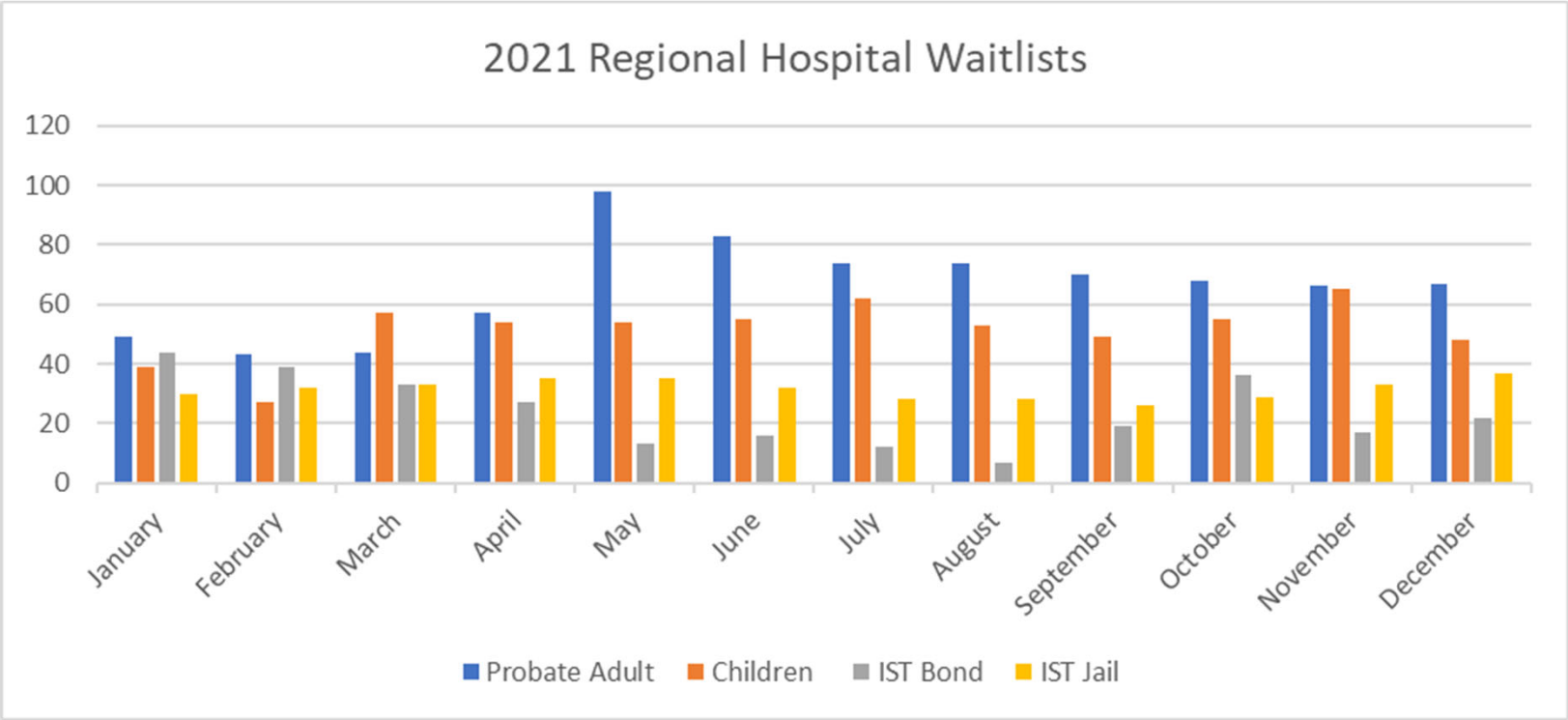
MDHHS

FY 2022 Progress: Psychiatric Residential Treatment Facilities

- Public Act 285 (2020).
- Provider of **inpatient psychiatric treatment services** to Medicaid-eligible individuals under the age of 21.
  - 42 CFR 441.151 through 441.182 & 483.350 through 483.376
- Must be accredited by **The Joint Commission**, or any other state-approved accrediting organization.
- Anticipated implementation **spring 2023**.

MDHHS

FY 2022 Challenges: State Hospital Waitlists




Governor Whitmer's
Executive Budget
Recommendation
FY 2023

$325M Gross/GF

Build a New Combined Psychiatric Hospital

Context

- **Excessive demand** and **persistent waitlists** for inpatient psychiatric services at state operated hospitals.
- **Aging physical plant infrastructure** at both **Walter Reuther Psychiatric Hospital** and **Hawthorn Center** has necessitated significant short-term investments to maintain necessary safety standards.
- Discontinuity in both hospitals' **physical plants do not reconcile** with current behavior health standards.
- **Significant future investments** to infrastructure will be needed in the coming years to maintain status quo.

Response

- Design and construct a **modern facility** that reconciles with current behavioral health standards.
- Keeping populations separate.
- Make **treatment and living spaces** contiguous.

Expected impact

- **Operational efficiencies are gained** by combining two facilities into one.
- Provision of treatment in a **modern setting**.
- Contiguous living spaces will **maximize therapeutic and staffing efficiencies** as well as **improve patient and staff safety**.

MDHHS

$69.3M Gross | $55M GF | 82 FTEs

Behavioral Health Capacity and Access

Context

- **Excessive demand** and **persistent waitlists** for inpatient psychiatric services at state operated hospitals.
- **Lack of community-based psychiatric beds** or facilities to immediately respond to patients transitioning out of state psychiatric hospitals.
- Long **admission delays** resulting in patients waiting in emergency rooms pending placement in a state facility.
- Michigan ranks **third in the nation** with the highest **shortages** of mental health professionals.

Response

- Expand **behavioral health inpatient community-based** treatment programs.
- Extend **behavioral health and opioid health homes** to additional counties.
- Fund staff and operational costs for two new units at the **Hawthorn Center**.
- Fund staff and operational costs for a new **Center for Forensic Psychiatry** satellite facility.

Expected impact

- **Increased access** to and **quality** of behavioral health services.
- **Improved patient outcomes**.

MDHHS

$3.6M Gross	$3.2M GF	29 FTEs

Occupational Health Clinics

Context

- The State of Michigan hospitals do not have an **occupational health clinic**.
- The COVID-19 pandemic exacerbated compliance issues with **occupational health and infection control requirements**, e.g., data entry, reporting, inventory, and surveillance, as well as flu vaccine and tuberculosis test administration.

Response

- Establish an occupational health clinic in the **five state psychiatric hospitals**.

Expected impact

- An occupational health clinic in each hospital will **operationalize** workplace safety, infection control, and medical and behavioral training and **improve health metrics** for all through quality control.

MDHHS

$1.1M Gross/GF | 8 FTEs

Centralized Administrative Support for State Psychiatric Hospital Activities

Context

- DHHS manages statutorily supported programs that **facilitate placement** of patients into **community settings** when community mental health cannot readily find placement.
- Additional FTEs are needed to **manage, monitor, and oversee** Careflow, MDHHS Community Transition Program (MCTP), and psychiatric residential treatment facilities (PRTF).

Response

Expand staffing infrastructure and supervision within the department.

Expected impact

- Admissions, discharges, and placement efforts will increase.
- Better utilization of limited state hospital beds and resources.

MDHHS

Wrap Up

Completion of **Caro Center** project.

Increase throughput.

Expansion of **education opportunities** Kalamazoo Psychiatric Hospital, Walter Reuther Psychiatric Hospital, and Caro Center.

Ongoing assessment of system-wide administrative and clinical processes.

Establishment of **Psychiatric Residential Treatment Facilities**.

Formal review of hospital operations for **forecasting trends** in physical plant management, bed capacity, and facility safety.

MDHHS

Contact: Chardae Burton
Phone: (517) 243-3221
Website: www.michigan.gov/mdhhs

MDHHS: FY23 Budget Executive Recommendation

Behavioral and Physical Health and Aging Services Administration

March 9, 2022

Farah A. Hanley, Chief Deputy Director for Health
Kate Massey, Senior Deputy Director, Health and Aging Services Administration
Al Jansen, Senior Deputy Director, Behavioral Health and Developmental Disabilities Administration

All Michiganders Should Have Access to Behavioral Health Services

Purpose

- To **improve behavioral health services,** the Behavioral Health and Developmental Disabilities Administration (BHDDA) programs are moving to different administrations and divisions within the department to **improve coordination of service** and **leverage expertise in these areas**.
- MDHHS will have **one voice** related to **adult physical** and **behavioral health** services.

Benefits

- Ensures **staff** and **resources** are available to address behavioral health service needs.
- Providers will have access to **more resources**, **expertise**, and **support**.
- External partners and stakeholders will have **better communication** and **collaboration** with MDHHS.
- Additional investments will be made in **workforce development** and **staffing**.

MDHHS

Behavioral and Physical Health and Aging Services Administration (BPHASA)

- The Health and Aging Services Administration will become the **Behavioral and Physical Health and Aging Services Administration** which will oversee:
  - Medicaid.
  - Aging services.
  - Community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders.
- Certain behavioral health operations will be aligned within BPHASA to avoid duplication, including customer service, managed care contract management, site reviews and financial management.

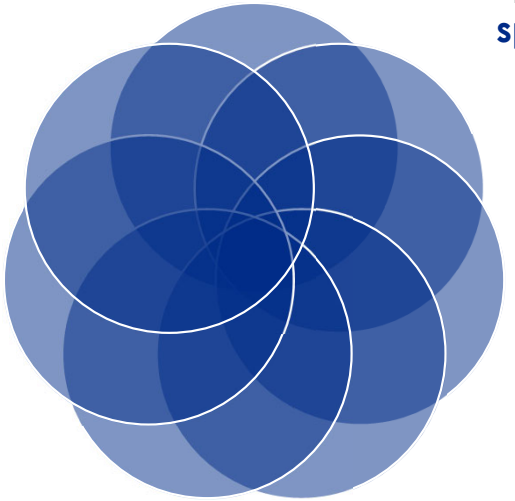
MDHHS

Bureau of Children's Coordinated Health Policy and Supports

Builds upon past work to **improve coordination and oversight** of children's behavioral health services.

Works hand-in-hand with other MDHHS administrations to **maximize use of all statewide resources**.

Proactively **restructures the delivery of specialty health services** to better serve children, youth, and families.



Establishes a **clinical review team** to remove barriers and secure access to care as it's needed.

Recognizes that **services must be specific** to the needs of children, youth and families.

Ensures youth receive **appropriate services when they are needed**, rather than turning to an emergency room setting.

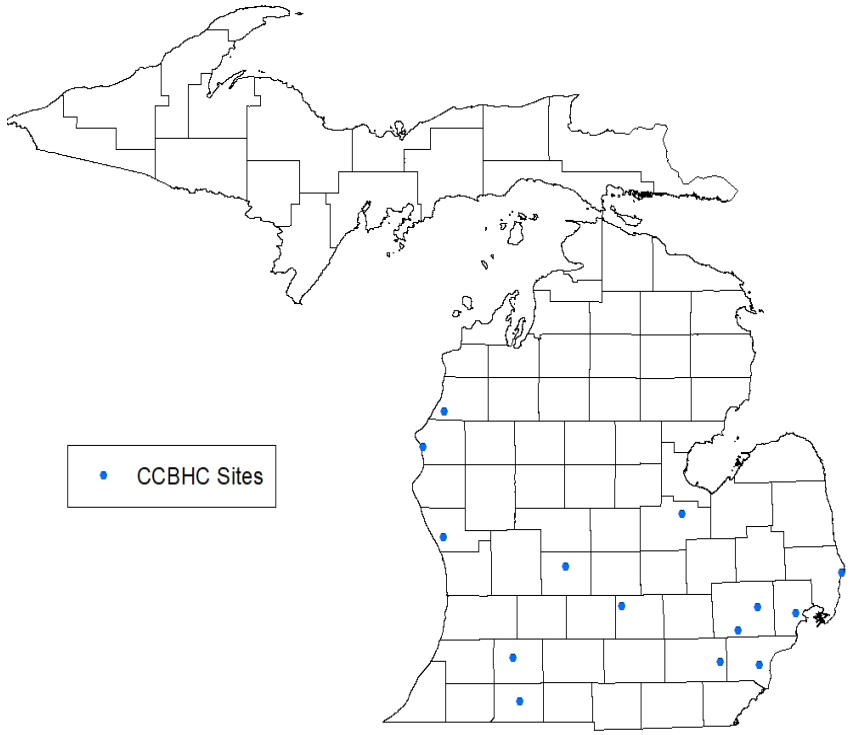
Emphasizes the importance of **including families** in addressing the health needs of children and youth.

MDHHS


Progress on
FY 2022
Investments

Certified Community Behavioral Health Clinic (CCBHC) Demonstration

- **Michigan launched its CCBHC Demonstration on October 1, 2021.**
- **CCBHCs:**
  - Serve all Michiganders with a mental health and/or substance use disorder regardless of severity or insurance or ability to pay.
  - Provide a comprehensive set of physical, behavioral, and social services.
  - Meet stringent state-based certification criteria.
  - Reimbursed at an enhanced Medicaid prospective payment system rate.



MDHHS

CCBHC Demonstration Highlights

Assignment

- Over 18,000 Michiganders assigned to a CCBHC (over 90% are Medicaid beneficiaries).

Certification Status

- All 13 sites have obtained provisional CCBHC certification from MDHHS.
- All 13 sites are on track to complete full certification by April 2022.

Policy Implementation, Monitoring, and Continuous Quality Improvement

- MDHHS technical assistance meetings with PIHPs and CCBHCs established.
- Ad-hoc workgroups established for key program components (e.g., sliding fee scale, mild-to-moderate screening, incarceration).
- Developing a CCBHC operational dashboard.
- Developing quality metric monitoring dashboards and reporting templates.

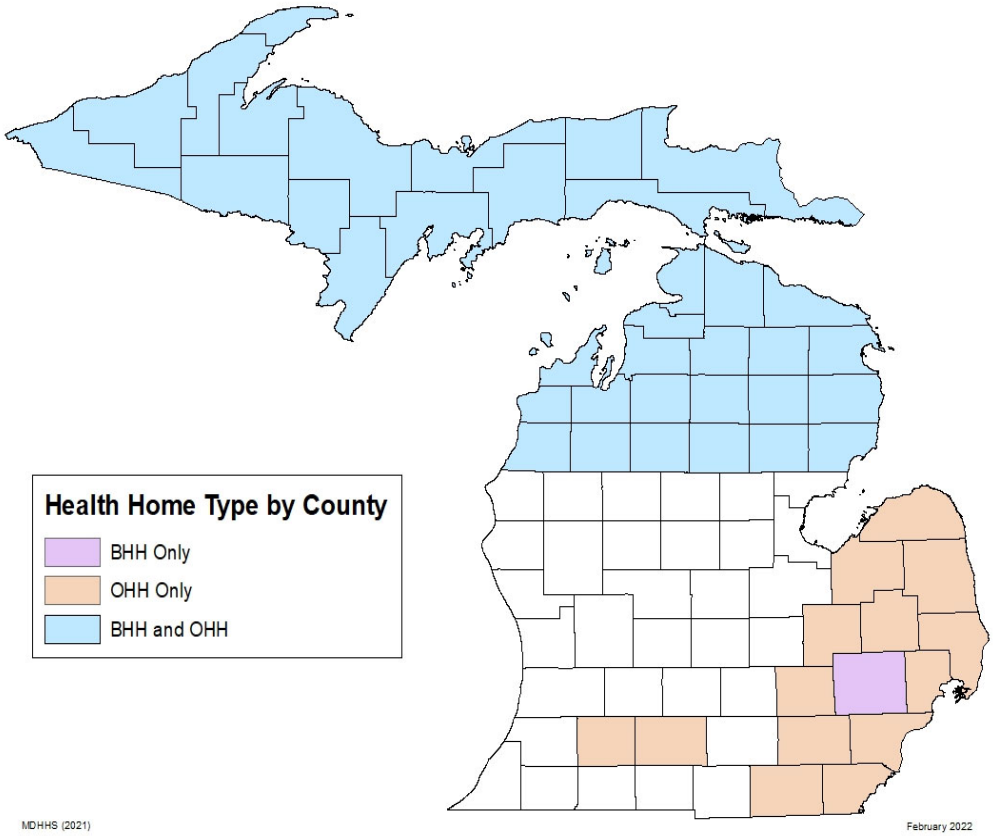
MDHHS

Medicaid Health Home Expansions

- In October 2021, MDHHS expanded the Opioid Health Home to three more PIHP Regions; the Behavioral Health Home will expand to two more PIHP Regions in April 2022.

- Since FY21, **enrollment has increased by 368%**
  - *Behavioral Health Home (BHH):*
    - increased 963% from 100 to 1063 enrollees
  - *Opioid Health Home (OHH):*
    - increased 260% from 550 to 1980 enrollees

- Health Homes provide comprehensive and integrated care management/ coordination to high-need Medicaid beneficiaries.



Direct Care Worker Wages

Context

- **Direct care workers** have been on the **front line of the COVID-19 public health crisis.**
- These individuals take care of our most **vulnerable** and ensures that they are included as a **valued part of their communities** and **empowered to live with the dignity** all people deserve.
- **A $2.35 hourly wage increase approved on an ongoing basis.**

Impact

- **Better attract and retain additional high-quality direct care workers.**
- **Improved health outcomes and quality of life for people served and cared for by direct care workers.**

Status

- **CMS approval secured.**
- **Implemented across all programs.**
- **MDHHS oversight underway.**

MDHHS

MI Choice Program Expansion

Context

- Through **MI Choice**, older or disabled persons who need help caring for themselves **can live independently**, while receiving nursing facility level of care.
- **70% of Michigan seniors** would like to be in their homes, but only about 50% are in this setting.
- Michigan **ranks 45th** in share of long-term care expenses on home- and community-based services.
- Currently ~**17,000 served** through MI Choice.

Impact

- **Improved health, welfare, and quality of life for elderly and disabled individuals.**
- **More cost-effective.**

Status

- **CMS approval for expansion secured.**
- **Waiver Agency contracts modified to include additional slots.**
- **Waiver Agencies working to fill slots but experiencing challenges due to DCW workforce shortages.**

MDHHS

Sickle Cell Disease Initiative

Context

- **Sickle Cell Disease (SCD)** is the **most common blood disorder** in the United States, affecting an estimated **3,500 to 4,000 Michiganders**.
- People with SCD are in **desperate need** of **pain crisis prevention** and **management**.
- **Timely** and **accurate diagnoses** are **imperative** to initiate preventative care measures, lifelong treatment, follow-up, and education.

Impact

- **Improved access to quality specialty care for all adults with SCD enrolled in CSHCS.**
- **Eligible children will have improved access to quality specialty care.**

Status

- **Eligibility expansion approved by CMS.**
- **Eligible individuals already enrolled.**
- **Education and outreach efforts with community partners ongoing.**

MDHHS

Governor Whitmer's Executive Budget Recommendation

FY 2023

$69.3M Gross | $55M GF | 82 FTEs

Behavioral Health Capacity and Access

Context

- Nearly **68% of adults** with **mental disorders** have another **medical condition**.
- **Excessive demand** and **persistent waitlists** for inpatient psychiatric services at state operated hospitals.
- **Lack of community-based psychiatric beds** or facilities to immediately respond to patients transitioning out of state psychiatric hospitals.
- Long **admission delays** resulting in patients waiting in emergency rooms pending placement in a state facility.
- Michigan ranks **third in the nation** with the highest **shortages** of mental health professionals.

Response

- Purchase access to new **private behavioral health supports** for 48 adults and 12 children.
- Expand **behavioral health inpatient community-based** treatment programs.
- Extend **behavioral health and opioid health homes** to additional counties.
- Fund staff and operational costs for two new units at the **Hawthorn Center**.
- Fund staff and operational costs for a new **Center for Forensic Psychiatry** satellite facility.

Expected impact

- **Increased access** to and **quality** of behavioral health services.
- **Improved patient outcomes**.

MDHHS

$25 Gross/GF

Michigan Essential Health Provider Loan Repayment Program

Context

- Michigan ranks **third in the nation** with the highest **shortages** of mental health professionals.
- Michigan's state hospital system struggles to hire and **retain** enough **qualified** and **trained** staff to provide psychiatric services statewide.
- One primary cause of this problem is **lower compensation** compared to the private sector.

Response

- A one-year bonus payment will be provided to almost **1,000 state psychiatric hospital direct care staff** and to approximately **50,000 behavioral health workers** operating in Michigan communities.
- The Michigan State Loan Repayment Program will be **expanded** to eligible **behavioral health practitioners** working in federally designated health professional shortages areas (HPSA).

Expected impact

- Improved **recruitment and retention** of direct care staff in Michigan.

MDHHS

$26.1M Gross

Additional Behavioral Health Investments

Investment	Description	Gross/GF
Jail Diversion Fund	Funding will support the jail diversion fund administered by the mental health diversion council, in accordance with recommendations of the Michigan joint task force on jail and pretrial incarceration.	$15 million
Multicultural Integration Organizations	Increased funding to Multicultural Integration organizations.	$8.6 million
First Responder Mental Health Funding	The program will primarily provide grants to behavioral health providers supporting firefighters, police officers, emergency medical services personnel, dispatchers, and correctional officers suffering from post-traumatic stress syndrome and other mental health conditions.	$2.5 million
	Total	**$26.1 million**

MDHHS

Medicaid Dental Program

Current Landscape

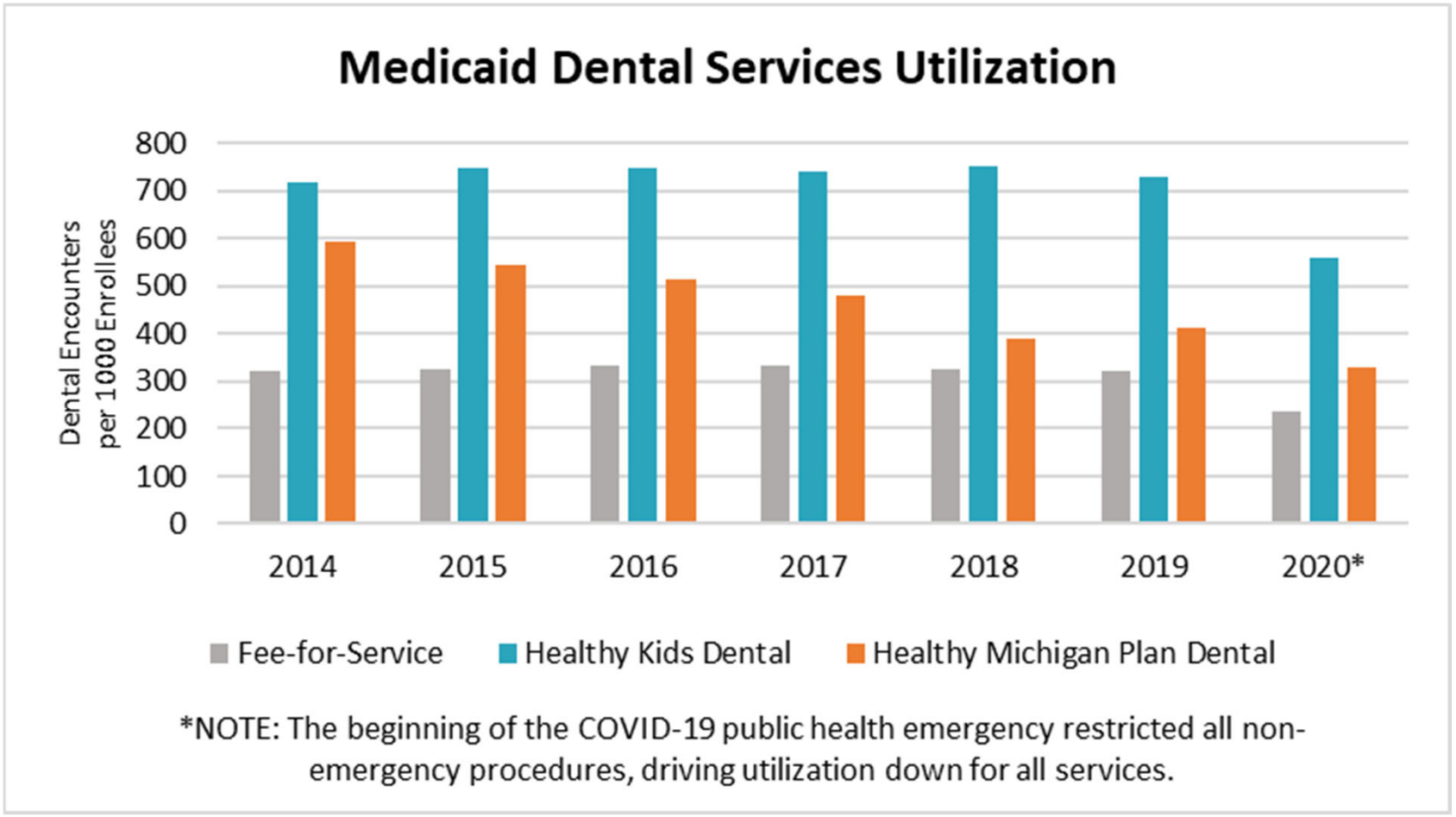
Michigan currently has a fragmented and uncoordinated system for delivering dental services for the Medicaid population.

	Average Program Enrollment	Delivery System Today
Healthy Kids Dental	948,998	Two Statewide Dental Health Plans
Healthy Michigan Plan Dental	528,347*	Nine Comprehensive Medicaid Health Plans
Medicaid Adult Dental	711,378	Base Medicaid fee-for-service (FFS) program

**Reflects managed care enrollment only, does not include HMP fee-for-service enrollee. Also includes pregnant women through 60-day postpartum period.*

MDHHS

Medicaid Dental Program Redesign



MDHHS

$247.6M Gross | $69.8M GF

Medicaid Dental Program Redesign

Context

- **Oral health** is an important component of general health.
- Adults and children who lack access to dental care are **more susceptible to infection and disease**.
- Poor oral health **impacts socialization, education, job retention, self-esteem**, and communication.
- Access to dental care for Michigan Medicaid enrollees was restricted by **stagnant fee-for-service rates** paid to providers.

Response

- **$243.3 million** to consolidate child and adult Medicaid and Healthy Michigan Plan dental benefit into a single managed care contract with Dental Health Plans.
- **$4.3 million** to increase the dental procedure reimbursement rate for outpatient hospitals and ambulatory surgical centers across the state.

Expected impact

- Increasing access to dental care will **improve the lives of thousands of adults and children**.

MDHHS

$15.5M Gross | $6.3M GF

Health Equity Across the Lifespan

Context

- **Health disparities** are persistent and increasing for both agricultural workers and Black and Hispanic people.
- Michigan's 2019 **infant mortality rate** of 6.3 per 1,000 live births is higher than the national average of 5.6 per 1,000 live births.
- There is a **disproportionate impact of recovering birth expenses** from Michigan's most vulnerable families.
- **Agricultural workers** face barriers to self-sufficiency due to undiagnosed and/or untreated medical conditions.

Response

- End the state's **Medicaid birth expenses recovery program**.
- Increase access to **doula care** for high-risk families.
- Support additional community health workers to help **migrants access health care services** at the four Federally Qualified Health Centers.

Expected impact

Reduce health disparities by improving health equity in vulnerable and marginalized populations from birth to adulthood.

MDHHS

$75.8M Gross **$27.4M GF**

Fee, Wage, and Payment Adjustments

Vaccine Administration Fee Increase

$14.1 million gross, $4.5 million GF/GP for a Vaccine Administration Fee Increase.

Michigan's **vaccine administration fees** have not changed since 1994.

- **Current rate**: $7 for injectable vaccines & $3 for oral vaccines.
- **Proposed rate**: $16.13 for injectable vaccines & $12.25 for oral vaccines.

The proposed rates are comparable with Medicare, and other state Medicaid programs.

Nursing Home Non-Clinical Staff Adjustment

$60 million gross, $21.2 million GF/GP for a **Nursing Home Non-Clinical Staff Adjustment.**

Provides for the annual cost of a $2.35 hourly wage increase.

Hospice Room and Board Payments

$1.7 million gross and GF/GP to increase **Hospice Room and Board payments** to facilities not certified by Medicare.

MDHHS

$20M Gross | $15M GF

One-Time Investments in Initiatives to Address Racial Disparities

Investment	Description	Gross	GF
Uterine fibroid disparities	Education and outreach programming to raise awareness of uterine fibroid disparities among minority populations.	$500,000	$500,000
Centering Pregnancy	Support for expansion of the number of Centering Pregnancy sites in the state.	$4.2 million	$4.2 million
Medicaid Health Plans Incentive Pool	New incentive pool to contracted Medicaid Health Plans to address racial disparities in medical services.	$10 million	$5 million
Michigan Area Health Education Centers	Statewide patient-centered training and technical assistance for health centers and hospitals.	$4 million	$4 million
Workforce development funds	Bolster efforts to enhance and diversify Michigan's healthcare workforce.	$1.3 million	$1.3 million
	Total	**$20 million**	**$15 million**

MDHHS

Contact: Chardae Burton
Phone: (517) 243-3221
Website: www.michigan.gov/mdhhs

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

ATTENDEES:	**Joanie Blamer, Connie Cadarette, Lauri Fischer, Kevin Hartley, Chip Johnston, Nancy Kearly, Eric Kurtz, Donna Nieman, Larry Patterson, Brandon Rhue, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

REVIEW AGENDA & ADDITIONS
Erin asked to have Hope Network Stability Payment request added to the meeting agenda.

MOTION BY ERINN TRASK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY FINANCE COMMITTEE MEETING AGENDA FOR MARCH 9, 2022 AS AMENDED; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE FEBRUARY 9, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY KEVIN HARTLEY. MOTION APPROVED.

MONTHLY FINANCIALS
January 2022

- Traditional Medicaid showed $66,440,248 in revenue, and $58,063,977 in expenses, resulting in a net surplus of $8,376,271. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $10,338,832 in revenue, and $7,570,183 in expenses, resulting in a net surplus of $2,768,649. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Net Position* showed net surplus Medicaid and HMP of $11,144,920. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $25,125,545. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $41,483,662.
- Health Home showed $399,719 in revenue, and $316,653 in expenses, resulting in a net surplus of $83,066.
- SUD showed all funding source revenue of $7,846,427, and $6,230,947 in expenses, resulting in a net surplus of $1,615,480. Total PA2 funds were reported as $5,723,748.

The Direct Care Wage Surplus was reported as $2,377,492. Deanna noted that “FY22 Projected Revenue” and “FY22 Allocated Projects” columns were added to the “Schedule of PA2 by County” page of the financial report at the request of the NMRE Board. Donna requested details regarding the county specific and region-wide liquor tax projects which Deanna agreed to provide. The first of three PA2 payments for FY22 is expected in April.

Clarification was made that the dip in eligibility for DABs is due to the time lag and is expected to catch up.

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

EDIT UPDATE

The next EDIT meeting is scheduled for April 21st. A request was made to add transcranial magnetic stimulation code to the meeting agenda.

Donna asked whether any of the CFOs have looked at the Standard Cost Allocation (SCA) report. She expressed that she is hopeful that PCE will be able to generate a report to complete the last tab due to the tremendous number of code combinations. Erinn reported that version 1.1 is scheduled for release this month that is supposed to contain updated provider code combinations.

Lauri asked whether any of the Boards are planning to submit the salary and wage survey on March 31st. Donna responded that the salary and wage survey is intended for entities providing services via contract arrangements with PIHPs or CMHSPs. Communication from the Department has been inconsistent. Eric advised that pursuant to MSA Bulletin 21-39 the salary and wage survey is not required for CMHSPs. This topic will be placed on the March 15th Operations Committee meeting agenda for further discussion. More information on Policy 21-39 reporting requirements may be found at MDHHS - Reporting Requirements (michigan.gov), including a recording of the January training.

EQI UPDATE

All reports were submitted by the February 28th deadline (EQI, FSR, MLR). Tricia reported that the process went much smoother than last year. Deanna thanked the Board for their quick responses to her questions related to completing the FSR.

OPEN HSW SLOTS

Four packets are pending approval, leaving an additional 19 slots open. Deanna stressed the importance of keeping the slots filled to avoid losing them. Donna reported that two additional packets are coming from Centra Wellness. Kevin reported that three packets from North Country were approved in February and 10 packets are currently in various stages of completion. Connie reported that Northeast Michigan just had one packet approved, one packet pending approval, four that have been submitted, and one more packet beginning the process.

PROVIDER STABILITY PAYMENTS

Erinn shared a request from Hope Network in the amount of $851.67 (percentage based on occupancy); Donna confirmed that Centra Wellness received a similar request. This topic will be placed on the March 15th Operations Committee meeting agenda for further discussion.

NEXT MEETING

The next meeting was scheduled for April 13th at 10:00AM.

Chief Executive Officer Report

March 2022

This report is intended to brief the NMRE Board of the CEO 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 accomplishments by the CEO.

Feb 22: Attended and participated in MDHHS/NMRE 1915(i) Waiver meeting.

Feb 25: Attended and participated in CMHAM SCA discussion.

Feb 28: Presented to AV Board regarding NMRE initiatives.

March 1: Chaired NMRE Internal Operations Committee meeting.

March 2: Attended and participated in PIHP CEO meeting.

March 3: Attended and participated in CMHAM advocacy briefing.

March 3: Attended MDHHS Behavioral Health reorg presentation.

March 7: Attended and participated in NMRE SUD Oversight Board meeting.

March 9: Attended and participated in NMRE Finance Committee meeting.

March 15: Chaired NMRE Operations Committee meeting.

Northern Michigan Regional Entity

January 2022 Finance Report

January 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	8,376,271	11,296,664	9,298,750
Healthy Michigan	2,768,649	5,061,832	7,059,746
	$ 11,144,920	$ 16,358,496	$ 16,358,496

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	482,468	1,496,818	3,345,153	2,967,366	713,109	1,721,696	418,311	$ 11,144,920
Direct Care Wage Estimated Surplus								(2,377,492)
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 25,125,545
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 41,483,662

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2021 through January 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 64,510,974	$ 1,548,402						$ 66,059,376
CMHSP Distributions	(62,119,466)		20,667,057	17,118,993	10,441,445	8,517,519	5,374,453	-
1st/3rd Party receipts			159,801	-	221,071	-	-	380,872
Net revenue	2,391,508	1,548,402	20,826,858	17,118,993	10,662,516	8,517,519	5,374,453	66,440,248
Expense								
PIHP Admin	768,146	14,813						782,959
PIHP SUD Admin		16,057						16,057
SUD Access Center		16,870						16,870
Insurance Provider Assessment	514,747	10,660						525,407
Hospital Rate Adjuster	688,072							688,072
Services		1,060,112	17,937,974	14,807,081	10,161,622	6,933,278	5,134,545	56,034,612
Total expense	1,970,965	1,118,512	17,937,974	14,807,081	10,161,622	6,933,278	5,134,545	58,063,977
Net Actual Surplus (Deficit)	$ 420,543	$ 429,890	$ 2,888,884	$ 2,311,912	$ 500,894	$ 1,584,241	$ 239,908	$ 8,376,271

Notes

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

Medicaid Savings - $11,296,867

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through January 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 6,662,950	$ 3,673,153						$ 10,336,103
CMHSP Distributions	(6,001,022)		2,187,726	1,816,033	744,656	747,878	504,730	-
1st/3rd Party receipts			-	-	2,729	-	-	2,729
Net revenue	661,928	3,673,153	2,187,726	1,816,033	747,385	747,878	504,730	10,338,832
Expense								
PIHP Admin	60,977	34,520						95,497
PIHP SUD Admin		37,420						37,420
SUD Access Center		39,315						39,315
Insurance Provider Assessment	46,534	24,451						70,985
Hospital Rate Adjuster	492,492							492,492
Services		2,470,519	1,731,457	1,160,579	535,170	610,422	326,327	6,834,474
Total expense	600,003	2,606,225	1,731,457	1,160,579	535,170	610,422	326,327	7,570,183
Net Surplus (Deficit)	$ 61,926	$ 1,066,928	$ 456,269	$ 655,454	$ 212,215	$ 137,456	$ 178,403	$ 2,768,649

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

Net Surplus (Deficit) MA/HMP	**$ 482,468**	**$ 1,496,818**	**$ 3,345,153**	**$ 2,967,366**	**$ 713,109**	**$ 1,721,696**	**$ 418,311**	**$ 11,144,920**
Direct Care Wage Estimated Surplus								**$ (2,377,492)**
Medicaid & HMP Carry Forward								**16,358,117**
Total Med/HMP Current Year Surplus								$ 25,125,545
Medicaid & HMP ISF - based on unaudited FSR								**16,358,117**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 41,483,662**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through January 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 88,760		139,335	9,827	20,356	16,145	125,296	$ 399,719
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	88,760	-	139,335	9,827	20,356	16,145	125,296	399,719
Expense								
PIHP Admin	4,345							4,345
BHH Admin	-							-
Insurance Provider Assessment	1,349							1,349
Hospital Rate Adjuster								
Services	-		139,335	9,827	20,356	16,145	125,296	310,959
Total expense	5,694	-	139,335	9,827	20,356	16,145	125,296	316,653
Net Surplus (Deficit)	$ 83,066	$ -	$ -	$ -	$ -	$ -	$ -	$ 83,066

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through January 31, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,548,402	$ 3,673,153	$ 1,101,459	$ 828,155	$ 695,258	$ 7,846,427
Expense						
Administration	30,870	71,940	26,698	48,815		178,323
OHH Admin			33,069	-		33,069
Access Center	16,870	39,315	-	7,768		63,954
Insurance Provider Assessment	10,660	24,451	6,185			41,296
Services:						
Treatment	1,060,112	2,470,519	916,844	488,154	695,258	5,630,887
Prevention	-	-	-	283,418	-	283,418
State targeted response	-	-	-	-	-	-
Total expense	1,118,512	2,606,225	982,796	828,155	695,258	6,230,947
PA2 Redirect			-			-
Net Surplus (Deficit)	$ 429,890	$ 1,066,928	$ 118,663	$ (0)	$ -	$ 1,615,480

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

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

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 64,510,974	$ 1,548,402	$ -	$ 66,059,376
Medicaid Savings	-	-	-	-
Healthy Michigan	6,662,950	3,673,153	-	10,336,103
Healthy Michigan Savings	-	-	-	-
Health Home	399,719	-	-	399,719
Opioid Health Home	-	1,101,459	-	1,101,459
Substance Use Disorder Block Grant	-	828,155	-	828,155
Public Act 2 (Liquor tax)	-	695,262	-	695,262
Affiliate local drawdown	224,900	-	-	224,900
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	11,367	-	11,367
Veteran Navigator Grant	33,358	-	-	33,358
SOR Grant Revenue	-	272,680	-	272,680
Gambling Grant Revenue	-	512	-	512
Other Revenue	-	-	2,487	2,487
Total operating revenue	71,831,901	8,130,990	2,487	79,965,378
Operating expenses				
General Administration	916,302	159,443	-	1,075,745
Prevention Administration	-	27,543	-	27,543
OHH Administration	-	33,069	-	33,069
BHH Administration	-	-	-	-
Insurance Provider Assessment	562,630	41,296	-	603,926
Hospital Rate Adjuster	1,180,564	-	-	1,180,564
Payments to Affiliates:				
Medicaid Services	54,593,628	1,060,112	-	55,653,740
Healthy Michigan Services	4,361,226	2,470,519	-	6,831,745
Health Home Services	310,959	-	-	310,959
Opioid Health Home Services	-	916,844	-	916,844
Community Grant	-	488,154	-	488,154
Prevention	-	255,875	-	255,875
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	695,258	-	695,258
Local PBIP	-	-	-	-
Local Match Drawdown	224,900	-	-	224,900
Miscellanous Grant	-	11,367	-	11,367
Veteran Navigator Grant	33,358	-	-	33,358
SOR Grant Expenses	-	272,680	-	272,680
Gambling Grant Expenses	-	512	-	512
Total operating expenses	62,183,567	6,432,672	-	68,616,239
CY Unspent funds	9,648,334	1,698,318	2,487	11,349,139
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	594,260	9,150,294	14,870,057	24,614,611
Unspent funds - ending	$ 10,242,594	$ 10,848,612	$ 14,872,544	$ 35,963,750

Northern Michigan Regional Entity

Statement of Net Position

January 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 19,754,325	$ 10,391,350	$ 14,872,544	$ 45,018,219
Accounts Receivable	12,239,302	1,915,545	-	14,154,847
Prepaids	76,791	-	-	76,791
Total current assets	32,070,418	12,306,895	14,872,544	59,249,857
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	32,070,418	12,306,895	14,872,544	59,249,857
Liabilities				
Current liabilities				
Accounts payable	21,599,151	1,395,838	-	22,994,989
Accrued liabilities	228,673	-	-	228,673
Unearned revenue	-	62,445	-	62,445
Total current liabilities	21,827,824	1,458,283	-	23,286,107
Unspent funds	$ 10,242,594	$ 10,848,612	$ 14,872,544	$ 35,963,750

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 64,310,364	$ 64,510,974	$ 200,610	0.31%
Carryover	11,296,664	11,296,664	-	(11,296,664)	(1)
Healthy Michigan					
Capitation	20,566,272	6,855,424	6,662,950	(192,474)	(2.81%)
Carryover	5,061,832	5,061,832	-	(5,061,832)	(100.00%)
Health Home	506,772	168,924	399,719	230,795	136.63%
Affiliate local drawdown	1,204,388	301,097	224,900	(76,197)	(25.31%)
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	36,668	33,358	(3,310)	(9.03%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	88,030,973	71,831,901	(16,199,072)	(18.40%)
Operating expenses					
General Administration	3,021,688	1,001,916	916,302	85,614	8.55%
BHH Administration	-	-	-	-	0.00%
Insurance Provider Assessment	1,645,387	548,462	562,630	(14,168)	(2.58%)
Hospital Rate Adjuster	4,001,228	1,333,741	1,180,564	153,177	11.48%
Local PBIP	1,334,531	-	-	-	0.00%
Local Match Drawdown	1,204,388	301,097	224,900	76,197	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	64,964	33,358	31,606	48.65%
Payments to Affiliates:					
Medicaid Services	173,402,120	57,800,707	54,593,628	3,207,079	5.55%
Healthy Michigan Services	15,233,944	5,077,981	4,361,226	716,755	14.11%
Health Home Services	456,768	152,256	310,959	(158,703)	(104.23%)
Total operating expenses	200,508,190	66,281,125	62,183,567	4,097,558	6.18%
CY Unspent funds	$ 32,503,361	$ 21,749,848	9,648,334	$ (12,101,514)	
Transfers in			-		
Transfers out			-	62,183,567	
Unspent funds - beginning			594,260		
Unspent funds - ending			$ 10,242,594	9,648,334	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 1,466,248	$ 1,548,402	$ 82,154	5.60%
Healthy Michigan	9,763,272	3,254,424	3,673,153	418,729	12.87%
Substance Use Disorder Block Grant	5,709,003	1,902,998	828,155	(1,074,843)	(56.48%)
Opioid Health Home	2,320,384	773,460	1,101,459	327,999	42.41%
Public Act 2 (Liquor tax)	1,533,979	-	695,262	695,262	0.00%
Miscellanous Grants	36,335	12,112	11,367	(745)	(6.15%)
SOR Grant	1,215,000	405,000	272,680	(132,320)	(32.67%)
Gambling Prevention Grant	200,000	66,667	512	(66,155)	(99.23%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	7,880,908	8,130,990	250,082	3.17%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	336,828	159,443	177,385	52.66%
Prevention Administration	90,144	30,048	27,543	2,505	8.34%
Insurance Provider Assessment	116,901	38,967	41,296	(2,329)	(5.98%)
Medicaid Services	3,387,649	1,129,216	1,060,112	69,104	6.12%
Healthy Michigan Services	7,453,459	2,484,486	2,470,519	13,967	0.56%
Community Grant	2,077,452	692,484	488,154	204,330	29.51%
Prevention	664,967	221,656	255,875	(34,219)	(15.44%)
State Disability Assistance	95,215	31,743	-	31,743	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	33,069	(33,069)	0.00%
Opioid Health Home Services	2,117,226	705,744	916,844	(211,100)	(29.91%)
Miscellanous Grants	36,335	12,112	11,367	745	6.15%
SOR Grant	1,215,000	405,000	272,680	132,320	32.67%
Gambling Prevention	200,000	66,667	512	66,155	99.23%
PA2	1,533,978	-	695,258	(695,258)	0.00%
Total operating expenses	20,058,810	6,154,950	6,432,672	(277,722)	(4.51%)
CY Unspent funds	$ 5,117,907	$ 1,725,958	1,698,318	$ (27,640)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			9,150,294		
Unspent funds - ending			$ 10,848,612		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 576,356	$ 522,962	$ 53,394	9.26%
Fringes	549,516	173,524	173,521	3	0.00%
Contractual	433,304	144,436	145,844	(1,408)	(0.97%)
Board expenses	16,100	5,368	6,466	(1,098)	(20.45%)
Day of recovery	14,000	9,000	250	8,750	97.22%
Facilities	152,700	50,900	35,928	14,972	29.41%
Other	127,000	42,332	31,331	11,001	25.99%
Total General Admin	$ 3,021,688	$ 1,001,916	$ 916,302	$ 85,614	8.55%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 160,736	$ 50,339	$ 110,397	68.68%
Fringes	166,800	55,600	15,597	40,003	71.95%
Access Salaries	194,484	64,828	48,987	15,841	24.44%
Access Fringes	57,588	19,196	14,967	4,229	22.03%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	33,332	25,443	7,889	23.67%
Board expenses	5,000	1,668	950	718	43.05%
Facilities	-	-	-	-	0.00%
Other	10,404	1,468	3,160	(1,692)	(115.26%)
Total operating expenses	$ 1,070,484	$ 336,828	$ 159,443	$ 177,385	52.66%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	832	2,487	1,655	198.92%
Total operating revenue	2,501	832	2,487	1,655	198.92%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 832	2,487	$ 1,655	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			14,870,057		
Unspent funds - ending			$ 14,872,544		

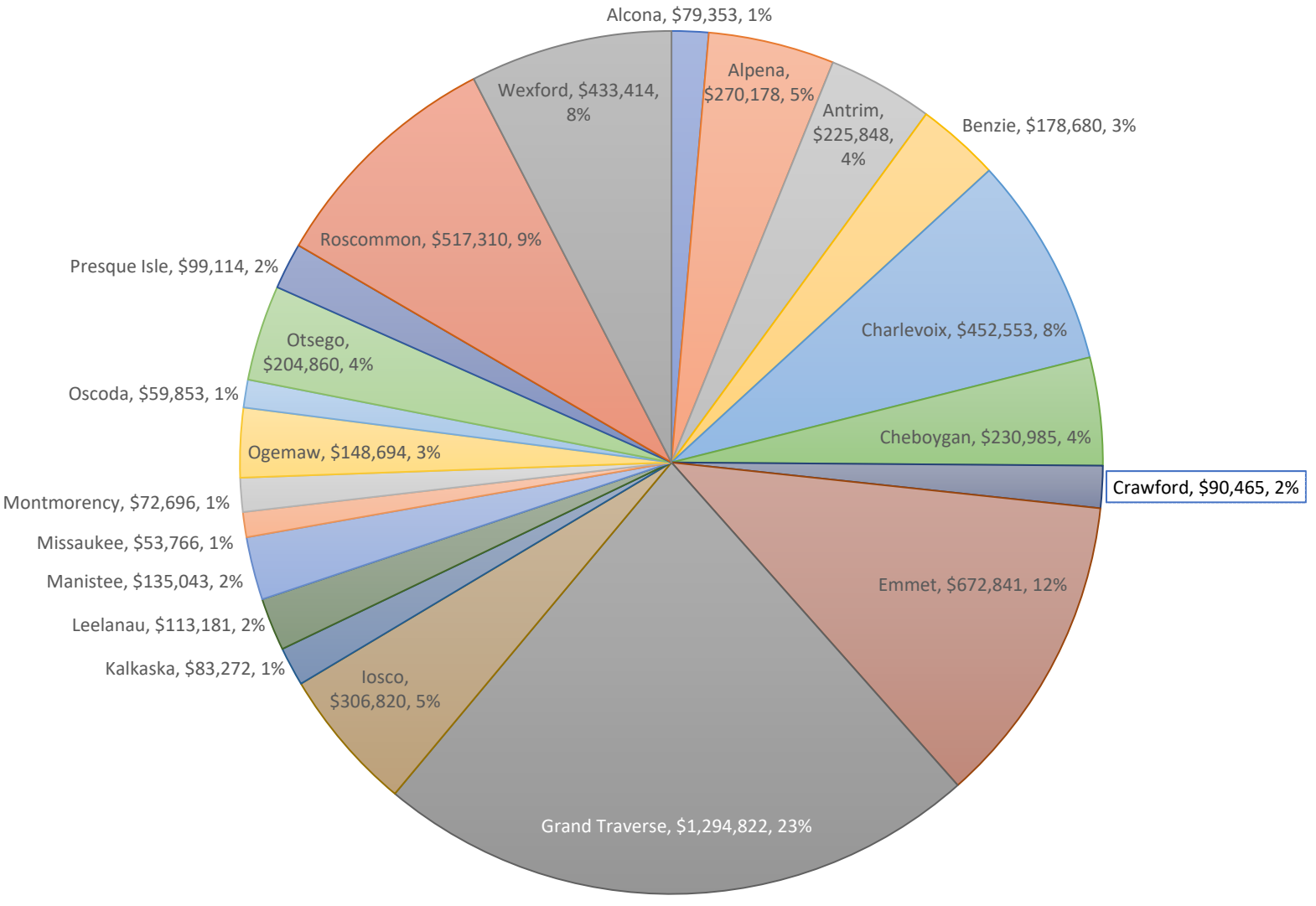
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through January 31, 2022

County	Beginning Balance	FY22 Projected Revenue	Current Receipts	FY22 Allocated Projects	County Specific Projects	Region Wide Projects by Population	Ending Balance
					Actual Expenditures by County		
Alcona	$ 83,635	$ 19,313	$ 0	$ 36,984	12,500	$ 888	$ 79,353
Alpena	315,554	66,080	-	156,384	42,488	2,440	270,178
Antrim	243,061	53,592	-	92,727	19,924	1,997	225,848
Benzie	144,391	49,804	-	25,655	8,633	1,507	178,680
Charlevoix	467,765	82,100	-	125,685	26,132	2,241	452,553
Cheboygan	280,756	68,778	-	167,698	46,973	2,175	230,985
Crawford	85,250	28,559	-	31,209	6,672	1,192	90,465
Emmet	754,134	145,253	-	268,790	39,399	2,846	672,841
Grand Traverse	1,615,220	376,032	-	897,902	193,600	7,872	1,294,822
Iosco	359,368	70,274	-	157,291	32,312	2,157	306,820
Kalkaska	73,813	33,023	-	40,421	15,345	1,512	83,272
Leelanau	131,774	48,924	-	94,499	25,126	1,857	113,181
Manistee	90,411	63,745	-	33,207	12,000	2,094	135,043
Missaukee	66,066	18,058	-	48,379	16,735	1,286	53,766
Montmorency	64,849	26,456	-	32,246	12,844	793	72,696
Ogemaw	164,571	54,659	-	90,136	17,801	1,799	148,694
Oscoda	76,895	17,086	-	42,763	7,924	711	59,853
Otsego	205,220	86,909	-	135,809	46,436	2,104	204,860
Presque Isle	102,301	20,617	-	39,015	14,114	1,097	99,114
Roscommon	488,633	75,491	-	66,562	17,699	2,049	517,310
Wexford	417,956	82,829	-	107,354	37,129	2,853	433,414
	6,231,626	1,487,584	0	2,690,716	651,784	43,471	5,723,748
PA2 Redirect							-
							5,723,748

PA2 Funds by County

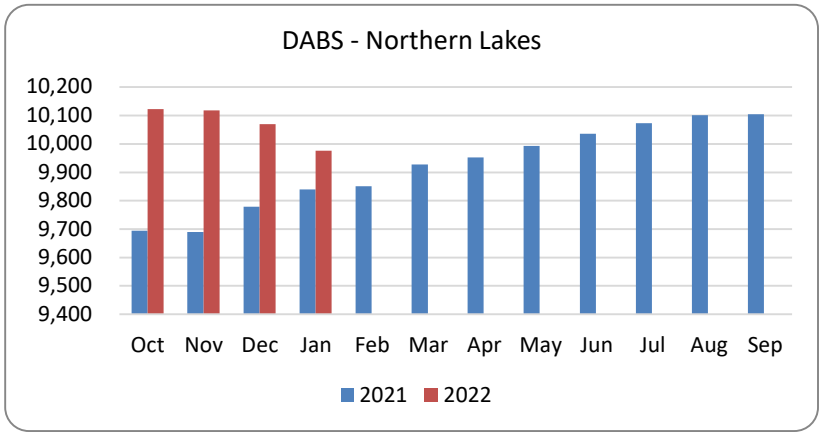


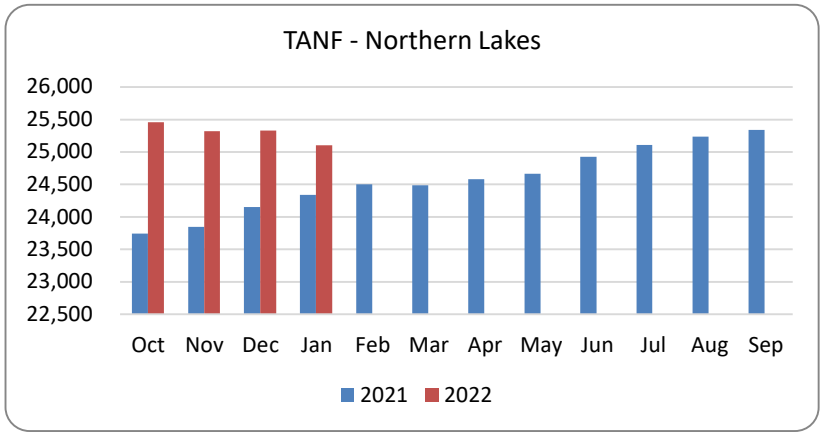
Northern Michigan Regional Entity

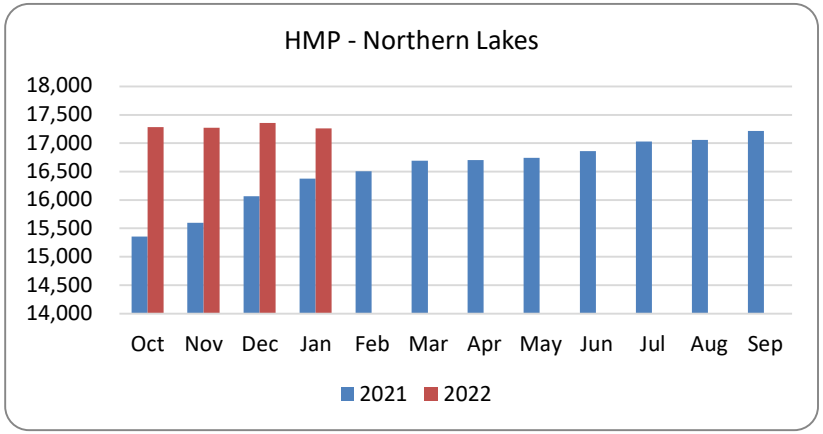
Narrative

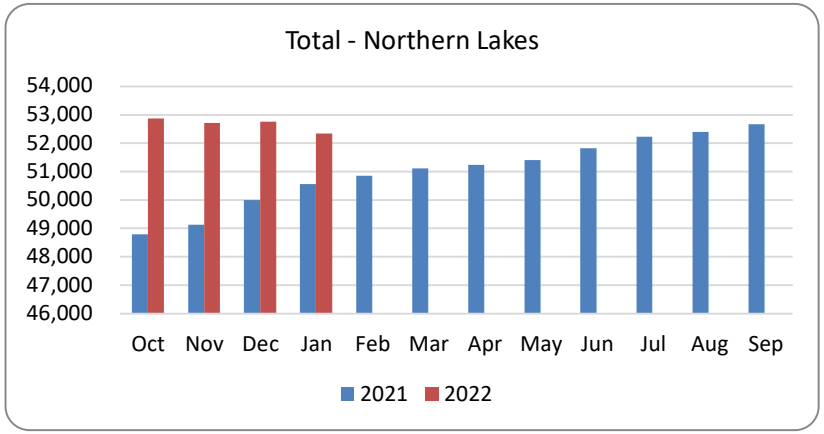
October 1, 2021 through January 31, 2022

Northern Lakes Eligible Trending







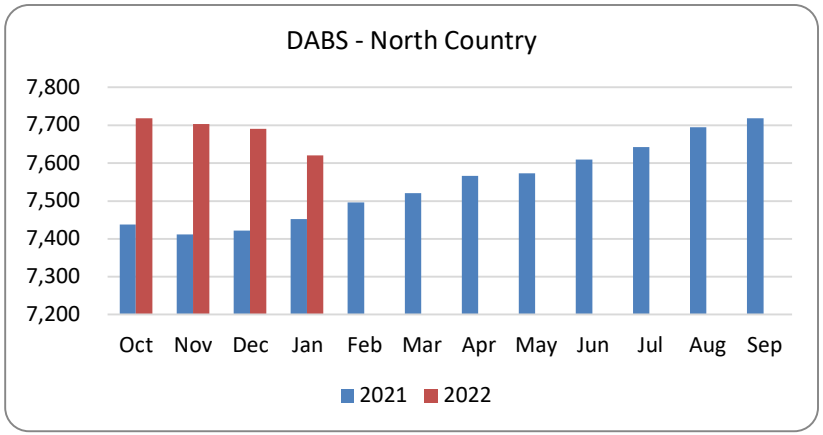


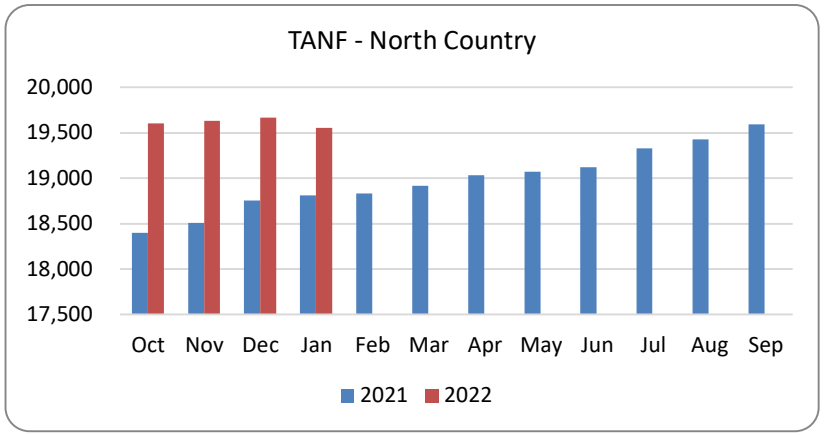
Northern Michigan Regional Entity

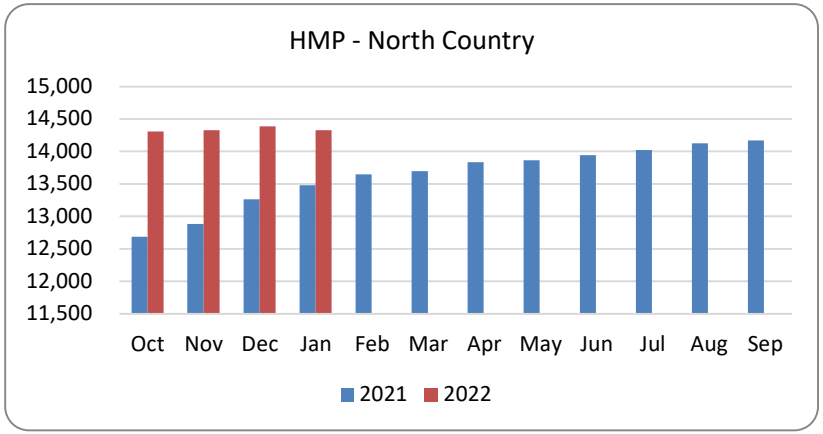
Narrative

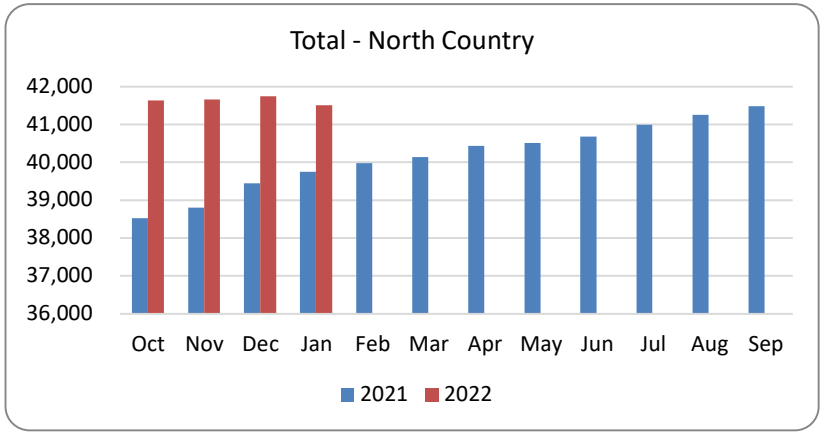
October 1, 2021 through January 31, 2022

North Country Eligible Trending







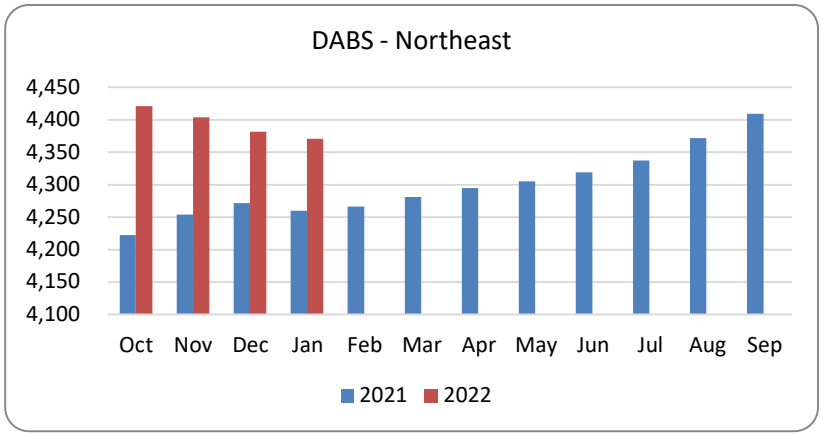


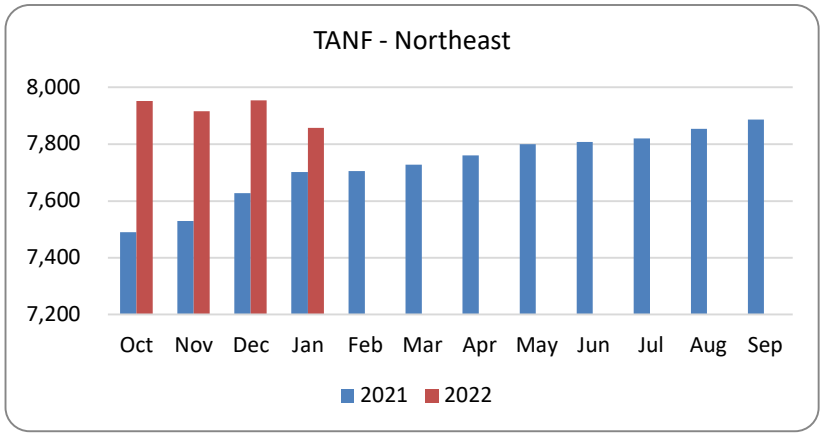
Northern Michigan Regional Entity

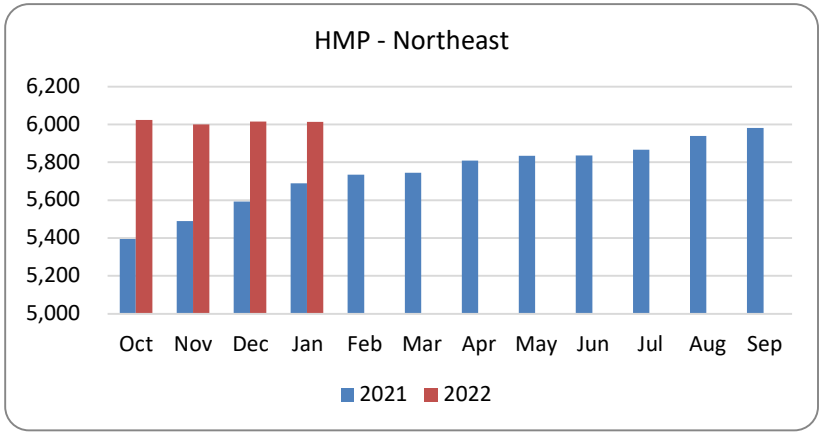
Narrative

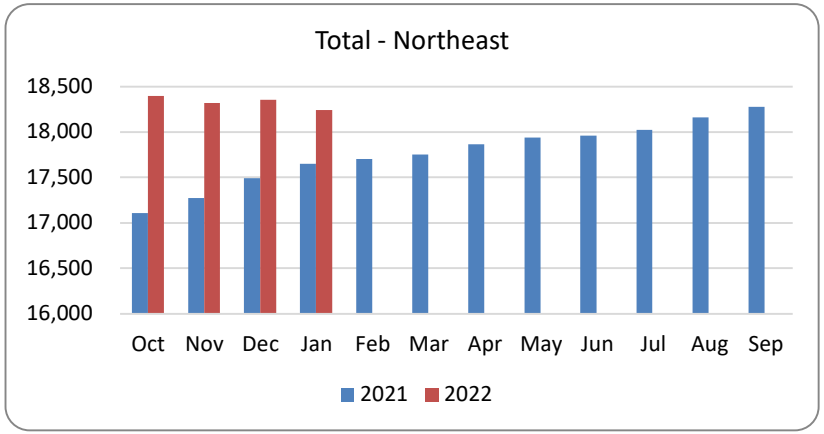
October 1, 2021 through January 31, 2022

Northeast Eligible Trending







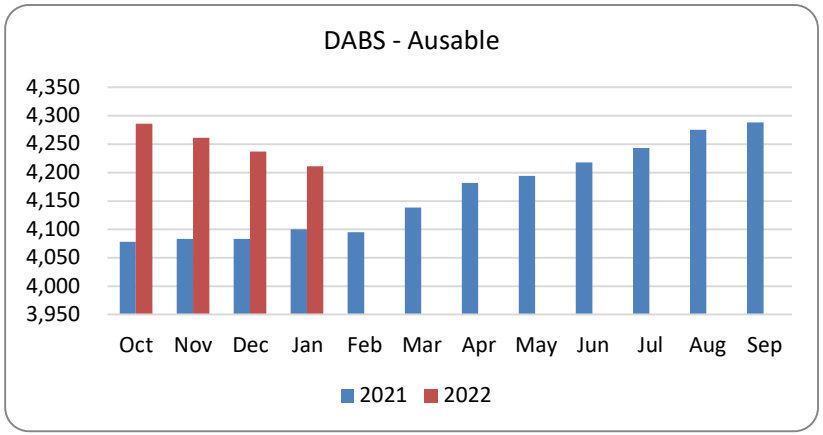


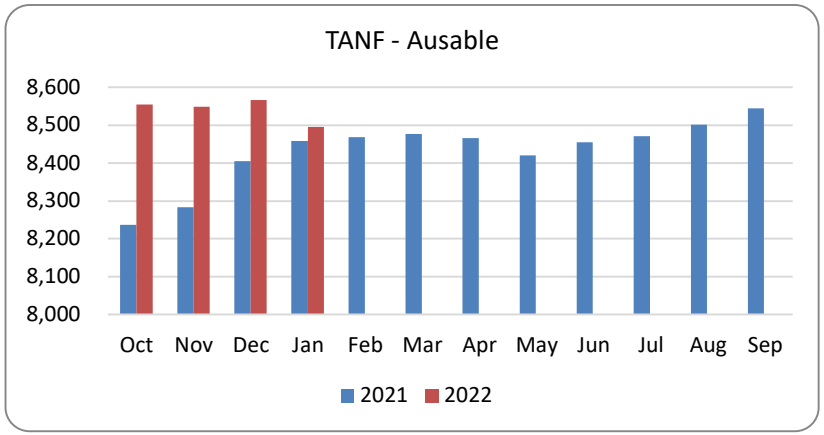
Northern Michigan Regional Entity

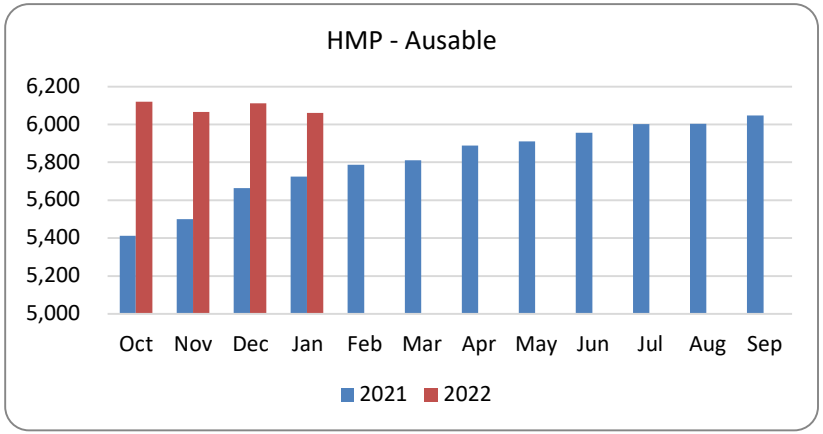
Narrative

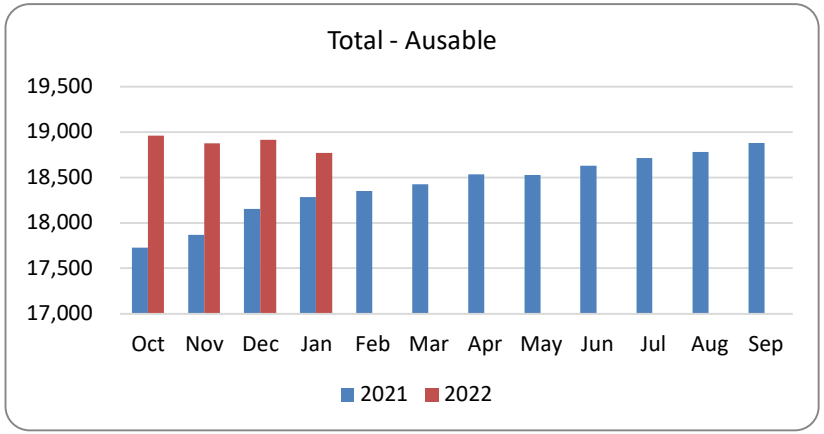
October 1, 2021 through January 31, 2022

Ausable Valley Eligible Trending







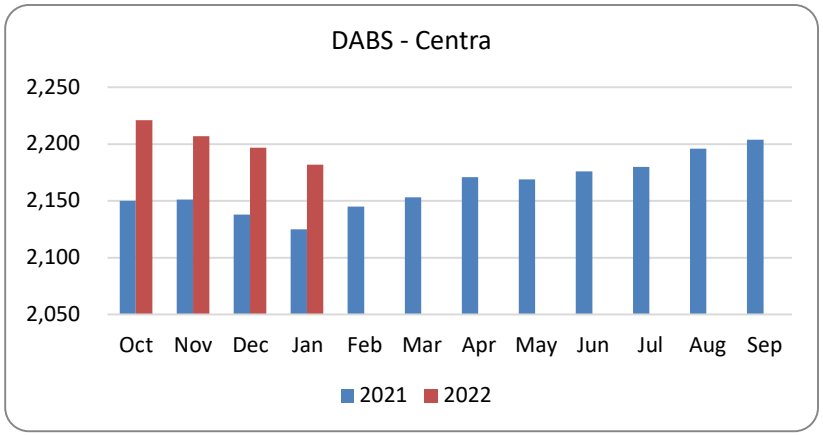


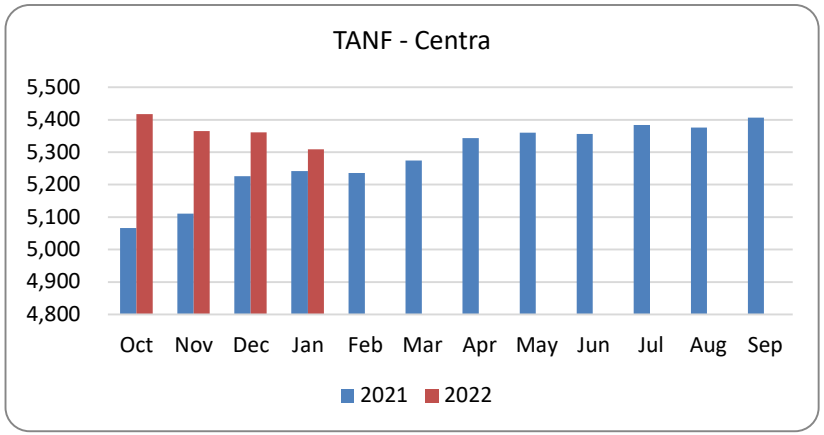
Northern Michigan Regional Entity

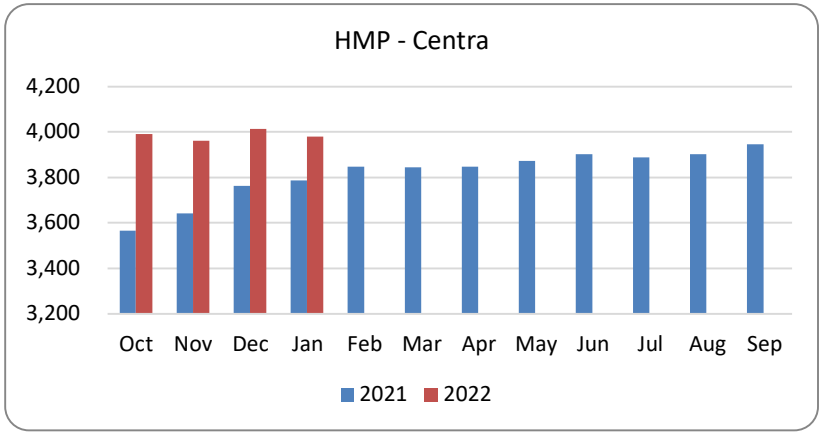
Narrative

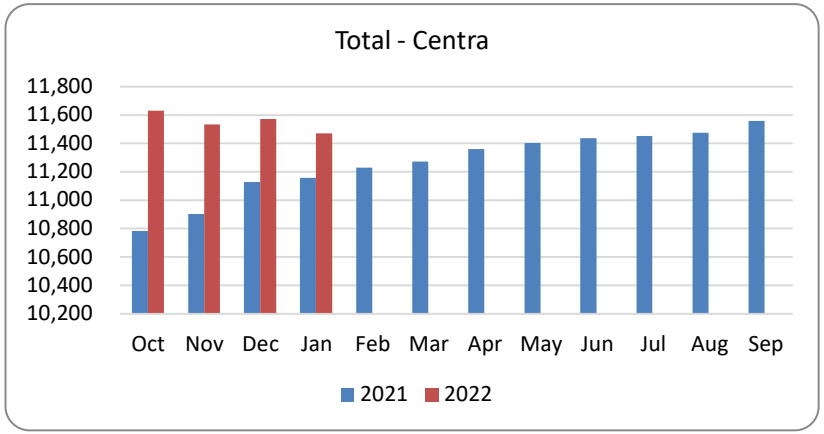
October 1, 2021 through January 31, 2022

Centra Wellness Eligible Trending







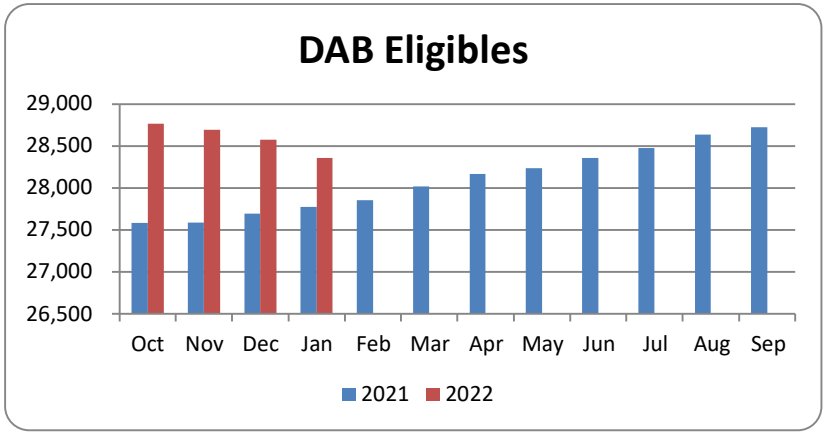


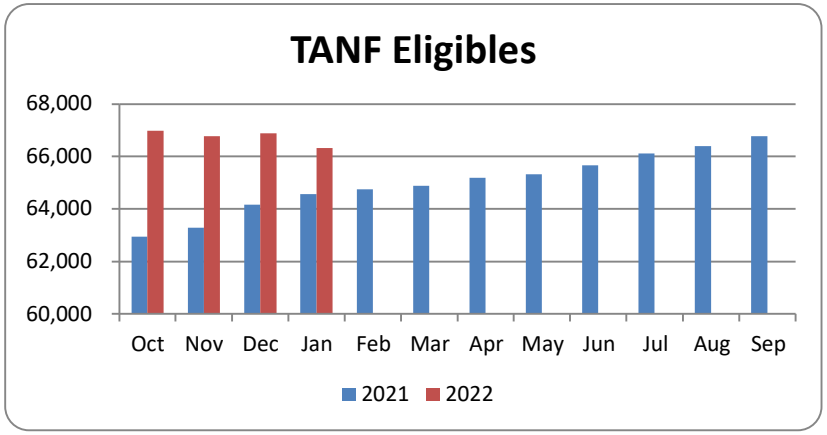
Northern Michigan Regional Entity

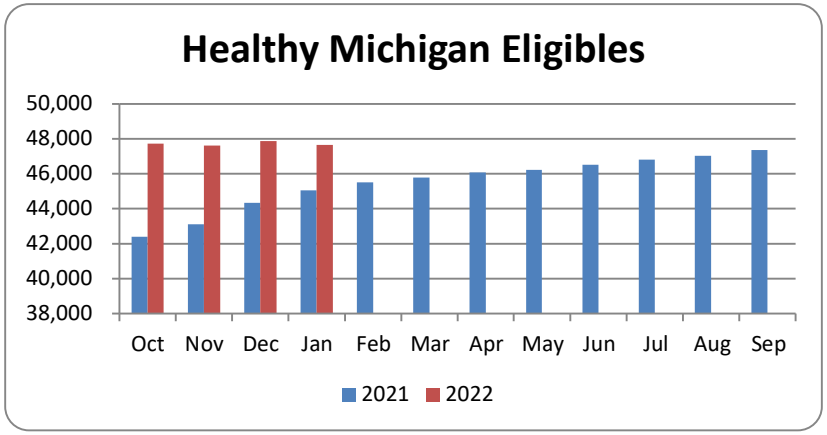
Narrative

October 1, 2021 through January 31, 2022

Regional Eligible Trending





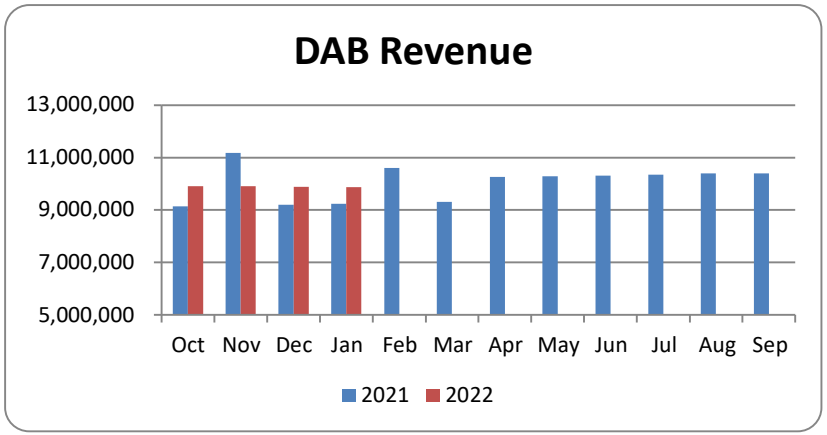


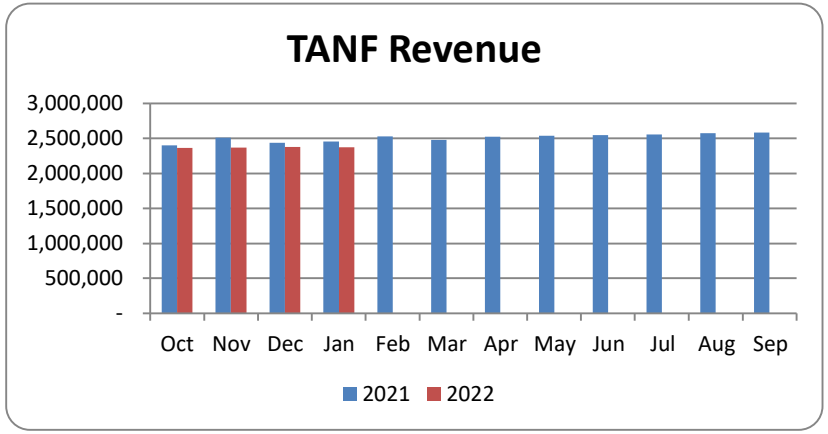
Northern Michigan Regional Entity

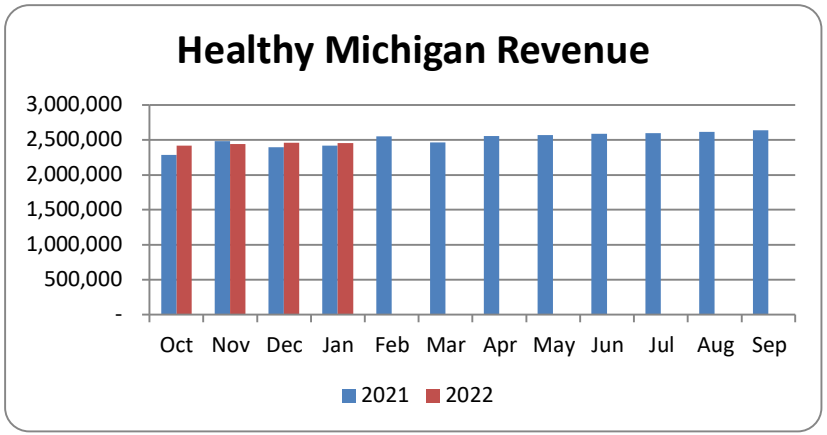
Narrative

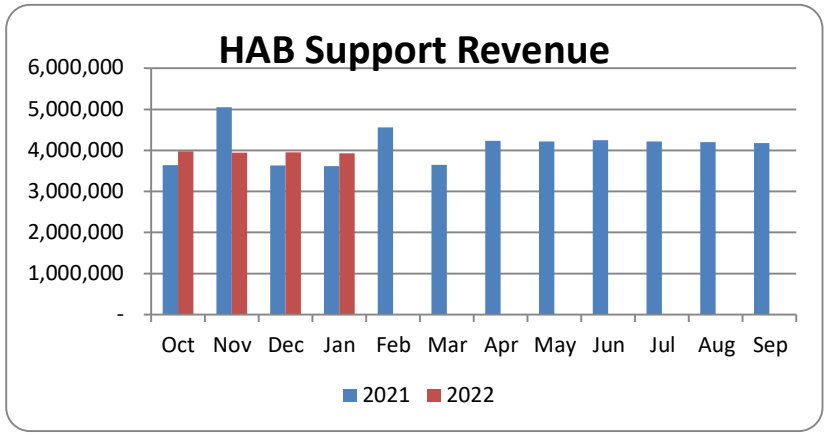
October 1, 2021 through January 31, 2022

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – MARCH 15, 2022
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Joanie Blamer, Christine Gebhard, Chip Johnston, Eric Kurtz, Diane Pelts, Nena Sork, Carol Balousek**

REVIEW OF AGENDA & ADDITIONS
Ms. Gebhard requested that the tiered residential rates workgroup and the NMRE delegated functions review be added to the meeting agenda.

APPROVAL OF PREVIOUS MINUTES
Ms. Pelts noted a couple corrections to the February 15, 2022 meeting minutes.

MOTION BY DIANE PELTS TO APPROVE THE MINUTES OF THE FEBRUARY 15, 2022 NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE MEETING AS AMENDED; SUPPORT BY CHIP JOHNSTON. MOTION APPROVED BY CONSENSUS.

FINANCE COMMITTEE & RELATED
January 2022 Financials

- Traditional Medicaid showed $66,440,248 in revenue, and $58,063,977 in expenses, resulting in a net surplus of $8,376,271. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $10,338,832 in revenue, and $7,570,183 in expenses, resulting in a net surplus of $2,768,649. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Net Position* showed net surplus Medicaid and HMP of $11,144,920. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $25,125,545. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $41,483,662.
- Health Home showed $399,719 in revenue, and $316,653 in expenses, resulting in a net surplus of $83,066.
- SUD showed all funding source revenue of $7,846,427, and $6,230,947 in expenses, resulting in a net surplus of $1,615,480. Total PA2 funds were reported as $5,723,748.

The Final FSR submitted on February 28th was also included for informational purposes.

MOTION BY JOANIE BLAMER TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JANUARY 2022; SUPPORT BY DIANE PELTS. MOTION APPROVED BY CONSENSUS.

FY22 Budget Stabilization
Ms. Blamer expressed that she recently learned that Summertree Residential Centers is struggling with staffing issues and may be requesting stability funds. Ms. Gebhard and Mr. Kurtz discussed scheduling time to speak about contracting with Dr. Ibrahim for the crisis residential home in Gaylord; Mr. Kurtz agreed to contract for facility operations. An optimistic target for the

home renovations to be finished was stated as the end of May. Ms. Blamer reported that she received word this week that that the appropriations request by Northern lakes was granted in the amount of $1.8M for a crisis center in Traverse City (in partnership with Munson Healthcare), including adult residential.

Behavioral Health Salary & Wage Survey
The regional finance committee discussed conflicting direction from the Department with regard to completing the Behavioral Health Salary and Wage Survey. Guidance provided on this date was to follow MSA Policy 21-39 which exempts CMHSPs from participating.

Stabilization Requests
Some of the CMHSPs (AuSable Valley, Centra Wellness, and North Country) received a request from Hope Network for stability payments due to "losses that jeopardize the sustainability of the program." Amounts requested were based on utilization. AuSable Valley responded with a request to view Hope Network's year-to-date organization wide financial statements, an explanation of the reason for this new request including when and how much (average percentage) staff wages increased, an explanation of how current year losses compare to prior years, and what factors need to change to allow the programs to be sustainable. Mr. Kurtz agreed that both the request for additional information and the request from Hope Network were appropriate.

BEHAVIORAL HEALTH REORGANIZATION
The major restructure/reorganization of MDHHS announced during a meeting of PIHP/CMHSP CEOs on March 3rd and its impact on current operations was discussed. Farrah Hanley, former Budget Director, was named the Chief Deputy for Health and will oversee behavioral and physical health and aging services, led by Kate Massey, and the State Hospital Administration, led by Dr. Mellos.

Ms. Gebhard stated a Senate hearing on HB-5165 (Whiteford), regarding individuals' ability to pay is scheduled for March 17, 2022; communication with legislators was encouraged.

Mr. Johnston agreed to send the updated Senate Fiscal Analysis of SB 597 & 598 revised March 14th.

MiCAL 988
Contact information for the NMRE and the five Boars was submitted to Krista Hausermann; trainings are being scheduled in preparation of the "go live" date of March 31st.

INPATIENT HOSPITAL RATES
War Memorial
Mr. Kurtz explained that North Country was locked into a single service rate of $1,300; NorthCare Network negotiated a 3-year rate of $975. Mr. Kurtz and Tim Kangas spoke with David John, hospital CEO and reached agreement for a regional contracted rate of $975 with a potential stabilization payment in October or November. The CMHSP Contract Managers were made aware of the agreement. It was noted that War Memorial is joining the MyMichigan (formerly MidMichigan) hospital network.

Munson
An increase was requested for the remainder of FY22 and FY23.

	FY21	FY22	Requested Increase 4/1/22 – 9/30/22	Requested FY23 10/1/22 – 9/30/23
Inpatient Per Diem	$1,035.00	$1,035.00	$1,071.23 (3.5%)	$1,103.36 (3%)
Partial Hospitalization	415.00	$415.00	$429.52 (3.5%)	$442.41 (3%)

McLaren
A request retroactive to October 1, 2021 through September 20, 2023 was requested for all sites.

	FY21	Requested FY22 – FY23 10/1/21 – 9/30/23
Inpatient Per Diem	$875	$950.00 (8.5%)
Partial Hospitalization	—	$475.00 (New)

MOTION BY CHRISTINE GEBHARD TO APPROVE THE RATE REQUESTS FOR MCLAREN AND MUNSON HEALTHCARE AS PRESENTED AND REVIEWED ON THIS DATE; SUPPORT BY CHIP JOHNSTON. MOTION APPROVED BY CONSENSUS.

PROTOCALL
Ms. Gebhard reported that she continues to collect call data from the Boards to monitor performance; ongoing issues will be brought to this Committee.

CARTER KITS
Ms. Pelts demonstrated "Carter Kits" as a potential use of surplus funds. Carter Kits are "sensory bags" designed for use by first responders, law enforcement, emergency departments, EMS, etc. to assist with situations involving children with autism spectrum disorder. The kits are currently used in 29 states and cost $80 per unit. A regional training outreach training was suggested to demonstrate and train individuals on the use of the kits.

MOTION MADE BY CHRISTINE GEBHARD TO RECOMMEND THE NORTHERN MICHIGAN REGIONAL ENTITY PURCHASE UP TO ONE THOUSAND FIVE HUNDRED (1,500) CARTER KITS FOR USE THROUGHOUT THE TWENTY-ONE COUNTY REGION; SUPPORT BY CHIP JOHNSTON. MOTION APPROVED BY CONSENSUS.

The suggestion was made that the "Carter Kits" be the placed on the March NMRE Board Agenda as the Board's Presentation.

SENATE BILLS & NORTHERN MICHIGAN COUNTY ASSOCIATION
Mr. Johnston agreed to share the summary of the third reading of the bills with the Committee. A vote could occur yet this month. A poll conducted by CMHAM found that 67% of likely Michigan voters prefer the public mental system to a private, for-profit companies. New versions of House Bills were released. Mr. Kurtz intends to schedule a meeting with Farrah Hanley to discuss the bills as soon as schedules permit.

DELEGATED FUNCTIONS SITE REVIEW
Ms. Gebhard expressed concern about the tenor of conversations surrounding the NMRE Annual Audit. Mr. Kurtz responded that he is monitoring the process closely. Ms. Gebhard stressed that ample time must be given to compile the required evidence.

STANDARD COST ALLOCATION UPDATE

Mr. Kurtz authored a memorandum regarding concerns with definitions of managed care rules and their relationship “the SCA model” and its cost allocation methods related to the Medical Loss Ratio calculation. No response has been received as of this date.

RESIDENTIAL TIERED RATES WORKGROUP

Ms. Gebhard expressed that rural geographic representation is needed on the workgroup. Mr. Kurtz advised that the CMHSPs that direct-run residential services be involved (AuSable Valley, Northeast Michigan).

NEXT MEETING

The next meeting was scheduled for April 19, 2022 at 9:30AM.

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

ATTENDEES:	**Robert Draves (Charlevoix), John Wallace (Cheboygan), Terry Newton (Emmet), Richard Schmidt (Manistee), Roger Frye (Montmorency), Terry Larson (Presque Isle), Gary Taylor (Wexford)**
VIRTUAL:	**Carolyn Brummund (Harrisville), Tim Markey (Beulah), Dave Freedman (Traverse City), Jay O'Farrell (Whittemore), Ron Quackenbush (Rose City), Chuck Varner (Mio)**
ABSENT:	**Robert Adrian (Alpena), Melissa Zelenak (Antrim), Sherry Powers (Crawford), David Comai (Kalkaska), Greg McMorrow (Leelanau), Doug Johnson (Otsego), Tim Muckenthaler (Roscommon)**
STAFF:	**Eugene Branigan, Eric Kurtz, Pamela Polom, Sara Sircely, Deanna Yockey, Carol Balousek, Lisa Hartley**

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

ROLL CALL
Let the record show that Robert Adrian, David Comai, Doug Johnson, Greg McMorrow, Tim Muckenthaler, Sherry Powers, and Melissa Zelenak were excused from the meeting on this date; all other NMRE Substance Use Disorder Oversight Board Members were in attendance either in person or virtually.

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

APPROVAL OF PAST MINUTES
The November 1, 2021 minutes were included in the materials for the meeting on this date.

MOTION BY TERRY NEWTON TO APPROVE THE MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD FOR NOVEMBER 1, 2021; SUPPORT BY JOHN WALLACE. MOTION CARRIED.

APPROVAL OF AGENDA
Ms. Sircely distributed a revised liquor tax request from Bear River Health to include a request for Medication Assisted Treatment (MAT) for Otsego County.

MOTION BY TERRY NEWTON TO APPROVE THE AGENDA FOR THE MARCH 7, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD AS AMENDED; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

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

ANNOUNCEMENTS

Mr. Kurtz reported that MDHHS called an unannounced meeting of PIHP and CMHSP CEOs on March 3rd during which a major restructure/reorganization of the Department was revealed. The PIHPs/CMHSPs will be working with three divisions within the Department. The Behavioral Health and Developmental Disabilities Administration (BHDDA) no longer exists under that name; now called the "Community Bureau" and was moved under Medicaid. Medicaid has been put under the direction of Farrah Hanley, former Budget Director. The Bureau of Children's Coordinated Health Policy and Supports was created (in response to the KB lawsuit). Substance Use Disorder Prevention was moved under Public Health. Mr. Kurtz agreed to share the presentation slides titled, "Behavioral Health Restructuring" dated March 3rd with SUD Oversight Board Members.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST

Let the record show that Mr. Frye called for any conflicts of interest to any of the meeting agenda items. Mr. Newton disclosed that he attends many Community Recovery Alliance (CRA) meeting but is not a member of its Board; the determination was made that this does not represent a conflict of interest.

INFORMATIONAL REPORTS

Admissions

The admissions report through January 31, 2022 was included in the materials for the meeting on this date. Overall admissions were down 15% from January of 2021. The data showed that outpatient was the highest level of treatment at 50.04%, and alcohol was the most prevalent primary substance at 50.19% (heroin was second at 16.09%). Sara Sircely noted that methamphetamine use is rising throughout the region reported as 15.62% vs. 11.12% in FY21.

Mr. Draves reported that a proposed ballet that would legalize psychedelics for adults (like Oregon) is being circulated.

Finance

December 2021 Monthly Report

SUD services through December 31, 2021 showed all funding source revenue of $5,864,110 and $4,562,086 in expenses, resulting in a net surplus of $1,302,024. Total PA2 funds were reported as $5,752,223. Three PA2 payments are received annually; the first payment for FY22 is expected in April. Mr. Schmidt requested that a column be added to show the anticipated FY22 revenue per county; this will be added beginning with the January 2022 report.

Projects List

Ms. Sircely reviewed the FY22 approvals to date by county. It was noted that $2.9M of the liquor tax fund balance has been allocated for projects previously approved. Clarification was made that Recovery Housing refers to a sober living environment.

RECOMMENDATION ITEMS

Recommendations List

The NMRE staff recommendations related to liquor tax use requests were included in the materials for the meeting on this date.

PA2 Fund Use Requests

1) Drug Free Northern Michigan 21-County Alliance – Marijuana Media Campaign

Alcona	$	1,316.87
Alpena	$	3,620.98
Antrim	$	2,963.25
Benzie	$	2,235.67

Charlevoix	$	3,325.45
Cheboygan	$	3,227.49
Crawford	$	1,769.27
Emmet	$	4,222.87
Grand Traverse	$	11,679.84
Iosco	$	3,201.15
Kalkaska	$	2,243.43
Leelanau	$	2,755.24
Manistee	$	3,107.64
Missaukee	$	1,908.07
Montmorency	$	1,176.80
Ogemaw	$	2,669.24
Oscoda	$	1,054.29
Otsego	$	3,121.77
Presque Isle	$	1,627.29
Roscommon	$	3,039.96
Wexford	$	4,233.43
	$	**64,500.00**

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM THE DRUG FREE NORTHERN MICHIGAN TWENTY-ONE COUNTY COALITION FOR LIQUOR TAX DOLLARS FROM ALL TWENTY-ONE COUNTIES IN THE NORTHERN MICHIGAN REGIONAL ENTITY REGION IN THE AMOUNT OF SIXTY-FOUR THOUSAND FIVE HUNDRED DOLLARS ($64,500.00) TO FUND A MARIJUANA MEDIA CAMPAIGN; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

Ms. Brummund suggested circulating this information to all the school liaisons in the 21-counties which Ms. Sircely agreed to do.

2) Emmet County Sheriff's Office – Polycom to Support SUD Services for Emmet County Inmates

Emmet	$	5,974.03

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM THE EMMET COUNTY SHERIFF'S OFFICE FOR EMMET COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF FIVE THOUSAND NINE HUNDRED SEVENTY-FOUR DOLLARS AND THREE CENTS ($5,974.03) FO POLYCOM TO SUPPORT SUBSTANCE USE DISORDER SERVICES FOR EMMET COUNTY INMATES; SUPPORT BY TERRY LARSON. MOTION CARRIED.

3) Bear River Health – Charlevoix Recovery House

Charlevoix	$	133,199

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM BEAR RIVER HEALTH FOR CHARLEVOIX COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF ONE HUNDRED THIRTY-THREE THOUSAND ONE HUNDRED NINETY-NINE DOLLARS ($133,199.00) TO SUPPORT THE RECOVERY HOUSING PROGRAM; SUPPORT BY BOB DRAVES. MOTION CARRIED.

4) Bear River Health – Peer Recovery Coach Services

Otsego	$	22,232

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM BEAR RIVER HEALTH FOR OTSEGO COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF TWENTY-TWO THOUSAND TWO HUNDRED THIRTY-TWO DOLLARS ($22,232.00) FOR PEER RECOVERY COACH SERVICES; SUPPORT BY JOHN WALLACE.

Mr. Freedman asked what the average salary is for a Peer Recovery Coach as the budget lists an amount of $12,200. Ms. Sircely responded that the budget likely indicates only a portion of the annual salary.

5) Bear River Health – Jail Medication Assisted Treatment (MAT) Services (continuation)

Otsego	$	20,156

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM BEAR RIVER HEALTH FOR OTSEGO COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF TWENTY THOUSAND ONE HUNDRED FIFTY-SIX DOLLARS ($20,156.00) FOR MEDICATION ASSISTED TREATMENT SERVICES FOR INMATES OF THE OTSEGO COUNTY JAIL; SUPPORT BY BOB DRAVES. MOTION CARRIED.

6) Community Recovery Alliance – Recovery Support Services

Otsego	$	16,642

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM COMMUNITY RECOVERY ALLIANCE FOR OTSEGO COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF SIXTEEN THOUSAND SIX HUNDRED FORTY-TWO DOLLARS ($16,642.00) FOR RECOVERY SUPPORT SERVICES; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

Let the record show that the total amount of liquor tax dollars recommended for approval on this date was **$262,703.03**. Assurance was made that a minimum balance equivalent to one year's liquor tax receipts was maintained for each county.

ITEMS FOR DISCUSSION

Opioid Settlement Funds

Ms. Sircely informed the SUD Oversight Board that opioid settlement funding is being released to counties. Ms. Sircely asked that if County Boards of Commissioners are unsure how to use the funds, that she be contacted for ideas. A resource document was prepared and will accompany the payments.

COMMENTS

Rev. Wallace referenced the parents charged with involuntary manslaughter when their son opened fire in Oxford High School; he noted that parents who supply drugs and alcohol to their children will likely be similarly charged. A shortage of juvenile detention beds was also noted.

NEXT MEETING

The next meeting was scheduled for May 2, 2022 at 10:00AM.

ADJOURN

Let the record show that Mr. Frye adjourned the meeting at 10:51AM.

Behavioral Health Restructuring

March 3, 2022

Updated 3/3/22

DISCLAIMER: This information is subject to change.

Michigan Department of Health & Human Services

Purpose of the Restructuring

- The administration of Behavioral Health and Developmental Disabilities Administration (BHDDA) programs is being moved to different administrations and divisions to improve coordination of service and leverage expertise in these areas.

- This is one step toward improving access to behavioral health services across Michigan and the desired outcomes for families and individuals who need those services. All Michiganders should have the same service experience – no matter where they live in our state.

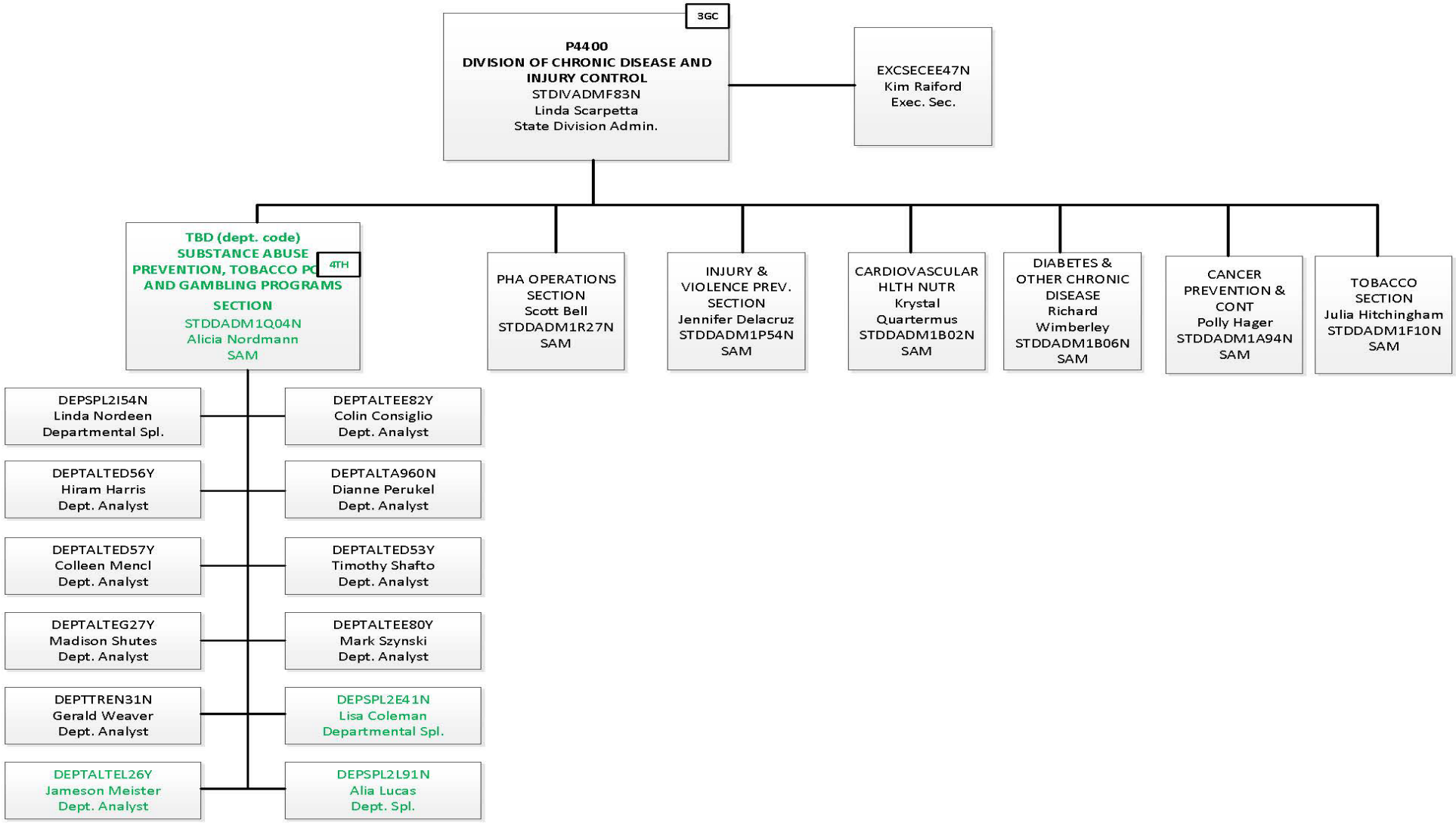
- This new structure will prioritize the improvement of behavioral health services and quality of care, as well as access to those services. This includes more investment in workforce development, and contract enforcement and management.

- MDHHS will have one voice regarding policy development related to adult physical/behavioral health services, which are now located in one department.

Substance use and gambling disorder prevention programs

- Prevention services for substance use and gambling disorder programs will move to the Bureau of Health and Wellness under the Division of Chronic Disease within Public Health Administration.
- This will align prevention resources into one division as part of a broader strategy with public health operations.
- This will also support a unified response strategy to address the opioid epidemic.

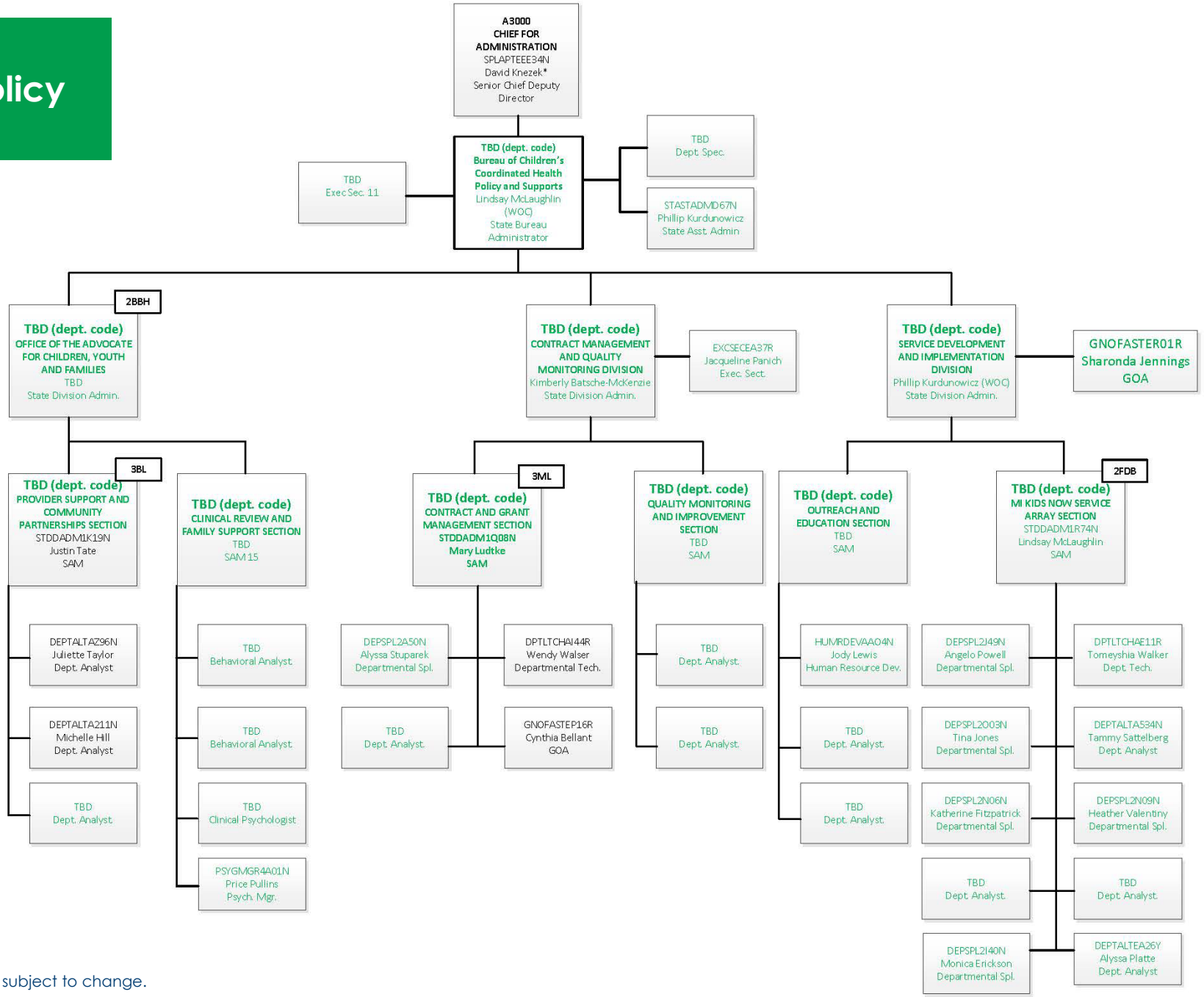
Division of Chronic Disease



Bureau of Children's Coordinated Health Policy and Supports

- Builds upon the work accomplished over the past 25 years to improve coordination and oversight of children's behavioral health services.
- Proactively restructures how we deliver publicly funded specialty health services to better serve Michigan children, youth and families.
- Recognizes that services must be designed specifically for the needs of children, youth and families.
- Emphasizes the critical importance of including families in addressing the health needs of children and youth.
- Reinforces protections for youth so they can access the appropriate services when they are needed, rather than turning to an emergency room setting.
- Establishes a clinical review team that will serve as a statewide resource, and review children's and families' needs and strengths to remove barriers to care.
- Works hand-in-hand with other MDHHS administrations to address children's behavioral health crises.

Bureau of Children's Coordinated Health Policy and Supports

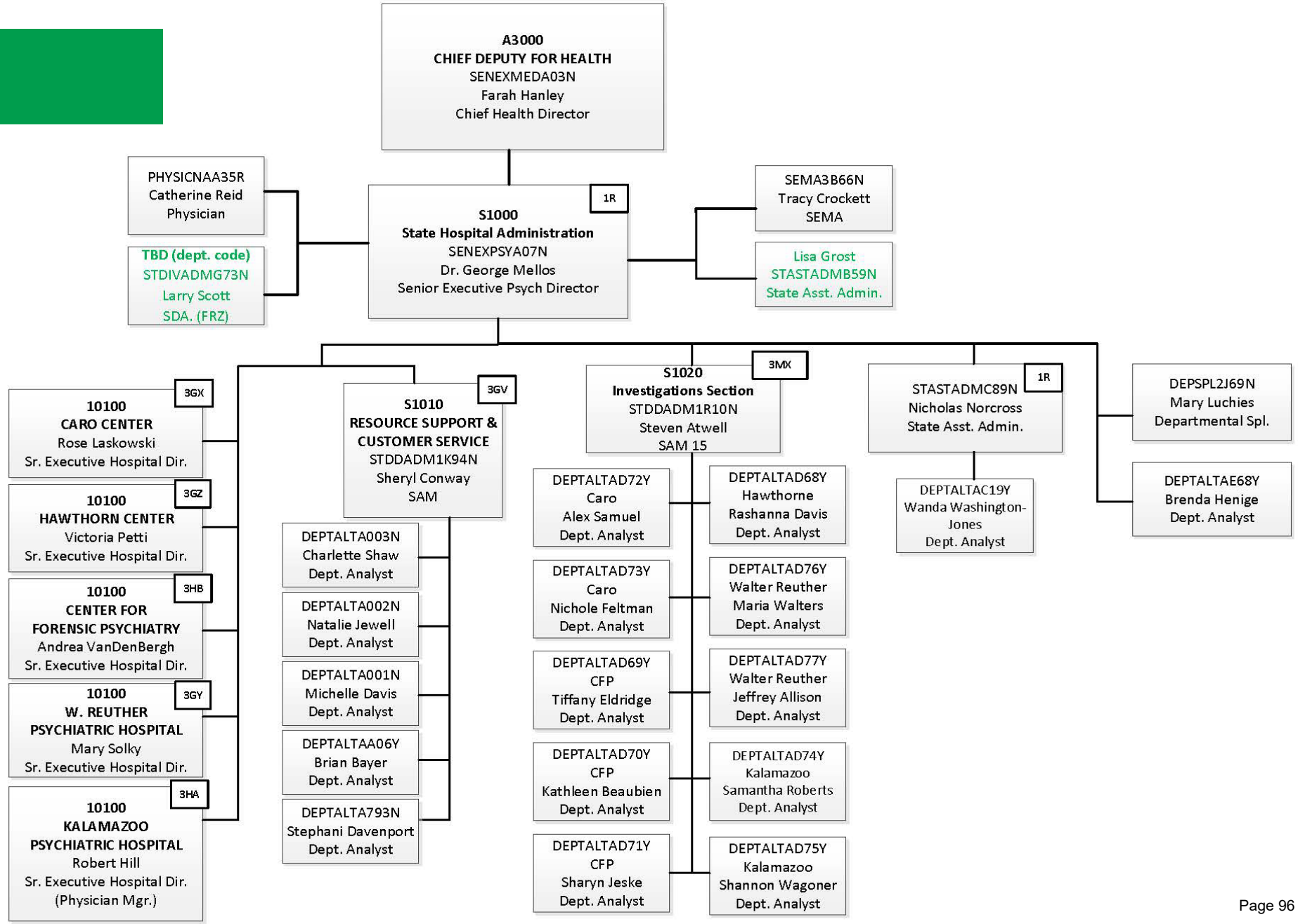


Chief Deputy for Health

- Farah Hanley will serve as the MDHHS Chief Deputy for Health effective March 7.
- She will oversee Behavioral and Physical Health and Aging Services, led by Kate Massey, Senior Deputy Director, and the State Hospital Administration, led by Dr. George Mellos, Senior Executive Psych Director.
- Hanley has served as the MDHHS Senior Deputy of Financial Operations since 2014; she also served as interim MDHHS Director in January 2019 during the transition to the new administration.

Chief Deputy for Health

State Hospital Administration



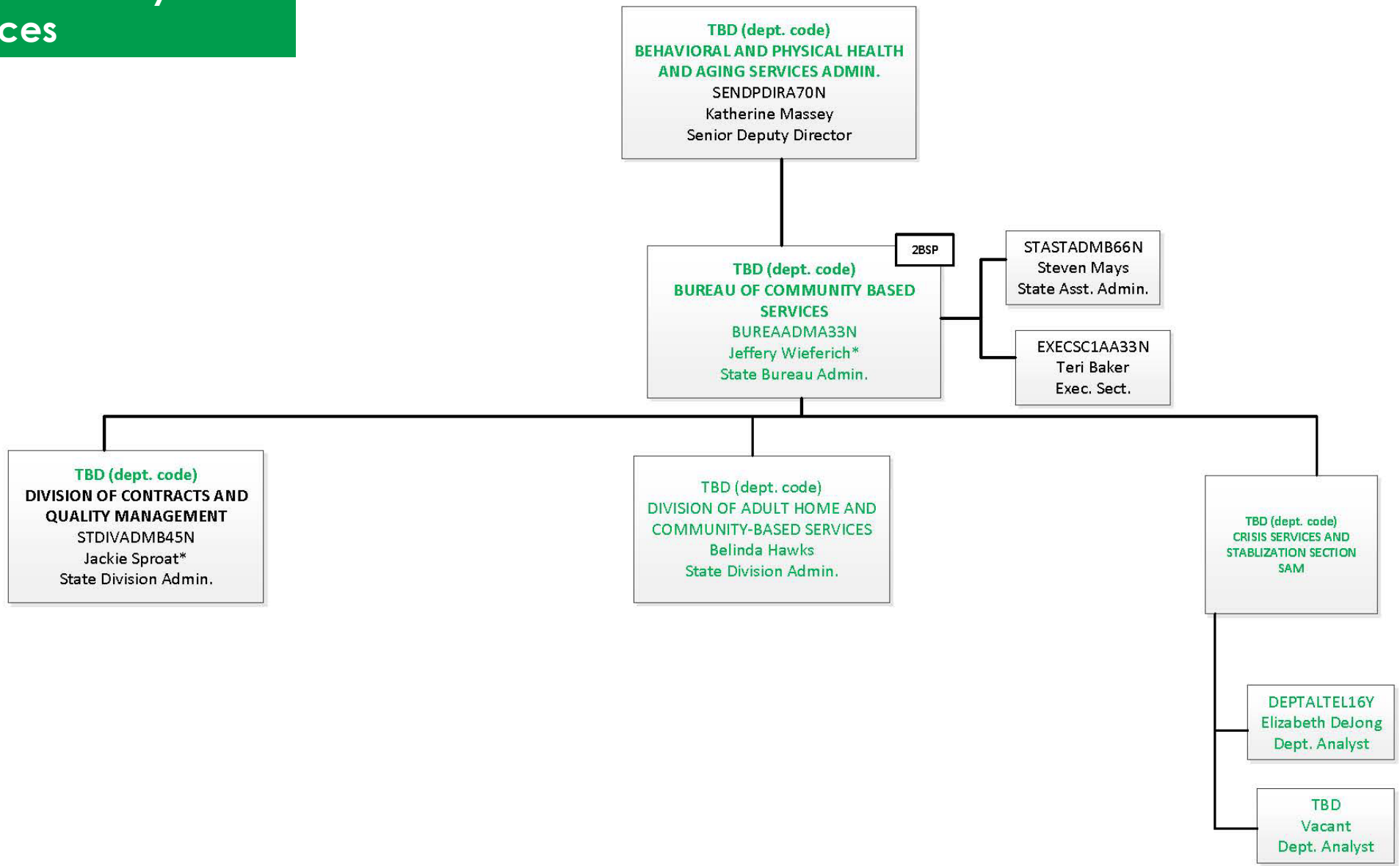
Behavioral and Physical Health and Aging Services Administration

- The Health and Aging Services Administration will become the Behavioral and Physical Health and Aging Services Administration.

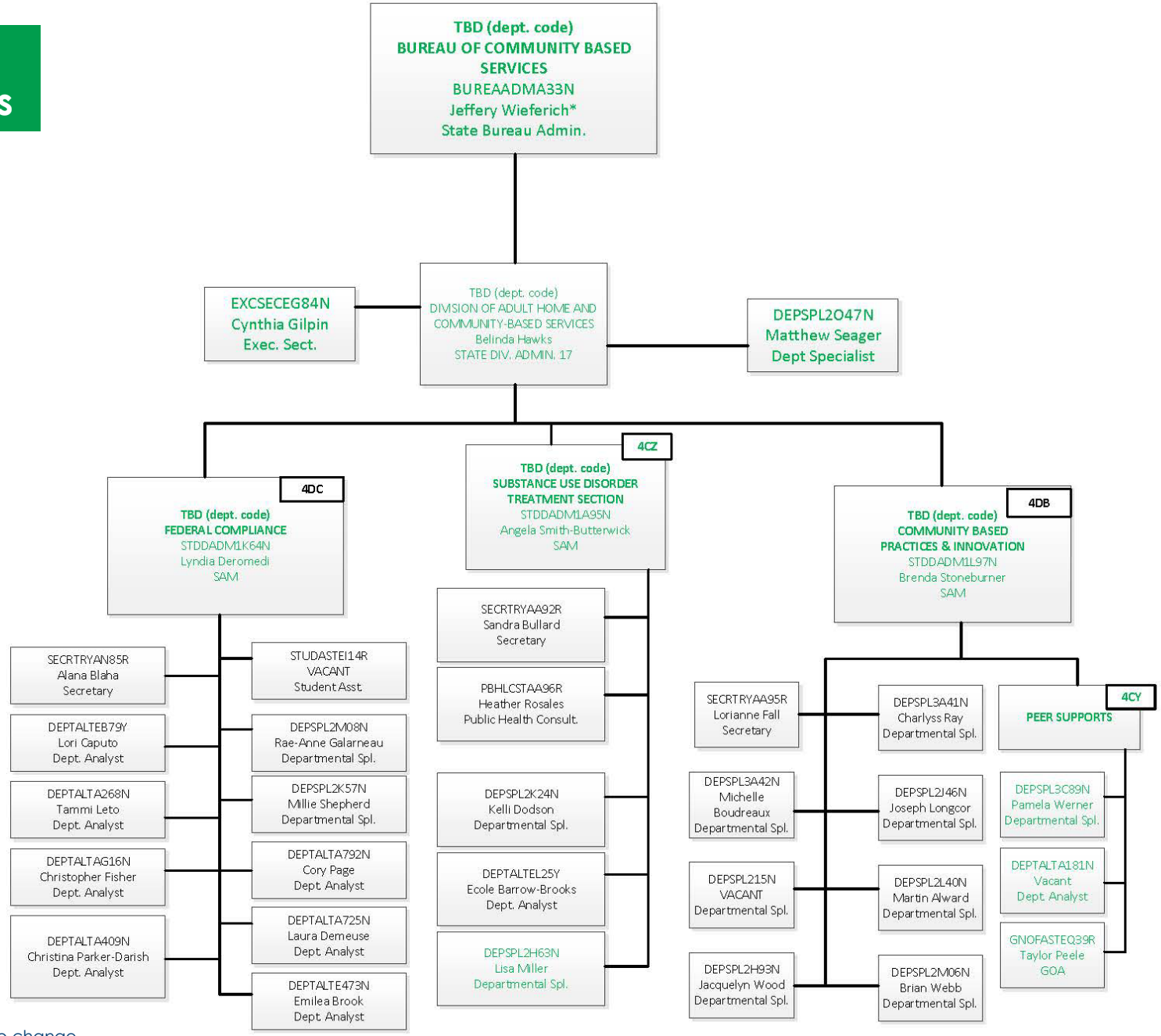
- In addition to Medicaid and aging services, it will oversee community-based services for adults with intellectual and developmental disabilities, serious mental illness and substance use disorders.
  - This will build upon the administration's existing efforts to deliver services to adults with mild to moderate mental illness.

- Certain behavioral health operations will be aligned within BPHASA to avoid duplication, including customer service, managed care contract management, site reviews and financial management.

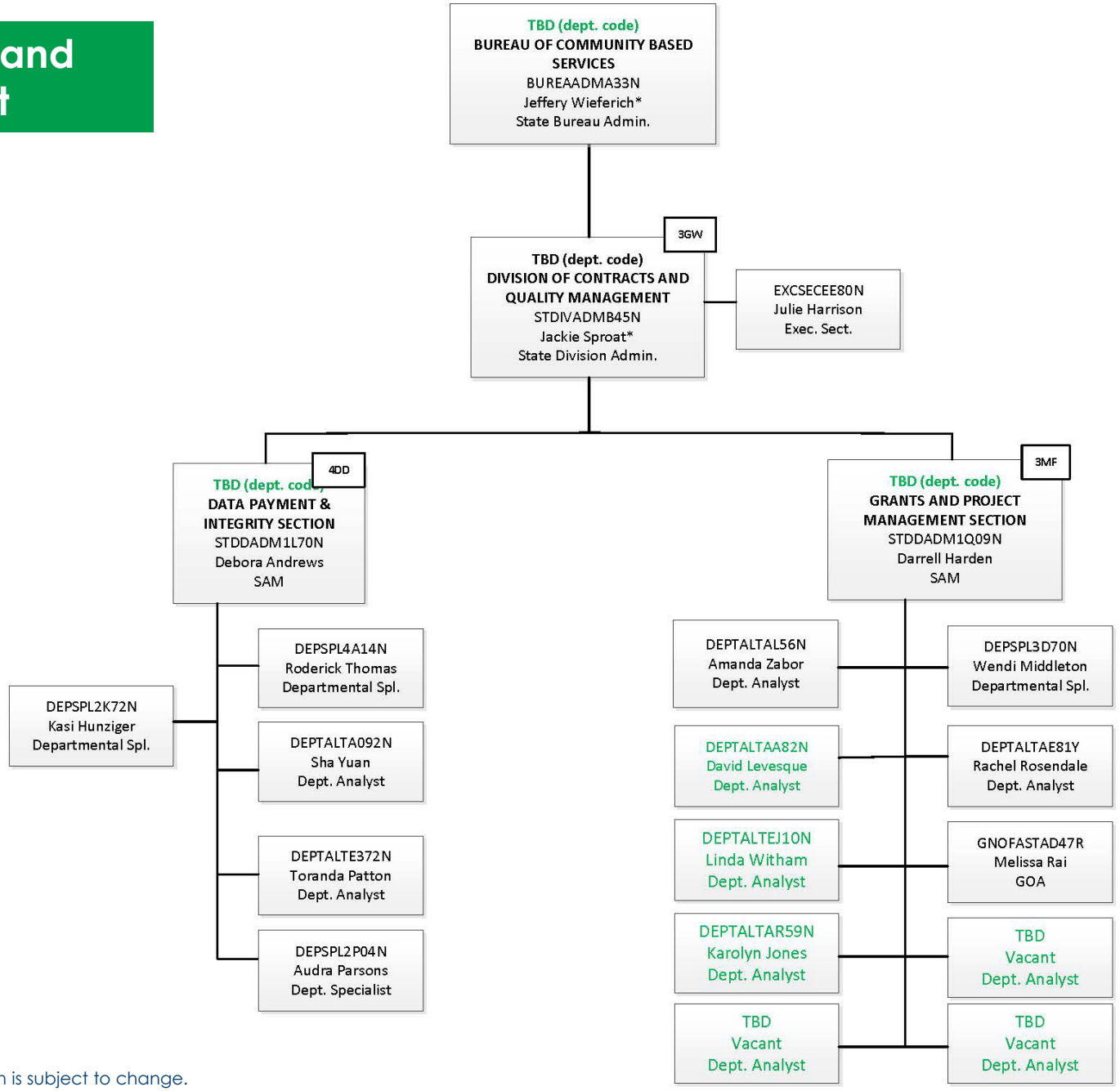
Bureau of Community-Based Services



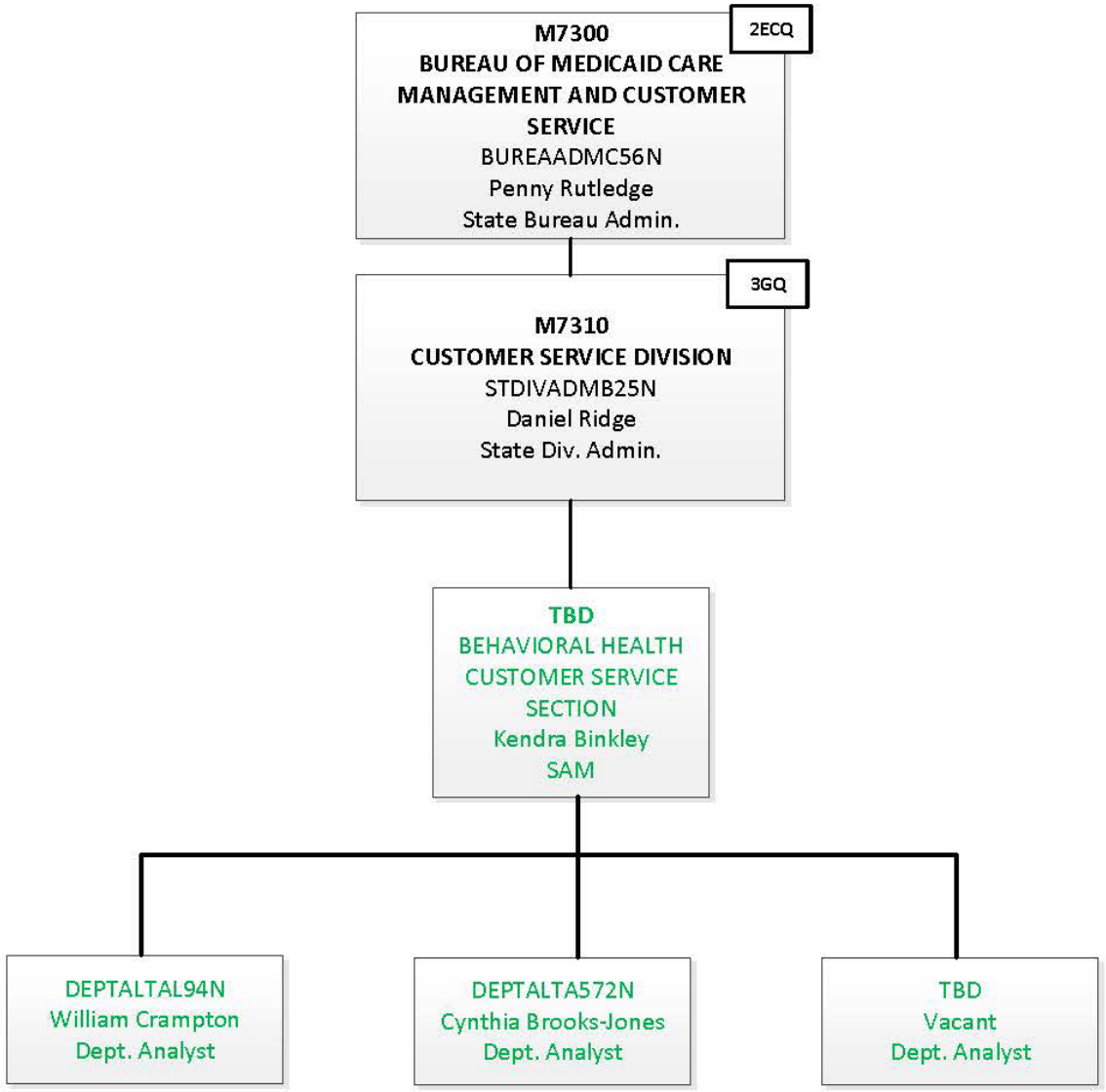
Adult Home and Community-Based Services



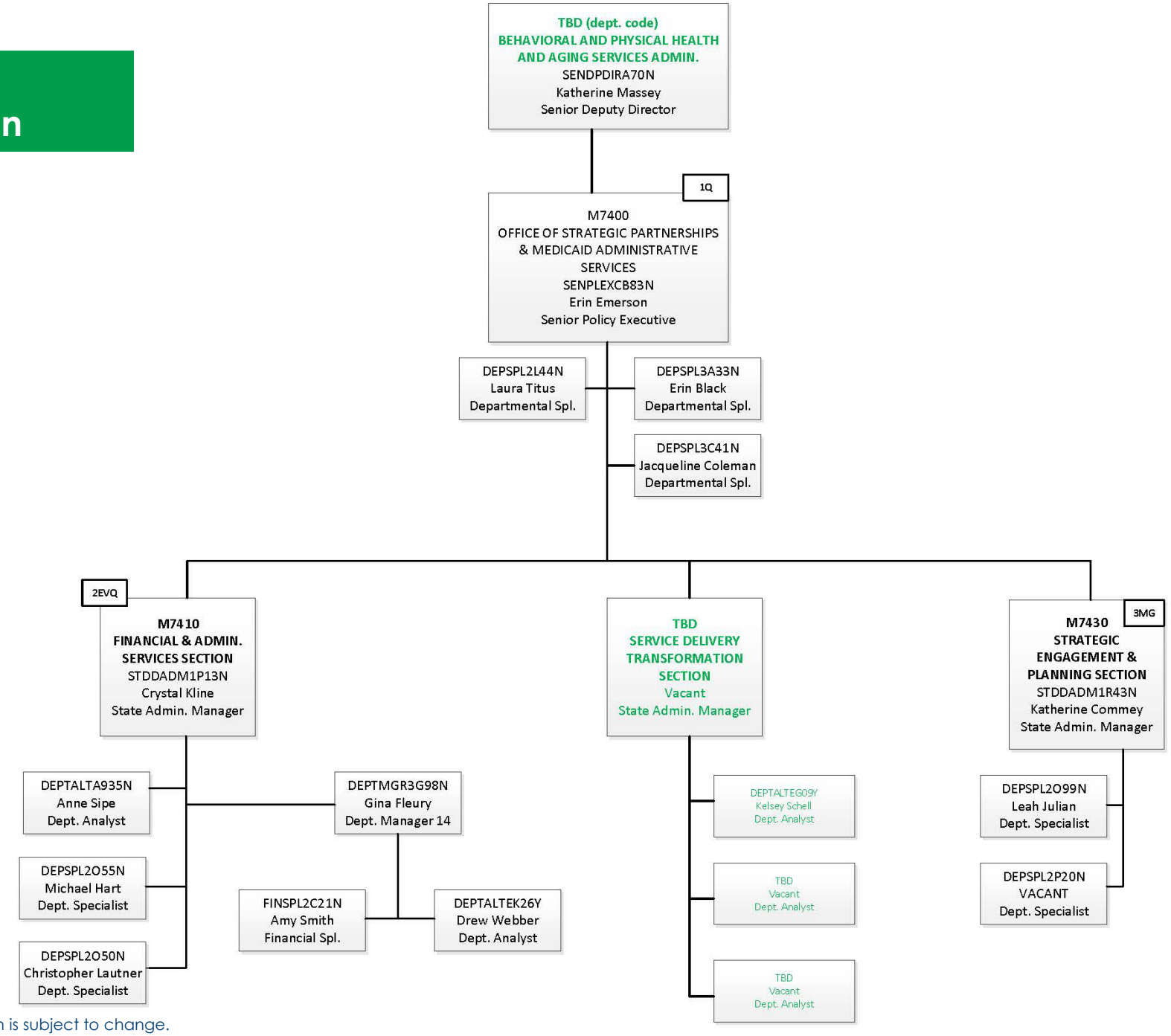
Division of Contracts and Quality Management



Behavioral Health Customer Service Section



Service Delivery Transformation Section



Benefits of the Restructuring

- The new structure ensures the staff and resources to guarantee success for Michigan children, youth, and families needing behavioral health services.
- Providers will now have access to even more resources, expertise and support.
- External partners and stakeholders will have better communication and collaboration with MDHHS.
- Additional investments will be made in workforce development and staffing. No current employees will lose their job or experience a decrease in wages.
  - New job roles are specific to necessary new departmental operations and are not duplicative of existing operations, including clinical review, quality monitoring, training and technical assistance, and more.

These changes will be effective March 21.

Questions?

For Immediate Release

Contact: Brenda Hu, Lambert & Co.
bhu@lambert.com; 517-827-1117

New Poll Finds Two out of Three Likely Michigan Voters and More Than 100 Michigan-Based Groups Prefer Public-led Mental Health System

LANSING, Mich. (February 21, 2022) – A new poll commissioned by the Community Mental Health Association of Michigan and conducted by third-party survey provider EPIC-MRA found 67% of Michigan voters prefer the public mental health system to be managed by public entities who specialize in mental health care vs. turning the system over to private, for-profit companies.

Last year, Michigan Senate Majority Leader Shirkey introduced Senate Bills 597 & 598 which would privatize all Medicaid mental health services by giving full financial control and oversight to for-profit insurance companies. **The EPIC-MRA polling shows two out of three Michigan voters would NOT support that change.**

The poll was conducted in January 2022 among active and likely November 2022 general election voters across Michigan with a margin error of +/-4%. It comes at a critical time as communities across Michigan and the U.S. face a growing need for mental health support in the wake of the coronavirus. Michigan's Governor Gretchen Whitmer also prioritized mental health funding in her State of the State address this past January, proposing $361 million to open school-based clinics and fund mental health professionals inside schools and increase access to mental health screenings. Other key data points from the poll include:

- Nearly 3 times as many Michiganders oppose the privatization of the state's mental health services for Medicaid patients (the purpose of Senate Bills 587 & 598). 67% oppose while only 24% support that privatization.
- 76% of voters are concerned that private, for-profit health plans, do not have a good track record in treating patients with mental health needs and fear they will make matters worse.
- 73% of voters are concerned that high overhead costs of the private health insurance companies (double that of the public system) and the corporate profits that these companies take out of the taxpayer-funded Medicaid system will lead to less mental health services for those in need.
- The data also found factors that make a public mental health care system more cost effective than a private system, including active management of comprehensive services, a person-centered planning approach and high medical loss ratios (low spending on administrative costs to allocate those dollars towards Medicaid beneficiaries).
- Nearly 4 times as many Michiganders are less likely to support their legislator if he/she supports privatization of mental health services for Medicaid patients than those more likely to support that legislator: 40% less likely compared with only 11% more likely.
- Twice as many Michiganders think that Governor Whitmer should veto legislation if it passes than those who think she should sign the bills: 54% favor veto with only 27% favoring signing

"Our members have heard of concerns first-hand from their constituents and these results just confirm voters worry about letting private health plans take control of the services for our most vulnerable populations," said Stephan Currie, the Executive Director of the Michigan Association of Counties. "It is clear that Michiganders and County Commissioners from across the state believe that keeping a local public mental health system is best."

For the past 50 years, the mental health system in Michigan has been run and operated by county-based government entities to serve Michiganders with complex mental health, emotional disturbance, intellectual and developmental disabilities, and substance use disorders. The study by the Center for Healthcare Innovation and

Integration found that Michigan's public mental health system has a long tradition of high performance. Each year more than 325,000 Michiganders receive their services and care from the Michigan public mental health care system. The legislation under consideration in the Michigan State Senate would eliminate the existing Michigan public mental health care system and shift $3.5 billion of these state and federal dollars spent annually on this to private for-profit insurance companies based in Missouri, California, Minnesota, Arizona and Indiana.

"When Michigan ultimately develops a better system of behavioral health care, it must be designed around the needs of the individuals and families being served," said Sherri Boyd, Executive Director of The Arc—Michigan. "While today's system needs work, the proposed legislation being discussed here reflects the needs of payers first, not people, which is the primary reason it is not being better received by the public. We believe better solutions are out there and look forward to working with our state's policy leaders to help identify and implement them."

In a separate report, The National Committee for Quality Assurance (NCQA) gave health insurance companies that provide mental health services for treatment of mild-to-moderate mental health cases 2.4 out of 5 stars. Supporters of the public mental health care system are concerned that health insurance companies will not be able to provide services for adults with severe mental health needs, according to this new poll. Additionally, other states (such as Iowa) who have selected private companies to manage mental health care have found they do not provide the same level of care or understand the unique needs.

"As survey findings underscore, Michiganders strongly oppose Senate Bills 597 & 598. Their concerns revolve around on the weak track record that the private health insurance companies have with mental health services and the high overhead costs and profit taking of these companies – syphoning tax dollars out of the system designed to serve some of the most vulnerable Michiganders," said Robert Sheehan, CEO of CMHA. "Michiganders see through the false portrayal of these bills as improving the lives of the Michiganders. They see the damage that these bills will do to the state's public Community Mental Health system and, as a result, to the health and quality of life of the 325,000 Michiganders who have long relied on this system for high quality mental health services and supports."

More than 100 Michigan-based groups oppose the privatization of mental health care, including the Michigan Sheriff's Association, the Michigan Association of Counties, over 30 boards of county commissioners, over 50 mental health provider organizations, judicial and school-based organizations, the Michigan Catholic Conference, The National Association for the Advancement of Colored People and organized labor groups.

For more information and to sign the petition against the privatization of Michigan's mental health system, please visit CMHAM.org/advocacy. You can also go to this site to sign up for advocacy notices that will link you to your State Legislators.

# # #

A New Day for Behavioral Health in Michigan: Roles of the Key Partners

Community Mental Health Services Programs (CMHSPs)
The CMHSPs will continue to be the foundational elements of Michigan's public behavioral health system. The changes in these bills strengthen the CMHSP's core role as service providers and streamlines administration, affording economies of scale and putting more money directly into services for Michiganders. The CMHSPs will also provide services to those with mild to moderate behavioral health conditions, solidifying their role as the home for public behavioral health care in their communities.

Michigan Department of Health and Human Services (MDHHS)
Under the Michigan Constitution, the state is charged with providing behavioral health services to all Michiganders. Therefore, the state holds the financial risk and is ultimately responsible for providing public behavioral health services. These bills reflect the state's constitutional charge and acknowledges that behavioral health and I/DD needs do not fit into traditional risk sharing arrangements offered through managed care entities that require utilization management.

Considering the above, MDHHS will carry out the provisions of Section 116 of the Mental Health Code, including:

- Contracting with CMHSPs for the provision of behavioral health services
- Contracting with an Administrative Services Organization (ASO) to assist in carrying out its core clinical, financial, and operational duties
- Receiving input from the Behavioral Health Advisory Council in the financing and operations of Michigan's behavioral health delivery system
- Utilizing value-based payment arrangements to reimburse for services, including but not limited to: full capitation, shared savings, pay-for-performance, traditional fee for service, case rates, and innovative funding models such as CCBHCs and Health Homes

MDHHS' Administrative Services Organization (ASO)
The ASO will augment MDHHS' staff and assist in the oversight and provision of public behavioral health services. Its main assist functions will include the following:

- Eligibility verification
- Utilization management
- Intensive care management and care coordination
- Provider network development and management in partnership with CMHSPs
- Critical incident, grievance, and appeals monitoring
- Customer services
- Coordination with recipient rights
- Corporate compliance
- Clinical management services

Locals are Fearful of Competition & Choice

Local officials are not telling the truth about Medicaid Reform (Senate Bills 597 & 598) because they're fearful of **competition** and **customer choice**. Below are the four most common false claims being made about Medicaid Reform by locals and the truth about the language in the bills that dispute their misrepresentations.

False Claim: SB 597 & 598 will eliminate the Community Mental Health (CMH) agencies

TRUTH: No, these bills do not eliminate community mental health agencies or providers. SB 598, page 8, Section 116 (b) lines 16-22, says the department must contract with licensed specialty integrated plans for financial and service delivery management of Medicaid-funded behavioral health services. These licensed specialty integrated plans **must contract with community mental health service programs**, consistent with this subdivision, to ensure an adequate and appropriate system of mental health services is provided.

False Claim: SB 597 & 598 will eliminate CMH contracts with community-based providers

TRUTH: No, these bills do not eliminate CMH contracts. SB 597 Section 109f (5) (b), page 23, **requires** a specialty integrated plan **to contract with each community mental health services program within its service area** for the provision of behavioral health specialty services and supports, including but not limited to, specialized residential services, respite care, community living supports, peer supports, respite and single point of entry crisis center intake services, and other services.

False Claim: CMH's can't bid to become a provider of integrated care (Specialty Integrated Plan)

TRUTH: Yes, CMH's can bid to provide integrated service. SB 597, page 22, Section 109f (3) lines 3-16 says the department **shall establish a competitive** contract and procurement process that outlines the eligibility requirements for **entities to apply to operate as a specialty integrated plan.**

False Claim: SB 597 & 598 privatize mental health services

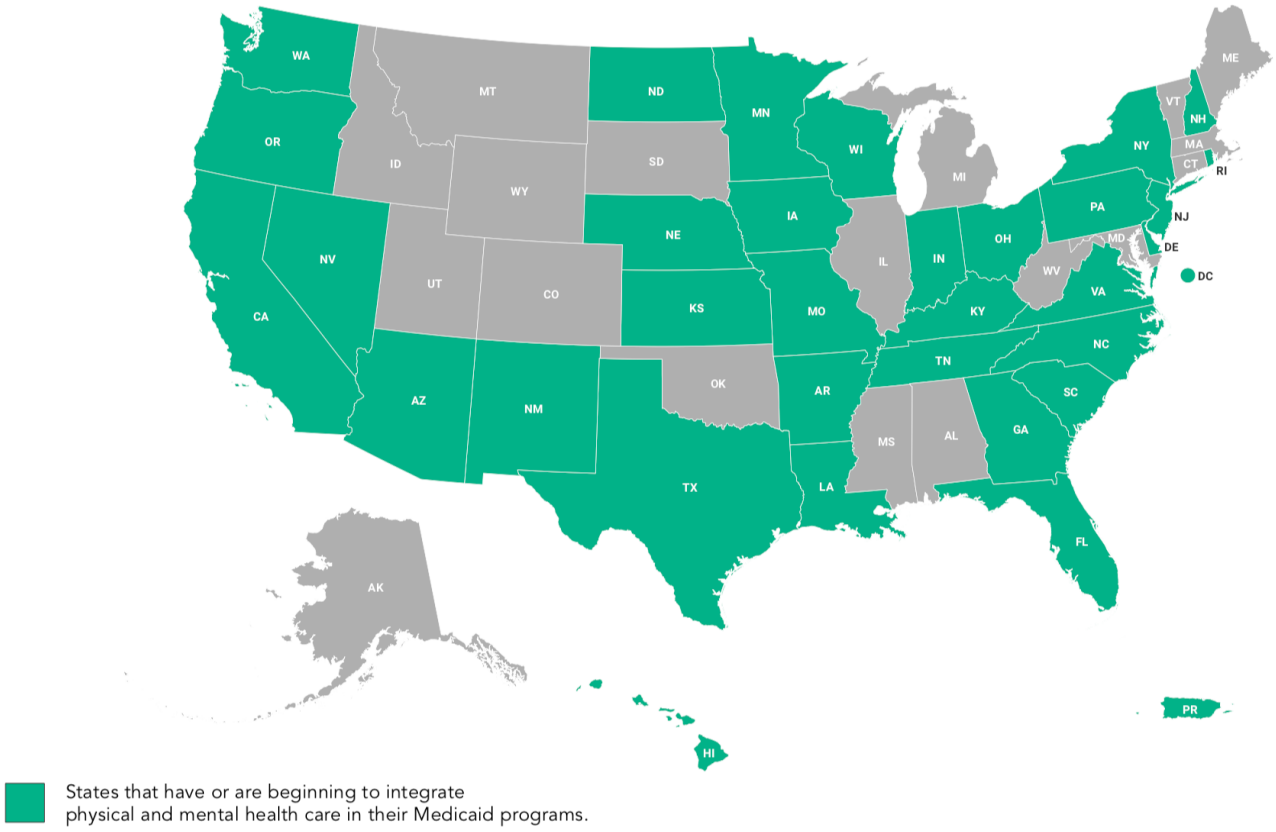
TRUTH: The fact is that mental health services today are already delivered by private sector psychologists, psychiatrists, social workers, drug rehabilitation operations and more. Those providers that are contracted through local community mental health agencies will continue to be used to deliver services under SB 597 & 598 – they just won't be the only providers consumers can use because managed care entities will also utilize their networks which offer more options to consumers to meet their mental healthcare needs.

If locals are willing to talk about improving mental health services, we would encourage you to ask them two very simple questions:

1) **Competition:** Are you opposed to having other entities compete to offer mental health services for Michigan's Medicaid population?

2) **Choice:** Are you opposed to giving Medicaid consumers a choice in selecting their behavioral health services like they have today for their physical health?

Thirty four states have successfully integrated physical and mental health services for their Medicaid consumers – this reform is long overdue!



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AUTISM Primer

Autism is on a continuum from minimally impaired to very impaired in a number of different areas. Autistic individuals do not process the world the way we do. Many individuals with autism will also be intellectually limited (not all are and it may be difficult at times, or it may take a few moments, to ascertain at what level they function intellectually.

The toys in the provided bag can be used as an avenue by which to establish rapport, trust, a way to start communications, or a way to engage them. It can also provide a distraction, provide them with a focus, while you attempt to engage the child/adult. Toys help the individual with autism use their senses, by providing stimulation. There is a great variety of toys in the bag because all have different preferences. We can notice many different shapes and colors (tactile and visual stimulation). Being occupied with a sensory toy may assist them staying calm or calming down, which will reduce the possibility of trauma.

The weighted blanket (also now being promoted for everyone it seems) offers a sense of tranquility putting the autonomic nervous system (ANS) at rest (ANS = a complex network of cells that control the body's internal state – in emergencies it activates fight or flight or freeze responses, otherwise it works to keep the body at rest). The weighted blanket may reduce anxiety by providing a sense of comfort. The deep pressure helps to release serotonin (a hormone involved in stabilizing mood and provides a sense of well-being).

This primer (a short introduction to a topic) will cover some of the impairment and associated limitations autistic children and adults may exhibit.

Communication limitations:

- Limited ability, and even lack of, spoken language.
- Speech can be abnormal in content and quality (Example: may repeat themselves, may use the wrong words for objects)
- Difficulties with expressing what they need or want (may point, whine, or yell).
- May not sustain a conversation.
- If given a toy, may not engage in imaginary play.

Social Interaction Limitations:

- Poor use of body language.
- Poor use of nonverbal communication such as: eye contact, facial expressions, gestures. May seem aloof, distant or detached.
- Lack of awareness of the feelings of others. May exhibit inappropriate emotional expressions. May express emotionality for reasons unclear to those present.

- May prefer to be alone, resulting in attempt to run away. They tend to have problems with noise, a busy (chaotic) environment, anything outside of their routine and predictability.
- May **not** want any physical contact. May **not** be comforted by physical contact.
- May **not** respond to verbal cues, questions, directives.

Repetitive behaviors/Restricted interests:

- Prefers routines (may respond angrily or with isolating to any change).
- May engage in ritualistic or compulsive behaviors (examples: rocking, lining up toys repeatedly, hand clapping, hitting self – these are primitive coping mechanisms, self-soothing).
- May be fixated on an object or part of an object (example: the wheel of a toy car).
- May be fixated on repetitive movement (examples: the spinning of a toy car wheel, turning lights off-and-on).
- When giving toys or the weighted blanket, offer it to them (do **not** cover them up).
- If you want them to walk with you, you can offer your hand outstretched, do **not** take their hand unless you indicated that you want to do so and see if they seem comfortable with it.

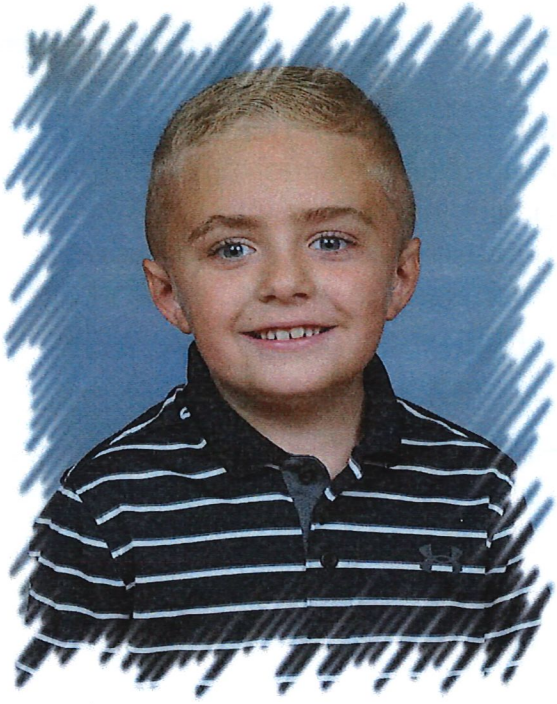
Caveats and Recommendations:

- Unlike other children (and autistic adults): those with autism may be scared of a uniform and may be scared of overhead lights and sirens.
- If at all possible, use a calm voice.
- Tell them who you are and why you are present using simple, easy to understand language.
- When asking them questions, give them time to respond (It may take a number of seconds before they reply.
- Offer children a toy or blanket to build rapport.
- Do not insist on them making and/or maintaining eye contact.
- Be slow in your movement, try to let them know what you are about to do but use simple, easy to understand language.
- Expect odd, and unpredictable, responses.
- Avoid touching them unless necessary (If you need to for issues related to safety, provide cues when possible – we know that, at times, quick action is needed).
- Do **not** try to stop repetitive behavior unless it is self-harmful (trying to stop repetitive behaviors will likely lead to an increase and/or an anger response).
- Avoid abstract language. Examples: Do **not** say "give me your attention" but say "look at me, please". Do **not** say "listen up" but say "listen to me, please". Do **not** say "spread eagle" but say "spread your legs apart".
- Avoid open ended questions.
- Expect answers with body language or primitive sounds (They may point, yell, turn away, etc. in response to questions posed).
- If medical equipment is used: let them look at it for a moment, and touch it if possible – again, in case of emergency this may not be possible.

CARTER KITS SENSORY BAGS

Used by First Responders, Teachers, and Parents alike. Carter Kits helps those with sensory needs (such as Autism Spectrum Disorder) to remain calm during stressful situations.

Clinically approved sensory bag. Each item is hand-picked by Dr. Ellen Preen.



"I recently encountered a violent 8-year-old child with autism. The recommendation was to administer Ketamine to sedate the patient. Thanks to Carter Kits, I was able to calm the agitated child without using medication and safely transport him to the ER. Thank you for the Carter Kits!" M.S. - Saginaw County EMT

Visit www.CarterKits.org to learn more!

Carter Kits™ began as a grass roots call to action embodied in a simple text message sent by Justin Severs to Brandon Hausbeck and Andrew Keller in 2019: "We need a tool to help us when we arrive at a scene with a special needs child." Justin is a detective with the Saginaw Township Police Department. Justin's son Carter has Autism Spectrum Disorder (ASD), and his idea was to equip as many police, fire and EMS vehicles as possible with the means to calm distressed children like Carter when arriving on scene.

Carter Kits are currently making a difference in 29 different States!

Andrew connected with a family friend, **Dr. Ellen Preen, a Clinical Neuropsychologist** who has both a daughter with Autism Spectrum Disorder, and extensive professional experience working with individuals impacted by ASD, trauma, anxiety, depression and learning challenges. Together, Andrew, Justin, Brandon (a local Firefighter/EMT) and Ellen see the need to expand the scope of these efforts to *any* child in crisis who may benefit from the contents of a **Carter Kits™** Sensory Bag.

It is the mission of Carter Kits to make the world a better place by developing and promoting an affordable means to address common comfort and security needs of children in crisis.

Helpful Tips for First Responders:

Remember, individuals with ASD may:

- Have no sense of danger
- Be overwhelmed by your presence
- Hyper-focus on your equipment

Their behavioral responses represent attempts to compensate

- They are not capable of being flexible – they are rigid
- You must find ways to be flexible in the moment to compensate on their behalf
  - ✓ This helps keep everyone safe and improve communication

Do's and Don'ts of Communication with an individual on the spectrum

- ✓ Assign one person to them (for consistency)
- ✓ Lay out clear rules and expectations
- ✓ Avoid power struggles
- ✓ Check for understanding frequently
- ✓ Build rapport (use the tools and their interests)
- ⊗ Don't take their behavior/responses personally

Considerations when using the Carter Kit

Weighted Blanket: Useful for hypo- (pressure, touch) and hyper- (feeling of security) sensitivities

Fidget Toys: Hyposensitivity. For patients that wish to be active and need stimuli

Earmuffs: Hypersensitivity. Useful for patients sensitive to loud noises such as sirens

Sunglasses: Hypersensitivity. Can help those who are bothered by bright lights or sunlight

Nonverbal Communication card: Useful for those who may not verbalize their needs or wants

For more information and additional training, visit www.carterkits.org

CARTER KITS
SENSORY BAGS

Autism Spectrum Disorder

What is Autism Spectrum Disorder (ASD)?

Diagnostic Criteria: Persistent deficits in social communication and social interaction across multiple contexts:

- ✓ Restricted, repetitive patterns of behavior, interests, or activities
- ✓ Insistence on sameness, routines, or rituals
- ✓ Highly restricted, fixated interests that are abnormal in intensity or focus
- ✓ Hyper- or Hypo- reactivity to sensory input or unusual interest in sensory aspects of the environment

Hyper-sensitivity: Over-responsiveness	**Hypo-sensitivity: Under-Responsiveness**
– Stimulation may be painful – Seeks calm – Examples: o Covers ears when confronted with noise o Squints and covers eyes when confronted with light o Physical touch is painful	– Shows no reaction to stimuli that others find uncomfortable – Seeks stimuli – Examples o Does not withdraw their hand from a hot stove o Wears a t-shirt in freezing weather o Wishes to touch every object they encounter

Common signs of ASD

- Poor eye contact
- Lacks facial expressions
- Speaks with abnormal tone or rhythm
- Socially awkward
- Fails to respond to his or her name

Did you know?

- ✓ 1 in 54 children has been identified as having ASD
- ✓ Occurs in all racial, ethnic, and socioeconomic groups
- ✓ 4x more common among boys than girls

Common Misconceptions (below are all false)

- ⊗ Always agreeable
- ⊗ No interest in peers
- ⊗ No interest in socializing
- ⊗ Always tell the truth
- ⊗ Do not question authority figures

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WWW.CARTERKITS.ORG