Northern Michigan Regional Entity

Board Meeting

January 26, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

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3.	Pledge of Allegiance	
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	e. NMRE SUD Oversight Board Report – Next Meeting is March 7, 2022	
11.	New Business	
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13.	Presentation/Discussion	
	FY21 Quality Assessment and Performance Improvement Program (QAPIP)	Pages 73 – 94
	Review FY22 QAPIP Workplan and	
	FY21 Compliance Summary and FY22 Compliance Workplan	Pages 95 – 113
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – February 23, 2022	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – DECEMBER 22, 2021
GAYLORD BOARDROOM

ATTENDEES:	**Roger Frye, Ed Ginop, Randy Kamps, Terry Larson, Christian Marcus, Gary Nowak, Justin Reed, Richard Schmidt, Don Smeltzer, Joe Stone, Don Tanner**
VIRTUAL ATTENDEES:	**Gary Klacking (West Branch), Mary Marois (Traverse City), Karla Sherman (Petoskey)**
ABSENT:	**Jay O'Farrell**
NMRE/CMHSP STAFF:	**Joanie Blamer, Christine Gebhard, Eric Kurtz, Diane Pelts, Brandon Rhue, Sara Sircely, Nena Sork, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Jackie Guzman, Sue Winter**

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

ROLL CALL
Let the record show Jay O'Farrell was excused from the meeting on this date; all other Board Members were in attendance.

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

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

APPROVAL OF AGENDA
Let the record show MDHHS-PIHP Contract Amendment No.4 was added to the Agenda under "New Business."

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR DECEMBER 22, 2021 AS AMENDED; SUPPORT BY JOE STONE. MOTION CARRIED.

APPROVAL OF PAST MINUTES
Let the record show that the November 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 NOVEMBER 24, 2021 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY GARY NOWAK. MOTION CARRIED.

CORRESPONDENCE

1) The minutes from the December 2, 2021 PIHP CEO meeting.
2) The Michigan Psychiatric Care Improvement Project (MPCIP) December 2021 Update.
3) MDHHS Behavioral Health Fee Schedule Provider Reporting Requirements.
4) A memorandum from Jeffery Wieferich at MDHHS dated December 2, 2021 regarding the premium pay increase for direct care workers.
5) Email correspondence from Bob Sheehan at CMHAM regarding Mr. Johnston's comments in a Gongwer article on HB 5165.
6) 9&10 News article by Kevin Hodge dated December 13, 2021 titled, "McLaren Begins Work on New Behavioral Health Center in Cheboygan."
7) December 2, 2021 updated list of groups in Opposition to Senate Bills 597 and 598 provided by CMHAM.
8) Email correspondence from CMHAM linking to an Online Petition Opposing Senate Bills 597 and 598.
9) Email correspondence from CMHAM linking to a story by Craig Mauger in the Detroit News dated December 13, 2021 titled, "Michigan Senate Leader's Nonprofit Got Nearly $1 Million From Secret Donors."
10) Draft minutes of the December 8, 2021 NMRE Regional Finance Committee meeting.

Mr. Kurtz drew the Board's attention to Mr. Johnston's comments regarding HB 5165 which would align state assistance for mental health services with federal ability to pay scales.

Mr. Kurtz also noted the article announcing McLaren's 16-bed psychiatric facility in Cheboygan; he acknowledged Ms. Gebhard's advocacy efforts to get this accomplished.

The Detroit News article regarding large donations made to Senator Shirkey's 501(c)(3) was discussed.

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 November Board Meeting.

CEOs Report

The NMRE CEO Monthly Report for December 2021 was included in the materials for the meeting on this date. Mr. Kurtz noted the meeting December 6th Northern Michigan Counties Caucus; the topic will be discussed further under "New Business."

Financial Report

Let the record show that there was no report for October 2021 due to year-end closeout. Mr. Kamps asked whether there is anything that the Board should be made aware of so that there are no surprises in the next report. Ms. Yockey responded that revenue appear to be in line with what was anticipated. The November 2021 Financial Report will be presented in January.

Operations Committee
The minutes from December 20, 2021 were distributed during the meeting on this date.

NMRE SUD Oversight Board Report
Ms. Sircely announced that the meeting scheduled for January 10th will be canceled due to a lack of Agenda items. The next meeting will be March 7, 2022.

NEW BUSINESS
Update on Northern Michigan Counties Meeting
It was reported that Mr. Kurtz, Mr. Tanner, Mr. Schmidt, and Mr. Johnston attended the December 6th meeting. The "pitfalls" of the Shirkey bills (SB 597 & 598) were discussed. Problems within the current system were identified as being created by the State, and not the PIHP/CMHSP structure. The public/private partnerships that are currently being explored were highlighted. Mr. Kurtz noted progress that Sen. VanderWall repeated the words "rural exception."

Mr. Kamps referred to the December 2nd PIHP CEO meeting notes; legitimate questions are met with ambiguous responses. He questioned to what extent Elizabeth Hertel is tuned in.

PIHP Contract Amendment #4
A "change request" to the PIHP Contract was received from the State Purchasing Department on December 20th. Copies of the Amendment summary were available to Board Members. Mr. Kurtz reviewed the proposed changes.

- New Contract Administrator, Nathaniel Oliver, was added.
- Change in dollar amount to cover the DCW increase back to October 1, 2021.
- The reduction of the local match drawdown was recognized.
- Performance Bonus Incentive Payment (PBIP) requirements for FY22 were added.
- Various Contract Attachment and policies were updated.
- The words "where applicable" were added under the Certified Community Behavioral Health Clinic section for those PIHPs that are participating in the CCBHC.

MOTION BY JOE STONE TO AUTHORIZE THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUITIVE OFFICE TO SIGN AMENDMENT NUMBER FOUR (NO.4) TO ITS CONTRACT WITH THE STATE OF MICHIGAN; SUPPORT BY RANDY KAMPS. MOTION CARRIED.

OLD BUSINESS
Senate Bills 597 & 598/House Bills 4925-4929 – The Latest
Mr. Kurtz reported that CMHAM (Bob Sheehan and Alan Bolter) is in contact with Elizabeth Hertel, though he cannot speak to the specific content of the discussions.

Differing opinions regarding the Standard Cost Allocation continue to be disputed. The joint CFI/PIHP Contract Negotiation teams requested the legal opinion from MDHHS supporting the Standard Cost Allocation (SCA); to date, all that has been received is an email from Jackie Sproat supporting the Department's position (which defines the CMHSPs as vendors of the PIHP). Bob Sheehan sent communication to the Department on December 21st that the CMHSP/PIHP system intends to stop all activity related to the Standard Cost Allocation development until the topic is properly discussed and resolved.

CMHAM Special Assessment
Legal opinions obtained from Feldesman, Tucker, Liefer, and Fidell and Cohl, Stoker, and Toskey were included in the materials for the meeting on this date. Mr. Tanner explained that, although the NMRE Board voted to send an amount on behalf of the NMRE and the five Member CMHSPs in November, the CWN Board voted to not participate (or have the NMRE participate on its behalf). A revised ask from CMHAM is anticipated.

Open Meetings Act
An opinion from Cohl, Stoker, & Toskey, PC was included in the materials for the meeting on this date. Effective January 1, 2022, "the only legal basis for a member of a public body to participate in a meeting via telephonic or video conferencing as a member of the public body (i.e., to vote, to be counted toward a quorum, or to deliberate toward a decision), is if that member is absent due to military duty. This amendment to the OMA eliminates the previously permissive practice of a public body allowing its members to participate and vote remotely if a physical quorum was present. (A public meeting could still have a partial "hybrid" remote component at the public body's option to allow members of the public and/or staff to attend and participate remotely if they can be heard by all persons attending the meeting. However, during such a hybrid meeting, board members *must* be present to be counted as part of the quorum, to vote, and to otherwise participate in a meeting as a member of the public body.)"

It was noted that the NMRE Bylaws conflict with this directive. Mr. Kurtz offered to reach out to Steve Burnham for further guidance.

PRESENTATION
Recovery Services
Sara Sircely, NMRE Managing Director of Substance Use Disorder Services, was in attendance to present on the NMRE's Recovery Services Plan.

Recovery Begins with Treatment

- ***Holistic Care***
  - Increase the number of Health Homes (OHH/BHH)
  - All clients will begin to receive Holistic Care Plans
  - Full array of services
  - Medications to treat Opioid Use Disorder
  - Evidence-Based Practices
  - Transportation
  - Family Services
  - Housing

- ***Recovery Coach Services***
  - Use of H0038 for State-trained Coaches (Medicaid, Healthy Michigan, Block Grant)
  - Use of T1012 for use of CCAR Trained Coaches (Block Grant)

- ***Supports for Individuals***
  - Recovery Community organizations
  - Group Meetings (AA, NA, SMART Recovery, Celebrate Recovery. Wellbriety, LifeRing, Women for Sobriety, etc.)
  - Treatment doesn't end when traditional services end

- ***Support for Families***
  - Families Against Narcotics
  - Al-Anon

- ***Support for Community Change***
  - Increase availability of Narcan
  - Increase knowledge of how to access care
  - Identify ways everyone can help prevent problem use

Various funding opportunities (Medicaid, Healthy Michigan, Block Grant, liquor tax, SOR II, ARP grants) were reviewed.

Mr. Kamps requested more specifics regarding each activity area with achievable timelines by June 2022.

COMMENTS

Board

Mr. Tanner asked attendees think about what's important over the holidays.

Mr. Smeltzer shared that he voted against the CMHAM Special Assessment during the Centra Wellness Board meeting despite voting for it during the November NMRE Board meeting.

Mr. Smeltzer related substance use recovery to an environmental concern.

Mr. Marcus apologized for being late.

Mr. Kamps thanked the Board for allowing open, honest discussion; he acknowledged that "we have an opportunity to move the needle" in terms of mental health and substance use disorder advocacy.

Staff/CMHSP CEOs

It was noted that the IRS Mileage Rate for 2022 is increasing to $0.585 per mile.

MEETING DATES

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on January 26, 2022.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:45AM.

PIHP CEO Meeting
January 6, 2022
9:00AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

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Attendees

Pre-paid Inpatient Health Plans (PIHP)

Dr. Timothy Kangas (Northcare Network)	Region 1
Eric Kurtz (Northern MI Regional Entity)	Region 2
Mary Marlatt-Dumas (Lakeshore Regional Entity)	Region 3
Brad Casemore (Southwest Michigan Behavioral Health)	Region 4
Joe Sedlock (Mid-State Health Network)	Region 5
Amanda Ittner (Mid-State Health Network)	Region 5
James Colaianne (CMH Partnership of Southeast Michigan)	Region 6
Eric Doeh (Detroit Wayne Mental Health Authority)	Region 7
Dana Lasenby (Oakland Community Health Network)	Region 8
Kelly VanWormer	Region 10

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie
Kendra Binkley
Audrey Dick
Belinda Hawks
Larry Scott
Jeff Wieferich
Carrie Rheingans
Brenda Stoneburner
Michelle Derose
Matthew Seager

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

Quality Management Updates

1. Belinda Hawks reported that the Quality Improvement Council has undergone redesign for both membership and agenda topics. Matthew Seager is part of that work, and both he and Belinda ask the PIHPs to provide them with feedback on the topics of discussion.
    a. Matt Seager shared that details on the Quality Improvement Council would be sent out in an email later January 6, 2022.
2. Belinda Hawks provided a summary document on the HCBS Rule work to the group via email.
    a. The approval process has been amended to address how to provide provisional approval for providers new to a PIHP's network. It also addresses what role the HCBS Leads have in determining initial compliance.
    b. Her team is offering consultation to the PHPs whenever a complex issue with the provisional approval process arises.
3. Belinda Hawks shared that the heightened scrutiny public comment period will be underway shortly.
    a. She expects the first public comment period to start no later than the end of February 2022, and it will be a 30-day public comment period for all providers on heightened scrutiny.
    b. The first public comment period will cover only the providers on heightened scrutiny in Region 5; MDHHS wants to ensure it has any technical issues sorted out before opening statewide.
    c. The second wave of public comment will be for all other PIHP regions.

SUD Capacity 1003 Demonstration Update

1. Carrie Rheingans stated that there were no updates at this time.

System Transformation Update

1. MDHHS shared that there are no updates. MDHHS is still in wait mode.

Supplemental Rate Certification

1. The PIHPs asked for the status of the supplemental rate certification for FY 2022 that they had been told to expect.
    a. MDHHS responded that MDHHS is still talking internally and looking at numbers.
    b. Milliman has not formally started the process yet, and the supplemental rate certification may be released closer to April.
    c. The supplemental rate certification would still be retroactive.

Request for Update on Vaccine Mandate

1. The PIHPs asked if there were any updates on overall state guidance for the vaccine mandate.

a. MDHHS reported that MDHHS is working on addressing CMS-level requirements in their guidance. There is nothing out yet from MDHHS on what the expectations are, but it will be a topic of discussion at the CMH forum on January 10, 2022.
b. MDHHS added that if an entity is certified by CMS, the vaccine mandate applies. So far, MDHHS is only aware of two CMHs in the entire system that are certified by CMS. All others would not be impacted by the mandate so far, but the provider networks for the certified CMHs would have to comply.

2. A PIHP requested that the BHDDA guidance on their COVID-19 page be updated to reflect the most current information, as it still appears to be from before vaccines for COVID-19 existed.
    a. Belinda Hawks shared an infographic in the group chat. The infographic is located at: https://www.cms.gov/files/document/covid-19-health-care-staff-vaccination-requirements-decision-tree-graphic.pdf.
        i. Belinda noted that the BHDDA may be sunsetting its COVID-19 information page and instead point to references and resources distributed by other groups.
    b. Kim Batsche-McKenzie shared a link to the CMS guidance posted on December 28, 2021. That guidance is located at: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-interim-final-rule-medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-0.
3. Belinda Hawks noted that there is also a difference between what Michigan Occupational Safety and Health Administration (MIOSHA) is requiring and what the CDC and CMS are, which complicates matters.

Action Items

None.

Community Mental Health Association of Michigan
DIRECTORS FORUM
January 10, 2022

Summary of key discussion topics and decisions

(Note: This summary is supplemented by the handouts distributed, electronically and in hard copy, in advance of, during, and subsequent to the Directors Forum.)

Legislative update:

SB 597 & 598 and advocacy efforts: **Roundtable discussion of advocacy efforts of CMHA and Directors Forum members**: From a number of signs, it appears that Senator Shirkey will be planning to move these bills, in the Senate, during the January – March period. This helps CMHA, its members, and allies to focus our efforts to oppose these bills. The advocacy efforts and resources developed and implemented by CMHA were reviewed, including recently developed videos, petitions, growing list of groups in opposition to the bills.

FY 22 supplemental budget: The Legislature is passing and the Governor is signing the supplemental budget bills that contain, in the main, federal ARPA dollars. This is a good sign in that it indicates that Senator Shirkey will not be holding (may not be able to hold) these dollars back to force the Governor to agree to support/sign bills SB 597 and 598.

Bills related to CSU funding, NHSC/Michigan poverty guidelines alignment: This bill looks to be moving along well and is likely to be passed and signed in early 2022. However, as noted by several CMH CEOs, that the changes made possible by this bill, while greatly appreciated, will only apply to CMHs, who have lost NHSC eligibility, during the next NHSC application period.

Redistricting maps: The redistricting maps that have been issued by the redistricting committee, while expected to be contested in court, are likely to be the final district maps. These maps are causing a number of incumbents to move to new home addresses to avoid competitive primaries and/or general elections. Additionally, the need for legislators to build support within a new electorate will help to build opposition to or, at least a neutral position, among a number of Senators and Representatives, on SB 597 and 598.

Discussion of and updates on a range of initiatives

Roundtable discussion, by Directors Forum members, regarding workforce recruitment and retention issues

CMHA survey results: The CMHA survey was reviewed with Directors Forum participants underscoring that the finding match their experience. The workforce shortage among administrative staff was underscored as another segment to the workforce shortage that is also making the work of the organizations

Actions taken by Directors Forum members that have proven successful: Some of the efforts include:

- Joint hiring for behavioral health practitioners by CMHs and local CMHs to hire staff with 31n dollars
- Local coalition, of CMHs, community partners, and persons served met with legislators around the need to close the direct support professional and broader behavioral health workforce gap. Seemed to have impact on legislators' understanding of the causes and depth of the issue and its impact.
- CMHs working with local media to get real-life stories in the public view.
- CMHs in dialogue with MDHHS/BHDDA around whether DSPs are healthcare professionals

Work to be done by CMHA and its members:

- Stem the drain of employees, especially to FQHCs
- Reduce the clinician, DCW, and supervisor training qualifications – to foster the recruitment of staff
- Survey of CMH, PIHP, provider system re: tenure of current staff
- Reduction in demands by MDHHS, given the workforce shortage of administrative staff
- Change federal legislation (with Senator Stabenow and National Council) to make CCBHCs automatically eligible for NHSC/HRSA loan forgiveness

Roundtable discussion: Methods for providing peer consultation and TA to those with interest in applying for SAMHSA CCBHC expansion grants; those with expansion grants as they lay groundwork for transition to demonstration status; those initiating BHH and OHH efforts: Due to the lack of time to discuss this item, in depth, CMHA will distribute a survey to Directors Forum members revolving around opportunities to facilitate peer consultation and technical assistance around these initiatives.

Discussion, with MDHHS leadership, of a range of policy, contractual, practice, and statutory issues

MDHHS/BHDDA efforts to address behavioral health workforce shortages: BHDDA is making a proposal to Meghan Groen (Deputy under Elizabeth Hertel) including the dollars needed to immediately address the DCW/DSP workforce gap. This document will be going to the State Budget Office, soon, for approval. BHDDA is also developing a broader set of recommendations on the entire behavioral health workforce as well as longer term approaches. Elizabeth Hertel underscored, to BHDDA leadership, that the healthcare workforce shortage is her and the Department's top priority. Recently, it was learned that workforce-related efforts are in the budget supplemental that is

MDHHS/BHDDA efforts related to improving access to inpatient psychiatric care in community and state hospitals: BHDDA is working to implement approaches to expanding staffing at community-based settings to speed the transition from state and community hospitals. The plan put forth, by BHDDA with preliminary SBO approval, is for 12 kids community beds and 48 adult community beds. This effort, in phase 1, will build on the current enhanced community transition initiative, led by Dr. Mellos, with expansion to a longer-term statewide effort.

MDHHS/BHDDA view on system design bills in Senate and House: Elizabeth Hertel indicated, to Al Jansen, that she is not concerned about either set of system redesign bills.

MDHHS/BHDDA guidance on whether federal/CMS vaccine mandate applies to CMHs, PIHPs, and/or providers in the CMH or PIHP networks: BHDDA is working, with other offices within MDHHS and LARA, to issue guidance on this front, citing the CMS guidance included as the last page of the Directors Forum packet. It was reinforced that clear guidance from BHDDA, on a statewide basis, is key to ensure uniform interpretation and application of the mandate.

MiCAL, CSUs, 988, PRTFs, crisis response/mobile teams and related crisis response initiatives: BHDDA staff sent, during the Directors Forum meeting, written updates on the roll-out of this effort. These materials will be sent to Directors Forum members. Michigan will be applying for federal grants ($3.4 million over 3 to 4 years) to support the state's 988 effort.

BHDDA has recently completed the draft CSU certification standards. This process will begin in earnest once the supplemental budget bills, that fund this effort, are passed and signed.

State hospital developments – Caro replacement, capacity expansion, barriers to discharge: State facilities are at the "crisis" staffing level (as per the COVID-related CDC staffing definitions). Waiting lists for admission to state hospitals: 70 adults in state hospitals persons on probate; 40 for kids; 15 to 20 during any given month for persons on IST orders; 30 on bond waiting list. The discharge ready list is at 120 persons.

MDHHS appreciates the response of the CMHs and providers in moving persons in state hospitals to home and community-based settings.

Final draft of Psychiatric Residential Treatment Facilities (PRTF) provider policy will be out soon.

The construction of the new Caro facility is moving forward, on schedule. Expected to be open by March 2023.

Mi Kids Now team update on MI Kids Now initiative: Lindsay McLaughlin (the new lead of the MI Kids Now initiative) provided and update on the status of the MKN initiative. Based on the forums held by the MKN team in November, this team has been able to refine the MKN effort. Because of the link of MKN to on-going litigation, the MKN team could not share much in writing or in much detail during those discussions or cannot now. The timetable for the MKN implementation is still unclear given the KB litigation. In response to a question, the MKN team indicated that the structure of the MKN effort is being guided the lead litigant and the Center for Health Care Strategies. However, it was pointed out that neither the lead litigant nor CHCS had any real grasp of Michigan's children's mental healthcare system. It was reinforced that: the implementation details of the MKN initiative must draw in Michigan's children's mental health services subject matter experts within CMHs, PIHPs, and provider organizations be drawn into the development of these details; the implementation of MKN needs to reflect the deep and prolonged workforce shortage.

MDHHS/BHDDA update on how Self Determination guidelines are being aligned with newly negotiated SD contract language: The guidance is being reviewed by the CFI Contract Negotiation Team to determine if the guidance document actually aligns with the contract's technical requirement. It appeared that while MDHHS thinks that the guidance document does line up, the CFI team has not

determined that the guidance aligns with the contract. The CFI team has empaneled a workgroup to determine if the guidance document does align with the contract and, if not, how the guidance document needs to be changed in order align with the contract. BHDDA agreed to review the guidance document and to differentiate between what is the elaboration of the technical requirements and what has a more aspirational aim.

MDHHS/BHDDA view on movement of BHDDA positions to the newly formed Health and Aging Services Administration (HASA): The movement of these 5 positions from BHDDA to the actuarial office of HASA/MSA is part of a 6-year effort, started under the Snyder administration, to move the Medicaid rate setting work for the public mental health system to MSA and Milliman. This movement is not a new strategic direction or realignment within MDHHS.

MDHHS/BHDDA guidance on vaccine mandate: Denise Parr and Chelsea Ludington (the Infection Prevention Resource and Assessment Team of the MDHHS Infection Control Office of MDHHS) provided an update on the isolation and quarantine standards for healthcare staff (paid and unpaid) professionals.

BHDDA leadership agreed to:

- Distribute a statewide clarification as to which DSPs/DCWs – in what settings – are healthcare workers and, thus, have their employment conditions impacted by the CDC standards.
- Examine and communicate the extent to which the hiring qualifications (for clinicians and supervisors) around EBP training and other qualifications and administrative demands can be altered to eliminate two of the major impediments

Next Directors Forums

- March 30, 31
- July 26, 27
- September 28, 29

Do the CMS staff vaccination requirements apply to my facility?

Please note: *This requirement is currently enjoined in the following states: AL, AK, AR, AZ, GA, ID, IN, IA, KS, KY, LA, MS, MO, MT, NE, NH, ND, OH, OK, SC, SD, TX, UT, WV, WY. Medicare- and Medicaid-certified providers and suppliers in those states are not required to comply with the requirements, pending future developments in the litigation.*

Are you one of the following Medicare- or Medicaid-certified facilities outside the 25 states listed above?

- Ambulatory Surgical Centers
- Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
- Community Mental Health Centers
- Comprehensive Outpatient Rehabilitation Facilities
- Critical Access Hospitals
- End-Stage Renal Disease Facilities
- Home Health Agencies
- Home Infusion Therapy Suppliers
- Hospices
- Hospitals
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Long Term Care Facilities
- Programs for All-Inclusive Care for the Elderly Organizations
- Psychiatric Residential Treatment Facilities
- Rural Health Clinics / Federally Qualified Health Centers

YES → ☑ **Staff Vaccination Requirements Apply**

No →

Do you provide services to certified facilities under contract or other arrangements? (Ex: EMS, physician w/ admitting privileges, pharmacies, etc.)

- **YES** → ☑ **Staff Vaccination Requirements Apply** *(Certified facilities must ensure individuals in this scenario are vaccinated)*
- **NO** → ☒ Staff Vaccination Requirements **Do Not Apply**

Do you have any staff who transition between your facility and a certified facility? (Ex: staff who transition between a nursing home and Assisted Living Facility)

- **YES** → ☑ **Staff Vaccination Requirements Apply** *(Certified facilities must ensure individuals in this scenario are vaccinated)*
- **NO** → ☒ Staff Vaccination Requirements **Do Not Apply**

How do I know if I'm a certified facility?

- You have gone through the Medicare enrollment process
- Have received a survey by State Survey Agency or CMS approved Accrediting Organization
- Received a National Provider Identifier (NPI) and CMS Certification Number (CCN)
- Can bill Medicare for services
- Medicare pays for services

You can verify whether you are certified via QCOR

If the staff vaccination requirements apply, your facility must:

1. Develop a process or plan for vaccinating staff, providing exemptions and accommodations, and track staff vaccinations by January 27, 2022.
2. Ensure eligible staff receive the first dose of a primary series or a single dose COVID-19 vaccine by January 27, 2022.
3. Ensure eligible staff are fully vaccinated by February 28, 2022.

Note: The staff vaccination requirement does not apply to full time telework staff.

Michigan Psychiatric Care Improvement Project (MPCIP)

December 2021 Update

Overview

Michigan House CARES Task Force and the Michigan Psychiatric Admissions Discussion evolved into the Michigan Psychiatric Care Improvement Project (MPCIP).

Two Part Crisis System

1. Public service for anyone, anytime anywhere: Michigan Crisis and Access Line (MiCAL) per PA 12 of 2020, Mobile crisis*, Crisis Receiving and Stabilization Facilities [1] *

2. More intensive crisis services that are fully integrated with ongoing treatment both at payer and provider level for people with more significant behavioral health and/or substance use disorder issues

Opportunities for improvement

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

MI-SMART (MEDICAL CLEARANCE PROTOCOL)

Overview

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

Current Activities: No changes

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- As of 12/1/21: Adopted/Accepted by: 30 Emergency Departments, 14 Psychiatric Hospitals, 13 CMHSPs. 19 more facilities are in the process of implementing.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption
- Developing a commitment letter for Psych hospitals, CMHSPs, and EDs to sign
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MiSMART can help meet
- Record high COVID numbers in Emergency Departments are impeding progress.

Michigan Crisis and Access Line (MiCAL)

Legislated through PA 12 of 2020, PA 166 of 2020.

CALL SIDE

Overview

- Crisis triage, support, and information and referral services 24/7 via phone, text, and chat
- Predicated on Recovery & Resiliency Principles: Caller-defined crisis, holistic, crisis support and triage, trauma informed, safety assessments, non-judgmental, referrals with follow up to help people connect to treatment when needed.

- Supports all Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. Integrated with BHDDA Peer/ Recovery Coach Warm line, warm hand-offs and follow-ups, crisis resolution and/or referral, 24/7 warm line, and information and referral offered.
- MiCAL will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, and Crisis Stabilization Units.
- Individual level performance measures.
- Opportunity for systems level change: data source for systems level needs i.e. to be addressed in collaboration with other systems including other crisis lines.
- Common Ground is the MiCAL staffing vendor.
- Target Dates: Pilot start date: Upper Peninsula and Oakland April 2021; Operational Statewide October 2022**.**
- Michigan Warmline is active statewide.
- Planned Design Activities:
    - Targeted Engagement Discussions to ensure MiCAL meets all Michiganders' needs. This process will pull together providers and people with lived experience for specific population groups to ensure that MiCAL is effectively outreaching and serving them.
    - Resources: Developing partnerships and technological integration with 211 and OpenBeds to ensure MiCAL has up to date resource information.

Current Activities

- Frontline Strong First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development. Crisis line is estimated to go live in Spring 2022.
- MiCAL and the Michigan Warmline staff have had over 29,000 encounters since April 19th (MiCAL go live); mostly calls. Over half the encounters have been on the Warmline.
- Pilot is focused on streamlining and routinizing care coordination process with CMHSPs and ensuring that CRM technology supports these processes.
- MiCAL integration with 211 is complete. Integration with OpenBeds/MiCARE is in progress.
- MiCAL Rollout: MiCAL will rollout statewide in two phases.
    - Phase 1 FY 22: Starting in January 2022, MiCAL will rollout statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time.
    - Phase 2 FY 23: CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout will occur one PIHP at a time.
- Overview of MICAL/988 Rollout with the rollout schedule was provided in a PIHP/CMHSP/CCBHC Director Overview on November 17th. The Rollout schedule is attached to this handout.

BHDDA Customer Relationship Management (CRM) – Internal Business Processes

Overview

- BHDDA will be transitioning all its internal business processes to a customer relationship management (CRM) system. The BHDDA CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between BHDDA and its customers: PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.
- The development process includes written documentation of the business process, describing the process and highlighting requirements, and the translation of the business process into technology. All this information is included in the user training.

- Stakeholders for each process are actively engaged throughout the design process and user testing.
- Training materials on the CRM and each of the business processes are housed within the CRM. Training materials include videos and written job aids.
- Virtual, synchronous training and "Learning Lab hours" are held when a business process goes live.

Current Activities

- Universal Credentialing (PA 282 of 2020): BHDDA has been holding stakeholder meetings and in partnership with stakeholders is exploring the most efficient and effective way to implement this legislation.
- Customer Service Inquiry and Contract Management Processes are rolled out statewide.
- ASAM Level of Care Certification Development Process testing and training is occurring now and will go live in January 2022.
- CMHSP Certification: Design work is still being done on this process. We are also working on rollout plans which will likely be a gradual rollout. We are designing a template to facilitate the upload of current CMHSP Certification Service information into the CRM. In the next several months, all CMHSPs will be offered the opportunity to update their Certification data via the template so it can be automatically uploaded rather than them manually entering all their certification data into the new CRM.

988 COALITION

Overview

- MDHHS received a grant from Vibrant Emotional Health (Vibrant) to plan for the implementation of a new, national, three-digit number for mental health crisis and suicide response (9-8-8), which will launch on or before July 16, 2022.
- The 9-8-8 Planning Coalition has gathered input from stakeholders to aid in the development of Michigan's implementation plan. They met monthly over the last several months to help develop, review
- Michigan's Draft Plan has two phases based on implementation time frames. Phase 1 focuses primarily on ensuring adequate call coverage statewide. Phase 2 will focus on metrics, operations requirements, and marketing. Note: Vibrant is still developing requirements so they suggested the "Phase" planning approach.
- Stakeholders have provided feedback throughout the planning process. Workgroup meetings have focused on topics such as vision, follow up care, resources, marketing, metrics, communications, and funding.
- Michigan's final plan is due January 30, 2022.
- 988 will have a soft launch in July 2022.
- Marketing will start at the federal level late 2022, early 2023. We have been asked to wait to market until we receive notice from Vibrant. They will send us marketing materials.

Current Activities

- We have Official 988 Draft Plan was approved by the Workgroup and BHDDA Leadership and has been submitted to Vibrant and SAMHSA for their review. We just received feedback from Vibrant and SAMHSA and their feedback is mainly asking for clarification. The final plan is due the end of January.
- It is important to note that 988 Coverage plans in Michigan are not firm and have already shifted since the Draft Plan was submitted. MiCAL will provide primary phone coverage for the large majority of the state population.
- We have developed an email list to keep Workgroup members up to date and to solicit their help as needed on topics such as marketing.
- Operations workgroup meetings with current NSPL centers are occurring to talk about Vibrant's expectations related to staff training, response times, follow up care, and resources.

- Resource workgroup meetings with 211, OpenBeds and NSPL centers have occurred and at this point in time all NSPL centers will have access to the same resources so no more meetings are necessary.
- As 988 gains publicity, there is increasing interest from community partners in the crisis services system and the role of 988, especially as this supports all Michiganders regardless of payer type.

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.
- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- The Psychiatric Bed Registry is housed in the MiCARE/ OpenBeds platform which is Michigan's behavioral health registry/ referral platform which is operated and funded by LARA.
- MiSMART will eventually house all private and public Behavioral Health Services and will have a public facing portal.
- The Psychiatric Bed Registry Advisory Group's purpose will transition from choosing a platform to supporting successful rollout and maximization of the OpenBeds platform to meet Michigan's needs.
- LARA is rolling out MiCARE regionally with a statewide completion date by early 2022.
- **Target audience:** Psychiatric Hospitals, Emergency Departments, CMHSP staff, PIHP staff.
    - Public and broader stakeholder access through MiCAL.
    - Broad cross-sector Advisory Workgroup.
- **Target Implementation Date:** Implemented statewide by January/ February 2022.

Current Activities

- LARA is in the process of rolling out MiCARE statewide to all the psychiatric hospitals. There are 58 facilities. 70% attended the initial orientation.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e. bed categorization, acuity and the rollout.
- MiCARE Demonstration to all CMHSP/PIHP staff is scheduled for Wednesday, December 8th at 2 pm.

CRISIS STABILIZATION UNITS

Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
    - MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders. Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.
- **Timing**: Michigan Model developed by 12/1. Draft Certification rules developed by March 2022, finalized by Sept. 2022

Current Activities

- Michigan CSU Model for adults has been drafted and approved by Workgroup.
- The Michigan Model is now being tailored to the needs of Children and Families.
- A very small subset of the Stakeholder group is developing draft certification criteria for adults. It will be presented to the larger workgroup in early 2022 for their feedback. There is special attention being paid to congruency with funding requirements, licensing requirements of related services, and accreditation.
- A rural crisis continuum meeting with a broad set of stakeholders will be held to provide feedback on certification criteria for rural areas and there is rural representation on certification subgroup.
- PSC 'extensive research on best practices in other states is being incorporated in the model.
- PSC is looking at available statewide data to help determine capacity needs.

MOBILE CRISIS SERVICES

Overview

- Mobile crisis services are one of the three major components that SAMHSA recommends as part of a public crisis services system.
- MDHHS goal is to eventually expand mobile crisis across the state for all populations, taking advantage of the enhanced Medicaid match.
- MDHHS has contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan, with special attention on strategies for rural areas.
- There is coordination with the MDHHS staff leading the KB lawsuit around services for children.

Target Date: Spring 2022

Current Activities – No new updates this month.

- PSC is doing research on mobile crisis models.
- PSC is coordinating work with the Diversion Council and Wayne State Center for Behavioral Health Justice (CBHJ) who are also focused on looking at adult mobile crisis models.
- PSC will start exploring adult crisis stabilization services offered by CMHSPs in Michigan.
- MDHHS plans to take advantage of the advanced Medicaid match coming in the spring of 2022.

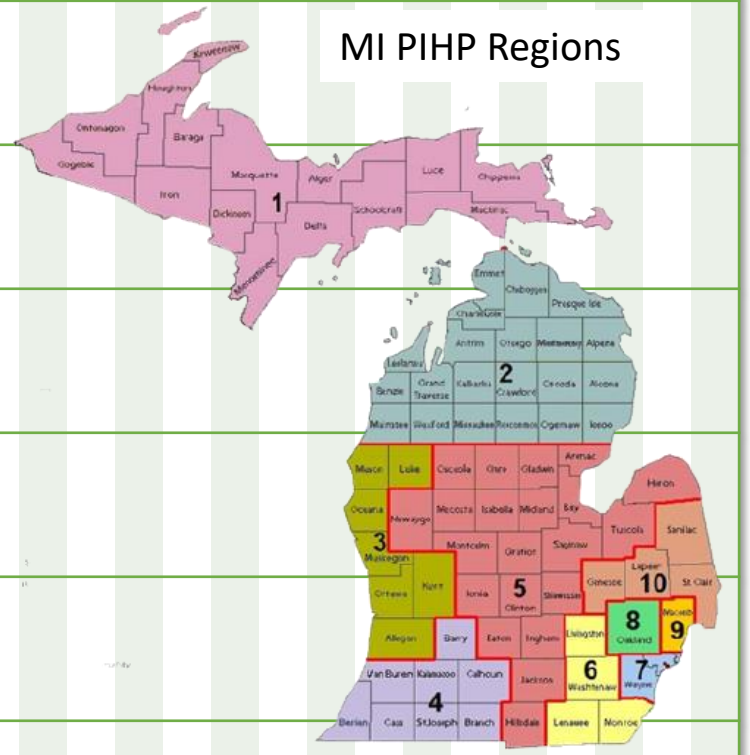
QUESTIONS OR COMMENTS?

- Krista Hausermann (hausermannk@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

MiCAL 988 Rollout Timeline (MiCAL/NSPL is active in Regions 1- UP & 8-Oakland)

	JAN 22'					FEB 22'				MAR 22'				APR 22'				MAY 22'					JUNE 22'				JULY 22'				AUG 22'				SEP 22'					OCT 22'			
	3	10	17	24	31	7	14	21	28	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	3	10	17	24	31
3 – Lakeshore Regional Entity																																											
10 – Region 10 PIHP																																											
2 – Northern MI Regional Entity																																											
5 – Mid-State Health Network																																											
6 – CMH Partnership of Southeast MI																																											
7 – Detroit Wayne Integrated Health Network																																											
4 – Southwest MI Behavioral Health																																											
9 – Macomb County CMH Services																																											

MI PIHP Regions



Michigan Integration Efforts

January 2022 Update

Overview

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

Goals

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

Opportunities for Improvement

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

Behavioral Health Homes (BHH)

Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes provide comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness or serious emotional disturbance by attending to a beneficiary's complete health and social needs.
- Providers are required to utilize a multidisciplinary care team comprised of physical and behavioral health expertise to holistically serve enrolled beneficiaries.
- As of October 1, 2020, Behavioral Health Home services are available to beneficiaries in 37 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), and 8 (Oakland County)

Current Activities:

- As of January 3, 2022, there are 1008 people enrolled:
    - Age range: 7-84 years old
    - Race: 22% African American, 73% Caucasian, 1% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- The State of Michigan budget allocated funding to expand behavioral health homes into two new regions. MDHHS is working on policy documents to expand in 2022.
- Regions are continuing to enroll eligible beneficiaries and working to expand health home partners to increase capacity to serve more beneficiaries.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Certified Community Behavioral Health Clinics (CCBHC)

Overview

- MI has been approved as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state by CMS. The demonstration will launch in October 2021 with a planned implementation period of two years. 14 sites, including 11 CMHSPs and 3 non-profit behavioral health providers, are eligible to participate in the demonstration. The CCBHC model increases access to a comprehensive array of behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay.
- CCBHCs are required to provide nine core services: crisis mental health services, including 24/7 mobile crisis response; screening, assessment, and diagnosis, including risk assessment; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans.
- CCBHCs must adhere to a rigorous set of certification standards and meet requirements for staffing, governance, care coordination practice, integration of physical and behavioral health care, health technology, and quality metric reporting.
- The CCBHC funding structure, which utilizes a prospective payment system, reflects the actual anticipated costs of expanding service lines and serving a broader population. Individual PPS rates are set for each CCBHC clinic and will address historical financial barriers, supporting sustainability of the model. MDHHS will operationalize the payment via the current PIHP network.

Current Activities

- The CCBHC Demonstration started on October 1, 2021!
- All CCBHCs are provisionally certified and have submitted applications for full certifications. MDHHS staff are reviewing the applications.
- The final CCBHC policy (MSA 21-34) and CCBHC Demonstration Handbook can be found on the CCBHC webpage MDHHS - Provider (michigan.gov)
- All technological systems met October 1st start date requirements. As of January 3, 2022, there are 8,757 people assigned to a CCBHC in the WSA. MDHHS is working with PIHPs and CCBHCs to make pertinent updates as needed.
- Final rates and implementation procedures have been submitted to CMS for approval. The Implementation Team has been engaging in ongoing technical assistance with CMS.
- An MDHHS marketing request has been submitted to begin a public marketing campaign. Marketing is intended to increase awareness of the CCBHC model, eligibility, and services among the public and other community providers. Marketing will target the sixteen counties with demonstration sites.

Questions or Comments

- Amy Kanouse (kanousea@michigan.gov)
- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Opioid Health Homes (OHH)

Overview

- Medicaid Health Homes are an optional State Plan Amendment under Section 1945 of the Social Security Act.
- Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration.
- Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.
- As of October 1, 2021, OHH services are available to eligible beneficiaries in 48 Michigan counties. Service areas include PIHP region 1, 2, 6,7, 9 and Calhoun and Kalamazoo counties in region 4.

Current Activities

- As of January 1, 2022, 1,880 beneficiaries enrolled in OHH services.
- MDHHS has recently expanded OHH services to an additional nine counties within PIHP region 6, 7, and 10. Existing OHH's are expanding access with new providers and growing services for more beneficiaries.
- MDHHS is working on collaborating with many state agencies such as the Maternal and Infant Health division to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

- Kelsey Schell (schellk1@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

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

Current Activities

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

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

- Shiawassee County is starting to see shared patient data in Azara DRVS. Implementation of the care management module is underway and Saginaw County is continuing to integrate the system into their practice.
- Providers are starting to deliver more in person appointments to enrollees, but telehealth is still offered and preferred by some patients.
- CMH's and FQHC's are partnering to provide COVID-19 vaccination clinics to CMH recipients.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

January 11, 2022

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs)

FROM: Audra Parsons, Quality Specialist AP
Performance Measurement Section
Bureau of Community Based Services

SUBJECT: Managed Care Program Annual Report

In accordance with Title 42 of the Code of Federal Regulations (CFR) §438.66 (e)(1)(i), States must submit to Center of Medicare and Medicaid Services (CMS) no later than 180 days after each contract year, a report on each managed care program administered by the State, regardless of the authority under which the program operates.

The Michigan Department of Health and Human Services (MDHHS) has made the decision to ask the PIHPs to fill out a portion of the requested information in The Managed Care Program Annual Report (MCPAR) rather than modify the existing Grievance and Appeals reports that are submitted on a quarterly basis. MDHHS is reviewing options on how to gather this information for future reporting.

The initial report will be due to CMS on June 20, 2023, for the 1/1/2022 – 12/31/2022 contract year. MDHHS will require this information be sent to Audra Parsons by April 22, 2023, to gather and input all 10 PIHPs information into the database.

The updated quarterly grievance, appeal, service authorization and semi-annual provider credentialing reports are being uploaded to the DCH-File-Transfer site. Please make sure to identify your PIHP and what quarter you are submitting when uploading your files to the DCH-File-Transfer site. Note: In both the Appeal and Grievance reports, there is a column to identify cases that are Certified Community Behavioral Health Clinics (CCBHC).

Should you have any questions, please contact me at ParsonsA@michigan.gov.

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

January 7, 2022

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Jeffery L. Wieferich, M.A., LLP JW
Director
Bureau of Community Mental Health Services

SUBJECT: Temporary Waiver of Child Mental Health Provider Qualifications

Due to the increased workforce shortages for behavioral health providers and the increased demand for children's service requests, the Behavioral Health and Developmental Disabilities Administration (BHDDA) has decided to implement a temporary waiver of provider qualifications for master's prepared Child Mental Health Professionals (CMHP).

The current Michigan Department of Health and Human Services provider qualifications for a CMHP are defined as an "individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, licensed or limited-licensed marriage and family therapist or registered nurse; or an individual with at least a bachelor's degree in a mental health related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families. For the BHT/ABA services individuals must be a BCBA or BCaBA or Psychologist working within their scope of practice with extensive knowledge and training on behavior analysis and BCBA certified by 9/30/2020."

BHDDA will temporarily waive the CMHP requirement of one year of experience in the examination, evaluation and treatment of minors and their families for individuals with a master's degree. This flexibility will be in effect for the current 2022 calendar year through December 31, 2022, at which time it will be reevaluated by BHDDA.

Each CMHSP who requires a CMHP waiver of provider qualification needs to complete the attached document and send to mdhhs-providerqualificationcode@michigan.gov. This information will help to track and justify the need for the staffing waiver request due to being unable to provide essential service for children and their families. Please note that the individual must continue to work towards their professional licensure and have weekly supervision with a CMHP.

c: Kim Batsche-McKenzie
Justin Tate
Lyndia Deromedi
Mary Ludtke
Belinda Hawks
Kasi Hunziger

The Health Safety Net Coalition's Recommended Investments

What Is the Health Safety Net Coalition?

The Michigan Health Safety Net Coalition (the Coalition) is a group of well-established, publicly funded health and human service providers, including the Community Mental Health Association of Michigan, the Area Agencies on Aging Association of Michigan, and the Michigan Primary Care Association. Together, these associations represent payers and providers in primary care, behavioral health, and social services for the aging population. Coalition partners prevent or treat illness and promote the health and wellness of individuals and communities. These partners are united by their common interests in the future of Michigan's health infrastructure and how Michigan can most effectively make budgetary and policy decisions to solve long-term systemic challenges of its most vulnerable residents and those who serve them.

Area Agencies on Aging Association of Michigan

CMHA Community Mental Health Association of Michigan

mpca The Voice of Community Health Centers

Who Does It Serve?

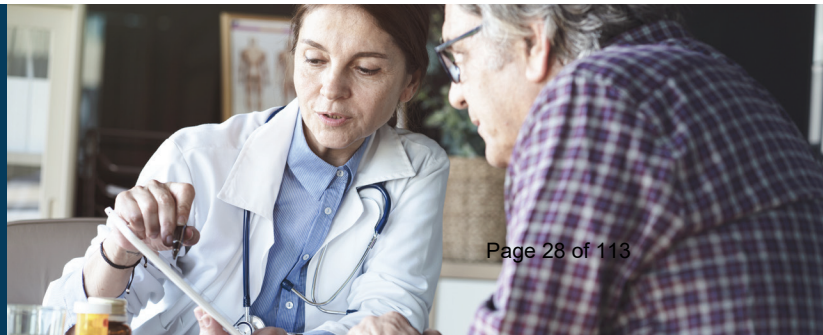
The healthcare providers that comprise the Coalition are the primary, behavioral, and aging services of first resort for low-income households statewide. These are often patients with the most complex health needs, including Medicare and Medicaid beneficiaries living in poverty. The Coalition does not turn away anyone, regardless of ability to pay and even if they have no payer. Ninety-five percent of those it serves live in poverty—but all Michiganders have access to these critical services. The need for the Coalition's services is growing, especially among Michigan's older adults.

Addressing Systemic Challenges with Transformative Funding

The Coalition and those it serves rely heavily on Michigan's public health and human services infrastructure—all of the components that ensure high-quality services can be delivered—workers, physical space, IT, and administration. The demand for these critical public health and human services has outgrown the current infrastructure and has not kept pace in resource generation as other private systems. ARPA creates an opportunity for transformation that safety net patients and providers deserve. The below are the priorities of the Coalition based on its expertise, lived experience, and visioning for the future of public healthcare and social services in Michigan.

Key Healthcare Issues

- Workforce
- Financing
- Physical infrastructure
- Information technology



WORKFORCE

Even before the coronavirus (COVID-19) pandemic, there was a known healthcare workforce shortage that was already anticipated to reach crisis levels in the next decade. The pandemic has accelerated the shortage, with some of the current workforce leaving the industry and fewer people choosing to launch careers in healthcare. ARPA dollars can fund several solutions to address the worker shortage, including the following:

- Increase funding to the state's public healthcare system to allow for competitive wages and benefits for direct support professionals—the people who provide daily supports in the homes and communities of people with disabilities—and clinical support staff. Currently COVID-19 relief funds are being used to fill the gap between the wages needed to retain staff before and during a pandemic. There is no reason to anticipate wages will decrease when the pandemic abates.
- Establish a MI Care Unit to coordinate direct care workforce development across state departments and care settings to efficiently monitor the state's investment in these programs and to ensure strategic alignment.
- Create regional caregiver resource centers to serve as a hub for caregiver training, education, crisis counseling, recruitment, and development of regional caregiver registries.
- Incentivize individuals serving in a Federally Qualified Health Center (FQHC) through training opportunities and loan repayment benefits. Michigan's health centers serve more than 725,000 patients annually in both rural and urban communities. According to MPCA, in 2018, they served an estimated 230,000 racial or ethnic minorities, 215,000 children, and 50,000 people experiencing homelessness.
- Remove financial barriers to education by offering loan repayment programs and job and skill training specifically for early career safety net providers and their private provider partners, especially in underserved Michigan communities. This will help attract new talent and upskill and retain current employees.

> **Michigan's health centers serve more than 725,000 patients annually in both rural and urban communities. According to MPCA, in 2018, they served an estimated 230,000 racial or ethnic minorities, 215,000 children, and 50,000 people experiencing homelessness.**

FINANCING

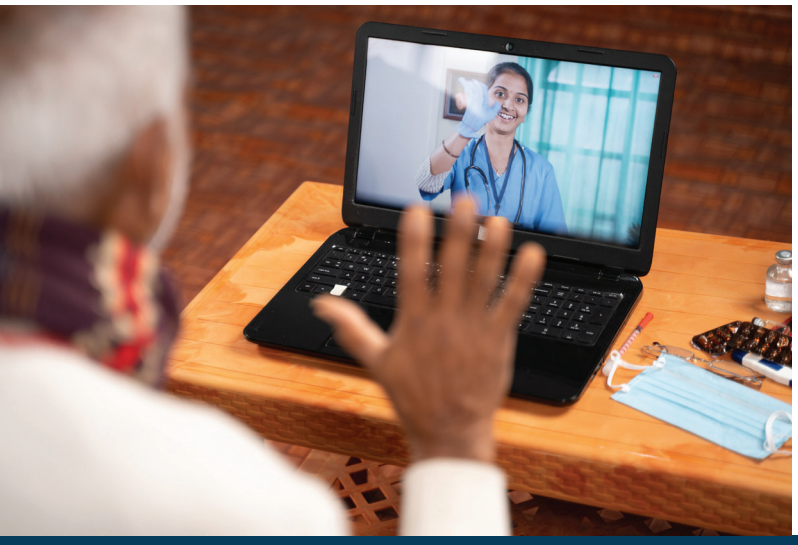
Like most other healthcare providers, health centers have seen decreased revenue during the COVID-19 pandemic due to a decrease in traditional face-to-face patient visits. They have quickly pivoted to ensure high-quality medical, dental, and behavioral healthcare services in nontraditional clinician visits, all developing telehealth and telemedicine options for their patients and community members. These are the best ways to reform healthcare rates and payment models to ensure the most vulnerable residents will have high-quality healthcare well into the future.

- Support the implementation of Michigan's Certified Community Behavioral Health Centers (CCBHC) in the initial pilot sites and then scale up statewide. This designation for the state's CMH centers and their provider network partners will bring federal dollars to Michigan to expand access to all Michiganders, rather than only those who are enrolled in Medicaid.
- Convert healthcare centers from fee-for-service prospective payment system to an FQHC alternative payment model. This will allow providers the flexibility to employ a more team-based model of care; support new and more convenient ways for patients to access care; encourage further investment in patient outreach, engagement, and coordination; and boost the implementation of evidence-based strategies that reimbursement models do not support today.
- Support reimbursement of community health worker (CHW) services through both the fee-for-service Medicaid program and Medicaid health plans to create a more sustainable financing for CHW services across the healthcare system, particularly given the importance of CHWs in understanding and working to address individuals' social determinants of health.
- Change policies related to first episode psychosis coverage so that CMH can serve these individuals—often adolescents—at the onset of schizophrenia rather than later in life when certain severity criteria are met. This will lead to both better health outcomes and lower costs over time.
- Support efforts to address issues with plans believing they have sufficient provider capacity when Medicaid patients are having difficulty finding a provider that is accepting new patients.
- Restore state general fund cuts made in 2015 that allowed Michiganders without any form of insurance to still receive services from CMH centers.
- Ensure older adults and people with disabilities who are not Medicaid beneficiaries can access home and community-based services (HCBS) through the Older Americans Act—this helps address most older adults' desire to age in place rather than transition to skilled nursing or other long-term care facility.
- Utilize Medicaid match incentives for HCBS to expand HCBS coverages available in Michigan. Increasing rates will incentivize transition services, address waiting lists for gaining network services, and rebalance state and federal expenditures to meet the growing demand for home- and community-based services.

PHYSICAL INFRASTRUCTURE

With increased demand for medical and behavioral services, it follows that the health safety net physical infrastructure also requires investment. These recommendations will address the unmet needs of Michigan's most vulnerable residents through building or adapting facilities and safety net capacity to improve and expand services.

- Incentivize private spending through a grant program aimed at increasing the number of long-term pediatric psychiatric inpatient hospitals or centers. The decades-long decline of pediatric psychiatric inpatient beds in the state has reached crisis levels; community-based hospitals are interested in providing this service but need support to do so.
- Create crisis, respite, and moderate-term residential options for children and adolescents who need a higher level of care than in-home care, but less intense than inpatient. CMH providers are seeing a significant increase in children being dropped off at emergency departments by foster parents who are unable to handle a child's behavioral challenges.
- Build on the crisis response components already in place by funding more crisis stabilization units in communities across the state as part of the state's effort to build a comprehensive mental health crisis response system.
- Expand in-home services provided through the Medicaid MIChoice program and home and community-based services for individuals not eligible for Medicaid.



INFORMATION TECHNOLOGY

The pandemic has drawn attention to the reliance on technology for healthcare delivery while simultaneously exacerbating that reliance. To make the most of the opportunity offered by ARPA funding, the Coalition believes the following activities would make a long-term, positive impact on its patients and providers.

- Provide financing to the state's CMH system and the providers in the CMH networks to build out their IT capacity—electronic health records (EHRs), telehealth capacity, and mobile connection capacity. It is important to know that behavioral health provider systems were excluded from the funding available to all other health care providers through the 2009 Health Information Technology for Economic and Clinical Health Act, which incentivized hospitals and other healthcare providers to make the switch to EHRs.
- Improve interoperability between health safety net and other EHR systems. Integrating the health safety net data with information collected by health plans can produce a more complete picture of a patient's health and could direct primary care and other clinicians to adjust treatment in cost-effective ways.
- Standardize SDoH definitions and measures statewide. Screening tools and access to community resources are inconsistent across providers and plans. The current model of health plans choosing their own method and definitions related to SDoH is not serving plan participants. Safety Net programs should be empowered to be leaders in identifying and addressing SDoH.
- Expand broadband access to older adults, persons with disabilities, and other disadvantaged populations. Broadband access has been critical throughout the pandemic to ensure people can continue receiving high-quality medical treatment through telemedicine appointments, online health education, tools that combat social isolation, and family and friends. The benefits of broadband access are apparent and can be used to address future needs as Michigan's population ages and is even more tech savvy. This is also an equity issue as a lack of access can hold people back from critical medical or behavioral care.
- Ensure the telehealth modalities that showed such promise in improving access and client and patient engagement during the pandemic become a permanent part of the healthcare landscape via permanent Medicaid policy and insurance regulation changes.

Need More Information?

To reach a Health Safety Net Coalition partner who can support these requests with additional research and examples, please contact:

Robert Sheehan, CEO
Community Mental Health Association of Michigan
517-237-3142
rsheehan@cmham.org

Dennis Litos, Interim CEO
Michigan Primary Care Association
517-827-0880
dlitos@mpca.net

David LaLumia, Executive Director
Area Agencies on Aging Association of Michigan
517-886-1029
davelalumia@4ami.org

Health Safety Net Coalition Requests

	Area Agencies on Aging Association of Michigan	Community Mental Health Association of Michigan	Michigan Primary Care Association
Workforce			
Maintain increased wages and benefits for direct support professionals (DSPs)[1]	**$99.8 million** over three years This will raise wages and benefits of 8,000 DSPs over a three-year period.	**$687 million** new annual cost The cost of the wage increase provided here is based on $176.2 million per $1/hour wage increase cited in the FY21 and FY22 budget bills. To increase starting wages from $14.10/hr to $18/hr would require $687 million in Medicaid funding, $240 million of which are state General Fund dollars with the balance being the federal share of these Medicaid expenditures.	**$284.5 million** new annual cost This increase will impact 4,300 licensed independent practitioners across 40 locations.
Create regional caregiver resource centers	**$16.8 million** These grant funds to Area Agencies on Aging (AAAs) will establish 16 regional caregiver resource centers that will be self-sustaining.		
Offer loan repayment programs and job training for early career safety net providers and their partners	**$2.7 million** one-time student loan repayment grants These student loan repayment grants will be provided to 90 nurses and licensed social workers who serve older adults. PLUS **$4 million** This will provide training grants for 200 DSPs to minimize barriers to entry in the field and help to professionalize the field. PLUS **$4.5 million** This investment will provide 90 train-the-trainer scholarships.	**$10 million** per year over three years (**$30 million** total over three years) These stipends will allow 1,000 new master of social work (MSW) candidates to afford advanced behavioral health training and a career in community mental health. PLUS **$100 million** This investment in and expansion of the Michigan State Loan Repayment Program (MSLRP) will be earmarked for behavioral healthcare clinicians, such as psychiatrists, nurses, social workers, psychologists, and speech therapists (who are currently excluded from this program). This will add between 1,000 and 2,000 behavioral health clinicians and DSPs (assuming $50,000–$100,000 in loan repayment per clinician). This will guarantee clinicians for two to eight years and includes state and private employer share.	**$3.89 million** per year for three years (**$11.67 million** over three years, no ongoing costs to the State) This investment will remove barriers to entry into the medical and dental assistant roles for those who will be trained and employed by federally qualified health centers (FQHCs). As a result of this initiative, 300 new medical assistants and 180 new dental assistants would be trained and certified and receive valuable on-the-job experience in critical underserved areas and with underserved populations.

[1] The coalition has chosen to use the term "direct support professional" in its materials. Sometimes this term is used interchangeably with "direct care worker."

Health Safety Net Coalition Requests

Financing

	Area Agencies on Aging Association of Michigan	Community Mental Health Association of Michigan	Michigan Primary Care Association
Implement and expand access to Certified Community Behavioral Health Clinics (CCBHCs) in their demonstration phase		**$10 million** one-year request (general fund) This one-time investment would fully fund the current CCBHC demonstration program at a level ensuring they can serve both insured and uninsured individuals who come to them without Medicaid coverage.	
Scale up CCBHCs statewide		**$125 million** ($35 million from general fund, remainder can come from federal funds) This investment would fully fund ten to 12 CCBHC sites not currently in the state demonstration program; $107 million net PPS (the CCBHC costs of Medicaid and HMP enrollees that are not covered with the base/subcapitated payment received by these sites); and $8 million to cover costs of serving those without Medicaid coverage (includes insured and uninsured).	
Convert healthcare centers from fee-for-service (FFS) to an FQHC alternative payment model			**$55.8 million** gross This investment is requested as a one-time approrpation of federal funds spanning the period leading up to alternative payment model implementation and shortly after implementation. More funding would be needed in the pre-implementation period, rather than equal annual installments.
Support reimbursement of community health worker services through both FFS Medicaid programs and Medicaid health plans			**$32.8 million** gross $11 million of this request will come from General Fund-General Purpose annually ongoing, $750,000 will be a one-time cost at Michigan Department of Health and Human Services (MDHHS) for implementing the policy change, the remainder will be Medicaid match.
Ensure older adults and people with disabilities who are not Medicaid beneficiaries can access home and community-based services (HCBS)	**$12.3 million**		
Utilize Medicaid match incentives for HCBS to expand coverages available in Michigan	**$24 million** This will improve Medicaid transition rates and adjust MI Choice Waiver Program rates.		

Health Safety Net Coalition Requests

	Area Agencies on Aging Association of Michigan	Community Mental Health Association of Michigan	Michigan Primary Care Association
Physical Infrastructure			
Fund more crisis stabilization units (CSUs) in communities across the state	**$3.8 million** This investment will create a way for aging network participants to purchase crisis stabilization services.	**$132 million** Based on the Crisis Now Resource Need Calculator (the nationally recognized source of uniform crisis system cost calculators) and the Crisis Stabilization Unit (CSU) structure and services described in MI law, with guidance from MI crisis centers with the deepest working knowledge of CSU-like operations: $120 million for annual operating costs of 6 fully funded CSUs, at an average cost of $20 million per CSU; $12 million to fund one-time costs of building and/or renovation, equipment, furniture, beds for these 6 CSUs.	
Expand in-home services provided through the Medicaid MI Choice program and HCBS for individuals not eligible for Medicaid	**$5.6 million**		

Health Safety Net Coalition Requests

	Area Agencies on Aging Association of Michigan	Community Mental Health Association of Michigan	Michigan Primary Care Association
Information Technology			
Build out IT capacity of CMH, PIHP, and provider systems. Note: the federal Health Information Technology for Economic and Clinical Health (HITECH) Act excluded the nation's behavioral healthcare systems in 2009 and it's time to invest now.		**$50 million** This will fund electronic health record (EHR) improvements, telehealth capacity, and mobile connection capability, integrating multiple systems like primary care, pharmacies, dental care, and others.	
Improve interoperability between health safety net EHRs and other EHR systems	**$16 million** These grants to AAAs would improve IT systems to address interoperability.		
Standardize social determinants of health (SDOH) definitions and measures statewide—screening tools and access to community resources are inconsistent across providers and plans	**$1 million** This investment would assess social determinants of health practices among safety net partners and include collaboration related to SDOH with healthcare, Michigan Health Information Network, and other community partners.		
Expand broadband access to older adults, persons with disabilities, and other disadvantaged populations	**$4.8 million** These grants to AAAs would help expand broadband to underserved areas and assist with consumer access costs for older adults.		
Ensure telehealth modalities that improved patient access and client and patient engagement during the pandemic become a permanent part of the healthcare landscape via permanent Medicaid policy and insurance regulation changes			

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

January 5, 2022

Robert Sheehan, Chief Executive Officer
Community Mental Health Association of Michigan
426 South Walnut Street
Lansing, MI 48933

Dear Mr. Sheehan:

Thank you for your December 21, 2021, email regarding your notice of a system halt to participation in the Standard Cost Allocation (SCA) workgroup. It was noted that the halt was initiated due to not having agreed upon contract language established. The Michigan Department of Health and Human Services (MDHHS) appreciates the partnership from select representatives of Michigan's Prepaid Inpatient Health Plans (PIHP), Community Mental Health Service Programs (CMHSPs), and the Community Mental Health Association of Michigan regarding the SCA initiative.

This workgroup was initiated to support compliance with federal regulations under the Medicaid Managed Care Medical Loss Ratio Standards (42 CFR §438.8(a)-Medical loss ratio (MLR). The workgroup was charged with establishing a standard cost allocation process and a comprehensive reporting template to enhance consistency in the reporting of unit cost for services, to enhance the reporting to MDHHS to support its program monitoring obligations, and to remove variation in unit cost reporting attributable to differences in accounting and cost allocation methods.

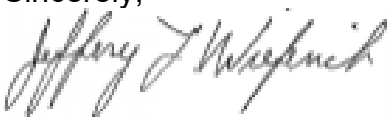
At the conclusion of this work, MDHHS with its actuary Milliman, developed a standard cost allocation methodology to be included in the PIHP FY2022 contract that will allow MDHHS to meet the reporting expectations of the Centers for Medicare and Medicaid Services. MDHHS understands that some of the CMHSPs have expressed concern about the methodology. As such, MDHHS secured an outside legal opinion to ensure the SCA methodology was consistent with the federal regulation and sub-regulatory guidance. The legal opinion is that the SCA is fully consistent with regulations and will move MDHHS towards federal compliance with its monitoring obligations of the behavioral health managed care program.

MDHHS agrees that further contract negotiations regarding the SCA are not necessary as MDHHS must fully require compliance with federal regulations. MDHHS will continue to negotiate in good faith when the contractual terms allow for flexibility. Compliance with federal reporting requirements and MDHHS oversight of the managed care behavioral health system does not provide such flexibility.

Robert Sheehan, Chief Executive Officer
Community Mental Health Association of Michigan
January 5, 2022

Thank you for your understanding and I look forward to your continued partnership in addressing the needs of the specialty behavioral health system.

Sincerely,



Jeffery L. Wieferich MA, LLP
Acting Senior Deputy Director
Behavioral Health and Developmental Disabilities Administration

c: Al Jansen
Leslie Asman
Brian Keisling
Penny Rutledge
Jackie Sproat
Belinda Hawks
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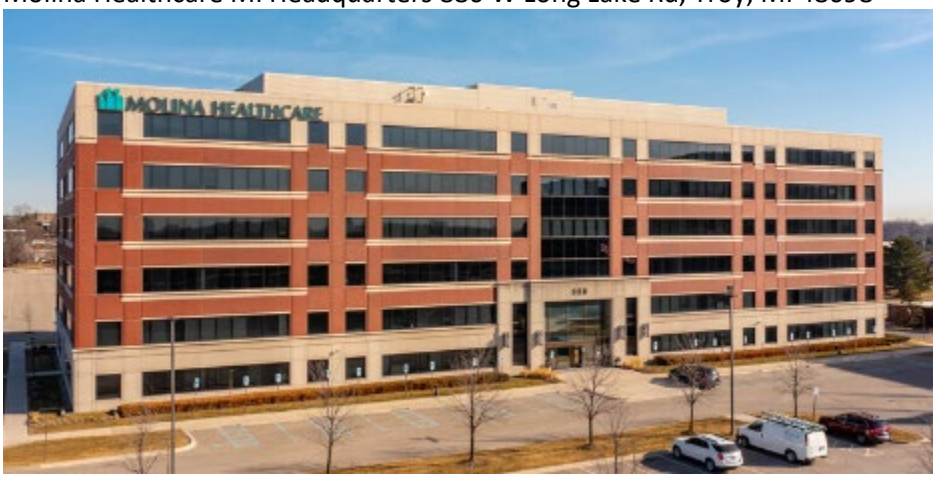
Meridian Michigan 1 Campus Martius #700, Detroit, MI 48226

Molina Healthcare MI Headquarters 880 W Long Lake Rd, Troy, MI 48098



Blue Cross Blue Shilds Michigan 600 E Lafayette Blvd Detroit MI 48231

Mid State Health Network 530 W Ionia St, Lansing, MI 48933

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – JANUARY 12, 2022
VIA TEAMS

ATTENDEES:	**Connie Cadarette, Lauri Fischer, Christine Gebhard, Kevin Hartley, Chip Johnston, Nancy Kearly, Eric Kurtz, Donna Nieman, Larry Patterson, Brandon Rhue, Nena Sork, Erinn Trask, Jennifer Warner, Deanna Yockey**

REVIEW AGENDA & ADDITIONS

No additions to the meeting Agenda were proposed. Donna stated that she would like to discuss Performance Indicators and Advance Benefit Determination in lieu of the EDIT update. Lauri requested that Exclusion Check Reporting be added to the Agenda. Erin requested a discussion of the MDHHS DCW survey email that Connie forwarded to the Finance Committee on January 6th.

REVIEW PRIOR MINUTES

The December minutes were included in the materials packet for the meeting.

MOTION BY KEVIN HARTLEY TO APPROVE THE MINUTES OF THE DECEMBER 8, 2021 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY LARRY PATTERSON. MOTION APPROVED.

MONTHLY FINANCIALS

November 2021

- Traditional Medicaid showed $33,635,159 in revenue, and $28,596,944 in expenses, resulting in a net surplus of $5,038,215. 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 $5,294,270 in revenue, and $3,738,856 in expenses, resulting in a net surplus of $1,555,414. 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 $6,593,629. Medicaid carry forward was reported as $16,358,496. The total Medicaid and HMP Current Year Surplus was reported as $21,510,645. 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 $37,869,141.
- Health Home showed $186,406 in revenue, and $151,675 in expenses, resulting in a net surplus of $34,731.
- SUD showed all funding source revenue of $3,835,348, and $2,915,418 in expenses, resulting in a net surplus of $919,930. Total PA2 funds were reported as $5,949,601.

The Direct Care Wage surplus was anticipated as $1,441,480. It was noted that the additional $0.35 in FY22 DCW will not be included in the revenue until April. DCW needs to continue to be tracked separately through the fiscal year.

It was noted that no expenses were reported for North Country for the Health Home due to the timing of its financial audit; claims were submitted on January 3, 2022 totaling approximately $30K.

Eligibility continues to trend up for all the Boards in all categories.

Deanna shared a rate analysis comparing Q1 FY22 revenue with Q1 FY21.

	HSW	Medicaid/HMP	Total Q1
FY21 Quarter 1	$12,130,943	$43,036,880	$55,167,823
FY22 Quarter 1	$11,874,062	$43,719,574	$55,593,636
Increase (Decrease) from FY21	($256,881)	$682,693	**$425,813**

Clarification was made that the region currently has 20 open HSW slots, with 5 pending for enrollment. The region has been unable to maintain an adequate number of packets to fill the open slots with the number of disenrollments due to death or moving to nursing homes.

Lauri asked the current status of spenddowns and redeterminations; agreement was reached that spenddowns are not being processed.

MOTION BY CONNIE CADARETTE TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2021; SUPPORT BY KEVIN HARTLEY. MOTION APPROVED.

EDIT UPDATE

The next EDIT meeting is scheduled for January 20, 2022.

PERFORMANCE INDICATORS

Donna reported that Centra Wellness had in issue with the change in codes from H0031 to 90791; 90791 wasn't being pulled properly for performance indicator reporting. Centra Wellness was able to resolve the issue with PCE; Connie reported a similar fix is being implemented at Northeast Michigan.

ADVANCE BENEFIT DETERMINATION

Historically, the State's (contractually required) Notice did not meet HSAG Compliance Audit requirements. A committee was formed to ensure that the Notice in PCE met all the necessary requirements for compliance. All entities were advised to use the ABD in the PCE system.

ENCOUNTER UPDATES

Brandon reported an issue with the State processing encounters. The State and PCE are aware and are working on a solution. As of January 11th, the State had updated its systems to mask the error and allow the files to process. A test batch was sent with a "no error" response received. NMRE is planning to resubmit encounters going back to early December and address any continuing errors individually. This will impact the date that Milliman pulls the data for matching up with the EQI.

Statewide CFOs are working on a spreadsheet to categorize funding sources that ties to the EQI. On the IT side, discussions are occurring at the State about requiring the submission of Coordination of Benefits loops in the EDI (837 files). MDHHS is hoping to implement this by October 1, 2022. A training/discover webinar is scheduled for COB on January 21st at 9:00AM. The meeting details were provided as:

Microsoft Teams meeting

Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only)
+1 248-333-6216,,883088473# United States, Pontiac
Phone Conference ID: 883 088 473#

FSR & EQI DUE DATE
The Due date to the NMRE was provided as February 14th; the due date to the State is February 28th.

EXCLUSION CHECK REPORTING
Lauri asked whether the other Boards are purchasing the Valenz platform for running monthly EPS checks. It was noted that this topic is mainly being discussed in the regional QOC committee meetings; Boards have looped IT and HR into the conversations as needed. Clarification was made that Boards may pursue other software options as long as it meets the exclusion check requirements, which NMRE Compliance Officer, Tema Pefok, has discussed over the past several months with QOC. Eric explained the reason for shifting the process from the NMRE to the Boards is to reduce threats to PII.

DIRECT CARE WAGE SURVEY
Erin thanked Connie for forwarding the email with the link to the survey; she asked whether any of the Boards have attempted to complete the survey. Connie responded that the survey asks how many individuals are in different “wage bands” and is fairly simple to complete. The instructions provided by MDHHS are for entities to complete this survey for the number of direct care workers employed during October 1, 2021 – December 31, 2021 for services provided through any of the eligible programs or services by February 1, 2022. CMHSPs were advised to complete the survey for themselves and forward the information on to Providers to complete for themselves (though MDHHS may have already sent communication to Providers). It was noted that completion of the survey is not included in the contractually obligated Reporting Requirements.

NEXT MEETING
The next meeting was scheduled for February 9th at 10:00AM.

Chief Executive Officer Report

January 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.

Jan 4: Met with MDHHS Behavioral Health Home consultant.

Jan 5: Attended and participated in Rural Crisis Stabilization Unit discussion.

Jan 6: Attended and participated in MDHHS/PIHP CEO Meeting.

Jan 10: Attended and participated in CMHAM Directors Forum.

Jan 12: Attended and participated in NMRE Regional Finance Committee Meeting.

Jan 13: Attended and participated in MDHHS PIHP/CMHSP COVID 19 call.

Jan 14: Attended and participated in MDHHS 1915(i) SPA Meeting.

Jan 18: Chaired NMRE Regional Operations Committee Meeting.

Jan 20: Attended Northern Lakes' Board Meeting to present on OHH.

Jan 25: Plan to Chair NMRE Internal Operations Committee Meeting.

November 2021 Finance Report

November 2021 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	5,038,215	11,296,664	9,298,750
Healthy Michigan	1,555,414	5,061,832	7,059,746
	$ 6,593,629	$ 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	1,346,082	808,922	1,399,404	1,211,793	691,764	909,901	225,762	$ 6,593,629
Direct Care Wage Estimated Surplus								(1,441,480)
Medicaid Carry Forward								16,358,496
Total Med/HMP Current Year Surplus								$ 21,510,645
Medicaid & HMP Internal Service Fund								16,358,496
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 37,869,141

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through November 30, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Ausable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 32,680,487	$ 771,386						$ 33,451,873
CMHSP Distributions	(31,144,515)		10,405,025	8,554,083	5,237,632	4,256,241	2,691,533	-
1st/3rd Party receipts			78,619	-	104,667	-	-	183,286
Net revenue	1,535,972	771,386	10,483,644	8,554,083	5,342,299	4,256,241	2,691,533	33,635,159
Expense								
PIHP Admin	363,526	6,494						370,020
PIHP SUD Admin		5,764						5,764
SUD Access Center		8,292						8,292
Insurance Provider Assessment	250,860	5,201						256,061
Hospital Rate Adjuster	-							-
Services		490,644	9,023,112	7,664,746	4,782,850	3,448,321	2,547,135	27,956,808
Total expense	614,386	516,395	9,023,112	7,664,746	4,782,850	3,448,321	2,547,135	28,596,944
Net Actual Surplus (Deficit)	$ 921,587	$ 254,991	$ 1,460,532	$ 889,337	$ 559,449	$ 807,920	$ 144,398	$ 5,038,215

Notes

Medicaid ISF - $9,298,750 - based on Interim FSR
Medicaid Savings - $11,296,664

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through November 30, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Ausable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 3,457,999	$ 1,834,445						$ 5,292,444
CMHSP Distributions	(2,978,858)		1,085,788	901,419	369,132	371,623	250,896	(0)
1st/3rd Party receipts			-	-	1,826	-	-	1,826
Net revenue	479,141	1,834,445	1,085,788	901,419	370,958	371,623	250,896	5,294,270
Expense								
PIHP Admin	31,814	16,121						47,935
PIHP SUD Admin		14,309						14,309
SUD Access Center		20,585						20,585
Insurance Provider Assessment	22,832	11,499						34,331
Hospital Rate Adjuster	-							-
Services		1,218,000	1,146,916	578,963	238,643	269,642	169,532	3,621,696
Total expense	54,646	1,280,514	1,146,916	578,963	238,643	269,642	169,532	3,738,856
Net Surplus (Deficit)	$ 424,496	$ 553,931	$ (61,128)	$ 322,456	$ 132,315	$ 101,981	$ 81,364	$ 1,555,414

Notes
HMP ISF - $7,059,746 - based on Interim FSR
HMP Savings - $5,061,832

Net Surplus (Deficit) MA/HMP	**$ 1,346,082**	**$ 808,922**	**$ 1,399,404**	**$ 1,211,793**	**$ 691,764**	**$ 909,901**	**$ 225,762**	**$ 6,593,629**
Direct Care Wage Estimated Surplus								**$ (1,441,480)**
Medicaid Carry Forward								**16,358,496**
Total Med/HMP Current Year Surplus								$ 21,510,645
Medicaid & HMP ISF - based on Interim FSR								**16,358,496**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 37,869,141**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through November 30, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Ausable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 186,406							$ 186,406
CMHSP Distributions	(149,161)		64,578	-	12,635	7,370	64,578	-
1st/3rd Party receipts								-
Net revenue	37,245	-	64,578	-	12,635	7,370	64,578	186,406
Expense								
PIHP Admin	1,974							1,974
Insurance Provider Assessment	540							540
Hospital Rate Adjuster								
Services			64,578	-	12,635	7,370	64,578	149,161
Total expense	2,514	-	64,578	-	12,635	7,370	64,578	151,675
Net Surplus (Deficit)	$ 34,731	$ -	$ -	$ -	$ -	$ -	$ -	$ 34,731

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through November 30, 2021

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 771,386	$ 1,834,445	$ 516,833	$ 383,334	$ 329,350	$ 3,835,348
Expense						
Administration	12,258	30,430	9,449	25,516		77,654
OHH Admin	-	-	15,371	-		15,371
Access Center	8,292	20,585	-	4,312		33,190
Insurance Provider Assessment	5,201	11,499	2,784			19,484
Services:						
Treatment	490,644	1,218,000	378,219	255,163	329,350	2,671,376
Prevention	-	-	-	98,343	-	98,343
State targeted response	-	-	-	-	-	-
Total expense	516,395	1,280,514	405,823	383,334	329,350	2,915,418
PA2 Redirect			-			-
Net Surplus (Deficit)	$ 254,991	$ 553,931	$ 111,010	$ (0)	$ -	$ 919,930

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through November 30, 2021

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 32,680,487	$ 771,386	$ -	$ 33,451,873
Medicaid Savings	-	-	-	-
Healthy Michigan	3,457,999	1,834,445	-	5,292,444
Healthy Michigan Savings	-	-	-	-
Health Home	186,406	-	-	186,406
Opioid Health Home	-	516,833	-	516,833
Substance Use Disorder Block Grant	-	383,334	-	383,334
Public Act 2 (Liquor tax)	-	329,350	-	329,350
Affiliate local drawdown	224,900	-	-	224,900
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	20,650	-	20,650
Veteran Navigator Grant	15,636	-	-	15,636
SOR Grant Revenue	-	137,826	-	137,826
Gambling Grant Revenue	-	418	-	418
Other Revenue	-	-	1,233	1,233
Total operating revenue	36,565,428	3,994,242	1,233	40,560,903
Operating expenses				
General Administration	434,066	74,092	-	508,158
Prevention Administration	-	11,503	-	11,503
OHH Administration	-	15,371	-	15,371
Insurance Provider Assessment	274,232	19,484	-	293,716
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	27,282,878	490,644	-	27,773,522
Healthy Michigan Services	2,401,870	1,218,000	-	3,619,870
Health Home Services	147,407	-	-	147,407
Opioid Health Home Services	-	378,219	-	378,219
Community Grant	-	255,163	-	255,163
Prevention	-	86,840	-	86,840
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	329,350	-	329,350
Local PBIP	-	-	-	-
Local Match Drawdown	224,900	-	-	224,900
Miscellanous Grant	-	20,650	-	20,650
Veteran Navigator Grant	15,636	-	-	15,636
SOR Grant Expenses	-	137,826	-	137,826
Gambling Grant Expenses	-	418	-	418
Total operating expenses	30,780,989	3,037,560	-	33,818,549
CY Unspent funds	5,784,439	956,682	1,233	6,742,354
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	4,780,705	8,733,347	14,799,394	28,313,446
Unspent funds - ending	$ 10,565,144	$ 9,690,029	$ 14,800,627	$ 35,055,800

Northern Michigan Regional Entity

Statement of Net Position

November 30, 2021

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 29,120,898	$ 10,425,855	$ 5,214,044	$ 44,760,797
Accounts Receivable	4,285,149	1,223,205	9,586,583	15,094,937
Prepaids	57,980	-	-	57,980
Total current assets	33,464,027	11,649,060	14,800,627	59,913,714
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	33,464,027	11,649,060	14,800,627	59,913,714
Liabilities				
Current liabilities				
Accounts payable	22,736,435	1,959,031	-	24,695,466
Accrued liabilities	162,448	-	-	162,448
Unearned revenue	-	-	-	-
Total current liabilities	22,898,883	1,959,031	-	24,857,914
Unspent funds	$ 10,565,144	$ 9,690,029	$ 14,800,627	$ 35,055,800

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 32,155,182	$ 32,680,487	$ 525,305	1.63%
Carryover	11,296,664	11,296,664	-	(11,296,664)	(1)
Healthy Michigan					
Capitation	20,566,272	3,427,712	3,457,999	30,287	0.88%
Carryover	5,061,832	5,061,832	-	(5,061,832)	(100.00%)
Health Home	506,772	84,462	186,406	101,944	120.70%
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	18,334	15,636	(2,698)	(14.72%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	52,345,283	36,565,428	(15,779,855)	(30.15%)
Operating expenses					
General Administration	3,021,688	505,458	434,066	71,392	14.12%
Insurance Provider Assessment	1,645,387	274,231	274,232	(1)	(0.00%)
Hospital Rate Adjuster	4,001,228	666,871	-	666,871	100.00%
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	32,482	15,636	16,846	51.86%
Payments to Affiliates:					
Medicaid Services	173,402,120	28,900,353	27,282,878	1,617,475	5.60%
Healthy Michigan Services	15,233,944	2,538,991	2,401,870	137,121	5.40%
Health Home Services	456,768	76,128	147,407	(71,279)	(93.63%)
Total operating expenses	200,508,190	33,295,611	30,780,989	2,514,622	7.55%
CY Unspent funds	$ 32,503,361	$ 19,049,672	5,784,439	$ (13,265,233)	
Transfers in			-		
Transfers out			-	30,780,989	
Unspent funds - beginning			4,780,705		
Unspent funds - ending			$ 10,565,144	5,784,439	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 733,124	$ 771,386	$ 38,262	5.22%
Healthy Michigan	9,763,272	1,627,212	1,834,445	207,233	12.74%
Substance Use Disorder Block Grant	5,709,003	951,499	383,334	(568,165)	(59.71%)
Opioid Health Home	2,320,384	386,730	516,833	130,103	33.64%
Public Act 2 (Liquor tax)	1,533,979	-	329,350	329,350	0.00%
Miscellanous Grants	36,335	6,056	20,650	14,594	240.99%
SOR Grant	1,215,000	202,500	137,826	(64,674)	(31.94%)
Gambling Prevention Grant	200,000	33,333	418	(32,915)	(98.75%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	3,940,454	3,994,242	53,788	1.37%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	168,414	74,092	94,322	56.01%
Prevention Administration	90,144	15,024	11,503	3,521	23.44%
Insurance Provider Assessment	116,901	19,484	19,484	(1)	(0.00%)
Medicaid Services	3,387,649	564,608	490,644	73,964	13.10%
Healthy Michigan Services	7,453,459	1,242,243	1,218,000	24,243	1.95%
Community Grant	2,077,452	346,242	255,163	91,079	26.30%
Prevention	664,967	110,828	86,840	23,988	21.64%
State Disability Assistance	95,215	15,875	-	15,875	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	15,371	(15,371)	0.00%
Opioid Health Home Services	2,117,226	352,872	378,219	(25,347)	(7.18%)
Miscellanous Grants	36,335	6,056	20,650	(14,594)	(240.99%)
SOR Grant	1,215,000	202,500	137,826	64,674	31.94%
Gambling Prevention	200,000	33,333	418	32,915	98.75%
PA2	1,533,978	-	329,350	(329,350)	0.00%
Total operating expenses	20,058,810	3,077,478	3,037,560	39,918	1.30%
CY Unspent funds	$ 5,117,907	$ 862,976	956,682	$ 93,706	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			8,733,347		
Unspent funds - ending			$ 9,690,029		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 288,178	$ 248,177	$ 40,001	13.88%
Fringes	549,516	86,762	82,619	4,143	4.78%
Contractual	433,304	72,218	72,785	(567)	(0.79%)
Board expenses	16,100	2,684	3,167	(483)	(18.00%)
Day of recovery	14,000	9,000	-	9,000	100.00%
Facilities	152,700	25,450	12,920	12,530	49.23%
Other	127,000	21,166	14,398	6,768	31.98%
Total General Admin	$ 3,021,688	$ 505,458	$ 434,066	$ 71,392	14.12%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 80,368	$ 16,817	$ 63,551	79.08%
Fringes	166,800	27,800	8,604	19,196	69.05%
Access Salaries	194,484	32,414	25,454	6,960	21.47%
Access Fringes	57,588	9,598	7,736	1,862	19.40%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	16,666	12,536	4,130	24.78%
Board expenses	5,000	834	950	(116)	(13.91%)
Facilities	-	-	-	-	0.00%
Other	10,404	734	1,995	(1,261)	(171.80%)
Total operating expenses	$ 1,070,484	$ 168,414	$ 74,092	$ 94,322	56.01%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2021 through November 30, 2021

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	416	1,233	817	196.39%
Total operating revenue	2,501	416	1,233	817	196.39%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 416	1,233	$ 817	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			14,799,394		
Unspent funds - ending			$ 14,800,627		

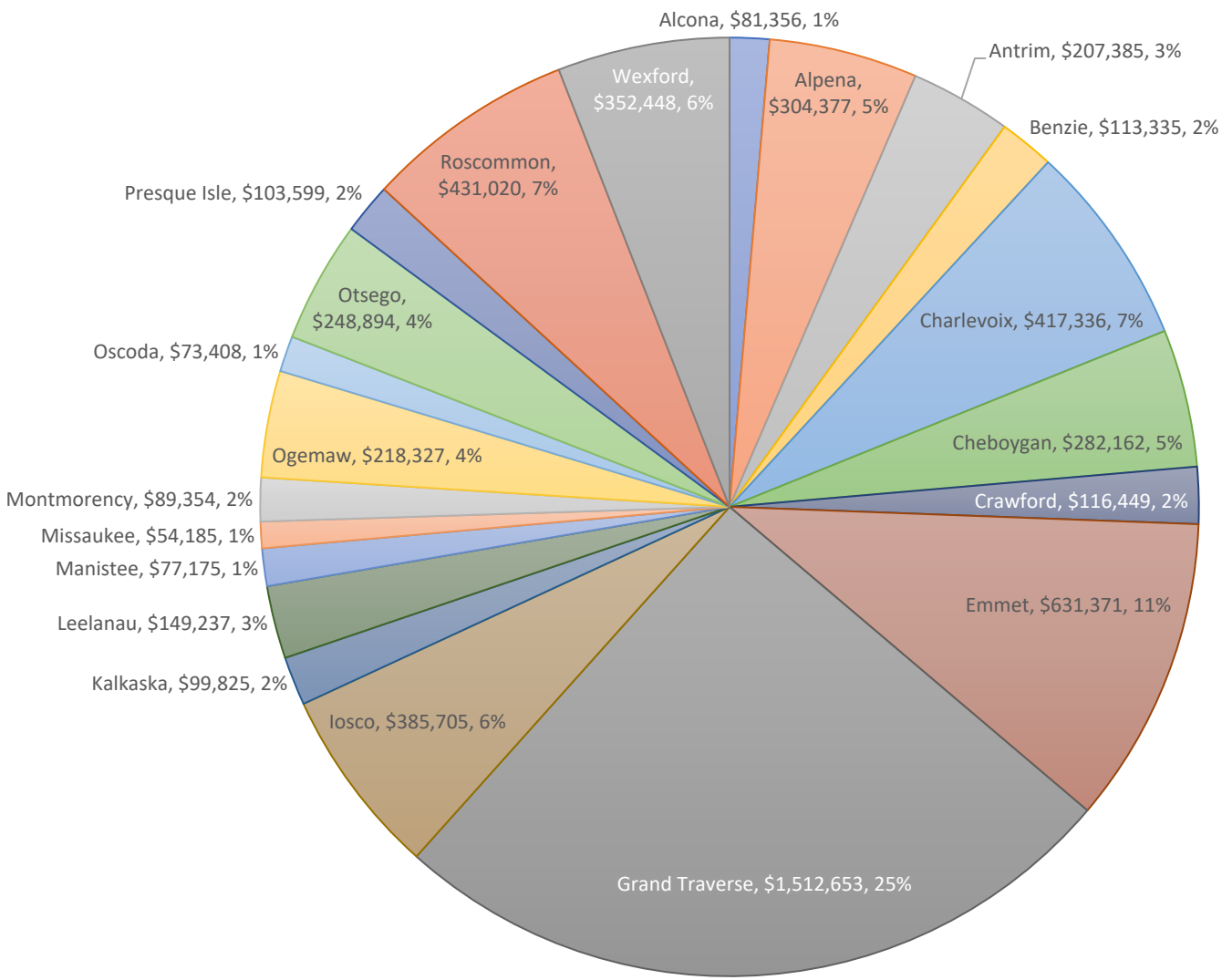
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through November 30, 2021

County	Beginning Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
Alcona	$ 88,107	$ -	6,036	$ 715	$ 81,356
Alpena	326,729	-	20,388	1,965	304,377
Antrim	218,487	-	9,494	1,608	207,385
Benzie	118,479	-	3,931	1,213	113,335
Charlevoix	432,993	-	13,852	1,805	417,336
Cheboygan	303,118	-	19,205	1,751	282,162
Crawford	121,414	-	4,005	960	116,449
Emmet	648,645	-	14,983	2,291	631,371
Grand Traverse	1,612,893	-	93,902	6,338	1,512,653
Iosco	401,902	-	14,459	1,737	385,705
Kalkaska	109,739	-	8,696	1,217	99,825
Leelanau	162,144	-	11,412	1,495	149,237
Manistee	84,324	-	5,464	1,686	77,175
Missaukee	63,191	-	7,971	1,035	54,185
Montmorency	96,078	-	6,084	639	89,354
Ogemaw	228,036	-	8,261	1,448	218,327
Oscoda	78,291	-	4,310	572	73,408
Otsego	257,837	-	7,249	1,694	248,894
Presque Isle	111,192	-	6,710	883	103,599
Roscommon	442,922	-	10,252	1,650	431,020
Wexford	372,430	-	17,685	2,297	352,448
	6,278,950	-	294,350	35,000	5,949,601
PA2 Redirect					-
					5,949,601

PA2 Funds by County

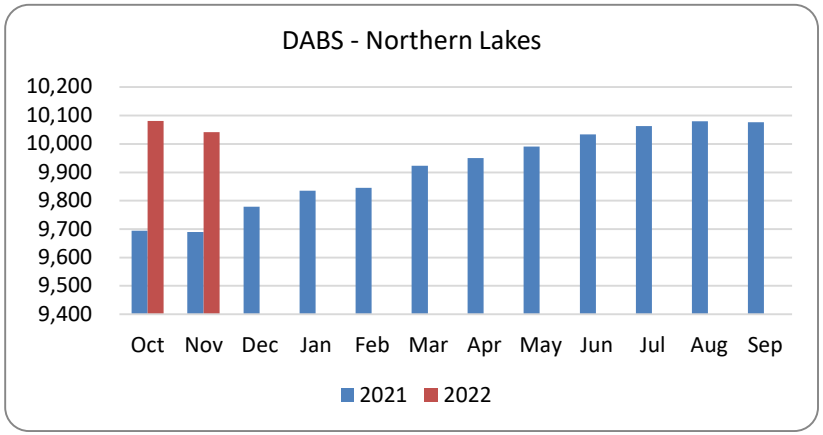


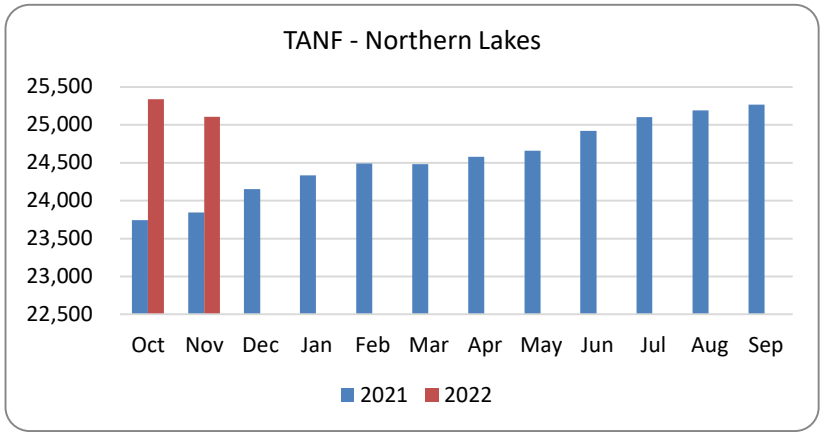
Northern Michigan Regional Entity

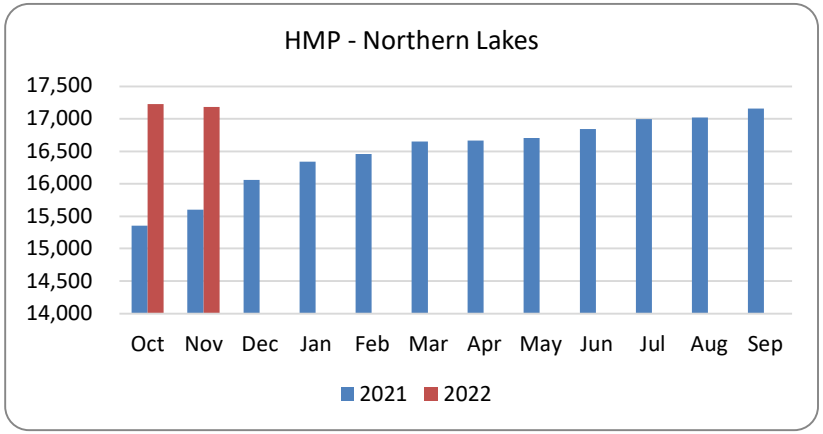
Narrative

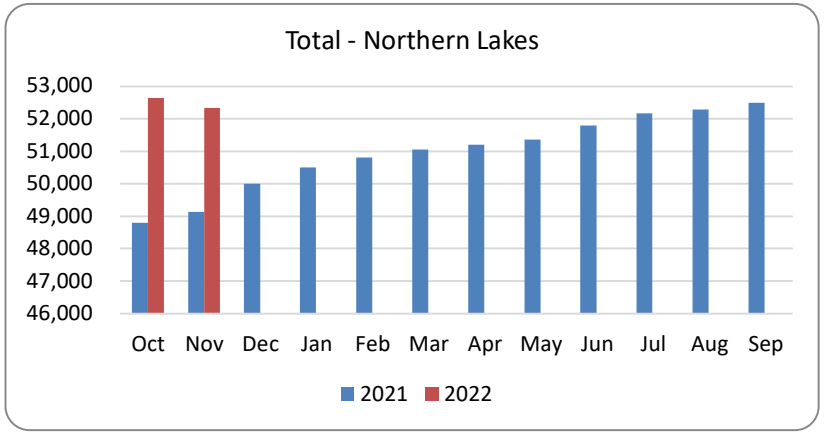
October 1, 2021 through November 30, 2021

Northern Lakes Eligible Trending







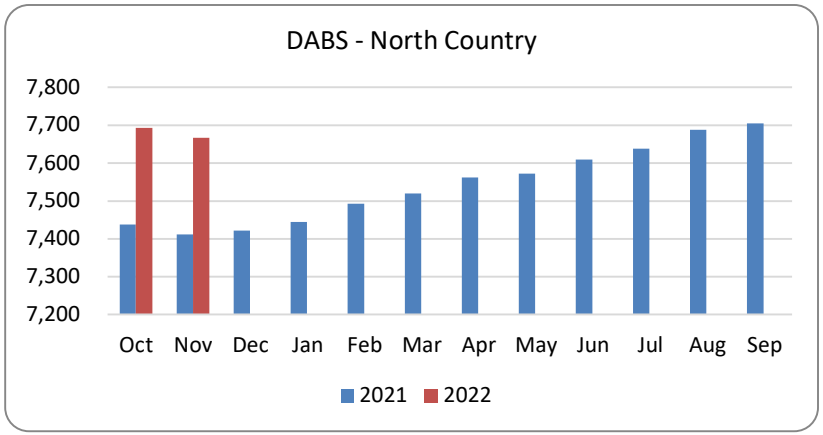


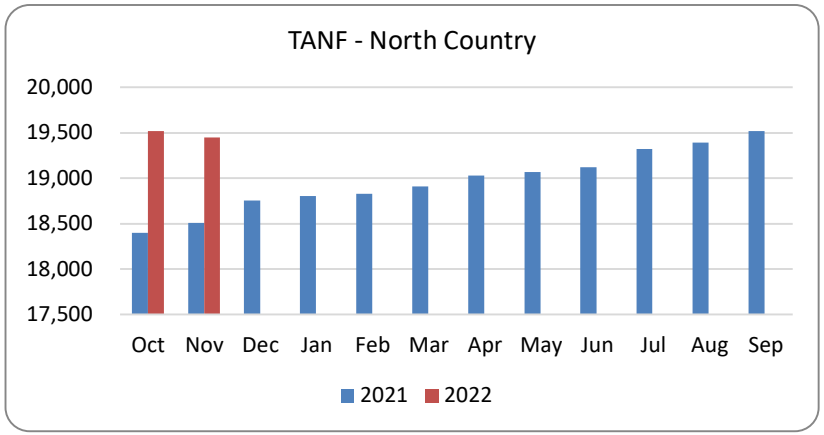
Northern Michigan Regional Entity

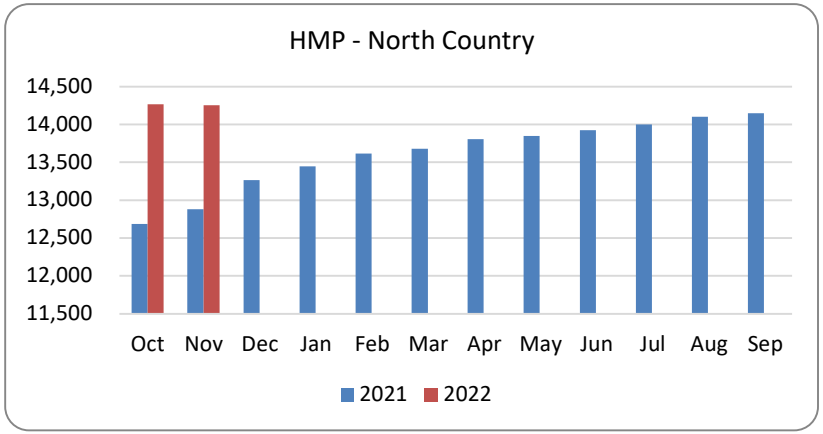
Narrative

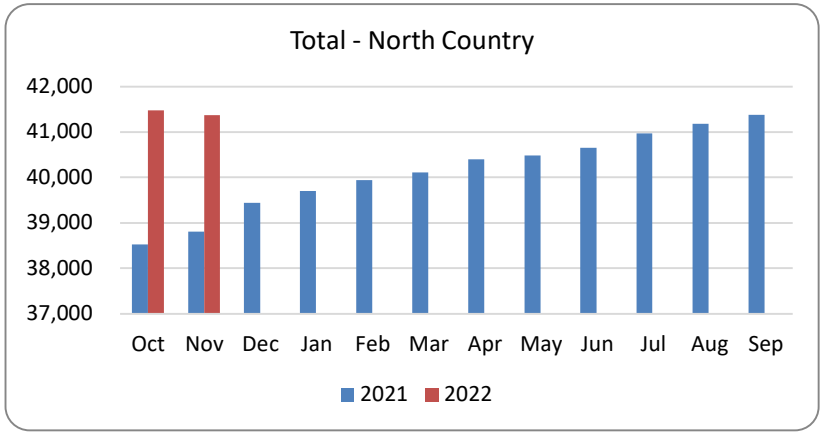
October 1, 2021 through November 30, 2021

North Country Eligible Trending







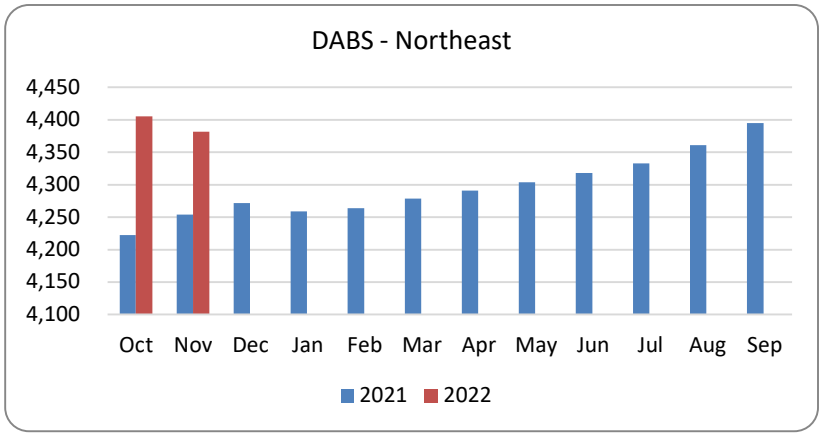


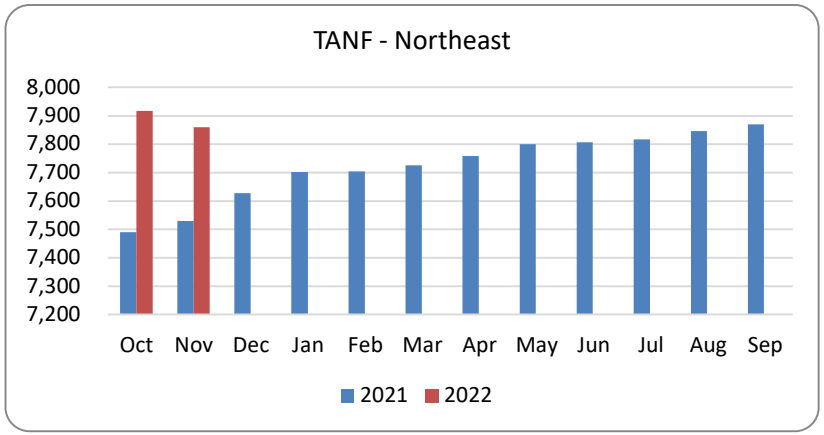
Northern Michigan Regional Entity

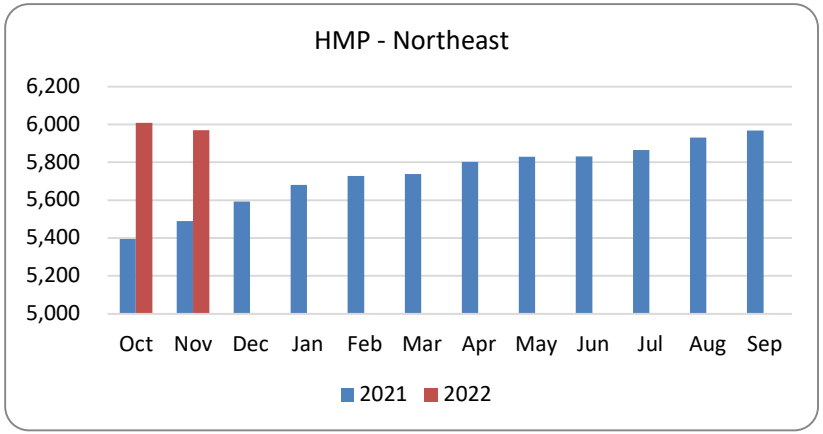
Narrative

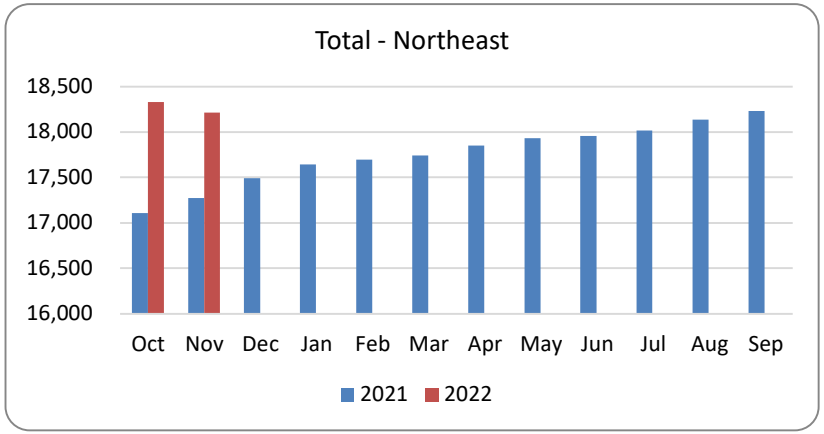
October 1, 2021 through November 30, 2021

Northeast Eligible Trending







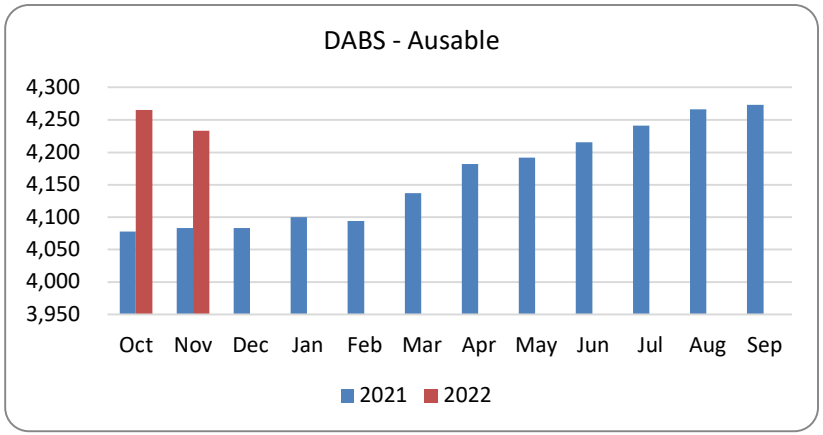


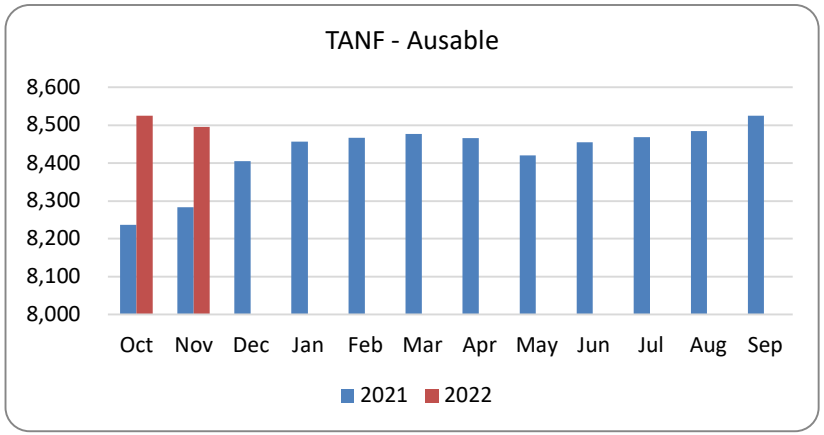
Northern Michigan Regional Entity

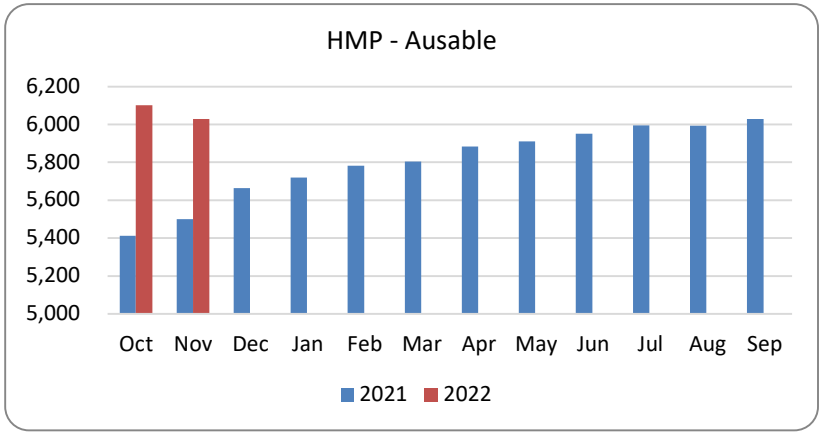
Narrative

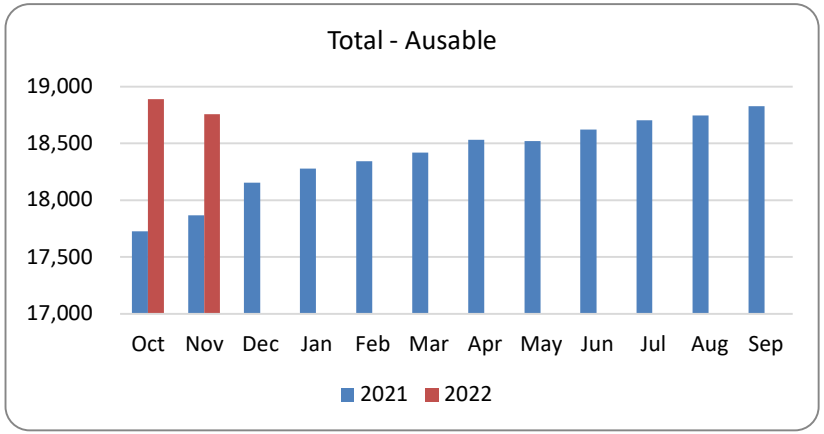
October 1, 2021 through November 30, 2021

Ausable Valley Eligible Trending







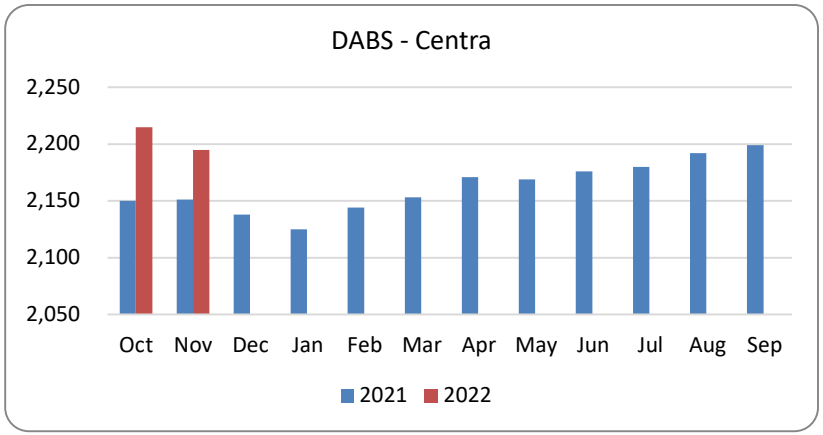


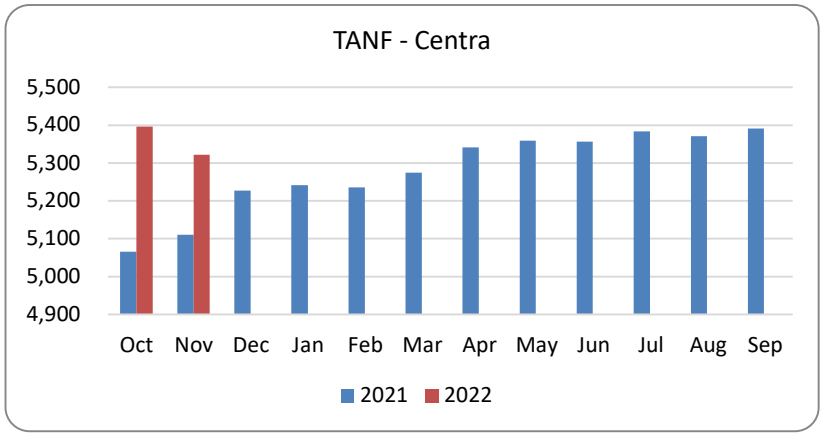
Northern Michigan Regional Entity

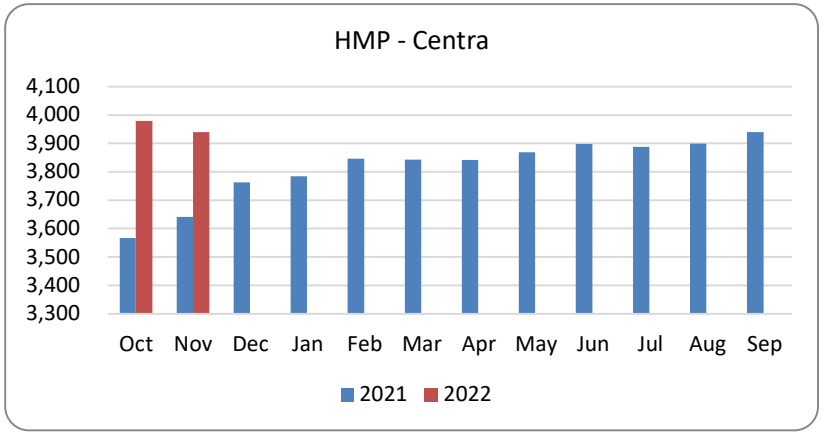
Narrative

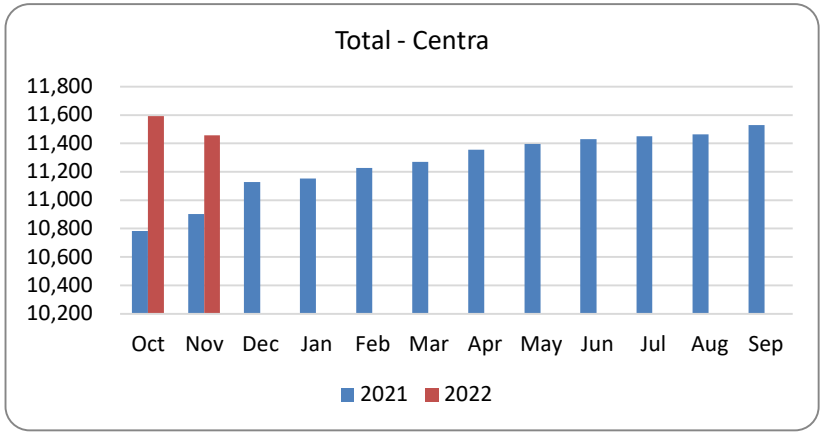
October 1, 2021 through November 30, 2021

Centra Wellness Eligible Trending







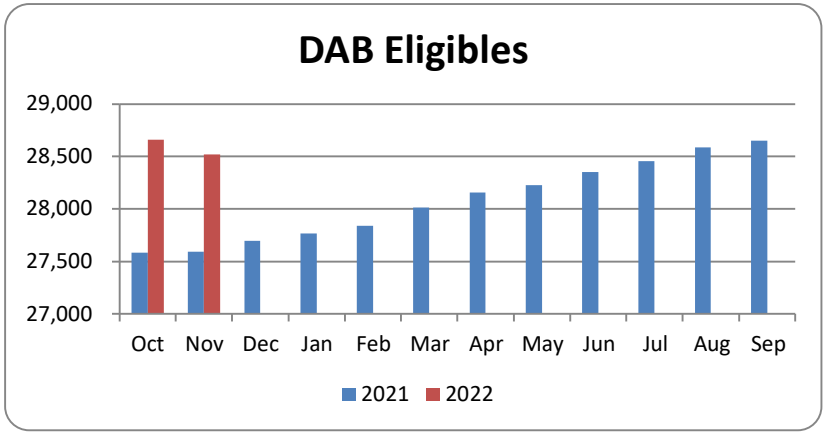


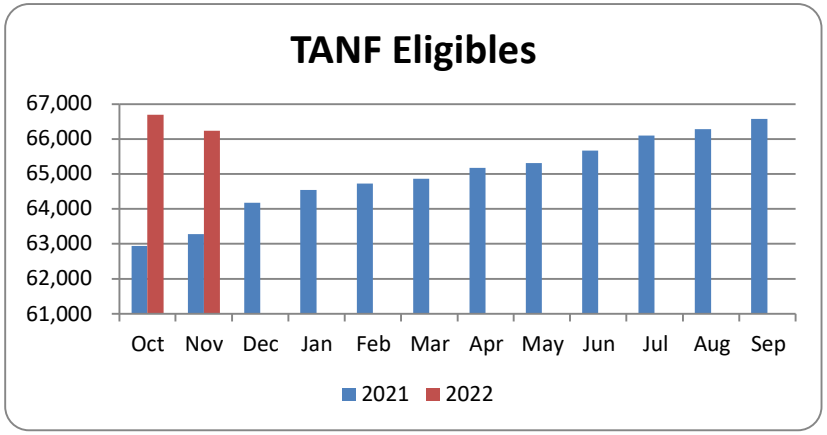
Northern Michigan Regional Entity

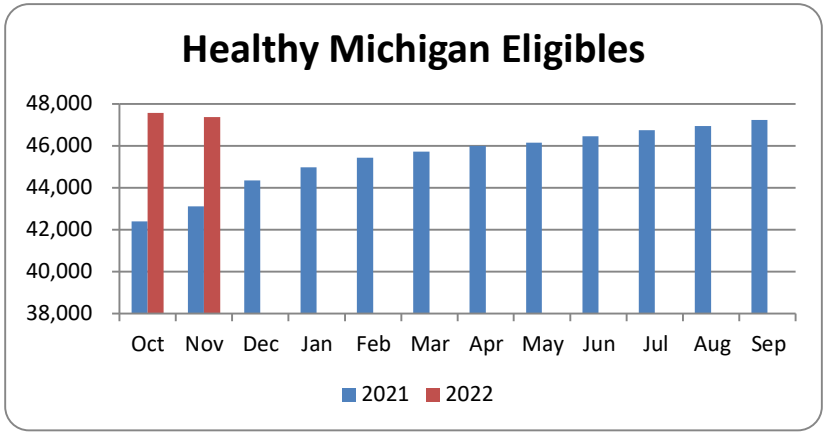
Narrative

October 1, 2021 through November 30, 2021

Regional Eligible Trending





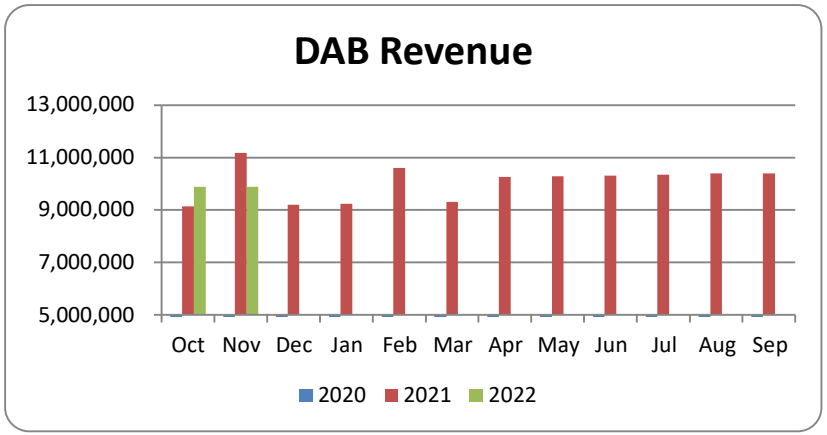


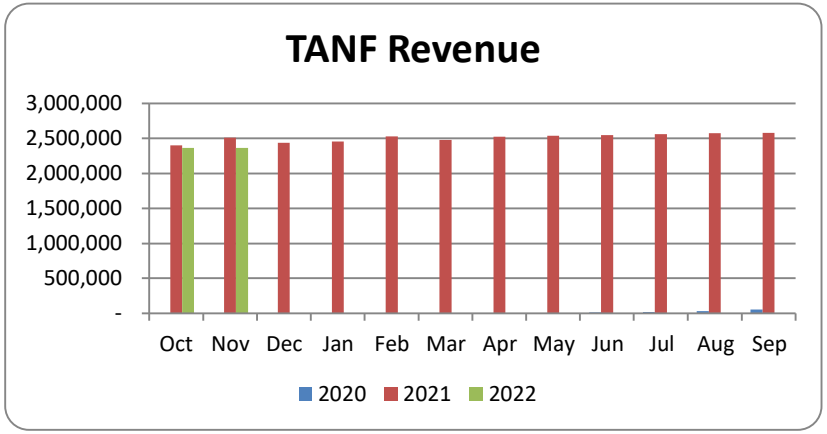
Northern Michigan Regional Entity

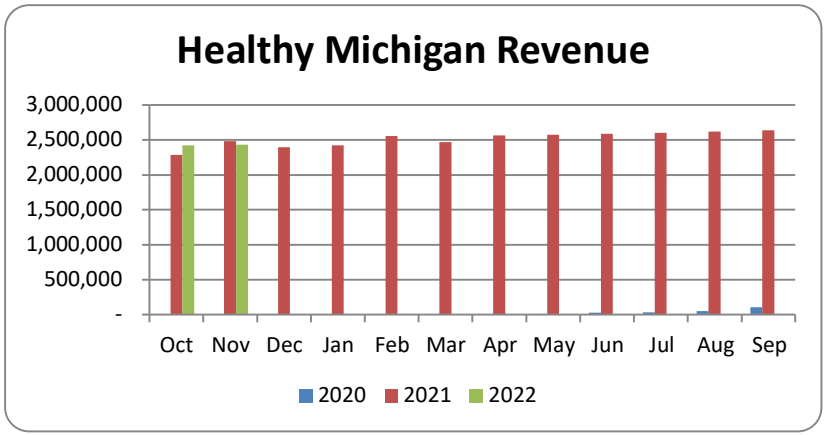
Narrative

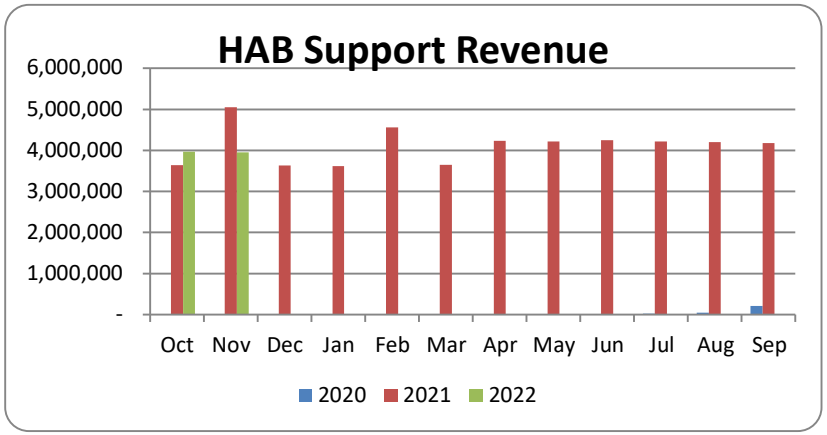
October 1, 2021 through November 30, 2021

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – JANUARY 18, 2022
GAYLORD CONFERENCE ROOM

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

REVIEW AGENDA & ADDITIONS
COB Workgroup/Finding Sources Document was added to the meeting Agenda.

APPROVAL OF PREVIOUS MEETING MINUTES
The December minutes were included in the meeting materials in draft form.

MOTION BY CHRISTINE GEBHARD TO APPROVE THE MINUTES OF THE DECEMBER 20, 2021 NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE MEETING; SUPPORT BY DIANE PELTS. MOTION APPROVED BY CONSENSUS.

FINANCE COMMITTEE AND RELATED
November Financials

- Traditional Medicaid showed $33,635,159 in revenue, and $28,596,944 in expenses, resulting in a net surplus of $5,038,215. 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 $5,294,270 in revenue, and $3,738,856 in expenses, resulting in a net surplus of $1,555,414. 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 $6,593,629. Medicaid carry forward was reported as $16,358,496. The total Medicaid and HMP Current Year Surplus was reported as $21,510,645. 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 $37,869,141.
- Health Home showed $186,406 in revenue, and $151,675 in expenses, resulting in a net surplus of $34,731.
- SUD showed all funding source revenue of $3,835,348, and $2,915,418 in expenses, resulting in a net surplus of $919,930. Total PA2 funds were reported as $5,949,601.

The Direct Care Wage surplus was anticipated as $1,441,480. It was noted that the additional $0.35 in FY22 DCW will not be included in the revenue until April.

Ms. Yockey shared a shared revenue analysis comparing Q1 FY22 revenue with Q1 FY21.

	HSW	**Medicaid/HMP**	**Total Q1**
FY21 Quarter 1	$12,130,943	$43,036,880	$55,167,823
FY22 Quarter 1	$11,874,062	$43,719,574	$55,593,636
Increase (Decrease) from FY21	($256,881)	$682,693	**$425,813**

MOTION BY CHRISTINE GEBHARD TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2021; SUPPORT BY NENA SORK. MOTION APPROVED BY CONSENSUS.

COB WORKGROUP/FINDING SOURCES DOCUMENT

The proposed reporting template and the EDIT COB Subgroup meeting notes for January 4th were shared with the Committee earlier on this date; reporting is intended to categorize funding sources that ties to the EQI. On the IT side, discussions are occurring at the State about requiring the submission of Coordination of Benefits loops in the EDI (837 files). MDHHS is hoping to implement this by October 1, 2022. A COB subgroup meeting is scheduled for later on this data and a training/discovery webinar is scheduled for on January 21st.

FY22 BUDGET STABILIZATION

The Committee discussed the opportunity of opening Crisis Stabilization Units within the Region. Ms. Gebhard discussed the Emergency Psychiatric Assessment, Treatment, and Healing/EmPATH model; EmPATH is an innovative approach to emergency mental health care designed to guide people safely through a current crisis while building coping skills that will guide them through future challenges. She has a meeting scheduled with McLaren and Spectrum Health Butterworth Hospital to further discuss.

Ms. Gebhard reported that she is currently getting bids for the remodel of the proposed site in Gaylord; completion is anticipated in May or June. Staffing shortages continue to be an issue. Staff sharing arrangements were discussed. Ms. Blamer reported on some initiatives currently underway at Northern Lakes to recruit staff including ad spots on TV 7&4/UpNorthLive and geofencing.

It was noted that Provider Stability payments may continue at this time. The U.S Department of Health and Human Services (HHS) has extended the federal public health emergency through April 16, 2022.

HSW SLOTS

The region currently has 20 open HSW slots, with 5 pending for enrollment. The Boards were encouraged to submit packets.

1915(i) DISCUSSION

The 1915(i) SPA will authorize the provision of Home & Community Based Services to Medicaid beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability. An extension has been requested to push the effective date out to 2023. The potential impact is 2800 individuals for Region 2. Mr. Kurtz noted that if the State denies and individual, the appeal comes to the PIHP and the PIHP has to supply due notice. Ms. Gebhard stressed the need to notify advocacy groups.

MCPAR REPORTING REQUIREMENTS

Memo from Audra Parsons dated January 11, 2022 was included in the meeting materials. MDHHS is asking PIHPs to fill out a portion of the requested information in The Managed Care Program Annual Report (MCPAR) rather than modify the existing Grievance and Appeal reports that are submitted on a quarterly basis. The Initial report will be due to CMH on June 20, 2023 for FY22. Audra Parsons and Lyndia Deromedi will be visiting the NMRE to review the process.

MDHHS AUDIT CAP

Issues continue with the verification of QIDP/QMHP. During the site review process, MDHHS is citing staff for not being a QIDP or being supervised by a one even if the staff have been there for 15+ years. They want quite a bit of personnel information to verify that the person was a QIDP when they were hired (even if, at the time of hire there, was no such thing as a QIDP). The Boards are having difficulty proving that some individuals who have been employed for a long time were QIDPs at the time of hire and/or their supervisors (which have often changed several times over the years) were QIDPs as well.

CRISIS STABILIZATION UNITS

The Concept Paper for Crisis Stabilization Units in Michigan (pursuant to PA 402) from Public Sector Consultants was included in the meeting materials. CSUs are meant to provide a short-term alternative to emergency department and psychiatric inpatient admissions for individuals who can be stabilized through treatment and recovery coaching within 72 hours.

The NMRE's Plan of Correction with the State was extended to January 28, 2022. Mr. Kurtz has communicated with Kendra Brinkley about the use of ICSS units in rural areas. It was noted that Northeast Michigan has an active ICSS program and promotes the service on its website.

SENATE BILLS, NORTHERN MICHIGAN COUNTY ASSOCIATION

The Northern Michigan County Association met with Sen. VanderWall recently and expressed their opposition to SB 597 & 598. Sen. Shirkey will be meeting with the Northern Michigan County Association on February 7th.

CMS MANDATE

Clarification was made that the CMS Vaccine Mandate only applies to New Center Community Mental Health (Detroit) & Oakland Child, Adolescent, and Family Center (Clarkston) in Michigan.

NEXT MEETING

The next meeting was scheduled for 9:30AM on February 15, 2022.

email correspondence

From: Naeyaert, Lindsey (DHHS-Contractor)
To: Adam Hamilton; Andrew Kulie; Ashlee Wililams; Branislava Arsenov (NMRE); Brittany Davis; tkangas; Dr. Zakia Alavi; Emily Patterson; Eric Kurtz (NMRE); Frances Kolody; Heidi Serven (NMRE); Joan Wallner; Judi Brugman; Katreena Hite; Kimberly Flowers; Megan Rooney; Morgan Breaugh; Nicole Dorie; rwedin; Sandra Lambert; Tami LeBlanc; Ying Ly
Cc: Jon Villasurda (State); Kelsey Schell (MI)
Subject: TCM and BHH Guidance
Date: Wednesday, January 19, 2022 2:50:59 PM
Attachments: image001.png

Good afternoon,

I'm writing to provide you with updated guidance regarding beneficiaries enrolled in Behavioral Health Home (BHH) and receiving Targeted Case Management (TCM) services. Through our research and work with external consultants, it has been concluded that TCM and BHH do have service overlap but are not wholly duplicative. Meaning, BHH and TCM can be billed in the same month. With that said, the chart below identifies those services that cannot be billed to both TCM and BHH in the same calendar month. For the avoidance of doubt, providers must bill either BHH or TCM for the services identified below. This information will be added to the BHH Handbook in February. Please reach out should you have any questions. Thank you!

Behavioral Health Home Service Definition	Included as Part of TCM
Comprehensive Care Management	
• *Conducting outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers.*	Yes
• *Completing a comprehensive needs assessment.*	Yes
• *Developing a comprehensive person-centered care plan.*	Yes
Care Coordination	
• *Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee's support member(s) and primary and specialty care providers.*	Yes
• *Participating in hospital discharge processes to support the enrollee's transition to a non-hospital setting.*	Yes
• *Communicating and consulting with other providers and the enrollee and enrollee's support member, as appropriate.*	Yes
Referrals to Community/Social Support Services	
• *Providing referral and information assistance to*	Yes

individuals in obtaining community-based resources and social support services;	
• *Identifying resources to reduce barriers to help individuals in achieving their highest level of function and independence.*	Yes
• *Monitoring and follow up with referral sources, enrollee, and enrollee's support member, to ensure appointments and other activities, including employment and other social community integration activities, were established and enrollees were engaged in services.*	Yes

Lindsey Naeyaert, MPH
Behavioral Health Innovation Specialist
Behavioral Health and Developmental Disabilities Administration
Michigan Department of Health and Human Services
naeyaertl@michigan.gov
Office: (517)-335-0076
Cell: (517)-896-9721

email correspondence

From: Chip Johnston
To: Eric Kurtz (NMRE); Don Tanner
Subject: FW: NMCA member list and meeting
Date: Friday, January 14, 2022 9:19:26 AM
Attachments: image001.png

From: Alan Bolter <ABolter@cmham.org>
Sent: Friday, January 14, 2022 9:09 AM
To: Robert Sheehan <rsheehan@cmham.org>; Tammy Warner <twarner@montcalmcare.net>; LisaH@WMCMHS.org; John Obermesik <jobermesik@cmhcm.org>; Chris Pinter <cpinter@babha.org>; Chip Johnston <CJohnston@centrawellness.org>; Diane Pelts <diane.pelts@avcmh.org>; Christine Gebhard <cgebhard@norcocmh.org>; Joanie Blamer <joanie.blamer@nlcmh.org>
Cc: Jon Smalley <JSmalley@mhsa.com>
Subject: FW: NMCA member list and meeting

All,

I wanted to give you a heads up that Sen. Shirkey will be meeting with the Northern Michigan County Association on February 7 to discuss his SBs 597 & 598. This group met with Sen. VanderWall recently and they expressed their opposition to the Shirkey legislation. This will be a good opportunity for this group to really speak out against Sen. Shirkey and his intent behind the bills. Below is the list of commissioners who are a part of the group, if you have any of them on your board or have a good relationship with them it is probably worth talking to them to make sure they fully understand what is at stake. MAC does have all our talking points / one-pagers etc, but it might be good for you to reach out to give them a quick refresher. This group could be a powerful voice on our behalf.

Let me know if you have any questions.

Bill Thompson- Alcona County
Kevin Osbourne- Alpena County
Christian Marcus- Antrin County
Bobbe Burke- Arenac County
Art Jeannot- Benzie County
Steve Warfield- Cheyboygan County
Neil Ahrens- Emmet County

Karen Moore- Gladwin County
Terry Dutcher- Iosco County
Jerry Jaloszynski- Isabella County
Don Arquette- Lake County
Chet Janik- Leelanau County *Admin
Richard Schmidt- Manistee County
Jody Hartley- Mason County
Scott Noesen- Midland County
Frank Vanderwal- Missaukee County
Mike Beach- Montcalm County
Jim Maike- Newaygo County
Ron Christians- Oceana County
Jenny David- Ogemaw County
Tim Michell- Osceola County
Jackie Bondar- Oscoda County
Ken Glasser- Otsego County
Robert Schneider- Roscommon County
Gary Taylor- Wexford County

From: Meghann Keit <keit@micounties.org>
Sent: Friday, January 14, 2022 8:16 AM
To: Alan Bolter <ABolter@cmham.org>
Subject: NMCA member list and meeting

Hi Alan,

Here is a list of county delegates included in the Northern Michigan County Association. It is usually a good turnout to the meetings- the next one if Feb 7th with Sen. Shirkey re MH reform. I imagine many will turn out for this… as mentioned, I unfortunately am unable to attend that day, but Deena will be in my place.

Bill Thompson- Alcona County
Kevin Osbourne- Alpena County
Christian Marcus- Antrin County
Bobbe Burke- Arenac County
Art Jeannot- Benzie County
Steve Warfield- Cheyboygan County
Neil Ahrens- Emmet County
Karen Moore- Gladwin County
Terry Dutcher- Iosco County
Jerry Jaloszynski- Isabella County
Don Arquette- Lake County
Chet Janik- Leelanau County *Admin
Richard Schmidt- Manistee County

Jody Hartley- Mason County
Scott Noesen- Midland County
Frank Vanderwal- Missaukee County
Mike Beach- Montcalm County
Jim Maike- Newaygo County
Ron Christians- Oceana County
Jenny David- Ogemaw County
Tim Michell- Osceola County
Jackie Bondar- Oscoda County
Ken Glasser- Otsego County
Robert Schneider- Roscommon County
Gary Taylor- Wexford County

Meghann Keit-Corrion
Governmental Affairs Associate
keit@micounties.org
Cell: (989) 225-8049

Capital Tower
110 W. Michigan Ave., Suite 200
Lansing, MI 48933
www.micounties.org
(800) 258-1152 (p) 517-482-4599 (f)

NMRE FY 2021 QAPIP Evaluation Summary Report

And

2022 QAPIP Workplan

Approved By	Date
Operations Oversight Committee (OOC)	
Quality Oversight Committee (QOC)	
Operations Committee	
Board of Directors	

1. Performance Improvement Projects (PIPs)

a. Increasing Diabetic Screenings for Consumers with SMU Prescribed an Antipsychotic Medication

While the Diabetic PIP is in maintenance mode, NMRE continues to monitor the progress of the CMHSPs. The Diabetic PIP data was shared bi-annually with the CMHSPs for their review and to identify areas for improvement. This is the last year working with this PIP.

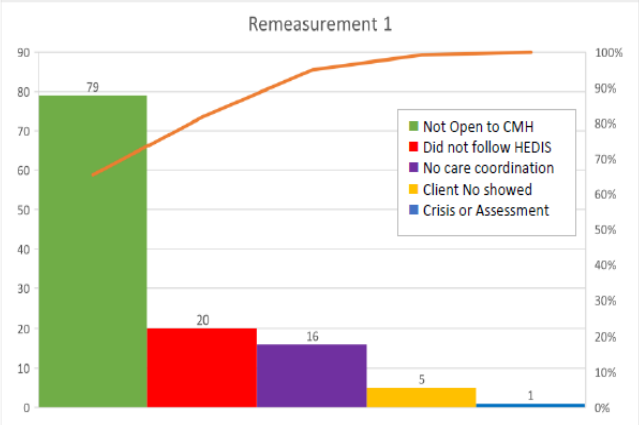
b. Follow-up Care for Children Prescribed ADD Medication (ADHD)

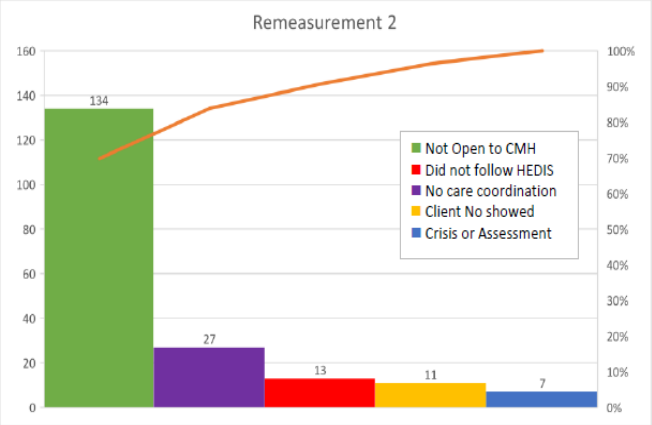
The NMRE uses a third-party data collection company called AFIA, to supply the data regarding the HEDIS measures. The data that AFIA provides is based on data they receive from the State of Michigan's claims' warehouse. Once received NMRE reviews to assure data accuracy.

There were a series of data challenges which produced highly skewed baseline data. As a result of the inaccurate baseline data, the NMRE was not able to meet the requirements of this PIP. However, monthly reports of individuals that were found to be non-compliant were provided to the CMHSPs for review. This allowed the CMHSPs to investigate those cases and complete the Causal Barrier Analysis (CBA). This data was also discussed quarterly at the QOC meetings.

NMRE ADHD PERFORMANCE IMPROVEMENT PLAN RE-MEASUREMENT 1 VS. REMEASUREMENT 2

	Remeas 1 AVCMH	Remeas 2 AVCMH	Remeas 1 CWN	Remeas 2 CWN	Remeas 1 NCCMH	Remeas 2 NCCMH	Remeas 1 NeMCMH	Remeas 2 NeMCMH	Remeas 1 NLCMH	Remeas 2 NLCMH	Total Remeas 1	Total Remeas 2
Crisis or Assessment	0	0	0	0	0	5	1	0	0	6	1	11
Client No showed	5	2	0	1	0	2	0	1	0	1	5	7
Not open to CMH at time Medication was prescribed.	12	24	13	10	23	32	6	21	25	47	79	134
No care coordination between CMH and prescribing provider	0	1	6	14	7	8	1	0	2	4	16	27
Did not follow HEDIS Prescribing procedure	8	1	0	1	5	7	6	2	1	2	20	13
Total	25	28	19	26	35	54	14	24	28	60		





2. Satisfaction Surveys

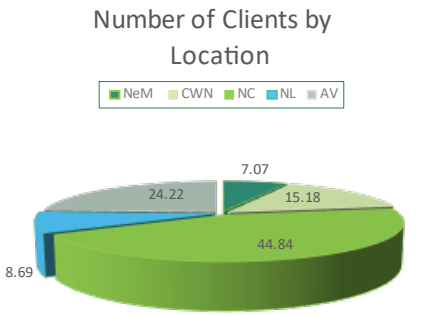
The NMRE conducted five satisfaction surveys in 2021.

1. Mental Health Services Survey - April 1st-April 22, 2021.
2. Home Base Services Survey – ongoing; given to consumers at close of case.
3. Substance Use Disorder (SUD) Survey
    a. Methadone - January 1st-Jan. 18th, 2021
    b. Detox - January 1st-Jan 18th
    c. Outpatient/SUD OHH- July 1st -July 23rd

a) **The Mental Health Services Survey** was consolidated: Outpatient Therapy, Medical Services, Adult Case Management, Youth Case Management, Assertive Community Treatment (ACT), Opioid Health Home (OHH), Peer Support Services, and Clubhouse Services.

Participation

- Total Responses: 853
- Total Served: 6,512
- Participation Rate: 13.1%



Location	# of Clients Completing Survey
Northeast Michigan CMH	61
Centra Wellness Network	131
North Country CMH	387
Northern Lakes CMH	75
AuSable Valley CMH	209

Key areas of improvement include:

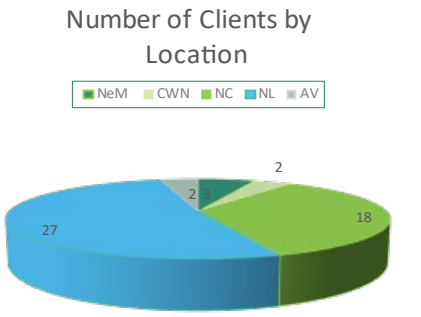
- Implement better survey administration and communication process.
- Improve information sharing and implementation of the grievance and appeals process.
- Share more information on OHH program to both staff and clients.
- Improve communication between staff and clients regarding coordination of care paperwork.

Overall, all CMHSPs scored above 90% in the areas of cultural competency, dignity, and respect, and communicating.

b) Home Based Services Survey was ongoing. It was given to consumers at the close of their case. Results were tallied at the end of the fiscal year and shared with the CMHSPs.

Participation

- Total Responses: 59

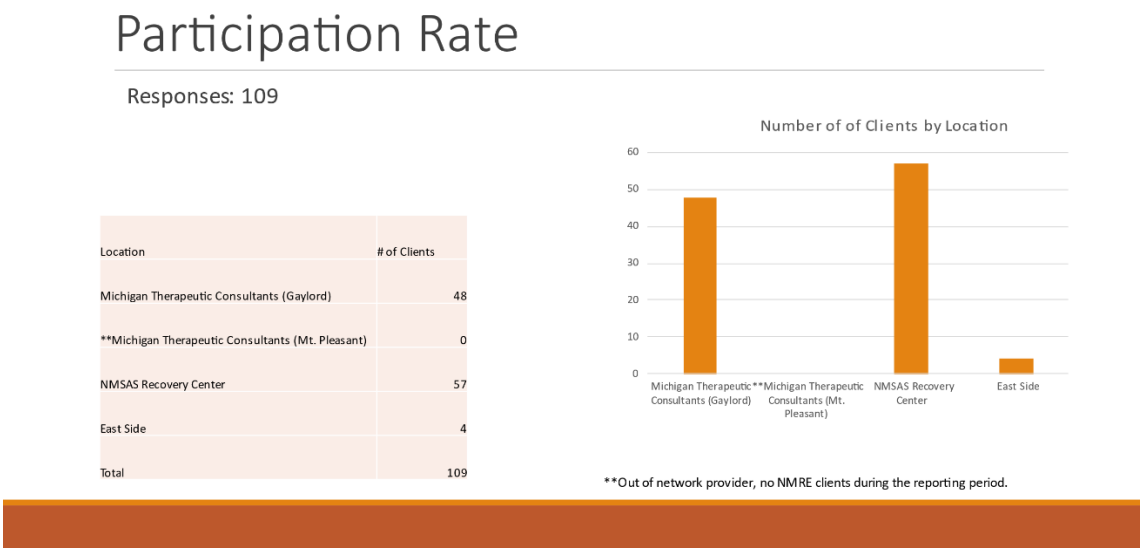


Location # of Clients Completing Survey	
Northeast Michigan CMH	3
Centra Wellness Network	2
North Country CMH	18
Northern Lakes CMH	27
AuSable Valley CMH	2

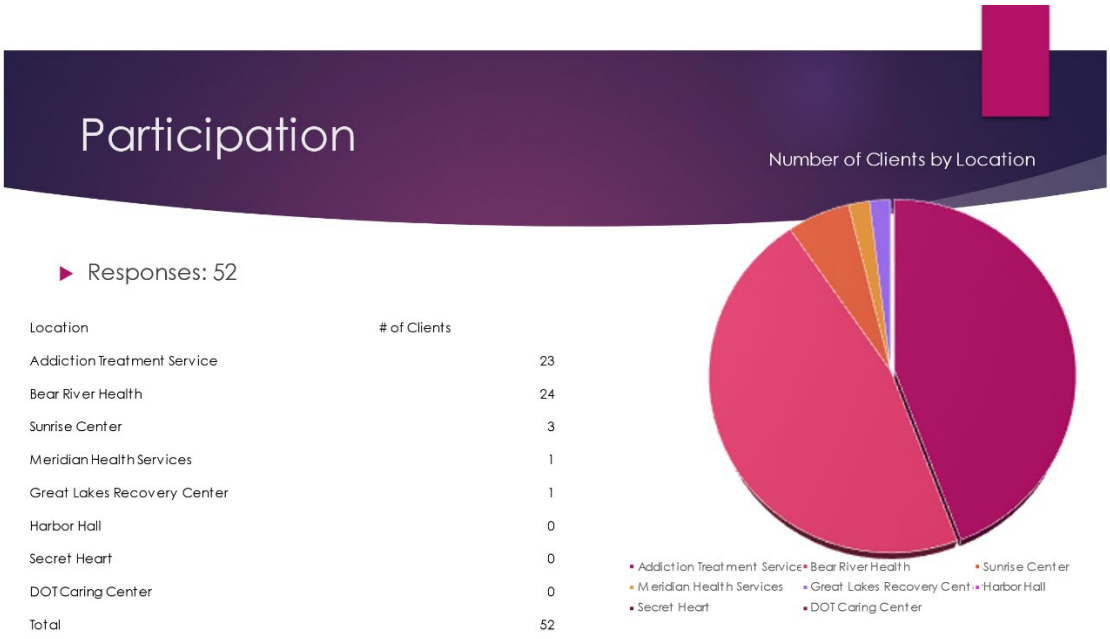
All CMHSPs scored above 85% in every area, indicating a decent level of satisfaction with the Home-Based Services Program. However, there are some opportunities for improvements mainly around information sharing.

c) Methadone – Providers scored above 95% in the areas of overall satisfaction, ease of access to their care team, comfort in asking questions about their treatment, recipient rights, information privacy, treatment goals, and funding.

The area that needs improvement is the need to share information about peer recovery support.



d) Detox - Regionally the participation rate was 93%. providers scored above 90% in the areas of cultural competency, dignity and respect, ease of access to the program, satisfaction with treatment during their stay, and speed of admission.



The areas in need of improvement were:

a. Sharing information regarding peer recovery support.

b. Discharge planning.

e) **Outpatient /SUD OHH –** Outpatient providers scored above 90% in all areas other than peer recovery support. Areas that scored above 95% included: explanation of services in a way the client could understand, information privacy, coordination of care, grievances, rights, funding, and recovery support resources.

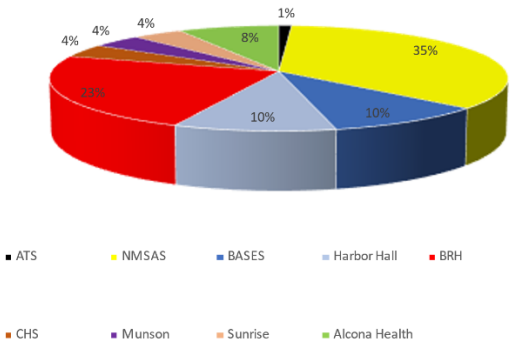
Participation

Outpatient Responses: 323

OHH Responses: 18

Total Responses: 341

Location	# of Clients
Addiction Treatment Service	3
Bear River Health	80
Sunrise Center	14
Catholic Human Services	15
Munson	12
Harbor Hall	34
BASES	35
NMSAS	120
GRACE Center	0
Traverse Health Clinic	0
Alcona Health	27
Thunder Bay	0



All survey results were shared with the providers and presented at the QOC meetings and SUD Directors meetings for discussions and learning opportunities. In the future, survey results will also be available on the NMRE website.

3. Performance Indicators

The NMRE continued to monitor data from the Michigan Mission Based Performance Indicator System. If a Provider fell below the standard for two consecutive quarters, a Corrective Action Plan was requested. No provider fell below the standard in 2021. Beginning April 1, 2020, MDHHS removed exceptions for Tables 2 and 3; the NMRE continued to monitor the impact of this change as part of its FY21 Work Plan. Performance Indicator reports were shared with the providers, the QOC and the NMRE Governing Board quarterly.

Table 1: Percentage Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition was Completed Within Three Hours ≥ 95%				
	1Q FY20	2Q FY20	3Q FY20	4Q FY20
Children	99.30%	99.49%	100%	98.82%
Adults	99.23%	99.02%	99.09%	99.27%
Totals	99.36%	99.13%	99.23%	99.18%

Table 2: The Percentage of New Persons Receiving a Face-to-Face Assessment with a Professional Within 14 Calendar Days of Non-Emergent Request for Services				
	1Q FY20	2Q FY20	3Q FY20*	4Q FY20*
MI Child	69.72%	72.04%	69.42%	54.96%
MI Adult	61.56%	65.97%	62.80%	52.29%
DD Child	81.82%	82.35%	70.67%	46.43%
DD Adult	80.77%	66.67%	62.16%	48.98%
total	65.52%	68.82%	65.49%	52.68%
Table 3: The Percentage of New Persons Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment With a Professional				
	1Q FY20	2Q FY20	3Q FY20*	4Q FY20*
MI Child	71.81%	75.47%	69.11%	63.92%
MI Adult	69.90%	74.76%	73.59%	68.05%
DD Child	86.89%	85.48%	76.92%	86.36%
DD Adult	86.96%	75.00%	79.17%	73.17%
total	72.17%	75.58%	72.29%	68.00%

Table 4a: The Percentage of Persons Discharged from a Psychiatric Inpatient Unit Who were seen for Follow-up Within 7 days ≥ 95%				
	1Q FY20	2Q FY20	3Q FY20	4Q FY20
Children	97.73%	100%	94.74%	100%
Adults	99.27%	98.74%	97.85%	97.83%
Total	98.50%	98.99	97.12%	98.39

Table 4b: The Percentage of Persons Discharged from a Substance Abuse Detox Unit Who were seen for Follow-up Within 7 days ≥ 95%

	1Q FY20	2Q FY20	3Q FY20	4Q FY20
SA	95.56%	91.18%	95.19%	80.65%

Table 6: The Percentage of Persons Readmitted to Inpatient Psychiatric Unit Within 30 Calendar Days of Discharge from a Inpatient Psychiatric Unit is 15% or Less				
	1Q FY20	2Q FY20	3Q FY20	4Q FY20
Children	9.62%	7.14%	8.57%	8.00%
Adults	11.27%	10.00%	11.92%	11.83%
Total	10.44%	9.46	11.21	11.02%

4. Annual Site Review

a) NMRE Site Review: The NMRE conducts regional CMH site reviews biannually where year one is a full review and year two is a review of the Corrective Action Plan (CAP) implementation. 2021 was a Corrective Action Plan (CAP) year for the NMRE's site review. This year the NMRE requested evidence of CAPs that were activated as a result of the 2020 NMRE site review. Upon review of the CAPs the Region was substantially compliant with the CAPs.

b) MDHHS Review: The team worked with the CMHSPs and MDHHS to complete the initial 2021 C Waiver (HSW, CWP, SEDW) review; this review occurs every other year. There were no outstanding trends among the 5 CMHSPs reviewed. However, there was a need for a technical assistance call with the five CMHSPs to clarify certain areas.

c) HSAG Review: The 2021 compliance review was the beginning of a new three-year cycle of HSAG compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable State contract requirements. The compliance review consists of 13 standards/program areas.

MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021). The remaining seven standards will be reviewed in Year Two (SFY 2022). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews.

The NMRE demonstrated compliance in 56 of 65 elements, with an overall compliance score of 86 percent, indicating that some program areas had the necessary policies, procedures, and initiatives in place to carry out many required functions of the contract, while other areas demonstrated opportunities for improvement. A CAP was submitted as required and the NMRE is actively working on implementing the CAPs aa indicated.

Below is a summary results of standards reviewed in SFY 2021.

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	7	0	0	**100%**
IV	Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
V	Coordination and Continuity of Care	14	14	14	0	0	**100%**
VI	Coverage and Authorization of Services	11	11	7	4	0	**64%**
	Total	**65**	**65**	**56**	**9**	**0**	**86%**

d) **SUD Provider Review:** The NMRE completed a full annual review of all SUD Providers in the region. This review process was a hybrid of in-person visit to all Providers as well as uploads of requested polices and program documents. The in-person visits were from June 3, 2021 – July 29, 2021. The DRAFT reports were submitted to the Providers for their review, and they were given a chance to submit any documentation they believed could have been missed.

2022 will be a CAP year, the NMRE will be requesting a Quality Improvement Plan (QIP) from each Provider in response to their individual review reports. The Compliance and Quality Department will be monitoring the QIP to verify that steps are taken, as reported, to correct any deficiencies.

Delegated Functions Administrative Review		Program Scores	Possible Scores	Not Applicable	Total Compliance Score
1	Information/Customer Service	297	336	0	88%
2	Enrollee Rights	286	336	24	92%
3	Grievance & Appeals	271	408	2	67%
4	Quality & Compliance	46	48	0	96%
5	Individual Treatment & Recovery Planning	296	312	0	95%
6	Coordination of Care/Quality Improvement	81	96	8	92%
7	Provider Staff Credentialing	391	408	14	99%
	Total	**1668**	**1994**	**48**	**88%**

Program Specific Services Review		Program Scores	Possible Scores	Not Applicable	Total Compliance Score
1	ASAM	48	48	0	100%
2	Residential	68	168	98	97%
3	Peer Recovery	18	24	6	100%
4	Women's Specialty Services	38	96	58	100%
5	Medication Assisted Programs	50	168	116	96%
6	Recovery Residences	35	216	180	97%
	Total	**257**	**720**	**458**	**98%**

Consumer		Program Scores	Possible Scores	Not Applicable	Total Compliance Score
1	Consumer Charts Totals	4424	12562	7264	84%

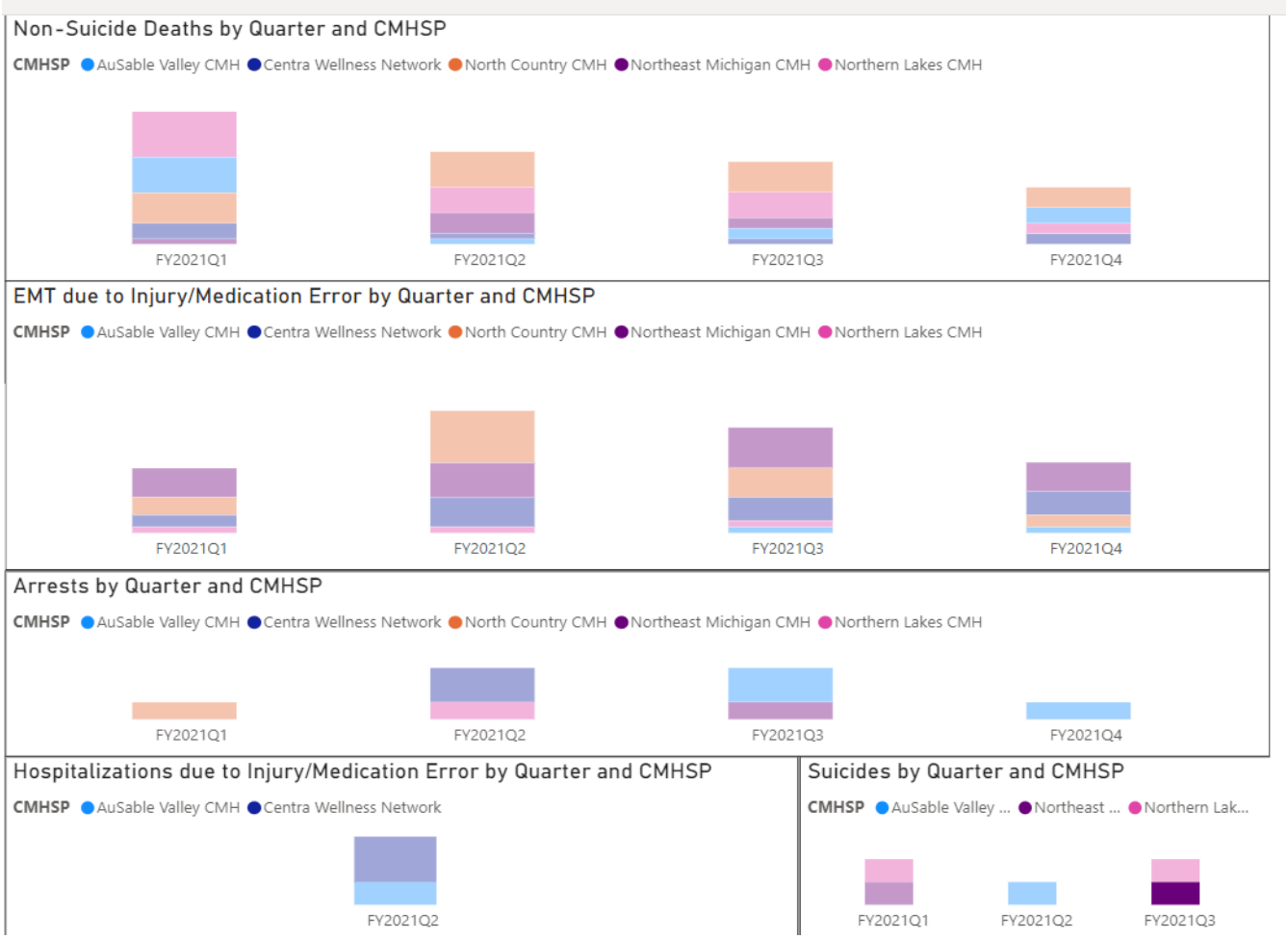
5. Critical Incidents, Sentinel Events and Risk Events

NMRE tracked critical incidents monthly. The total number of incidents in FY2020 compared to FY2021 increased from 123 to 149; an increase of 26 incidents.

Based on the analysis, most of the incidents were from Non-Suicide death. The second highest came from EMT due to Injury/Medication Error. Suicide also went up compared to 2020. Hospitalization due to injury or medication error and Arrest both went down.

Providers were required to complete an RCA on Sentinel Events. The NMRE Compliance and Quality team reviewed the RCA summary to ensure that proper corrective action plans were implemented. During site reviews, the team also reviews the implemented CAPs and the credentials of the staff involved.

NMRE FY 2020 and 2021 Critical Incident Comparison			
	FY 2020	**FY2021**	**Difference**
Suicide	1	5	↑**4**
Non-Suicide Death	47	71	↑**24**
EMT due to Injury/Medication Error	61	62	↑**1**
Hospitalization due to Injury/Medication Error	6	3	↓ **3**
Arrest	16	8	↓ **8**
Totals	**123**	**149**	↑**26**



Risk Events

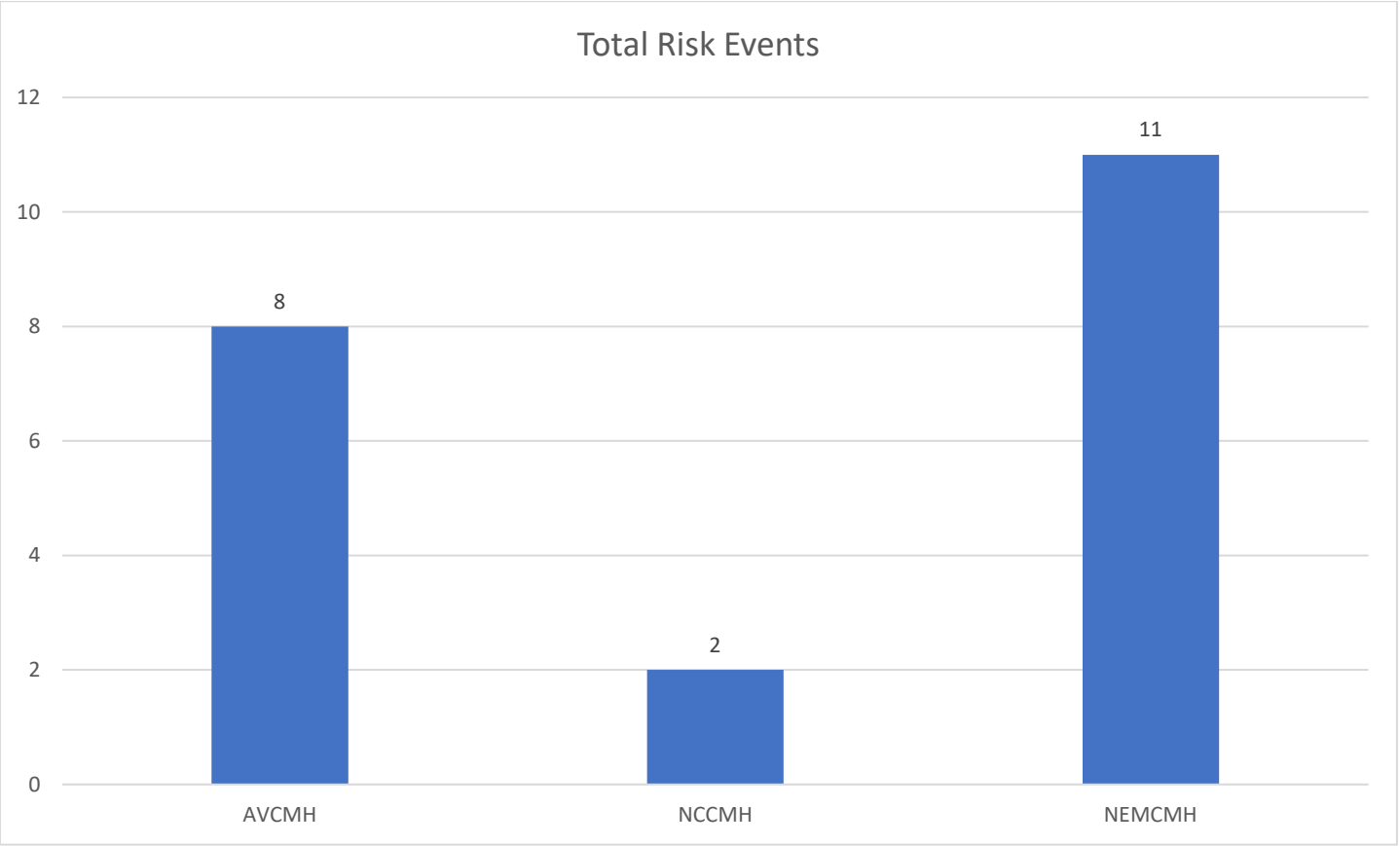
The collecting and analyzing of risk events data is a new process for the CMHSPs

Although there continue to be challenges with this data, some progress is being made.

Not all the CMHSPs provided timely data, but the group went ahead and analyzed what

was received for a start. The committee will continue to identify better ways to gather and analyze risk events data.

	Harm to Self	Harm to Others	Police Call	Emergency use of Physical Management due to a Behavioral Crisis	Physical Management	Unscheduled Hospitalization	Total Events
AVCMH	0	0	0	0	2	6	8
NCCMH	0	0	1	1	0	0	2
NEMCMH	2	0	9	0	0	0	11



6. Behavior Treatment

The NMRE had ongoing challenges with aggregating the behavior treatment data in a systematic way. This is because the collection of data from the five CMH providers has not been consistent with each other in the past. A new process has been implemented.

The five CMH providers will send their Behavioral Treatment Review Committee (BTRC) meetings minutes along with any trends identified during the BTRC meetings to the NMRE. These trends will be tallied quarterly and presented for discussion during the QOC meetings.

The NMRE will continue to work with the five CMH providers on this new process to best accommodate all involved and to adequately trend and review the data at a regional level for improvement.

FY22 Work Plan

Goal #1: The NMRE will conduct Performance Improvement Projects (PIPs) that will include ongoing measurements and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that are expected to have positive impact on health outcomes and member satisfaction.

Objective 1: The NMRE Data Analyst will continue to collect ADHD data and share with the CMHSPs to conduct analysis and follow up with individuals that meet criteria. This data will be discussed quarterly with QOC to identify areas for improvement.

Objective 2: The Compliance and Quality team will work with HSAG and MDHHS to identify a new PIP starting FY2022.

Goal #2: The NMRE Compliance and Quality team will continue to work with IT and QOC to develop a standardized method to collect data on risk events and sentinel events.

Objective 1: The NMRE Compliance and Quality team will draft a form that will be used to collect risk event data by the CMHSPs.

Objective 2: The NMRE Compliance and Quality team will share the Risk Event reporting form with the CMHSPs and continue to educate them on how to complete the form and the importance of this activity.

Objective 3: The NMRE Compliance and Quality (C&Q) team will review the reporting process and requirements of the events data with the providers to avoid under reporting by 09/30/22.

Objective 4: Through the annual site review process, the C&Q team will check to assure that interventions are improving patient safety. This will be done by reviewing the data submitted which will include the numbers or events.

Objective 5: The analysis of Sentinel Events, Critical incidents, and Risk Events will include a review of data per event type per 1,000 members to complete a comparative analysis and trend these data over time.

Goal #3: The NMRE will continue to conduct quantitative and qualitative assessments of member experiences with services. These assessments will be representative of the persons served and the services and supports offered.

Objective 1: The NMRE will revise survey questions to assure the right questions are asked and that the questions are returning meaningful data.

Objective 2: The NMRE will work with providers to identify ways to implement surveys in a way that will not cause survey fatigue amongst participants.

Objective 3: The NMRE will take specific actions on individual cases of the survey results as appropriate.

Objective 4: Survey results will be shared with QOC to discuss and identify possible solutions to resolve areas of dissatisfaction on an ongoing basis.

Objective 5: Survey results will be shared directly with providers and presented to the NMRE Board of Directors. Survey results will also be made accessible to participants and the public on the NMRE website.

Goal #4: The NMRE will measure its performance using standardized indicators based upon the systemic, ongoing collection and analysis of valid and reliable data.

Objective 1: The NMRE QOC will monitor comparative provider performance of quarterly MMBPIS measures within 30 days of the quarterly report from MHDDS.

Objective 2: NMRE will share performance data with CMHSPs for their review. This data will be discussed in QOC quarterly.

Objective 3: The NMRE QOC will continue to monitor the impact of removing exceptions for Tables 2 and 3 performance indicators by 09/30/2022.

Goal #5: The team will continue to monitor its Network Providers at least annually.

Objective 1: The NMRE will coordinate and conduct site reviews annually for all contracted service providers by 9/30/2022.

Objective 2: The NMRE will monitor and follow-up with corrective action plans to assure these CAPs are being implemented as stated by the network providers.

Objective 3: The NMRE QOC will receive regular updates from the providers on the progress of the site review CAPs.

Objective 4: The NMRE will perform quarterly audits to verify Medicaid and Healthy Michigan Plan claims/encounters submitted within the provider network. This will include verifying data elements from individual claims/encounters to ensure proper codes are used.

Goal #6: Update and improve NMRE Provider Directory and work with NMRE's contracted providers in the region to update their directories accordingly.

Objective 1: Gather information from NMRE's providers about physical accommodations such as ramps, restrooms, electronic doors, exams rooms, etc. to each specific location.

Objective 2: Create a more user-friendly interface; rather than a spreadsheet platform, this will include using drop down options, more visible links to CMH pages, and maps with travel distances.

Goal # 7: Update and improve the Network Adequacy Plan that will incorporate time/distance standards within the region.

Objective 1: The NMRE will create a report that will allow users to determine mileage from a geographic location to a provider clinic using network adequacy standards for each individual mental health and SUD provider service.

Objective 2: Once the network adequacy plan is in place, the NMRE will make it accessible to the public through its website.

Goal #8: The NMRE Compliance and Quality Team will conduct quarterly reviews and analyses of data from the CMHSP Providers where intrusive, or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.

Objective 1: The NMRE will monitor that only techniques permitted by the Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the member or his/her guardian may be used with members through annual site reviews by 9/30/2022.

Objective 2: QOC will oversee the operations of the Behavioral Health Treatment operations through 09/30/2022 by reviewing data and trends.

Objective 3: QOC will review/discuss behavior treatment data; this includes trends analysis received from individual CMHSPs quarterly through 12/31/2022.

Goal #9: NMRE will continue to improve the process to provide quarterly updates to the Governing Body regarding routine QAPIP activities.

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

Objective 2: The QAPIP quarterly evaluation report will be share with the NMRE Governing Board.

NMRE FY 2021 Compliance Program Evaluation Summary Report

And

2022 Compliance Workplan

Approved By	Date
Operations Oversight Committee (OOC)	
Quality Oversight Committee (QOC)	
Operations Committee	
Board of Directors	

The compliance program is about prevention, detection, collaboration and enforcement of the law, requirements from the federal, state, other regulatory bodies, and NMRE's compliance policies, procedures, and Code of Ethics.

1. **Compliance Activities:**
    a. Policies, Procedures, and Compliance documents: The following documents, policies, and procedures were created/updated approved and implemented in 2021:
        i. NMRE Code of Ethics
        ii. Compliance Program Manual
        iii. Information Systems Security Awareness Training
        iv. Non-Retaliation Policy and Procedure
        v. Provider Monitoring and Oversight Policy and Procedure
        vi. Provider Termination Policy and Procedure
        vii. SUD Recipient Rights Policy and Procedure
        viii. Peer Review Policy and Procedure
        ix. NMRE's Notice of Privacy Practice (NPP)
        x. Service Authorization Policy and Procedure
        xi. Denial of Payment Policy and Procedure
        xii. Utilization Management Attestation
    b. Consumer Material: The following information was created/updated, and disseminated to providers:

i. NMRE Newsletters: 3 annual publications: January, May, and September.
ii. Limited English Proficiency (LEP) Materials including Braille, large print versions of the Guide to Services and other materials, taglines, website information in machine readable format, American Sign Language (ASL) Interpreter information, language line information
iii. Guide to Services: 10,000 copies given to providers, bi-annual updates
iv. Informational posters
v. SUD brochures
vi. Advance Directive brochures
vii. Notice of Privacy Practice brochures
viii. Grievance, Appeal, and Second Opinion brochures
ix. Rights Information

2. Compliance Oversight

Current Compliance oversight activities include:

a. Exclusion/sanctions Verifications
    i. The NMRE completed exclusion checks for all NMRE employees, contractors, contract entities/providers and Board Members upon hire or extending a contract and monthly thereafter.

ii. The NMRE also completed monthly checks for SUD Providers, CMHSPs, and their Board Members.

iii. The databases that were searched included:

1. MI_SPL – Michigan Medicaid List of Sanctioned Providers
2. OIG – Office of Inspector General – List of Excluded Individuals/Entities
3. OIG_Most_Wanted – Office of Inspector General – Most Wanted Fugitives
4. SAM System for Award Management: Excluded Parties
5. SDN – Office of Foreign Assets Control – Specially Designated Nationals

b. Grievances, Appeals, and Right Complaints.

i. Grievances

This report shows the results of an analysis of reported grievances, and rights complaints by CMHSPs and SUD providers in Region 2 during FY21. The collected data included: grievance category, dates of receipt and closure, determination, and intervention. This data was utilized to identify grievance trends and pinpoint areas where corrective action was necessary to improve services as well as identify providers who were not adhering to state-mandated timelines for grievance resolution. The total number of reported Member's Served was 37,268.

Grievance Category	Number of Cases Closed	Percentage of Closed Cases	Number of Cases Substantiated	Number of Interventions	Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution
Quality of Care	130	39%	87	134	130	8
Access and Availability	50	15%	32	74	50	9
Interaction with Provider or Plan	69	21%	46	102	69	9
Member Rights	22	6.60%	7	34	22	7
Transportation	5	1.50%	5	5	5	8
Abuse, Neglect, or Exploitation	0	0%	0	0	0	0
Financial or Billing Matters	7	2.10%	4	11	7	7
Safety/Risk Management	10	3%	4	16	10	7
Service Environment	18	5.40%	14	22	18	7
Other	22	6.60%	11	23	22	9
TOTAL	**333**	**100%**	**210**	**421**	**333**	**8**

Out of 333 closed cases reported, 210 were substantiated and required corrective action. 39% of these cases were in connection with perceived quality of care. Of the 22 reported rights violations, 7 were substantiated and required corrective action. All 333 closed cases were completed, and notice was sent to interested parties within 90 calendar days.

ii. Appeals

The collected data included: type of case (standard or expedited), description of service being appealed, dates of receipt, notice of resolution, determination, and reason for the adverse decision. This data is utilized to identify appeal trends and pinpoint areas where corrective action is necessary to improve services as well as identify providers who are not adhering to state-mandated timelines for standard or expedited appeal resolution.

Reason for Adverse Decision on Appeal	Cases Closed	Percentage of Closed Cases	Number of Decisions Made Timely-Standard	Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited
Medical Necessity Criteria not Met	24	50%	22	2	0	0
Not a PIPH-Covered Benefit	0	0	0	0	0	0
Clinical Documentation not Covered	5	10.40%	2	3	0	0
Treatment/Service Plan Goals Met	1	2%	1	0	0	0
Member not Eligible for Services	4	8.3	4	0	0	0
Member Non-Compliant with Treatment/Service Plan	8	16.6	7	1	0	0
Failure of the PIHP/CMHSP/SUD Provider to Render a Decision Timely	0	0	0	0	0	0
Other	0	0	0	0	0	0
Not Applicable	6	12.50%	6	0	0	0
TOTAL	48	100%	42	6	0	0

Most appealed cases involved clients appealing the decision to deny services based on lack of medical necessity. Of 48 appeals, 21 (44%) were upheld while 22 (46%) were overturned. 88% were completed within the 90 calendar days allowed timeframe, while 33% were not resolved timely.

	Count	Percentage
Appeals	48	
Appeals Upheld	21	44%
Appeals Overturned	22	46%
Appeals Partially Upheld/Overturned	5	10%

3. Training and Education (Focused and General) for Providers

a. The NMRE provided the following trainings to providers:

   i. Habilitation Support Waiver (HSW) goal and objective writing to CMH Case Mangers

   ii. Home and Community Based Services (HCBS) Policy update training to CMH Case Managers

   iii. Grievances, Appeals, Rights, LEP, Denials, Adverse Benefit Determinations (ABDs), notice requirements, and MDHHS reporting requirements

   iv. Provider RECON training

b. NMRE Staff received the following trainings:

i. Code of Ethics training
ii. Annual Compliance training
iii. Non-Retaliation Policy training
iv. Provider Monitoring and Oversight Policy training

4. Lines of communication:

The Compliance program provides the following lines of communication:

a. Internal: There are three ways that employees can voice their concerns:
    i. The compliance hotline is fully functional, and the number is available on the NMRE website. Employees can raise their concerns openly or anonymously.
    ii. The NMRE has a Compliance email account where concerns can be made via email.
    iii. The NMRE has an open-door policy where employees can raise their concern to management without any fear of retaliation.
    iv. Employees can also approach the Compliance Officer to express their concerns.
b. External: There are two ways that clients can voice their concerns:
    i. The Compliance hotline is fully functional, and the number is available on the NMRE website.
    ii. Clients can use the Compliance email account to share their concerns via email.

5. Auditing and Monitoring

a. Medicaid Encounter Verification audits were conducted quarterly. This process allows the NMRE to ensure that all claims for services are properly documented and services were provided prior to payment. This audit was completed quarterly, and the results were shared with the providers. If an audited sample yielded less than 95% accuracy, a Plan of Correction was required. If an audited population fell below 90% accuracy during a 12-month period, a stratified sample was pulled, and a Plan of Correction required.

   In 2021, 4 out of 5 CMHSPs received 100% in the MEV audit. Overall, all 5 CMHSPs received above 95% in the audit. 7 out of 11 SUD Providers received above 95% in the Audit. The 4 SUD Providers that received below 95% all submitted a CAP.

b. New State Modifiers Set-Up

   The NMRE had to re-configure the systems as the State started to monitor costing considerations in services rendered. This considered the staff qualifications, group size, programming codes, and new residential Level of Care (LOC) modifiers for SUD specific codes. The Compliance and Quality Team re-evaluated the way that services were being reported and how the processes on the Provider's side needed to be modified to reflect these new requirements. New crosswalks were created in the RECON

system to validate the logic. The team will continue to monitor these modifiers in the RECON system through 2022.

c. SUD Grants

The Compliance and Quality Team oversees the Jail Medication Assisted Treatment (MAT) grant, and the Medication set-up/ordering. This involves collaboration with the NMRE Finance Department, the drug reps, and other external entities. Currently there are 7 jails set up to order medications through this process. The Compliance and Quality Department will continue to utilize this process for all Medication purchases using the State Opioid Response (SOR) funding for 2022 as more locations are added.

d. Prevention Program

The NMRE contracts with five prevention providers to deliver evidence-based programs with fidelity standards as well as other services to prevent youth: drinking, marijuana misuse, drug misuse and youth tobacco sales within a 21 County region. The annual audit involves a random sample method that includes Program Monitoring, Staff Verifications, and MPDS Verifications and is conducted through site visits (if applicable), desk review and ending with an exit interview.

Provider	Program Monitoring	Staff	MPDS	Synar Complete	Total	Records Audited
Catholic Human Services	100%	100%	100%	100%	100%	29
Centra Wellness CMH	98%	100%	100%		99%	6
District Health Dept #10	100%	100%	100%		100%	9
Health Department Northwest Mich.	98%	100%	100%	100%	99%	13
District Health Dept #2**				100%		
NMRE Grand Total	**99%**	**100%**	**100%**	**100%**	**100%**	**57**

** Provided was only contracted to provide Synar services.

Definitions/Explanations

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

Staff Verification- Credentials, background checks, and trainings

MPDS- Michigan Prevention Data System-Direct services are entered into this State System within 30 days of service. Contracted providers deliver supporting documentation that this activity occurred as billed.

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

6. Investigation and Remediation

a. The NMRE conducted an unannounced provider side visit in response to allegations received. This visit revealed a few areas on non-compliance. A CAP was received in response to the citations. NMRE will continue to monitor the site in question for continued compliance.

7. Customer Service Calls

Calls for assistance came in via the customer services direct line. Requests were also submitted by providers or consumers using the online NMRE Ticket system. The most common reasons for calls received in 2021 from consumers were:

a) Did not understand the ABD they received
b) Request for local resources
c) Not getting the assistance from the CMH they feel they should receive
d) SUD Grievances

The most common categories of calls received in 2021 from non-consumers were:

a) Provider request for information
b) Grievance, Appeal, or Rights processes
c) Materials requests
d) Case Consultations

8. Support Tickets

The NMRE utilizes a ticketing system for all Providers to submit issues, request, and new hire forms. Within this system, the Compliance and Quality Department gets assigned tickets ranging from coding questions, modifier questions, billing issues, staffing set up, new hire forms, password resets, RECON (system) issues, SUD grants, etc. For FY21, the department was assigned a total of 467 tickets.

Categories	Percentages
Provider Support: General	7.5%
System Set up	12.42%
New Hire Notification	62.1%
Passwords	1.07%
Invoicing	3%
Reporting	.21%
Contracts	.21%
RECON Training	.21%
Discharge	.43%
Deactivation of Staff	11.78%
Jail MAT Meds	1.07%

9. Virtual Day of Recovery Education

NMRE held a virtual Day of Recovery (VDRE) mini-conference on May 21st from 1:00-3:00 pm in honor of Mental Health Month.

The focus of the conference was self-advocacy and personal responsibility. Tina Biers from CWN CPSS team volunteered to be the main speaker. The REP group hosted a 'Panel of Friends' that shared their personal experiences with recovery and responsibility and answered questions

regarding the challenges and changes they have faced during COVID. The Customer Services Specialist moderated this panel.

Consumers played several rounds of Bingo, $5 gift cards were given to each winner. Overall, the feedback received was overwhelmingly positive considering the logistical difficulties in organizing a virtual event due to the pandemic.

10. Waivers

a. Habilitation Support Waiver (HSW)
    i. 36 New cases enrolled for HSW services
    ii. 665 Recertifications completed in the WSA
    iii. 488 Level of Care extensions approved by MDHHS
b. Children's Waiver Program (CWP) Services
    i. 2 New cases enrolled
c. Serious Emotional Disturbances Waiver (SEDW) Services
    i. 3 New cases enrolled

11. Home and Community Based Services) HCBS

a. Validation

    i. The Compliance and Quality Department worked with the CMHs and their providers to validate homes for compliance with the HCBS rules that are going into effect in March of 2023.

b. Surveys

    i. Completed 3 provisional HCBS surveys through the Qualtrics survey system.

12. ABA (Applied Behavior Analysis)

a. Approximately 174 initial and reenroll evaluations entered in WSA

b. Approximately 175 revaluations entered in WSA

COMPLIANCE PLAN

FY 2022

Goal 1: Transition Exclusion Checks activities from the NMRE to the CMHSPs. (The NMRE will continue to run exclusion checks for the SUD providers in 2022)

Objective 1: Develop an Exclusion Check policy that is acceptable to both the NMRE and its Providers.

Objective 2: Share the Exclusion Checks policy with Providers and receive feedback to make sure everyone is on the same page.

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

Goal 2: Begin running SUD licensed providers against the National Provider Database (NPDB). The NPDB is a database operated by the U.S. Department of Health and Human Services that contains medical malpractice payment and adverse action reports on health care professionals.

Objective 1: Obtain all required documents and complete registration to access the NPDB

Objective 2: Obtain required information from providers to enter into the database.

Objective 3: Start running monthly checks against the database for SUD providers.

Goal 3: Update the Provider Network Directory and the directories for regional CMHSPs in accordance with HSAG site review recommendation.

Objective 1: Include physical accommodations such as ramps, restrooms, electronic doors, exams rooms, etc. to each specific location.

Objective 2: Create a more user-friendly interface; rather than a spreadsheet platform, the direction will encompass using drop down options, more visible links to CMH pages, and maps with travel distances.

Goal 4: Update the Network Adequacy Plan to fulfil the PIHP/MDHHS contract requirement.

Objective 1: Incorporating time/distance standards into the Network Adequacy Plan.

Objective 2: Create a report that will allow NMRE to determine mileage from a geographic location to a provider clinic using network adequacy standards for each individual mental health and SUD provider service.

Objective 3: More effectively ensure access for NMRE beneficiaries.

Goal 5: Implement DocuSign functionality for contracts and other NMRE documents needing external signatures.

Objective 1: Ensure that all NMRE contract documents are executed on a legally binding, and secure, platform.

Goal 6: Improve Medicaid Encounter Verification (MEV) reporting capability by transitioning into Power BI.

Objective 1: Provide details to IT on the current flow, what kind of data is entered and the expected outcome for reports to be run through the Power BI functionality.

Objective 2: Collaborate with IT to work through the design and the testing of the new Power BI reporting functionality.

Objective 3: Validate date in the new system.

Goal 7: Exploit existing options to effectively track incidents within the RECON system.

Objective 1: Discuss requirements and expected outcome with IT

Objective 2: Review proposed set up with IT

Objective 3: Collaborate with IT to ensure expected outcome is met with some system update, otherwise, explore other options.