Northern Michigan Regional Entity

Board Meeting

January 22, 2025

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – October 23, 2024	Pages 2 – 9
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11.	New Business	
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	b. NMRE Business Central Quote Approval	Pages 85 – 88
	c. New Substance Use Disorder Provider – Quality Behavioral Health	Page 89
12.	Old Business	
	a. Northern Lakes Update	
	b. FY25 PIHP Contract Injunction and Complaint - Update	Pages 90 – 120
13.	Presentation	
	FY24 Quality Assessment and Performance Improvement (QAPIP) Evaluation and FY25 QAPIP Workplan	Pages 121 – 142
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – February 26, 2025 at 10:00AM	
16.	Adjourn	

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – DECEMBER 18, 2024
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Tom Bratton, Ed Ginop, Gary Klacking, Eric Lawson, Mary Marois, Michael Newman, Gary Nowak, Ruth Pilon, Richard Schmidt, Karla Sherman, Don Smeltzer, Don Tanner, Chuck Varner**
ABSENT:	**Jay O'Farrell**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brady Barnhill, Brian Babbitt, Carol Balousek, Lisa Hartley, Chip Johnston, Eric Kurtz, Brian Martinus, Diane Pelts, Brandon Rhue, Nena Sork, Denise Switzer, Deanna Yockey**
PUBLIC:	**Chip Cieslinski, Jackie Guzman, Kevin Hartley, Larry LaCross, Madeline McConnell, Pat McGinn, 5 Unknown**

CALL TO ORDER
Let the record show that Board Chairman, Gary Klacking, called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that all NMRE Board Members were in attendance in Gaylord.

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

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

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

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR DECEMBER 18, 2024; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

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

MOTION BY CHUCK VARNER TO APPROVE THE MINUTES OF THE OCTOBER 23, 2024 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY DON TANNER. MOTION CARRIED.

CORRESPONDENCE
1) The minutes of the October 1, 2024 Statewide CEO meeting
2) MDHHS Service Delivery Transformation Section September 2024 Update.

3) 9 and 10 News article by Jodi Miesen and Jacob Johnson dated November 12, 2024 regarding the theft of $50,000 from Club Cadillac (a psychosocial rehabilitation clubhouse operated by Northern Lakes CMHA).
4) Email correspondence from Bob Sheehan, CEO of the Community Mental Health Association of Michigan (CMHAM) dated November 6, 2024 announcing the "Accurate Picture" media campaign.
5) Email correspondence from Bob Sheehan, CEO CMHAM dated November 19, 2024 regarding a US Department of Justice (DOJ) investigation of Michigan's state psychiatric hospitals.
6) 2025 Healing and Recovery Regional Appropriations – MDHHS and PIHP Contract.
7) A press release from MDHHS dated November 20, 2024 announcing the use of a new mapping tool to improve substance use disorder treatment access.
8) A document from CMHAM outlining the migration of Medicaid beneficiaries from the Disabled, Aged, and Blind (DAB) category to the Temporary Assistance for Needy Families (TNF), Healthy Michigan Plan (HMP), and Plan First categories.
9) PowerPoint slides from MDHHS dated November 22, 2024 titled, "MIHealthyLife: Mental Health-Related Updates" outlining the vision of the Mental Health Framework .
10) The FY24 Region 2/Northern Michigan Regional Entity Performance Improvement Project Validation Report from the Health Services Advisory Group (HSAG).
11) The draft minutes of the December 11, 2024 regional Finance Committee meeting.

DOJ Investigation of Michigan's State Psychiatric Hospitals
The US Justice Department announced on November 13, 2024 that it opened an investigation under the Americans with Disabilities Act (ADA) into whether the State of Michigan unnecessarily institutionalizes adults with serious mental illness in state psychiatric hospitals. The DOJ indicated that it would investigate whether the state fails to provide necessary community-based mental health services to enable people to transition from the state psychiatric hospitals and remain stable in the community.

Migration of Medicaid Beneficiaries from DAB to TANF, HMP, and Plan First
Using data supplied by the NMRE, CMHAM has advocated on behalf of the persons with Michigan's Disabled, Aged, and Blind (DAB) coverage who were moved to other Medicaid programs with per enrollee per month (PEPM) rates fare below those of DAB. For the NMRE, the revenue lost from 2020 – 2024 is greater than $35M ($18M for FY24). Systemwide, the loss may equate to as much as $689M ($35M in FY24).

As of December 13, 2024, all 10 PIHPs have signed a Letter of Agreement with (electronic health record vendor) PCE to run a similar analysis for the entire state. It was noted that this trend has disproportionately affected the aged population.

Mental Health Framework (MHF)
According to the Department's newly unveiled Mental Health Framework, Medicaid Health Plans will be responsible for new mental health services for enrollees with mild-to-moderate mental health needs, incorporating mental health and physical health care coverage for those individuals, including inpatient care (which violates the mental health code). PIHPs will continue to cover all mental health services for enrollees with intensive needs. A new benefit plan will be identified in CHAMPS called "PIHP+" to identify enrollees for whom the PIHP is responsible for mental health coverage (effective October 1, 2025). MHPs will be responsible for covering most mental health care to enrollees not assigned to the "PIHP+" benefit plan.

Opioid Settlement Funding
The state has made $1M in opioid settlement funds available to PIHPs to support infrastructure and inventory and/or invest in community engagement and planning activities. The NMRE will be issuing a Request for Information (RFI) on January 2, 2025 to obtain details regarding provider capabilities for enhancing the region's substance use disorder (SUD) framework, including:

- Infrastructure improvements for treatment providers
- Vehicle purchases
- Anticipatory harm reduction supplies (safer use, wound care, communicable disease testing, and drug checking supplies)

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

PUBLIC COMMENT
Let the record show that Chip Cieslinski, Chief Executive Officer for Catholic Human Services, shared that he is retiring at the end of December. Larry LaCross will be assuming the position of CEO on January 1, 2025.

REPORTS
Executive Committee Report
The Executive Committee met at 9:15AM on this date to review the FY24 NMRE CEO Evaluation. A full report will be given under "New Business."

CEO Report
The NMRE CEO Monthly Report for November/December 2024 was included in the materials for the meeting on this date. Mr. Kurtz noted that a successful Day of Substance Use Disorder (SUD) Education took place at Treetops Resort on October 30th.

Financial Report
Let the record show that there was no monthly Financial Report for October 2024. The November Report will be reviewed in January.

Ms. Yockey indicated that the NMRE's FY24 Interim FSR showed a $2.9M carry forward from FY24 into FY25.

The NMRE will continue to submit reports of unpaid Habilitation Supports Waiver (HSW) slots to MDHHS until the end of December; a fix is expected in January 2025. The NMRE is monitoring all payment activity. Currently the region is not being paid for approximately 50 filled HSW placements, amounting to over $2.5M.

Operations Committee Report
The draft minutes from December 10, 2024 were included in the materials for the meeting on this date.

The monthly 1/12th payment arrangement between the NMRE and Alpine CRU/North Shores Center will be ending on December 31, 2024. Beginning January 1, 2025, The CMHSPs will be contracting with the facility (amend the zero-payment contract) on a fee-for-service arrangement with per diem rates of $600 for crisis residential and $350 for respite; the NMRE will continue to

pay 50% of the facility's costs ($49,229K per month/$443,061K total). A total of 952 units were billed in FY24.

The Department of Technology, Management, & Budget's Procurement office has completed an RFP to solicit responses for selection of Contractors to provide Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs). The term of this contract is seven (7) years, with up to three (3) renewal options. Awards for the 21-county NMRE service area were given to:

- Humana Medical Plan of Michigan, Inc.
- Meridian Health Plan of Michigan, Inc.
- Molina Healthcare of Michigan, Inc.
- Priority Health Choice, Inc.
- United Healthcare Community Plan, Inc.

Ms. Arsenov noted that this will affect the MHP/PIHP Joint Metrics (30% of total withhold) portion of the PIHP's annual Performance Incentive Bonus Payment, which requires collaboration between Medicaid Health Plans and PIHPs for ongoing coordination and integration of services.

NMRE SUD Oversight Committee Report
The draft minutes from November 4, 2024 were included in the materials for the meeting on this date.

NEW BUSINESS
Liquor Tax Requests
The following liquor tax requests were recommended for approval by the NMRE Substance Use Disorder Oversight Committee on November 4, 2024.

	Requesting Entity	Project	County	Amount
1.	217 Recovery	"Tipping the Pain Scale" Movie Screening	Grand Traverse	$2,000.00
2.	Centra Wellness Network	Medication Assisted Treatment (MAT) Clinic Transition	Benzie and Manistee	$46,000.00
3.	Centra Wellness Network	Safenet Prevention Program	Benzie and Manistee	$55,000.00
4.	Sunrise Centre	Building and Enhancing Recovery Capital	Alcona, Alpena, Iosco, Montmorency, Oscoda, Presque Isle	$70,305.00
			Total	**$173,035.00**

MOTION BY DON TANNER TO APPROVE THE LIQUOR TAX REQUESTS FOR FISCAL YEAR 2025 AS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE ON NOVEMBER 4, 2024, IN THE TOTAL AMOUNT OF ONE HUNDRED SEVENTY-THREE THOUSAND THIRTY-FIVE DOLLARS ($173,035.00); SUPPORT BY GARY NOWAK.

Discussion: Ms. Marois asked how Board Members can be assured that recipients of liquor tax funds are doing what they've indicated. Ms. Arsenov responded that the NMRE receives quarterly

updates and checks billing codes to ensure services are being provided. NMRE staff meets monthly to review projects and outcomes. Ms. Marois indicated that she would like to see annual reports come to the Board. Presentations from providers will continue to be placed on the agenda for both the SUD Oversight Committee and the NMRE Board.

Madeline McConnell, Executive Director of Sunrise Centre, noted that money spent on SUD prevention lowers money needed for SUD treatment. Clarification was made that at the end of the fiscal year, any (allocated) unspent funds remain with the county.

Ms. Yockey confirmed that the amount of PA2 funds needed to supplement block grant funds for SUD treatment in FY24 did not affect the counties' one-year fund balances.

ROLL CALL VOTE.

"Yea" Votes:	R. Adrian, T. Bratton, E. Ginop, G. Klacking, E. Lawson, M. Marois, M. Newman, G. Nowak, R. Pilon, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner, C. Varner
"Nay" Votes:	Nil

MOTION CARRIED.

NMRE CEO Evaluation
The NMRE Executive Committee met earlier on this date to review the NMRE Chief Executive Officer FY24 Evaluation Report and contract terms. The decision was made to offer Mr. Kurtz a 3% cost of living adjustment (COLA) for FY25, which is the same amount that has been budgeted but not yet issued to NMRE staff. The 3% staff COLA (approximately $77K), which may be made in the form of a salary adjustment or one-time retention payment, will be placed on the Agenda for the January meeting.

MOTION BY GARY NOWAK TO APPROVE A THREE PERCENT COST OF LIVING ADJUSTMENT TO THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUTIVE OFFICER'S SALARY FOR FISCAL YEAR 2025; SUPPORT BY KARLA SHERMAN. ROLL CALL VOTE.

"Yea" Votes:	R. Adrian, T. Bratton, E. Ginop, G. Klacking, E. Lawson, M. Marois, M. Newman, G. Nowak, R. Pilon, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner, C. Varner
"Nay" Votes:	Nil

MOTION CARRIED.

New Horizons Training Credits
NMRE Chief Information Officer, Brandon Rhue, reported that the NMRE purchased $50K in training credits in February 2024 for a total of $100K in training credits, due to a 1:1 match offered by the vendor. November 1st, there was a balance of $50K remaining. Mr. Rhue proposed an additional purchase of $20K, for a total of $40K in training credits.

MOTION BY RICHARD SCHMIDT TO APPROVE THE PURCHASE OF NEW HORIZONS LEARNING CREDITS IN THE AMOUNT OF TWENTY THOUSAND DOLLARS ($20,000.00); SUPPORT BY ERIC LAWSON. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, T. Bratton, E. Ginop, G. Klacking, E. Lawson, M. Marois, M. Newman, G. Nowak, R. Pilon, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

OLD BUSINESS

Northern Lakes CMHA Update

An NMRE Board Executive Committee meeting has been scheduled for January 3, 2025 at 10:00AM to review the Rehmann forensic investigation report of Northern Lakes.

Mr. Bratton added that, since a governing model has been established and bylaws have been approved, the Northern Lakes Board is preparing to restart the search for a permanent CEO. A CEO Search Committee meeting has been scheduled for January 9th.

FY25 PIHP Contract Injunction and Complaint

An injunction and complaint filed against the State of Michigan, State of Michigan Department of Health and Human Services, and Elizabeth Hertel by the law firm of Taft, Stettinius & Hollister, LLP on behalf of Northcare network Mental Health Care Entity, Northern Michigan Regional Entity, and Region 10 PIHP were included in the materials for the meeting on this date. An article by Ben Solis appearing in Gongwer on December 18, 2024 titled, "3 Prepaid Inpatient Health Plans Sue DHHS Over Allegedly Illegal Provisions", was distributed to Board Members during the meeting.

The suit stems from the fact that, although the plaintiffs signed modified versions of the FY25 Contract (striking out language related to the Waskul settlement, IFS capitation, and Certified Community Behavioral Health Clinics), the Department refused to counter-sign. The defendants recently retaliated against the plaintiffs by stating that MDHHS will not provide Medicaid dollars to fund the expansion of the Substance Use Disorder Health Home (SUDHH) in the plaintiff's regions. This decision by the state could have potentially affected additional services to approximately 7,886 eligible beneficiaries (as of December). It was noted that the three disputed areas of the contract have nothing to do with client care. After discussions with the Attorney General's Office and legal counsel, this MDHHS decision has been reversed.

The CHM Partnership of Southeast Michigan has received approval from its Board of Directors to join the lawsuit as an additional plaintiff. Several CMHSPs have also expressed interest in joining.

The Attorney General's office has asked for a 60-day extension to respond. In the interim, MDHHS has offered to reinstate the SUD Health Home program.

Additionally, communication was received from MDHHS on December 16th stating that the PIHPs FY24 FSR Bundle submission, due on February 28, 2025, will not be accepted if any IFS balance shown is greater than 7.5% of the annual operating budget. Rejected FSR bundles will be considered "late" and will be disqualified from receiving the performance bonus incentive payment for timely reporting. This issue has been added to the injunction and complaint.

PRESENTATION

Quality Assessment and Performance Improvement Program (QAPIP) Update

NMRE Chief Clinical Officer, Bea Arsenov, provided an update on the NMRE Quality Assessment and Performance Improvement Program (QAPIP) to the Board. A QAPIP is required for all PIHPs.

The QAPIP is intended to serve several functions, including but not limited to:

- Serve as the quality improvement structure for the managed care activities of the NMRE as the PIHP for the twenty-one-county service area.
- Provide oversight of the CMHSPs' quality improvement structures and ensure coordination with PIHP activities, as appropriate.
- Provide leadership and coordination for the PIHP Performance Improvement Projects (PIPs).
- Coordinate with the regional Compliance Coordinator and regional Compliance Committee for verification of Medicaid claims submitted.
- Describe how these functions will be executed within the NMRE's organizational structure.

The NMRE's QAPIP lists 13 goals. Ms. Arsenov provided updates on the following:

Goal 1/Objective 1: To Improve the number of individuals enrolled in the Opioid Health Home (OHH) Program by September 30, 2024. This goal has been achieved, as evidenced below.

WSA OHH Breakout: Eligible vs. Enrolled						
Time Period	**Running Date**	**Enrolled**	**Eligible**	**% of PE Enrolled**	**% Enrolled Change**	**% Eligible Change**
Pre-Baseline	<= 9/30/20	284	5,372	5.29%	0%	0%
Baseline	<= 9/30/21	587	7,603	7.72%	106.69%	41.53%
Post-Baseline	<= 9/30/22	890	8,398	10.90%	51.62%	10.46%
Year 1 (NEW)	<= 9/30/23	936	6,400	14.63%	5.17%	-23.79%
Year 2 (NEW)	<= 9/30/24	820	7,142	11.48%	-12.39%	11.59%
Year 3 SUDHH	<= 9/30/25	986	7,174	**13.74%**	5.34%	12.09%

Goal 2/Objective 2: To improve the number of individuals enrolled in the CMHSP Behavioral health Home (BHH) Program from 3.56% to 5% by September 30, 2024. This goal has been achieved, as evidenced below.

BHH Comparison of Receiving BHH Waiver Services vs. Potential Enrollees			
CMHSP	**Receiving BHH Waiver Services**	**Enrolled + Potential Enrollees who are actively enrolled w/CMHSP**	**Percent Enrolled**
Centra Wellness	155	907	17.09%
North Country	88	2,662	3.31%
Northeast MI	97	1,560	6.22%
Northern Lakes	170	3,858	4.41%
Wellvance	84	1,774	4.74%
Total	**594**	**10,761**	**5.52%**

Goal 2: The NMRE QOC, as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. The QOC will also work on improving the data quality and timeliness in reporting events.

- Jan 2024: An ITR was created to make the changes necessary in the PCE system to allow for timely and accurate reporting of events.
- December 2024: Changes were in place and active in the system.

Goal 6/Objective 2: The NMRE will establish regional Healthcare Effectiveness Data and Information Set (HEDIS) measures to demonstrate the effectiveness of improvements in the quality of healthcare and services for members.

- Follow-Up After Hospitalization for Mental Illness within 30 Days (FUH) – The NMRE surpassed the MDHHS defined benchmark of 58% for FY22 (73.49%) and FY23 (68.21%).
- Follow-Up After Emergency Department Visit for Substance Use – The NMRE surpassed the MDHHS defined benchmark of 36.4% for FY22 (43.89)) and FY23 (41.87%).

COMMENTS

Board

Mr. Nowak wished everyone a safe and happy holiday.

Staff/CMHSP CEOs

Ms. Pelts announced that she will be retiring from the position of Chief Executive Officer of Wellvance effective August 1, 2025. Wellvance will be working with Rehmann to conduct a CEO Search.

MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on January 22, 2025.

ADJOURN

Let the record show that Mr. Klacking adjourned the meeting at 11:44AM.

PIHP CEO Meeting
December 5, 2024
9:30 a.m. – 12 p.m.
Microsoft Teams Meeting

Contents

MDHHS Attendees:

Kristen Jordan
Michelle Mills
Audra Parsons
Meghan Groen
Jackie Sproat
Audrey Dick
Angela Smith-Butterwick
Crystal Williams
Dana Moore
Keith White
Brian Keisling
Phil Kurdunowicz
Leah Julian
Laura Kilfoyle
Erin Emerson
Lyndia Deromedi
Alex Kruger
Nicole Hudson
Ernest Papke
Kayla Rosen
Matt Seager
Krista Hausermann
Eric Houghtaling
Alyssa Stuparek
Lindsey Naeyaert
Alicia Cosgrove
Belinda Hawks

PIHP Attendees:

Jim Johnson
James Colaianne
Joe Sedlock
Manny Singla
Megan Rooney
Dana Lasenby
Mary Marlatt-Dumas
Traci Smith
Eric Kurtz
Stephanie VanDerKooi
Mila Todd

Children's Bureau Update

a. Phil Kurdunowicz provided updates.
    1. MichiCANS memo: related requirements are limited on changes until March of 2026 or until the funding expires.
    2. SDD Waiver Workflow workgroup: coordinating in December and January to talk through a high-level workflow workgroup.
    3. MichiCANS Ratings: CMH/PIHPs are collecting ratings for individuals who have been assessed. Working on a tool to allow data to be shared.
    4. Waiver Renewal Updates: Still waiting for feedback from CMS on the waiver application.
        i. Currently have an extension through the end of December, will work with CMS if we need another extension.
    5. SDD Waiver Retroactive Medicaid Coverage memo: Were able to reopen the pathway and issued some additional guidance going forward.

Integrated Care Updates

a. Matt Seager provided updates.
    1. Matt opened a discussion for the group:
        i. Do any of the PIHPs or affiliates have relations with the PACE organizations to serve their members?
    2. PIHP withdrawal from MiHealth Link contract guidance has been updated.
    3. MI Coordinated Health updated bid results are out. Press release will be forthcoming.

HCBS Update

a. Lyndia Deromedi provided HCBS updates.
    1. In the process of responding to CMS on-site review report.
        i. Five settings were reviewed and the out of compliance findings are posted on the HCBS webpage.
    1. CMS is currently reviewing heightened scrutiny.
        i. Will work on the corrective action plan when we get it back from CMS.

Crisis Updates

a. Krista Hausermann provided updates.
    1. Working on revising the policy around Intensive Crisis Stabilization to ensure that it is aligned with the mental health code and various regulations.
    2. Will have the draft policy out for public comment in the next few weeks.

PIHP Contract Updates

a. Jackie Sproat provided updates.
    1. Amendment for the FY25 PIHP contract should be issued by the end of next week.
    2. There is consideration underway for FY25 for a rate amendment that would include ensuring that there is adequate funding for our system to support the legislatively mandated ABA rate.
    3. A SPA has been submitted to CMS for the legislatively mandated methadone rate. Will share information when the response is received.

Updates/Topics from PIHP's

a. CMS Site Visit – implications for PIHP provider systems, State Policy
b. HCBS/BTPRC policy conflicts
c. ABA Behavior Technician Rates

Service Delivery Transformation Section

November 2024 Update

CONTENTS

Service Delivery Transformation Section Overview

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

Our Team

Lindsey Naeyaert – Section Manager
Naeyaertl@michigan.gov
- Leads programmatic, policy, and implementation of integrated health projects within section

Danielle Hall – Behavioral Health Innovation Specialist
HallD32@michigan.gov
- Behavioral Health Home

Amy Kanouse – Behavioral Health Program Specialist
Kanousea@michigan.gov
- CCBHC Demonstration
- Emergency Grants to Address Mental Health and Substance Use During COVID-19

Hailey Mueller – CCBHC Analyst
Muellerh1@michigan.gov
- CCBHC Programmatic Support

Jennifer Ruff – CCBHC Certification Manager
RuffJ3@michigan.gov
- CCBHC Certification and Monitoring

Chance Thick - Certification Specialist
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- CCBHC Site Monitoring and Oversight

Amanda Zabor - Certification Specialist
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- CCBHC Site Monitoring and Oversight

Behavioral Health Home

Behavioral Health Home Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes (BHH) 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.
- BHH services are available to beneficiaries in 63 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), 5 (Mid-State), 6 (Southeast Michigan), 7 (Wayne County), and 8 (Oakland County).

Current Activities

- As of December 4, 2024, there are 3,198 people enrolled:
    - Age range: 4-86 years old
    - Race: 26% African American, 68% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- Resources, including the BHH policy, directory, and handbook, are available on the Michigan Behavioral Health Home website. Behavioral Health Home (michigan.gov).
- State Plan Amendment 24-1500 to expand BHH in regions 3,4, and 9, add eligible codes to increase access for children and youth with SED, and add Youth Peer Support to the BHH staffing structure was approved on October 3, 2024.
- The FY25 BHH Handbook V2.0 was finalized and distributed to LEs in November.

Certified Community Behavioral Health Clinic Demonstration

Certified Community Behavioral Health Clinic Demonstration Overview

- MI has been approved as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state by CMS. The demonstration launched in October 2021 with a planned implementation period of two years. The Safer Communities Act was signed with provisions for CCBHC Demonstration expansion, extending MI's demonstration until October 2027. 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

- As of December 4, 2024, 112,415 Medicaid beneficiaries and 28,104 non-Medicaid individuals are assigned in the WSA to the 33 demonstration CCBHC sites.
- MDHHS conducted a health information technology survey amongst CCBHCs in 2023 to solicit feedback on the WSA operations and activities. Feedback resulted in stakeholders finding the WSA to be administratively burdensome, has frequent time outs and errors, as well as duplication of data entry between the EMR and the WSA. MDHHS has funding and is working with internal staff and contractors to develop a bidirectional EMR/WSA API Web Services benefit for stakeholders that will address feedback received. This project wrapped up on August 29th and is awaiting demo testing and onboarding of providers. MDHHS will continue working with state contractors on this effort.
- MDHHS continues to partner with evaluators at the Center for Healthcare Research Transformation at the University of Michigan on formal evaluation activities. CHRT has shared preliminary findings of key themes from interviews with PIHPs and CCBHCs and are beginning data review activities.
- The FY25 CCBHC Handbook V2.0 was finalized, posted to the CCBHC mailbox, and distributed to PIHPs and CCBHCs in early October.
- MDHHS put forth a CCBHC expansion announcement that identified eligibility requirements for sites interested in joining the CCBHC Demonstration with an application due date of July 1st, 2024. Application reviews are finalized and the CCBHC Demonstration Team was pleased to welcome 3 additional sites to the demonstration effective 10/1/24. An orientation was held in September to welcome all the new fully certified sites. The 3 new sites that joined on October 1, 2024 are Van Buren CMH, EasterSeals Morc Macomb, and Heigra Health, INC.
- Provisional Certification was achieved by 3 CCBHC Demonstration expansion sites. If these sites can satisfy all application deficiencies by November 22, 2024, they will join the CCBHC Demonstration on January 1, 2025. The application to CMS to expand the demonstration to these sites was submitted on December 1, 2024.
- Final Quality Bonus Payment awards for Demonstration Year 2 were distributed to PIHP on August 29. For DY2 awards, CCBHCs must have met benchmarks for all 6 CMS-designated measures to receive the quality bonus payment.

Questions or Comments

Lindsey Naeyaert, MPH
Service Delivery Transformation Section Manager
Behavioral and Physical Health and Aging Services Administration
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STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

M E M O R A N D U M

DATE: January 3, 2025

TO: Prepaid Inpatient Health Plans (PIHP) and Community Mental Health Services Programs (CMHSP) Leadership

FROM: Patricia Neitman, MS LLP, Bureau Director PLN
Bureau of Children's Coordinated Health, Policy, and Supports

SUBJECT: Update on 1915(c) Waiver Programs for Children

The Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) is providing the following update on the renewal applications for the Waiver for Children with Serious Emotional Disturbances (SEDW) and Children's Waiver Program (CWP).

Waiver for Children with Serious Emotional Disturbances (SEDW):

The Michigan Department of Health and Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) for the renewal of the SEDW program on December 18, 2024. The waiver has been approved for a five-year period with an effective date of October 1, 2024. The renewal application included several programmatic changes, which are listed below. MDHHS will provide interim guidance to the PIHPs and CMHSPs in January 2025 that will address the following items, and MDHHS will also issue a policy bulletin in 2025 that will incorporate these items into the Medicaid Provider Manual.

- Revision to assessment tools including the addition of the Michigan Children and Adolescent Needs and Strengths (MichiCANS) tool
- Revision of Overnight Health and Safety Supports eligibility and coverage
- Removal of Wraparound from SEDW and Addition of Intensive Care Coordination with Wraparound (ICCW) to State Plan
- Removal of Family Support and Training from SEDW and 1915(i) and transition to the Parent Support Partner State Plan Amendment
- Addition of Equine Therapy as a new service type
- Change in name from "Children's Therapeutic Foster Care" to "Children's Therapeutic Family Care" and update to the best practice model
- Revision and addition of some performance measures for the Quality Improvement Strategy
- Update of Electronic Visit Verification language
- Update of Conflict Free Access and Planning requirements

- Language change from “Fiscal Intermediary” to “Financial Management Services”
- Change in frequency of provider qualification verifications from 2 years to 3 years
- Change in site review frequency from biennially to annually

Children’s Waiver Program (CWP)
MDHHS has not received approval from CMS for the renewal application for the CWP. MDHHS submitted and received approval for an extension request for the current waiver approval to allow for finalization of the updated waiver application.

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

MEMORANDUM

To: Executive Directors of Pre- Paid Inpatient Health Plans (PIHP) and Community Mental Health Services Programs (CMHSP)

From: Kristen Morningstar, Director
Bureau of Specialty Behavioral Health Services

Date: January 16, 2025

RE: Update on 1915(c) Habilitation Supports Waiver (HSW).

The Bureau of Specialty Behavioral Health Services (BSBHS) is providing the following update on the renewal application for the 1915(c) Habilitation Supports Waiver (HSW).

The Michigan Department of Health and Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) for the renewal of the HSW program on December 20, 2024. The waiver has been approved for a five-year period with an effective date of October 1, 2024. The renewal application included several programmatic changes, which are listed below. MDHHS will provide interim guidance to the PIHPs and CMHSPs in January 2025 that will address the following items, and MDHHS will also issue a policy bulletin in 2025 that will incorporate these items into the Medicaid Provider Manual.

List of changes in the HSW renewal approval with an effective date of October 1, 2024:

- Revision of Overnight Health and Safety Supports eligibility and coverage.
- Revision and addition of some performance measures for the Quality Improvement Strategy.
- Update of Electronic Visit Verification language.
- Update of Conflict Free Access and Planning requirements.
- Language change from “Fiscal Intermediary” to “Financial Management Services”.
- Change in frequency of provider qualification verifications from 2 years to 3 years.
- Change in site review frequency from biennially to annually.
- Elimination of Pre-Vocational Services.
- Update of Home and Community-Based Services implementation language,
- Update of Goods and Services Language.
- Removal of vehicle modification from Enhanced Medical Equipment and Supplies language.
- Added language to Family Training.

- Updated Environmental Modification language.
- Updated respite services to expand provider language.
- Separation of Supported Employment services into two distinct services, Individual Supported Employment and Small Group Employment.
- Expanded eligibility group to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) Medicaid group.
- Added assessment tool to identify potential enrollees for HSW (WHODAS 2.0 – New Assessment tool) for adult I/DD population.
- Added language indicating the Case Manager's role in securing Community Living Support (CLS) services.
- Updated language to service planning implementation and monitoring requirements.
- Removal of consolidated reporting language in system design section of the waiver application.
- Added language to indicate that a copy of completed certification at initial enrollment and recertification must be provided to beneficiary/guardian and documented in EHR/EMR.

Community Mental Health Association of Michigan

2024 Lame Duck Tracker – Final Update (I HOPE!!)

BILLS SENT TO THE GOVERNOR

HB 4224 – Repeals Work Requirements for Health Michigan Plan

HB 4224 passed the FULL Senate on December 20 (20-18 vote)

HB 4224 repeals workforce engagement requirements for Healthy Michigan plan. e HMP is Michigan's Medicaid-expansion program that provides health care benefits to low income individuals who do not qualify for Medicaid. The workforce engagement requirements were blocked by a Federal judge following a ruling in the Young v Azar case, in which four low-income individuals from Michigan filed a lawsuit challenging the waiver.1 Given that the workforce engagement requirements were ruled as unenforceable, it has been suggested to remove them from the Act to avoid confusion about HMP eligibility.

HBs 5077 & 5078 – Naloxone Distribution

HBs 5077 & 5078 passed the FULL Senate on Tuesday, December 10 (37-0-1 vote)

House Bill 5077 would amend the Administration of Opioid Antagonists Act to specify that an agency that purchased or otherwise obtained and possessed an opioid antagonist or an employee of an agency who possessed an opioid antagonist distributed to that employee or agency could distribute that opioid antagonist directly or indirectly to any individual.

House Bill 5078 would amend the Public Health Code to allow a prescriber to issue a prescription for and a dispensing prescriber or pharmacist to dispense an opioid antagonist to an agency authorized to obtain an opioid antagonist under the Administration of Opioid Antagonists Act.

HB 6058 – Public Employer Health Insurance Contribution Caps

HB 6058 passed the FULL Senate on December 20 (20-18 vote)

The bill would increase the hard caps for employer insurance contributions:

- $8,258 for single-person coverage

- $17,271 for individual-and-spouse coverage
- $22,523 for family coverage

These increases represent a jump of 7.25 percent from 2024 levels. The bill maintains an inflationary adjustment tied to the medical care component of the U.S. Consumer Price Index (CPI), but adds a floor of a 3 percent annual increase, ensuring the caps rise even during periods of low inflation. On top of the indexed or 3 percent increase, the bill also allows for an additional 5 percent increase that would be a subject of bargaining.

However, HB 6058 also makes significant changes to the 80/20 cost-sharing option. PA 152 now requires employers to pay "no more" than 80 percent of the cost of health premiums. HB 6058 would require employers to pay "no less" than 80 percent, effectively opening this provision to collective bargaining.

Lastly, HB 6058 also allows for different bargaining units to have different caps, effectively slating some bargaining units to pay less for health premiums than others.

MAC is concerned this change would reduce predictability for public employers and potentially increase costs. While MAC supports raising the hard caps to better reflect the rising costs of health care, MAC seeks a simpler approach to the readjustment by tying the caps to a more appropriate inflationary index that better tracks health insurance premium increases.

BILLS THAT DIED (WILL NOT BE GOING TO THE GOVERNOR)

All of these must start the legislative process over next session – regardless how far the made it this session.

SBs 915 – 918 - Assisted Outpatient Treatment Bills

SBs 915-918 died on the House Floor due to inaction

- Allows law enforcement officers to take someone in for a psychiatric examination if they have "reasonable cause" to believe they need community mental health treatment. Currently, officers must personally witness signs of uncontrolled mental illness.
- Expands petition for access to assisted outpatient treatment to additional health providers
- Provides outpatient treatment for misdemeanor offenders with mental health issues
- Allows use of mediation as a first step in dispute resolution

SBs 651-654 – Tobacco Use, Sales and Prevention
HBs 6002 – 6005 (same bills)

HBs 6002 – 6005 & SB 651-654 died due to House inaction (these bills were all tied-barred together)

- Would end the sale of flavored tobacco products (including flavored e-cigarettes and menthol-flavored cigarettes)
- Require tobacco retailers to be licensed
    - Establishes licensure requirements for retailers ($1500 application fee goes into a Nicotine and Tobacco Regulation Fund, LARA would put towards enforcement and compliance)
    - MI is one of only 10 states that do not require a license to sell tobacco
- Tax e-cigarettes and vaping products containing nicotine for the first time
- Increase tobacco taxes
- Eliminate local preemption on tobacco restrictions
- Repeal penalties that punish kids for tobacco purchase and use.

HB 5785 – Limited Licensed Psychologist Supervision

HB 5785 died the Senate

- Change criteria regarding limited licensese to practice psychology (notably by removing supervision requirements for a person practicing under a limited license and requiring a longer period of supervised postgraduate experience to apply).
- Allow the two-year temporary limited license for individuals getting their required amount of supervised postgraduate experience to be extended for two additional two year periods (instead of just one), for a total of six years (instead of four).

HBs 5371 & 5372 – CCBHC Codification

HBs 5371 & 5372 died the Senate

The bills would codify the CCBHC program into state statute, for example it would:

- Would require DHHS to develop, in accordance with federal law and regulations, a prospective payment system under the medical assistance program for funding all of the following:
    - A CCBHC.
    - A community mental health service program (CMHSP), nonprofit organization, or private organization that provides mental health services that is certified by DHHS as a CCBHC, is licensed by DHHS, and adheres to all federal CCBHC requirements.
    - A mental health provider who is certified by DHHS as a CCBHC and who adheres to all federal CCBHC requirements.
- Ensure continuing compliance with DHHS licensing and certification requirements.
- Prohibit the state government from implementing a policy that contradicts or interferes with the implementation of federal definitions or requirements for a CCBHC.
- Require the state government to develop a process of determination for additional CCBHC sites in specific geographic regions that must comply with federal CCBHC requirements, to address service area overlap.

- Require the state government to continue to participate with the federal government to implement CCBHCs. The bill states, "To opt out of participation, there must be a vote of the legislature."

HB 5178 – Syringe Service Programs (SSP)

HB 5178 died the Senate

This bill allows communities to opt-in to a SSP. Under the bill, the possession, distribution, or delivery of any of the following by an individual who is served by, or who acts as an employee or volunteer for, a program described above would not be a violation of section 7401 or 7403 of the Public Health Code1 or a local ordinance that substantially corresponds to those sections or that provides criminal penalties for the possession of drug paraphernalia:

- A needle or hypodermic syringe, including one that is empty or unused.
- Drug paraphernalia.
- A controlled substance in a trace or residual amount in a used needle, hypodermic syringe, or drug paraphernalia.
- Drug testing equipment, including a test strip or reagent.

HB 4833 – Dual Licensure Requirements / SUD

HB 4833 died the Senate

Under the bill, except as described below, a person could not establish, conduct, or maintain a substance use disorder services program that offers any service that is a substance use disorder treatment and rehabilitation service unless it is licensed under Part 62.

A license under Part 62 would not be required to provide substance use disorder prevention services.

A license under Part 62 would not be required by any of the following:

- A person that is otherwise licensed to provide psychological, medical, or social services.
- A hospital licensed under Article 17 of the Public Health Code.
- A psychiatric hospital or psychiatric unit licensed under section 134 of the Mental Health Code.

The bill would change references in Part 62 to licensure of a substance use disorder services program so that they would apply only to the licensure of substance use disorder treatment and rehabilitation services.

Finally, the bill would remove a provision that now requires the Department of Licensing and Regulatory Affairs (LARA), before issuing a license to an applicant under Part 62, to provide an opportunity for individuals in the applicant's service delivery area to comment.

SB 870 – Open Meetings Act Change for persons with disabilities

SB 870 died the House

Senate Bill 870 would amend the Open Meetings Act to allow an appointed member of a public body who has a disability to participate remotely in a meeting of the public body upon request. The member would not be required to disclose the nature or extent of the disability. The member would have to be physically present in Michigan throughout the meeting. The allowed remote participation would apply only to members absent due to a disability (that is, those who do not have a disability could not also participate in the meeting electronically).

These provisions would not apply to either of the following:

- A member elected directly by the electors to serve on the public body.
- A meeting of a state legislative body at which a formal vote is taken.

SB 802 – Mental Health and SUD Registry (CMHA Opposes)

SB 802 died the Senate – never passed the Seante

- Require the Department of Health and Human Service's (DHHS's) electronic inpatient psychiatric bed registry to include community-based services.
- Require community mental health services programs to provide the DHHS with the number, type, and other pertinent information on the community-based mental health and substance use disorder services available in the local area.
- Add acute care hospitals or emergency department staff and community mental health services programs to the list of required representatives on the committee that guides the operations of the registry.
- Require the DHHS to compile a list of available community mental health services programs and substance use disorder services program and disclose that information to individuals that used the Michigan Crisis and Access Line.

CMHA believes SB 802 adds another unnecessary administrative burden onto the system. This information is already provided to MDHHS and is available on local websites. This bill is being pushed by the Michigan Hospital Association in the name of transparency.

HB 4693 – Open Meetings Act Change

HB 4693 died in the House – never passed the House

House Bill 4693 would amend the provisions to allow a public body to meet electronically under any circumstances if the following conditions are met:

- No member of the public body is directly elected by the voters to serve on the body.
- No member is compensated for their service.

- The body is not legally authorized to directly raise revenue by imposing any tax, millage, assessment, or fee on persons, property, or transactions within its jurisdiction.
    - A public body's receipt of one-time funding from another governmental entity, including the state or federal government, would not disqualify it from being able to meet remotely under these provisions.

The public body would have to establish procedures that do all of the following:

- Allow absent members to participate in, and vote on, business before the public body and include procedures for two-way communication.
- Provide a way to notify the public of a member's absence and let them know how to contact that member before the meeting to give input on anything that will come before the public body.
- Require a member attending remotely to specify the county, city, township, or village and state where they are physically located.

HB 4707 – Mental Health and SUD Parity expansion – died in the House – never passed the House

HBs 5184 & 5185 – Social Worker Licensure Change – died in the House – never passed the House

- **HB 5179 – Fentanyl Testing Strips** – died in the Seante

- **SB 542 – Opioid Antagonist Expansion** – died in the House

- **No supplemental budget action –** Never brought up in either chamber

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Update on Waskul settlement
Date: Tuesday, January 7, 2025 2:48:48 PM
Attachments: image001.png

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Update on Waskul settlement

An update on the *Waskul* case: In late December, 2024, the Court indicated that it was going to approve the *Waskul* settlement reached by MDHHS and Plaintiffs. The Court did not provide its reasoning yet and has not entered its order. While the judge has approved the settlement, this issue is far from settled. Once the settlement is formally approved by the court, MDHHS must satisfy the following conditions:

1. Minimum fee schedule provisions:
    1. For the minimum fee schedule provisions to take effect: CMS approval of any amendments to the HSW, any contract amendment to the MDHHS contract with the Community Mental Health Partnership of Southeast Michigan (CMHPSM), and any capitation rate increase for all PIHPs. CMHPSM must agree to the MDHHS contract amendment for the minimum fee schedule provisions to take effect.
    2. In the event the minimum fee schedule provisions do not take effect, MDHHS must amend the Medicaid Provider Manual to change the costing out rules.
2. MDHHS must change the Administrative Law Judge (ALJ) rules, applying to Medicaid Fair Hearings, to expand the ALJ's authority over HSW Self-Determination CLS participants' appeals. These rule changes include:
    1. ALJ authority to review authorized units for HSW SD CLS and HSW SD OHSS;
    2. ALJ authority to review HSW SD CLS budget attached to a recipient's IPOS;
    3. ALJ authority to order a specific budget or authorization for HSW SD CLS and HSW SD OHSS;
3. MDHHS must change the Medicaid Fair Hearings rules to give ALJs the authority to review a decision to terminate an Self Determination arrangement.
4. MDHHS must also make a number of other changes to the Medicaid Provider Manual and separately provide non-binding guidance on all of the new rules.

CMHA will keep you posted as this process moves forward.

Robert Sheehan
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Indicator 1a: Percentage of Children Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition was Completed within Three Hours – 95% Standard

	Percentage	Number of Emergency Referrals for Children	Number Completed in Three Hours for Children
Detroit Wayne Mental Health Authority	96.83	568	550
Lakeshore Regional Entity	98.35	364	358
Macomb Co CMH Services	95.86	169	162
Mid-State Health Network	99.47	754	750
Northcare Network	100	48	48
Northern Michigan Regional Entity	96.67	150	145
Oakland Co CMH Authority	100	246	246
Region 10	99.59	241	240
CMH Partnership of Southeast MI	100	133	133
Southwest MI Behavioral Health	99.52	210	209
Statewide Total		**2,883**	**2,841**

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

	Percentage	Number of Emergency Referrals for Adults	Number Completed in Three Hours for Adults
Detroit Wayne Mental Health Authority	97.47	2,526	2,462
Lakeshore Regional Entity	98.84	1,468	1,451
Macomb Co CMH Services	97.08	994	965
Mid-State Health Network	99.51	2,454	2,442
Northcare Network	100	259	259
Northern Michigan Regional Entity	98.18	603	592
Oakland Co CMH Authority	97.96	1,227	1,202
Region 10	99.20	874	867
CMH Partnership of Southeast MI	99.22	645	640
Southwest MI Behavioral Health	99.89	933	932
Statewide Total		**11,983**	**11,812**

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

	Percentage	# of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.37	3,275	1,846
Lakeshore Regional Entity	55.02	1,254	690
Macomb Co CMH Services	64.93	998	648
Mid-State Health Network	67.27	4,174	2,808
Northcare Network	62.92	507	319
Northern Michigan Regional Entity	64.62	944	610
Oakland Co CMH Authority	56.02	1,005	563
Region 10	54.41	2,202	1,198
CMH Partnership of Southeast MI	48.57	1,153	560
Southwest MI Behavioral Health	77.82	2,565	1,996
Statewide Total		**18,077**	**11,238**

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

	Percentage	# MI Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	51.57	628	325
Lakeshore Regional Entity	57.30	459	263
Macomb Co CMH Services	67.37	236	159
Mid-State Health Network	66.16	1,321	874
Northcare Network	66.10	177	117
Northern Michigan Regional Entity	62.23	278	173
Oakland Co CMH Authority	53.19	282	150
Region 10	54.83	600	329
CMH Partnership of Southeast MI	58.76	291	171
Southwest MI Behavioral Health	79.21	659	522
Statewide Total		**4,931**	**3,083**

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

	Percentage	# MI Adults Who Requested Mental Health or I/DD Services and are Referred for a Biopsychosocial Assessment	# MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.93	1,876	1,068
Lakeshore Regional Entity	54.90	561	308
Macomb Co CMH Services	64.72	519	400
Mid-State Health Network	69.97	2,461	1,722
Northcare Network	60.96	292	178
Northern Michigan Regional Entity	64.00	550	352
Oakland Co CMH Authority	60.76	655	398
Region 10	55.87	1,244	695
CMH Partnership of Southeast MI	41.51	713	296
Southwest MI Behavioral Health	76.73	1,702	1,306
Statewide Total		**10,672**	**6,723**

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

	Percentage	# DD Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.34	655	369
Lakeshore Regional Entity	60.43	139	84
Macomb Co CMH Services	68.57	105	72
Mid-State Health Network	52.78	288	152
Northcare Network	63.16	19	12
Northern Michigan Regional Entity	73.08	78	57
Oakland Co CMH Authority	24.14	29	7
Region 10	43.26	282	122
CMH Partnership of Southeast MI	61.05	95	58
Southwest MI Behavioral Health	84.62	143	121
Statewide Total		**1,833**	**1,054**

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

	Percentage	# DD Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	72.41	116	84
Lakeshore Regional Entity	36.84	95	35
Macomb Co CMH Services	43.59	39	17
Mid-State Health Network	57.69	104	60
Northcare Network	63.16	19	12
Northern Michigan Regional Entity	73.68	38	28
Oakland Co CMH Authority	20.51	39	8
Region 10	68.42	76	52
CMH Partnership of Southeast MI	64.81	54	35
Southwest MI Behavioral Health	77.05	61	47
Statewide Total		**641**	**378**

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

		Admissions			
	Percentage	# of Non-Urgent Admissions to a Licensed SUD Treatment Facility as Reported in BH TEDS	# of Expired Requests Reported by the PIHP	Total	# of Persons Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request
Detroit Wayne Mental Health Authority	68.00	3,357	959	4,316	2,935
Lakeshore Regional Entity	64.08	1,246	302	1,548	992
Macomb Co CMH Services	69.78	1,230	365	1,595	1,113
Mid-State Health Network	73.43	2,529	531	3,060	2,247
Northcare Network	74.19	463	64	527	391
Northern Michigan Regional Entity	54.52	1,004	500	1,504	820
Oakland Co CMH Authority	83.11	819	140	959	797
Region 10	79.04	1,675	281	1,956	1,546
CMH Partnership of Southeast MI	58.59	874	261	1,135	665
Southwest MI Behavioral Health	71.64	1,134	266	1,400	1,003
Statewide Total		**14,331**	**3,669**	**18,000**	**12,509**

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

	Percentage	# of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# of Persons Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	92.96	2,670	2,482
Lakeshore Regional Entity	59.41	1,057	628
Macomb Co CMH Services	76.69	798	612
Mid-State Health Network	67.19	3,161	2,124
Northcare Network	74.16	387	287
Northern Michigan Regional Entity	73.57	647	476
Oakland Co CMH Authority	98.25	798	784
Region 10	78.72	1,490	1,173
CMH Partnership of Southeast MI	69.82	772	539
Southwest MI Behavioral Health	59.80	2,112	1,263
Statewide Total		**13,892**	**10,368**

Table 3a: The Percentage of New Children with Emotional Disturbance During the Quarter Starting any Medically Necessary Ongoing Service within 14 Calendar Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Children Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	90.42	501	453
Lakeshore Regional Entity	56.91	376	214
Macomb Co CMH Services	67.66	201	136
Mid-State Health Network	61.60	974	600
Northcare Network	70.63	143	101
Northern Michigan Regional Entity	69.66	178	124
Oakland Co CMH Authority	98.26	230	226
Region 10	80.60	402	324
CMH Partnership of Southeast MI	69.67	211	147
Southwest MI Behavioral Health	60.41	533	322
Statewide Total		**3,749**	**2,647**

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

	Percentage	# MI Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Adults Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	93.75	1,487	1,394
Lakeshore Regional Entity	58.15	454	264
Macomb Co CMH Services	80.21	480	385
Mid-State Health Network	67.95	1,819	1,236
Northcare Network	74.76	210	157
Northern Michigan Regional Entity	71.55	355	254
Oakland Co CMH Authority	98.01	502	492
Region 10	75.69	839	635
CMH Partnership of Southeast MI	65.91	440	290
Southwest MI Behavioral Health	59.76	1,399	836
Statewide Total		**7,985**	**5,943**

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

	Percentage	# DD Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Children Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	92.43	568	525
Lakeshore Regional Entity	66.67	147	98
Macomb Co CMH Services	85.39	89	76
Mid-State Health Network	83.64	275	230
Northcare Network	94.44	18	17
Northern Michigan Regional Entity	84.81	79	67
Oakland Co CMH Authority	100	28	28
Region 10	88.30	188	166
CMH Partnership of Southeast MI	84.62	78	66
Southwest MI Behavioral Health	55.12	127	70
Statewide Total		**1,597**	**1,343**

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

	Percentage	# DD Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Adults Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	96.49	114	110
Lakeshore Regional Entity	65.00	80	52
Macomb Co CMH Services	53.57	28	15
Mid-State Health Network	62.37	93	58
Northcare Network	75.00	16	12
Northern Michigan Regional Entity	88.57	35	31
Oakland Co CMH Authority	100	38	38
Region 10	78.69	61	48
CMH Partnership of Southeast MI	83.72	43	36
Southwest MI Behavioral Health	66.04	53	35
Statewide Total		**561**	**435**

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

	Percentage	# Children Discharged from Psychiatric Inpatient Unit	# Children Seen for Follow-Up Care within 7 Days
Detroit Wayne Mental Health Authority	100	59	59
Lakeshore Regional Entity	96.47	85	82
Macomb Co CMH Services	89.36	47	42
Mid-State Health Network	99.24	132	131
Northcare Network	100	25	25
Northern Michigan Regional Entity	97.14	35	34
Oakland Co CMH Authority	97.37	38	37
Region 10	97.70	87	85
CMH Partnership of Southeast MI	96.77	31	30
Southwest MI Behavioral Health	98.44	64	63
Statewide Total		**603**	**588**

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

	Percentage	# Adults Discharged from Psychiatric Inpatient Unit	# Adults Seen for Follow-Up Care within 7 Days
Detroit Wayne Mental Health Authority	98.58	633	624
Lakeshore Regional Entity	96.17	287	276
Macomb Co CMH Services	88.34	223	197
Mid-State Health Network	96.22	635	611
Northcare Network	97.87	94	92
Northern Michigan Regional Entity	96.00	150	144
Oakland Co CMH Authority	96.22	185	178
Region 10	95.18	311	296
CMH Partnership of Southeast MI	92.65	204	189
Southwest MI Behavioral Health	95.75	306	293
Statewide Total		**3,028**	**2,900**

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

	Percentage	# SA Discharged from Substance Abuse Detox Unit	# SA Seen for Follow-Up Care within 7 Days
Detroit Wayne Mental Health Authority	98.74	554	547
Lakeshore Regional Entity	100	80	80
Macomb Co CMH Services	100	244	244
Mid-State Health Network	90.95	199	181
Northcare Network	93.94	33	31
Northern Michigan Regional Entity	94.89	137	130
Oakland Co CMH Authority	98.79	165	163
Region 10	91.67	72	66
CMH Partnership of Southeast MI	99.06	106	105
Southwest MI Behavioral Health	99.22	128	127
Statewide Total		**1,718**	**1,674**

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

	Percentage	Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients
Detroit Wayne Mental Health Authority	6.66	46,189	693,784
Lakeshore Regional Entity	6.41	17,823	278,110
Macomb Co CMH Services	5.47	12,143	221,838
Mid-State Health Network	8.53	34,392	403,002
Northcare Network	8.33	5,419	65,026
Northern Michigan Regional Entity	8.46	9,985	117,986
Oakland Co CMH Authority	8.74	16,943	193,905
Region 10	8.57	17,402	202,970
CMH Partnership of Southeast MI	7.64	9,822	128,556
Southwest MI Behavioral Health	8.75	18,702	213,740
Statewide Total		**188,820**	**2,518,917**

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

	Percentage	# of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	Total Number of HSW Enrollees
Detroit Wayne Mental Health Authority	95.84	945	986
Lakeshore Regional Entity	96.18	605	629
Macomb Co CMH Services	94.83	385	406
Mid-State Health Network	95.45	1,384	1,450
Northcare Network	98.38	364	370
Northern Michigan Regional Entity	82.58	545	660
Oakland Co CMH Authority	95.63	722	755
Region 10	96.86	493	509
CMH Partnership of Southeast MI	94.29	611	648
Southwest MI Behavioral Health	97.27	678	697
Statewide Total		**6,732**	**7,110**

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

	Percentage	# of Children Discharged from Inpatient Care	# Children Discharged that were Readmitted within 30 Calendar Days
Detroit Wayne Mental Health Authority	12.14	206	25
Lakeshore Regional Entity	16.07	112	18
Macomb Co CMH Services	11.67	60	7
Mid-State Health Network	8.95	190	17
Northcare Network	13.33	30	4
Northern Michigan Regional Entity	13.64	44	6
Oakland Co CMH Authority	10.42	48	5
Region 10	10.77	130	14
CMH Partnership of Southeast MI	5.26	38	2
Southwest MI Behavioral Health	6.80	103	7
Statewide Total		**961**	**105**

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

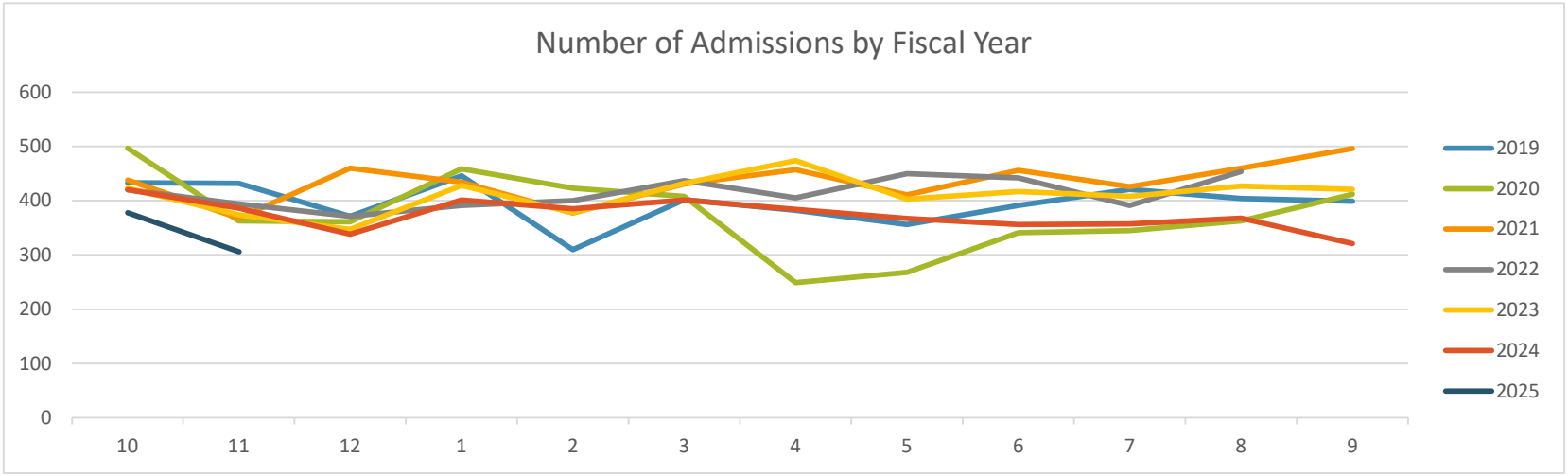
	Percentage	# of Adults Discharged from Inpatient Care	# Adults Discharged that were Readmitted within 30 Calendar Days
Detroit Wayne Mental Health Authority	16.52	1695	280
Lakeshore Regional Entity	8.99	434	39
Macomb Co CMH Services	18.38	506	93
Mid-State Health Network	11.44	1,136	130
Northcare Network	15.60	109	17
Northern Michigan Regional Entity	15.81	234	37
Oakland Co CMH Authority	12.93	317	41
Region 10	13.90	597	83
CMH Partnership of Southeast MI	14.24	288	41
Southwest MI Behavioral Health	11.03	553	61
Statewide Total		**5,869**	**822**

Northern Michigan Regional Entity
Substance Use Disorder Services

Admission Report

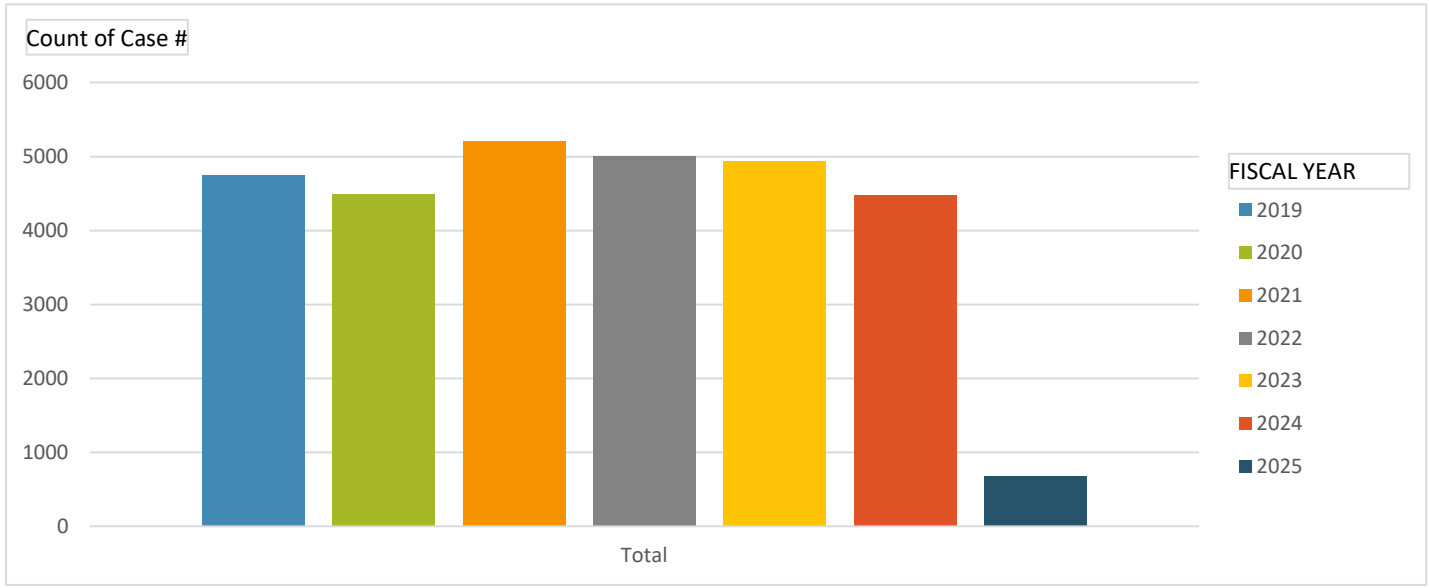
Total Number of Admissions Per Fiscal Year by Month

Count of Case #	Column Labels												
Row Labels	10	11	12	1	2	3	4	5	6	7	8	9	Grand Total
2019	433	432	371	446	310	402	382	356	391	421	404	399	**4747**
2020	497	363	361	459	423	408	249	268	341	345	363	412	**4489**
2021	438	368	460	434	377	431	457	411	456	426	460	496	**5214**
2022	420	394	371	391	400	437	405	450	442	391	454	453	**5008**
2023	423	374	347	428	378	432	474	403	417	408	427	421	**4932**
2024	420	386	338	401	385	401	384	367	356	357	368	321	**4484**
2025	378	306											**684**
Grand Total	**3009**	**2623**	**2248**	**2559**	**2273**	**2511**	**2351**	**2255**	**2403**	**2348**	**2476**	**2502**	**29558**



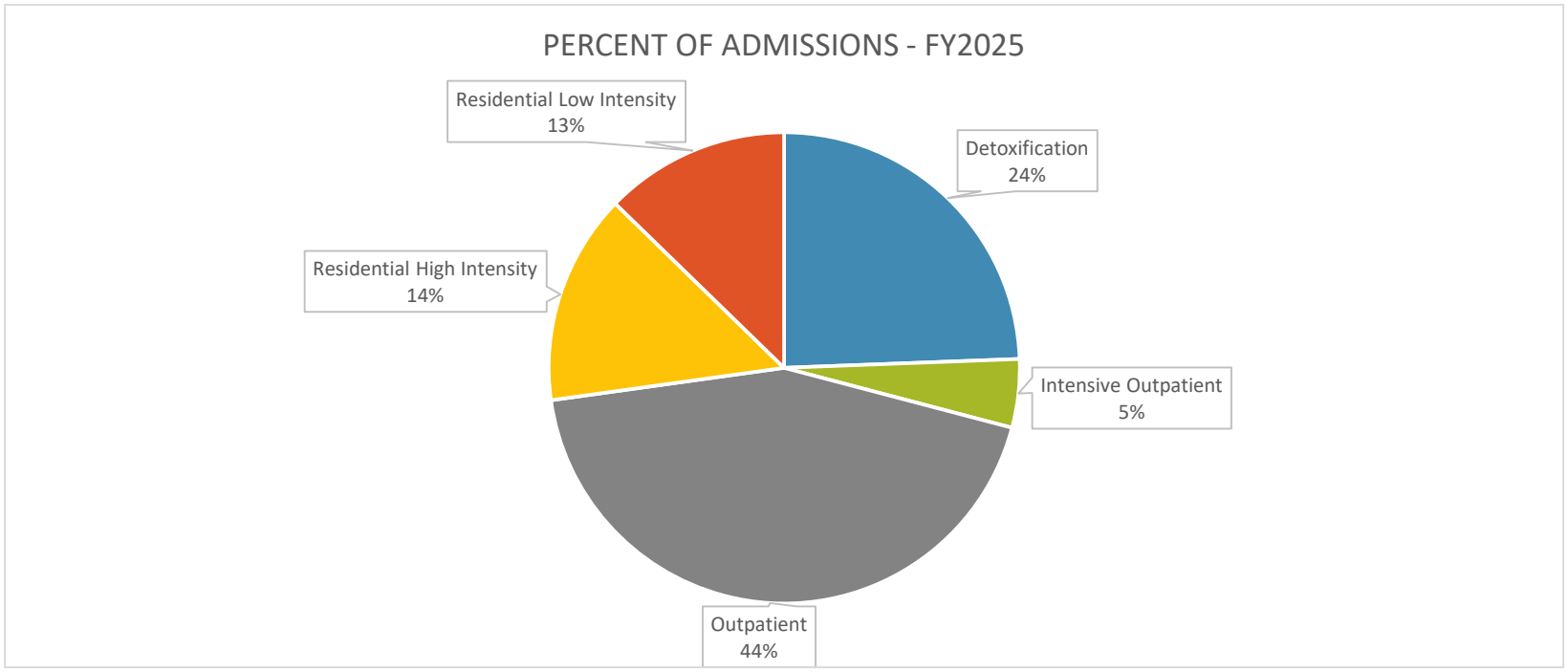
Total Number of Admissions Per Fiscal year

	2019	2020	2021	2022	2023	2024	2025	Grand Total
Count of Case #	**4747**	**4489**	**5214**	**5008**	**4932**	**4484**	**684**	**29558**



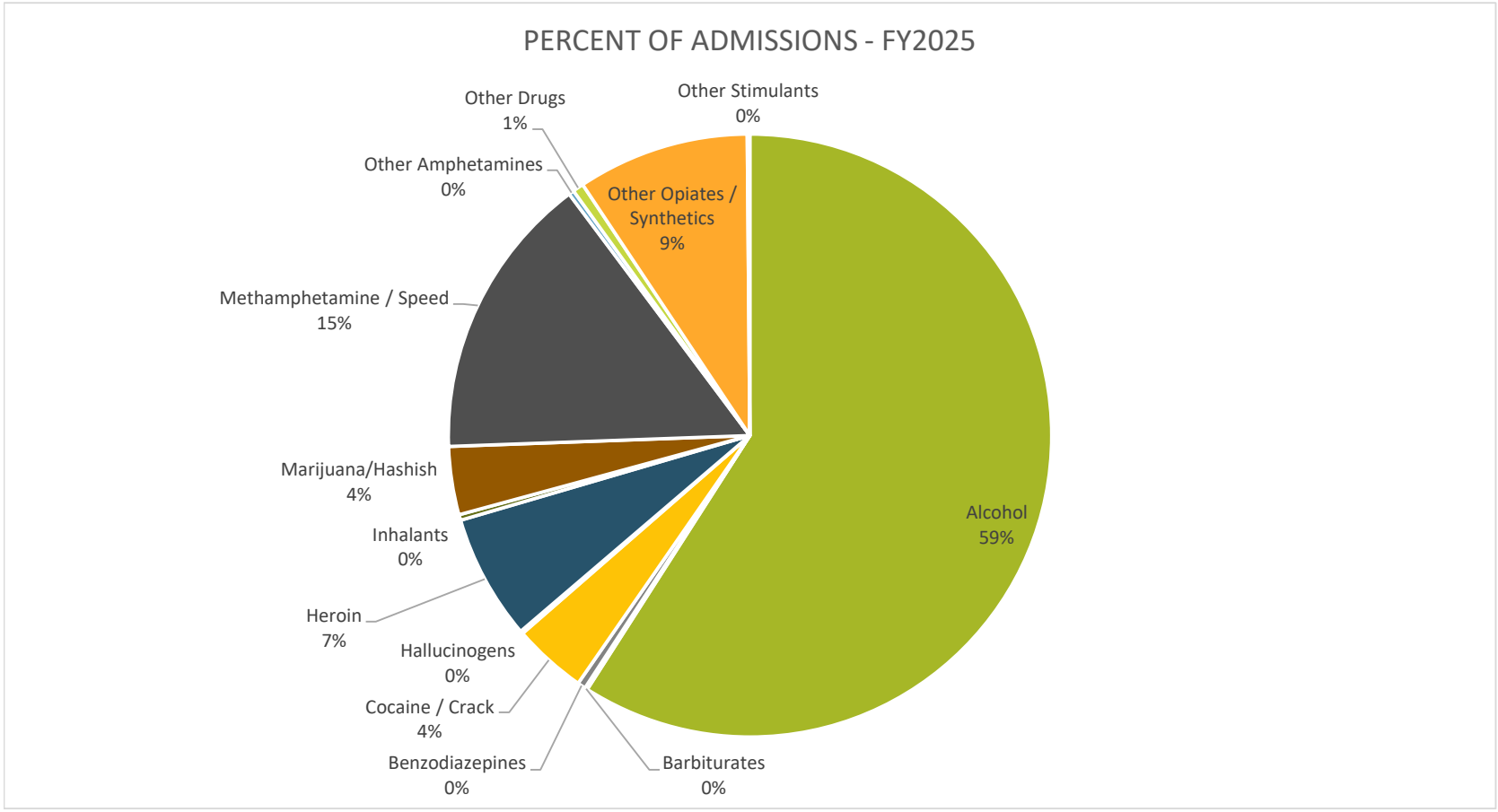
Treatment Setting at Admission

Count of Case #	Column Labels							
Row Labels	2019	2020	2021	2022	2023	2024	2025	Grand Total
Detoxification	1077	980	1033	933	1109	1209	167	6508
Intensive Outpatient	41	87	113	110	140	200	32	723
OHH	395	374	490	704	155			2118
Outpatient	2371	2165	2471	2029	2164	1833	299	13332
Residential High Intensity	767	753	993	1076	982	714	99	5384
Residential Low Intensity	96	130	114	156	382	528	87	1493
Grand Total	**4747**	**4489**	**5214**	**5008**	**4932**	**4484**	**684**	**29558**



Total Number of Admissions Per Fiscal year

Row Labels		2019	2020	2021	2022	2023	2024	2025	Grand Total
(None)					1				1
Alcohol	2416		2192	2320	2294	2635	2644	404	14905
Barbiturates			2	1	3	2	2	1	11
Benzodiazepines	22		16	19	25	30	22	3	137
Cocaine / Crack	72		67	45	57	79	100	27	447
Hallucinogens	5		2	2	1	3	2	1	16
Heroin	460		560	806	665	559	399	46	3495
Inhalants	4		3		3	5	11	2	28
Marijuana/Hashish	352		269	255	178	159	145	25	1383
Methamphetamine / Speed	234		361	599	623	819	755	105	3496
Non-prescription methadone	13		12	13	7	9	2		56
Not collected (exception, etc.)					1				1
Other Amphetamines	14		11	22	11	14	8	2	82
Other Drugs	1		16	8	14	12	17	4	72
Other Opiates / Synthetics	738		590	612	397	428	370	63	3198
Other Sedatives / Hypnotics	11		4	2	3	2	2		24
Other Stimulants	5		8	14	10	14	3	1	55
Other Tranquilizers			1	1	1				3
Over-the-Counter Medications	5			4	4	3	1		17
PCP - phencyclidine					1				1
(blank)	395		375	491	709	159	1		2130
Grand Total	**4747**		**4489**	**5214**	**5008**	**4932**	**4484**	**684**	**29558**


PERCENT OF ADMISSIONS - FY2025
Other Drugs 1%
Other Stimulants 0%
Other Amphetamines 0%
Other Opiates / Synthetics 9%
Methamphetamine / Speed 15%
Marijuana/Hashish 4%
Inhalants 0%
Heroin 7%
Hallucinogens 0%
Cocaine / Crack 4%
Benzodiazepines 0%
Barbiturates 0%
Alcohol 59%

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – JANUARY 8, 2025
VIA TEAMS

ATTENDEES:	Brian Babbitt, Connie Cadarette, Ann Friend, Kevin Hartley, Chip Johnston, Nancy Kearly, Eric Kurtz, Brian Martinus, Allison Nicholson, Donna Nieman, Branon Rhue, Nena Sork, Erinn Trask, Tricia Wurn, Deanna Yockey, Carol Balousek

REVIEW AGENDA & ADDITIONS

Donna asked that the cost settling process for BHH be added to the meeting agenda. Connie asked that EQI data be added to the meeting agenda. Erinn asked that discussion of the Minimum Wage increase and Earned Sick Time Act be added to the meeting agenda.

REVIEW PREVIOUS MEETING MINUTES

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE DECEMBER 11, 2024 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY KEVIN HARTLEY. MOTION APPROVED.

MONTHLY FINANCIALS

November 2024

- Net Position showed net deficit Medicaid and HMP of $721,431. Carry forward was reported as $2,909,566. The total Medicaid and HMP Current Year Surplus was reported as $2,188,135. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $22,764,291.
- Traditional Medicaid showed $33,339,219 in revenue, and $33,746,942 in expenses, resulting in a net deficit of $407,723. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $4,372,373 in revenue, and $4,686,081 in expenses, resulting in a net deficit of $313,708. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $2,909,566.
- Health Home showed $563,897 in revenue, and $455,038 in expenses, resulting in a net surplus of $108,859.
- SUD showed all funding source revenue of $4,638,753 and $3,653,034 in expenses, resulting in a net surplus of $985,719. Total PA2 funds were reported as $4,612,270.

Denna acknowledged that the ISF is currently overfunded. Communication was received from MDHHS on December 16th stating that the PIHPs FY24 FSR Bundle submission, due on February 28, 2025, will not be accepted if any IFS balance shown is greater than 7.5% of the annual operating budget. Rejected FSR bundles will be considered "late" and will be disqualified from receiving the performance bonus incentive payment for timely reporting. Milliman's 2024 analysis found that the NMRE's ISF should be funded at approximately 15% of annual revenue.

PA2/Liquor Tax was summarized as follows:

Projected FY25 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$4,765,231	$1,847,106	$2,068,850	$4,543,487

Actual FY25 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$0	$152,961	$4,612,270

As expected, PA2 funds in the amount of $301K were needed to supplement block grant funding for FY24. The dip into PA2 funds did not affect county withhold balances.

Both Medicaid and HMP are running at a deficit two months into FY25. It is unclear whether the $18M due to the NMRE in FY24 due to the migration of individuals from DAB to TANF, HMP, and Plan First and the $2.5M due to the NMRE for unpaid, filled HSW slots will compensate for the shortfall. The NMRE continues to work on getting these payments. It is unknown whether either of the issues will persist in FY25. Donna questioned a potential rate adjustment.

Brian B. asked how other PIHPs are positioned for FY25. Deanna responded that a PIHP CFO meeting scheduled for 11:00 on this date; she will ask what was shown by other PIHPs' FSRs.

This topic will be discussed further during the regional Operations Committee meeting on January 21st.

MOTION BY KEVIN HARTLEY TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2024; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

NMRE REVENUE AND ELIGIBLE ANALYSIS

An analysis of November 2023 – December 2024 Revenue and Eligibles was included in the meeting materials.

Children's Waiver Program			
	November 2023	December 2024	% Change
Revenue	$37,040	$32,754	-11.57%
Enrollees	11	10	-9.09%

DAB			
	November 2023	December 2024	% Change
Revenue	$9,796,214	$9,720,886	-0.77%
Enrollees	27,979	24,785	-11.42%
Average Payment per Enrollee	$350.00	$392.00	12.02%

HMP			
	November 2023	December 2024	% Change
Revenue	$2,286,849	$2,182,165	-4.58%
Enrollees	45,924	33,232	-27.64%
Average Payment per Enrollee	$50.00	$55.00	31.87%

HSW			
	November 2023	December 2024	% Change
Revenue	$4,692,308	$5,274,886	12.42%
Enrollees	663	700	5.58%
Average Payment per Enrollee	$7,077.00	$7,536.00	6.47%

SED			
	November 2023	December 2024	% Change
Revenue	$43,326	$23,468	-45.83%
Enrollees	22	34	54.55%
Average Payment per Enrollee*	$1,969.00	$690.00	-64.95%

*SED revenue was moved into DAB October 1, 2024.

TANF			
	November 2023	December 2024	% Change
Revenue	$2,763,765	$2,697,168	-2.41%
Enrollees	65,030	54,406	-16.34%
Average Payment per Enrollee	$42.00	$50.00	16.65%

FY24 FINAL FSR
The final FY24 FSR is due to MDHHS on February 28th. Reports have been requested from the CMHSPs by February 14th.

EDIT UPDATE
The next EDIT meeting is scheduled for January 16th at 10:00AM. Will be discussing caregiver training codes. Donna indicated that caregiver training codes will be a topic of discussion.

EQI UPDATE
The full FY24 EQI report is due to MDHHS on February 28th. Reports have been requested from the CMHSPs by February 14th.

Connie noted an issue with the data using the P3 template ($8K in DAB disappeared); however, the data pull on January 3rd didn't appear to have any issues. Tricia asked the CMHSPs to use data pulled on the morning of January 9th.

ELECTRONIC VISIT VERIFICATION (EVV)
Donna reported that HHAX continues to resolve technical issues. A statewide PIHP, CMHSP, and MDHHS EVV Leads meeting is scheduled for 11:00AM on this date.

HSW OPEN SLOTS UPDATE

Until today, the NMRE had had all its 697 slots filled for January; currently two slots have opened. Packets have been submitted to fill the vacancies. The next payment detail will be available on January 15th.

DAB TRANSITION

Beginning this month, PCE is conducting a statewide analysis to identify the many issues related to eligibility changes (movement of Medicaid beneficiaries from DAB to TANF, HMP, and Plan First). A subgroup of CIO Forum members has been formed to work with PCE.

Centra Wellness noticed DAB enrollments going up during the pandemic and then back down to pre-pandemic levels.

ALPINE CRISIS RESIDENTIAL UNIT

The monthly 1/12th payment arrangement between the NMRE and Alpine CRU/North Shores Center ended on December 31, 2024. Beginning January 1, 2025, The CMHSPs will be contracting with the facility (amend the zero-payment contract) on a fee-for-service arrangement with per diem rates of $600 for crisis residential and $350 for respite; the NMRE will continue to pay 50% of the facility's costs ($49,229K per month/$443,061K total).

FY24 GF units are needed from the CMHSPs for reimbursement to the NMRE.

Clarification was made that no costs should be attached to units on the CMHSPs' EQI reports; the NMRE submitted its EQI with the costs attached (in PIHP data). Erinn expressed that she thinks costs should be included on the CMHSPs' EQI reports for general funds.

NMRE TRANSITION TO BUSINESS CENTRAL

Because Microsoft will end support for Dynamics Great Plains (GP) on September 30, 2029, the NMRE is planning to move to Business Central in FY26. A proposal from the TM Group was included in the meeting materials.

Total Annual Software Investment	$21,912
Total Services Investment	$76,340
Total Investment	**$98,252**

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE PURCHASE OF MICROSOFT DYNAMICS SOFTWARE WITH SUPPORT PROVIDED BY THE TM GROUP, INC. FOR A TOTAL AMOUNT OF NINETY-EIGHT THOUSAND TWO HUNDRED FIFTY-TWO DOLLARS; SUPPORT BY KEVIN HARTLEY. MOTION CARRIED.

BHH/OHH COST SETTLING

The NMRE's Interim FSR identified variances in health home costing between CMHSPs. Eric clarified that health home programs are intended to be fee-for-service, full risk programs. Northern Lakes ended FY24 with a significant deficit due to costing. Kevin noted that Northern Lakes is revamping the costing methodology.

Deanna explained that health home over-expenditures can be booked as receivables from NMRE for cost settling. The importance of all five CMHSPs' costing models to be consistent was also stressed.

MINIMUM WAGE INCREASE AND EARNED SICK TIME ACT

Erinn drew attention to the effect of the minimum wage increase ($12.48/hour effective February 21, 2025) and earned sick time act on provider rates and self-determination budgets. It was noted that most current self-determination arrangements have no provisions for sick time. Budgets will need to be increased or pay rates reduced. Erinn stressed that the impact on provider network rates and self-determination budgets needs to be addressed by the Department (not built into FY25 rates).

Eric said that he has heard of a potential rate adjustment coming for FY25.

It was noted that both the Michigan House and Senate have introduced legislation that would change the wage and sick time laws prior to February 21st.

Eric advised the CMHSPs to seek clarification from their respective legal counsels.

Erinn requested that the NMRE make the state aware that the minimum wage increase and earned sick time are unfunded and request a revenue adjustment. Chip responded that this task might be better left to another region due to the NMRE's current stance on the FY25 PIHP Contract.

NEXT MEETING

The next meeting was scheduled for February 12th at 10:00AM.

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD EXECUTIVE COMMITTEE MEETING
10:00AM – JANUARY 3, 2025
GAYLORD CONFERENCE ROOM

ATTENDEES:	Gary Klacking, Ruth Pilon, Karla Sherman, Don Tanner
VIRTUAL ATTENDEES:	Eric Lawson
STAFF:	Eric Kurtz, Brian Martinus, Sonya Russell, Deanna Yockey, Carol Balousek
INVITED GUESTS:	Laura Argyle, Avi Beliak, Steve Burnham, Richard Carpenter, Bill Edwards, 1 Anonymous

The meeting of the NMRE Executive Committee was called on this date to review the **Rehmann Corporate Investigative Services Forensic Accounting Report** of Northern Lakes Community Mental Health Authority.

COST MISALLOCATION

The State of Michigan began requiring Community Mental health Services Programs (CMHSPs) to abide by the Standard Cost Allocation (SCA) methodology in FY22. Prior to that time, allocation methodologies and costing were required to adhere to the Code of Federal Regulations, Chapter 2, Part 200 (2 CFR 200).

A review of FY23 expense allocations by the new Deputy CFO for the cost allocations made by the former CFO revealed that expenses were being misallocated and that neither the SCA methodology nor 2 CFR 200 were being properly applied. Expenses related to payroll were not accumulated in a way to match the expense with the specific consumer service activities to be reported under the SCA.

The Q1 FY23 Board Budget report covering the first four months of the fiscal year submitted to the State had a final expense variance of $1,944,584. The most significant difference was due to accruals being computed by applying ⅓ of the annual budget amount less the year-to-date expenses as opposed to using actual results.

Another variance was related to the billing of services provided in a jail setting. Use of the "QJ" modifier was not consistently used resulting in services likely being billed to Medicaid, rather than general funds, totaling $200K - $300K.

Additionally, there is no evidence that any administrative overhead was charged to State of Michigan grants, except for OBRA.

The method for calculating the MI Choice Waiver and the related Nursing Facility Transition Grant expenses cannot be determined. Based on a review of the formulas, it appears that the expenses were based on actual capitated revenues received, less approximately 10%. It is unclear whether the former CFO allocated administrative costs to the MI Choice program. Required administration not properly charged to the MI Choice program would have overstated Medicaid and Healthy Michigan Plan (HMP) expenses.

The former CFO submitted documents to MDHHS certifying the use of the SCA methodology. However, the Deputy CFO identified numerous discrepancies, indicating that the former CFO's practices were inconsistent with the SCA methodology and federal cost principles.

It is estimated that, without correction, the final FY23 administrative allocation methodology would have resulted in an overstatement of just under $2.2M to Medicaid/HMP with the resulting understatements to the General Fund, MI Choice Waiver, and Grant programs. The Deputy CFO adjusted journal entries to ensure that no misallocation will be reported for this fiscal year.

It is likely that expense misallocation errors occurred in previous years.

Mr. Kurtz clarified that the MI Choice Waiver is a 100% risk program for Northern Lakes; Northern Lakes' arrangement with NMRE is one of shared risk.

(Mr. Carpenter exited the meeting)

LEASED PROPERTIES

Northern Lakes CMHA operates 19 facilities, 13 of which are owned by NLCMHA and 6 of which are leased. The leased properties were investigated to ensure that there were no conflicts of interest between NLCMHA and current or former employees. Based on the research conducted, no evidence of a conflict of interest with respect to the ownership of the six leased properties was found.

INTERIM CEO OVERTIME

The former Interim CEO of Northern Lakes CMHA claimed overtime hours during the time she was acting in the position of Interim CEO. No evidence was found to indicate that overtime compensation was authorized.

During her time as Interim CEO, the individual volunteered to perform services and the NLCMHA Welcoming Center (CWC) as well as working on cases in the Intellectual/Developmental Disabilities (I/DD) program.

The overtime hours claimed by and paid to the former Interim CEO in FY23 totaled 562 hours and $47,732.29. The overtime claimed could not be reconciled to the CWC schedules and no

documentation was available regarding I/DD scheduling, reports, or logbooks which could capture hours worked in the I/DD program other than 42.2 hours of face-to-face service to one individual. It appears that the former Interim CEO was able to claim overtime over and above the face-to-face time spent with I/DD patient. Therefore, the total overtime claimed in the I/DD program could not be reconciled.

INTERIM CEO STIPEND

The former Interim CEO of Northern Lakes CMHA was granted a $1,100 weekly stipend upon the retirement of the previous CEO, which was to continue until a new CEO was put in place. The former Interim CEO, however, continued to receive the $1,100 stipend after the current Interim CEO was placed in the position. An additional stipend of $7,200 was also paid in July 2023 with no documentation or notation to explain the payment. The total of the stipend overpayment was calculated at $56,700.00.

PROCUREMENT

Northern Lakes CMHA staff expressed concerns regarding whether the Maintenance Supervisor had followed NLCMHA's procurement policies, namely, soliciting multiple bids and selecting the lowest. The investigation confirmed that in many instances no bids were submitted with purchase orders for payment. Purchase orders that did include three bids either had bids that were undated or bids that were dated after the purchase date. In only two instances were there purchase orders that included bids dated prior to the purchase.

Since the Maintenance Supervisor developed a pattern of not obtaining the required 3 bids for purchase orders exceeding $600, there are concerns of a conflict of interest on the part of the Maintenance Supervisor.

Mr. Burnham noted that there are times under exigent circumstances where exceptions to the 3-bid requirement can be made (like a boiler). Mr. Beliak confirmed that the cases in question were not emergency situations.

CREDIT CARDS

According to Northern Lakes CMHA policy, "no more than five (5) general purpose credit cards may be issued for the Chief Executive Office and designee(s) to use." It was observed, however, that credit card purchases were made by six staff members who had each been issued credit cards.

A JP Morgan Chase credit card was opened by the former CFO during FY23. The account earned reward points for purchases made with the card that could be redeemed for goods or cash. As of August 2023, the points had a cash value of $14,918. The points were not recovered by the former CFO when the account was closed.

(Mr. Beliak and Mr. Edwards exited the meeting.)

RECOMMENDATIONS

Mr. Kurtz stressed that the role of the NMRE is to ensure Medicaid funds were used appropriately. Any personnel issues identified in the report should be taken up by the Northern Lakes CMHA Board of Directors.

Mr. Kurtz indicated that a decision is needed regarding the need to go back additional years for the Cost Allocation portion. Mr. Kurtz recommended looking back an additional 5-7 years. There is the potential for Medicaid recoupment and/or movement from Medicaid to a different funding source (local funds) at NLCMHA depending on the results. An overallocation of administration to Medicaid/NMRE was likely made in past years. The $2.2M observed in FY23 has been cleaned up.

MOTION BY KARLA SHERMAN TO RECOMMEND THAT REHMANN BE AUTHORIZED TO GO BACK AN ADDITIONAL FIVE TO SEVEN YEARS FOR THE COST ALLOCATION PORTION OF THE FORENSIC INVESTIGATION; SECOND BY DON TANNER. MOTION CARRIED.

The preceding recommendation will be presented to the full NMRE Board of Directors during the meeting on January 22, 2025. Mr. Kurtz will obtain costs from Rehmann in the interim.

Future questions related to the report may be directed to Mr. Beliak avi.beliak@rehmann.com or Mr. Edwards Bill.Edwards@rehmann.com.

DISSEMINATION OF THE REPORT

The report will be shared with the full NMRE Board of Directors on this date.

ADJOURNMENT

Mr. Klacking adjourned the meeting at 11:11AM.

Chief Executive Officer Report

January 2024

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

Jan 3: Attended and participated in NMRE Executive Committee Meeting.

Jan 6: Attended and participated in NMRE SUD Oversight Committee Meeting.

Jan 7: Attended and participated in GTC/Munson Crisis Committee Meeting.

Jan 8: Attended and participated in NMRE Regional Finance Committee Meeting.

Jan 9: Attended and participated in MDHHS and PIHP CEO Meeting.

Jan 10: Attended and participated in Regional Provider Network Managers Training.

Jan 21: Plan to Chair Regional Operations Committee Meeting.

November 2024 Finance Report

November 2024 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	(407,723)	-	13,510,136
Healthy Michigan	(313,708)	2,909,566	7,066,020
	$ (721,431)	$ 2,909,566	$ 20,576,156

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	324,710	950,260	(1,422,964)	(400,474)	(130,526)	(135,913)	93,477	$ (721,431)
Carry Forward		-	-	-	-	-	-	2,909,566
Total Med/HMP Current Year Surplus	324,710	950,260	(1,422,964)	(400,474)	(130,526)	(135,913)	93,477	$ 2,188,135
Medicaid & HMP Internal Service Fund								20,576,156
Total Medicaid & HMP Net Surplus								$ 22,764,291

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through November 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 32,189,886	$ 1,149,333						$ 33,339,219
CMHSP Distributions	(31,078,218)		9,977,565	8,439,296	5,316,117	4,441,358	2,903,882	(0)
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	1,111,668	1,149,333	9,977,565	8,439,296	5,316,117	4,441,358	2,903,882	33,339,219
Expense								
PIHP Admin	479,941	9,544						489,485
PIHP SUD Admin		23,962						23,962
SUD Access Center		-						-
Insurance Provider Assessment	289,559	6,004						295,563
Hospital Rate Adjuster	-							-
Services		642,237	11,034,681	8,736,813	5,339,484	4,436,550	2,748,167	32,937,932
Total expense	769,500	681,747	11,034,681	8,736,813	5,339,484	4,436,550	2,748,167	33,746,942
Net Actual Surplus (Deficit)	$ 342,168	$ 467,586	$ (1,057,116)	$ (297,517)	$ (23,367)	$ 4,808	$ 155,715	$ (407,723)

Notes

Medicaid ISF - $13,510,136 - based on current FSR
Medicaid Savings - $0

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through November 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 2,343,262	$ 2,029,111						$ 4,372,373
CMHSP Distributions	(2,288,778)		841,080	653,065	295,746	311,926	186,961	(0)
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	54,484	2,029,111	841,080	653,065	295,746	311,926	186,961	4,372,373
Expense								
PIHP Admin	45,589	21,654						67,243
PIHP SUD Admin		54,366						54,366
SUD Access Center		-						-
Insurance Provider Assessment	26,354	13,272						39,626
Hospital Rate Adjuster	-							-
Services		1,457,145	1,206,928	756,022	402,906	452,647	249,199	4,524,847
Total expense	71,943	1,546,437	1,206,928	756,022	402,906	452,647	249,199	4,686,081
Net Surplus (Deficit)	$ (17,458)	$ 482,674	$ (365,848)	$ (102,957)	$ (107,160)	$ (140,721)	$ (62,238)	$ (313,708)

Notes
HMP ISF - $7,066,020 - based on current FSR
HMP Savings - $2,909,566

Net Surplus (Deficit) MA/HMP	**$ 324,710**	**$ 950,260**	**$ (1,422,964)**	**$ (400,474)**	**$ (130,526)**	**$ (135,913)**	**$ 93,477**	**$ (721,431)**
Medicaid/HMP Carry Forward								**2,909,566**
Total Med/HMP Current Year Surplus								$ 2,188,135
Medicaid & HMP ISF - based on current FSR								**20,576,156**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 22,764,291**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through November 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 206,258		99,325	60,016	65,280	37,905	95,113	$ 563,897
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	206,258	-	99,325	60,016	65,280	37,905	95,113	563,897
Expense								
PIHP Admin	6,572							6,572
BHH Admin	6,244							6,244
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	84,583		99,325	60,016	65,280	37,905	95,113	442,222
Total expense	97,399	-	99,325	60,016	65,280	37,905	95,113	455,038
Net Surplus (Deficit)	$ 108,859	$ -	$ -	$ -	$ -	$ -	$ -	$ 108,859

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2024 through November 30, 2024

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,149,333	$ 2,029,111	$ 638,204	$ 669,147	$ 152,958	$ 4,638,753
Expense						
Administration	33,506	76,020	29,162	44,497		183,185
OHH Admin			14,619	-		14,619
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	6,004	13,272	-			19,276
Services:						
Treatment	642,237	1,457,145	558,963	312,607	152,959	3,123,911
Prevention	-	-	-	134,237	-	134,237
ARPA Grant	-	-	-	177,806	-	177,806
Total expense	681,747	1,546,437	602,744	669,147	152,959	3,653,034
PA2 Redirect			-	-		-
Net Surplus (Deficit)	$ 467,586	$ 482,674	$ 35,460	$ 0	$ -	$ 985,719

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2024 through November 30, 2024

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 32,189,886	$ 1,149,333	$ -	$ 33,339,219
Medicaid Savings	-	-	-	-
Healthy Michigan	2,343,262	2,029,111	-	4,372,373
Healthy Michigan Savings	-	-	-	-
Health Home	563,897	-	-	563,897
Opioid Health Home	-	638,204	-	638,204
Substance Use Disorder Block Grant	-	669,147	-	669,147
Public Act 2 (Liquor tax)	-	152,957	-	152,957
Affiliate local drawdown	148,704	-	-	148,704
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	-	-	-
Veteran Navigator Grant	15,652	-	-	15,652
SOR Grant Revenue	-	249,227	-	249,227
Gambling Grant Revenue	-	34,558	-	34,558
Other Revenue	-	-	531	531
Total operating revenue	35,261,401	4,922,537	531	40,184,469
Operating expenses				
General Administration	580,520	134,766	-	715,286
Prevention Administration	-	18,313	-	18,313
OHH Administration	-	14,619	-	14,619
BHH Administration	6,244	-	-	6,244
Insurance Provider Assessment	315,913	19,276	-	335,189
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	32,786,900	642,237	-	33,429,137
Healthy Michigan Services	3,193,532	1,457,145	-	4,650,677
Health Home Services	442,222	-	-	442,222
Opioid Health Home Services	-	558,963	-	558,963
Community Grant	-	312,607	-	312,607
Prevention	-	115,924	-	115,924
State Disability Assistance	-	-	-	-
ARPA Grant	-	177,806	-	177,806
Public Act 2 (Liquor tax)	-	152,959	-	152,959
Local PBIP	-	-	-	-
Local Match Drawdown	148,704	-	-	148,704
Miscellanous Grant	-	-	-	-
Veteran Navigator Grant	15,652	-	-	15,652
SOR Grant Expenses	-	249,227	-	249,227
Gambling Grant Expenses	-	34,558	-	34,558
Total operating expenses	37,489,687	3,888,400	-	41,378,087
CY Unspent funds	(2,228,286)	1,034,137	531	(1,193,618)
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	14,972,511	7,082,656	20,583,069	42,638,236
Unspent funds - ending	$ 12,744,225	$ 8,116,793	$ 20,583,600	$ 41,444,618

Northern Michigan Regional Entity

Statement of Net Position

November 30, 2024

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 48,829,551	$ 6,275,920	$ 20,583,600	$ 75,689,071
Accounts Receivable	719,502	2,983,726	-	3,703,228
Prepaids	59,521	-	-	59,521
Total current assets	49,608,574	9,259,646	20,583,600	79,451,820
Noncurrent Assets				
Capital assets	449,198	-	-	449,198
Total Assets	50,057,772	9,259,646	20,583,600	79,901,018
Liabilities				
Current liabilities				
Accounts payable	37,035,788	1,142,853	-	38,178,641
Accrued liabilities	277,759	-	-	277,759
Unearned revenue	-	-	-	-
Total current liabilities	37,313,547	1,142,853	-	38,456,400
Unspent funds	$ 12,744,225	$ 8,116,793	$ 20,583,600	$ 41,444,618

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2024 through November 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 31,292,118	$ 32,189,886	$ 897,768	2.87%
Carryover	11,400,000	-	-	-	-
Healthy Michigan					
Capitation	19,683,372	3,280,562	2,343,262	(937,300)	(28.57%)
Carryover	5,100,000	-	-	-	0.00%
Health Home	1,451,268	241,878	563,897	322,019	133.13%
Affiliate local drawdown	594,816	148,704	148,704	-	0.00%
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	18,334	15,652	(2,682)	(14.63%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	227,426,695	34,981,596	35,261,401	279,805	0.80%
Operating expenses					
General Administration	3,591,836	599,876	580,520	19,356	3.23%
BHH Administration	-	-	6,244	(6,244)	0.00%
Insurance Provider Assessment	1,897,524	316,254	315,913	341	0.11%
Hospital Rate Adjuster	4,571,328	761,888	-	761,888	100.00%
Local PBIP	1,737,753	-	-	-	0.00%
Local Match Drawdown	594,816	148,704	148,704	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	15,286	15,652	(366)	(2.39%)
Payments to Affiliates:					
Medicaid Services	176,618,616	29,436,436	32,786,900	(3,350,464)	(11.38%)
Healthy Michigan Services	17,639,940	2,939,990	3,193,532	(253,542)	(8.62%)
Health Home Services	1,415,196	235,866	442,222	(206,356)	(87.49%)
Total operating expenses	208,177,013	34,454,300	37,489,687	(3,035,387)	(8.81%)
CY Unspent funds	$ 19,249,682	$ 527,296	(2,228,286)	$ (2,755,582)	
Transfers in			-		
Transfers out			-	37,489,687	
Unspent funds - beginning			14,972,511		
Unspent funds - ending			$ 12,744,225	(2,228,286)	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2024 through November 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 779,772	$ 1,149,333	$ 369,561	47.39%
Healthy Michigan	11,196,408	1,866,068	2,029,111	163,043	8.74%
Substance Use Disorder Block Grant	6,467,905	1,077,983	669,147	(408,836)	(37.93%)
Opioid Health Home	3,419,928	569,988	638,204	68,216	11.97%
Public Act 2 (Liquor tax)	1,533,979	-	152,957	152,957	0.00%
Miscellanous Grants	4,000	667	-	(667)	(100.00%)
SOR Grant	2,043,984	340,664	249,227	(91,437)	(26.84%)
Gambling Prevention Grant	200,000	33,333	34,558	1,225	3.67%
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	4,668,475	4,922,537	254,062	5.44%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	170,430	134,766	35,664	20.93%
Prevention Administration	118,428	19,738	18,313	1,425	7.22%
Insurance Provider Assessment	113,604	18,934	19,276	(342)	(1.81%)
Medicaid Services	3,931,560	655,260	642,237	13,023	1.99%
Healthy Michigan Services	10,226,004	1,704,334	1,457,145	247,189	14.50%
Community Grant	2,074,248	345,708	312,607	33,101	9.57%
Prevention	634,056	105,676	115,924	(10,248)	(9.70%)
State Disability Assistance	95,215	15,875	-	15,875	100.00%
ARPA Grant	-	-	177,806	(177,806)	0.00%
Opioid Health Home Admin	-	-	14,619	(14,619)	0.00%
Opioid Health Home Services	3,165,000	527,500	558,963	(31,463)	(5.96%)
Miscellanous Grants	4,000	667	-	667	100.00%
SOR Grant	2,043,984	340,664	249,227	91,437	26.84%
Gambling Prevention	200,000	33,333	34,558	(1,225)	(3.67%)
PA2	1,533,978	-	152,959	(152,959)	0.00%
Total operating expenses	25,222,653	3,938,119	3,888,400	49,719	1.26%
CY Unspent funds	$ 4,322,183	$ 730,356	1,034,137	$ 303,781	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			7,082,656		
Unspent funds - ending			$ 8,116,793		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2024 through November 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 320,302	$ 330,757	$ (10,455)	(3.26%)
Fringes	666,212	105,604	101,397	4,207	3.98%
Contractual	683,308	113,886	71,415	42,471	37.29%
Board expenses	18,000	3,000	1,909	1,091	36.37%
Day of recovery	14,000	9,000	-	9,000	100.00%
Facilities	152,700	25,450	23,897	1,553	6.10%
Other	135,804	22,634	51,145	(28,511)	(125.97%)
Total General Admin	$ 3,591,836	$ 599,876	$ 580,520	$ 19,356	3.23%

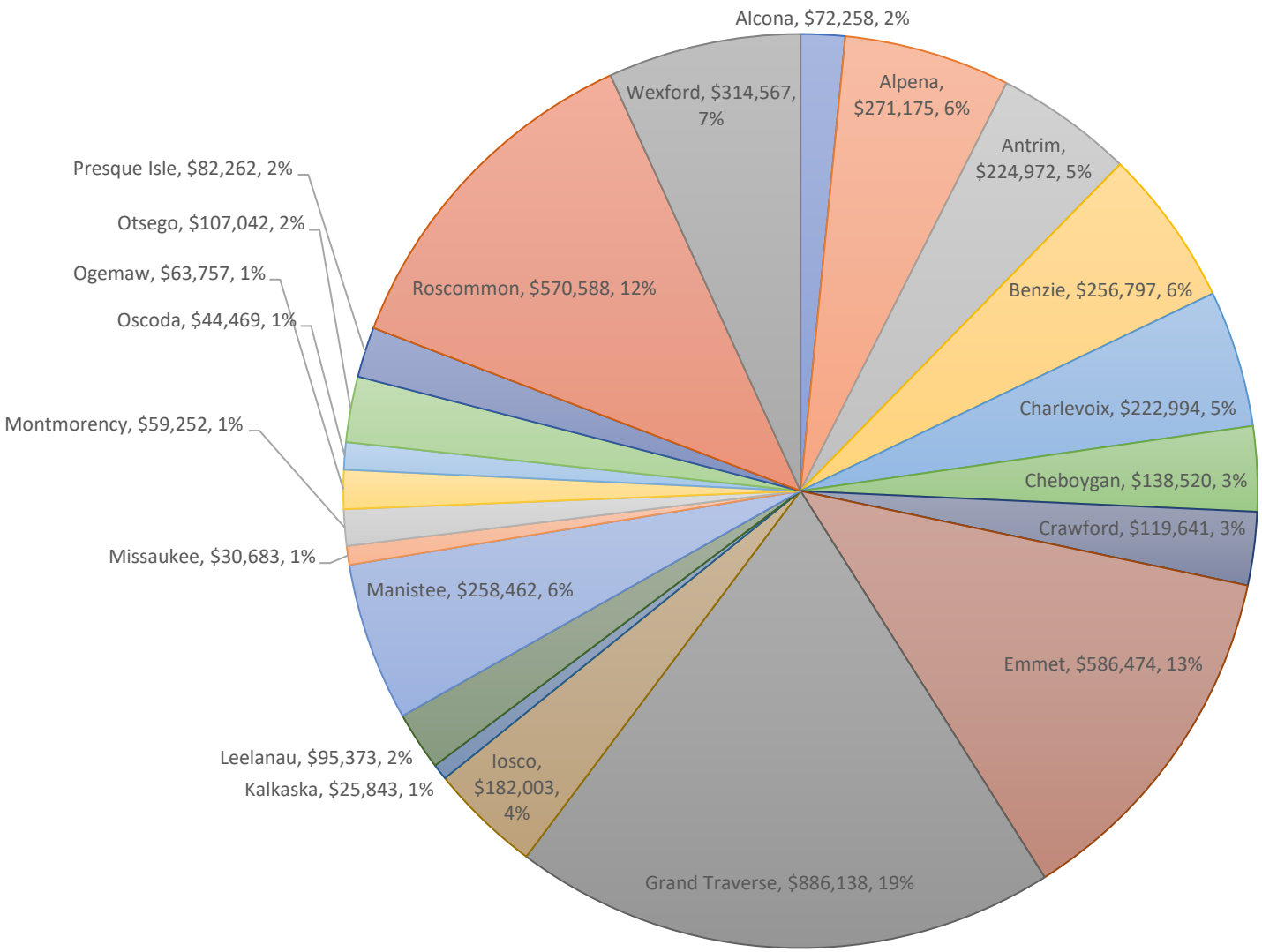
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2024 through November 30, 2024

	Projected FY25 Activity				Actual FY25 Activity			
	Beginning Balance	FY25 Projected Revenue	FY25 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 71,885	$ 23,013	$ 21,562	$ 73,336	$ -	626	$ -	$ 71,258
Alpena	276,605	81,249	115,352	242,502	-	5,431	-	271,175
Antrim	225,891	71,430	37,276	260,045	-	919	-	224,972
Benzie	257,777	64,021	52,479	269,320	-	980	-	256,797
Charlevoix	240,410	106,977	164,773	182,613	-	17,416	-	222,994
Cheboygan	141,238	85,508	65,816	160,930	-	2,717	-	138,520
Crawford	126,884	36,205	68,993	94,096	-	7,243	-	119,641
Emmet	604,860	182,951	363,695	424,117	-	18,386	-	586,474
Grand Traverse	947,150	464,163	558,074	853,238	-	61,012	-	886,138
Iosco	186,997	84,319	73,780	197,537	-	4,994	-	182,003
Kalkaska	25,843	41,796	2,436	65,203	-	-	-	25,843
Leelanau	97,166	63,811	39,737	121,240	-	1,793	-	95,373
Manistee	259,014	82,480	62,120	279,374	-	551	-	258,462
Missaukee	30,683	22,352	20,908	32,127	-	-	-	30,683
Montmorency	59,540	30,318	8,457	81,401	-	288	-	59,252
Ogemaw	64,110	68,787	11,101	121,797	-	354	-	63,757
Oscoda	44,727	21,668	7,577	58,818	-	258	-	44,469
Otsego	112,969	105,067	98,424	119,612	-	5,927	-	107,042
Presque Isle	82,660	24,977	11,701	95,936	-	398	-	82,262
Roscommon	576,714	87,317	55,007	609,024	-	6,126	-	570,588
Wexford	332,107	98,696	229,583	201,220	-	17,540	-	314,567
	4,765,231	1,847,106	2,068,850	4,543,487	-	152,961	-	4,612,270
PA2 Redirect								-
								4,612,270

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration

October 1, 2024 through November 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 723,372	$ 120,562	$ 72,584	$ 47,978	39.80%
Fringes	212,604	35,434	22,187	13,247	37.38%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	12,500	21,383	(8,883)	(71.06%)
Board expenses	5,000	834	1,060	(226)	(27.10%)
Day of Recover	-	-	10,128	(10,128)	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	1,100	7,424	(6,324)	(574.91%)
Total operating expenses	$ 1,082,576	$ 170,430	$ 134,766	$ 35,664	20.93%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2024 through November 30, 2024

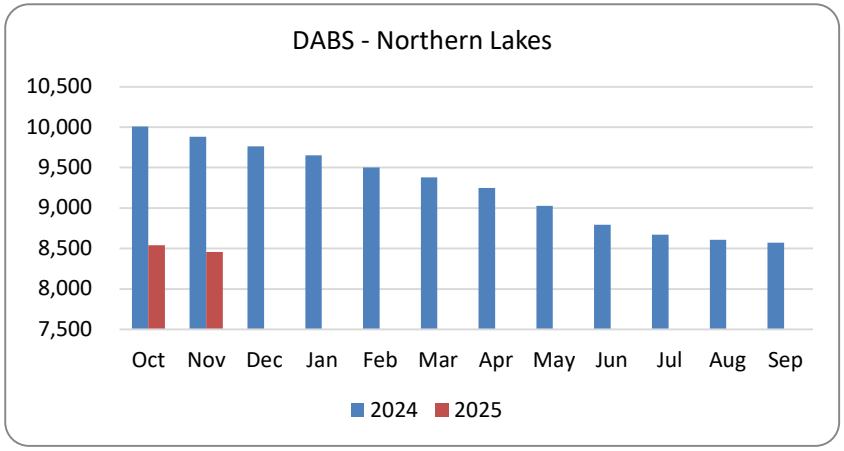
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	1,250	531	(719)	(57.52%)
Total operating revenue	7,500	1,250	531	(719)	(57.52%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 1,250	531	$ (719)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,583,069		
Unspent funds - ending			$ 20,583,600		

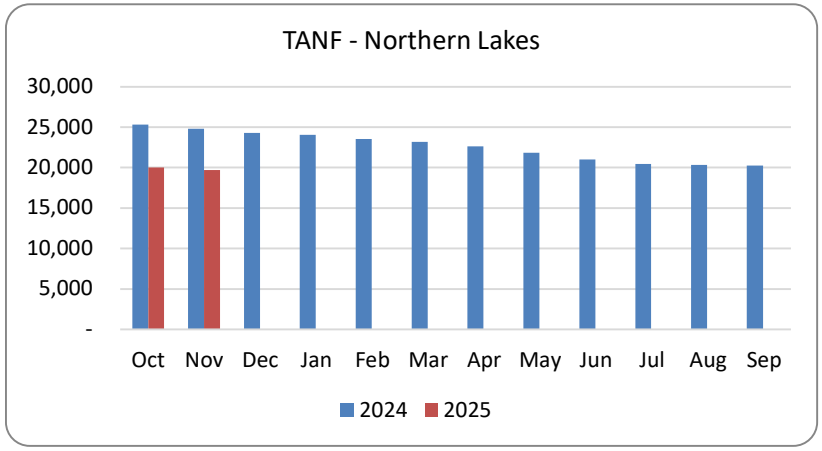
Northern Michigan Regional Entity

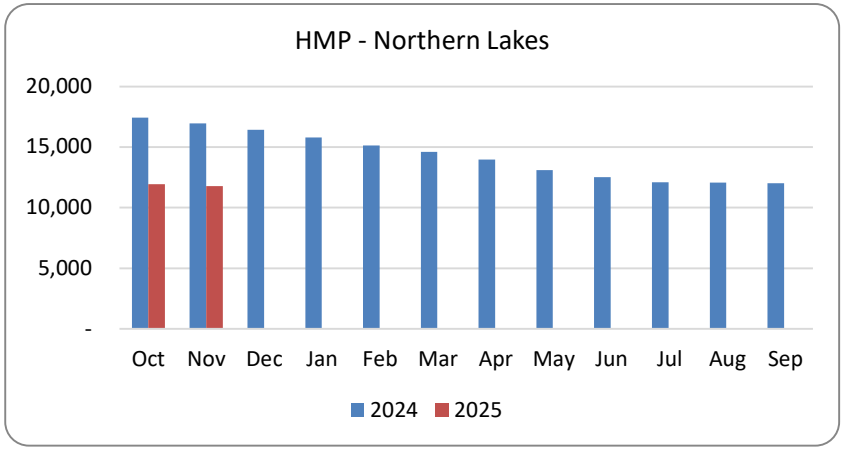
Narrative

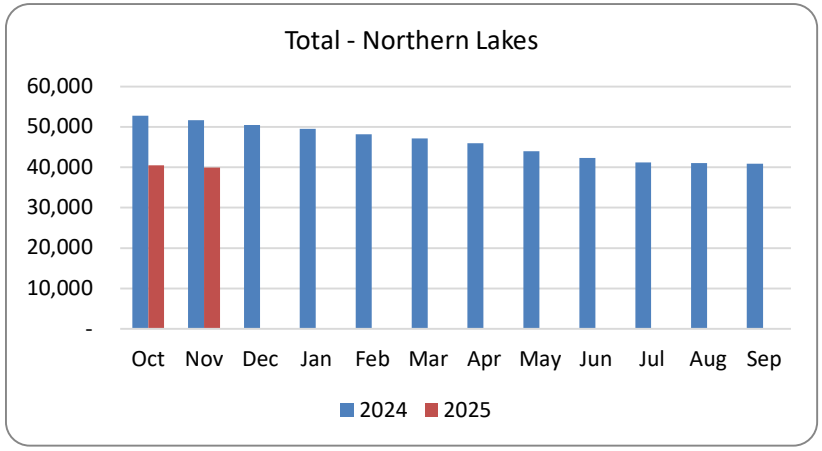
October 1, 2024 through November 30, 2024

Northern Lakes Eligible Members Trending - based on payment files







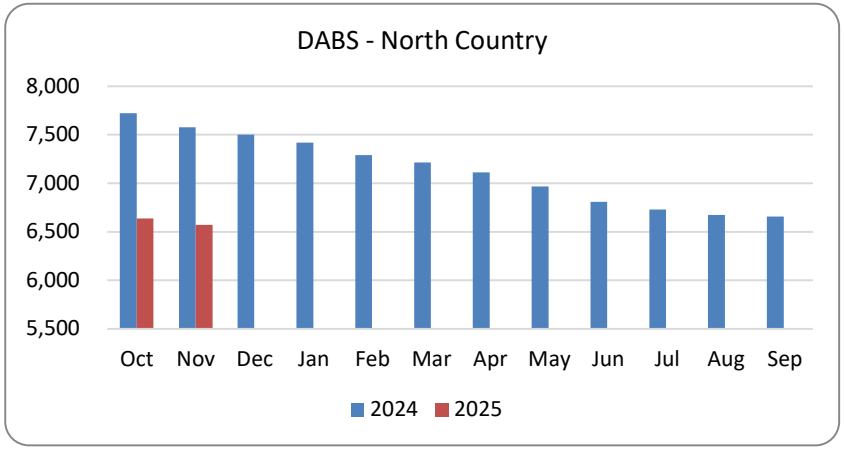


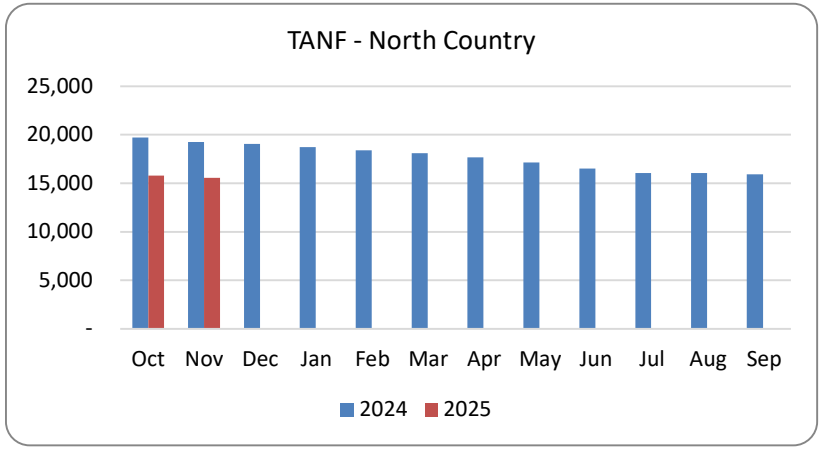
Northern Michigan Regional Entity

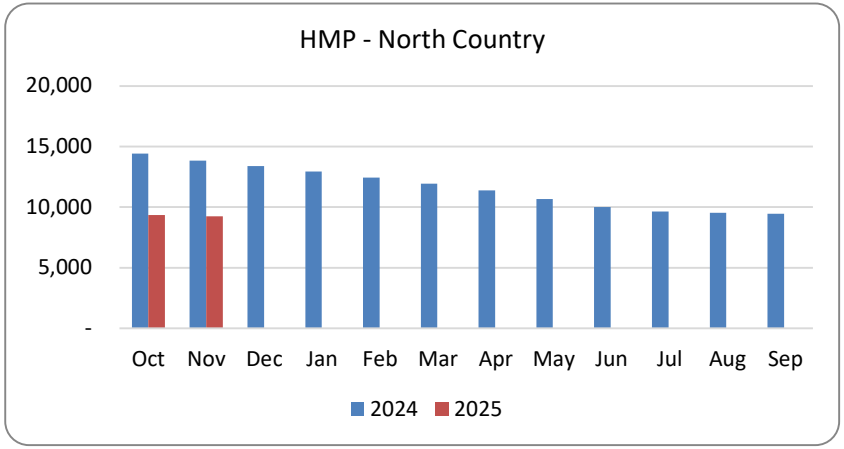
Narrative

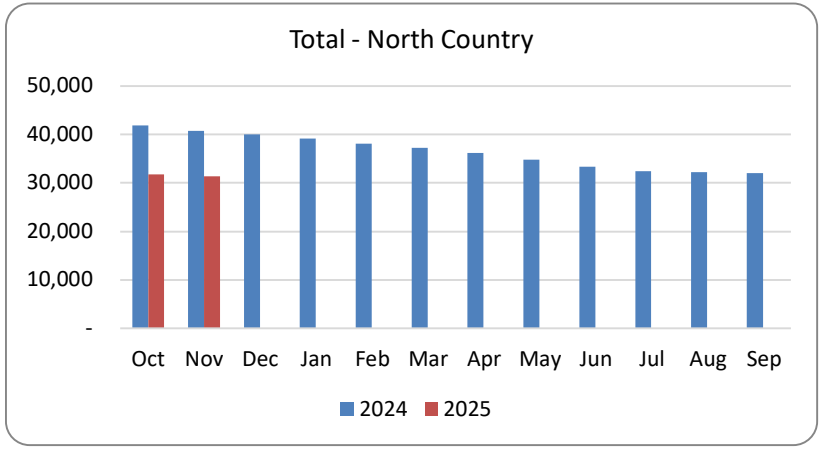
October 1, 2024 through November 30, 2024

North Country Eligible Members Trending - based on payment files







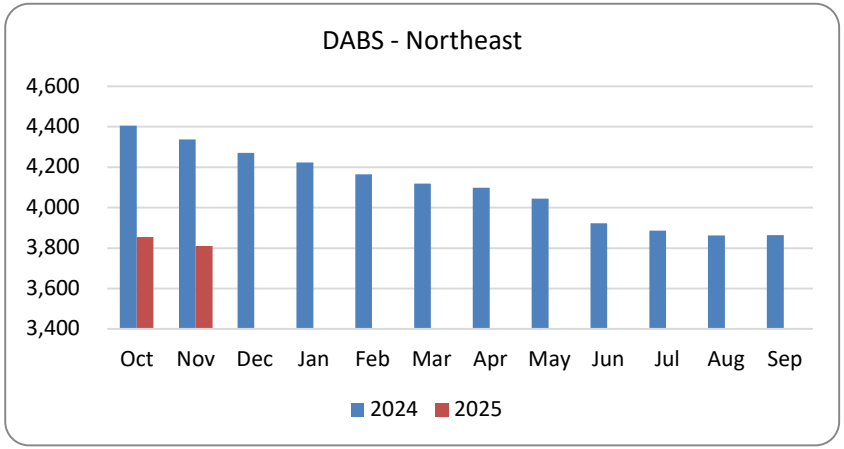


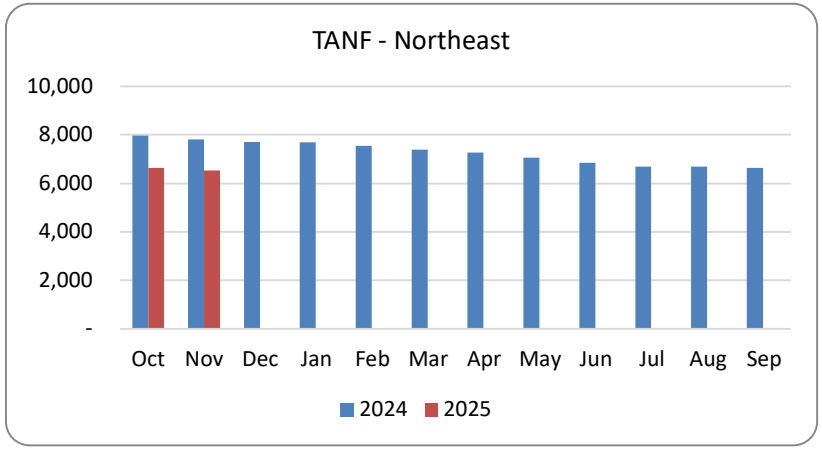
Northern Michigan Regional Entity

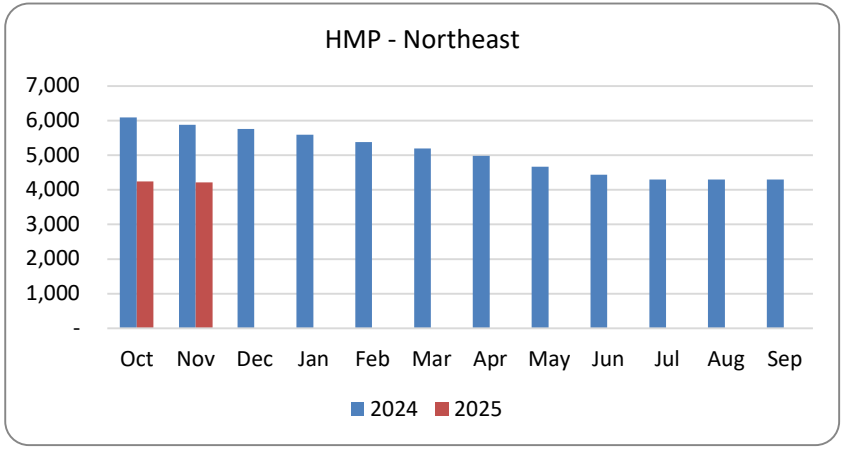
Narrative

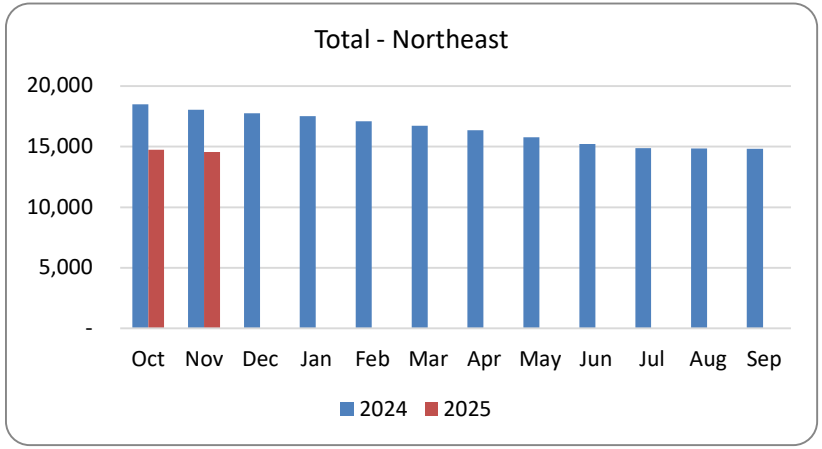
October 1, 2024 through November 30, 2024

Northeast Eligible Members Trending - based on payment files







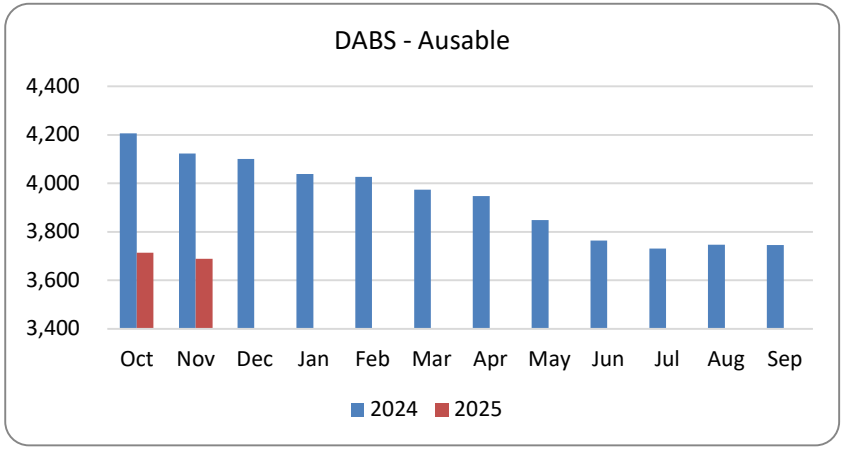


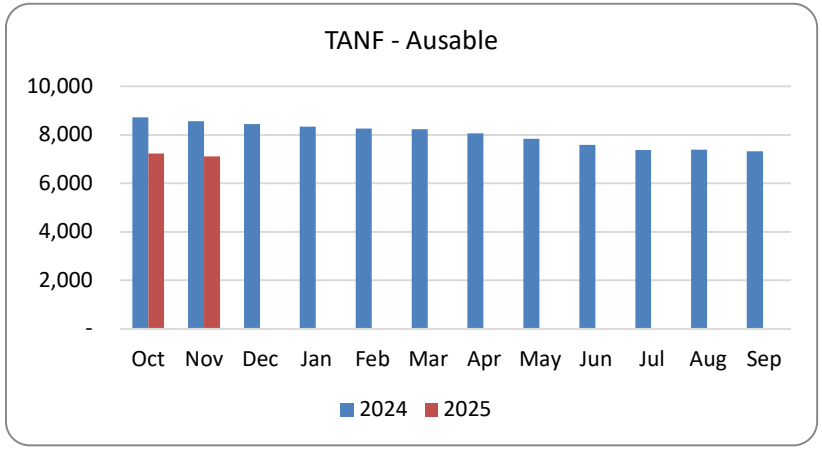
Northern Michigan Regional Entity

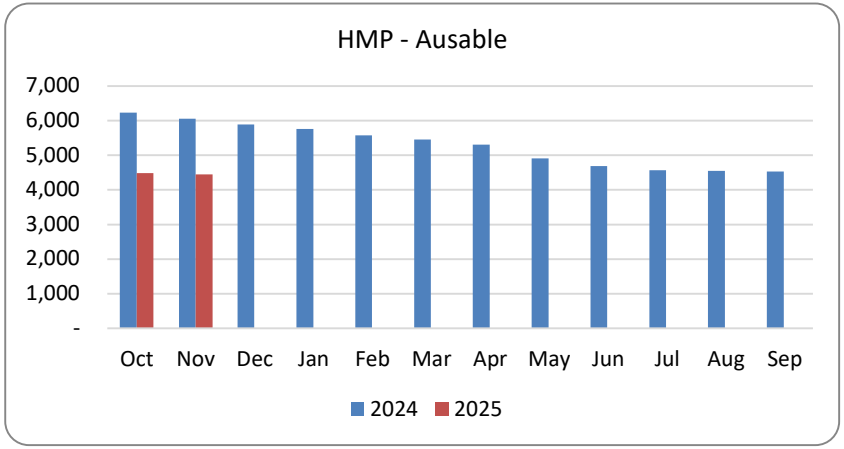
Narrative

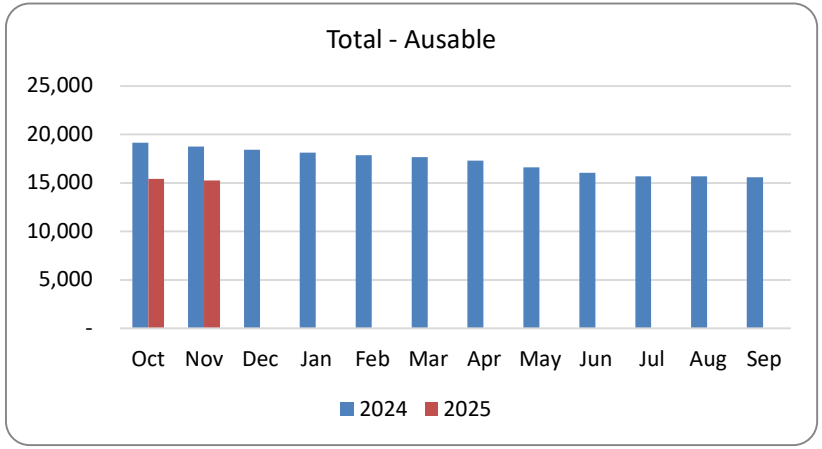
October 1, 2024 through November 30, 2024

AuSable Valley Eligible Members Trending - based on payment files







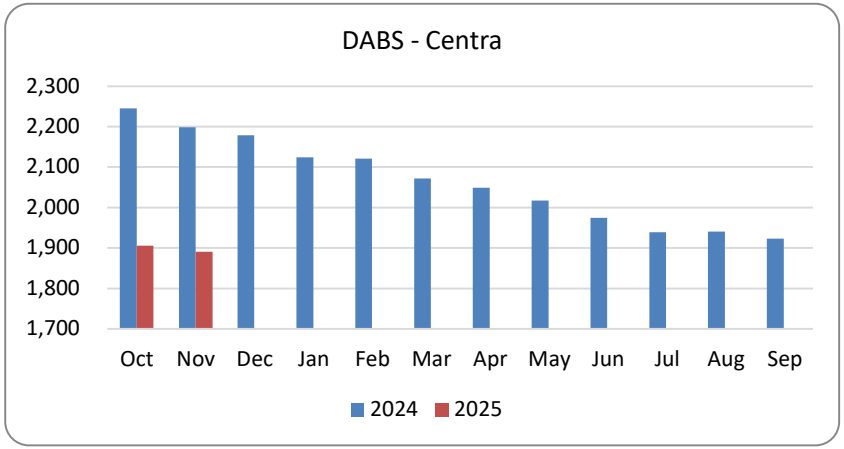


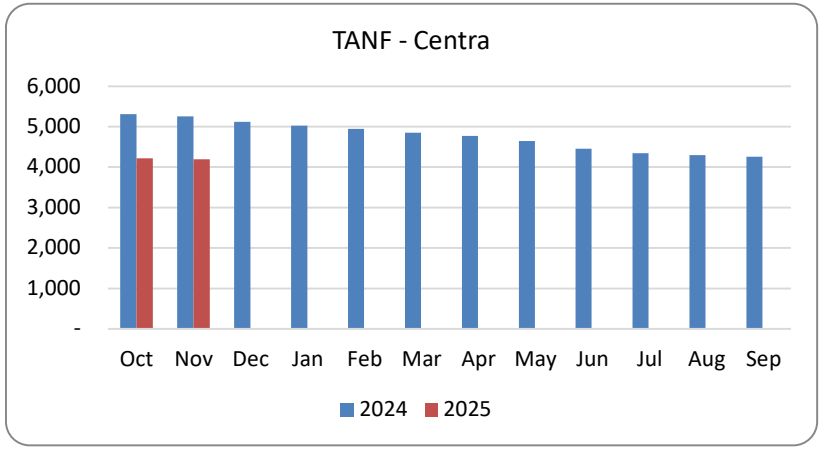
Northern Michigan Regional Entity

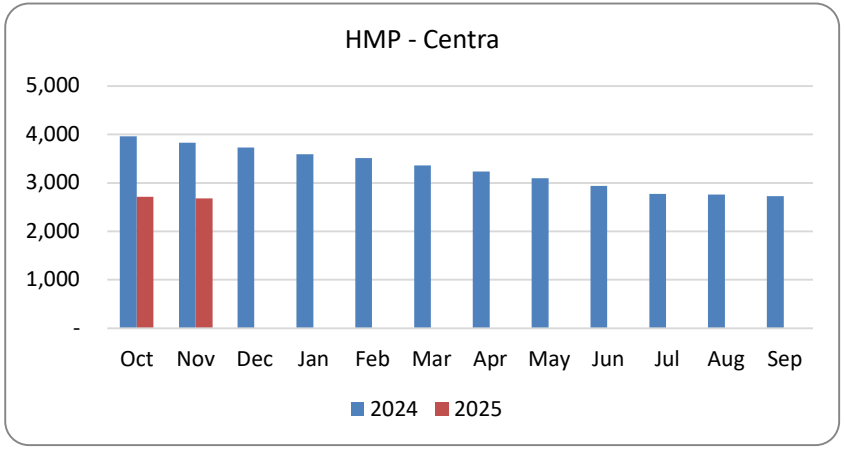
Narrative

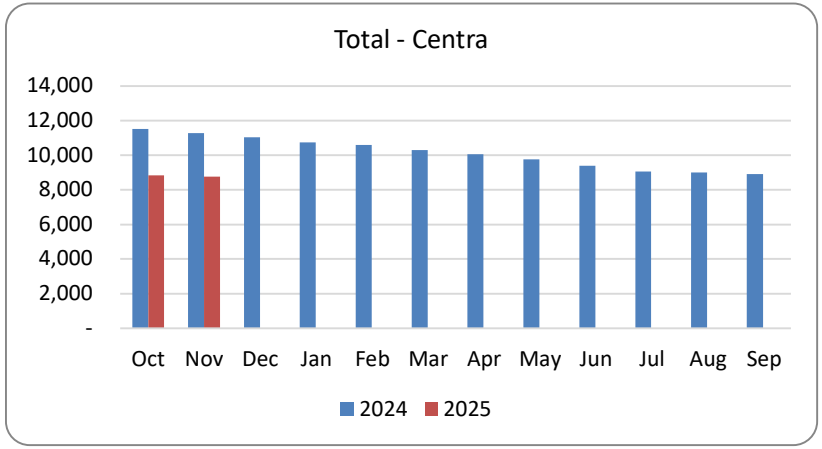
October 1, 2024 through November 30, 2024

Centra Wellness Eligible Members Trending - based on payment files







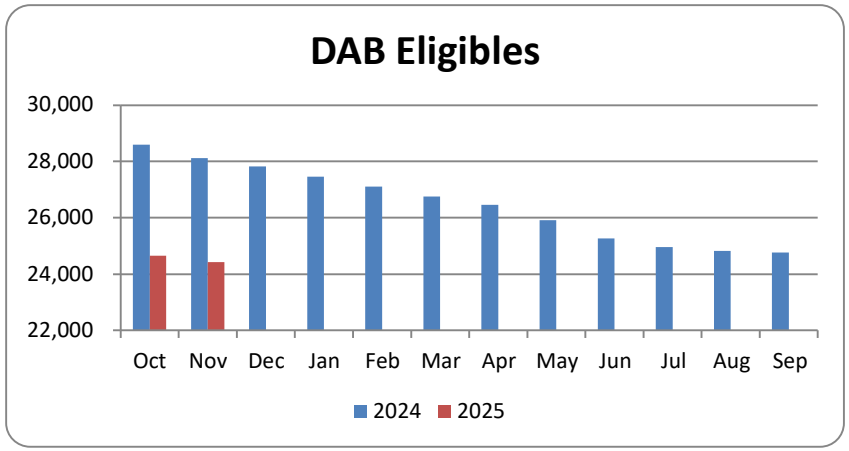


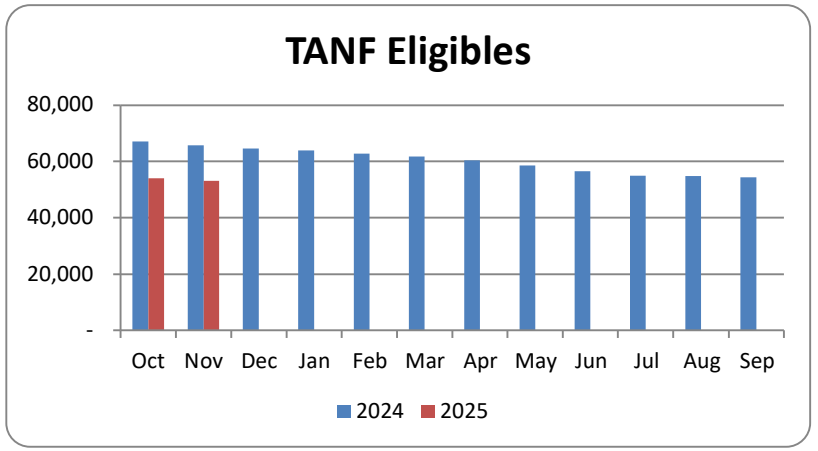
Northern Michigan Regional Entity

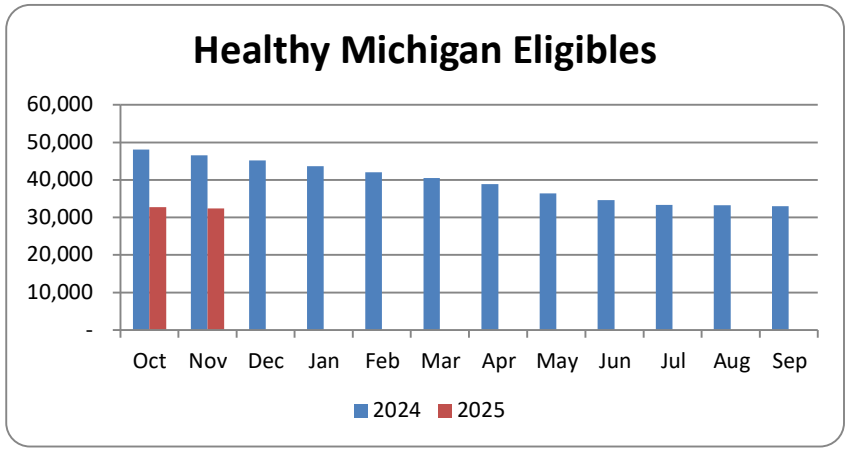
Narrative

October 1, 2024 through November 30, 2024

Regional Eligible Trending





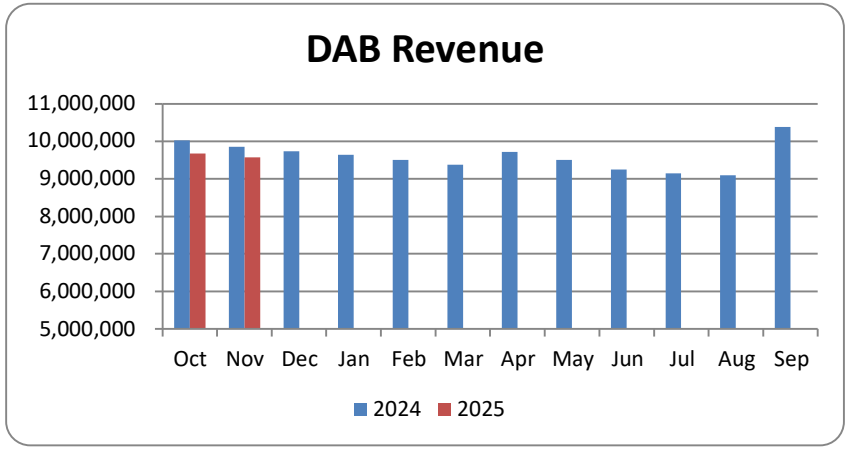


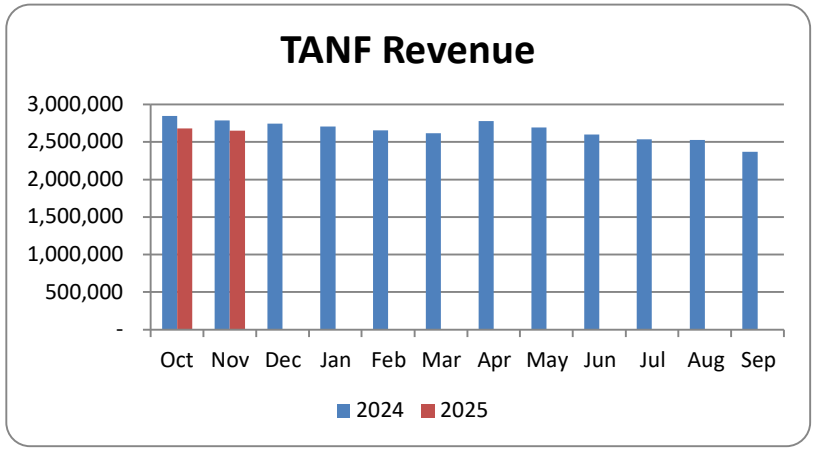
Northern Michigan Regional Entity

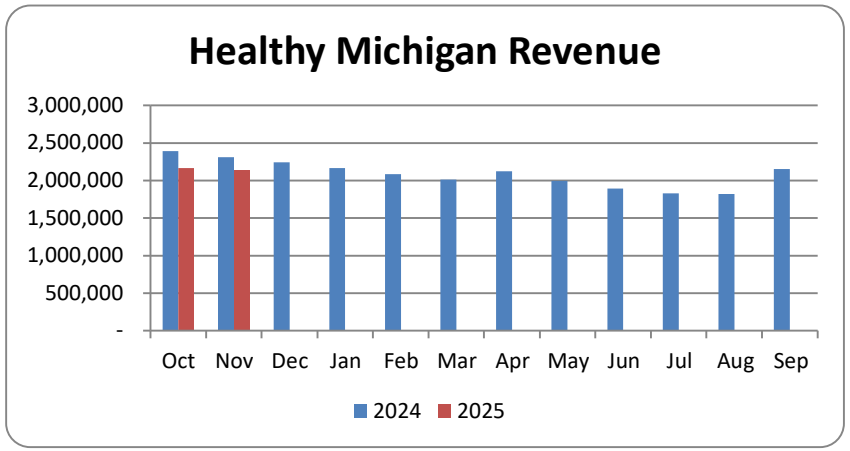
Narrative

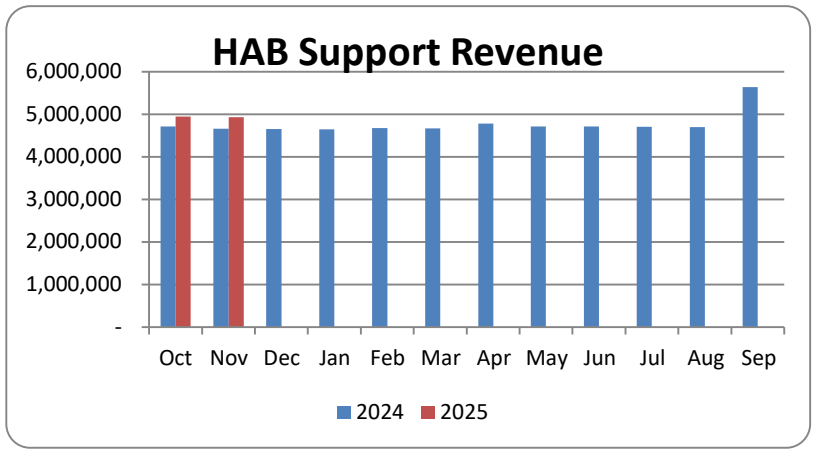
October 1, 2024 through November 30, 2024

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING
10:00AM – JANUARY 6, 2025
GAYLORD CONFERENCE ROOM & MICROSOFT TEAMS

Alcona	☒ Carolyn Brummund	**Kalkaska**	☐ David Comai
Alpena	☐ Brenda Fournier	**Leelanau**	☐ Vacant
Antrim	☒ Pam Singer	**Manistee**	☒ Richard Schmidt
Benzie	☒ Tim Markey	**Missaukee**	☐ Dean Smallegan
Charlevoix	☒ Joshua Chamberlain	**Montmorency**	☒ Michelle Hamlin
Cheboygan	☒ John Wallace	**Ogemaw**	☒ Ron Quackenbush
Crawford	☐ Vacant	**Oscoda**	☒ Chuck Varner
Emmet	☒ Terry Newton	**Otsego**	☒ Doug Johnson
Grand Traverse	☒ Dave Freedman	**Presque Isle**	☒ Dana Labar
		Roscommon	☒ Darlene Sensor
Iosco	☒ Jay O'Farrell	**Wexford**	☒ Gary Taylor

Staff	☒ Bea Arsenov	Chief Clinical Officer
	☒ Jodie Balhorn	Prevention Coordinator
	☒ Carol Balousek	Executive Administrator
	☒ Lisa Hartley	Claims Assistant
	☒ Eric Kurtz	Chief Executive Officer
	☐ Pamela Polom	Finance Specialist
	☐ Brandon Rhue	Chief Information Officer/Operations Director
	☒ Denise Switzer	Grant and Treatment Manager
	☒ Chris VanWagoner	Contract and Provider Network Manager
	☒ Deanna Yockey	Chief Financial Officer
Public	Samantha Borowiak, Whitney Dettmer, Joyce Fetrow, Lou Gamalski, Genevieve Groover, Stephanie Hector, Jeanne Marriott, Nichole Scott, James Wing	

CALL TO ORDER
Let the record show that Committee Vice-Chair, Jay O'Farrell, called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that David Comai and Dean Smallegan were absent for the meeting on this date; all other SUD Oversight Committee Members were in attendance either in Gaylord or virtually. It was noted that some SUD Oversight Committee Members have transitioned off the committee due to the election in November and 2025 commissioner assignments.

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

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

MOTION BY TERRY NEWTON TO APPROVE THE MINUTES OF THE NOVEMBER 4, 2024 NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING; SUPPORT BY CAROLYN BRUMMUND. MOTION CARRIED.

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

MOTION BY CAROLYN BRUMMUND TO APPROVE THE AGENDA FOR THE JANUARY 6, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE AS AMENDED; SUPPORT BY JOSHUA CHAMBERLAIN. MOTION CARRIED.

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

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

CORRESPONDENCE
- The 2024 Legislative Lame Duck Tracker supplied by the Community Mental Health Association of Michigan (CMHAM), which includes Senate Bills (SB) 915 – 918 regarding assisted outpatient treatment. SBs 651 – 645 regarding tobacco use, sales, and prevention, House Bill (HB) 5178 regarding syringe service programs, and HBs 5077 – 5078 regarding naloxone distribution.
- 2025 Healing and Recovery Regional Appropriations – MDHHS and PIHP Contract document announcing the availability of $1M in opioid settlement funds to PIHPs to support infrastructure and inventory and/or invest in community engagement and planning activities.
- The NMRE's announcement of a Request for Information (RFI) dated January 2, 2025 to allow providers to apply (through February 7, 2025) for a portion of the $1M opioid settlement funds for the following purposes:
  - Infrastructure improvements for treatment providers
  - Vehicle purchases
  - Anticipatory harm reduction supplies (safer use, wound care, communicable disease testing, and drug checking supplies)

INFORMATIONAL REPORTS
FY24 Admissions Report
The admissions report through October 31, 2024 was included in the materials for the meeting on this date. Fiscal year 2025 admissions were down 10% from the same period in FY24, likely due to individuals losing Medicaid and Healthy Michigan (HMP) after the resumption of redeterminations. The data showed that outpatient was the highest level of treatment admissions at 44%, and alcohol was the most prevalent primary substance at 59%, all opiates (including heroin) was second most prevalent primary substance at 16%, and methamphetamine was the third most prevalent primary substances at 15%. It was noted that stimulant use has risen sharply throughout the 21-county region.

Mr. Freedman questioned whether the decline in admissions could partially be attributed to enhanced prevention efforts. Ms. Singer added that naloxone distribution and reduced stigma could also be factors.

County-specific reports were also included in the meeting materials. The county-specific reports are intended to be shared with Boards of Commissioners and other community stakeholders.

Financial Report
As expected, PA2 funds in the amount of $301K were needed to supplement block grant funding for FY24. The dip into PA2 funds did not affect county withhold balances.

The anticipated PA2 revenue for FY25 was reported as just under $1.9M.

LIQUOR TAX PARAMETERS
The Liquor Tax funds parameters approved by the NMRE Board of Directors on April 24, 2024 were included in the meeting materials to inform the SUD Oversight Committee's decision whether to recommend approval of the liquor tax requests brought before the Committee on this date.

CURRENT FUND BALANCES

County	One-Year Fund Balance (Withheld)	Projected Available Balance for Projects
Alcona	$21,394.00	$50,322.81
Alpena	$84,263.20	$161,253.40
Antrim	$80,488.80	$188,614.67
Benzie	$67,707.20	$205,298.38
Charlevoix	$106,516.40	$35,636.84
Cheboygan	$87,302.40	$75,422.42
Crawford	$35,114.80	$57,891.09
Emmet	$183,166.80	$241,165.42
Grand Traverse	$455,155.20	$389,075.88
Iosco	$87,380.80	$113,217.42
Kalkaska	$41,230.40	$23,406.64
Leelanau	$60,592.80	$57,428.57
Manistee	$80,450.80	$154,804.43
Missaukee	$24,997.60	$9,774.95
Montmorency	$28,700.00	$51,082.96
Ogemaw	$68,804.80	$53,009.40
Oscoda	$24,394.80	$37,150.05
Otsego	$105,978.80	$14,544.70
Presque Isle	$25,208.80	$70,959.17
Roscommon	$87,715.20	$521,707.15
Wexford	$95,416.00	$102,523.79
TOTAL	**$1,851,979.60**	**$2,614,290.14**

FY25 LIQUOR TAX REQUESTS

1. 33rd Circuit Court DWI Court Charlevoix $40,000.00 Additional Request

   Meets PA2 Parameters? ☒ Yes ☐ No

MOTION BY JOSH CHAMBERLAIN TO APPROVE THE REQUEST FROM THE THIRTY-THIRD (33RD) CIRCUIT COURT FOR CHARLEVOIX COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF FORTY THOUSAND DOLLARS ($40,000.00) TO FUND THE DRUG/DRIVING WHILE INTOXICATED COURT PROGRAM; SUPPORT BY PAM SINGER. MOTION CARRIED.

2.	District Health Department #10	Substance Use Education and Awareness	Manistee	$42,090.00	New Request

Meets PA2 Parameters? ☒ Yes ☐ No

During the meeting on September 9, 2024 Mr. Labar suggested that initials be placed in the boxes on the liquor tax application for the sections beginning with: "I understand" and "I certify." Mr. Labar made the same request during the meeting on this date.

MOTION BY DOUG JOHNSON TO APPROVE THE REQUEST FROM THE DISTRICT HEALTH DEPARTMENT NUMBER TEN (#10) FOR MANISTEE COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF FORTY-TWO THOUSAND NINETY DOLLARS ($42,090.00) TO FUND THE SUBSTANCE EDUCATION AND AWARENESS (SEA) MANISTEE COALITION.; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

County Overviews
The impact of the liquor tax requests approved on this date on county fund balances was shown as:

	Projected FY25 Available Balance	Amount Approved January 6, 2025	Projected Remaining Balance
Charlevoix	$75,636.84	$40,000.00	$35,636.84
Manistee	$196,894.43	$42,090.00	$154,804.43
Total	**$272,531.27**	**$82,090.00**	**$190,441.27**

The "Projected Remaining Balance" reflects funding available for projects while retaining a fund balance equivalent of one year's receivables.

NEW PROVIDER REQUEST
NMRE Contract and Provider Network Manager, Chris VanWagoner, presented a request to add a new provider to the NMRE Substance Use Disorder Treatment Services Provider Panel.

The NMRE was contacted in October 2024, by Quality Behavioral Health, Inc (QBH), a SUD Treatment provider with a licensed outpatient location in Manistee County. The NMRE provider panel was closed during this time, however, pursuant to the NMRE Procurement Policy and applicable law, the NMRE may directly purchase services without a competitive procurement process in certain circumstances, including if the services involved are professional and of limited quantity and duration or if there is a public urgency to obtain the service.

This provider completed and submitted application materials to the NMRE, and primary source verifications were conducted to ensure provider qualifications. An NMRE staff team reviewed this location on November 6, 2024, and confirmed the need and ability to add this location to its network.

The NMRE currently only has one provider of the same service within 45 minutes drivetime of this location; extension of contract award ensures continuity of service availability beyond a single provider and increases outpatient capacity in this very rural area.

Ms. Brummund asked whether any mobile medication assisted treatment (MAT) providers are interested in covering the east side of the state, as clients currently have to travel to Gaylord multiple times per week. Ms. Arsenov responded that the two methadone clinics in the region are both in Gaylord. An interested provider would have to expand to the east side, which is not under the NMRE's control.

MOTION BY GARY TAYLOR TO RECOMMEND APPROVAL OF QUALITY BEHAVIORAL HEALTH TO THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER TREATMENT SERVICES PROVIDER PANEL; SUPPORT BY PAM SINGER. MOTION CARRIED.

PRESENTATION

Jeanne Marriott, Northern Michigan Opioid Response Consortium (NMORC) Project Associate, Nichole Scott, Emmet County Community Corrections Director, and Stephanie Hector, Community Recovery Alliance Program Coordinator were in attendance to promote an upcoming Jail Release Simulation Events on January 17th in Petoskey, February 18th in Alpena, and March 20th in Gaylord.

The primary objective of the Jail Release Simulation is to raise awareness among participants about the systemic struggles faced by individuals due to oppression, as well as the challenges posed by supervision during probation and parole.

Through a series of immersive, scenario-based activities, participants explore the complex realities of life after incarceration, emphasizing the barriers that formerly incarcerated individuals face in navigating probation or parole systems.

By the end of the simulation, participants have a deeper understanding of the compounded challenges faced by individuals under probation and parole supervision, and are better equipped to advocate for more compassionate, rehabilitative approaches that address the root causes of criminal behavior and prevent further oppression.

PUBLIC COMMENT

Mr. Quackenbush asked what can be done to determine whether the driver of a motor vehicle is under the influence of marijuana or other substances. Ms. Arsenov responded that, at the time of arrest, the driver can be taken to a hospital to have a blood test preformed.

NEXT MEETING

The next meeting was scheduled for March 3, 2025 at 10:00AM.

ADJOURN

MOTION BY RON QUACKENBUSH TO ADJOURN THE MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING FOR JANUARY 6, 2025; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

Let the record show that Mr. O'Farrell adjourned the meeting at 11:37AM.

PA2/Liquor Tax Criteria for Review/Adoption

- The NMRE will update projected end balances for each county for the current fiscal year monthly. New applications will be compared to projected end balances to ensure that there is adequate funding in the county to financially support the request.
- If possible, depending on SUD Block Grant usage, a balance equivalent to one year's revenue will remain as a fund balance for each county.
- Project requests for services that can be covered by routine funding from other sources (Medicaid, Healthy Michigan) will not be considered.
- Applications that include any purchase of or renovations to buildings, automobiles, or other capital investments* will not be considered.
- To be considered, applications must be for substance use disorder prevention, treatment, or recovery services or supports.
- Region-wide (21 county) requests should be limited to media requests; other region-wide requests will be evaluated on a case-by-case basis.
- Multi-county requests (2 or more) must include detailed information on the provision of services and/or project activities for each county from which funds are requested.
- Staff who receive staffing grants via liquor tax approvals will not be eligible to bill services to the NMRE.
- Budget Requirements:
  - Budgets must include information in all required fields.
  - Fringe benefit budget requests that exceed 30% should be broken out by Health, Dental, Vision, Retirement, taxes, etc. totals and be subject to NMRE staff and Board approval.
  - Indirect costs, when applicable, should **not** exceed 10% of the requested budget total.
  - Liquor tax funds may be used to cover up to one FTE (across all projects) per person.

- The amount requested for salaries should be based on the staff person's actual salary and not the billable rate.
- All staff participating in PA2 funded activities are to be listed under budget FTEs (not under indirect cost).

- Requests for liquor tax funds should be coordinated with area stakeholders (CMHSPs, SUD Oversight Committee Members, County Commissioners, courts, law enforcement, SUD services providers) whenever possible.
  - Requestor should inform the county of the request submission at the same time submission to NMRE is completed.

* "Capital.investment‹ .refers.to.funds.invested.in.a.company.or.enterprise.to.further.its.business objectives¡.Capital.investments.are.often.used.to.acquire.or.upgrade.physical.assets.such.as property?buildings?or.equipment.to.expand.or.improve.long_term.productivity.or.efficiency¡ (Source¿Nasdaq)

If at the end of the NMRE's fiscal year there is excess SUD Block Grant funding available, it will be used to offset liquor tax expenses as opposed to lapsing SUD Block Grant funding. In reverse, if SUD Block Grant funding runs a deficit, PA2 funding is used for treatment deficits. Normally for under or uninsured clients.

33RD CIRCUIT HYBRID DRUG/DWI COURT – ADDITIONAL REQUEST

Organization/Fiduciary:	**Charlevoix County Circuit Court**
County:	**Charlevoix**
Project Total:	**$ 40,000**

DESCRIPTION:

The 33rd Circuit Hybrid Drug/DWI Court for Charlevoix County is in the early stages of operation and was provisionally certified by the State Court Administrator's Office on February 9, 2024. This program targets nonviolent adult offenders in felony-controlled substance and driving while intoxicated cases. Program criteria includes individuals with a moderate to severe substance use disorder residing in Charlevoix County and are prison-presumptive based upon their Michigan Sentencing Guideline range calculated as a straddle or prison cell. The program consists of a 9-person multi-disciplinary team and evidence-based practices to assist participants in transitioning into long term recovery while reducing risks to the community.

- ***This was an initial request that was approved at a lower total than initially requested due to Liquor Tax funding concerns. They are now requesting the additional $40,000 to come to a total request of $140,000 for this project. Budget sheet displays the full budget breakdown for the Project total of $140,000.***

Meets Parameters for PA2 Funding:	Yes

County	Project	Requested Budget
Charlevoix	33rd Circuit Hybrid Drug/DWI Court	$40,000

CAPACITY BUILDING FOR SUBSTANCE USE EDUCATION AND AWARENESS - NEW

Organization/Fiduciary:	**District Health Dept #10**
County:	**Manistee**
Project Total:	**$ 42,090**

DESCRIPTION:

This project will provide technical assistance for capacity building for the Substance Education and Awareness (SEA) Manistee Coalition. Funding will be used for a backbone staff person from District Health Department #10 to expand the coalition, specifically to include persons with substance use disorder, and to engage current coalition members in actions to increase access to SUD services and harm reduction services and to provide community education regarding the benefits of harm reduction. This funding will include contractual funding for Dr. Pennie Foster-Fishman of Transform Change, LLC to develop SEA Manistee's collective impact and systems change capacity. As a relatively new cross-sector network, this is an opportune time to both understand current competencies related to planning and implementation of substance use and overdose prevention strategies and strategies to support recovery and to engage key stakeholders in these efforts. Overall, this scope of work will include technical assistance, evaluation, and facilitation support to promote the following outcomes:

- Reduce barriers to effective collaboration among SEA Manistee members to increase support for harm reduction services and recovery supports
- Promote aligned vision and shared outcomes
- Promote ability to use and respond to data, particularly qualitative data collected from those with lived experience

Meets Parameters for PA2 Funding:	Yes

County	Project	Requested Budget
Manistee	Capacity Building for SU Education and Awareness	$42,090

Northern Michigan Regional Entity

Microsoft Dynamics 365
Business Software & Services Proposal

November 22, 2024

Microsoft Dynamics 365 ERP

		Unit of Sale	Annual Unit Price	Annual Investment
6	Dynamics 365 Business Central Essentials	User/Year	$840	$5,040
2	Dynamics 365 Business Central Team Member	User/Year	$96	$192
1	TMG Cloud SaaS Insights (free version - 3 data points)	Tenant/Year	$0	$0
	TMG Cloud SaaS Insights (full version - 12 data points)	Tenant/Year	$1,100	$0
1	eOne SmartConnect Business (5 Connections Included)	Tenant/Year	$7,800	$7,800
6	Tangicloud Fundamentals Full User	User/Year	$1,440	$8,640
2	Tangicloud Fundamentals Team User	User/Year	$60	$120
1	Azure Plan - TMG Cloud SaaS Insights Only	Usage/Year	$120	$120
			Total Software Investment:	$21,912

Professional Services

Services estimate includes General Ledger, Accounts Payable, Sales Invoicing, Accounts Receivable, Bank Reconciliation, Tangicloud Fundamentals and PCE Integration.

	Code	Estimated Hours	Total Services
Implementation Planning Study (IPS) Fee, Statement of Work - See note 4	PM		$14,000
Engagement Management (EM) Fee - See note 4	IMP		$9,000
Status Meeting (SM) Fee - See note 4	SM		$5,040
Solution Architect	SA	0	$0
Installation	SY	6	$1,260
Configuration	CFG	33	$6,930
Current Data Migration	MIG	36	$7,560
Historical Data Migration	MIG	0	$0
Data Integration	INT	40	$8,400
Customization	DV	0	$0
Reporting	RPT	32	$6,720
Consulting	CN	7	$1,470
Training	TN	31	$6,510
User Acceptance Testing	UAT	29	$6,090
Support	SUP	16	$3,360
Total Professional Services Estimated Investment:		230	$76,340

Investment Summary

Total Annual Software Investment	$21,912
Total Services Investment	$76,340
Total Investment	$98,252

Payment Information

First Year Subscriptions Deposit Due Upon Order	$21,912
First Month Project Management Fee Due Upon Order	$2,400
First Month Status Meeting Due Upon	$900
Planning Fee Due Upon Order	$9,000
Total Due Upon Order	$34,212

Notes

1 The quoted software/subscription prices are guaranteed for a period of thirty days from the date of this quote.

2. SUBSCRIPTIONS

a. Microsoft subscriptions can be 1 month or 1 year contracts. The Dynamics prices listed above are the prices for the 1 year term. If you want to have a monthly contract for your Dynamics or other subscriptions, the monthly price is 20% higher. The importance of the term is that you can add users at any time during the contract term, but you can only reduce users at the end of each term.

b. Microsoft subscriptions cannot be cancelled or transferred until the end of the chosen term. If client leaves within a contract year, the remaining payments of the contract will be due. Contracts will auto-renew at the end of their term in the increments of the chosen term unless cancelled/terminated with 90 days advance notice.

c. Subscriptions require EFT Authorization form completion before order can be initiated and payments must remain current for the term of the contract. If EFT payment is declined, unpaid subscriptions for longer than thirty (30) days may be suspended thereby preventing you from accessing your system. You will still be responsible for the subscription costs for the term of the agreement and access will be restored upon payment of overdue balance.

d. Subscriptions and software will not be ordered until the IPS has been completed and the Statement of Work has been accepted unless directed by the client. Then, they will be ordered at the appropriate time in the project.

e. The TMG SaaS Insights is a system monitoring tool that we use to help support your system and keep you at optimum performance. The free version has 3 key data points monitored. The paid version ($1,100/year) provides 9 additional key data point monitoring and some more advanced / detailed reports. The paid version is required for larger / more complex projects.

f. The Azure Plan covers Azure pay as you go services such as Azure Data Lake, Azure functions or Azure applications. The TMG Cloud SaaS Insights uses Azure functions.

3. SERVICES

a. This Engagement will begin with the IPS and continue through post go-live activities. Upon payment of the funds due listed above, your TMG sales representative will meet with the TMG Engagement Management Team. The assigned TMG Engagement Manager will then schedule an Engagement Kickoff Meeting with the client's designated internal Project Manager.

b. Other than IPS, EM and SM fees, services are estimated and will be billed as utilized.
This engagement is quoted at the rate of $210/hour for all services except for those listed below. A prepaid hours discount of $10/hour is available for a minimum of 100 hours prepaid. This proposal does not include the prepaid discount.

c. The quoted services are based on our current knowledge of client's environment and the client's required solution.

d. The IPS fee will be billed as a flat fee for this engagement and is due upon acceptance of this proposal. Result of the IPS will be a full Statement of Work including project milestones, timeline and revised estimate of costs. All hours will be validated during the IPS - some categories may increase, others may decrease.

e. The EM fee will be billed as a monthly fee throughout the duration of the engagement, beginning with Engagement Kickoff meeting and continuing until the Client Project Manager and TMG Engagement Manager agree the project is complete. The first month for the EM fee is due upon acceptance of this proposal. The second and subsequent billings will occur on the 1st of the month after the Engagement Management Kickoff. Upon completion of the IPS, if the scope of the implementation has changed, the monthly EM fee may be adjusted. Monthly EM fees are not prorated.

f. The SM fee will be billed as a monthly fee throughout the duration of the engagement, beginning with Engagement Kickoff Meeting and continuing until the Client Project Manager and TMG Engagement Manager agree the project is complete. The first month for the SM fee is due upon acceptance of this proposal. The second and subsequent billings will occur on the 1st of the month after the Engagement Management Kickoff. Upon completion of the IPS, if the scope of the implementation has changed, the monthly SM fee may be adjusted. Monthly SM fees are not prorated.

g. Solution Architecture (or Design) services, if required, are billed at $275/hour. Solution Architecture time will be included in any integration or development services to be provided and may be included for other complex portions of the project.

h. Travel time, if required, will be billed both ways at half the project rate from the location of the relevant TMG personnel. This is NOT quoted in the time above.

i. The fixed fee charges and service estimates provided above assume that the project continues uninterrupted once it has started. Should the client pause a project for more than 4 weeks, service billings may increase. In some circumstances, TMG will execute a change order to update service estimates and/or increase fixed fee charges when the client is ready to resume the project. Note that periods where TMG is performing work that does not require involvement with the client does not mean the project has paused.

4. DATA MIGRATION, INTEGRATION & DEVELOPMENT

a. Current Data Migration (Data Readiness) consists of the migration of master data files like Chart of Accounts, Customers, Vendors and Items as well as transactional data like open AP/AR, open Sales Orders and open Purchase Orders. Only open transactions (no historic transactions) are migrated into Dynamics 365. Current data migration is a part of every project. This project estimate has included trial data migrations during the project and prior to the CRP.

b. Historical Data Migration consists of the closed or posted transactional data like posted payables, posted invoices, posted & cleared checks, etc. Historical transactions do not get migrated into Dynamics 365. It is generally not cost effective to try to force historical data from one system into another system with a different data structure. Historical data can be moved into a data repository that is outside of Dynamics 365 but is queriable within Dynamics 365. This is not a standard part of most projects but can be included.

c. Integration and development hours (if stated) are only a preliminary estimate and maybe updated as part of the IPS. Solution Architect hours are a key part of the integration and development processes.

5. GO-LIVE PLANNING & READINESS

a. User Acceptance Testing is intended to be performed by the client with support from TMG. Upon completion of the UAT, TMG will review the UAT documentation and advise the client if they are ready to go live. Should the client choose to go live against the recommendation of TMG, the client will be required to prepay for go-live support in the amount of $10,000 or equal to 10% of the overall project budget, whichever is higher. These prepaid funds will not expire and can be used for subsequent projects or ongoing support.

6. This proposal is subject to the terms and conditions of The TM Group Master Services Agreement.

Proposal Acceptance

We agree to the terms of the proposal as stated above. We understand that purchased software is non-refundable.

Signature: _____

Name: _____

Title: _____

Date: _____

[x] **Payment by EFT Withdrawal**

[ ] **Subscribe with Monthly Contract Term**

[x] **Subscribe with Annual Contract Term**

NMRE Recommendation for Contract Award for SUD Treatment Services

January 6, 2024

Summary:

The NMRE was contacted in October, 2024, by Quality Behavioral Health, Inc (QBH), a SUD Treatment provider with a licensed outpatient location in Manistee County. The NMRE provider panel was closed during this time, however, pursuant to the NMRE Procurement policy and applicable law, the NMRE may directly purchase services without a competitive procurement process in a number of circumstances, including if the services involved are professional and of limited quantity and duration or if there is a public urgency to obtain the service.

This provider completed and submitted application materials to the NMRE, and primary source verifications were conducted to ensure provider qualifications. An NMRE staff team reviewed this location on November 6, 2024, and confirmed the need and ability to add this location to its network.

The NMRE currently only has 1 provider of the same service within 45 minutes drivetime of this location; extension of contract award ensures continuity of service availability beyond a single provider and increases outpatient capacity in this very rural area.

Request from NMRE staff to support extending contract award to provider as described below:

Provider Name	Quality Behavioral Health, Inc
Administrative Address	1059 Owendale Troy, MI 48083
Service Address	300 Care Center Dr Manistee, MI 49660
NMRE Staff Recommended Service Level Approval	Outpatient (ASAM 1.0) at service address above
Additional Notes	Location provides block grant funded Mobile Methadone program licensed through Detroit, MI facility at 6821 Medbury. NMRE recommendation is for outpatient services. Per provider, site may include residential and withdrawal management in the future. Provider also provides buprenorphine, naloxone, peer recovery and support, case management and integrated treatment.

Planned Timeline:

NMRE SUD Oversight Committee notification:	January 6, 2025
NMRE Board Recommendation:	January 22, 2025
Issue of Contract Materials:	Immediately following NMRE Board Approval
Contract Effective Date:	Once signed by both parties

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY,
NORTHERN MICHIGAN REGIONAL ENTITY,
COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
and
REGION 10 PIHP

Plaintiffs,

v

STATE OF MICHIGAN,
STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, a Michigan State Agency, and its Director,
ELIZABETH HERTEL, in her official capacity,

Defendants.

Case No. 24-000198-MZ

Hon. Sima Patel

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FIRST AMENDED VERIFIED COMPLAINT

Plaintiffs, by and through counsel, TAFT, STETTINIUS & HOLLISTER, LLP, state for their First Amended Verified Complaint:

OVERVIEW

1. Defendants are trying to strong-arm Plaintiffs into a "take it or leave it" contract that contains illegal and detrimental provisions that reduce Plaintiffs' ability to provide necessary behavioral health services to the residents of Michigan.

2. Plaintiffs are 4 of Michigan's 10 Prepaid Inpatient Health Plans that facilitate the delivery of behavioral health services for individuals with mental illness, developmental disabilities, and substance use disorders in 44 counties across the State.

3. In an attempt to bully Plaintiffs into agreeing to unreasonable and illegal provisions in its FY25 contract ("FY25 Contract" – Exhibit A), MDHHS threatened that if Plaintiffs did not sign by October 31, 2024, MDHHS would terminate its relationship with Plaintiffs and cut off the funding Plaintiffs need to ensure recipients in their respective regions continue to receive behavioral health services. Plaintiffs each signed the FY25 Contract after modifying the offending provisions, but MDHHS refused to counter-sign. As explained in more detail below, Defendants attempted to withhold Medicaid funds from Plaintiffs to the detriment of the beneficiaries Plaintiffs serve.

4. On behalf of all Plaintiffs, this suit seeks a declaration that three aspects of MDHHS's form FY25 Contract are void.

5. First, Schedule A – Statement of Work, § 4, relates to Plaintiffs' ability to fund and manage an Internal Service Fund ("ISF"). Certain provisions in that section violate state and federal law because they purport to restrict Plaintiffs' ability to fund and utilize their respective ISF accounts. More specifically, Defendants placed an arbitrary 7.5% limit on the amount Plaintiffs can contribute to their respective ISF accounts and a 7.5% limit on the balance that can be held in an ISF account. The limits are not based on recognized accounting standards or principles, are not actuarially sound, and therefore fail to comply with federal regulations.

Defendants further purport to prohibit Plaintiffs from using ISF funds to pay for services rendered during a prior fiscal year and impose other restrictions on the ISF. These provisions also violate federal law.

6. Second, Schedule A - Statement of Work, § 1, ¶ R.20., purports to require Plaintiffs to abide by a settlement agreement involving MDHHS and certain non-parties (the "Waskul Settlement"). Requiring Plaintiffs to abide by the contemplated Waskul Settlement would permit the State to illegally direct Plaintiffs' Medicaid expenditures. Requiring Plaintiffs to abide by the Waskul Settlement would also benefit a select subset of Medicaid recipients, while detrimentally hurting the vast majority of recipients who receive the same services.

7. Third, Schedule A – Statement of Work, § 1, ¶ G.14., is an attempt by MDHHS to shift the financial burden of managing Certified Community Behavioral Health Clinics ("CCBHCs") to Plaintiffs without State funding in violation of Article 9, § 25 and § 29 of the Michigan Constitution. Defendants' own auditor concluded that the FY25 arrangement would require Plaintiffs to undertake 11 categories of "major new responsibilities" without "any increase to the variable administrative percentages" (i.e., without any funding). Defendants also included provisions in the FY25 that would allow Defendants to change or add to Plaintiffs' responsibilities at any time Defendants choose.

8. This suit also seeks a declaration that even in the absence of a contract, MDHHS is statutorily obligated to continue providing funding to Plaintiffs.

9. Defendants recently retaliated against Plaintiffs by stating MDHHS will not provide Medicaid dollars to fund the Substance Use Disorder Health Home ("SUDHH") programs in their respective regions. The SUDHH program is an expansion of the existing Opioid Health Home program, and has absolutely nothing to do with the parties' dispute. While this shameful

negotiation tactic would have harmed Plaintiffs, who each expended resources in reliance on Defendants fulfilling their obligation to provide the funding, the most significant harm would have come to the citizens eligible to receive the expanded SUDHH services. MDHHS's pronouncement would mean individuals currently enrolled program to receive the expanded SUDHH services will no longer receive those services. And it means that the thousands of Michiganders who are eligible to enroll to receive the expanded SUDHH services would no longer be able to enroll. Those residents were directed by Defendants to contact Plaintiffs to obtain SUDHH services, but Plaintiffs were being directed to turn them away. After the filing of the initial Verified Complaint, the parties negotiated and entered a preliminary injunction requiring Defendants to provide SUDHH funding and permitting the SUDHH program to move forward until further order of Court. See Stipulated Order re: Initial Pleadings and Injunction as to Substance Use Disorder Health Home Program entered December 23, 2024. Plaintiffs seek permanent injunctive relief prohibiting Defendants from cutting off funding for the SUDHH program.

10. Finally, on December 16, 2024, MDHHS sent an email to Plaintiffs asserting that Plaintiffs were not permitted to have an ISF balance above 7.5% of their annual operating budgets for FY24, even though the total limitation on the ISF appears for the first time in the FY25 Contract (a provision to which Plaintiffs did not agree). The FY24 contract contained a limit—albeit an illegal one—on how much additional money Plaintiffs could contribute to its ISF on a *yearly* basis, but did not contain any limit on the *total* amount that could be in the ISF. Plus, even if the FY24 contained such a provision, it would violate federal law. Accordingly, this lawsuit seeks a declaration that the FY24 contract does prohibit Plaintiffs from maintaining an ISF balance greater than 7.5% of their annual operating budget.

FACTS COMMON TO ALL CLAIMS FOR RELIEF

I. The Parties and Jurisdiction.

11. Plaintiffs are Prepaid In-Patient Health Plans ("PIHPs") created by MCL § 330.1204b and related statutes.

12. Plaintiffs help facilitate delivery of behavioral health services for individuals with mental illness, developmental disabilities, and substance disorders in the counties in their respective regions.

13. Defendant Michigan Department of Health and Human Services ("MDHHS") is an agency of the State of Michigan.

14. Elizabeth Hertel is the Director of MDHHS.

15. Pursuant to MCL 600.6419, this Court has jurisdiction over this action because it seeks declaratory relief against the State of Michigan, a department of the State of Michigan (MDHHS), and an officer of the State of Michigan (Director of MDHHS); seeks a writ of mandamus; and alleges violations of the Headlee Amendment to the Michigan Constitution.

II. Background.

16. Medicaid is a joint federal/state program that provides medical assistance to qualifying individuals who are unable to pay or do not have private insurance.

17. To qualify to receive federal Medicaid funds, states are required to create a Medicaid State Plan that complies with various federal requirements.

18. Each state's Medicaid State Plan must be approved by the Centers for Medicare and Medicaid Services ("CMS").

19. After approval of the Medicaid State Plan, states receive federal money to spend on services covered by the Medicaid program.

20. In Michigan, the Medicaid program is administered by MDHHS.

21. Pursuant to Michigan law, behavioral health services are provided at the county level through community mental health services programs ("CMHs"). To be sure, MCL 330.1116(2)(b) requires MDHHS to "shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program…."

22. MDHHS is required to "promote and maintain an adequate and appropriate system of community mental health services programs throughout the state." MCL 330.1116(2)(b).

23. The State is required to financially support CMHs. MCL 330.1202(1) ("The state shall financially support…community mental health services programs….")

24. In fact, the State "shall pay 90% of the annual net cost of a community mental health services program…." MCL 330.1308(1).

25. The "purpose of a community mental health services program" is to "provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay." MCL 330.1206.

26. CMHs must be a county community mental health agency, a community mental health organization, or a community mental health authority.

27. CMHs have numerous statutory rights set forth in the Mental Health Code. Among those rights, CMHs have the right to organize together and form a regional entity.

28. MCL 330.1204b(1) states that a "combination of community mental health organizations or authorities may establish a regional entity by adopting bylaws that satisfy the requirements of this section."

29. Plaintiffs are regional entities.

30. Regional entities help manage services that are provided by individual CMHs, thus reducing administrative burden on the CMHs that form the regional entity.

31. Regional entities are public governmental entities separate from the county, authority, or organization that establishes them. MCL 330.1204b(3).

32. CMHs and regional entities are units of Local Government for purposes of Const. 1963, Art. 9, § 29. See Const. 1963, Art. 9, § 33.

33. After organizing into a regional entity, the regional entity has all of the "power, privilege, or authority that the participating community mental health services programs share in common and may exercise separately under the act…." MCL 330.1204b(2).

34. The State is required to financially support each regional entity. MCL 330.1202(1); MCL 330.1204b(2).

35. MDHHS is required to provide Medicaid-covered specialty services and supports through PIHPs. MCL 400.109f(1).

36. CMHs and regional entities can operate as PIHPs, which is true of each of the Plaintiffs. MCL 330.1232b(1).

37. PIHPs are public managed care organizations that receive funding from the State and arrange to pay for Medicaid services. MCL 400.109f(2).

38. The State of Michigan has 10 PIHPs (regions), and Plaintiffs collectively represent 3 of the 10 regions:

a. Plaintiff NorthCare Network Mental Health Care Entity ("NorthCare") is the PIHP for Region 1, and was formed by Pathways CMH (serving Alger, Delta, Luce, and Marquette counties), Copper Country CMH (serving Baraga, Houghton, Keewanaw, and Ontonagon counties), Hiawatha CMH (serving Chippewa, Mackinac, and Schoolcraft counties), Northpointe CMH (serving Menominee, Dickinson, and Iron counties), and Gogebic CMH (serving Gogebic county).

b. Plaintiff Northern Michigan Regional Entity ("NMRE") is the PIHP for Region 2, and was formed by AuSable CMH (serving Oscoda, Ogemaw, and Iosco counties),

Manistee-Benzie CMH (serving Manistee and Benzie counties), North Country CMH (serving Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego counties), Northern Lakes CMH (serving Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford counties), and Northeast CMH (serving Alcona, Alpena, Montmorency, and Presque Isle counties).

c. Plaintiff Community Mental Health Partnership of Southeast Michigan ("CMHPSM") is the PIHP for Region 6, and was formed by Washtenaw CMH (serving Washtenaw county), Lenawee CMH (serving Lenawee county), Livingston CMH (serving Livingston county), and Monroe CMH (serving Monroe county).

d. Plaintiff Region 10 PIHP ("Region 10") is the PIHP for Region 10, and was formed by Genesee Health Systems (serving Genesee county), Lapeer CMH (serving Lapeer county), Sanilac CMH (serving Sanilac county), and St. Clair CMH (serving St. Clair county).

39. Because MDHHS is required to provide services through PIHPs, Michigan law restricts MDHHS's ability to terminate its relationship with a PIHP.

40. MCL 330.1232b requires that as a condition for receiving Medicaid dollars, a PIHP shall certify that (a) it is in substantial compliance with the standards promulgated by the department and with applicable federal regulations, and (b) that the PIHP has established policies and procedures to monitor compliance with the standards promulgated by the department and with applicable federal regulations and to ensure program integrity. Each Plaintiff has done so.

41. MDHHS may only sanction or terminate a PIHP if the PIHP is not in substantial compliance with promulgated standards and with established federal regulations, if the PIHP has misrepresented or falsified information reported to the state of the federal government, or if the PIHP has failed substantially to provide necessary covered services to recipients. None of the Plaintiffs have done so.

42. According to the Mental Health Code, before imposing a sanction on a PIHP, MDHHS is required to provide that PIHP with notice of the basis and nature of the sanction and an opportunity for hearing to contest or dispute MDHHS's findings and intended sanction.

43. Historically, Plaintiffs and MDHHS have been parties to annual PIHP contracts ("PIHP Contracts").

44. In the simplest of terms, the PIHP Contracts provide that MDHHS will make capitated payments to Plaintiffs, which Plaintiffs use to pay administrative expenses and fund services provided by CMHs in the counties represented within each respective region.

45. Michigan's Medicaid State Plan, as approved by CMS, relies heavily on MDHHS's representations that Medicaid services will be provided by CMHs, through PIHPs. For example, the approved Medicaid State Plan for Michigan states:

a. that for Home and Community Based Services (HCBS) benefit functions, MDHHS "contracts with regional managed care Pre-paid Inpatient Health Plans (PIHP), as the other contracted entity, to assist in monitoring functions of the HCBS benefit….. The PIHP…and local non-state entities/Community Mental Health Service Programs (CMHSP) will all be actively involved in assuring quality and implementation of identified quality improvement activities…."

b. "MDHHS/BHDDA as the state Medicaid agency will deliver 1915(i) SPA services through contracted arrangements with its managed care PIHPs regions. The PIHPs have responsibility for monitoring person-centered service plans and the network's implementation of the 1915 (i) SPA services, which require additional conflict of interest protections including separation of entity and provider functions within provider entities."

c. that to meet federal requirements that HCBS benefits eligibility be determined by an independent evaluation/reevaluation, MDHHS relies on assessments provided by the "PIHP provider network."

d. that to meet federal requirements concerning individualized, person-centered service plans, MDHHS relies on PIHPs to "monitor quality of implementation of person-centered planning" and places responsibility for "the development and implementation of the Individual Plan of Services" on the CMHSP under contract with the PIHP.

III. FY25 PIHP Contract Negotiations.

46. In the Summer/Fall of 2024, leading up to the filing of this Complaint, negotiations concerning the FY25 Contract between MDHHS and Plaintiffs broke down, centered primarily around three provisions detailed below.

47. After much negotiation, Plaintiffs each signed MDHHS's form FY25 Contract after modifying/redlining the offending provisions. MDHHS refused to counter-sign.

48. On October 23, 2024, MDHHS stated it would not negotiate the contract any further. Instead, MDHHS stated the:

> PIHPs will have until 5:00 PM EST on October 31, 2024, to electronically sign the FY 25 contract using the State of Michigan's authorized electronic signature software application, e-Signature. Should any contracts remain unsigned by after this deadline, those PIHPs will be required to adhere to the Transition Responsibilities Language contained in Standard Contract Term 26 of the FY24 contract.

49. In other words, MDHHS stated that Plaintiffs were required to either sign the form FY25 Contract as presented by MDHHS without modification, or MDHHS would terminate its relationship with Plaintiffs.

50. Plaintiffs refused to sign the FY25 Contract because it contains illegal provisions that will hurt the region, the CMHs within the region, and most importantly, negatively impact their ability to properly and adequately serve the recipients of services within the region.

IV. Void Provisions in the form FY25 Contract.

A. ISF – Schedule A – Statement of Work, § 4.

51. The relationship between MDHHS and the PIHPs is a "shared risk" arrangement.

52. The historic PIHP Contracts contain risk-sharing provisions between Plaintiffs and MDHHS, whereby Plaintiffs are responsible for expenses that exceed capitated payments, up to a certain amount.

53. Risk-sharing is permitted by federal regulations, provided the arrangement meets certain requirements.

54. Federal law and the PIHP contracts (both historically and as proposed by MDHHS in the FY25 Contract) permit PIHPs to establish an Internal Service Fund ("ISF") as part of its risk corridor as a "method for securing funds as part of the overall strategy for covering risk exposure." Exhibit A.

55. An ISF account is like a savings account or reserve account, "established for the purpose of securing funds necessary to meet expected risk corridor financing requirements under the State/Contractor Contract." Exhibit A.

56. In other words, when capitated payments from MDHHS exceed a PIHP's expenses, PIHPs add excess funds to their ISF so that they have money in reserve. On the other hand, when expenses exceed the amount of the MDHHS capitated payments, PIHPs use the funds in their ISF to make up the shortfall.

57. Federal regulations require that "all applicable risk-sharing mechanisms…be developed in accordance with…generally accepted actuarial principles and practices." 42 C.F.R. § 438.6(b)(1).

58. In addition, all ISF accounts must be established in compliance with GASB [Government Accounting Standards Board] Statement No. 10, Accounting and Financial Reporting for Risk Financing and Related Insurance Issues. (Exhibit A, Page 115.)

59. GASB Statement No. 10 states that "the total charge by the internal service fund to the other funds may also include a reasonable provision for expected future catastrophe losses." (GASB Statement No. 10, ¶ 66c.)

60. Among other things, Schedule A – Statement of Work, § 4 of the FY25 Contract states that "[t]he ISF cannot be funded more than 7.5% of the annual operating budget in any given year...the ISF balance cannot be less than $0." (Exhibit A, Page 112.)

61. The FY25 Contract also states the PIHPs "may not reflect an ISF that exceeds 7.5% in any of [the PIHP's] reporting requirements contained in this contract. If the Department determines that the ISF is over-funded, the ISF must be reduced within one fiscal year through the abatement of current charges. If such abatements are inadequate to reduce the ISF to the appropriate level, it must be reduced through refunds…." (Exhibit A, Page 113.)

62. In other words, if at any time a Plaintiff's ISF exceeds 7.5% of its annual operating budget, that Plaintiff would be required to give the money back to MDHHS, irrespective of whether the 7.5% limit is actuarially sound.

63. Rather than develop the risk-sharing mechanisms in accordance with generally acceptable actuarial principles and practices, the FY25 Contract imposes an arbitrary 7.5% limit on the amount of funds Plaintiffs may hold in their respective ISF accounts or contribute to their respective ISF accounts on a yearly basis.

64. Plaintiffs have determined that the 7.5% limit is not actuarially sound. Likewise, Plaintiffs have determined that the arbitrary 7.5% limit does not constitute a reasonable limit sufficient to cover future catastrophic losses.

65. Plaintiffs' conclusion is supported by federal law. For example, 2 CFR Pt. 200, App. V states: "Internal service funds are dependent upon a reasonable level of working capital reserve to operate from one billing cycle to the next. Charges by an internal service activity to provide for the establishment and maintenance of a reasonable level of working capital reserve, in addition to the full recovery of costs, are allowable. A working capital reserve as part of retained

earnings of up to 60 calendar days cash expenses for normal operating purposes is considered reasonable."

66. 60 calendar days equates to an ISF limit of 16.4%, far in excess of the arbitrary 7.5% limit contained in the FY25 Contract.

67. Accordingly, the FY25 Contract does not comply with 42 CFR § 438.6(b)(1).

68. The FY25 Contract also purports to prohibit PIHPs from using ISF funds to pay for services rendered during previous fiscal years.

69. It is basic accounting that during some years, a PIHP (and in turn the ISF) may operate in a deficit, whereas in other years, a PIHP (and in turn the ISF) may operate in a surplus.

70. GASB Statement No. 10 makes it clear that at times, an ISF may even have a negative balance: "The total charge by the internal service fund to the other funds is based on an actuarial method or historical cost information and adjusted over a reasonable period of time so that internal service fund revenues and expenses are approximately equal." (GASB Statement No. 10, ¶ 66b.)

71. GASB Statement No. 10 also states that deficits do not need to be funded in any one year, but rather, can be funded over a reasonable period: "Deficits, if any, in the internal service fund…do not need to be charged back to the other funds in any one year, as long as adjustments are made over a reasonable period of time."

72. The FY25 Contract provisions purporting to prohibit Plaintiffs from using ISF funds to pay for services rendered incurred in previous years violates GASB Statement No. 10 and 42 CFR § 438.6(b)(1).

73. The FY25 Contract provisions purporting to prohibit Plaintiffs from using ISF funds to pay for services rendered in previous years also violate 42 CFR 438.6(c)(1), which prohibits the State from directing a PIHP's Medicaid expenditures.

B. Waskul Settlement – Schedule A – Statement of Work, § 1, ¶ R.20.

74. Community Living Supports ("CLS") services are designed to allow individuals with disabilities to live independently in their communities, rather than in institutions. The vast majority of Michigan's CLS recipients receive services through agency providers.

75. Pursuant to a Medicaid Waiver—known as the Habilitation Supports Waiver—separate funding is allocated to a program that allows the individuals receiving CLS services to participate in the decision-making process about what CLS services they will receive. This process of selecting services is known by several names including participant-direction, self-direction, or self-determination.

76. Recipients develop participant-centered service plans, which Michigan calls Individual Plans of Service ("IPOS"). Each IPOS sets forth medically necessary services designed to permit the beneficiary to achieve community inclusion, community participation, and independence.

77. After the IPOS is developed, it is implemented through a budging process. The cost of services set forth in the IPOS are determined and a budget is created. The budgeting process is handled between the participant and the PIHP.

78. After the budget is created, the participants may select any provider he or she wishes to furnish the actual services. The amount the providers are paid is determined through negotiations between the participant (or his/her family/guardian) and the provider. In other words, providers are not necessarily paid the amount set forth in the IPOS budget.

79. On March 15, 2016, Derek Waskul, by his guardian Cynthia Waskul, and others filed a lawsuit against MDHHS and others, Eastern District of Michigan Case No. 2:16-cv-10936 (the "Waskul Case").

80. In a nutshell, the plaintiffs in the Waskul Case took issue with the budgeting process for CLS self-directed services. The lawsuit claimed that before 2015, an IPOS was created for each participant, and then a budget was created by multiplying staff hours by a prescribed rate. The amount and cost of other items needed in the budget that were not based on staff hours were then added separately to the budget. Plaintiff alleged that in 2015, the PIHP flipped the process, requiring participants to start with a fixed rate of $13.88 per hour, inclusive of workers compensation, transportation, community participation, taxes, and training. Plaintiffs alleged that the new budgeting procedure reduced the amount recipients could pay staff, which in turn reduced CLS services available to enrollees.

81. The State and the Waskul plaintiffs reached a proposed settlement that would increase the rates to be applied during the budgeting process for CLS services via the self-determination modality ("Waskul Settlement Agreement" – Exhibit B).

82. Although the object of the settlement is apparently to increase funding for those participants who take advantage of the self-determination modality, many believe the settlement will adversely impact the vast majority of CLS recipients who do not elect self-determination.

83. Among other things, the Waskul Settlement Agreement requires MDHHS to amend its contract with the PIHPs, and requires PIHPs to create the CLS budget using a minimum fee schedule that is set forth in the Waskul Settlement Agreement.

84. The Waskul Settlement Agreement does not set forth any minimum fee schedule that the PIHPs or the participants are *actually* required to pay providers. In other words, the

minimum fee schedule only impacts the calculation of the budget and payment to the recipient, *not* payments to providers.

85. The FY25 Contract being proposed by MDHHS contains a provision purporting to require Plaintiffs to comply with the Waskul Settlement Agreement.

86. Specifically, the FY25 Contract states: "Contractor must comply with all terms and conditions of the Waskul Settlement Agreement once it is approved, and all contingencies have been met." (Exhibit A, Page 80.)

87. Among the numerous problems with the FY25 Contract is that it does not account for the fact that not a single one of the Plaintiff PIHPs are parties to the Waskul Settlement Agreement.

88. Most importantly, the Waskul Settlement Agreement violates federal regulations because it illegally directs PIHPs expenditures.

89. 42 CFR 438.6(c)(1) provides that a State may not direct a PIHP's Medicaid expenditures.

90. Subpart (iii)(A) (42 CFR 4.386.6(C)(1)(iii)(A)) contains a limited exception allowing a State to require a PIHP to "adopt a minimum fee schedule for providers that provide a particular service under the contract using State plan approved rates."

91. 42 CFR 4.386.6(C)(1)(iii)(A) does not apply because the Waskul Settlement Agreement incorporated into the FY25 Contract does not require PIHPs to pay providers any minimum rate. Instead, the Waskul Settlement Agreement only requires the PIHPs to use the rate when calculating and creating a budget with self-directed CLS recipients.

92. Moreover, even if 42 CFR 438.6(C)(1)(iii)(A) applied to the budget rates in the Waskul Settlement Agreement, where a State directs a payment, it must "[d]irect expenditures

equally, and using the same terms of performance, for a class of providers providing the service under the contract." 42 CFR 438.6(C)(2)(ii)(B).

93. In other words, the State cannot create a minimum fee schedule and then treat providers providing the same services differently. And that is exactly what the State proposes to do by treating providers providing services via the self-determination modality different than providers providing the exact same services, using the exact same billing codes, via a different modality.

94. Because the Waskul Settlement Agreement violates federal law, the requirement in the FY25 Contract purporting to require the PIHPs to abide by the Waskul Settlement Agreement is void.

C. CCBHCs – Schedule A – Statement of Work, § 1, ¶ G.14.

95. Federal legislation created the Certified Community Behavioral Health Clinic ("CCBHC") Medicaid Demonstration Program, designed to provide funding to help expand access to substance use disorder and mental health services.

96. States must apply to CMS to receive funding. Michigan did so and became a CCBHC Demonstration state in 2020, with a start date in 2021. The initial two-year demonstration was set to expire in 2023, but additional legislation extended the demonstration by another 4 years.

97. CCBHC clinics are designed to expand services and ensure coordinated, comprehensive behavioral care. CCBHCs have requirements unique to those clinics that are not required of other providers: (1) 24/7/365 crisis response services, (2) screening, assessment, and diagnosis/risk management, (3) patient-centered treatment planning, (4) outpatient mental health and substance use disorder services, (5) outpatient clinic primary care screening, (6) case management, (7) psychiatric rehabilitation, (8) peer support and counseling services, and (9) intensive community-based care for members of the armed forces and veterans.

98. The State of Michigan, and more specifically MDHHS, is responsible for certifying and monitoring CCBHCs and ensuring that the State is complying with the demonstration waiver. The State is responsible for overseeing the demonstration program, including clinic certification, payment, and compliance with federal reporting requirements. 42 USC § 1396a.

99. Under State and Federal law, Plaintiffs bear no responsibility for running, administering, or otherwise having any involvement in the CCBHC demonstration.

100. Nonetheless, over the past several years, MDHHS has systematically shifted responsibility for running the CCBHC program to Plaintiffs without providing appropriate funding.

101. The FY25 Contract and MDHHS policy purport to shift even more of the State's administrative responsibilities to Plaintiffs without providing Plaintiffs any funding for the new responsibilities.

102. The FY25 Contract states that Plaintiffs with a CCBHC Demonstration Site in their region must execute the PIHP duties and responsibilities set forth in the "MDHHS MI CCBHC Demonstration Handbook Version 2.0," (Exhibit C) which MDHHS claims it can amend as and when MDHHS deems fit.

103. Among the responsibilities MDHHS attempts to shift to the PIHPs per the FY25 Contract are: CCBHC oversight and support, CCBHC enrollment and assignment, CCBHC coordination and outreach, CCBHC payment, CCBHC reporting, CCBHC grievance monitoring, and encounter and review submissions.

104. Through the FY25 Contract, MDHHS is compelling and/or attempting to compel Plaintiffs to undertake new and additional activities and services without appropriating any funds to compensate Plaintiffs for the increased costs being imposed upon them.

105. Historically, the amount of the "supplemental payment" made by MDHHS to Plaintiffs was 1% of the rates paid pursuant to the CCBHC Demonstration.

106. To support the alleged actuarial soundness of the payments made to Plaintiffs, MDHHS retained the services of Milliman, Inc. to provide actuarial and consulting services.

107. On or about September 23, 2024, Milliman published its "State Fiscal Year 2024 Behavioral Health Capitation Rate Certification" for the period of October 1, 2024 through September 30, 2025 ("FY25 Milliman Rate Certification" – Exhibit D).

108. The FY25 Milliman Rate Certification acknowledges MDHHS is shifting additional responsibility for managing the CCBHC Demonstration to PIHPs via the CCBHC Handbook starting in FY25, yet specifically acknowledges there will be no corresponding increase in funding.

109. To be sure, the FY25 Milliman Rate Certification sets forth 11 categories of "major new responsibilities" being shifted to Plaintiffs, while simultaneously acknowledging that Defendants are not providing any additional funding:

> *Section 223 CCBHC Demonstration*
>
> We have reviewed the CCBHC handbook developed by MDHHS that outlines the roles and responsibilities of the PIHPs and CCBHCs to operationalize the demonstration program and utilized this information to support the PIHP administrative percentage of 1.0% added to the SFT 2025 CCBHC PPS-1 rates.
>
> Many of the PIHP responsibilities for the CCBHC Demonstration are currently being performed as part of the existing program. <u>The following are some of the major new responsibilities included in the CCBHC Handbook:</u>
>
> - Provide information about CCBHC benefits to all potential enrollees (community referral, peer support specialist/recovery coach networks other providers, courts, health departments, law enforcement, schools, other community-based settings), including informational brochures, posters, outreach materials, identify and assign beneficiaries to the pertinent CCBHC site within Waiver Supports Application (WSA); includes verifying beneficiary consent to share information

- Review and process all CCBHC recommended potential enrollees; verify enrollment and attestation for eligibility
- Reimbursing CCBHC's at their PPS-1 rate for each valid CCBHC Medicaid daily visit in a timely manner
- PIHP-CCBHC quarterly reconciliation of actual to projected expense and utilization by CCBHC (may be separate reconciliations based on operational plan of PIHP)
- MDHHS-PIHP annual reconciliation of actual to projected expense and daily visits by CCBHC
- Reporting and distribution for quality bonus payments
- Additional contracting requirements related specifically to CCBHCs
- Establishing an infrastructure to support CCBHCs in care coordination and providing required services, including coordinated crisis services with the Michigan Crisis and Access Line (MiCAL), when available
- Additional trainings and technical assistance to support CCBHC delivery of services
- Distribution, review, validation, and submission of CCBHC data requests, quality metrics, level of care (LOC) data, and ad-hoc requests from MDHHS
- Monitor, collect, and report grievance, appeal, and fair hearing information as it relates to CCBHC services

(Exhibit D at pages 46-47 – emphasis added).

110. The FY25 Milliman Rate Certification makes it clear that despite MDHHS shifting responsibilities to the PIHPs—which Milliman characterizes as "major new responsibilities"—MDHHS is not providing *any* additional funding to the PIHPs: "We have reviewed the historical administrative expenditures reported in the EQI reports and *have not included any increase to the variable administrative percentages* based on this data." (Emphasis added.)

V. Substance Use Disorder Health Home ("SUDHH") Program.

111. The SUDHH Program is designed to "provide comprehensive care management and coordination services to Medicaid beneficiaries" with opioid use disorder ("OUD"), alcohol

use disorder ("AUD"), and stimulant use disorder ("StUD"). The program previously existed only for individuals with OUD and was known as the Opioid Health Home program ("OHH"). Michigan, with the approval of CMS, expanded the program to include AUD and StUD, and thus OHH became SUDHH.

112. On Wednesday, November 27, 2024, NorthCare received an email from MDHHS, stating that because it refused to sign the FY25 Contract, MDHHS would not be providing Medicaid funds NorthCare needs to provide SUDHH benefits to recipients:

> I apologize that we didn't make this connection sooner, but without a signed Medicaid contract Northcare is not able to implement the SUDHH with Medicaid funds. You can continue with OHH activities and any billable services for those with AUD or StUD, but those SUDHH beneficiaries will have to be removed from the WSA. Please work with Kelsey to get the beneficiary list updated.
>
> Exhibit E.

113. NMRE, CMHPSM and Region 10 received substantively the same email as was received by NorthCare.

114. As of December, 2024, NorthCare's region contains 4,080 individuals who are eligible for SUDHH benefits. NMRE's region contains 7,886. CMHPSM's region contains 6,120. Region 10's region contains 19,039.

115. Without SUDHH funding, the over 37,000 Michigan residents in Plaintiffs' regions who are entitled to receive the benefits of the SUDHH program will no longer be eligible to enroll.

116. After the initial Verified Complaint was filed, the parties negotiated a preliminary injunction requiring Defendants to fund the SUDHH program and permitting the SUDHH program to proceed until further order of the Court. See Stipulated Order re: Initial Pleadings and Injunction as to Substance Use Disorder Health Home Program entered December 23, 2024.

VI. FY24 ISF Dispute.

117. Each of the Plaintiffs are parties to separate contracts with MDHHS that address FY24 (each a "FY24 Contract" and collectively the "FY24 Contracts"). Each FY24 Contract is materially the same. A sample FY24 Contract is attached as Exhibit F. Defendants are in possession of the FY24 Contracts between MDHHS and the remaining Plaintiffs. MCR 2.113(C)(1)(b).

118. The FY24 Contracts contain provisions addressing Plaintiffs' respective ISF accounts.

119. The FY24 Contracts purport to prohibit Plaintiffs from using ISF funds to pay for medical services rendered in prior fiscal years and imposes other restrictions on the ISF, in violation of federal law. (Exhibit F, Page 101 – Schedule A, § 4.B.)

120. The FY24 Contract also purports to limit the amount that Plaintiffs may contribute to their ISF each year, limiting the amount to 7.5% of its Medicaid/Healthy Michigan Plan pre-payment authorization: "Contractor may transfer Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization to the ISF *in any given year*. Contractor may not transfer any funds in excess of that percentage to the ISF *in any year*." (Exhibit F, Page 101 – Schedule A, § 4.C) (emphasis added).

121. The FY24 Contract does not contain a limit on the total amount that can be present in an ISF account, only on the amount that can be contributed each year.

122. Nonetheless, on December 16, 2024, MDHHS notified Plaintiffs that their FY24 Financial Status Reports ("FSRs") would not be accepted "if any ISF balance shown therein is greater than 7.5% of the annual operating budget." MDHHS stated that rejected submissions would be returned for "corrections" and if not thereafter accepted, would be "considered 'late' for purposes of determining PIHP eligibility for Contractor Performance Bonus Payments."

123. In other words, MDHHS stated that if any Plaintiff maintained an ISF over 7.5%, MDHHS would sanction MDHHS for doing so by issuing a financial penalty.

124. MDHHS's pronouncement violates the FY24 Contract, because the FY24 Contract does not contain any limitation on the total amount that Plaintiffs can maintain in an ISF account.

125. MDHHS's pronouncement also violates the FY24 Contract because MDHHS states it will impose a financial sanction upon Plaintiffs without providing for notice and an opportunity for hearing before doing so. Schedule A, § 1.D.3. of the FY24 Contracts (Exhibit F, Page 35) states:

> *before* imposing a sanction on a Contractor, the State will provide Contractor with timely written Contract compliance notice that explains both of the following:
>
> a. The compliance issue along with its statutory/regulatory/contractual basis and the objective evidence upon which the finding of fault is based.
>
> b. The opportunity for a hearing to contest or dispute the State's findings and intended sanction, *prior to imposition of the sanction.* A hearing under this Section is subject to the provision governing a contested case under the Administrative Procedures Act…
>
> Exhibit F, Page 35 (*emphasis added*).

126. Moreover, even if the FY24 Contract limited the total amount Plaintiffs can maintain in their ISF accounts to 7.5% of their annual budget, such a limitation would violate federal law. See § IV.A., above.

COUNT I: DECLARATORY RELIEF RE: ISF
(ON BEHALF OF ALL PLAINTIFFS)

127. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

128. Defendants claim they can impose a limit on the amount that Plaintiffs can contribute to their ISF accounts on an annual basis to 7.5% of Plaintiffs' respective capitated Medicaid & Healthy Michigan Plan revenues. Defendants seek to include a provision containing such limitation in the FY25 Contract, and seek to enforce the FY24 Contract that contains such

purported limitation. On the other hand, Plaintiffs maintain that imposing such a 7.5% annual limit violates federal law because it is an arbitrary limitation, is not based on any acceptable actuarial method, and is not actuarially sound.

129. Defendants also claim they can impose a limit on the amount Plaintiffs can maintain in their ISF accounts to 7.5% of their respective capitated Medicaid & Health Michigan Plan revenues. Defendants seek to include a provision containing such limitation in the FY25 Contract, and claim that the FY24 Contract already contains such limitation. On the other hand, Plaintiffs maintain that imposing such a 7.5% limit violates federal law because it is an arbitrary limitation, is not based on any acceptable actuarial method, and is not actuarially sound. Moreover, Plaintiffs maintain that the FY24 Contract contains no such limitation, and that even if it did, it is not valid.

130. Defendants claim they can prevent Plaintiffs from using ISF funds to pay for services rendered in prior fiscal years and imposes other restrictions on Plaintiffs use of ISF funds. On the other hand, Plaintiffs maintain that restricting the ISF violates federal law.

131. Thus, there is an actual and present controversy between the parties.

132. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide Plaintiffs' future conduct to preserve their legal rights, and to settle the dispute between the parties.

COUNT II: DECLARATORY RELIEF RE: WASKUL SETTLEMENT (ON BEHALF OF ALL PLAINTIFFS)

133. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

134. Defendants claim they can require Plaintiffs to create a CLS budget using a minimum fee schedule set forth in the Waskul Settlement Agreement, and that doing so does not violate federal law.

135. On the other hand, Plaintiffs maintain that Defendants' attempt to compel Plaintiffs to create a CLS budget using the rates set forth in the Waskul Settlement violates federal law

including because it improperly directs Plaintiffs' expenditures under the contract, and otherwise fails to direct expenditures equally for providing the same services.

136. Thus, there is an actual and present controversy between the parties.

137. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide Plaintiffs' future conduct to preserve their legal rights, and to settle the dispute between the parties.

COUNT III: DECLARATORY RELIEF RE: ADDED RESPONSIBILITIES RELATED TO THE CCBHC DEMONSTRATION BEING IMPOSED IN FY25 (ON BEHALF OF PLAINTIFFS CMHPSM AND REGION 10)

138. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

139. Via the FY25 Contract and MDHHS MI CCBHC Demonstration Handbook Version 2.0, Defendants claim they can require CMHPSM and Region 10 to undertake various additional duties that are otherwise Defendants' responsibility.

140. On the other hand, CMHPSM and Region 10 maintain Defendants cannot require them to undertake various additional duties imposed upon Defendants pursuant to the CCBHC Demonstration via the FY25 Contract, including those set forth in the MDHHS MI CCBHC Demonstration Handbook Version 2.0, because Defendants have not appropriated any funds to pay for the necessary increased costs of those additional duties in violation of the Headlee Amendment and MCL 21.235.

141. Thus, there is an actual and present controversy between the parties.

142. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide CMHPSM and Region 10's future conduct to preserve their legal rights, and to settle the dispute between the parties.

COUNT IV: VIOLATION OF THE HEADLEE AMENDMENT RE: ADDED RESPONSIBILITIES RELATED TO THE CCBHC DEMONSTRATION BEING IMPOSED IN FY25
(ON BEHALF OF PLAINTIFFS CMHPSM AND REGION 10)

143. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

144. Cost. 1963, Art. 9, § 25, part of the Headlee Amendment, states in part:

> The state is prohibited from requiring any new or expanded activities by local governments without full state financing, from reducing the proportion of state spending in the form of aid to local governments, or from shifting the tax burden to local government.

145. Const. 1963, Art. 9, § 29, also part of the Headlee Amendment, states:

> The state is hereby prohibited from reducing the state financed proportion of the necessary costs of any existing activity or service required of units of Local Government by state law. A new activity or service or an increase in the level of any activity or service beyond that required by existing law shall not be required by the legislature or any state agency of units of Local Government, unless a state appropriation is made and disbursed to pay the unit of Local Government for any necessary increased costs. The provision of this section shall not apply to costs incurred pursuant to Article VI, Section 18.

146. MCL 21.235 requires the legislature to appropriate an amount sufficient to make disbursements for the necessary cost of each state requirement. An initial disbursement is required to be made in advance, at least 30 days prior to the effective date of the requirement. MCL 21.235(1) & (2).

147. Defendants, including through the FY25 Contract and the MDHHS MI CCBHC Demonstration Handbook Version 2.0, are shifting new activities and services, and increasing the level of other activities and services, related to administering and running the CCBHC Demonstration, to CMHPSM and Region 10, without making any appropriation at all for any of the necessary increased costs.

148. The new activities and services relate to the administration of the CCBHC Demonstration, and include the new "major responsibilities" referenced in the FY25 Milliman

Rate Certification (Exhibit D, Pages 46-47) and the new activities and services to be rendered by CMHPSM and Region 10 as set forth in the MDHHS MI CCBHC Demonstration Handbook Version 2.0.

149. Defendants are in violation of the prohibition of unfunded mandates ("POUM") provisions of the Headlee Amendment (i.e., the second sentence of Const. 1963, Art. 9, § 29), Const. 1963, Art. 9, § 25, and MCL 21.235.

150. CMHPSM and Region 10 do not need to plead and prove the extent of the harm caused, because neither the Legislature nor MDHHS have made any appropriation or disbursements necessary to cover the cost of the increased mandates. *Adair v Michigan*, 497 Mich 89, 96; 860 NW2d 93 (2014).

151. CMHPSM and Region 10 do not anticipate any particular factual questions that require resolution by the Court related to this Count. MCR 2.112(M).

152. There are no ordinances or municipal charter provisions involved. Available documentary evidence supportive of this claim includes the MDHHS CCBHC Handbook Version 2.0 (Exhibit C) and the FY25 Milliman Rate Certification (Exhibit D).

153. Plaintiffs reserve the right to supplement this pleading with additional documentary evidence as it becomes available. MCR 2.112(M).

COUNT V: DECLARATORY RELIEF RE: CONTINUED FUNDING (ON BEHALF OF ALL PLAINTIFFS)

154. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

155. Defendants claim they can terminate their contractual relationship with Plaintiffs simply because Plaintiffs refused to sign the FY25 Contract inclusive of the illegal/void provisions contained therein. Defendants further claim that they can withhold SUDHH and other Medicaid funds from Plaintiffs.

156. On the other hand, Plaintiffs maintain that State and Federal law require Defendants to continue funding, including by providing SUDHH funding to, Plaintiffs even in the absence of a signed FY25 Contract.

157. In addition, Plaintiffs maintain that the steps Defendants have taken to terminate MDHHS's contractual relationship with Plaintiffs constitutes an action for which Plaintiffs are entitled to notice and opportunity for hearing to contest the proposed action. MCL 330.1232b.

158. Thus, there is an actual and present controversy between the parties.

159. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide Plaintiffs future conduct to preserve their legal rights, and to settle the dispute between the parties.

COUNT VI: WRIT OF MANDAMUS
(ON BEHALF OF ALL PLAINTIFFS)

160. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

161. Defendants have a non-discretionary statutory duty to continue funding Plaintiffs, even in the absence of a signed contract. MCL 330.1202(1); MCL 330.1204b(2); MCL 330.1116; MCL 400.109f.

162. Defendants also have a non-discretionary statutory duty to supply Plaintiffs with a hearing prior to issuing a sanction or terminating their relationship. MCL 330.1232b. Defendants are violating their duty by purporting to terminate their relationships with Plaintiffs and by purporting to issue sanctions without first providing for a hearing.

163. Defendants' obligations are ministerial acts, leaving nothing to the exercise of discretion or judgment.

164. Plaintiffs have no adequate remedy at law.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs request:

1. A declaration that:

    a. Plaintiffs can fund their respective ISF accounts on both an annual and total basis up to an amount determined to be actuarially sound despite any contractual provision to the contrary;

    b. Defendants cannot restrict Plaintiffs' use of ISF funds despite any contractual provision to the contrary;

    c. Plaintiffs are not required to comply with the Waskul Settlement Agreement despite any contractual provision to the contrary;

    d. CMHPSM and Region 10 are not required to undertake any added administrative responsibilities related to the CCBHC Demonstration imposed starting in FY25, or alternatively, that Defendants must provide adequate funding before requiring CMHPSM and Region 10 to undertake said administrative responsibilities;

    e. Defendants must continue to provide Medicaid and general funding to Plaintiffs; and

    f. Defendants must provide Plaintiffs with notice and an opportunity for hearing prior to issuing sanctions and prior to attempting to terminate their relationship with Plaintiffs.

2. A Writ of Mandamus compelling Defendants to:

    a. continue to provide Medicaid and general funds to Plaintiffs;

    b. retract all communications and actions taken to terminate the relationship between MDHHS and Plaintiffs;

    c. retract all communications and actions taken to issue or threaten sanctions related to the FY24 FSR;

    d. supply Plaintiffs with the opportunity for a hearing to contest and dispute MDHHS's proposed termination; and

    e. supply Plaintiffs with the opportunity for a hearing to contest and dispute MDHHS's proposed sanctions related to the FY24 FSR.

3. Compensatory damages in the amounts that should have been appropriated to CMHPSM and Region 10 but for Defendants' violation of the Headlee Amendment.

4. An award in favor of Plaintiffs granting them all attorneys' fees, expenses, and costs incurred in bringing this action.

5. All other relief as the Court deems just and proper.

TAFT, STETTINIUS & HOLLISTER, LLP

Dated: January 10, 2025

By: */s/Christopher J. Ryan*

Christopher J. Ryan (P74053)
Gregory W. Moore (P63718)
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Southfield, MI 48034
(248) 727-1553
cryan@taftlaw.com
Attorneys for Plaintiffs

VERIFICATION

I declare under penalties of perjury that this First Amended Verified Complaint has been examined by me and that its contents are true to the best of my information, knowledge, and belief. MCR 1.109(D)(3).

NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY

Signed by:
By: Megan Rooney
D7E069AB71074A0...
Megan Rooney
Subscribed and sworn to before me this ___ day of 1/13/2025, 2024
DocuSigned by:
Deborah Gutierrez
6BA59119555B41A...
_____, Notary Public
_____ County, Michigan
My Commission Expires: _____

NORTHERN MICHIGAN REGIONAL ENTITY

Signed by:
By: Eric Kurtz
1C0A25D25D3B447...
Eric Kurtz
Subscribed and sworn to before me this ___ day of 1/10/2025, 2024
DocuSigned by:
Deborah Gutierrez
6BA59119555B41A...
_____, Notary Public
_____ County, Michigan
My Commission Expires: _____

DEBORAH GUTIERREZ
Notary Public - State of Michigan
County of Wayne
My Commission Expires Aug. 22, 2025

REGION 10 PIHP

Signed by:
By: Jim Johnson
B6621BB227E44EE...
Jim Johnson
Subscribed and sworn to before me this ___ day of 1/10/2025, 2024
DocuSigned by:
Deborah Gutierrez
6BA59119555B41A...
_____, Notary Public
_____ County, Michigan
My Commission Expires: _____

DEBORAH GUTIERREZ
Notary Public - State of Michigan
County of Wayne
My Commission Expires Aug. 22, 2025

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Signed by:
By: James Colaianne
155692BF28ED4A2...
James Colaianne
Subscribed and sworn to before me this ___ day of 1/10/2025, 2024
DocuSigned by:
Deborah Gutierrez
6BA59119555B41A...
_____, Notary Public
_____ County, Michigan
My Commission Expires: _____

DEBORAH GUTIERREZ
Notary Public - State of Michigan
County of Wayne
My Commission Expires Aug. 22, 2025

Northern Michigan Regional Entity
FY24 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP) **Evaluation**

1. Performance Improvement Projects

The NMRE continues to engage in Performance Improvement Projects (PIPs), addressing clinical as well as non-clinical aspects of care. PIPs must involve measurable and objective quality indicators, interventions leading to improvement, as well as evaluation of effectiveness. The goal of PIPs is to improve health outcomes and member satisfaction.

PIP #1 (Opioid Health Home PIP) Non-clinical / HSAG Validated

The NMRE Quality and Compliance Oversight Committee (QOC) collected data, conducted ongoing analysis, and coordinated with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program. The NMRE showed evidence of enrollment improvement from the baseline to post baseline (by September 30, 2024).

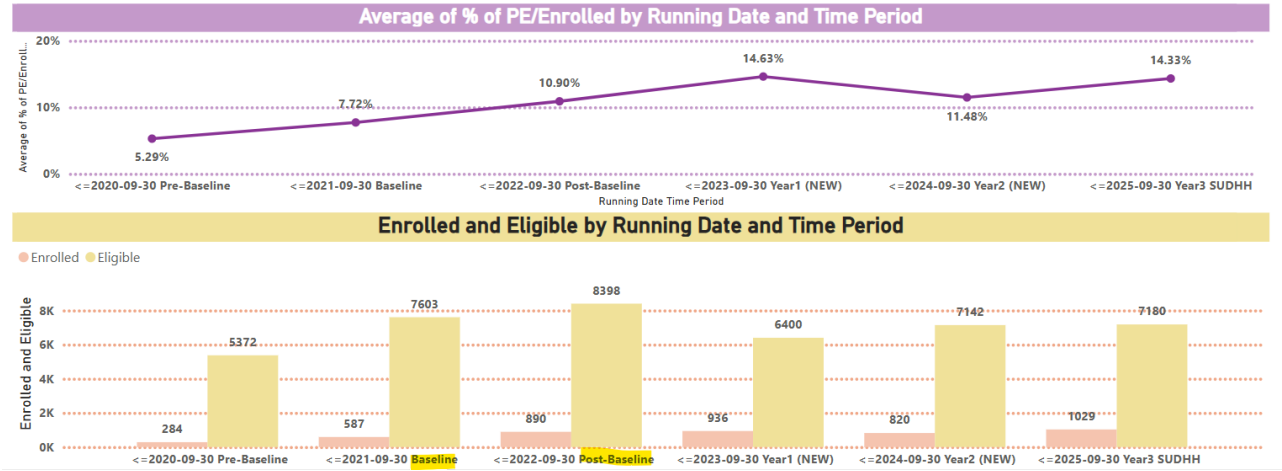
Goals:

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

The NMRE has aimed to increase enrollment by:

1. Providing monthly meetings with providers. These monthly meetings have helped to keep providers more engaged and motivated.
2. Providing resources and reports regarding Public Health Emergency (PHE) ending.
3. Funding Community Health Worker (CHW) training.
4. Expanding Provider network by adding Health Home Partners (HHP).

Table with enrollment tracking shows trends and enrollment changes for all the reporting periods:



Challenges:

Staffing remains a big challenge in the NMRE region, however, the biggest challenge and obstacle for enrollment was the end of PHE, resulting in 7.68% in FY23 (FY24, 37.60%) of OHH clients being disenrolled from the benefit. Even with these noted challenges, HEDIS Measures for the Health Home remain very good, allowing for Pay for Performance funds to be allocated to the HHPs.

> NMRE distributed 100% of these funds back to HHPs to further support the implementation of health homes in the region.

It is important to note that this HSAG validated PIP received final validation score of 100% for FY24:

The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service PIP received a Met validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements across the first eight steps validated, and a High Confidence validation status. The PIHP developed a methodologically sound improvement project. The causal/barrier analysis process included the use of appropriate QI tools to identify and prioritize barriers, and interventions were initiated in a timely manner. The PIP received a Met validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements for Step 9, and a High Confidence validation status. The performance indicator demonstrated a statistically significant improvement over the baseline for the first remeasurement period.

PIP #2 (Behavioral Health Home PIP) Non-Clinical

The NMRE QOC collected data and conducted analysis for Behavioral Health Home (BHH) enrollment. The NMRE continues to improve the percentage of individuals who are enrolled in the Behavioral Health Home program and receiving CMHSP services. BHH enrollment the within CMHSPs setting is at 5.53% (compared to 4.69% at the last reporting period). Overall BHH enrollment numbers are higher, however, as FQHC HHP enrollment numbers are not included in this calculation (additional 150 beneficiaries).

Goals:

a. Improve care management for beneficiaries with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED).
b. Improve care coordination between physical and behavioral health services.
c. Improve care transitions between primary care, specialty services, and inpatient settings.
d. Improve care coordination for youth and children as well as their families.

HHBH Comparison of Receiving HHBH Waiver Services versus Potential Enrollees

Receiving BHH Waiver Services	Enrolled + Potential Enrollees who are actively enrolled w/CMHSP	Percent Enrolled	CMHSP
155	892	17.38%	Centra Wellness Network
87	2627	3.31%	North Country CMH
98	1549	6.33%	Northeast Michigan CMH
165	3802	4.34%	Northern Lakes CMH
83	1768	4.69%	Wellvance
588	**10638**	**5.53%**	

Positive Interventions:

1. CMHSPs changed their referral processes resulting in increased enrollments.
2. CMHSPs utilize BHH to aid in the transition between levels of care.
3. CMHSPs attended NMRE provided/paid CHW training to aid staffing expansion.
4. NMRE, as the lead entity, continues to provide technical support and trainings to all HHPs.

It is important to state that this population is not seeing as much of an impact of PHE ending and redetermination as they typically belong to Medicaid, compared to OHH client that are mostly MHP population.

Challenges:

Provider/ staff capacity remains the biggest challenge for BHH enrollment; however, HEDIS outcomes continue to be very good and 100% of these funds are administered back to CMHSPs.

PIP #3 (Clinical PIP Development) Clinical/ Not HSAG Validated

Performance Indicator 3 (PI 3) improvement goal:

> Increase the percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.

50*th* Percentile	75*th* Percentile	NMRE Annualized FY23 Percentage
72.9%	83.80%	67.82%

It was noted that the NMRE fell below the 50th percentile

1. Anticipated Barriers: Staffing and lack of appointment slots due to staffing issues.
2. Anticipated Strengths/Challenges: Staffing, trained staff, automated appointment reminders; consumers cancelling, rescheduling, or requesting outside of the 14-day window due to their own schedules, no-shows, requesting in-person (not telehealth) services, reducing the number of available therapists.
3. Interventions: Ongoing review of performance indicators to learn about trends and potential process changes that may be needed, additional staff training, availability of telehealth being offered, successful strategies to be reviewed and shared with QOC members.

2. Event Reporting and Notification

The NMRE Quality and Compliance Oversight Committee (QOC), as part of the QAPIP, continues to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. Members of QOC and regional IT departments formed a small committee that reviewed and implemented changes needed to improve the data quality and timeliness in reporting events.

Training and information

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

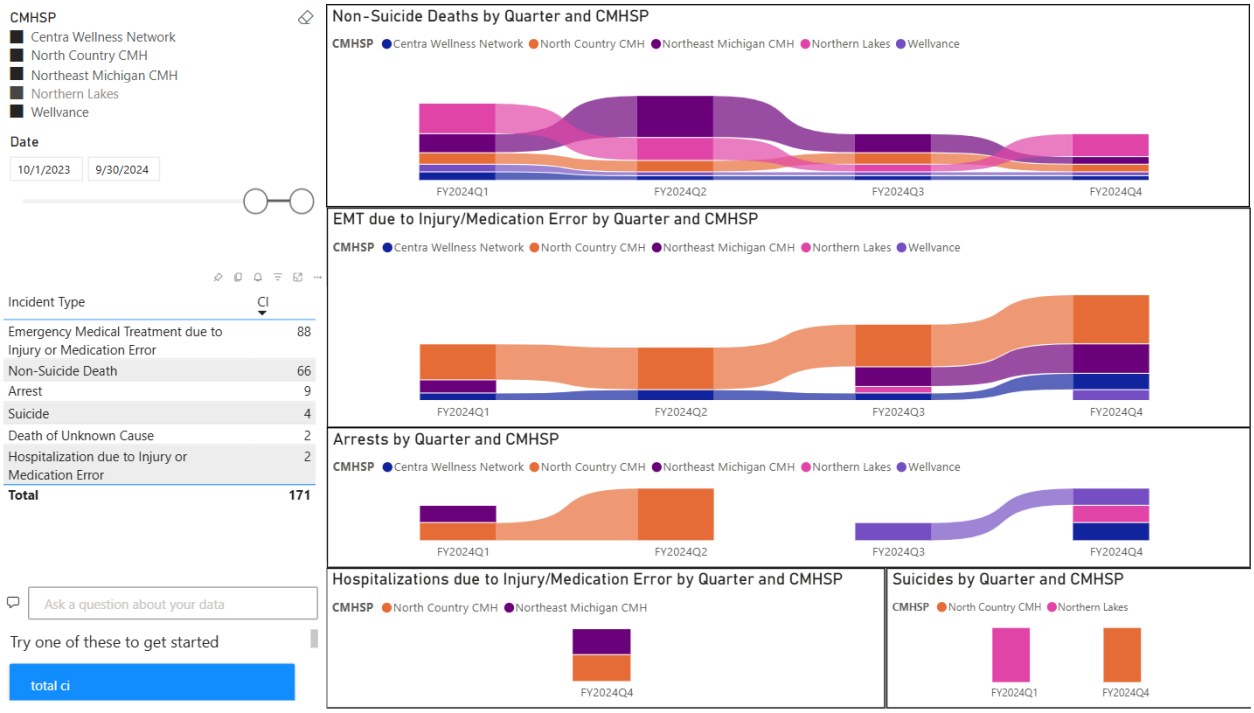
Changes to Reporting Platforms

The NMRE updated the reporting system within PCE to better meet reporting needs and ensure timely and accurate reporting of these events to PIHP/MDHHS. Changes were completed and implemented within the PCE system in FY24.

Data Collection and Review

The NMRE continues to collect events data quarterly, analyzes trends, and implements necessary interventions.

The table below shows the NMRE monitoring tool that allows trends to be monitored across all five CMHSPs.



3. Consumer Experience Assessments

The NMRE continues to conduct ongoing quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments are representative of persons served, including long-term supports and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract with MDHHS.

Assessment results are used to improve services, processes, and communication. Outcomes are shared in the annual newsletter/mailer. The NMRE identifies and provides possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

Responses from CMHSP Surveys for FY22, FY23, and FY24 are shown below:

LTSS (Long Term Supports and Services)

The NMRE incorporates consumers receiving long-term supports or services (LTSS) into the review and analysis of the information obtained from quantitative and qualitative methods.

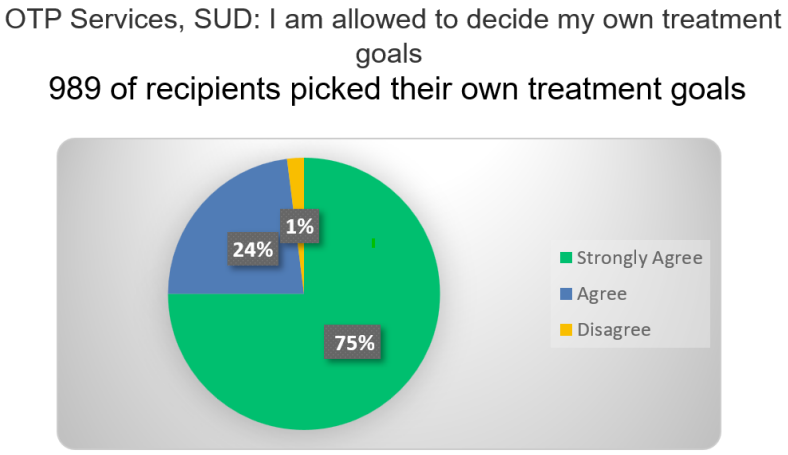
Outcomes

The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction. Processes found to be effective will be continued while those less effective or not satisfactory will be revised and followed up with. NMRE will provide additional support and training for CMHSPs administrative as well as direct clinical staff.

Substance Use Disorder (SUD)

The NMRE conducted separate SUD surveys that included Withdrawal Management/Detox and Methadone service surveys, to identify specific member experiences. Additional support and training will be offered to SUD providers in documented areas of need and dissatisfaction.

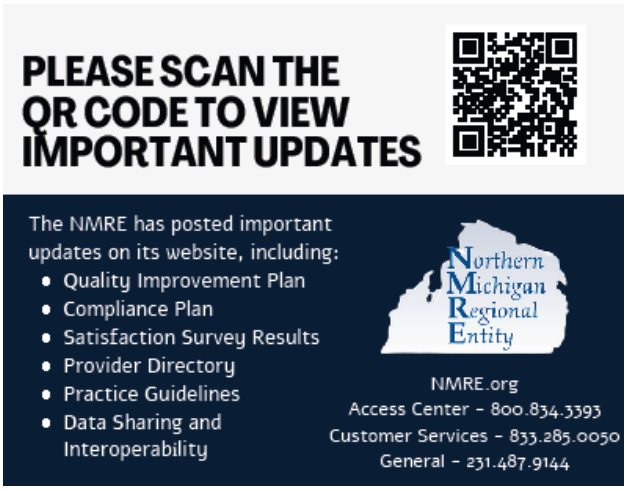
Furthermore, a training on the Recipient Rights reporting template was conducted for SUD providers and a reporting spreadsheet was created and provided, to improve tracking and reporting.



Evaluation Efforts

The NMRE outlines systemic action steps to follow-up on the findings from survey results on an ongoing basis.

The NMRE shares survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), network providers, Board of Directors, the Regional Consumer Council (Regional Entity Partners), and posts a copy to the NMRE.org website. The mailer below will be shared with NMRE beneficiaries to update them on important information located on the NMREs website:



4. Provider Network Monitoring

To ensure compliance, the NMRE conducted annual monitoring for all directly contracted providers in region, and out of region as needed and appropriate, utilizing reciprocity when necessary.

Monitoring

NMRE conducted site reviews for all contracted service providers in FY24. The NMRE monitored and followed-up on corrective action plans to ensure Corrective Action Plans (CAPs) were being implemented as stated by network providers.

Verification of Medicaid Services

The NMRE performed quarterly audits to verify Medicaid claims/encounters to ensure Medicaid services were furnished to beneficiaries by CMHSPs, SUD providers, providers, and/or subcontractors. This included verifying data elements from individual claims/encounters to ensure proper codes were used and proper documentation was in place. For FY24, the overall percentage of valid encounters was at 90%, which is a decrease from 95% in FY23. Corrective action plans will be developed to address all the areas of concern, such as lack of client signatures on the IPOS/Treatment Plans.

Northern Michigan Regional Entity
Medicaid Encounter Verification Results

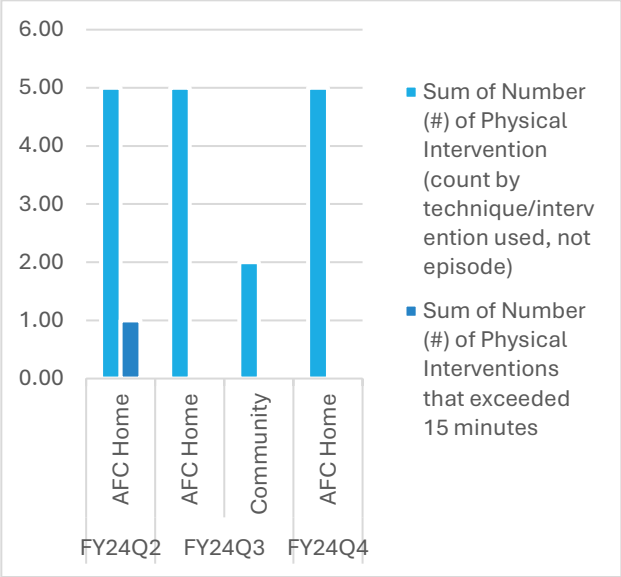
Total	Number Valid	Number Audited	Valid Dollar Amount	Total Dollar Amount Audited	Percent Valid Number
CMH Contracted Services	189	200	85235.4	87335.09	95%
CMH Direct Services	195	200	43581.29	44478.61	98%
NMRE Contracted SUD	140	180	$ 42,998.87	$ 47,686.85	78%
Grand Total	**524**	**580**	**$ 171,815.56**	**$ 179,500.55**	**90%**

5. Behavior Treatment Review

The NMRE QOC conducted quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques were approved for use with members and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Trends and patterns were reviewed to determine if systems and process improvement initiatives were necessary.

Data

In FY24 the NMRE introduced a new data tracking sheet that ensured uniformed data collection allowing easy trending and monitoring. Data included numbers of interventions and length of time the interventions used with individuals. The NMRE QOC was tasked with reviewing the data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that have been approved by the members or their guardians during person-centered planning were used.



6. Quality Measures (HEDIS measures)

The NMRE provided HEDIS measure reports to the NMRE QOC on at least a quarterly basis. Upon review, QOC identified interventions to improve outcomes where necessary.

Measures

The NMRE collected and reviewed data for the HEDIS measures tied to the Performance Bonus Incentive Pool.

- Follow-up after hospitalization (FUH) for mental illness within 30 days.
- Follow-up after (FUA) emergency department visit for Alcohol and Other Drug Dependence.
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (new)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) (new)

NMRE access staff continues to implement procedural changes that assist in score improvement, such as reaching out to NMRE beneficiaries who present at the emergency room due to SUD concerns and linking them to appropriate services (FUA 30, Adults measure score):

FUA-30AD	MICHIGAN MEDICAID TOTAL	6,184	17,416	35.51	03/31/2024
FUA-30AD	NORTHERN MICHIGAN REGIONAL ENTITY -	301	750	40.13	03/31/2024

7. Performance Indicators

The NMRE monitored the performance indicators for the NMRE CMHSP network as well as individually. Performance data was reviewed and discussed by QOC on a quarterly basis. The Michigan Mission Based Performance Indicator System (MMBPIS) is utilized by the NMRE to address areas of access, efficiency, and outcomes, and to report to the State as established in the PIHP contract. The NMRE requires corrective action from CMHSPs and providers for each indicator not met twice in a row.

Indicators

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

The NMRE worked with the CMHSPs to improve indicators 2, 2e, and 3 and move them into at least 50th percentile, increasing them to 57%, 68.2%, and 72.9% respectively.

For Indicator 2 NMRE reached the 75th percentile (>62%) for each population and overall total.

For indicator 3 the NMRE reached 50th percentile (>72.9%) for overall total, however, MI population was under the 50th percentile needs improvement (already recorded by NMREs PIH #3)

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	178	124	**69.66%**
MIA	355	254	**71.55%**
DDC	79	67	**84.81%**
DDA	35	31	**88.57%**
Total	**647**	**476**	**73.57%**

8. Monitoring and Evaluation

The NMRE continued to provide updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities. QAPIP activities were reviewed and evaluated by QOC. The QAPIP is reviewed and updated at least annually with the input from CMHSPs, providers, stakeholders, and approved by the Governing Board. Update reports were shared with the Governing Board periodically, but at least annually. This workplan is a living document that may be updated throughout the year.

Additionally, QAPIP activities were shared with consumers through the regional Consumer Council (Regional Entity partners) and other stakeholders through committees and posting to the NMRE.org website.

9. Practice Guidelines

The NMRE and its network providers implemented a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and Michigan Department of Health and Human Services (MDHHS) and designated annual review cycle that occurs every March.

The NMRE, in collaboration with its QOC, NMRE Clinical Leadership, as well as network providers, reviewed and adopted practice guidelines established by APA and MDHHS. The NMRE disseminated adopted practice guidelines to all affected providers, members, stakeholders, and potential members as needed via the nmre.org website and annual mailer.

10. Contracting

The NMRE updated Sub-contractual Relationships and Delegation Agreements to include the language: “the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later”.

New Contracts

The NMRE ensured that agreements contain a specific language referencing Sub-contractual Relationships and Delegation Agreements.

11. Credentialing and Recredentialing

Updates and Monitoring

The NMRE updated its annual monitoring tools, as applicable, to ensure evidence is collected in policy, procedure, and practice regarding its delegation review of member concerns, grievances, appeal information, or quality issues during periods of individual practitioner recredentialing.

The NMRE will annually and periodically ensure that the CMHSPs’ processes for exclusions checks are maintained each month and verify their processes for validation of the reports.

During FY2024, the NMRE successfully implemented a new tool for monitoring credentialing and recredentialing practices the region's CMHSP's for organizational providers. The new tool was based upon the standards of Health Services Advisory Group's own auditing tool of the NMRE. The goal of using this new tool is to ensure compliance with credentialing and recredentialing standards and attachments of the MDHHS/PIHP contract, as well as federal and state regulations.

During FY2024's comprehensive CMHSP monitoring, the NMRE reviewed credentialing practices, policies, and procedures for both individual practitioners and provider organizations. All standards in the MDHHS Credentialing and Recredentialing Guidelines were reviewed, including application materials, primary source requirements, and timeframes.

During FY2024, the NMRE also reviewed the corrective actions of SUD Treatment providers credentialing of practitioners from the prior year's findings. Where necessary, new samples of providers for the review period were requested to ensure compliance. Annual review of monitoring tools and NMRE policy will continue to ensure compliance with the current MDHHS master contract and policies.

Prior to FY2024, the NMRE hosted "Credentialing Roundtables" with CMHSP contractors and provider network managers in the region; these educational sessions will continue into FY2025 in the form of onsite training days to share credentialing requirements and best practices with appropriate CMHSP staff.

Lastly, the MDHHS has notified the NMRE of completion of its "Universal Credentialing" module within the Salesforce Customer Relationship Management (CRM) system. The system is designed to house all credentialing data for practitioners and organizations within the PIHP/CMHSP system. The NMRE was directed to implement this system on November 21, 2024. The NMRE has been working with its member CMHSPs and SUD Treatment providers to implement the new CRM into practice.

The NMRE will continue to host Credentialing Roundtables for the region with the intention of educating staff that do the actual individual credentialing. This will allow the NMRE to drive a series of interactive meetings that allow the CMHSPs to discuss their processes as a group.

12. Exclusion Checks

In July 2024, the NMRE and its SUD providers completed the transition of SUD providers running their own staff exclusion verifications; at that time the NMRE discontinued running staff exclusions on their behalf. Annual monitoring of SUD provider verifications will continue and include assurance of checks for the OIG exclusion database, Michigan Medicaid Sanctioned Provider list, and System for Award Management (SAM). The region's CMHSP's will continue to run their own exclusion checks. During monitoring, the NMRE will review the exclusion

verification practices, policies, and written procedures for both individual practitioners and contracted organizational providers.

Policy

The NMRE updated its "Excluded Provider Screening" policy in January 2024 and accompanying procedure in April 2024. The policy and procedure are applicable to the PIHP, the NMRE provider network, applicable subcontractors, and reflect requirements of the MDHHS/PIHP contract and federal laws to include the Balanced Budget Act, Social Security Act, Code of Federal Regulation (including Federal Acquisition Regulation), Office of Inspector General, and US Code.

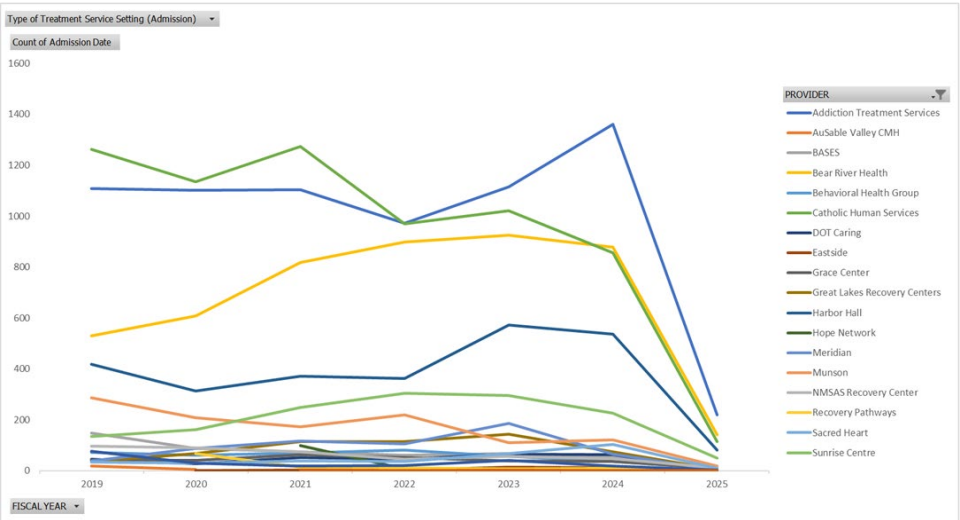
13. Utilization Management and Authorization of Services

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

Trending

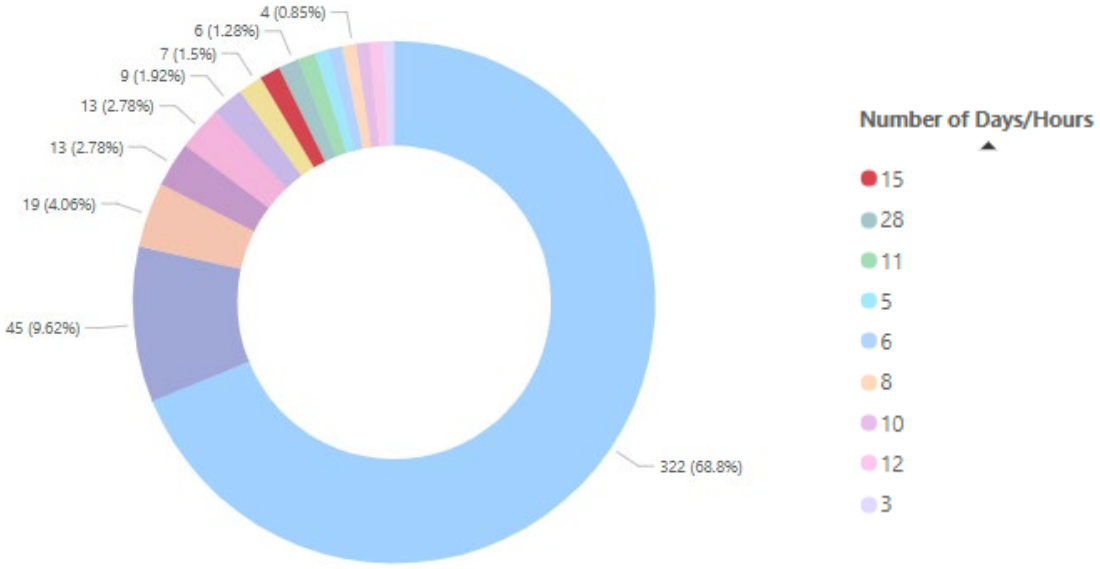
NMRE developed dashboards to monitor, trend, and review SUD admissions and level of care utilization in the NMRE region. These reports were provided to NMRE SUD Oversight Committee on a regular basis.

Additional analysis on areas with significant variation in utilization patterns was conducted to identify root causes and opportunities for improvement. Funding utilization was monitored on at least monthly basis.



NMRE hired a UM Care Manager in December of 2023, who also completed ASAM specific Utilization Training to ensure authorization requests were reviewed according to ASAM standards.

An internal process for timely review and approval of authorization was created, which included the development of a system flag showing a countdown of days left per request. Requests resulting in denials, exceptions, and/or extensions were processed in a timely fashion. In FY23 15.83% denials were completed outside of the required 14/28-day timeframe, however, in FY24 only 1.28% of these were processed outside of the required timeframe, which marks a significant improvement in timeliness.



Approvals:

Regional Quality and Compliance Oversight Committee	January 7, 2025
NMRE Internal Operations Committee	January 8, 2025
NMRE Board of Directors	

Northern Michigan Regional Entity
FY25 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

1. Performance Improvement Projects

The NMRE will engage in Performance Improvement Projects (PIPs), addressing clinical as well as non-clinical aspects of care. PIPs will involve measurable and objective quality indicators, interventions leading to improvement, as well as evaluation of effectiveness. The goal of PIPs is to improve health outcomes and member satisfaction.

PIP #1 (Opioid Health Home PIP)

The NMRE Quality and Compliance Oversight Committee (QOC) will continue to collect data, conduct ongoing analysis, and coordinate with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program. The NMRE will collect data and conduct analysis to show evidence of enrollment improvement from the baseline by September 30, 2025. Non-clinical / HSAG Validated

PIP #2 (Behavioral Health Home PIP)

The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 5% to 6% by September 30, 2025. Non-Clinical

PIP #3 (Clinical PIP Development)

Implementation and monitoring- Regional Clinical PIP December 31, 2025.

Performance Indicator 3 (PI 3) improvement goal:

> Increase percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.

1. Anticipated Barriers: Staffing and lack of appointment slots due to staffing issues.
2. Anticipated Strengths/Challenges: Staffing, trained staff, automated appointment reminders, consumers cancelling, rescheduling, or requesting outside of the 14-day window due to their own schedules, no-shows, requesting in-person (not telehealth) services, which significantly reduces the number of available therapists.

3. Interventions: Ongoing review of performance indicators to learn about trends and potential process changes that may be needed, additional staff training, availability of telehealth being offered; successful strategies to be reviewed and shared with QOC members.

2. Event Reporting and Notification

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

Training and information

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

Changes to Reporting Platforms

The NMRE will update the reporting system within PCE to better meet reporting needs and ensure timely and accurate reporting of these events to PIHP/MDHHS.

Data Collection and Review

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

3. Consumer Experience Assessments

The NMRE will conduct ongoing quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract with the State. Assessment results will be used to improve services, processes, and communication. Outcomes will be shared in the annual mailing. The NMRE will identify and provide possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

LTSS (Long Term Supports and Services)

The NMRE will incorporate consumers receiving long-term supports or services (LTSS) into the review and analysis of the information obtained from quantitative and qualitative methods. LTSS programs provide service needs from complex-care to assistance with everyday activities of daily living.

Outcomes

The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction. Processes found to be effective will be continued while those less effective or not satisfactory will be revised and followed up with.

Substance Use Disorder (SUD)

The NMRE will conduct separate SUD surveys, including Withdrawal Management/Detox and Methadone surveys, to identify specific member experiences.

Evaluation Efforts

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

The NMRE will share survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), network providers, Board of Directors, the Regional Consumer Council (Regional Entity Partners), and post a copy to the NMRE.org website. The NMRE's annual mailer will include instructions to direct consumers to locate the information on the NMRE.org website.

4. Provider Network Monitoring

To ensure compliance, the NMRE conducts annual (at minimum) monitoring for all directly contracted providers in the region, and out of region as needed and appropriate, utilizing reciprocity when necessary.

Monitoring

The NMRE will conduct site reviews annually for all contracted service providers by 9/30/2025. The NMRE will monitor and follow-up on corrective action plans to ensure Corrective Action Plans (CAPs) are being implemented as stated by network providers. The NMRE QOC will request, on a regular basis, updates from providers regarding the progress of their Quality Improvement Workplans and CAPs.

The NMRE will enhance its SUD monitoring tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Additionally, education will be provided to contracted SUD treatment providers informing them that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file.

The NMRE will ensure that its provider directory, and any delegated CMHSPs' provider directories, include all the required information from 42 CFR 438.10 as listed on the (HSAG) Provider Directory Checklist, and will make its provider directory available on the PIHP's website in a machine-readable file and format as specified by the Secretary.

Verification of Medicaid Services

The NMRE will perform quarterly audits to verify Medicaid claims/encounters to ensure Medicaid services were furnished to beneficiaries by CMHSPs, SUD providers, providers, and/or subcontractors. This will include verifying data elements from individual claims/encounters to ensure proper codes are used and proper documentation is in place. CAPs will be developed where appropriate per NMREs MEV policy.

5. Behavior Treatment Review

The Regional Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques were approved for use with members and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Trends and patterns will be reviewed to determine if systems and process improvement initiatives are necessary.

Data

Data will include the numbers of interventions and length of time the interventions were used with the individual(s). The NMRE regional BTRC will be tasked with reviewing data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that were approved by the members or their guardians during person-centered planning have been used.

6. Quality Measures (HEDIS measures)

The NMRE will review the following HEDIS measures to demonstrate and ensure quality care. The NMRE will provide HEDIS measure reports to the NMRE QOC on a quarterly basis. Upon review, QOC will identify interventions to improve outcomes where necessary.

Measures

The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool.

- Follow-up after hospitalization (FUH) for mental illness within 30 days.
- Follow-up after (FUA) emergency department visit for Alcohol and Other Drug Dependence.
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (new)
- Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) (new)

- Implement data driven outcomes measurement to address social determinants of health (new)
- Increased participation in patient-centered medical homes
- Implementation of Joint Care Management Processes

7. Performance Indicators

The NMRE will monitor the performance indicators for the NMRE CMHSP network as well as individually. Performance data will be reviewed and discussed by QOC on a quarterly basis. The Michigan Mission Based Performance Indicator System (MMBPIS) will be utilized by the NMRE to address areas of access, efficiency, and outcomes, and to report to the State as established in the PIHP contract. The NMRE will require corrective action from CMHSPs and providers for each indicator not met twice in a row.

Indicators

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

The NMRE will work with member CMHSPs to improve indicators 2, 2e, and 3 and move them into at least 50th percentile, increasing to 57%, 68.2%, and 72.9% respectively.

These measures will be sunsetting as new HEDIS measures are introduced by MDHHS. The PIHPs last report is 7/1-9/30/25 (Q4 FY25 MMBPIS).

The NMRE will educate providers during the transition process from MMBPIS to HEDIS measures.

8. Monitoring and Evaluation

The NMRE will continue to provide updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities. QAPIP activities will be reviewed and evaluated by QOC. The QAPIP is reviewed and updated at least annually with the input from CMHSPs, providers, stakeholders, and approved by the Governing Board. Update reports will be shared with the Governing Board periodically, but at least annually. This workplan is a living document that may be updated throughout the year.

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

The NMRE is to maintain QOC meetings.

9. Practice Guidelines

The NMRE and its network providers implemented a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and Michigan Department of Health and Human Services (MDHHS).

The NMRE, in collaboration with its QOC, Clinical Services Directors, as well as network providers, will review and adopt practice guidelines established by APA and MDHHS annually, every March. The NMRE will disseminate adopted practice guidelines to all affected providers, members, stakeholders, and potential members as needed via the nmre.org website, mailer, and/or annual newsletter.

10. Contracting

The NMRE updated Sub-contractual Relationships and Delegation Agreements to include the language: “the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later”.

New Contracts

The NMRE will ensure that in future agreements there is a specific language referencing Sub-contractual Relationships and Delegation Agreements.

11. Credentialing and Recredentialing

FY2025 will see the NMRE collaborating with the MDHHS to implement a new universal credentialing platform (as appropriate) and continue regional educational sessions.

Implementation of Credentialing CRM

Due to the completion of the “Universal Credentialing” module within the MDHHS’s Salesforce Customer Relationship Management (CRM) system, NMRE’s providers will begin using the system in FY2025. The NMRE will assist providers in adopting this new platform to the extent necessary.

As the purpose the Universal Credentialing system is to allow agencies and PIHPs to subscribe to each other’s credentialed providers, thereby eliminating additional administrative burden as some details of provider demographic information will be shared. The objectives of the NMRE for FY2025 will be to 1) ensure regional credentialing staff are educated on the use of the system, 2) ensure that regional providers understand the requirements and how to use the system, and 3) ensure that the system complies with state and federal requirements by safeguarding confidential information as appropriate.

Regional Education

The NMRE has hosted "Credentialing Roundtables" with CMHSP contractors and provider network managers in the past; these will persist in FY2025 as topics of interest in PIHP hosted regional trainings.

The goal of the PIHP will be to host three onsite training days for provider network management staff during FY2025, with the objectives of: 1) educating regional provider network and credentialing staff on the requirements of the MDHHS and PIHP, 2) ensure ongoing compliance in both practice and policy with MDHHS and PIHP standards, and 3) facilitate the adoption of best practices regionally.

12. Exclusion Checks

The NMRE will conduct its first annual review of SUD Treatment providers running their own staff's monthly exclusion checks during FY2025, having fully completed this transition in FY2024. This review will be part of a comprehensive monitoring which includes practices, policies, and procedures.

Pending the outcome of FY2025 monitoring, the NMRE will prepare comprehensive steps for corrective action, which will be mandatory and must comply with state and federal law. The NMRE is prepared to host training with individual staff or providers of the network as needed. As this is a federal requirement, the NMRE will collaborate with network providers immediately to come into compliance.

13. Utilization Management and Authorization of Services

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

An ongoing review of the MCG tool utilization will take place during QOC.

All NMRE staff completing SUD service authorizations will attend ASAM IV edition training for PIHPs in preparation for this new edition to take place.

Trending

NMRE developed reports to monitor, trend, and review SUD admissions and level of care utilization in the NMRE region. These reports are provided to NMRE SUD Oversight Committee on a regular basis and will be available on NMREs website at www.nmre.org .

Additional analysis will be conducted for areas with significant variation in utilization patterns to identify root causes and opportunities for improvement. The NMRE will develop an internal process for timely authorization denials, as well es exceptions and extensions.

14. Regional Trainings

The NMRE will collect feedback from its member CMHSPs and SUD Providers, as well as record areas of improvement during site visits, and will conduct a series of trainings to aid in process improvement as well as overall compliance.

IPOS training was completed on 10/10-10/11/2024 for all five CMHSPs.
Adverse Benefit Determination training is scheduled for 1/23-1/24-2025.

15. Maintaining the Handbook

The NMRE will obtain MDHHS approval, in writing, prior to publishing the original and revised editions of its member handbook. The NMRE will use MDHHS-developed model member handbooks and member notices and ensure that its member handbook and member notices include all MDHHS-developed template language. The NMRE, and any delegates performing activities on behalf of the NMRE, will ensure that all written materials for potential members and members use a font size no smaller than 12 point, and are written at or below the 6.9 grade reading level.

16. Adverse Benefit Determination

The NMRE will ensure that each ABD notice meets federal and state-specific requirements, as well as content requirement, and is written at or below the 6.9 reading grade level. The NMRE will conduct training and monitoring of its provider network to measure compliance.

Approvals:

Regional Quality and Compliance Oversight Committee	January 7, 2025
NMRE Internal Operations Committee	January 8, 2025
NMRE Board of Directors	