Northern Michigan Regional Entity

Board Meeting

April 27, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
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3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – March 23, 2021	Pages 2 – 6
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	e. NMRE SUD Oversight Board Report – The next meeting is scheduled for May 9, 2022	
11.	New Business	
	a. NMRE Nominating Committee Report and Election of Officers	
	b. Mid-Year COLA/Retention	
12.	Old Business	
	b. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest	
13.	Presentation/Discussion	
	Information Technology Security Assessment	Pages 102 - 116
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – May 25, 2022 at 10:00 am	
16.	Adjourn	

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

ATTENDEES:	**Roger Frye, Randy Kamps, Ed Ginop, Terry Larson, Christian Marcus, Mary Marois, Gary Nowak, Jay O'Farrell, Justin Reed, Richard Schmidt, Karla Sherman, Don Smeltzer, Don Tanner**
VIRTUAL ATTENDEES:	**Gary Klacking (West Branch), Gary Nowak (Rogers City), Jay O'Farrell (Whittemore), Joe Stone (Belleville, KS)**
NMRE/CMHSP STAFF:	**Jodie Balhorn, Joanie Blamer, Eugene Branigan, Christine Gebhard, Eric Kurtz, Brian Martinus, Diane Pelts, Denise Switzer, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Tom Bratton, Marie Fielder, Chris Frasz, Kassondra Glenister, Susan Pulaski, Kara Steinke**
GUESTS:	**Brandon, Hausbeck, Justin Severs**

CALL TO ORDER
Let the record show that Chairman Don Tanner called the meeting to order at 10:05AM.

ROLL CALL
Let the record show that all NMRE Board Members were in attendance for the meeting on this date, either in Gaylord or remotely.

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

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

APPROVAL OF AGENDA
Mr. Tanner stated that a Nominating Committee is needed for upcoming election of officers; this will be added under "New Business".

MOTION BY RANDY KAMPS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR MARCH 23, 2022 AS AMENDED; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

APPROVAL OF PAST MINUTES
Let the record show that the February minutes of the NMRE Governing Board were included in the materials for the meeting on this date. Mr. Kamps noted one error which will be corrected.

MOTION BY ROGER FRYE TO APPROVE THE MINUTES OF THE FEBRUARY 23, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS AS AMENDED; SUPPORT BY RANDY KAMPS. MOTION CARRIED.

CORRESPONDENCE

1) Center for Healthcare Integration & Innovation and Community Mental Health Association of Michigan (CMHAM) 2021/2022 Summary Report dated February 2022.
2) MDHHS FY23 Budget Executive Recommendation for the State Hospital Administration presentation dated March 9, 2022.
3) MDHHS FY23 Budget Executive Recommendation for Behavioral and Physical Health and Aging Services Administration presentation dated March 9, 2022.
4) Draft minutes of the March 9, 2022 NMRE Regional Finance Committee meeting.

ANNOUNCEMENTS

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

PUBLIC COMMENTS

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

REPORTS

Executive Committee Report

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

CEOs Report

The NMRE CEO Monthly Report for March 2022 was included in the materials for the meeting on this date. Mr. Kurtz thanked AuSable Valley for the invitation to present to its Board of Directors on February 28th.

Financial Report

January 2022

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

Ms. Yockey reported that additional columns were added to the “Schedule of PA2 by County” page per the Board’s request. Clarification was made that PA2 can be spent on prevention and treatment of substance use disorders. Mr. Kamps asked whether it makes sense to encourage counties with excess funds to reduce their balances by putting funds into services. Mr. Kurtz explained that part of the reason for the current high balances is the implementation of Healthy Michigan Plan; prior to HMP, liquor tax funds would have been used to pay for services to uninsured, indigent individuals. Mr. Kamps requested that Mr. Kurtz work with the Substance Use

Disorder Oversight Board to examine the issue. The annual anticipated revenue was reported as $1,487,584 which will come to the NMRE from the counties in three payments, the first of which is expected in April.

MOTION BY CHRISTIAN MARCUS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JANUARY 2022; SUPPORT BY MARY MAROIS.

Discussion: Mr. Kamps noted eligibility trends are up in all categories; however, revenue remains flat. Mr. Kamps also recognized that the region currently has 19 open HSW slots and a very large surplus (partly due to the pandemic and the halt in Medicaid redeterminations); he is fearful that the actuary will reduce rates based on unspent funds.

Voting took place on Mr. Marcus's motion. MOTION CARRIED.

Operations Committee Report
The draft minutes from March 15, 2022 were included in the materials for the meeting on this date. A discussion of the Department's salary and wage survey and Milliman's Standard Cost Allocation reporting occurred. Pursuant to MSA policy 21-39, CMHSPs are required to comply with the Standard Cost Allocation methodology, which "will fulfill the detailed reporting requirement for providers."

PRESENTATION
Carter Kits
During its March 15th meeting, the Operations Committee recommended using surplus funds to purchase Carter Kits Sensory Bags for communities in region. Brandon Hausbeck, Carter Kits President and CEO and Justin Severs, Vice President of Operations, joined the meeting virtually. Carter Kits were designed to help first responders when they arrive at a scene with a special needs individual, particularly someone with an autism spectrum disorder. Each Sensory Bag contains a weighted blanket, sunglasses, noise reducing earmuffs, sensory toys, and non-verbal cue cards at a cost of $80. More information can be found at Carter Kits - Home.

MOTION BY MARY MAROIS TO AUTHORIZE THE NORTHERN MICHIGAN REGIONAL ENTITY TO PURCHASE UP TO TWO THOUSAND (2000) CARTER KITS SENSORY BAGS AT A TOTAL COST NOT TO EXCEED ONE HUNDRED SIXTY THOUSAND DOLLARS ($160,000.00) INCLUDING TRAINING AND SUPPORT; SUPPORT BY ROGER FRYE. ROLL CALL VOTE.

"Yea" Votes:	**R. Frye, E. Ginop, R. Kamps, T. Larson, C. Marcus, M. Marois, J. Reed, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner**
"Nay" Votes:	**Nil**

Voting took place on Ms. Marois's motion. MOTION CARRIED.

The suggestion was made that the 500 kits currently in stock be distributed during the April 27th Board meeting to coincide with Autism Acceptance month; media coverage will be arranged.

NMRE SUD Oversight Board Report
The draft minutes from March 7, 2022 were included in the materials for the meeting on this date. Liquor tax requests will be presented for approval under "New Business."

NEW BUSINESS

Liquor Tax Requests

1) Drug Free Northern Michigan 21-County Alliance – Marijuana Media Campaign – All 21 Counites - $64,500.
2) Emmet County Sheriff's Office – Polycom System to Support SUD Services for Emmet County Inmates – Emmet County - $5,974.03
3) Bear River Health – Charlevoix Recovery House – Charlevoix County - $133,199.
4) Bear River Health – Peer Recovery Coach Services – Otsego County - $22,232.
5) Bear River Health – Jail Medication Assisted Treatment (MAT) Services – Otsego County - $20,156.
6) Community Recovery Alliance – Recovery Support Services – Otsego County - $16,642.

The total dollar amount requested was $262,703.03.

MOTION BY MARY MAROIS TO APPROVE THE REQUESTS FOR LIQUOR TAX FUNDS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD ON MARCH 7, 2022 IN THE TOTAL AMOUNT OF TWO HUNDRED SIXTY-TWO THOUSAND SEVEN HUNDRED THREE DOLLARS AND THREE CENTS ($262,703.03); SUPPORT BY KARLA SHERMAN. ROLL CALL VOTE.

"Yea" Votes: R. Frye, E. Ginop, R. Kamps, T. Larson, C. Marcus, M. Marois, J. Reed, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

Voting took place on Ms. Marois's motion. MOTION CARRIED.

MDHHS Behavioral Health Reorganization

The MDHH Behavioral Health Restructuring Presentation dated March 3, 2022 was included in the materials for the meeting on this date.

- The Division of Chronic Disease was created (Linda Scarpetta), which includes SUD Prevention; the Office of Recovery Oriented Systems of Care was dissolved.
- The Bureau of Children's Services was formed (Lindsay McLaughlin) partially in response to the KB lawsuit and to put more focus on children services.
- Farrah Hanley was named Chief Deputy of Health, overseeing Behavioral and Physical Health and Aging Services (Kate Massey) and the State Hospital Administration (Dr. George Mellos).
- The Bureau of Community-Based Services (Jeff Wieferich) is a parred down version of the former Behavioral Health and Developmental Disabilities Administration containing four divisions:
  1) Adult Home and Community Based Services (Belinda Hawks)
  2) Division of Contracts and Quality Management (Jackie Sproat)
  3) Behavioral Health Customer Services Section (Kendra Brinkley)
  4) Service Delivery Transformation Section (Vacant) will include Health Home and Certified Community Behavioral Health Clinics (CCBHC).

Mr. Kamps expressed great pride in the fact that PIHP Regions 1 and 2 (NorthCare Network and NMRE) are engaged in both the Behavioral and Opioid Health Homes; since FY21, enrollment has increased by 368%.

NMRE Nominating Committee
The Election of Board Officers will occur during the May 25th meeting. A nominating committee was formed to consist of: Roger Frye, Randy Kamps, Christian Marcus, Jay O'Farrell, and Don Smeltzer. A Nominating Committee meeting will occur via Teams prior to the May Board meeting.

OLD BUSINESS

Senate Bills 597 & 598/House Bills 4925 – 4929 – The Latest
Included in the materials for the meeting on this date were:

1) A Press Release from CMHAM titled "New Poll Finds Two out of Three Likely Michigan Voters and More Than 100 Michigan-Based Groups Prefer Public-led Mental Health System" dated February 21, 2022.
2) Document from CMHAM titled "A New Day for Behavioral Health in Michigan: Roles of the Key Partners"
3) Document from the Michigan Association of Health Plans titled "Locals are Fearful of Competition & Choice".

A discussion about a rural exception occurred. Mr. Kurtz clarified that the rural exemption is a law put in place to allow states to exempt rural areas from multiple Health Plans as competition for services is basically limited to current providers. Mr. Kurtz has learned that in the development of both the Senate and House bills consideration was given to allow for a rural exceptions but have not made it in either bills.

It was noted that Rep. Whiteford will be attending the Northern Counties Association meeting on April 18th.

COMMENTS

Board

- Mr. Tanner encouraged attendees to think about Ukrainians.
- Mr. Reed apologized for being late to the meeting. He reminded the Board that after two years of COVID isolation, re-engaging has been difficult for some individuals.

MEETING DATES

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on April 27, 2022.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:55AM.

PIHP CEO Meeting
April 7, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

Pre-paid Inpatient Health Plans (PIHP)

Dr. Timothy Kangas (Northcare Network)	Region 1
Eric Kurtz (Northern MI Regional Entity)	Region 2
Mary Marlatt-Dumas (Lakeshore Regional Entity)	Region 3
Brad Casemore (Southwest Michigan Behavioral Health)	Region 4
Joe Sedlock (Mid-State Health Network)	Region 5
James Colaianne (CMH Partnership of Southeast Michigan)	Region 6
Eric Doeh (Detroit Wayne Mental Health Authority)	Region 7
Dana Lasenby (Oakland Community Health Network)	Region 8
Dave Pankotai (Macomb County CMH Services)	Region 9
Jim Johnson	Region 10

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie
Kendra Binkley
Audrey Dick
Erin Emerson
Matthew Ellsworth
Darrell Harden
Krista Hausermann
Belinda Hawks
Kristen Jordan
Leah Julian
Brian Keisling
Phil Kurdunowicz
Kate Massey
Lindsay McLaughlin
Lindsey Naeyaert
Carrie Rheingans
Kelsey Schell
Jackie Sproat
Brenda Stoneburner
Scott Wamsley
Molly Welch-Marahar
Keith White
Jeff Wieferich
Amanda Zabor

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

Opioid Settlement Roles & Duties

1. The PIHPs asked what assets, resources, and duties the regional entities, CMHs, and PIHPs have in the opioid settlement process.
    a. Ideally, they would like resources and guidance for the proper and effective management of the opioid settlement.
    b. The PIHPs have raised the question with Farah Hanley and Kate Massey; they feel they are in the early phases of elevating the topic and issue. At least one region has already been contacted by individuals soliciting information, reports, and data.
2. MDHHS reported that they had done checking on their end, and that the PIHPs can expect MDHHS to reach out to have a meeting to discuss their concerns with the Attorney General so everyone is on the same page.
    a. The PIHPs thanked MDHHS for the rapid response and willingness to work this through.

Social Determinants of Health Presentation

1. Molly Welch-Marahar introduced herself and presented on Michigan's Roadmap to Healthy Communities.
    a. The PowerPoint slides have been distributed to the group.
    b. The next quarterly update will occur on April 13, and Molly Welch-Marahar would be happy to provide information on that to the PIHPs. She said she would encourage anyone who would like to attend the quarterly update to do so.
2. The PIHPs asked if MDHHS had any specific asks for the PIHPs at this time other than awareness of MDHHS initiatives and strategy.
    a. The PIHPs appreciate the upcoming engagement opportunities.
    b. Mid-State Health Network stated that they have heavily invested in recovery housing and would love to work with MDHHS. Mid-State offered for Molly Welch-Marahar to reach out any time Mid-State could be of help and stated that they would do the same.

MDHHS Reorganization

1. Jeff Wieferich noted that this was the first meeting since the reorganization to the Behavioral and Physical Health and Aging Services Administration (BPHASA).
    a. The plan is to continue to host this meeting monthly; the biggest change at this meeting should be additional people participating.

HCBS Update

1. Belinda Hawks reported that since the reorganization, her area is primarily focused on adult Home and Community Based Services.
    a. On the topic of Heightened Scrutiny, she reported that MDHHS planned to have the public comment link live for the Mid-State Health Network region on Friday April 8, 2022. This public comment period will be live for 30 days, after which MDHHS will move to release the public comment periods for the rest of the regions in the state.

2. Belinda Hawks reported on the Conflict-free Access and Planning workgroup.
    a. This workgroup was started in January to address the HCBS rule requirements to have conflict free case management.
    b. The next meeting will be held April 27, 2022.
    c. She anticipates the implementation phase for this work will begin in March 2023.
    d. She thanked the PIHPs for their great participation and their support staff's efforts on this topic.
    e. A PIHP noted that a staff member who attended the meeting had been left with the impression that MDHHS had already settled on what its strategy would be, rather than the discussion the PIHP thought it was meant to be.
        i. Belinda Hawks thanked the PIHP for checking in. MDHHS has not decided on a strategy yet. MDHHS has been sharing the models available on a federal level, as well as what other states have in their conflict-free process.
        ii. MDHHS is in the inform phase at this point, and has covered two of the three models MDHHS believes would move Michigan in the direction of compliance. The third model will be reviewed during the April meeting.
        iii. The PowerPoint from the Conflict-Free Access and Planning Workgroup meeting has been shared with the group via email.
3. Belinda Hawks shared that Michigan is moving to mandatory implementation on the Supports Intensity Scale (SIS) for those age 16 and over. In the state's 1915(i) application, MDHHS points to the SIS as the eligibility assessment tool it will use to make determinations for that benefit.
    a. MDHHS is asking for an extension of another year on the go-live, but the SIS is a requirement under that benefit.
    b. MDHHS also points to the SIS as the tool that will inform residential tiered rate work. MDHHS is working with stakeholders and Milliman in a workgroup to set the rates for group homes, and the group will be looking at the SIS as the assessment tool to inform that work.
        i. The SIS is already at a high level of compliance and completion for those living in group homes, but MDHHS wants to be sure the PIHPs are aware from a resource perspective and for communications related to the shift.
    c. The PIHPs asked if they should continue to expect ongoing discussion of SIS Child from another area of MDHHS, and, if so, which area of MDHHS should they expect that from?
        i. MDHHS will continue to talk through what makes the most sense with the Children's Bureau, but at this point use of the SIS Child has been paused.
        ii. MDHHS did not include SIS Child in its renewal for the IDD population.
        iii. Phil Kurdunowicz shared that he was not here to announce any changes in policy today, but the SIS Child is something that will continue to be discussed between the Children's Bureau and BPHASA.
            1. One issue has been identified is the assessment process; the Children's Bureau is working through enhancements for the assessment process, and it will be something they will provide announcements and updates to Belinda Hawks on.

Evaluation Guidance for ASD Referrals

1. Phil Kurdunowicz reported on a key change that happened in MDHHS as part of the reorganization. The management of the ABA Benefit for Children and Families and the coordination of Autism Council meetings have both transitioned to the new Bureau of Children's Coordinated Health Policy and Supports.
    a. One key question has been how to reconcile the evaluation guidance with Medicaid policy and contracts. The short answer is that it will be an extended process to work through the issue and reconcile the guidance against Medicaid policy.
    b. The Bureau doesn't have an immediate approach for the long-term solution. They intend to work on the short-term issue they are currently trying to resolve, and then build out a long-term solution for reconciling the two.
    c. One of the issues that arose in the evaluation guidance was how a child is potentially screened for autism in an early-on program, a primary care setting, or some other settings, including schools. If there is a positive screen, how is the child referred? Is a full medical evaluation required from the primary care provider prior to the child being referred?
        i. Right now, the Medicaid guidance and the process do not agree.
2. Phil Kurdunowicz shared two questions the Children's Bureau will have for the PIHPs as they work through this process. MDHHS wants to know the PIHPs' level of concern about:
    a. The current referral pathways. These pathways include primary care referral, self-referral, referral from early-on, and referral from a school-based provider.
    b. Having a full medical evaluation from a primary care provider prior to the child being referred to the PIHP for assessment.
3. Phil Kurdunowicz reported that the Children's Bureau is hoping to convene a time-limited team on this issue under the Autism Council to work through this issue as a joint effort between ABA diagnosticians, providers, CMHs, PIHPs, and potentially primary care providers.
    a. The PIHPs expressed their support.

New Children's Bureau

1. Jeff Wieferich mentioned the new Children's Bureau and shared that the Children's Bureau is committed to working with BPHASA in this meeting. He asked if there was anything specific the PIHPs wanted the Children's Bureau to address in this forum over time.
    a. A PIHP shared that their biggest concern is that the Children's Bureau stays aware of staff losses and turnover. Master of Social Work professionals are leaving the workforce in droves, and the PIHP knows it will be a big problem for the CMHs downstream.
        i. Phil Kurdunowicz responded that he understood and hoped to address that as part of the MI Kids Now initiative and within the larger Bureau. One of the Bureau's priorities is shoring up and providing direct work support for the clinician population.
        ii. The PIHP shared that in their region, some of the schools have reached out to contract with the CMHs rather than hiring staff, though that has not been a

universal approach. It is a model they said their region would like for MDHHS to be able to encourage, though, before they have no children's staff left.

iii. Another PIHP shared that they have a good partnership with an intermediate school district in their region and are working on a contractual relationship. The PIHP wants to focus on coordination of benefits between what is provided school-side and what the CMHs can provide, as that is becoming less clear and could benefit from clarification. The PIHP wants to ensure these services are best coordinated to support children.

1513 Inpatient Rate Workgroup

1. Jackie Sproat presented on the 1513 Inpatient Rate Workgroup.
    a. These slides have been distributed to the group.
2. A PIHP asked if there would be utilization management guidelines established that correspond with the hospital tiers.
    a. Jackie Sproat said she would have to get back to them about that.
    b. A PIHP noted that it was important to highlight the topics of physician orders and of no intention to interfere with utilization management review.
        i. Jackie Sproat stated that the existence a physician order existed was not intended to supersede the existing continued stay review process.
        ii. Joe Sedlock is a member of the workgroup and clarified that to his understanding, inpatient hospitals and units will document the need for an enhanced staffing arrangement and thus trigger a tiered rate via a physician's order. He added that Jackie has been very clear with the workgroup that the existence of a physician order does not necessarily trigger an authorization for any tier other than the one the patient happens to be presently in. The existing utilization review or state review process would make the determination to authorize the additional tier or not based on clinical information that is presented at that time.
        iii. Jackie Sproat thanked him and added that the expectation is that when a patient has additional staffing needs, the hospital does not need to wait to implement that necessary staffing. MDHHS does understand that crisis situations happen.
3. Jackie Sproat reported that the intention is finalize the tier groups in the next couple of months.
    a. Joe Sedlock added that the workgroup has considered and believes they have resolved the issue about the date at which the tiered rate will be effective and over what period.
    b. Jackie Sproat concurred that this was on the agenda for the workgroup meeting on April 7, 2022. The intent is to use a process similar to how billing and payment occurs for inpatient days, where if a person is admitted, regardless of time, the hospital is paid for that day, and there is no payment on the day of discharge.
4. A PIHP asked if they would need to renegotiate contracts with CMHs that extend past the end of the 2022 fiscal year.
    a. Jackie Sproat responded that they might. She suggested informing the CMHs in the region if they have contracts extending beyond the fiscal year.

5. A PIHP requested for the future of this topic to also address any thoughts to align the national coverage determination criteria by PIHP with level of care rate tiers. This is part of the utilization management process and accreditation standards and requirements.
    a. Jackie Sproat promised to make a note of it.

MPCIP & MI CAL Update

1. Krista Hausermann provided the MPCIP and MI CAL Update.
    a. A written version of the update has been distributed to the group via email.
2. She highlighted that MDHHS needed feedback on the Psychiatric Bed Registry.
    a. The bed registry is part of the MI CARE platform that LARA is rolling out, and will incorporate SUD treatment options, mental health outpatient treatment, and eventually all behavioral health resources in the state of Michigan. The bed registry will be integrated with MI CAL so that MI CAL staff can use it for referrals, though staff would still send people to the CMHs to get more intense support.
    b. MDHHS is looking for a reaction from the PIHPs about the possibility of including a requirement of some kind in the contracts for the psych hospitals to enter bed availability into the registry to encourage the hospitals to enter the data.
    c. The advisory workgroup is working hard to identify barriers, make the process smooth as possible, and to identify benefits the hospitals can get from this process.
    d. A PIHP stated that their initial reaction was to say that they did not think the representatives from the 1513 group had fully digested the tiered rates that are going into place, so their anticipation is that this whole process will essentially be budget neutral. The psych hospitals may view putting utilizing the bed registry within the contract as an additional administrative burden that may not be offset by the base rate.
        i. A second PIHP said that they felt updating the registry would be a lower administrative burden than answering phones and chasing paperwork for prescreening. It could be a significant personnel cost-saving benefit.
    e. Another PIHP stated that they have supported the bed registry for a long time. They feel it is important to find policy or contractual levers that can be used to ensure the systems are used effectively. This region will need time to discuss it, but their intention would be to prepare a regional contract template that would include the requirement/statement that their CMHs intend to only use the MI CARES platform to facilitate referrals and thus the hospital is expected or required to use it as exclusive way of dealing with referrals.
        i. However, the PIHP noted that it may be hard to contractually require its use when there are situations that may require working with the vendor to get help for a suffering individual.
    f. A third PIHP suggested that it might be better to require the use of the bed registry in licensing, as the PIHPs will need to find beds for clients by any means they can; having the registry be part of licensing or Medicaid policy would have more weight.

3. Krista Hausermann added that there would be the opportunity to track denial data within the platform, as she knew getting denial data in a separate platform was time-intensive for the CMHs. MDHHS does not want to go back to that if they can use MI CARE platform.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Erin Emerson introduced herself as the Director of the Office of Strategic Partnerships and Administration Services.
    a. As part of the reorganization, all items in this portion of the agenda belong to a section established in her area.
    b. Now that the reorganization is in effect, her area is working to establish a section management position. She will share the posting when it goes up. Once that position is posted and filled, MDHHS will also hire two analysts to support the work in that section, in addition to the ones the PIHPs have already been working with.
2. Erin Emerson shared that MDHHS is applying to expand Opioid Health Homes statewide in FY 2023. MDHHS is continuing to work with regions that are not currently participating to prepare them.
3. Lindsey Naeyaert shared that the Behavioral Health Homes currently have 1,117 people enrolled and will be expanding into regions 6 and 7 on May 1, 2022. MDHHS hosted a kickoff to orient these regions to the model on March 1 and 2, 2022.
4. Lindsey Naeyaert also shared on the topic of the PIPBIC Grant.
    a. The Azara technology implementation continues; currently MDHHS is working to share patient data between the CMHS and Federally Qualified Health Centers (FQHCs) through this platform. Two of the three counties involved are currently seeing shared patient data between the two CMHs and the FQHC they are both working with.
    b. MDHHS is also working through measure validation in this area.
5. Erin Emerson reported on the CCBHC topic.
    a. At the end of March 2022 there were approximately 26,000 Medicaid individuals and 4,500 individuals without Medicaid assigned to the 13 demonstration sites.
    b. MDHHS is working through final CCBHC certification on those applications; they have been reviewed, and the CCBHCs are responding to feedback and policies and resubmitting any documentation as necessary to validate they meet the certification requirements.
    c. If the CCBHC has outstanding unmet requirements, a time-limited certification action plan will be developed to address those issues.
    d. She also shared that SAMHSA has offered a new CCBHC funding opportunity with two grant funding types.
        i. The first is for new sites, and the second is for existing sites, or sites currently certified as part of the state demonstration.
        ii. This round also requires applicants to submit letters from the state mental health authority indicating approval of their proposal and noting whether the state will be responsible for the CCBHC certification.

1. MDHHS will not be assuming responsibility for the certification of the grantees. Rather, the applicants can attest to meeting the SAMHSA criteria.
2. MDHHS does stand ready to issue the letters of support to potential applicants to facilitate their applications. MDHHS will ask that applicants submit a copy of their narrative or public health impact statement to the CCBHC mailbox, which is MDHHS-CCBC@Michigan.gov. MDHHS is prepared to turn these around quickly to support submission by the May 17, 2022, deadline.

Self-Determination Contract Language

1. The PIHPs stated that in December 2021 there was a joint CMHSP/PIHP contractual workgroup working on the self-determination policy and implementation guide.
    a. There were quite a few concerns that the policy was approved but the implementation guide still needed work and was largely considered a best practice rather than a guide. The PIHPs and CMHs were primarily using the previous implementation guide.
    b. The new version has been presented to behavioral health clients and advocates and is causing quite a bit of turmoil.
2. The PIHPs requested that MDHHS be extremely clear in the naming of the documents. Their understanding is that the second document, titled Self-Directed Services Technical Documentation Guide, is best practices, and that there is not currently strict enforcement of anything within it.
3. The PIHPs would like to make sure also that communication between MDHHS and the PIHPs on this is clear.
    a. MDHHS responded that once the membership for the workgroup is established, they will send out a poll survey to learn what is desired in the way of objectives and discussion points.
4. A PIHP raised the point that in previous iterations of the implementation guide, there were policy directives that were not embedded in the technical requirement. The PIHPs seek to ensure that the technical requirements and the guidance do not conflict.

PIHP Compliance Officers & HSAG

1. Eric Kurtz let MDHHS know that the PIHP Compliance Officers Group, of which he is the lead representative, is putting together a document regarding things they would like to see discussion on.
    a. This document should be provided to Belinda Hawks and Jeff Wieferich before the May 5, 2022, meeting in hopes of a facilitated discussion about some of the topics in the document and working together.
    b. The group wants to have dialogue with MDHHS as issues come up.
2. Belinda Hawks thanked Eric for the notice and added she would like to coordinate with Kathy Haines and her team on the HSAG component.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

March 29, 2022

Mr. Eric Kurtz, Chief Executive Officer
Northern Michigan Regional Entity
1999 Walden Drive
Gaylord, MI 49735

Dear Mr. Kurtz:

We have completed a review of Northern Michigan Regional Entity's (NMRE) FY 2022 Risk Management Strategy. The components of NMRE's Risk Management Strategy are in compliance with PIHP contract sections 4.I Internal Service Fund, 7.I Risk Corridor and the Policy and Practice guideline *Internal Service Fund Technical Requirement* at: www.michigan.gov/documents/mdhhs/Internal-Service-Fund-Technical-Requirement_704454_7.pdf and the MDHHS policy regarding risk management strategies as established in the Technical Advisory issued October 10, 2008.

If there are any anticipated changes to NMRE's FY 2022 Risk Management Strategy during the fiscal year, please submit a revised plan to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

Sincerely,

Jackie Sproat, Director
Division of Contracts and Quality Management
Bureau of Community Based Services

cc: Darrell Harden, MDHHS
David Waldo-Levesque, MDHHS
Amanda Zabor, MDHHS
Deanna Yockey, NMRE

Michigan Psychiatric Care Improvement Project (MPCIP)

April 2022 Update

Overview

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

Two Part Crisis System

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

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

Opportunities for improvement

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

988 IMPLEMENTATION

Overview

- 988 is the new three digit dialing code for the National Suicide Prevention Lifeline.
- 988 will go live July 16, 2022.
- Michigan completed an extensive 988 Implementation planning process with stakeholder involvement which was funded by Vibrant. Michigan's Official 988 Plan was submitted to Vibrant and SAMHSA on January 21, 2022.
- The plan focuses on topics such as vision, follow up care, resources, marketing, metrics, communications, and funding.
- Marketing will start at the federal level early 2023. We have been asked to wait to market until we receive notice from Vibrant. They will send us marketing materials.
- Over the next several months to a year, Michigan will transition from a regional call coverage system to statewide call coverage through MiCAL except for Network 180 covering Kent County and Macomb CMH covering Macomb County.
- MiCAL will provide statewide text and chat coverage.

Current Activities

- NSPL/MMDHHS applied for a 988 Implementation Grant which was submitted January 31st. SAMHSA 988 Implementation grants should be awarded by the end of April. Key focus areas are: stable diversified funding, adequate statewide coverage, common practices for centers, stakeholder engagement/marketing, and 911/ 988 collaboration.
- Statewide Coverage: MiCAL is rolling out statewide. See the MiCAL section for more information.
- Stakeholder engagement: Written updates are provided every 1 to 2 months. MDHHS is developing a stakeholder engagement plan with an emphasis on marketing.
- NSPL Center Practices: Operations workgroup meetings with current NSPL centers are focused on developing common practices around Imminent Risk.
- 911/988 Collaboration: State level 911/988 workgroup is meeting to develop collaborative practices.
- Stable diversified funding: MDHHS is assessing FY 23 funding needs and exploring diverse funding sources to meet those needs.

MICHIGAN CRISIS AND ACCESS LINE (MICAL)

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

Overview

- Overall Model: One statewide line which links to local services tailored to meet regional and cultural needs.
- It will provide a clear access point to the varied and sometimes confusing array of behavioral health services in Michigan.
- Crisis triage, support, and information and referral services 24/7 via phone, text, and chat
- Predicated on Recovery & Resiliency Principles; caller-defined crisis, holistic, crisis support and triage, trauma informed, collaborative support, least restrictive, and non-judgmental.
- Supports all Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. Warm hand-offs and follow-ups, crisis resolution and/or referral, safety assessments,24/7 warm line, and information and referral offered.
- MiCAL will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, and Crisis Stabilization Units.
- Individual level performance measures.
- Opportunity for systems level change: data source for systems level needs i.e. to be addressed in collaboration with other systems including other crisis lines.
- Common Ground is the MiCAL staffing vendor.
- Target Dates: Pilot start date: Upper Peninsula and Oakland April 2021; Operational Statewide October 2022.
- Integrated with BPHASA Peer/ Recovery Coach Warm line
- Michigan Warmline is active statewide.
- MiCAL Rollout: MiCAL will rollout statewide in two phases.
    - Phase 1 FY 22: Starting in January 2022, MiCAL will rollout statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time.
    - Phase 2 FY 23: CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout will occur one PIHP at a time.
- Planned Design Activities:
    - Targeted Engagement Discussions to ensure MiCAL meets all Michiganders' needs. This process will pull together providers and people with lived experience for specific population groups to ensure that MiCAL is effectively outreaching and serving them. This will occur through 988 Implementation process.
    - Resources: Developing partnerships and technological integration with 211 and OpenBeds to ensure MiCAL has up to date resource information.
    - Ongoing small improvements to the CRM system.

Current Activities

- Frontline Strong First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development. Crisis line is estimated to go live in Summer 2022. Staff recruitment is underway.
- MiCAL and the Michigan Warmline staff have had over 55,000 encounters since April 19th (MiCAL go live); mostly calls. Over half the encounters have been on the Warmline.
- Pilot is focused on streamlining and routinizing care coordination process with CMHSPs and ensuring that CRM technology supports these processes.
- Warmline is refining data gathered during the call, i.e. reason for the call and services provided.

- Stakeholder dashboards are being developed.
- Common Ground is hiring staff in preparation for the rollout.
- MiCAL integration with OpenBeds/MiCARE is in progress.
- MiCAL/NSPL is rolling out statewide a region at a time. It is developing coordination protocols with CMHSPs and state demonstration CCBHCs as the rollout progress.
- MiCAL/NSPL is live in Prepaid Inpatient Health Plan geographic regions 1, 2, 3, 8, and 10. It will be live in Region 5 by the end of May. Map of the Prepaid Inpatient Health Plans (michigan.gov)

CRISIS STABILIZATION UNITS

Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
    - MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders. Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.
- Timing: Michigan Model developed by 12/1. Draft Certification rules will be developed by summer 2022, draft administrative rules and draft Medicaid policy will be completed by September 30, 2022.

Current Activities

- Draft Certification Standards deadline is being extended to summer 2022. A small subset of the stakeholder group is developing draft certification criteria for adults. There is special attention being paid to congruency with funding requirements, licensing requirements of related services, and accreditation. PSC extensive research on best practices in other states is being incorporated in the model.
- MDHHS is exploring internal staffing necessary to certify CSUs.
- PSC is looking at available statewide data to help determine capacity needs. They are also using the new Crisis Talk Crisis Services Calculator.
- PSC is also researching funding models for this service.
- The Michigan Model is being tailored to the needs of Children and Families. Stakeholder meetings will be held in in late spring/ early summer.

MOBILE CRISIS INTERVENTION SERVICES

Overview

- Mobile crisis services are one of the three major components that SAMHSA recommends as part of a public crisis services system.
- MDHHS goal is to eventually expand mobile crisis across the state for all populations, taking advantage of the enhanced Medicaid match.

- MDHHS has contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan, with special attention on strategies for rural areas.
- There is coordination with the MDHHS staff leading the KB lawsuit around services for children.

Target Date: September 2022

Current Activities –

- Multiple parts of MDHHS are working on expanding mobile crisis services: Diversion Council, Mi Kids Now, and Bureau of Community Based Services. Internal meetings are occurring to ensure that models for children/families and adults stay aligned whenever possible.
- PA 162 and 163 of 2021 set up a Diversion Fund and pilot program for mobile crisis. MDHHS is coordinating internally around implementation plans, prior to stakeholder involvement.
- MDHHS will pursue the advanced Medicaid match and ensure that the model meets requirements.
- Public Sector Consultants is pulling together legislative and funding requirements and best practices to develop a draft model for adults.
- PSC is coordinating work with the Diversion Council and Wayne State Center for Behavioral Health Justice (CBHJ) who are also focused on looking at adult mobile crisis models.

MI-SMART (MEDICAL CLEARANCE PROTOCOL)

Overview

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

Current Activities:

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- As of 4/1/22 Adopted/Accepted by 45 Emergency Departments, 19 Psychiatric Hospitals, 13 CMHSPs.
- 26 more facilities are pursing the implementing at their facility, including McLaren Bay Region, Beaumont Health, and UPHS Marquette.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption
- Partnering with MHA to distribute a survey targeted to provider groups with the goal of outreach and recruitment.
- Developing a commitment letter for Psych hospitals, CMHSPs, and EDs to sign.
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MiSMART can help meet.
- Record high COVID numbers in Emergency Departments are impeding progress.

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.

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

Current Activities

- LARA is in the process of rolling out MiCARE statewide a PIHP region at a time. The focus is on substance use disorders treatment services.
- Targeted rollout to psychiatric hospitals was paused due to this last wave of COVID.
- The Onboarding date was pushed back from February 2022 to June 30,2022.
- Psychiatric hospitals are being encouraged to onboard as they are able. There are 58 facilities. 70% attended the initial orientation.
- MDHHS PBR Implementation Team is developing a survey of psychiatric facilities for a status on MiCARE implementation.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e. bed categorization, acuity, the rollout, and referral process.

Behavioral Health Customer Relationship Management (CRM) – Internal Business Processes

Overview

- BPHASA will transition its internal business processes to a customer relationship management (CRM) system. The Behavioral Health CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between BPHASA and its customers: PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.
- The development process includes written documentation of the business process, describing the process and highlighting requirements, and the translation of the business process into technology. All this information is included in the user training.
- Stakeholders for each process are actively engaged throughout the design process and user testing.
- Training materials on the CRM and each of the business processes are housed within the CRM. Training materials include videos and written job aids.
- Virtual, synchronous training and "Learning Lab hours" are held when a business process goes live.
- Completed Processes: Customer Service Inquiry, CCBHC Certification

Current Activities

- Contract Management: Review of training materials and development of retraining plans will occur over the next few months

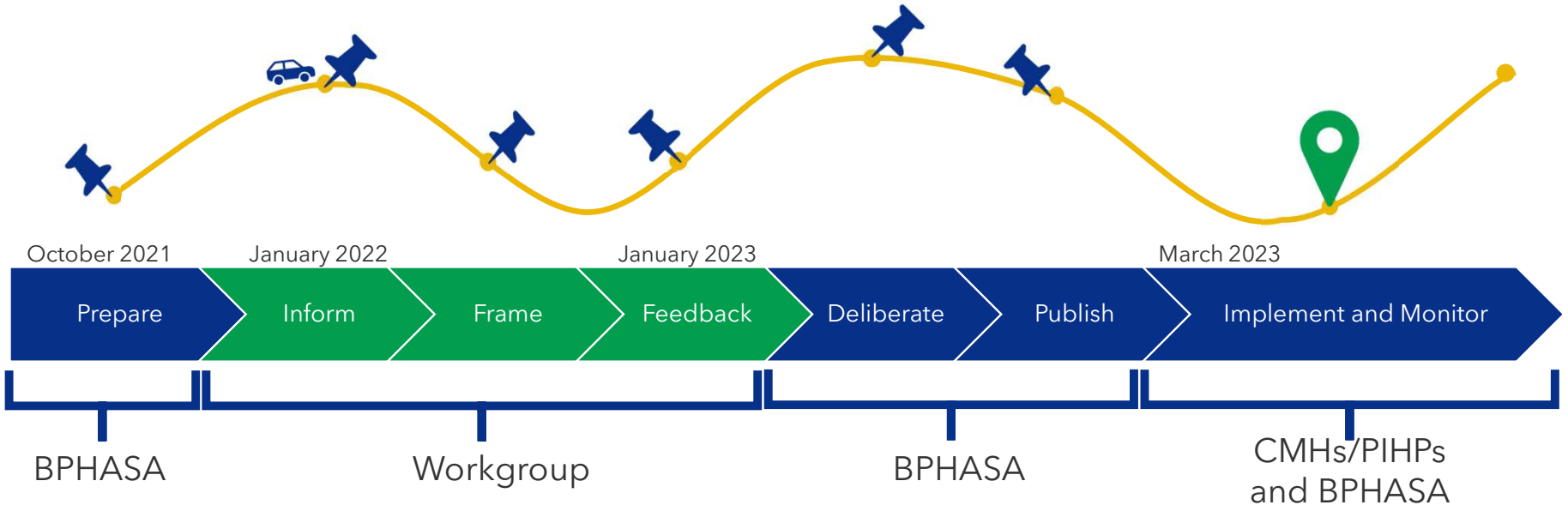
- Universal Credentialing (PA 282 of 2020): Stakeholder workgroup composed of representatives from CMHSPs, PIHPs, and BPHASA is meeting regularly to develop the business process for Universal Credentialing. After this step is complete then the Stakeholder group will participate in automating the business process in the CRM.
- Specialty Program Certifications: Business Process development has been completed. Requirements for CRM development is in progress. Programs included are: is starting on certification for specialty programs: homebased, ACT, intensive crisis stabilization, clubhouse, therapeutic foster care, crisis residentials, and wraparound.
- The Critical Incident Database project is in the CRM development phase. It has a go live date of October 1, 2022.
- CMHSP Certification: The CRM work is complete. Rollout plans and training are being developed.
- ASAM Level of Care Certification Development Process is live in Detroit Wayne and the Upper Peninsula.

QUESTIONS OR COMMENTS?

- Krista Hausermann (hausermannk@michigan.gov)

Update on State Reorganization

Journey


October 2021
January 2022
January 2023
March 2023
Prepare
Inform
Frame
Feedback
Deliberate
Publish
Implement and Monitor
BPHASA
Workgroup
BPHASA
CMHs/PIHPs
and BPHASA

Decision-Support Journey

Inform

What are the CMS requirements?

What does a strict interpretation of the requirements entail?

Frame

What will be impacted by requirements?

What change is reasonable?

Where does my organization's practices stand with regard to these requirements? (Conduct readiness assessment)

Feedback

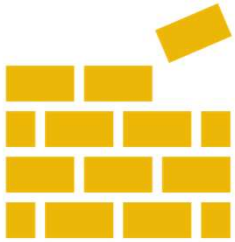
How will requirements impact people served and service provision?

What are the strengths and weaknesses of each option across categories?

What is most important?

BPHASA Decision

What is a Firewall?



"Entities that evaluate eligibility or provide case management services cannot…have a financial interest in any entity paid to provide care to the individual."*

Provider Organization A

Eligibility and Needs Assessment

Planning Activities
(Plan Development and Monitoring)

Provider Organization B

Direct Service Delivery

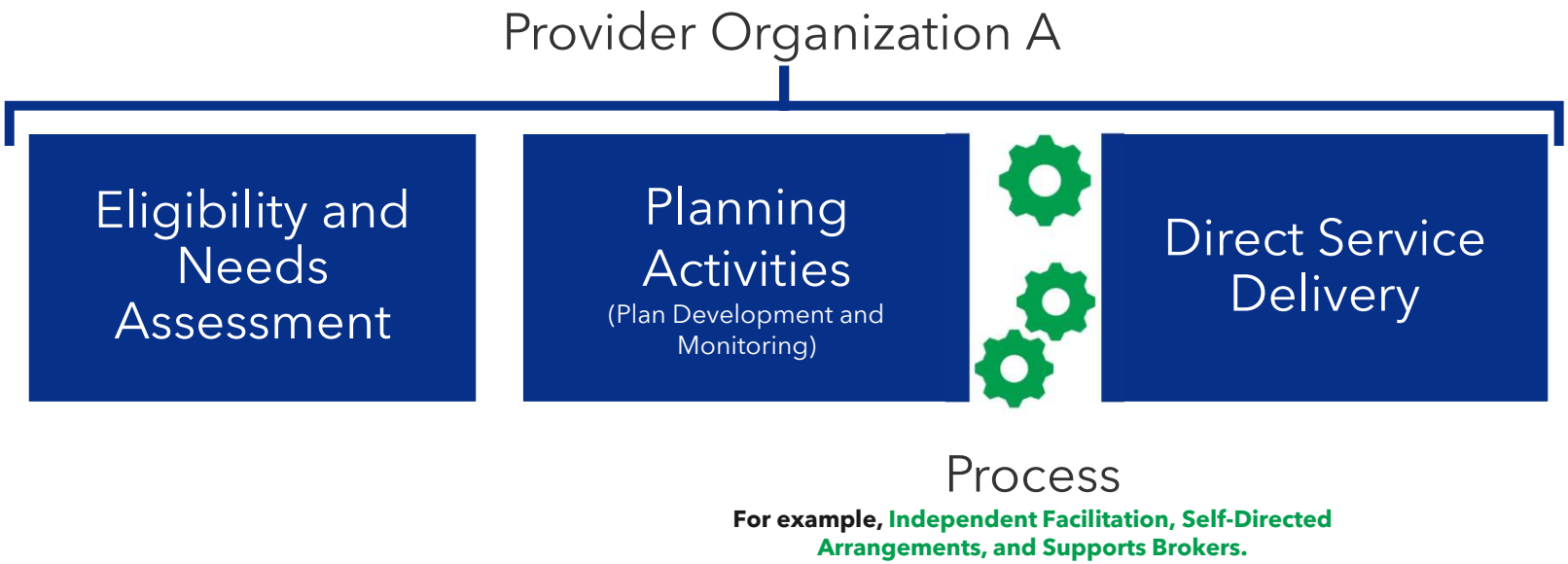
Firewall

**CMS COI in Medicaid Authorities Training (reference to 1915(i) State Plan Requirements), 2016*

What is a Safeguard?

A Safeguard is a process which attempts to mitigate against conflict. Many best practices put the person at the center of decision making and because of this they guard against conflict of interest.

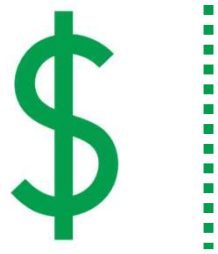
However, **by themselves, they do not strictly meet CMS requirements to mitigate against conflict.**



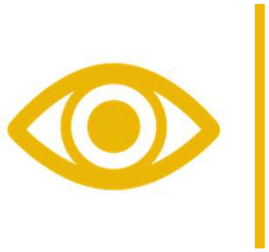
Use of Safeguards

Per the strictest interpretation of CMS requirements, Safeguards alone are not a compliant state-wide approach.

- Safeguards are only allowed, as an exception, if a region has only one willing and qualified provider.
- The State will decide whether to allow regional exceptions to the rule.
- Best practices which put the person at the center of decision making should be continued and improved upon, but they cannot make the State compliant with CFA&P.



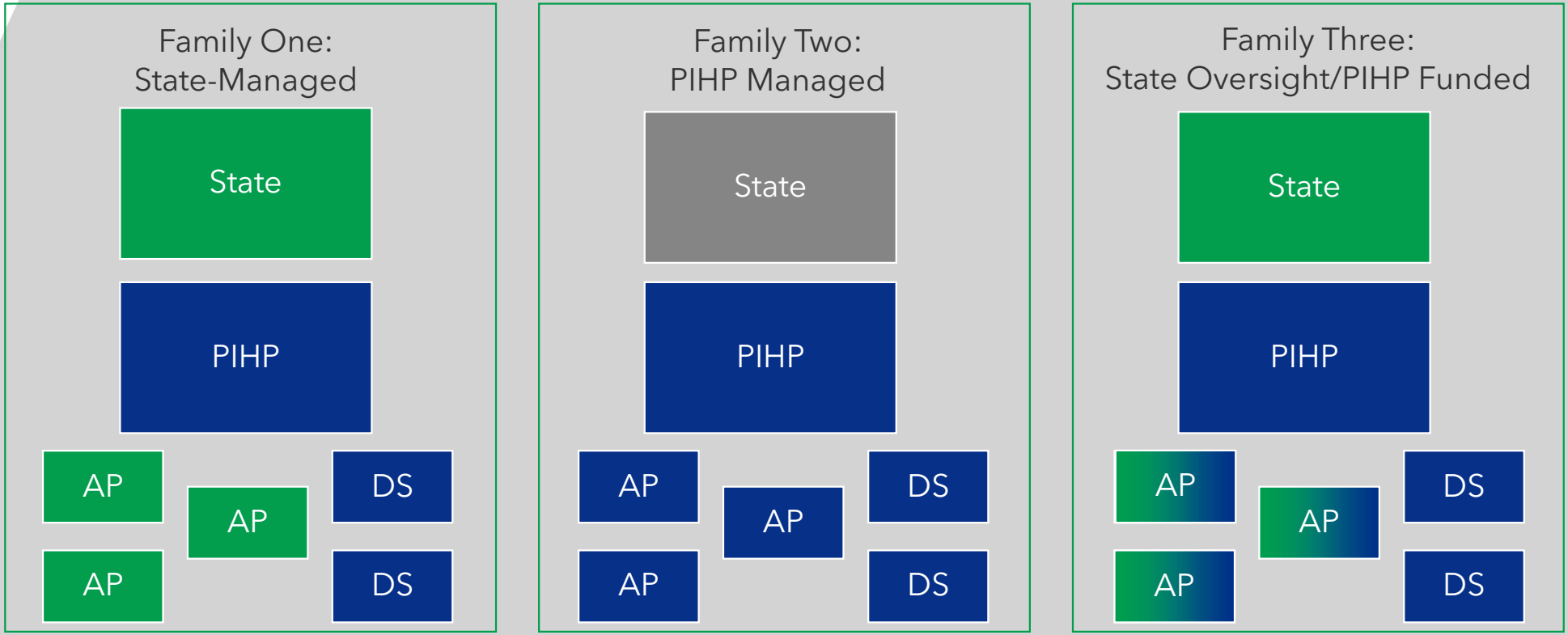
Funding Stream



Oversight System

Sample Options

Firewall Option "Families"

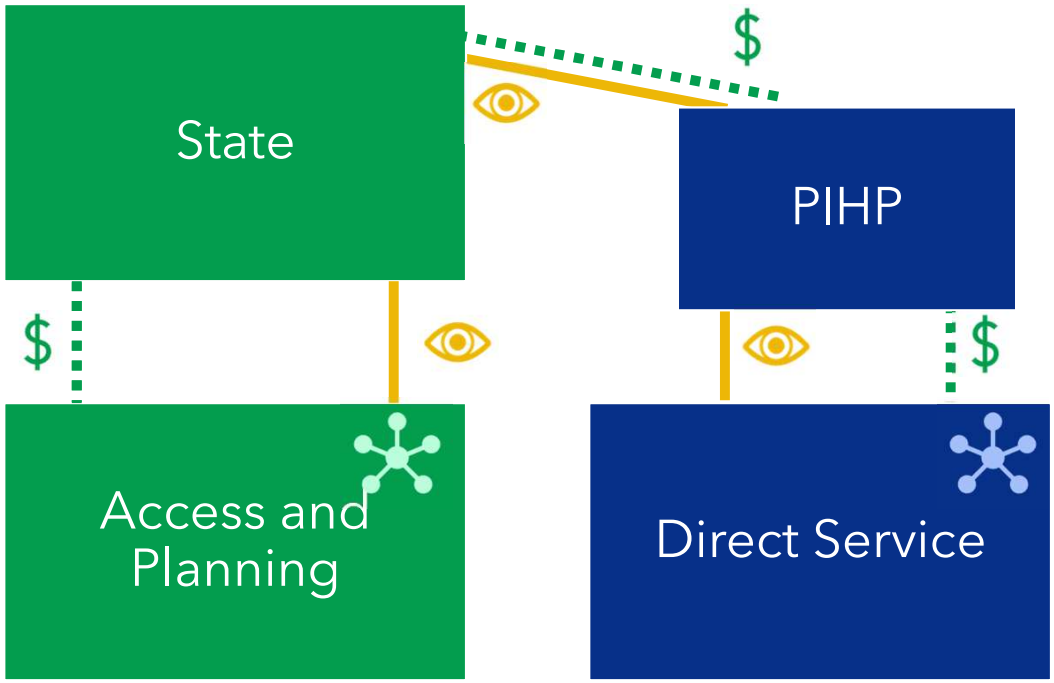


Family One: State-Managed

Family One: State-Managed

Change From Current System

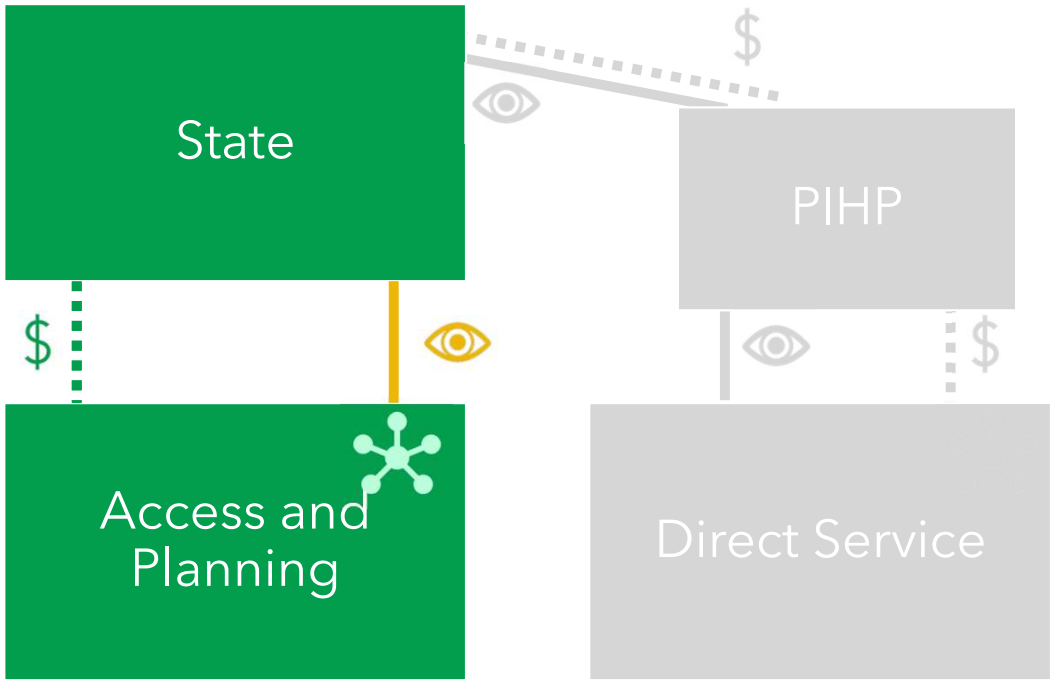
- System manages DS providers as it currently does.
- State manages a separate group of AP providers.
- AP providers are not overseen or funded by PIHPs.
- AP provider organizations cannot also provide direct services.



Family One: Example

Example* of State-Managed Access and Planning

- South Dakota's I/DD System has four case management regions.
- Each region has 2 or more Case Management providers.
- Case Managers manage assessment, conduct planning, and facilitate monitoring.
- Community Support Providers (direct service providers) conduct assessments as required by Case Managers, deliver direct services, and communicate life changes to the Case Manager.



*Each example includes details beyond what the provided visual can display. This is an example of a component of this family.

Family One: Example

Example* of State-Managed Access and Planning

- South Dakota's I/DD System has four case management regions.
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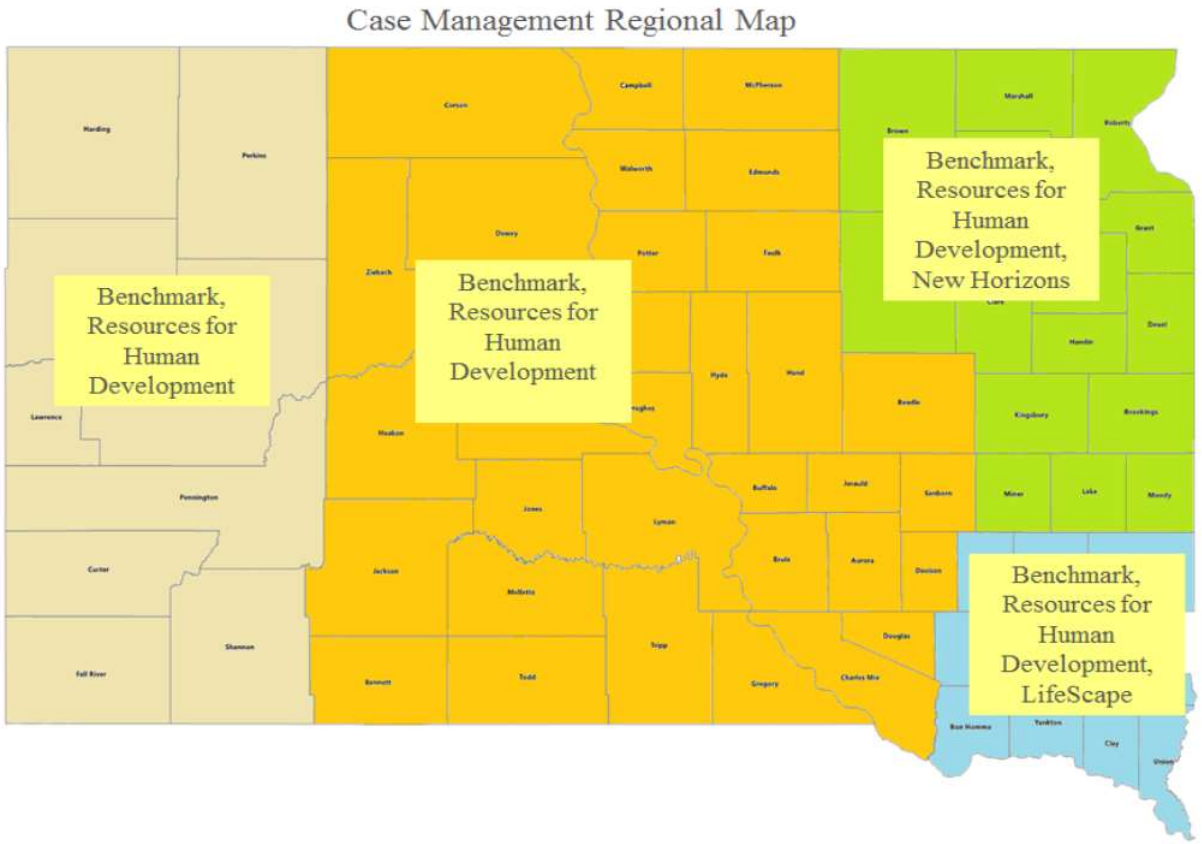


Family One: Example

Example* of State-Managed Access and Planning

- To support its transition, SD mapped out the roles and responsibilities of each service provider organization.
- The image to the left displays a portion of their responsibility definitions.

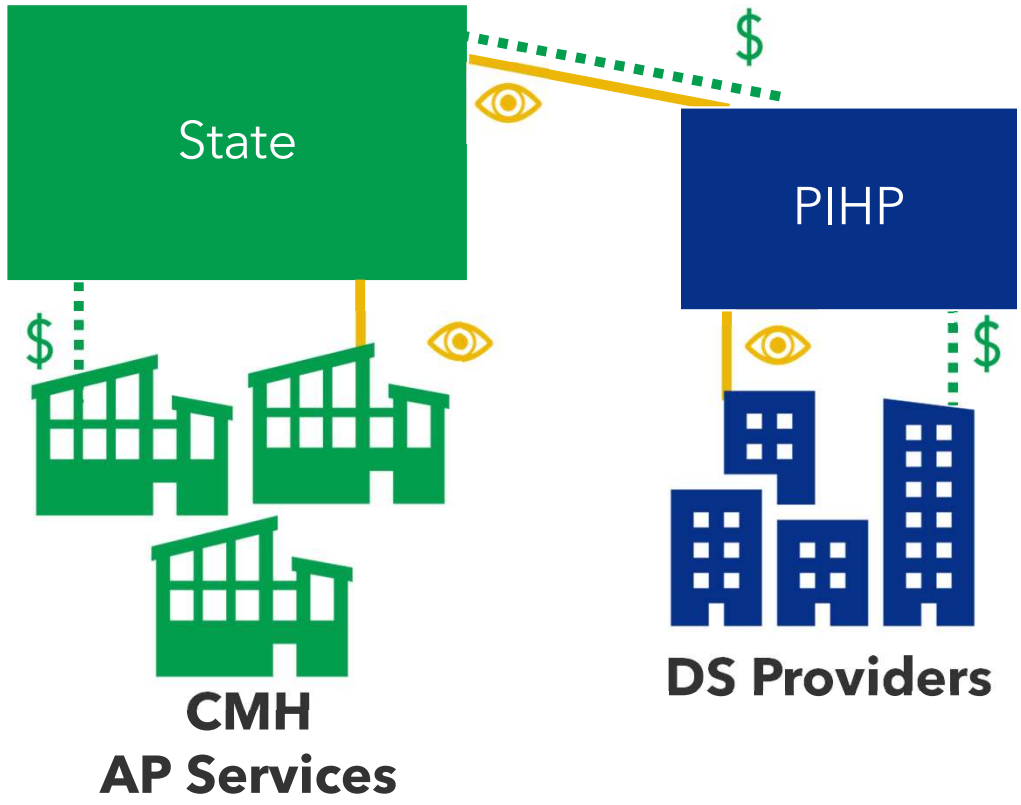
Conflict-Free Case Management

Responsibilities	Case Manager	Community Support Provider
Point of Entry • Point of entry responsibilities *differ* when a participant transitions from an institutional setting (SDDC, nursing homes, HSC, etc.) Please refer to the SDDC manual for further instruction.	• Receive Referral • Submit Funding Request to DDD • Complete and submit DSS 240 or 265e form to DSS Benefits Specialist • Collect and submit LOC information to DDD • CM is responsible to get to know the person, identify and coordinate services and supports as needed, • CM identifies and writes the supports needed in the first 30 days at CSP until the initial ISP is held • Assist the participant in application to preferred CSP(s) for direct services as requested • Administer ICAP and share a copy with the CSP • Completes initial social history • Identifies team within 15 days • Complete Initial application for SSI/SSDI benefits	• Review participant applications for direct services as received from CM • Referral to CM organizations in the event an applicant approaches a CSP first. CSP may provide a packet of information regarding CSP supports available as well as Case Management providers in the region • Follow internal CSP process for new admissions (tours, staff matching, etc.)
ISP Development **Shared Responsibility** • Invites • Review ICAP • Inform each other of discovered life changes	• Conduct and coordinate assessment completion for assessments determined warranted by the ISP Team • Administer ICAP annually in collaboration with ISP Team and others as needed • After completing the ICAP, share with CSP to review prior to submission	• Complete assessments as determined warranted by team and/or requested by CM • Provide information pertinent to ICAP to CM annually • Utilize Person Centered Planning approaches and complete PCT tools for discovery as determined by the team

Family One: Examples

For example…

and not a proposed approach

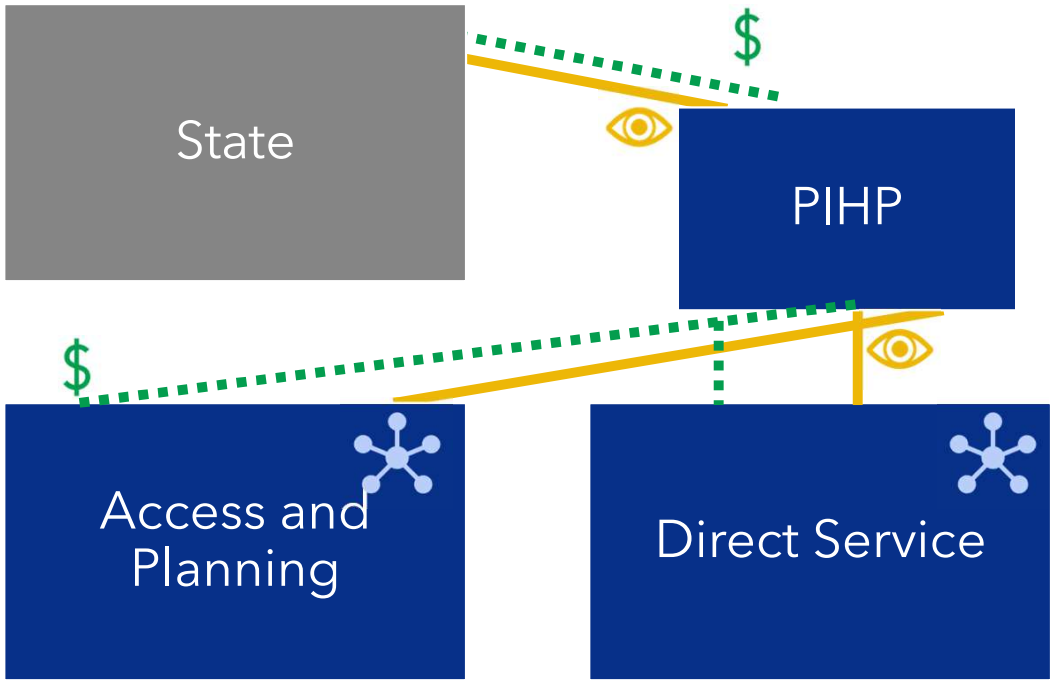


Family Two: PIHP Managed

Family Two: PIHP Managed

Change From Current System

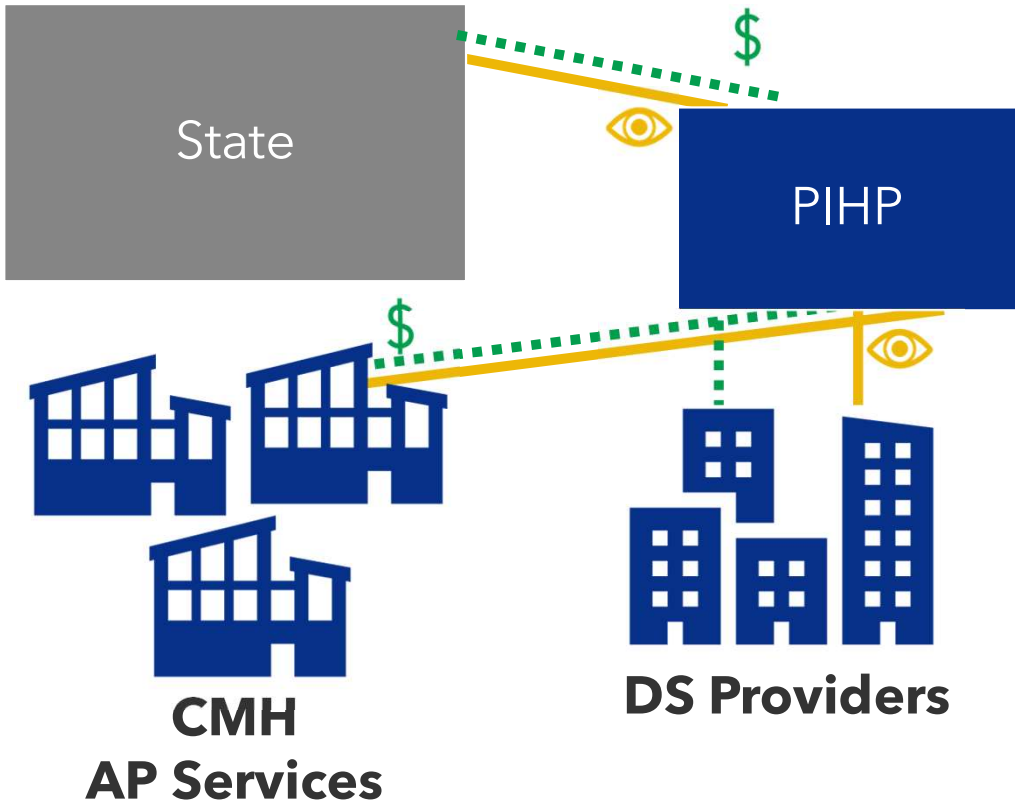
- System manages DS providers as it currently does.
- PIHP manages a separate group of AP providers.
- AP provider organizations cannot also provide direct services.



Family Two: Example

For example…

and not a proposed approach

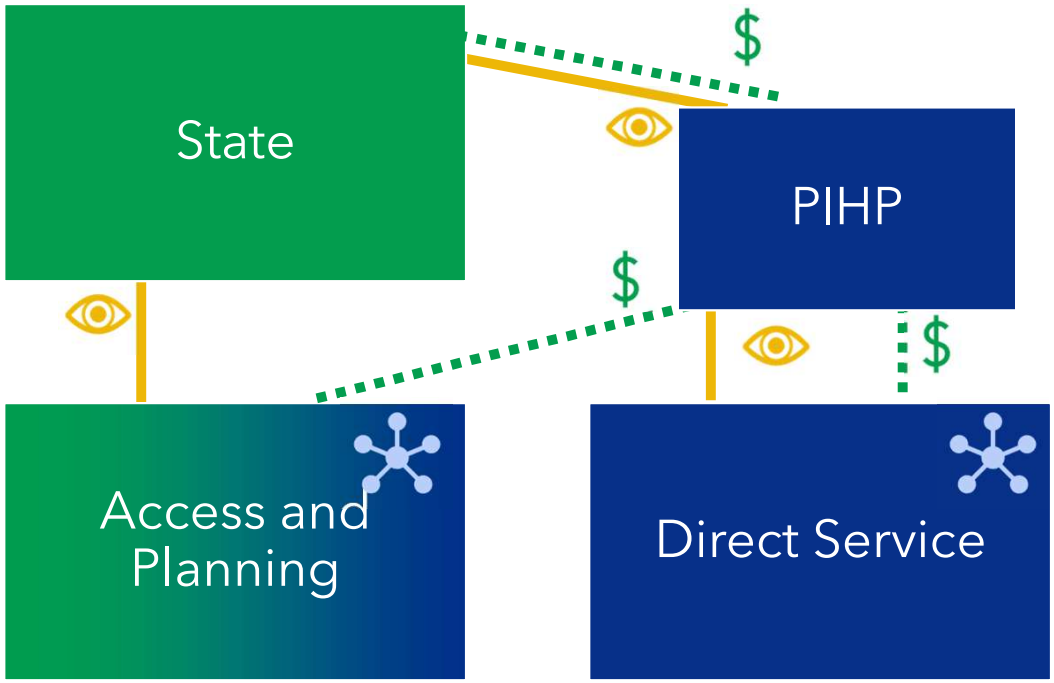


Family Three: State Oversight/ PIHP Funded

Family Three: State Oversight/ PIHP Funded

Change From Current System

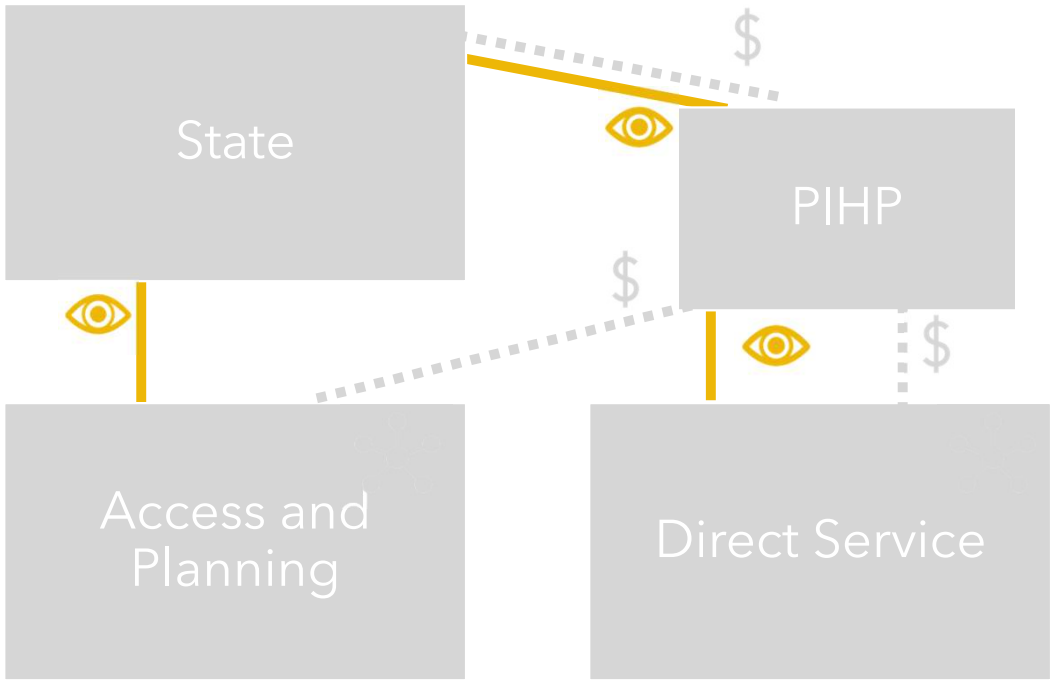
- System manages DS providers as it currently does.
- System funds AP providers the same as in current system.
- State directly oversees AP providers.
- PIHP funds but does not oversee AP providers.
- AP provider organizations cannot also provide direct services.



Family Three: Example

Example* of Shared Oversight

- Ohio's I/DD System is requiring its County Boards to choose between Access/Planning and Direct Service.
- Oversight of Direct Service Providers is shared by the state and County Boards.
- By 2024, no one can receive both AP and DS from the same provider.



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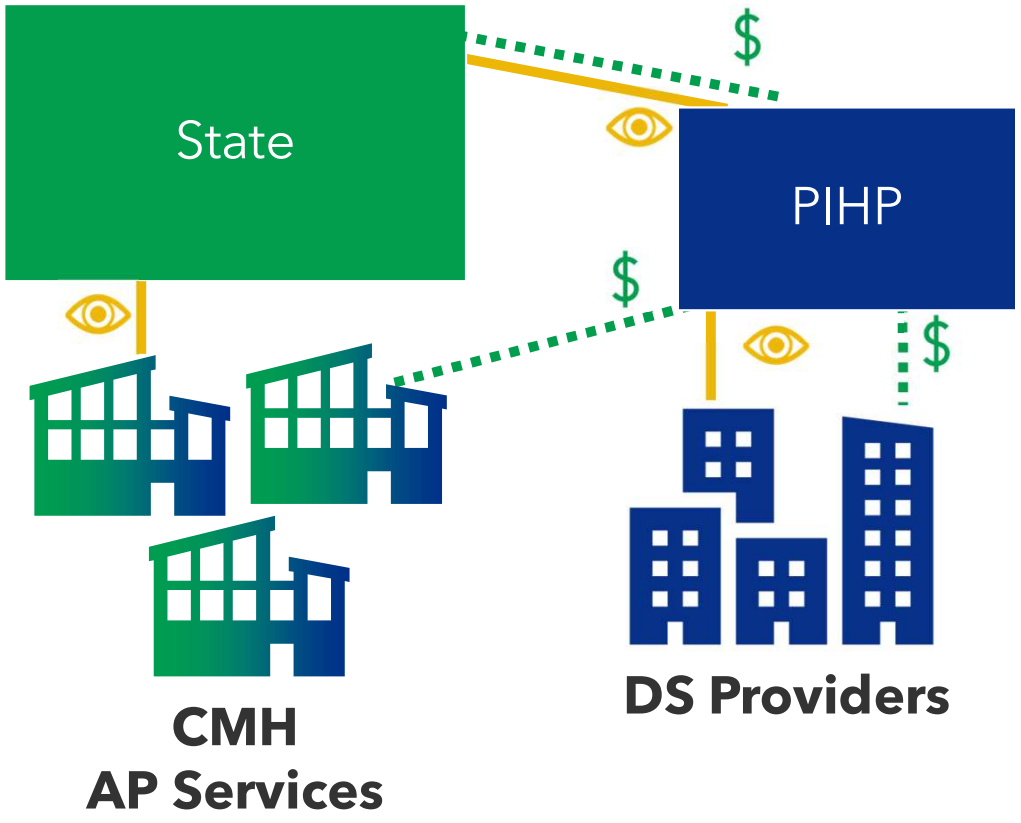
Family Three: Example

For example…

and not a proposed approach



MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

Behavioral and Physical Health and Aging Services Administration
Section 1513 Inpatient Tiered Rate Workgroup Update

April 7, 2022

Background

PA 27 2019, Sec. 1513. (1) The department shall participate in a workgroup to determine an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care.

PA 87 2021, Sec. 1513. By September 30 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the implementation of recommendations made by the workgroup required by section 1513 of 2019 PA 67. The report shall include, but is not limited to, the following: (a) Updates on the recommendations being implemented. (b) Updates on the recommendations not being implemented and barriers preventing implementation.

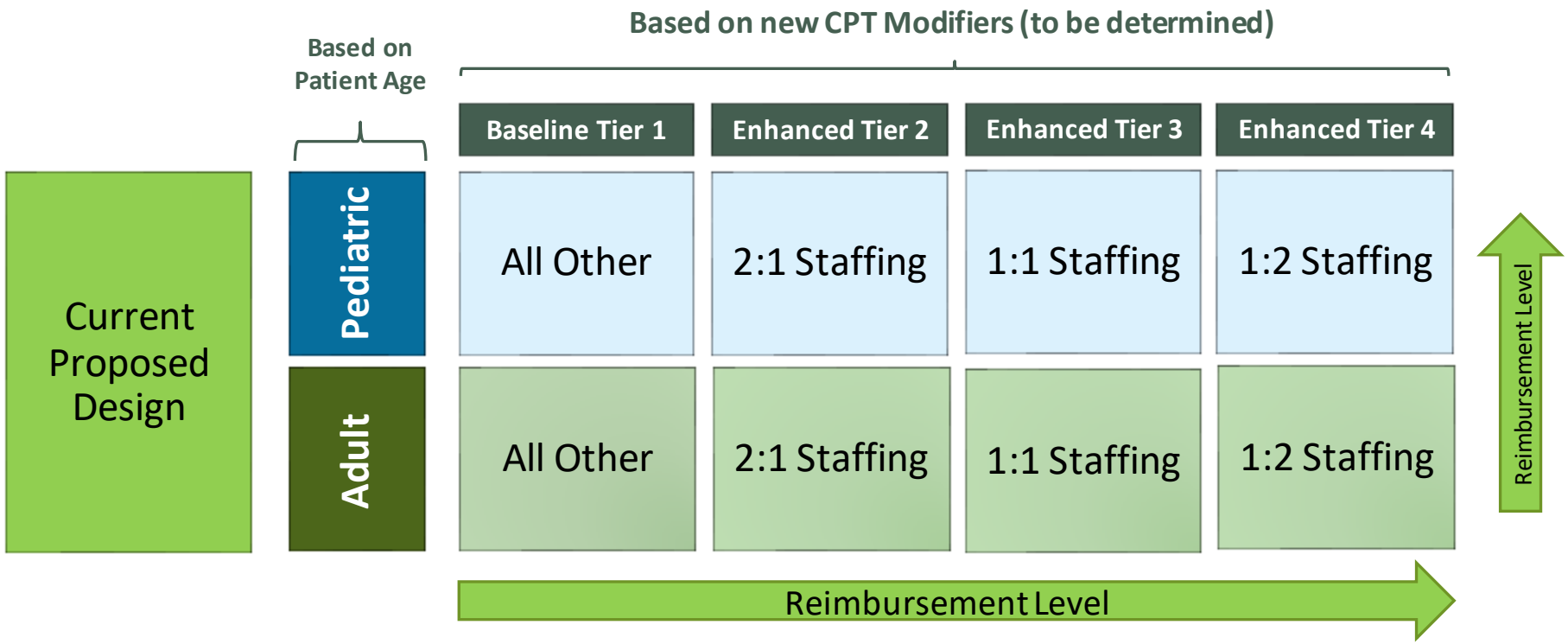
Project Timeline

Task	Nov	Dec	Jan	Feb	Mar	Apr	Additional Information
	2021		2022				
1. *Discuss preliminary tiered rate structure*							• *Supplemental information and review of service utilization levels may be requested from workgroup*
2. *Follow-up discussion on proposed approach for identifying violent behavior, 1:1 levels of care, and the use of a prospective vs retrospective tier assignment*							• *DHHS to share conceptual design of tiered rate methodology with summaries for violent behavior recipients and proposed identification methods –* ***Requires provider input***
3. *Discuss preliminary conceptual design and preliminary statewide model results*							
4. *Review proposed approach for tiered rate assignment and preliminary per diem rates*							• *Preliminary tiered rates* • *Workgroup to provide feedback on preliminary tiered rates, rate assignment methodology, and provider survey*
5. *MDHHS to refine rate calculations and proposed tiered assignment*							• *Preliminary tiered rates*
6. *MDHHS to develop proposed rates to share with providers and present PIHP contract changes to contract negotiation group*							• *Review provider and PHIP survey results and incorporate in rate calculations*

Additional dates:

- **July 1, 2022**: PIHP encounters include reporting newly created tiers.
- **October 1, 2022**: Implementation of tiered rates for inpatient psychiatric care.
- **March 31, 2024**: MDHHS/Milliman review of new rate structure impact toward intended goals

Proposed Tiered Rate Categories



Note: Ratios reported as **Patients : Hospital Staff**

Issues under consideration

- FY19 MUNC and Hospital Survey data currently being reviewed to better understand service provision for proposed inpatient psychiatric tiered per diem rate based on patient to staff ratios.
- MDHHS preference between Minimum Fee Schedule vs. State Directed Payment.
- Tiered coding options using National modifiers or Michigan specific modifiers.
- Current focus is on all-inclusive revenue code 0100 which includes room and board plus ancillary/physician services. Revenue code 0100 represents approximately 90% of days reported in SFY 2019 MUNC.

Implications for PIHPs

- Tiered rates may be higher or lower than CMH/PIHPs current contracted rates.
- Addition of ‘Physician Order’ to Continued Stay review process when determining higher tier.

Next steps

- Incorporate hospital provider survey data into tiered rate calculations and payment impact estimates.
- MDHHS and Milliman will continue to work with the 1513 inpatient workgroup to finalize tiers.

Contact: Jackie Sproat, sproatj@michigan.gov

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

April 7, 2022

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

Dear Mr. Kurtz:

Thank you for the cooperation extended to the Behavioral and Physical Health and Aging Services Administration staff during the March 22, 2022 State Opioid Response (SOR) grant virtual site visit.

PRESENT AT THE SITE VISIT

Northern Michigan Regional Entity:	Sara Sircely, Substance Abuse Prevention and Treatment (SAPT) Director Tema Pefok, Chief Compliance Officer/Privacy Officer Denise Switzer, Treatment Coordinator Pamela Polom, Accountant Jodie Balhorn, Prevention Coordinator Chris VanWagoner, Provider Network Manager Tricia Wurn, Financial Analyst
Behavioral and Physical Health and Aging Services Administration:	Angela Smith-Butterwick, Treatment Manager Logan O'Neil, Project Coordinator – SOR Two Foua Hang, Project Assistant – SOR Two Danyle Proctor, Opioid Care Liaison – SOR Two Choua Gonzalez-Medina, State Opioid Coordinator
Wayne State University:	Danielle Hicks, Project Manager – SOR

The purpose of the Grant Year Two Site Visit was to verify that Northern Michigan Regional Entity's State Opioid Response (SOR) grant activities and services for opioid use disorder (OUD) are following federal and state requirements to support prevention, treatment, and recovery activities.

SOR REQUIREMENTS

Prepaid Inpatient Health Plans (PIHP) must utilize funds within programs for individuals with opioid use disorders to fulfill federal and state funding requirements. SOR funds are distributed to increase the availability of prevention, treatment and recovery services designed for individuals with an OUD.

SITE VISIT FINDINGS

After careful consideration and review of the requirements and documentation submitted, we have determined that Northern Michigan Regional Entity is in substantial compliance with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Funding Opportunity Announcement **(**FOA**)** and Michigan Department of Health and Human Services (MDHHS) Contract. Two corrections were indicated and related to the PIHP at the time of the review. The PIHP followed up with documentation to satisfy one correction and updated a policy to satisfy the other correction. As such, no Corrective Action Plan is requested at this time.

- **Monitoring of Providers**

  Requirement: The PIHP must adopt written policy and must implement procedures to monitor providers. (PIHP Contract)

  Action Taken: The PIHP has updated the grant monitoring policy to include a mechanism for contractors submitting invoices and verifying expenses submitted by treatment contractors are appropriate for SOR.

Currently, Northern Michigan Regional Entity has all the necessary tools in place to manage, maintain, and report on SOR activities and data from their provider network. Their providers will screen individuals to assess their needs and provide or make referrals for interventions as needed for individuals with an OUD.

We greatly appreciate Northern Michigan Regional Entity's preparation for the site visit and their commitment to provide our staff with the necessary documentation.

If you have any further questions, please contact Logan O'Neil, at ONeilL@michigan.gov.

Sincerely,

Belinda Hawks, MPA
Director
Division of Adult Home and Community Based Services
Behavioral and Physical Health and Aging Services Administration

BH/dp

Enclosure (if applicable)

c: Sara Sircely
Angie Smith-Butterwick
Logan O'Neil

Southwest Michigan Behavioral Health to Withdraw from MI Health Link Demonstration Effective December 31, 2022

Embargoed Until April 8, 2022, 12:00 Noon EDT

Southwest Michigan Behavioral Health (SWMBH) a Regional Entity (RE) founded by eight Community Mental Health Service Providers, a DHHS-designated Community Mental Health Entity (CMHE) and DHHS contract Prepaid Inpatient Health Plan (PIHP) will withdraw from the federal-state Financial Alignment Initiative (FAI) Demonstration known as MI Health Link (MHL) effective December 31, 2022.

The Financial Alignment Initiative was authorized under Section 3021 of the *Patient Protection and Affordable Care Act* (P.L. 111-148, as amended) "to test ways to improve care for dually eligible beneficiaries and reduce program costs by aligning financing and coordinating care across Medicare and Medicaid."

SWMBH expressed interest in being a MHL Demonstration Region to the Michigan Department of Community Health (DCH) (now Michigan Department of Health and Human Services) in 2013. Meridian Health Plan and Aetna Better Health were awarded MHL Integrated Care Organization (ICO) contracts in 2014. SWMBH worked with them to launch and operate MHL in SWMBH's eight counties (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren). Meridian and Aetna contracted with SWMBH to manage the MHL Medicare mental health and substance abuse services benefits. Enrollments in MHL began in March 2015 and MHL has been in continuous operation since then.

SWMBH has always and will continue to manage the Medicaid behavioral health benefits for the specialty populations with severe mental illness, serious emotional disturbance, autism spectrum disorders, intellectual and developmental disabilities, and substance use disorders after December 31, 2022.

The primary reasons for withdrawal from MI Health Link are:

- The depth, breadth, and rapid pace of positive changes underway to improve the public behavioral health system requiring additional resources and operational changes. These include but are not limited to Opioid Health Homes, Certified Community Behavioral Health Clinics, Healthcare Information Exchange, Healthcare Data Analytics, expanded MDHHS and Health Services Advisory Group Surveys, American Society of Addiction Medicine Continuum of Care Tool installation and analyses, electronic consent management development and installation, Provider Stability efforts, Conflict Free Access and Planning initiative, financial reporting requirement changes, child and adolescent behavioral health services improvements, racial and ethnic health disparity and inequity improvements, the MICAL and national 988 crisis lines, inpatient psychiatric bed registry, and others.

- The resources required to administer MHL for relatively few enrollees has increased significantly over the years. External audits, reviews and information requests have placed unanticipated burdens on administrative and clinical staff. MHL Demonstration Healthcare Information Exchange, Healthcare Data Analytics and process automation did not develop as well as anticipated. In a related move, SWMBH recently ceased pursuit of its renewal of National Committee for Quality Assurance (NCQA) Managed Behavioral Health Organization (MBHO) Accreditation. SWMBH has been Accredited since 2018 and will continue to be so through June 25, 2022. This Accreditation applied only to the MHL service line, was not mandatory, brought material direct expense and opportunity costs and did not bring adequate relief from Audits as originally hoped.

SWMBH, its Board and MHL Providers thank the Michigan Department of Health and Human Services, Meridian Health Plan and Aetna Better Health of Michigan for their diligence and collaboration during the eight year MHL Demonstration.

Our priority is collaborating with MDHHS, Meridian, Aetna, MI Health Link Enrollees and MHL Providers for successful care transitions between now and December 31, 2022.

MHL Member Contact: customerservice@swmbh.org (800) 676-5814

MHL Provider Contact: swmbhprovidernetwork@swmbh.org (800) 676-0423 prompt 6

MHL Operational Contact: Ellie DeLeon, ellie.deleon@swmbh.org

<END>

Community Mental Association of Michigan

Summary of advocacy efforts to ensure the strength and survival of Michigan's public mental health system – in the face of legislative threat

April 2022

System threatening Senate bills introduced

In 2021, Michigan Senate Majority Leader Shirkey introduced Senate Bills 597 & 598 which would move the management of all of Michigan's Medicaid mental health services to private health plans. These bills and their analysis can be found here.

These bills have moved out of the Senate Committee, to which the bills were referred, and have not been voted out of the full Senate. At this point, it is clear that Senator Shirkey has not had the votes, since the summer of 2021, to pass the bill out of the Senate and is still many votes short. Opposition to the bills is also growing in the House – opposition that will be essential if and when the bills move to the House.

Structure of Michigan's current system

Since 1997, the state's public system has been a Medicaid carve out system, in which the Medicaid behavioral health benefit is managed by public specialty/behavioral Medicaid health plans. These specialty plans (known as Prepaid Inpatient Health Plans [PIHP] in federal parlance) have been designed in various forms and regions since 1997 – all with the Medicaid managed care role being played by public organizations formed by and accountable to local county governments.

The current public specialty/behavioral health plans were formed and are governed by the state's public Community Mental Health (CMH) centers. These specialty/behavioral y plans receive Medicaid dollars from the State of Michigan via risk-bearing capitated payments and make sub-capitated payments to the state's CMHs who formed them. These CMHs, using these Medicaid dollars are a much smaller allocation of state/non-Medicaid dollars, directly provide and purchase the full range of behavioral health services to adults with mental illness, children and adolescents with emotional disturbance, and persons with intellectual and developmental disabilities. in a very efficient, comprehensive, and tightly managed provider network. Additionally, in most communities, the substance use disorder prevention and treatment network is directly managed by the public specialty plans and not through the state's CMHs (the result of the historic funding streams used in Michigan's SUD system). It is this three part system – public specialty/behavioral Medicaid health plans, public Community Mental Health centers, and private providers in the networks of these two public bodies – that make up Michigan's public mental health system.

Components of comprehensive advocacy effort in opposition to these bills

In response to these bills and the harm that they would do to the state's high performing public mental health system and the 300,000 Michiganders and their families and communities who are served by that system, a comprehensive advocacy effort, opposing these bills, has been designed and implemented. This advocacy effort is the collective work of the Community Mental Health Association of Michigan (CMHA), its members, and allies, persons served, the state's major advocacy groups, Lambert (CMHA's longtime public relations partner), and EPIC-MRA (one of the state's premier public opinion polling firms).

The components of this effort are summarized below.

1. Large and diverse coalition opposing Senate bills 597 and 598: Built on the longstanding collaboration among the state's public mental health system and its local community partners, over 100 organizations, representing a diverse set of interests and geography, have come out in opposition to these bills.

2. Strong opposition by Michigan counties: Based on the longstanding partnership with the Michigan Association of Counties (MAC), MAC and over 2/3 of Michigan counties have come out strongly against these bills. MAC's stance upon and action in opposition to these bills is captured in the recent notice from MAC, below:

> **Podcast 83 interviews state mental health leader about threat to local control in Senate Bills 597-98**
>
> Legislation that would bring in private companies to handle mental health services in Michigan would wreck longstanding local oversight and almost assuredly weaken assistance for those in need, a state leader in the field said during a special episode of MAC's Podcast 83.
>
> Alan Bolter, associate director of the Community Mental Health Association of Michigan, discussed Senate Bills 597-98 with Meghann Keit-Corrion, MAC governmental affairs associate and point person on mental health issues.
>
> MAC and CMHA are among organizations that have opposed these measures, which are backed by Senate Majority Leader Mike Shirkey (R-Jackson). First introduced in July 2021, the bills cleared a Senate committee last fall and are before the full Senate.
>
> Use MAC's advocacy platform to send a message of opposition to your senator. MAC also has a talking points sheet on mental health legislation for members' use.
>
> A poll commissioned by the Community Mental Health Association of Michigan and conducted by third-party survey provider EPIC-MRA found 67 percent of Michigan voters prefer the public mental health system to be managed by public entities who specialize in mental health care vs. turning the system over to private, for-profit companies.
>
> Sixty-two Michigan counties have passed resolutions in support of local control and against SBs 597-98.

3. Opposition letter signed by key allies: Early in the advocacy effort, a number of organizations joined CMHA and the Michigan Association of Counties in signing a joint statement in opposition to the bills.

4. Talking points and infographics: A number of talking point documents and infographics have been developed for use with local and statewide advocacy efforts. Those documents include:

- SB 597 & 598: The Wrong Step at the Wrong Time: Dangerous, Costly & Bad for Michigan:
- Wrong Step at the Wrong Time: Care Cost, Governance, Performance
- These stars do not align with quality behavioral health

5. "Within our Reach": concrete approaches to advancing the system – as alternative to system damaging proposals: While much of this advocacy approach focuses on opposition to the legislative proposals, CMHA and its members also proposed a number of concrete actions that, if taken, would actually address the areas in which advancement of the system is needed. These recommendations are captured in a document Within Our Reach: Concrete approaches to building a world class public mental health system in Michigan.

6. Illustrated video highlighting the dangers of the bills: This video, developed jointly by CMHA and one of its members, West Michigan CMH System, outlines the dangers of these bills using illustrations and drawings – in language and drawings that make the arguments against these bills accessible to a wide and diverse audience.

7. Action Alerts: Since these bills were introduced, CMHA has issued eight electronic Action Alerts to its members and allies, urging them to express their opposition to these bills. The CMHA Action Alert system allow any person/potential advocate, with only a handful of keystrokes and using the advocate's zip code (to identify the advocate's legislative district), to send an email to his or her State Senator, Representative, and the state's Governor. The advocate can use the language provided in the action alert, personalize that message, or write a completely original e-mail. CMHA members and allies sign onto receiving regular Action Alerts by signing onto the CMHA system.

These Action Alerts have resulted in over 14,000 e-mails to Michigan legislators (each from a constituent in the legislator's own district), with nearly 4,500 additional e-mails sent to Michigan's Governor.

8. Social media posts: A set of "to the point" social media posts have been developed and, with the increased presence purchased by CMHA, through Lambert, they are getting wide distribution. These social media posts are attached.

9. First person hard-hitting video: Working with a videographer team, its members, and a number of persons served, CMHA developed the advocacy video "They must think that we are not paying attention; enough is enough". That video, with very high production values, has been welcomed by stakeholders and partners across the state, putting a face and a voice to those who would be directly impacted by these bills.

10. Public polling: CMHA contracted with EPIC-MRA (one of the state's preeminent public polling firms) to gauge the public sentiment around Senator Shirkey's bills. The poll was conducted in January 2022 among active and likely November 2022 general election voters across Michigan with a margin error of +/-4. Key data points, highlighted in the press release announcing the poll results, include:

- Nearly 3 times as many Michiganders oppose the privatization of the state's mental health services for Medicaid patients (the purpose of Senate Bills 587 & 598). 67% oppose while only 24% support that privatization.
- 76% of voters are concerned that private, for-profit health plans, do not have a good track record in treating patients with mental health needs and fear they will make matters worse.
- 73% of voters are concerned that high overhead costs of the private health insurance companies (double that of the public system) and the corporate profits that these companies take out of the taxpayer-funded Medicaid system will lead to less mental health services for those in need.
- The data also found factors that make a public mental health care system more cost effective than a private system, including active management of comprehensive services, a person-centered

planning approach and high medical loss ratios (low spending on administrative costs to allocate those dollars towards Medicaid beneficiaries).

- Nearly 4 times as many Michiganders are less likely to support their legislator if he/she supports privatization of mental health services for Medicaid patients than those more likely to support that legislator: 40% less likely compared with only 11% more likely.
- Twice as many Michiganders think that Governor Whitmer should veto legislation if it passes than those who think she should sign the bills: 54% favor veto with only 27% favoring signing

11. Electronic media messages: CMHA and Lambert developed banner advertisements to run, daily, on both of Michigan's capitol news services, MIRS and Gongwer - services religiously read by the state's legislators, staff, and policy makers.

12.Multi-state analysis: In 2022, CMHA conducted a study of the impact of the movement of the management of a state's Medicaid behavioral health benefit to private health plans. This study was released by the Center for Healthcare Integration and Innovation (CHI2), the research and analysis arm of CMHA. This study provides a clear-eyed picture of what happens to persons served and the public and private provider systems upon which they rely when states move the control of Medicaid behavioral health dollars to private for-profit health insurance companies.

Highlighted in this white paper is a sample of just some of the states that have moved their publicly sponsored and funded (primarily Medicaid) mental health system to the private sector. Some of the harm to the state's providers and the persons and communities that they serve include: significant payment delays, inaccurate payment rates, and inexplicable rejections of claims – when combined resulted in closures of providers. Also noted is the lack of expertise regarding behavioral health care on the part of private insurance companies. Additionally, the providers and persons served in these states reported that the definition, by the private health plans, of medically necessary services is vastly different from that of public behavioral health, both in direct client care and regarding services related to social determinants of health such as housing, employment, transportation, and education. A number of states reported the erosion or complete loss of longstanding and vital community partnerships around primary care, law enforcement, education, and housing and homeless services. Additionally, a number of private plans have been charged with Medicaid fraud. As a result of these moves to privatization, persons served across these states have experienced reduced access to quality care due to challenges finding available providers

and premature termination or reduction in services, with disparities exacerbated for BIPOC and LGBTQ+ communities due to lack of linguistically and culturally concordant providers.

This is the latest analysis carried out by CMHA, CHI2, and their partners around the impact of this wrong-headed policy. The earlier studies are found here and here.

13. Petition in opposition to bills: Several components of this advocacy campaign urge allies to sign the petition against these bills. To date, over 7,000 Michiganders have signed this petition.

14. Press coverage: Working with Lambert, CMHAs: The media relations components of this campaign – led by CMHA, Lambert, and the public relations lead on the staff of CMHA member organizations in communities across the state - have generated a large number of new stories underscoring the danger of these bills and the publics opposition to those bills. A sampling of these news stories can be found at:

- Stabenow opposes Shirkey mental health integration bills: https://www.cmham.org/wp-content/uploads/2022/03/Stabenow-Opposes-Shirkey-Mental-Health-Integration-Bills.pdf
- 300,000 people rely on Michigan's public mental health system. Republicans want to privatize it: https://gandernewsroom.com/2022/03/17/michigan-public-mental-health-system-republicans-privatize/
- Our benefits work – please don't change them: https://www.ourmidland.com/opinion/voices/article/Our-benefits-work-please-don-t-change-them-17007206.php
- Poll: Michigan voters oppose privatization of mental health services: https://www.michigansthumb.com/local-news/article/Poll-shows-voters-oppose-privatization-of-mental-16947329.php
- Bills would threaten community 'safety net' for mental health patients, opponents say:
- Build on Michigan's proven public mental health system: https://www.crainsdetroit.com/other-voices/commentary-build-michigans-proven-public-mental-health-system
- Latest effort to reform Michigan's mental health system finds critics: https://www.bridgemi.com/michigan-health-watch/latest-effort-reform-michigans-mental-health-system-finds-critics
- Michigan Senate leader's plans to overhaul mental health system worries advocates: https://cmham.org/wp-content/uploads/2021/05/Detroit-News-Senate-leaders-plans-May-2021.pdf

15. Regular advocacy briefings: CMHA's Associate Director, the leader of CMHA's government relations work, conducts half-hour briefings on these bills, related legislation, and the collective advocacy efforts of CMHA and its allies. These briefings allow CMHA members to hear, in a brief and informal dialogue, the latest on these bills and the advocacy efforts around them.

16. Dialogue with Governor: The success of this advocacy effort to bring the gravity of and opposition to these bills to the political forefront and CMHA's strengthened financial support for key elected officials led to meetings with Michigan's Governor Whitmer. Those discussions centered on the threat that these bills pose to the state's public mental health system and those Michiganders who rely upon that system.

17. Advocacy with Michigan Senators and House Members: For months, CMHA, in partnership with its multi-client lobbying partners, Muchmore, Harrington, and Smalley; and RWC, has been holding a series of focused meetings with key Senators and members of the Michigan House, urging them to oppose Senator Shirkey's bills.

18. Dialogue with the leadership of the Michigan Department of Health and Human Services: Akin to the discussions held with the Governor, State Senators, and House Members, CMHA met with the leadership of the Michigan Department of Health and Human Services. To underscore the threat that these bills pose to the state's public mental health system and those Michiganders who rely upon that system.

Renewal of Determination That A Public Health Emergency Exists

As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective April 16, 2022, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I renewed on April 15, 2021, July 19, 2021, October 15, 2021, and January 14, 2022, that a public health emergency exists and has existed since January 27, 2020, nationwide.

April 12, 2022
_____
Date

/s/
_____
Xavier Becerra

Email Correspondence

From: Chris VanWagoner (NMRE)
To: SUD Program Directors
Subject: ARPA RFP - SUD Prevention, Treatment, Recovery Supports
Date: Thursday, April 14, 2022 1:40:03 PM
Attachments: image001.png
image002.png
ARPA-RFP-FY2022.xlsx

Good afternoon,

Please be advised that NMRE has issued an RFP for "American Rescue Plan Act" (ARPA) project funding. The public RFP can be found as a posting on the NMRE website. A direct link is below.

This Request for Proposal (RFP) represents the Northern Michigan Regional Entity's (NMRE) intent to solicit interest from Substance Use Disorder Providers for the provision of ARPA SABG Grant service projects during Fiscal Year 2022 (April 1, 2022 – September 30, 2022) as listed below:

- Prevention: Evidence-Based Practices: $119,060.00
- Treatment: Same Day Admission for High Intensity Services: $50,000.00
- Treatment: Health Home Maintenance: $5,000.00
- Treatment: Telehealth Technology: $75,000.00
- Recovery Supports: Development of New Recovery Community: $150,000 (up to 4 per year)
- Recovery Supports: Recovery Housing: $100,000.00
- Recovery Supports: Recovery Support Services to Individuals who are Pregnant, Parenting or Have Jeopardized Child Custody: $75,000.00

This RFP will be open until, and proposals must be submitted no later than, Friday, May 13, 2022 at 5pm. Proposals are to be sent to providersupport@nmre.org and must include the attached file "ARPA RFP FY2022" (also included on the website)…completed for EACH individual project proposal. Instructions for completion are on the first tab of the file. Additional details for budgets, etc., are listed with the RFP here:
https://www.nmre.org/american-rescue-plan-act-rfp/

Please contact me with any questions and have a great weekend.

Chris

Chris VanWagoner | **Provider Network Manager**
Northern Michigan Regional Entity
1999 Walden Dr, Gaylord, MI 49735
P: 231.303.3429
Cell: 231.330.0877
F: 989.448.7078
www.nmre.org

Be The Solution

FY2022 Q1 PIHP Final PI Numbers

CMHSP Medicaid Only & SUD All-Funding

10/01/2021 – 12/31/2021

FY2022 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2021 – 12/31/2021

NORTHERN MICHIGAN REGIONAL ENTITY

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	246	243	**98.78%**
Adults	616	609	**98.86%**
Total	**862**	**852**	**98.84%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	444	236	**53.15%**
MIA	798	404	**50.63%**
DDC	61	34	**55.74%**
DDA	32	15	**46.88%**
Total	**1,335**	**689**	**51.61%**

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

Population	Admissions	Expired	In 14 Days	% In 14 Days
SA	Calculated	**249**	Calculated	Calculated **%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	329	208	**63.22%**
MIA	511	349	**68.30%**
DDC	59	51	**86.44%**
DDA	33	27	**81.82%**
Total	**932**	**635**	**68.13%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	60	14	46	46	**100.00%**
Adults	228	75	153	153	**100.00%**
Total	**288**	**89**	**199**	**199**	**100.00%**

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

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
SA	169	54	115	110	**95.65%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	60	0	60	3	**5.00%**
Adults	229	3	226	27	**11.95%**
Total	**289**	**3**	**286**	**30**	**10.49%**

Produced by: Valerie McBain

FY2022 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2021 – 12/31/2021

AVCMH - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	64	63	**98.44%**
Adults	119	117	**98.32%**
Total	**183**	**180**	**98.36%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	98	42	**42.86%**
MIA	152	70	**46.05%**
DDC	5	4	**80.00%**
DDA	6	0	**0.00%**
Total	**261**	**116**	**44.44%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	61	43	**70.49%**
MIA	99	67	**67.68%**
DDC	9	6	**66.67%**
DDA	7	5	**71.43%**
Total	**176**	**121**	**68.75%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	7	2	5	5	**100.00%**
Adults	17	5	12	12	**100.00%**
Total	**24**	**7**	**17**	**17**	**100.00%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	7	0	7	0	**0.00%**
Adults	17	0	17	1	**5.88%**
Total	**24**	**0**	**24**	**1**	**4.17%**

FY2022 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2021 – 12/31/2021

CWN - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	5	5	**100.00%**
Adults	9	9	**100.00%**
Total	**14**	**14**	**100.00%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	41	19	**46.34%**
MIA	107	51	**47.66%**
DDC	5	3	**60.00%**
DDA	7	3	**42.86%**
Total	**160**	**76**	**47.50%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	30	20	**66.67%**
MIA	54	36	**66.67%**
DDC	2	2	**100.00%**
DDA	7	6	**85.71%**
Total	**93**	**64**	**68.82%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	1	1	0	0	**0.00%**
Adults	8	2	6	6	**100.00%**
Total	**9**	**3**	**6**	**6**	**100.00%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	1	0	1	0	**0.00%**
Adults	8	0	8	0	**0.00%**
Total	**9**	**0**	**9**	**0**	**0.00%**

FY2022 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2021 – 12/31/2021

NCCMH - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	37	36	**97.30%**
Adults	126	125	**99.21%**
Total	**163**	**161**	**98.77%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	106	69	**65.09%**
MIA	212	140	**66.04%**
DDC	25	21	**84.00%**
DDA	9	7	**77.78%**
Total	**352**	**237**	**67.33%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	80	51	**63.75%**
MIA	159	111	**69.81%**
DDC	21	19	**90.48%**
DDA	8	7	**87.50%**
Total	**268**	**188**	**70.15%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	12	0	12	12	**100.00%**
Adults	56	10	46	46	**100.00%**
Total	**68**	**10**	**58**	**58**	**100.00%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	12	0	12	1	**8.33%**
Adults	57	0	57	3	**5.26%**
Total	**69**	**0**	**69**	**4**	**5.80%**

FY2022 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2021 – 12/31/2021

NEMCMH - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	79	78	**98.73%**
Adults	90	89	**98.89%**
Total	**169**	**167**	**98.82%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	71	35	**49.30%**
MIA	65	38	**58.46%**
DDC	1	0	**0.00%**
DDA	6	2	**33.33%**
Total	**143**	**75**	**52.45%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	51	38	**74.51%**
MIA	45	36	**80.00%**
DDC	0	0	**0.00%**
DDA	7	5	**71.43%**
Total	**103**	**79**	**76.70%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	11	2	9	9	**100.00%**
Adults	17	3	14	14	**100.00%**
Total	**28**	**5**	**23**	**23**	**100.00%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	11	0	11	1	**9.09%**
Adults	17	0	17	0	**0.00%**
Total	**28**	**0**	**28**	**1**	**3.57%**

FY2022 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2021 – 12/31/2021

NLCMH - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	61	61	**100.00%**
Adults	272	269	**98.90%**
Total	**333**	**330**	**99.10%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	128	71	**55.47%**
MIA	262	105	**40.08%**
DDC	25	6	**24.00%**
DDA	4	3	**75.00%**
Total	**419**	**185**	**44.15%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	107	56	**52.34%**
MIA	154	99	**64.29%**
DDC	27	24	**88.89%**
DDA	4	4	**100.00%**
Total	**292**	**183**	**62.67%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	29	9	20	20	**100.00%**
Adults	130	55	75	75	**100.00%**
Total	**159**	**64**	**95**	**95**	**100.00%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	29	0	29	1	**3.45%**
Adults	130	3	127	23	**18.11%**
Total	**159**	**3**	**156**	**24**	**15.38%**

FY2022 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2021 – 12/31/2021

Substance Use Disorder

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

Population	Expired
SA	**249**

Table 4b – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
SA	169	54	115	110	**95.65%**

Produced by: Valerie McBain

Northern Michigan Regional Entity

Friday, May 20, 2022
10 am—3pm
(Registration begins at 9:30 am)
Treetops Resort—Gaylord

Day of Mental Health Education

"Bridging the Gap"

"Bridging the Gap"

Joseph Reid

Executive Director/Founder of Broken-people.org

Author of "Broken Like Me: An Insider's Toolkit for Mending Broken People"

Breakout Sessions :

A. The Sharing Circle ~ Tom Melnik, LBSW, LPC

B. Living with Dissociative Identity Disorder~ Katherine Robino

C. Peer Support and Advocacy~ TBD

D. Supporting People With MI ~ TBD

Recipients who plan on attending are encouraged to bring a guest: this can be a friend, family member, employer, or other person who would like to learn how they can help support those in their lives with a Mental Illness. All attendees must register, so make sure your guest fills out a registration!

Includes:
- Plated Lunch
- Health Checks
- Door Prizes
- Info Displays
- Entertainment

If you have any questions
Call Mari Hesselink at 833-285-0050
Register with your Clubhouse or Drop-in Center, or CMH by May 6th

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – APRIL 13, 2022
VIA TEAMS

ATTENDEES:	**Joanie Blamer, Connie Cadarette, Lauri Fischer, Nancy Kearly, Eric Kurtz, Donna Nieman, Larry Patterson, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

REVIEW AGENDA & ADDITIONS
Lauri asked to add a discussion of self-determination to the agenda. Eric asked to add retention payments/cost of living increases. Erinn asked to add a discussion of continuing the $2.35/hour DCW increase in FY23.

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

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

MONTHLY FINANCIALS
February 2022

- Net Position* showed net surplus Medicaid and HMP of $8,910,933. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $25,269,050. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $41,067,167.
- Traditional Medicaid showed $82,905,388 in revenue, and $73,350,750 in expenses, resulting in a net surplus of $9,554,638. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $12,890,175 in revenue, and $10,562,014 in expenses, resulting in a net surplus of $2,328,160. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $572,681 in revenue, and $426,233 in expenses, resulting in a net surplus of $146,448.
- SUD showed all funding source revenue of $9,977,841, and $7,987,460 in expenses, resulting in a net surplus of $1,990,381. Total PA2 funds were reported as $5,646,552.

Deanna noted that the DCW surplus was estimated at $2,971,865; estimates by Board were also provided. Lauri requested FY21 FSR which Deanna agreed to share at the conclusion of the NMRE's compliance examination. Deanna reminded the Boards to forward their final FY21 compliance examinations to her attention. It was noted that no PA2 payments for FY22 have been received to date (three are expected). Deanna drew attention to the "Eligibles" tables which show an increase in all categories for all Boards. October 1, 2021 – March 31, 2022 revenue was reported as $1.9M above the same period in FY21.

MOTION BY LAURI FISCHER TO RECOMMEND APPROVAL OF THE NORTHERN

MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR FEBRUARY 2022; SUPPORT BY ERINN TRASK. MOTION APPROVED.

EDIT UPDATE

The next EDIT meeting is scheduled for April 21st. Donna shared that the public health emergency was extended until July 15, 2022. It was also noted that 60 days-notice will be given prior to the termination of the public health emergency declaration for COVID-19. This likely halts any movement on Medicaid redeterminations and spend downs.

OPEN HSW SLOTS

An Email from Stewart Mills on April 6th stated that for the Month of April the region currently has 5 packets pending, 11 packets ready for submission, and 26 open slots; if all the packets get enrolled this month, the open slots will be down to 10. Lauri asked an individual with a dual MI/IDD diagnosis can be enrolled if MI is primary; Eric responded that he believes IDD must be primary. Connie reported that Northeast Michigan is preparing three additional packets.

HOPE NETWORK STABILITY PAYMENTS

All Boards reported receiving a stability payment request from Hope Network; AuSable Valley, Centra Wellness, and Northern Lakes sent the payments. Eric noted that other CMHSPs in the state declined the request: Erin added that Network 180 is currently in negotiations with Hope Network regarding the request. Donna stated the Centra Wellness doesn't intend to continue to supply stability payments; Hope Network needs to include their increased costs in their rates. Erinn reported that AuSable Valley incorporates stability payments through the EHR as a retroactive rate adjustment and amends the Contract (cost settled).

SALARY/WAGE SURVEY

Agreement was reached in March to not complete the survey (CMHSPs exempt from participating). Lauri asked whether the other Boards collect training by credential as this information would be difficult to collect; the Boards responded that they do not.

SCA STATUS

Eric reported that during the most recent PIHP Contract Negotiations meeting the Department stated that it is collecting input and obtaining further legal opinions which will be shared at some point in the future; CMHAM has reengaged with the workgroup.

Donna noted that PCE is not ready to cost services using the SCA model (or any other model) currently (by minute, by code, by modifier, etc.) Lauri acknowledged having problems with location codes requiring a lump sum dollar value credit to Medicaid and debit to GF. Donna agreed to share a summary of the April 14th EQI Workgroup meeting to the Committee.

EQI UPDATE

Deanna reported that Milliman is in the process of setting up 1:1 meetings with the PIHPs to review FY21 EQI data. Eric suggested compiling a list of concerns prior to the meeting. Reports for the May 31st submission will be due to the NMRE on May 17th.

SELF-DETERMINATION

Lauri commented that she has three high profile cases for which state-level advocates are pressuring her to move the budget values equal to contract values in self-determined arrangements.

Eric explained that the MDHHS BHDDA Self-Direction Technical Requirement Implementation Guide dated January 2022 has not been finalized, though it may be used for guidance and best

practice. A workgroup is being formed by MDHHS to address concerns raised by the CMHSPs/PIHPs. Clarification was made that the MDHHS BHDDA Self-Directed Services Technical Requirements Policy dated November 10, 2021 has been approved and went through a joint negotiations group of CFI and the PIHPs.

Lauri stated that one of advocates pressuring her to move the budget values for SD arrangements to equal contract amount is also one of the authors of the Technical Implementation Guide (Jan Lampman); Lauri is struggling with how to push back because she's being told that she has to comply. Eric responded that he believes that Community Mental Health Partnership of Southeast Michigan ended up in a class action lawsuit about this issue and agreed to contact CEO James Colaianne. Lauri provided the contract rate (including DCW) as $22.20/hour versus an average of $17.00/hour (including DCW) for SD. In at least one case, approval of the budget is holding up signing and implementing the IPOS. Eric asked what accounts for the difference in rates to which the Boards responded that the overhead is completely different (liability insurance, office space, training, scheduler, etc.) Stated in the January 2022 MDHHS BHDDA Self-Direction Technical Requirement Implementation Guide is the statement, "the service cost must not be less than the contracted, provider rate for the same service for the same level of need for that individual."

Erinn suggested taking the entire SD budget plus what is being paid to SE Contractor and dividing it by the total number of approved units to determine the rate per unit.

This topic will be placed on the April 19th Operations Committee meeting agenda for further discussion.

RETENTION/COST OF LIVING PAYMENTS

Eric asked whether the Boards are planning any mid-year retention payments or cost of living increases given the current rate of inflation.

- **AuSable Valley** – A 3% COLA was given effective April 1st, retention payments are planned in the summer, additional dollars have been allocated for recruiting and additional payments are being made to Bay Human Services, which staffs AVCMH-owned AFC homes.
- **Centra Wellness Network** – Donna reported that a 4% salary increase was implemented in April and $500/month retention payments are being made to providers (staff who work 80 hours/month) through June.
- **Northeast Michigan** – Connie reported that retention payments and deferred compensation payments are being considered.
- **Northern Lakes** – A 5% COLA was given to staff on January 1st.

DCW

This topic was placed on the Agenda due to an email originating from Bob Sheehan on April 11th regarding the permanency of the $2.35/hour wage increase for direct care workers that was included in the FY22 budget. The email asserted that, according to the State Budget Office, "the $2.35 wage included in the FY22 appropriation is **baked into the FY23 Executive Budget Recommendation**. This adjustment was included in ongoing service lines and you will see no adjustment in the FY23 budget detail removing this cost." Eric reported that a FY23 rate setting meeting is planned but a date has not yet been set. The process of collecting Attestations was discussed. Deanna reported that the NMRE will have $7M pulled back from FY21 due to unspent DCW.

NEXT MEETING

The next meeting was scheduled for May 11th at 10:00 am.

Chief Executive Officer Report

April 2022

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

March 17: Attended and participated in CMH/PIHP/CMHAM meeting regarding MDHHS reorg.

March 25: Attended and participated in CMHAM SCA discussion.

March 25: Attended and participated in PIHP/MDHHS Contract Negotiations meeting.

March 29: Reviewed NMRE IT Audit Findings.

March 29: Chaired NMRE Operations Committee meeting.

April 6: Attended and participated in PIHP CEO meeting.

April 7: Attended and participated in PIHP/MDHHS CEO meeting.

April 7: Attended and participated in MiCARE meeting regarding Bed Registry.

April 8: Attended and participated in COVID Waiver evaluation.

April 12: Chaired NMRE Operations Oversight Committee meeting.

April 13: Attended and participated in NMRE Finance Committee meeting.

April 18: Chaired NMRE Operations Committee meeting.

April 21: Presented to Emmet County BOC regarding NMRE.

February 2022 Finance Report

February 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	9,554,638	11,296,867	9,298,368
Healthy Michigan	2,328,160	5,061,250	7,059,749
	$ 11,882,798	$ 16,358,117	$ 16,358,117

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	587,974	1,533,159	1,767,339	3,139,236	478,350	851,211	553,664	$ 8,910,933
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 25,269,050
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 41,627,167

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through February 28, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 80,503,725	$ 1,939,385						$ 82,443,110
CMHSP Distributions	(77,723,397)		25,860,121	21,393,380	13,056,813	10,677,838	6,735,246	-
1st/3rd Party receipts			178,093	-	284,185	-	-	462,278
Net revenue	2,780,328	1,939,385	26,038,214	21,393,380	13,340,997	10,677,838	6,735,246	82,905,388
Expense								
PIHP Admin	924,042	17,618						941,660
PIHP SUD Admin		21,660						21,660
SUD Access Center		21,065						21,065
Insurance Provider Assessment	640,177	13,261						653,438
Hospital Rate Adjuster	688,072							688,072
Services		1,328,844	23,170,601	18,539,810	12,460,890	9,392,466	6,132,244	71,024,855
Total expense	2,252,291	1,402,448	23,170,601	18,539,810	12,460,890	9,392,466	6,132,244	73,350,750
Net Actual Surplus (Deficit)	$ 528,037	$ 536,937	$ 2,867,613	$ 2,853,570	$ 880,108	$ 1,285,372	$ 603,002	$ 9,554,638

Notes

Medicaid ISF - $9,298,368 - based on unaudited FSR
Medicaid Savings - $11,296,867

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through February 28, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 8,266,710	$ 4,621,468						$ 12,888,178
CMHSP Distributions	(7,569,176)		2,763,617	2,289,667	939,585	941,655	634,651	-
1st/3rd Party receipts			-	-	1,997	-	-	1,997
Net revenue	697,534	4,621,468	2,763,617	2,289,667	941,582	941,655	634,651	12,890,175
Expense								
PIHP Admin	87,155	42,112						129,267
PIHP SUD Admin		51,772						51,772
SUD Access Center		50,352						50,352
Insurance Provider Assessment	57,950	30,200						88,150
Hospital Rate Adjuster	492,492							492,492
Services		3,176,308	2,867,582	1,596,838	861,012	830,164	418,078	9,749,982
Total expense	637,597	3,350,744	2,867,582	1,596,838	861,012	830,164	418,078	10,562,014
Net Surplus (Deficit)	$ 59,937	$ 1,270,724	$ (103,965)	$ 692,829	$ 80,570	$ 111,491	$ 216,573	$ 2,328,160

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

Direct Care Wage Estimated Surplus		**(274,502)**	**(996,309)**	**(407,164)**	**(482,328)**	**(545,652)**	**(265,911)**	**$ (2,971,865)**
Net Surplus (Deficit) MA/HMP/DCW	**$ 587,974**	**$ 1,533,159**	**$ 1,767,339**	**$ 3,139,236**	**$ 478,350**	**$ 851,211**	**$ 553,664**	**$ 8,910,933**
Medicaid & HMP Carry Forward								**16,358,117**
Total Med/HMP Current Year Surplus								$ 25,269,050
Medicaid & HMP ISF - based on unaudited FSR								**16,358,117**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 41,627,167**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through February 28, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 153,623		170,571	31,237	32,640	23,866	160,744	$ 572,681
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	153,623	-	170,571	31,237	32,640	23,866	160,744	572,681
Expense								
PIHP Admin	5,556							5,556
BHH Admin	-							-
Insurance Provider Assessment	1,619							1,619
Hospital Rate Adjuster								
Services	-		170,571	31,237	32,640	23,866	160,744	419,058
Total expense	7,175	-	170,571	31,237	32,640	23,866	160,744	426,233
Net Surplus (Deficit)	$ 146,448	$ -	$ -	$ -	$ -	$ -	$ -	$ 146,448

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through February 28, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,939,385	$ 4,621,468	$ 1,451,359	$ 1,075,368	$ 890,261	$ 9,977,841
Expense						
Administration	39,278	93,884	34,924	62,193		230,279
OHH Admin			44,574	-		44,574
Access Center	21,065	50,352	-	9,859		81,276
Insurance Provider Assessment	13,261	30,200	7,577			51,038
Services:						
Treatment	1,328,844	3,176,308	1,181,564	621,927	890,261	7,198,904
Prevention	-	-	-	381,389	-	381,389
State targeted response	-	-	-	-	-	-
Total expense	1,402,448	3,350,744	1,268,639	1,075,368	890,261	7,987,460
PA2 Redirect			-			-
Net Surplus (Deficit)	$ 536,937	$ 1,270,724	$ 182,720	$ -	$ 0	$ 1,990,381

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through February 28, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 80,503,725	$ 1,939,385	$ -	$ 82,443,110
Medicaid Savings	11,296,867	-	-	11,296,867
Healthy Michigan	8,266,710	4,621,468	-	12,888,178
Healthy Michigan Savings	5,061,250	-	-	5,061,250
Health Home	572,681	-	-	572,681
Opioid Health Home	-	1,451,359	-	1,451,359
Substance Use Disorder Block Grant	-	1,075,368	-	1,075,368
Public Act 2 (Liquor tax)	-	890,261	-	890,261
Affiliate local drawdown	449,800	-	-	449,800
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	14,227	-	14,227
Veteran Navigator Grant	40,695	-	-	40,695
SOR Grant Revenue	-	374,524	-	374,524
Gambling Grant Revenue	-	23,813	-	23,813
Other Revenue	-	-	3,054	3,054
Total operating revenue	106,191,728	10,390,405	3,054	116,585,187
Operating expenses				
General Administration	1,117,485	210,823	-	1,328,308
Prevention Administration	-	35,404	-	35,404
OHH Administration	-	44,574	-	44,574
BHH Administration	-	-	-	-
Insurance Provider Assessment	699,746	51,038	-	750,784
Hospital Rate Adjuster	1,180,564	-	-	1,180,564
Payments to Affiliates:				
Medicaid Services	69,233,733	1,328,844	-	70,562,577
Healthy Michigan Services	6,571,677	3,176,308	-	9,747,985
Health Home Services	419,058	-	-	419,058
Opioid Health Home Services	-	1,181,564	-	1,181,564
Community Grant	-	621,927	-	621,927
Prevention	-	345,985	-	345,985
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	890,261	-	890,261
Local PBIP	-	-	-	-
Local Match Drawdown	449,800	-	-	449,800
Miscellanous Grant	-	14,227	-	14,227
Veteran Navigator Grant	40,695	-	-	40,695
SOR Grant Expenses	-	374,524	-	374,524
Gambling Grant Expenses	-	23,813	-	23,813
Total operating expenses	79,712,758	8,299,292	-	88,012,050
CY Unspent funds	26,478,970	2,091,113	3,054	28,573,137
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,254,458	6,231,624	16,358,117	24,844,199
Unspent funds - ending	$ 28,733,428	$ 8,322,737	$ 16,361,171	$ 53,417,336

Northern Michigan Regional Entity

Statement of Net Position

February 28, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 21,886,797	$ 7,701,581	$ 16,361,171	$ 45,949,549
Accounts Receivable	36,664,838	2,096,420	-	38,761,258
Prepaids	76,791	-	-	76,791
Total current assets	58,628,426	9,798,001	16,361,171	84,787,598
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	58,628,426	9,798,001	16,361,171	84,787,598
Liabilities				
Current liabilities				
Accounts payable	29,670,998	1,412,819	-	31,083,817
Accrued liabilities	224,000	-	-	224,000
Unearned revenue	-	62,445	-	62,445
Total current liabilities	29,894,998	1,475,264	-	31,370,262
Unspent funds	$ 28,733,428	$ 8,322,737	$ 16,361,171	$ 53,417,336

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2021 through February 28, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 80,387,955	$ 80,503,725	$ 115,770	0.14%
Carryover	11,296,664	11,296,664	11,296,867	203	0
Healthy Michigan					
Capitation	20,566,272	8,569,280	8,266,710	(302,570)	(3.53%)
Carryover	5,061,832	5,061,832	5,061,250	(582)	(0.01%)
Health Home	506,772	211,155	572,681	361,526	171.21%
Affiliate local drawdown	1,204,388	602,194	449,800	(152,394)	(25.31%)
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	45,835	40,695	(5,140)	(11.21%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	106,174,915	106,191,728	16,813	0.02%
Operating expenses					
General Administration	3,021,688	1,250,145	1,117,485	132,660	10.61%
BHH Administration	-	-	-	-	0.00%
Insurance Provider Assessment	1,645,387	685,578	699,746	(14,168)	(2.07%)
Hospital Rate Adjuster	4,001,228	1,667,177	1,180,564	486,613	29.19%
Local PBIP	1,334,531	-	-	-	0.00%
Local Match Drawdown	1,204,388	602,194	449,800	152,394	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	81,205	40,695	40,510	49.89%
Payments to Affiliates:					
Medicaid Services	173,402,120	72,250,883	69,233,733	3,017,150	4.18%
Healthy Michigan Services	15,233,944	6,347,477	6,571,677	(224,200)	(3.53%)
Health Home Services	456,768	190,320	419,058	(228,738)	(120.19%)
Total operating expenses	200,508,190	83,074,979	79,712,758	3,362,221	4.05%
CY Unspent funds	$ 32,503,361	$ 23,099,936	26,478,970	$ 3,379,034	
Transfers in			-		
Transfers out			-	79,712,758	
Unspent funds - beginning			2,254,458		
Unspent funds - ending			$ 28,733,428	26,478,970	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2021 through February 28, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 1,832,810	$ 1,939,385	$ 106,575	5.81%
Healthy Michigan	9,763,272	4,068,030	4,621,468	553,438	13.60%
Substance Use Disorder Block Grant	5,709,003	2,378,748	1,075,368	(1,303,380)	(54.79%)
Opioid Health Home	2,320,384	966,825	1,451,359	484,534	50.12%
Public Act 2 (Liquor tax)	1,533,979	-	890,261	890,261	0.00%
Miscellanous Grants	36,335	15,140	14,227	(913)	(6.03%)
SOR Grant	1,215,000	506,250	374,524	(131,726)	(26.02%)
Gambling Prevention Grant	200,000	83,333	23,813	(59,520)	(71.42%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	9,851,135	10,390,405	539,270	5.47%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	421,035	210,823	210,212	49.93%
Prevention Administration	90,144	37,560	35,404	2,156	5.74%
Insurance Provider Assessment	116,901	48,709	51,038	(2,329)	(4.78%)
Medicaid Services	3,387,649	1,411,520	1,328,844	82,676	5.86%
Healthy Michigan Services	7,453,459	3,105,608	3,176,308	(70,700)	(2.28%)
Community Grant	2,077,452	865,605	621,927	243,678	28.15%
Prevention	664,967	277,070	345,985	(68,915)	(24.87%)
State Disability Assistance	95,215	39,677	-	39,677	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	44,574	(44,574)	0.00%
Opioid Health Home Services	2,117,226	882,180	1,181,564	(299,384)	(33.94%)
Miscellanous Grants	36,335	15,140	14,227	913	6.03%
SOR Grant	1,215,000	506,250	374,524	131,726	26.02%
Gambling Prevention	200,000	83,333	23,813	59,520	71.42%
PA2	1,533,978	-	890,261	(890,261)	0.00%
Total operating expenses	20,058,810	7,693,686	8,299,292	(605,606)	(7.87%)
CY Unspent funds	$ 5,117,907	$ 2,157,449	2,091,113	$ (66,336)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,231,624		
Unspent funds - ending			$ 8,322,737		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2021 through February 28, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 720,445	$ 645,716	$ 74,729	10.37%
Fringes	549,516	216,905	214,764	2,141	0.99%
Contractual	433,304	180,545	168,103	12,442	6.89%
Board expenses	16,100	6,710	7,585	(875)	(13.04%)
Day of recovery	14,000	9,000	250	8,750	97.22%
Facilities	152,700	63,625	47,403	16,222	25.50%
Other	127,000	52,915	33,664	19,251	36.38%
Total General Admin	$ 3,021,688	$ 1,250,145	$ 1,117,485	$ 132,660	10.61%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2021 through February 28, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 200,920	$ 69,810	$ 131,110	65.25%
Fringes	166,800	69,500	20,423	49,077	70.61%
Access Salaries	194,484	81,035	62,747	18,288	22.57%
Access Fringes	57,588	23,995	18,529	5,466	22.78%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	41,665	34,730	6,935	16.64%
Board expenses	5,000	2,085	950	1,135	54.44%
Facilities	-	-	-	-	0.00%
Other	10,404	1,835	3,634	(1,799)	(98.04%)
Total operating expenses	$ 1,070,484	$ 421,035	$ 210,823	$ 210,212	49.93%

Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through February 28, 2022

County	Beginning Balance	FY22 Projected Revenue	Current Receipts	FY22 Approved Projects	County Specific Projects	Region Wide Projects by Population	Ending Balance
					Actual Expenditures by County		
Alcona	$ 83,635	$ 19,313	$ 0	$ 38,301	16,267	$ 888	$ 81,802
Alpena	315,554	66,080	-	160,005	50,016	2,440	274,085
Antrim	243,061	53,592	-	95,690	30,770	1,997	233,731
Benzie	144,391	49,804	-	27,891	7,921	1,507	175,732
Charlevoix	467,765	82,100	-	262,209	42,976	2,241	332,873
Cheboygan	280,756	68,778	-	176,925	71,896	2,175	246,680
Crawford	85,250	28,559	-	32,978	7,742	1,192	89,766
Emmet	754,134	145,253	-	278,987	63,923	2,846	687,169
Grand Traverse	1,615,220	376,032	-	909,582	238,495	7,872	1,328,037
Iosco	359,368	70,274	-	160,492	38,026	2,157	309,333
Kalkaska	73,813	33,023	-	42,665	14,631	1,512	80,314
Leelanau	131,774	48,924	-	97,254	26,007	1,857	111,307
Manistee	90,411	63,745	-	36,315	11,010	2,094	130,946
Missaukee	66,066	18,058	-	50,287	18,470	1,286	53,593
Montmorency	64,849	26,456	-	36,920	14,790	793	69,969
Ogemaw	164,571	54,659	-	80,483	32,569	1,799	173,115
Oscoda	76,895	17,086	-	43,817	13,284	711	64,159
Otsego	205,220	86,909	-	210,283	71,723	2,104	155,673
Presque Isle	102,301	20,617	-	47,065	18,076	1,097	95,026
Roscommon	488,633	75,491	-	63,178	17,219	2,049	520,213
Wexford	417,956	82,829	-	111,588	40,979	2,853	433,030
	6,231,626	1,487,584	0	2,962,916	846,788	43,471	5,646,552
PA2 Redirect							(0)
							5,646,552

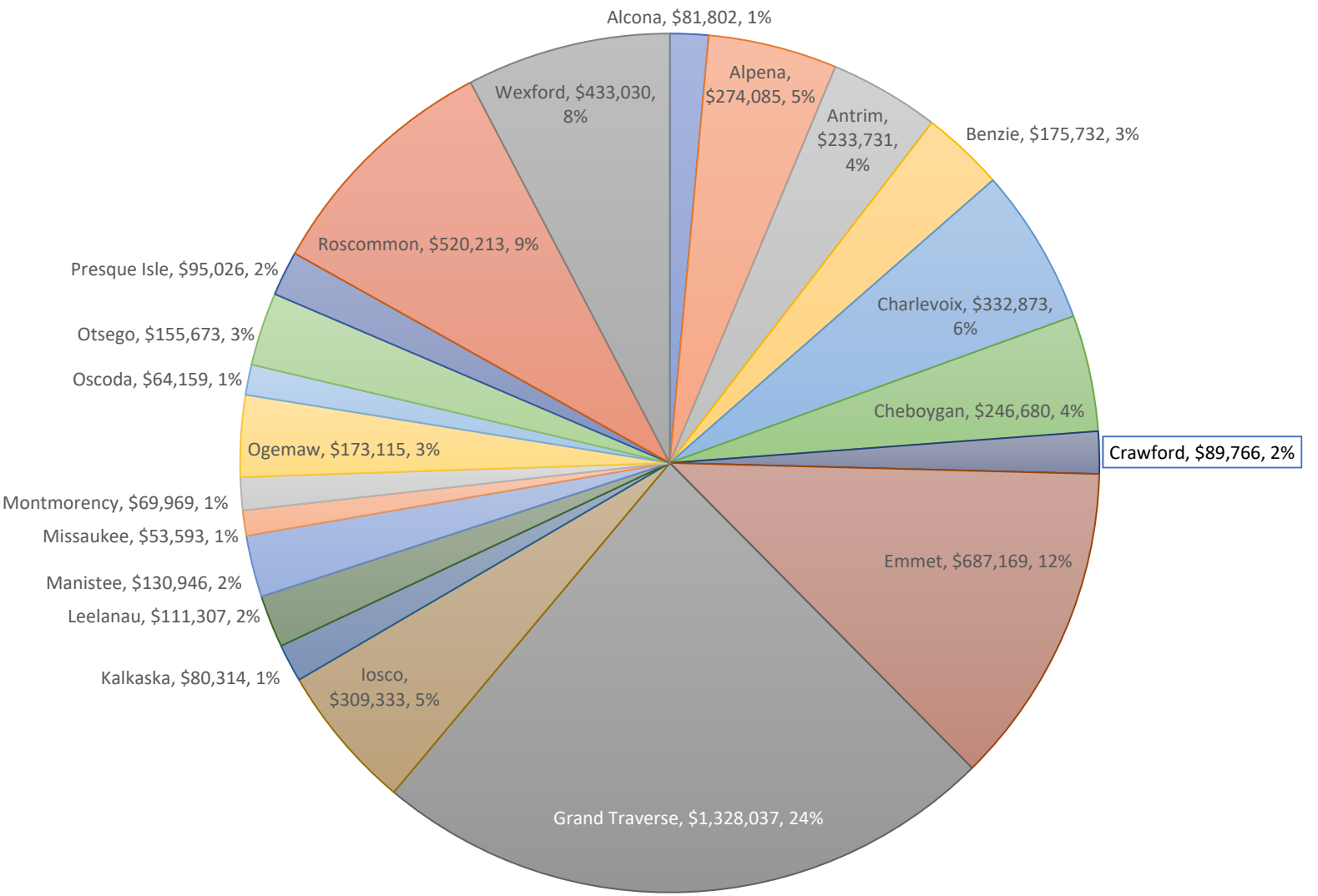
Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2021 through February 28, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	1,040	3,054	2,014	193.65%
Total operating revenue	2,501	1,040	3,054	2,014	193.65%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 1,040	3,054	$ 2,014	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,358,117		
Unspent funds - ending			$ 16,361,171		

PA2 Funds by County

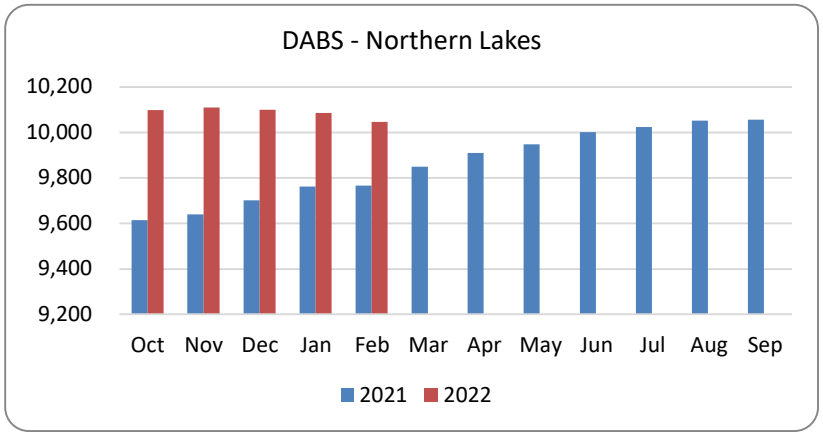


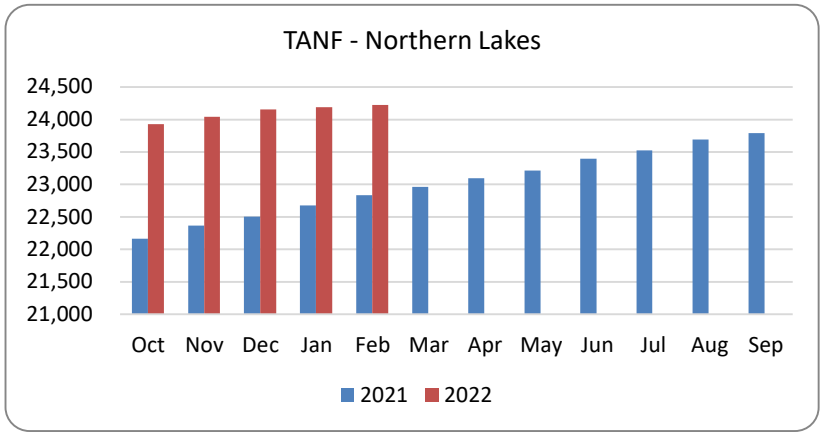
Northern Michigan Regional Entity

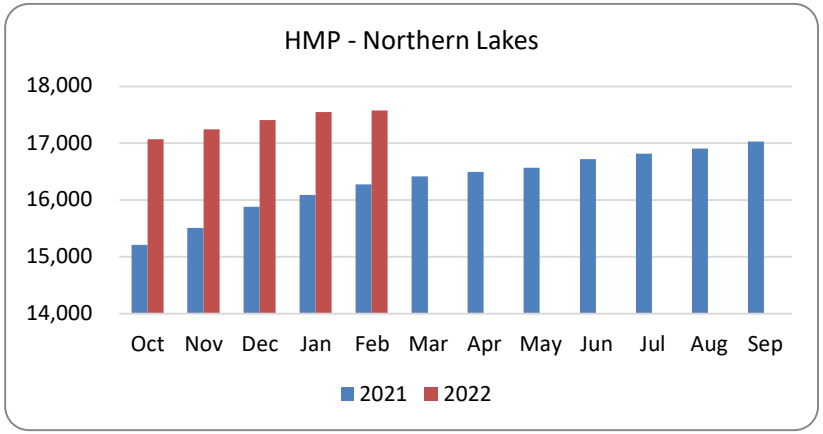
Narrative

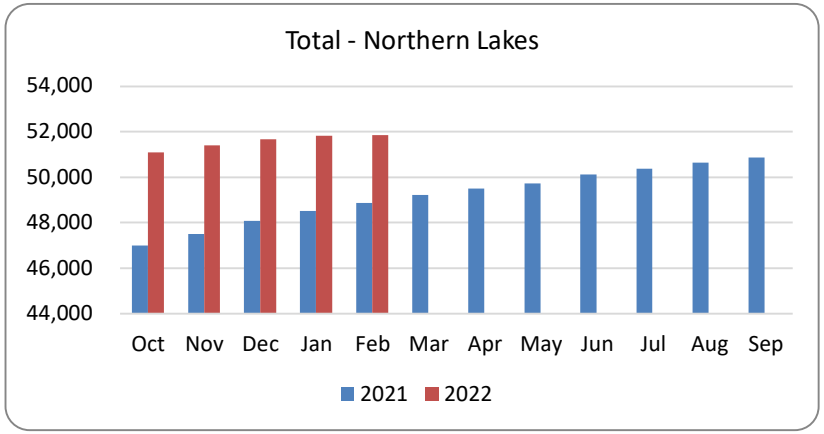
October 1, 2021 through February 28, 2022

Northern Lakes Eligible Trending - based on payment files







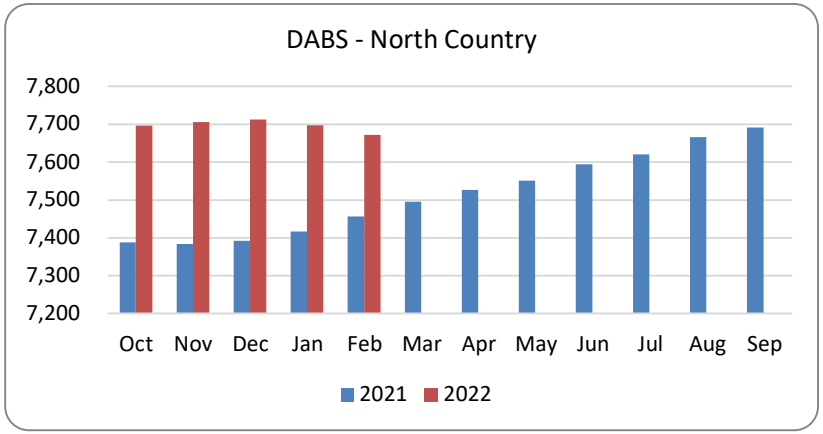


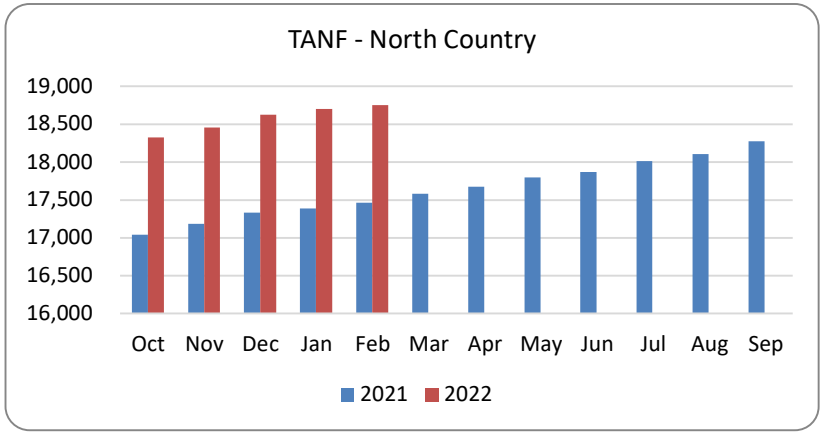
Northern Michigan Regional Entity

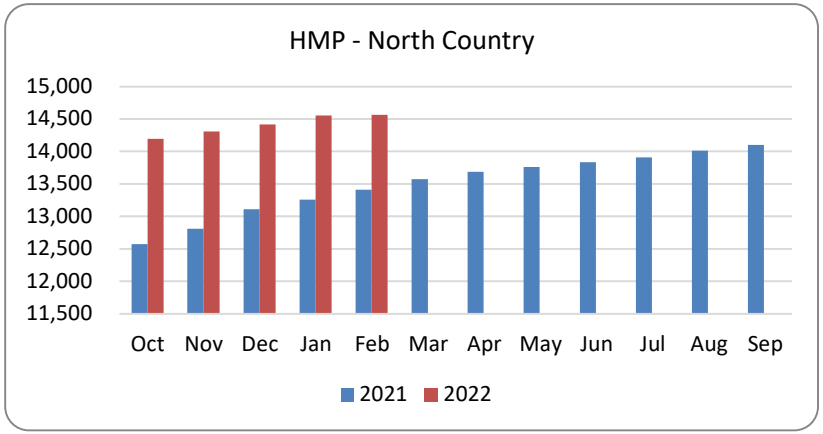
Narrative

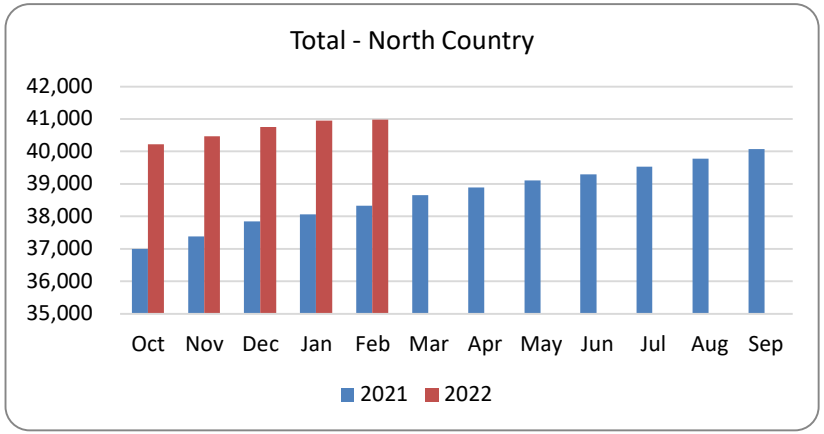
October 1, 2021 through February 28, 2022

North Country Eligible Trending - based on payment files







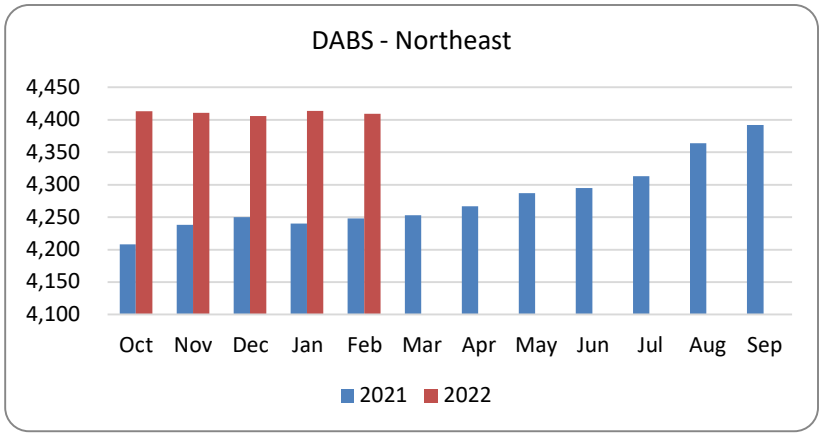


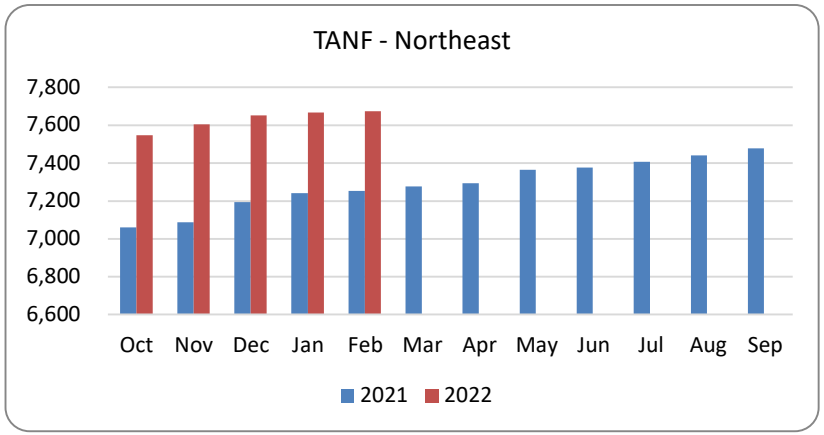
Northern Michigan Regional Entity

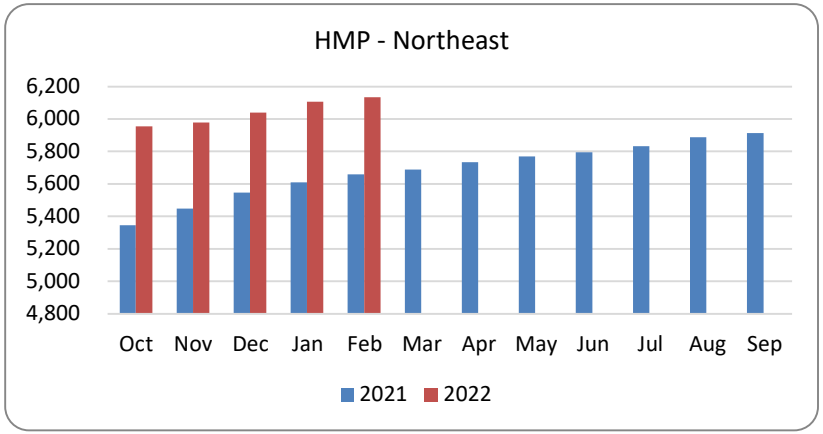
Narrative

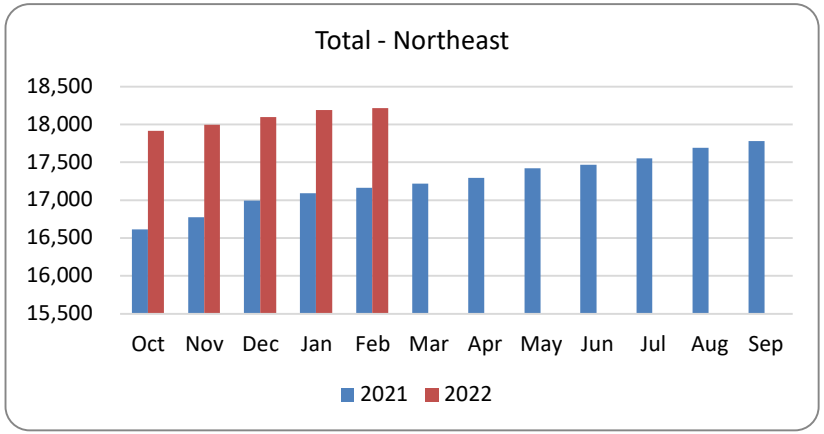
October 1, 2021 through February 28, 2022

Northeast Eligible Trending - based on payment files







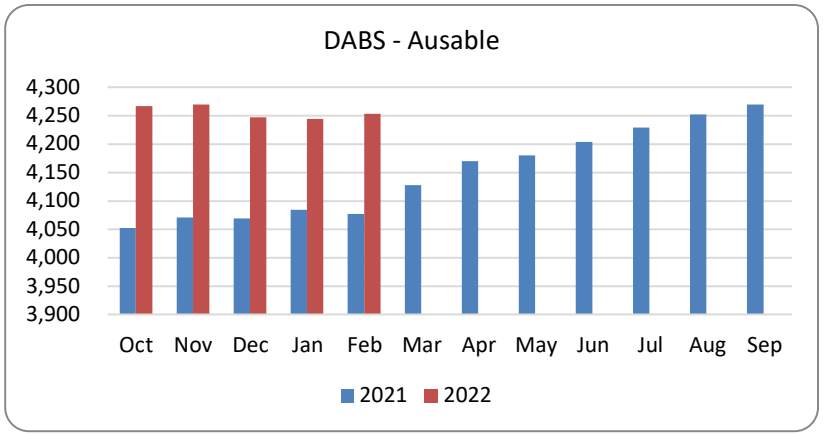


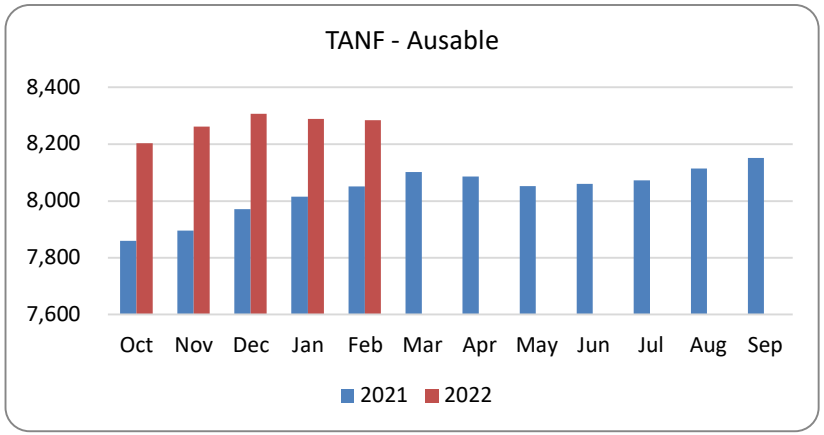
Northern Michigan Regional Entity

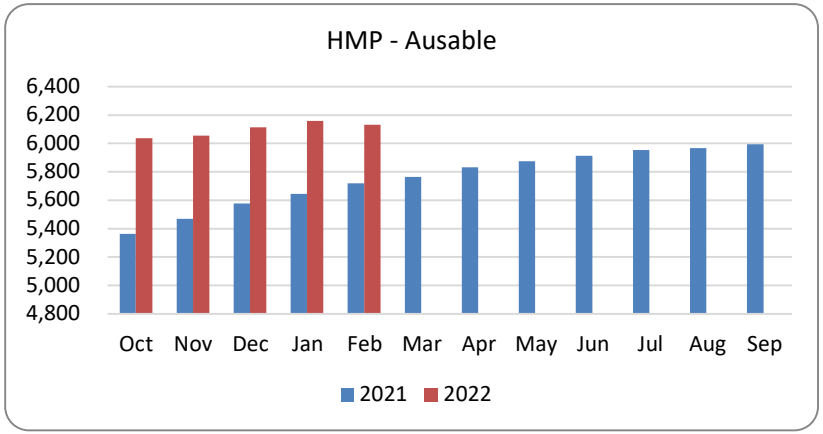
Narrative

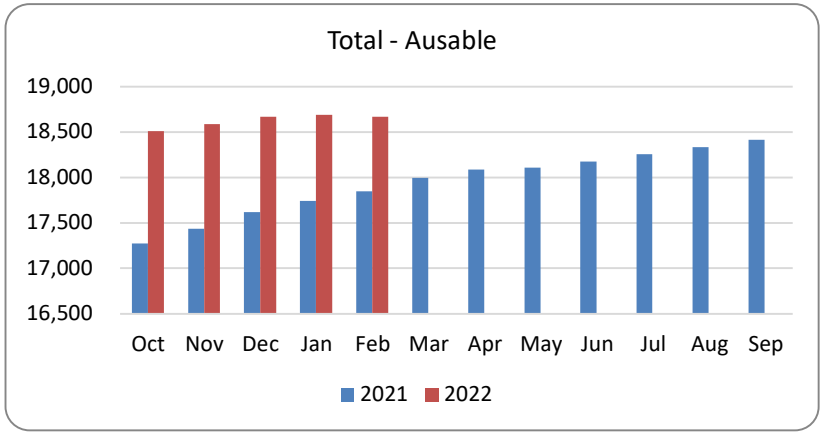
October 1, 2021 through February 28, 2022

Ausable Valley Eligibles Trending - based on payment files







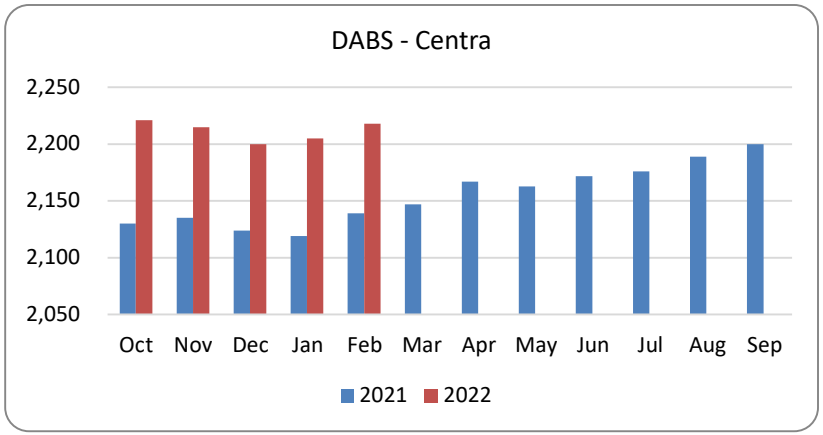


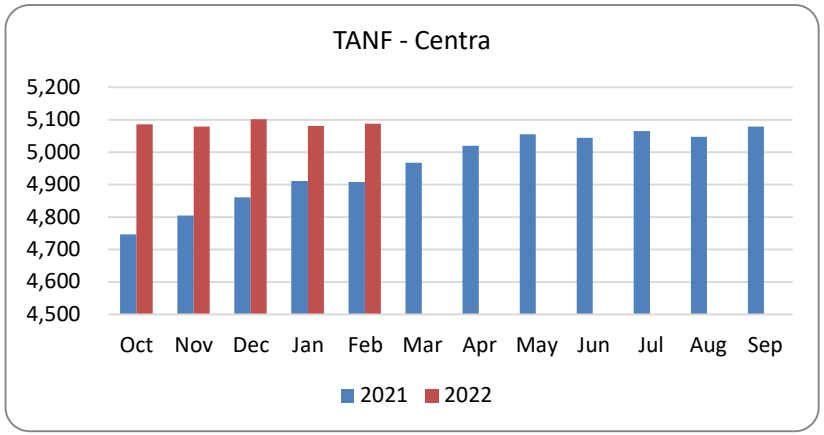
Northern Michigan Regional Entity

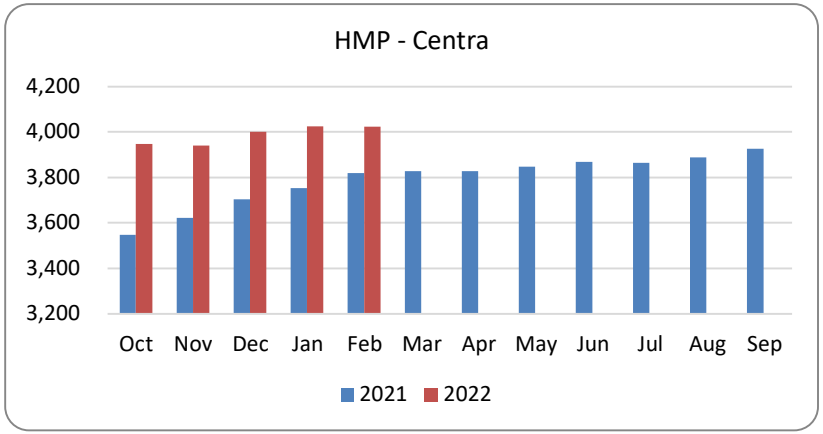
Narrative

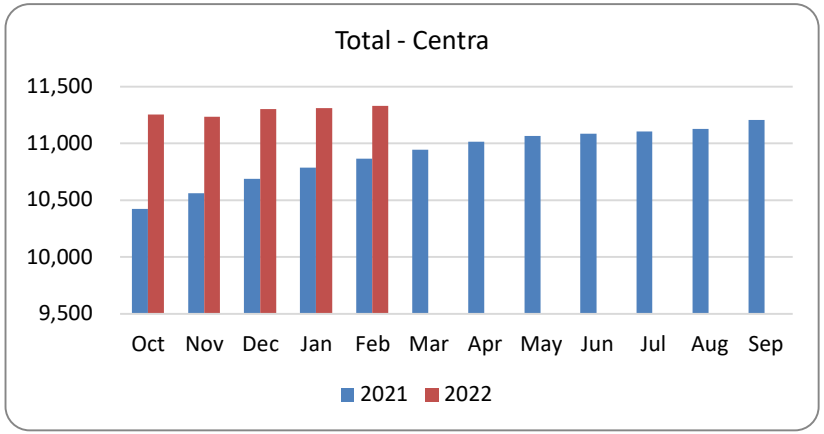
October 1, 2021 through February 28, 2022

Centra Wellness Eligibles Trending - based on payment files







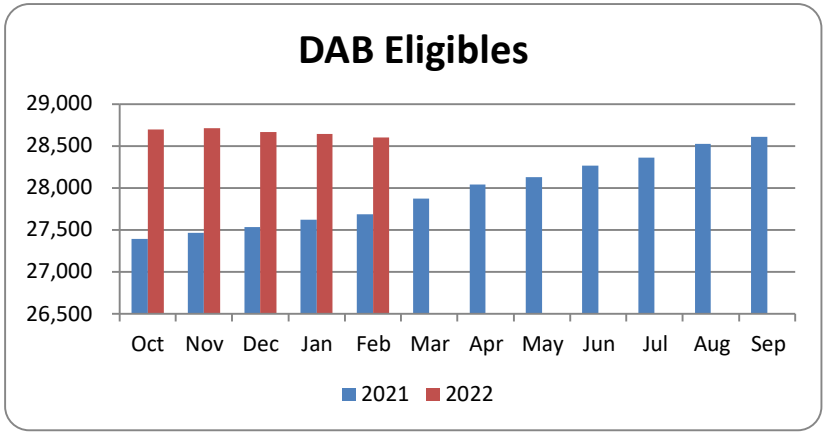


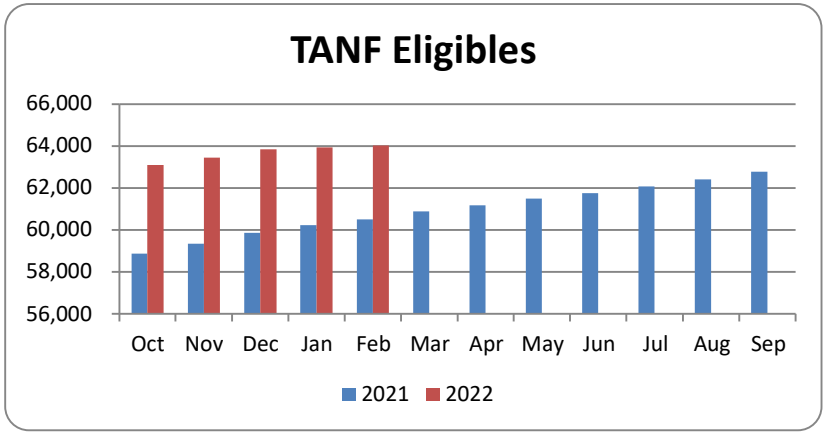
Northern Michigan Regional Entity

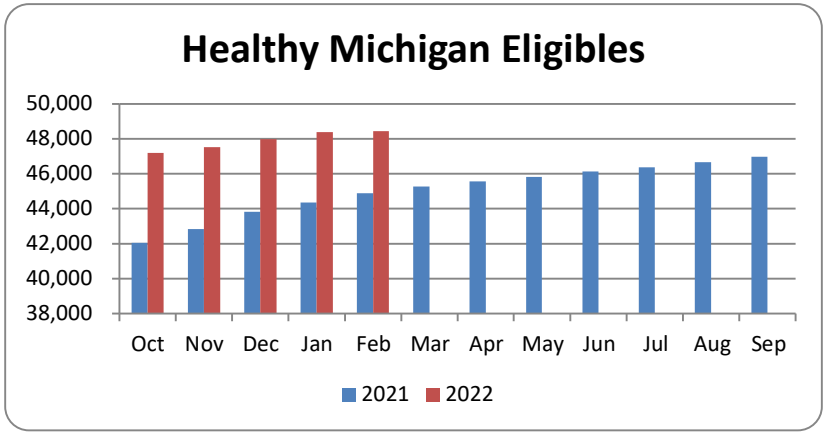
Narrative

October 1, 2021 through February 28, 2022

Regional Eligible Trending





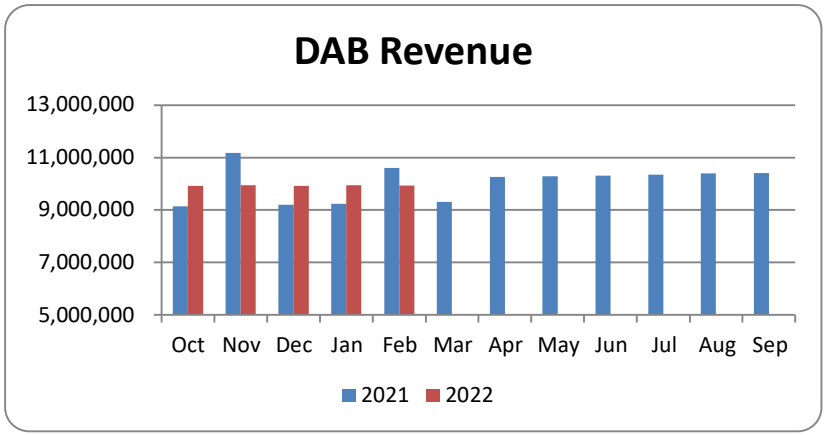


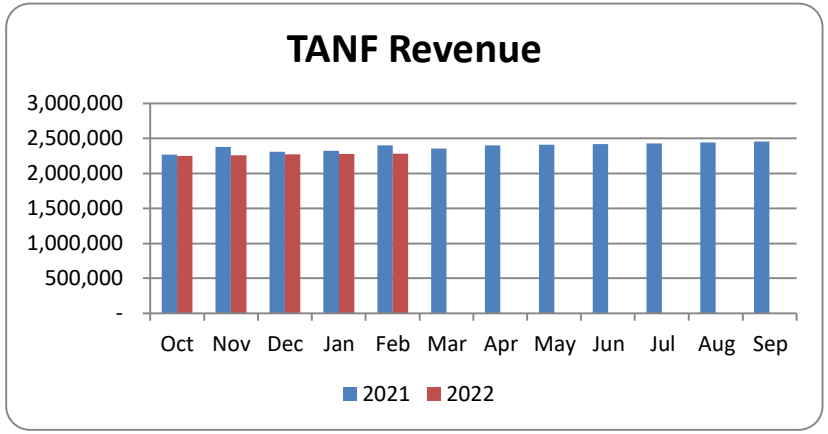
Northern Michigan Regional Entity

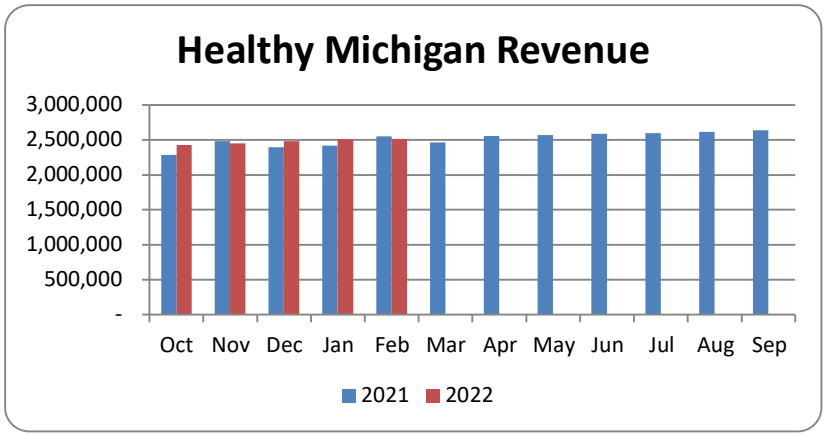
Narrative

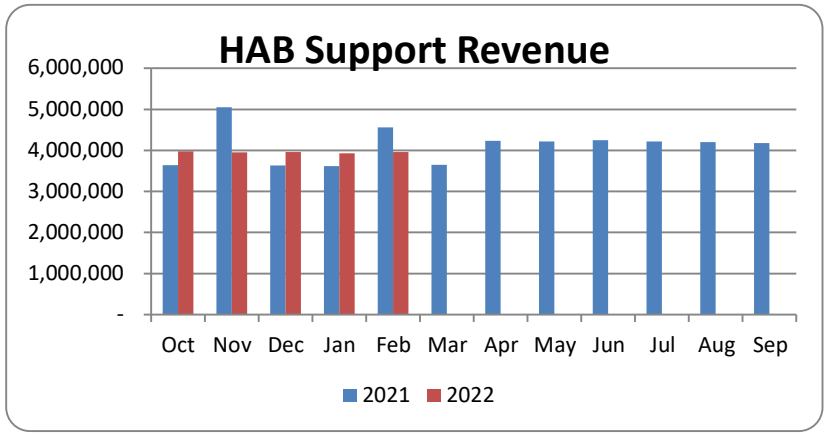
October 1, 2021 through February 28, 2022

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30 AM – APRIL 19, 2022
GAYLORD CONFERENCE ROOM & TEAMS

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

REVIEW AGENDA & ADDITIONS

Ms. Gebard requested that a discussion of the Psychiatric Residential Treatment Facility (PRTF) services survey be added to the meeting Agenda.

APPROVAL OF PREVIOUS MINUTES

The minutes from March 15th were included in the meeting materials.

MOTION BY CHIP JOHNSTON TO APPROVE THE MINUTES OF THE MARCH 15, 2022 NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE MEETING; SUPPORT BY CHIP JOHNSTON. MOTION APPROVE BY CONSENSUS.

FINANCE COMMITTEE AND RELATED

February 2022 Financial Report

- Net Position* showed net surplus Medicaid and HMP of $8,910,933. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $25,269,050. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $41,067,167.
- Traditional Medicaid showed $82,905,388 in revenue, and $73,350,750 in expenses, resulting in a net surplus of $9,554,638. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $12,890,175 in revenue, and $10,562,014 in expenses, resulting in a net surplus of $2,328,160. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $572,681 in revenue, and $426,233 in expenses, resulting in a net surplus of $146,448.
- SUD showed all funding source revenue of $9,977,841, and $7,987,460 in expenses, resulting in a net surplus of $1,990,381. Total PA2 funds were reported as $5,646,552.

October 1, 2021 – March 31, 2022 revenue was reported as $1.9M above the same period in FY21 despite reduced rates (2.5%). When Medicaid redeterminations resume, 600,000 individuals may be dropped. It was noted that the Federal Public Health Emergency was extended earlier this month to July 15, 2022. States will receive 60 days-notice before the end of the PHE to prepare for the resumption of pre-PHE rules. Assurance has been given from Milliman that rates would then be recalculated. CMS expects states to complete all pending eligibility and enrollment actions and clear any backlogs within six months after the PHE ends.

MOTION BY NENA SORK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR FEBRUARY 2022; SUPPORT BY JOANIE BLAMER. MOTION APPROVED BY CONSENSUS.

Self-Determination
Mr. Kurtz stated that in mid-December the Self-Determination Policy and Implementation Guide were rolled as final; he stressed that only the policy was vetted through the joint CFI/PIHP contract negotiations workgroup. Mr. Kurtz raised this topic during a PIHP CEO meeting; the majority of the CEOs were under the impression that the Implementation Guide was not in the MDHHS-PIHP contract and was, at best, a "guide" and "best practice" and not held by policy (one concern is that fiscal intermediaries are a grievable service). A workgroup has now been resurrected with Mr. Kurtz and Lori Fischer to be included.

During the Regional Finance Committee Meeting on April 13th, Self-determination vs. Contracted rates for the same services was discussed. Northern Lakes has some cases for which state-level advocates are pressuring her to move the budget values equal to contract values in self-determined arrangements. Mr. Kurtz indicated that the hourly wages in Self -Determination arrangements should be similar, but that rates and wages are two different things. Mr. Johnston stressed that rate setting must follow procurement rules.

FY22 Budget Stabilization
Mr. Kurtz asked whether the Boards are planning any mid-year retention payments or cost of living increases for staff given the current rate of inflation.

- AuSable Valley – Ms. Pelts reported that two lump sum payment for staff are planned on off-payroll weeks ($750) and a 3% COLA recently went into effect.
- Centra Wellness – Mr. Johnston reported that providing mileage reimbursement to/from the office is being discussed and a 4% salary increase was implemented this month.
- North Country – Ms. Gebhard reported that some form of retention is planned but she did not provide specifics.
- Northeast Michigan – Ms. Sork reported that a year-end retention payment and/or retirement contribution is being considered.
- Northern Lakes – Ms. Blamer reported that a recommendation for a one-time retention will likely come forward in May or June.

NMRE Mid-Year COLA/Retention
Mr. Kurtz indicated that he will be proposing a midyear COLA for NMRE staff to the NMRE Board this month.

Regional CFO Bench
Ms. Gebhard reported that North Country will have a vacant CFO position beginning April 25th; plans are underway to bring in Rehmann on an interim basis (6 months). The suggestion was made for the NMRE to recruit for a "pinch hitter" CFO position; this person would work for NMRE and provide assistance and expertise to the Boards when needed. The additional staff would allow the region to conduct more financial management and forecast projections.

MOTION BY CHIP JOHNSTON TO AUTHORIZE THE NORTHERN MICHIGAN REGIONAL ENTITY TO RECRUIT AND HIRE AN ADDITIONAL FINANCE STAFF TO ACT AS A

SURROGATE CHIEF FINANCIAL OFFICER FOR THE REGION; SUPPORT BY NENA SORK. MOTION APPROVED BY CONSENSUS.

REGIONAL RECRUITMENT POSITION

Mr. Kurtz expressed that he would like the NMRE to act as a regional recruiter based on CEO conversations from the recent Directors Forum; he is currently working out the details with the NMRE Human Resources Manager. A Regional Job Bank would be developed, in addition to outreach to develop internship programs, etc. The Boards were in favor of this approach.

Ms. Blamer noted that she is speaking with Munson Healthcare about putting Northern Lakes workers in their Emergency Department.

CARTER KITS BOARD DAY

The distribution of the available Carter Kits will occur during the NMRE Board meeting on April 27th. Six individuals plan to attend in person and four virtually. A Teams link will be sent to the Boards. Training will occur from 1:00PM – 2:00PM. Andrew Keller, Carter Kits Vice President of Advertising, Communications, and Marketing will arrange for media. Ms. Gebhard added that she will also contact Deb Freed of Freed Communications.

PSYCHIATRIC BED REGISTRY

Mr. Kurtz shared that he attended a MiCARE engagement meeting on April 7th. It was noted that the Psychiatric Bed Registry Workgroup did not include all hospitals. Ms. Gebhard read an email from North Country's Chief Clinical Officer outline current concerns.

1) They want to require hospitals to use the MISMART medical clearance tool. Not all hospitals utilize this and there may be a possibility that not all insurances will cover the tests that are part of this assessment tool.
2) The registry is only accurate and effective if the hospitals are able to keep the information (bed availability) up to date and "live".
3) They reported that CMHs will only be able to refer to 3 hospitals at a time but that wasn't discussed in the NMRE presentation.
4) Each inpatient unit can mandate what each of their referral/intake packets looks like, and to have to use their specific form(s).
5) Will this system be running 24/7? Will hospitals be updating this information 24/7?
6) There are really no processes that have been developed for a statewide inclusive system like this.
7) Communication, education, piloting, and implementation information have been minimal at best.

Mr. Kurtz was asked by MDHHS to scheduling a meeting with the five regional CEOs; Mr. Johnston refused. Consensus was reached that, although the initial intention of the registry in an effort to secure inpatient placements was a good one, the process has become overly complicated.

1513 INPATIENT TIERED RATE WORKGROUP

Jackie Sproat reported on the 1513 Inpatient Rate Workgroup during the April 7th PIHP CEO meeting. Mr. Kurtz explained how the process works on the physical healthcare side. He asserted that this is not achievable in the rural north at the rates currently being proposed. Mr.

Kurtz and NorthCare CEO, Tim Kangas, will be jointly working on a memorandum to the Department.

SOM STRATEGIC PLAN

The State of Michigan Strategic Plan for FY 2023 – 2027 was included in the meeting packet for informational purposes.

SIS

During the April 7th PIHP CEO meeting, Belinda Hawks shared that Michigan is moving to mandatory implementation on the Supports Intensity Scale (SIS) for those age 16 and over. In the state's 1915(i) application, MDHHS points to the SIS as the eligibility assessment tool it will use to make determinations for that benefit.

PRTF SURVEY

CMHSPs were recently asked by MDHHS to complete a survey to estimate their use of Psychiatric Residential Treatment Facilities for children and adolescents.; Mr. Kurtz didn't respond.

OTHER

House Bill 5175 Ability to Pay legislation was reported out of the Senate committee last week. Mr. Johnston suggested that if it fails to pass, Federal Ability to Pay guidance be used.

NEXT MEETING

The next meeting was scheduled for May 17th at 9:30 am.

NORTHERN MICHIGAN REGIONAL ENTITY

INFORMATION TECHNOLOGY SECURITY ASSESSMENT

BOARD OF DIRECTORS REPORT
JANUARY 2022

PROVIDED BY:

OPEN SYSTEMS TECHNOLOGIES

An Information Technology Security Assessment was conducted for Northern Michigan Regional Entity on the 25th of January 2022. This report summarizes the ratings and recommendations related to this assessment.

Fifty-Six (56) network devices were comprehensively scanned using a variety of tools. The team has determined that 24 high/critical vulnerabilities exist within the NMRE network environment. A weighted vulnerability index of 0.345 has been assigned and a determination has been made that the exploitability related to the reported vulnerabilities is “Elevated”.

OST has provided the organization with detailed recommendations and information on how to reduce the risks that were identified from this assessment process.

Overall, NMRE has been assigned a security rating of 7.1. A potential rating of 8.5 is possible. Improvements to the Final Security Rating will occur as IT related risk is removed from the organization.

A Periodic Security Assessment is scheduled for January 2023.

Sincerely,

W. Scott Montgomery
Security Practice Manager
Open Systems Technologies

INFORMATION TECHNOLOGY SECURITY ASSESSMENT

JANUARY 2022

FINDINGS AND RECOMMENDATIONS

1

Northern Michigan Regional Entity

Presentation Agenda

- Findings and Recommendations
- Discussion
- Information Technology Security Assessment Project Sign-off

2

Findings and Recommendations

This presentation provides a summary of the activity that was performed as part of the Information Technology Security Assessment.

Specific technical details have purposely been left out of this presentation.

Please refer to the accompanying USB Flash Drive for all detail related to the information presented here.

3

Acknowledgements

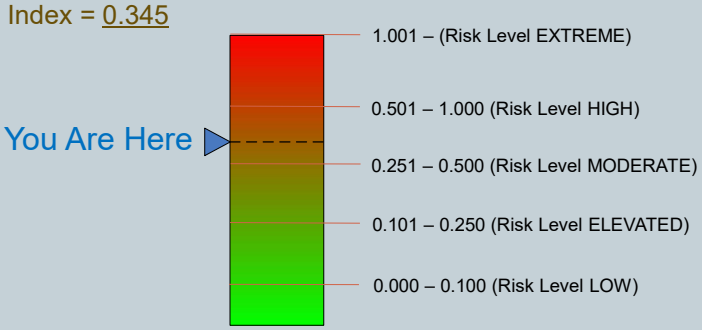
- Guest wireless is properly isolated from production.

4

Findings and Recommendations

24 High/Critical Vulnerabilities identified on 56 IP Addresses

Vulnerability Index = 0.345



5

Findings and Recommendations

Security Issues

- Account separation issues with the domain administrators' groups.
- Two administrator accounts are assigned weak passwords.
- Default administrator credentials on network devices (Yealink phones and one Tripp Lite UPS).
- HP ILO reports multiple vulnerabilities.
- Unsupported version of SQL Server.
- Weak network service configurations (TCP/IP ISN issue and SNMP community string).
- IPMI service is vulnerable to password hash disclosure.
- SSL version 2 and 3 is used.
- Authenticated scanning identifies missing Microsoft January 2022 Security Updates and missing updates for Microsoft Office and Oracle Java.

6

Findings and Recommendations

Virus Protection

Antivirus software was detected and up-to-date on each system.

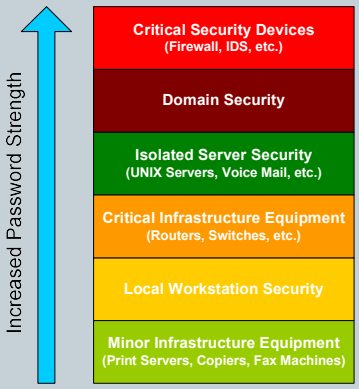
7

Findings and Recommendations

Classification

Provide unique passwords at all security levels within an enterprise.

Strong passwords should be used at all levels, but should also increase in complexity as the device(s) becomes more critical to overall security.



8

Findings and Recommendations

SpyWare

Spyware (Malware) protection: Workstations with internet access are prone to spyware infection. Spyware is quickly becoming a serious issue and is difficult to block. Spyware detection and removal tools are necessary to reduce the risk from this new threat.

Spyware can cause a wide variety of issues from slow, sluggish computer operation to key-logging.

Antivirus and web filtering installations are working to reduce this security threat by blocking and detecting many SpyWare variants.

9

Findings and Recommendations

External Exposure

No High or Critical vulnerabilities identified.

10

Findings and Recommendations

System/Software Updates

Organizations should ensure that all operating systems, applications, and network devices are up-to-date and supported by the vendor.

100% of reviewed workstations and servers are running supported versions of their operating systems.

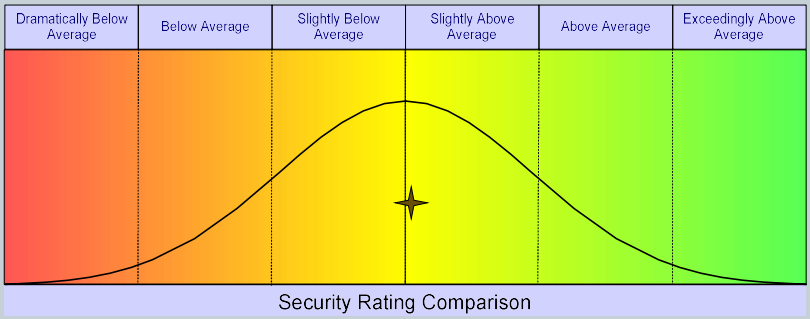
11

Final Security Rating

Final Security Rating

12

Statistical Distribution



When compared to the overall security of similar organizations, you are rated Slightly Above Average.

13

Potential Security Rating

Final Security Rating can be increased upon implementation of recommendations shown on the next slide.

14

Recommendations (Prioritized)

- Ensure proper account separation for all employees that are provided administrator level accounts.
- Require that all administrator level accounts are assigned strong complex passwords.
- Install the latest HP ILO updates.
- Update the Microsoft SQL Server to a supported version.
- Update the manufacturer default passwords on the Yealink phones and the reported Tripp Lite UPS devices.
- Review authenticated scanning reports and install updates as reported. Microsoft Office updates, Microsoft January Security Updates, Oracle Java updates, etc.
- Work with Honeywell to resolve the TCP/IP ISN issue on the NetAXS-123 device.
- Change the SNMP Community String from "Public" to a unique variable.
- Configure all devices that us SSL protocol version 2 and 3 to use TLS version 1.2 or higher.

15

Recommendations (Advisable)

- A Periodic Security Assessment is scheduled for January 2023.

Optimum security can be achieved by implementing these recommendations.

16

Discussion

17

Project Sign-Off

- Sign-Off document provides authorization for OST to close this project.
- Communicates satisfaction with project deliverables.

18

Conclusion

- Next steps?....

Thank You

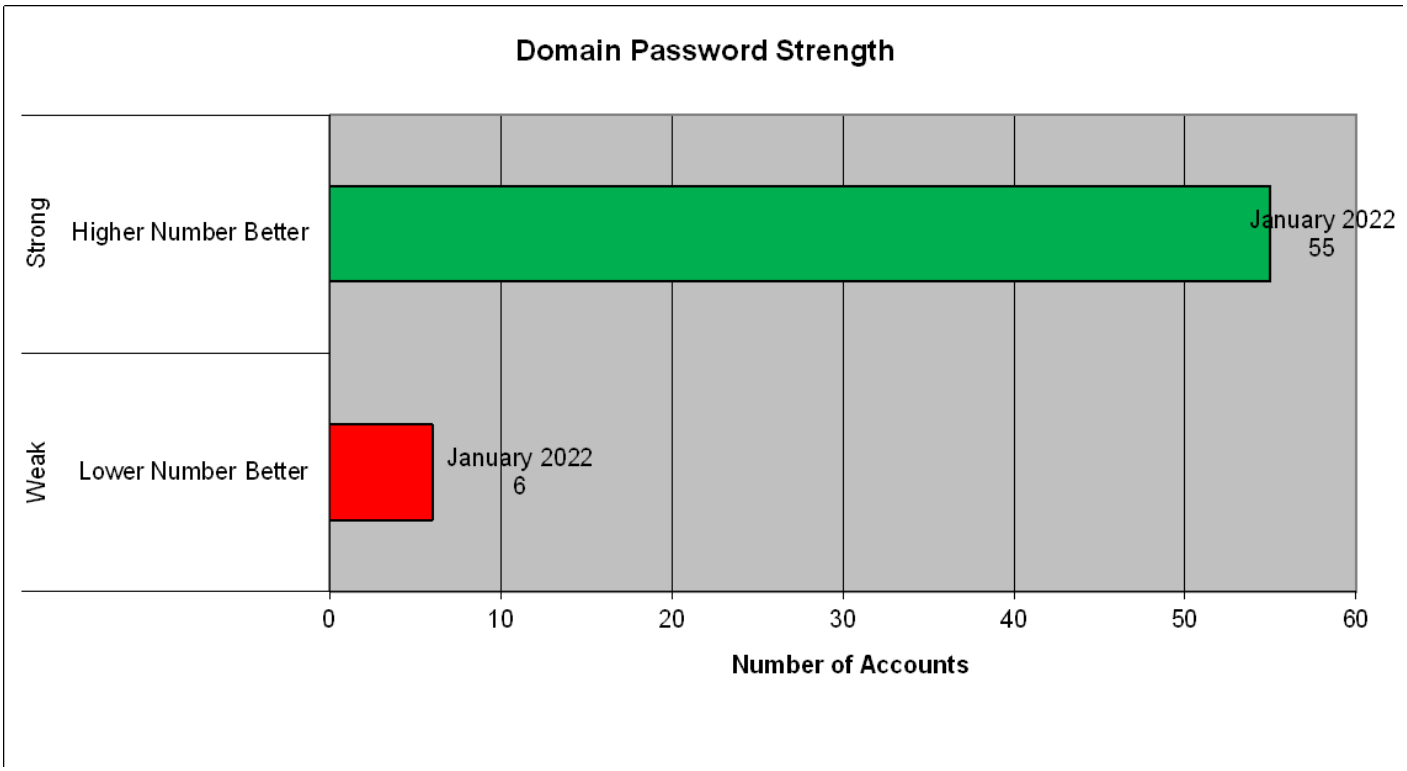
19

The following ratings have been assigned to the organization based on the information gathered and analyzed during this assessment process.

Password Strength

Security Risk Level Elevated

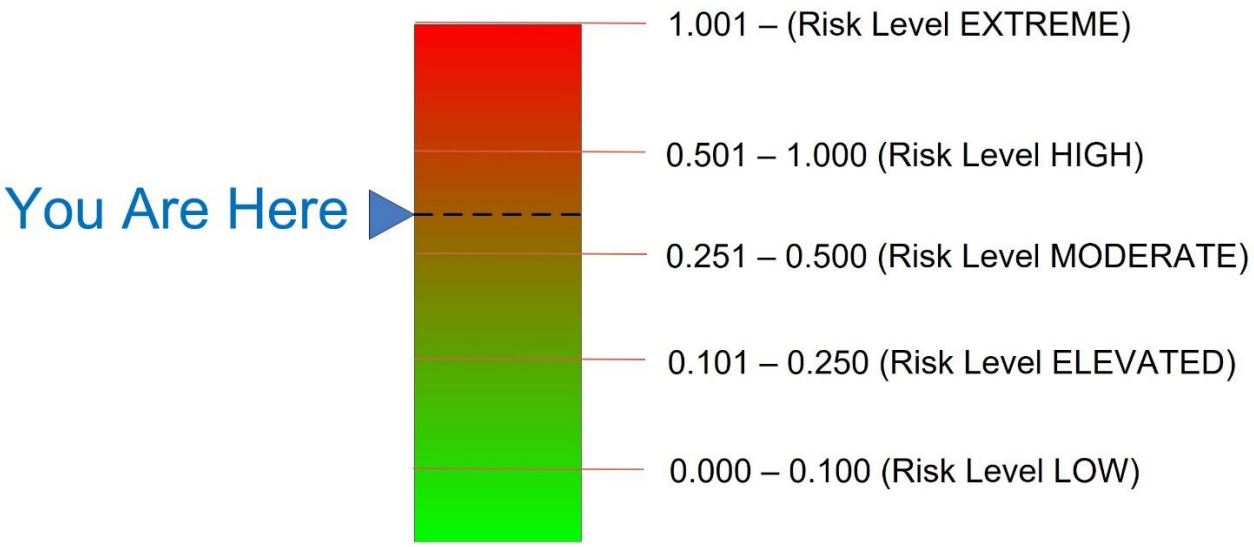
Password Strength History



Physical Security

Security Risk Level Low

System Vulnerability Index (Current 0.345)

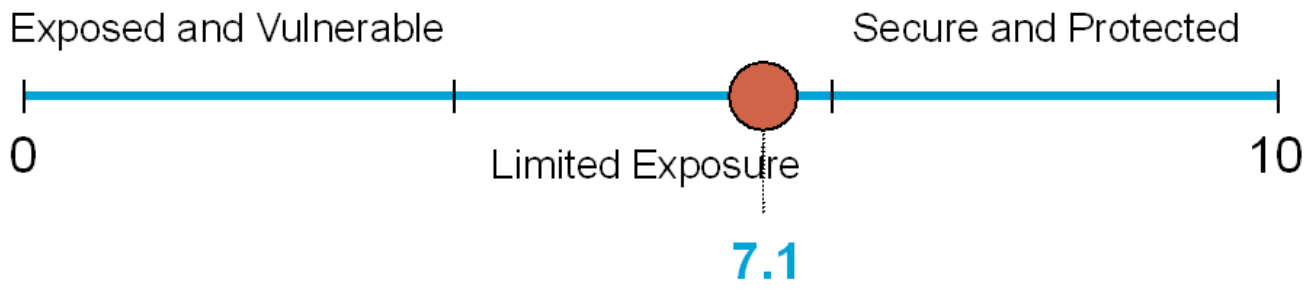


Exploitability

Wireless Networking Risk

MalWare/Zero-Day Virus Risk

Final Security Rating (Possible Maximum Rating of 8.5)



Comparative Results by Industry