Northern Michigan Regional Entity

Board Meeting

February 23, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

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3.	Pledge of Allegiance	
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5.	Approval of Agenda	
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11.	New Business	
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12.	Old Business	
	b. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest	Pages 84 – 85
13.	Presentation/Discussion	
	Substance Use Disorder Prevention Coalition Updates	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – March 23, 2022	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – JANUARY 26, 2022
GAYLORD BOARDROOM

ATTENDEES:	**Roger Frye, Ed Ginop, Randy Kamps, Terry Larson, Christian Marcus, Gary Nowak, Jay O'Farrell, Justin Reed, Richard Schmidt, Karla Sherman, Don Smeltzer, Joe Stone, Don Tanner**
VIRTUAL ATTENDEES:	**Gary Klacking (West Branch), Mary Marois (Destin, FL)**
NMRE/CMHSP STAFF:	**Joanie Blamer, Eugene Branigan, Christine Gebhard, Chip Johnston, Eric Kurtz, Tema Pefok, Diane Pelts, Sara Sircely, Nena Sork, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Dave Freedman, Jim Harrington**

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

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

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

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

APPROVAL OF AGENDA
Let the record show that Annual Compliance Training added to the Agenda.

MOTION BY JOE STONE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR JANUARY 26, 2022 AS AMENDED; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

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

MOTION BY ROGER FRYE TO APPROVE THE MINUTES OF THE DECEMBER 22, 2021 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY GARY NOWAK. MOTION CARRIED.

CORRESPONDENCE
1) The minutes from the January 6, 2022 PIHP CEO meeting.
2) The minutes from the January 10, 2022 Directors Forum meeting.
3) CMS staff vaccination requirements infographic.
4) Michigan Psychiatric Care Improvement Project (MPCIP) December 2021 Update.

5) Michigan Integration Efforts January 2022 Update.
6) Memorandum from Audra Parsons at MDHHS dated January 11, 2022 regarding the Managed Care Program Annual Report (MCPAR).
7) Memorandum from Jeffery Wieferich at MDHHS dated January 7, 2022 regarding the Temporary Waiver of Child Mental Health Provider Qualifications.
8) The Health Safety Net Coalition's Recommended Investments and Requests.
9) Letter to Bob Sheehan (CMHAM) from Jeffery Wieferich (MDHHS) dated January 5, 2022 regarding the halt in participation in Standard Cost Allocation workgroups.
10) Photographs of Michigan's Medicaid Health Plan offices versus Community Mental Health Services Providers titled "A Picture Is Worth a Thousand Words."
11) Draft minutes of the January 12, 2022 NMRE Regional Finance Committee meeting.

Mr. Kurtz drew attention to visual comparison represented in the photographs titled "A Picture Is Worth a Thousand Words."

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 December Board Meeting.

CEOs Report
The NMRE CEO Monthly Report for January 2022 was included in the materials for the meeting on this date. Mr. Kurtz noted that he and NMRE Managing Director of Substance Use Disorder Services, Sara Sircely, presented on the Opioid Health Home to the Northern Lakes CMHA Board on January 20th. Mr. Kamps thanked Mr. Kurtz and Ms. Sircely for the well-organized presentation.

Financial Report
November 2021
- Traditional Medicaid showed $33,635,159 in revenue, and $28,596,944 in expenses, resulting in a net surplus of $5,038,215. Medicaid ISF was reported as $9,298,750 based on the interim FSR. Medicaid Savings was reported as $11,296,664.
- Healthy Michigan Plan showed $5,294,270 in revenue, and $3,738,856 in expenses, resulting in a net surplus of $1,555,414. HMP ISF was reported as $7,059,746 based on the interim FSR. HMP savings was reported as $5,061,832.
- Net Position* showed net surplus Medicaid and HMP of $6,593,629. Medicaid carry forward was reported as $16,358,496. The total Medicaid and HMP Current Year Surplus was reported as $21,510,645. Medicaid and HMP combined ISF was reported as $16,358,496; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $37,869,141.
- Health Home showed $186,406 in revenue, and $151,675 in expenses, resulting in a net surplus of $34,731.
- SUD showed all funding source revenue of $3,835,348, and $2,915,418 in expenses, resulting in a net surplus of $919,930. Total PA2 funds were reported as $5,949,601.

The direct care wage surplus was reported as $1.4M.

Mr. Kamps commented that the region should be creating spending plans for surplus funds to avoid a lapse to the State. Mr. Kurtz responded that “FY22 Budget Stabilization” is a current standing Operations Committee meeting Agenda item for discussion. Ms. Gebhard noted that she would like to hire additional staff, but recruitment efforts have been fruitless. Ms. Sherman acknowledged the need to have competitive wages/salaries and benefits. Mr. Marcus expressed frustration with the lack of communication from MDHHS and not knowing what’s in the mid-year supplemental budget adjustment. Mr. Russell stressed the need for affordable housing in Grand Traverse County. Mr. Kamps emphasized the need to enhance the status of the behavioral health industry in terms of its value to society. Mr. Russell added that outreach to educational systems is needed.

Mr. Marcus referred to the January 10th Directors Forum Meeting minutes announcing the movement of five BHDDA positions to the newly formed Health and Aging Services Administration (HASA); he asked whether this would affect our system in a positive way regarding administrative demands. Mr. Kurtz responded that moving the BHDDA staff over to Medicaid will not likely help with the administrative demands; overregulating paperwork/billing requirements, etc. were cited as deterrents to working in behavioral health. Mr. Kamps requested a list of “stupid rules” to which the PIHPs/CMHSPs are being held so that he can present it to his legislators.

Mr. Stone asked how the FY22 revenue/expenses compare to the budget. Ms. Yockey responded that, at two months into the fiscal year, revenue is $400K above Q1 FY21. Mr. Stone asked whether something can be done now (rather than the end of the year) to get spending plans in place. Ms. Gebhard responded that the Operations Committee is working on implementing crisis residential units within the NMRE Region; bids have been issued to remodel a home in Gaylord to meet this need.

MOTION BY ROGER FRYE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2021; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Operations Committee
The minutes from January 18, 2022 were included in the materials for the meeting on this date. Mr. Kurtz explained that the 1915(i) waiver will authorize the provision of Home & Community Based Services to Medicaid beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability; the potential impact to Region 2 was provided as approx. 2800 individuals.

Mr. Kamps asked what can be done to increase enrollment in the Behavioral Health Home; Northern Lakes CMHS currently has 75 individuals enrolled (18,000 potential eligible enrollees have been identified regionwide.) Mr. Johnston referred to the “Health Safety Net Coalition Requests” included in the meeting packet under “Correspondence;” he noted no funding was requested to expand the Behavioral Health Home. In contrast, millions in additional funding were requested for the Certified Community Behavioral Health Centers (CCBHC). According to a report on expenditures from CMHAM, CCBHC is overspent $3.8M as of December 31, 2021. The BHH is a model that works in rural areas and is creating local dollars.

NMRE SUD Oversight Board Report

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

NEW BUSINESS
Let the record show that there was no New Business on the Agenda for the meeting on this date.

OLD BUSINESS
BHH TCM vs. CSM
TCM and BHH Guidance from Lindsay Naeyaert dated January 19, 2022 was included in the materials for the meeting on this date. It was concluded that TCM and BHH do have service overlap but are not wholly duplicative; meaning, BHH and TCM can be billed in the same month. Specific services were identified that cannot be billed to both TCM and BHH in the same calendar month.

The NMRE will likely need to more closely monitor Individual Plans of Services to ensure that there is no overlap of services being provided by the BHH.

Senate Bills/Northern Michigan Counties Association (NMCA) Meeting
An email from Alan Bolter (CMHAM) dated January 14, 2022 announcing Sen. Shirkey's expected attendance at the NMCA meeting on February 7th was included in the materials for the meeting on this date. The recipient rights components included in SB 598 were discussed.

PRESENTATION
NMRE Chief Compliance and Quality Officer, Tema Pefok, was in attendance to provide updates to the Board on the NMRE's Quality Assessment and Performance Improvement Program (QAPIP) and Compliance Workplan and provide the Board's Annual Compliance Training.

FY21 Quality Assessment and Performance Improvement Program (QAPIP) Review and FY22 Workplan
Ms. Pefok provided a summary overview of the NMRE's FY21 QAPIP and the Goals and Objectives in the FY22 Workplan.

FY22 QAPIP Workplan Goals	Objectives
1. The NMRE will conduct Performance Improvement Projects (PIPs) that will include ongoing measurements and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that are expected to have positive impact on health outcomes and member satisfaction.	1. The NMRE Data Analyst will continue to collect ADHD data and share with the CMHSPs to conduct analysis and follow-up with individuals that meet criterial This data will be discussed quarterly with the Compliance and Quality Oversight Committee (QOC) to identify areas for improvement. 2. The Compliance and Quality Team will work with HSAG and MDHHS to identify an new PIP starting FY22.
2. The NMRE Compliance and Quality Team will work with IT and QOC to develop a standardized method to collect data on risk events and sentinel events.	1. The NMRE Compliance and Quality Team will draft a form that will be used to collect risk event data from the CMHSPs. 2. The NMRE Compliance and Quality Team will share the Risk Event Reporting form with the CMHSPs and continue to educate them on how to complete the form and the importance of this activity.

	3. The NMRE Compliance and Quality Team will review the reporting process and requirements of the vent data with the Providers to avoid under reporting. 4. Through the annual site review process, the Compliance and Quality Team will check to assure that interventions are improving patient safety. This will be done by reviewing the data submitted, which will include the number of events. 5. The analysis of Sentinel Events, Critical Incidents, and Risk Events will include a review of data per event type per 1,000 members to complete a comparative analysis and trend these data over time.
3. The NMRE will continue to conduct quantitative and qualitative assessments of member experiences with services. These assessments will be representative of the persons served and the services and supports offered.	1. The NMRE will revise survey questions to assure the right questions are asked and that the questions are returning meaningful data. 2. The NMRE will work with Providers to identify ways to implement surveys in a way that will not cause survey fatigue amongst participants. 3. The NMRE will take specific actions on individual cases of the survey results, as appropriate. 4. Survey results will be shared with the QOC to discuss and identify possible solutions to resolve areas of dissatisfaction on an ongoing basis.
4. The NMRE will measure its performance using standardized indicators based on the systemic, ongoing collection and analysis of valid and reliable data.	1. The NMRE QOC will monitor comparative provider performance of quarterly MMBPIS measures within 30 days of the quarterly report from MDHHS. 2. The NMRE will share performance data with the CMHSPs for their review. These data will be discussed quarterly by the QOC. 3. The NMRE QOC will continue to monitor the impact of removing exceptions for Performance Indicators Tables 2 and 3.
5. The Compliance and Quality Team will continue to monitor its Provider Network at least annually.	1. The NMRE will coordinate and conduct site reviews annually for all contracted services providers. 2. The NMRE will monitor and follow-up with Corrective Action Plans (CAPs) to assure that they are being implemented as stated by Providers. 3. The NMRE QOC will receive regular updates from the providers on the progress of the site review CAPs. 4. The NMRE will perform quarterly audits to verify Medicaid and Health Michigan Plan

	claims/encounters submitted by Providers. This will include verifying data elements from individual claims/encounters to ensure proper codes are used.
6. The NMRE will update and improve its Provider Directory and work with Providers in the region to update their Directories accordingly.	1. The NMRE will gather information from its Providers about physical accommodations such as ramps, restrooms, electronic doors, exam rooms, etc. specific to each location. 2. The NMRE will create a more user-friendly interface; rather than a spreadsheet platform, the NMRE will include drop-down options, more visible links to CMHSP pages, and maps with travel distances.
7. The NMRE will update and improve its Network Adequacy Plan to include time/distance standards within the region.	1. The NMRE will create a report that will allow users to determine mileage rom a geographic location to a Provider site using Network Adequacy Standards for each individual mental health and SUD services provider. 2. Once the NMRE's Network Adequacy Plan is in place, it will be made accessible to the public through its website.
8. The NMRE Compliance and Quality Team will conduct quarterly reviews and analysis of data from the CMHSPs where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.	1. The NMRE will monitor that only techniques permitted by the Technical Requirements for Behavior Treatment Plans that have been approved during person-centered planning by the member and his/her guardian may be used through the annual site review process. 2. The NMRE QOC will oversee the operations of the behavioral health treatment operations by reviewing data and trends. 3. The NMRE QOC will quarterly review/discuss behavior treatment data; this includes trend analyses received from individual CMSHPs.
9. The NMRE will continue to improve the process to provide quarterly updates to the Governing Body regarding QAPIP activities.	1. QAPIP activities will be reviewed and evaluated by the NMRE QOC quarterly. 2. The QAPIP quarterly evaluation report will be shared with the NMRE Governing Board.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY FISCAL YEAR 2021 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM SUMMARY AND THE FISCAL YEAR 2022 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM WORKPLAN; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

Review of FY21 Compliance Summary and FY22 Compliance Workplan
Ms. Pefok provided a summary overview of the NMRE's FY21 Compliance Program and the Goals and Objectives in the FY22 Workplan.

Board Annual Compliance Training for FY22
Ms. Pefok provided that Board with its Annual Compliance Training for 2022. The training objectives were stated as:

- Understand the purpose of the Compliance Program
- Describe key elements of the Compliance Program
- Understand safeguards around confidential information
- Understanding the role of Board Members with respect to identifying and reporting compliance issues/concerns.

COMMENTS

Board

- Mr. Stone reminded Board Members to watch the Governor's State of the State address later on this date.
- Mr. Stone noted that a recent CMHAM Zoom meeting was hacked; attendees will now be required to wait in the virtual lobby before being admitted to meetings.
- Mr. Frye voiced support for Canadian truckers opposing a cross-border vaccine mandate.

Staff/CMHSP CEOs
Ms. Gebhard announces that she will be retiring from her position as CEO of North Country CMHA effective July 1, 2022.

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

ADJOURN
Let the record show that Mr. Tanner adjourned the meeting at 12:04PM.

PIHP CEO Meeting
February 3, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

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Strategic Behavioral Health Integration and Coordination Initiatives.....
SUD Capacity 1003 Demonstration Update.....
System Transformation Update.....

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
Audrey Dick
Belinda Hawks
Larry Scott
Jackie Sproat
Jon Villasurda
Jeff Wieferich
Krista Hausermann
Brenda Stoneburner
Allen Jansen
Michelle Derose
Steven Schreier
Wendell Thompson
Price Pullins
Jody Lewis

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

Dashboard Presentation

1. Steven Schreier and Wendell Thompson presented a dashboard page that is in development.
    a. The dashboard will be able to show different views of the data for each PIHP and can be sorted out demographically or geographically.
2. The PIHPs asked the source of the data.
    a. MDHHs answered that the data came from encounters submitted; MDHHS has an agreement with TBD Solutions to access the data warehouse to pull the information needed to create this dashboard.
3. The PIHPs noted that the penetration rate seemed low and asked if the data set included all populations served, including SUD.
    a. Steven Schreier said that he believed it to be all populations but said he would validate that.
4. The PIHPs asked if multiple months could be selected, or just one.
    a. Wendell Thompson responded that it was just one month right now.
5. The PIHPs noted that some of the dashboard may be similar or the same as the Milliman Drive Tool. They asked if there were any collaborative communications between the developers of this Dashboard and the Milliman Drive developers.
    a. MDHHS said that it was a good inquiry, but that there was not.
    b. MDHHS proposed touching base with Josh at TBD solutions about it.

MI Kids Now

1. A written update was shared with the group via email.

Status of Afghan Arrivals Resettling in MI

1. Price Pullins provided an update on the numbers of Afghan arrivals who have resettled in Michigan so far. Approximately the same number of individuals are still in the process, so the number of arrivals fully resettled should double in the next few months.
2. A PIHP asked if Genesee County was no longer under consideration for receiving new arrivals, as that was not on the list of locations.
    a. Price Pullins recommended asking the person running the list.
3. A PIHP asked what, if anything, the team had observed regarding the behavioral health needs of the new populations.
    a. Price Pullins responded that he had heard of significant needs early on. Over the last reporting period, he has not heard of as many significant needs. The population has been receiving support from University of Michigan and Michigan State University medical schools. A professor at MSU, Dr. Alavi, has been helping with cultural nuance to prepare families to make the transition and navigate cultural changes.

Quality Management Updates

1. Belinda Hawks provided the Quality Management update.

a. There is a free case manager e-learning course, "Supporting a Vision for Employment" under Brenda Stoneburner's section. The email about this course was sent out around January 21, 2022. The first class starts February 21 and runs through March 18, 2022. There will be three more e-learning rotations in late July.
b. The MI CAL CRM process is being designed to take critical incident reports. This will allow critical incidents to transition away from the current platform and be supported under the CRM platform. The date MDHHS is aiming for is October 2022, but they are working through the design and flowchart process now.
c. The public comment relating to heightened scrutiny will publish both residential and non-residential providers on the heightened scrutiny list. This public comment will start with Mid-State Health Network only, and then the rest of the state will be conducted afterwards. MDHHS hopes to begin this process in late February or early March 2022.
d. The first kickoff meeting for conflict-free access and planning (also known as conflict-free case management) was conducted. The focus for this kickoff was around the historical perspective when conflict-free first came to be in the federal rules and what the requirements were in 2014 and 2015.
    i. The meeting also discussed safeguards, procedural steps to take within an organization to ensure it is conflict-free, and firewalls, which is having a separate entity provide that decision-making around treatment and planning.
    ii. The group hopes to have monthly meetings, though the remainder of the year has not yet been scheduled.
    iii. Belinda Hawks pledged to share the PowerPoint presentation that will accompany each workgroup as they are available.

1115 Waiver Update

1. Jon Villasurda reported that for the SUD Health IT Plan, MDHHS has created a filter path as part of the SUD user role in Care Connect 360. This filter path will allow a user to select one or many specific Substance Use diagnoses and then filter by other demographic and geographic categories within that view. This is currently in the quality testing environment.
    a. The PIHPs asked if this user role was intended for the PIHP level, or for clinicians downstream.
        i. Jon Villasurda responded that the user role was at the PIHP level, allowing the PIHPs to see utilization for any SUD service; it would only be available downstream if the PIHPs were to provide someone with that delegated role.

MPCIP & MI CAL Update

1. A written update from Krista Hausermann has been distributed to the group via email.
    a. Krista Hausermann shared that the medical clearance work continues to move ahead; it is slowed somewhat due to COVID-19, but more entities are expressing interest in it. The difficulty now is with the staffing needed to implement the change.

b. MI CAL and 988 have begun to roll out across the state; MDHHS has now coordinated with Region 3 and is working with Region 10. MDHHS plans to go live with Region 10 at the end of February 2022 and begin work with Region 2 in March 2022. MDHHS is not currently rolling out after-hours coverage.
    i. After discussions and feedback from SAMHSA and Vibrant, MDHHS will need to take the leadership role with all centers that will be answering 988, regardless of if MDHHS is providing funding or has a contractual relationship with them. Current National Suicide Prevention Lifeline (NSPL) centers are exceptions to this, as they already meet the requirements to have close coordination and to be able to activate crisis services.

Strategic Behavioral Health Integration and Coordination Initiatives

1. A written update from Jon Villasurda was distributed to the group via email.
    a. He shared that Behavioral Health Homes now have over 1000 people enrolled. MDHHS hopes to expand this into Region 6 and Region 7.
    b. He reported that MDHHS hopes to get all of Michigan onboarded to the Opioid Health Home service within fiscal year 2023.
        i. A PIHP asked about the timetable for standing that up, and when the PIHPs would expect to engage with MDHHS personnel on this.
        ii. Jon Villasurda answered that there have been preliminary conversations already, but that he would expect it to take a good six months as funding is organized.
    c. MDHHS is also piloting a full SUD health home in Region 2 with block grant funding, as Michigan does not currently have Medicaid authority to broaden the Opioid Health home to a SUD Health Home with Medicaid money.

SUD Capacity 1003 Demonstration Update

1. Jon Villasurda reported no major updates.

System Transformation Update

1. Allen Jansen reported that he had been working on an evaluation structure that they could use when asked to evaluate any proposals for system transformation. He had finished that and run it by Dr. Khaldun, and the two of them were interested in making it more of a public document, but then Dr. Khaldun left, and he went on medical leave.
    a. He meets with Director Elizabeth Hertel the week of February 7, 2022, and this document is on the agenda. He would like to see if the document reflects her views on what MDHHS feels it should be asking about with any proposal that moves forward.
    b. Once the conversation with Director Hertel is complete, he will see what can be done to include the PIHPs in the conversation.
    c. A PIHP asked if the evaluation tool would become a public document at some point after review and/or adoption by the executive office.

    d. Allen Jansen responded that that was where he had been headed, but that he does not know at this point if it will be made public or not. He said he feels good about the series of reviews that MDHHS will do and the questions they will ask of any proposals put to them.
2. Allen Jansen encouraged the PIHPs to contact both himself and Director Hertel if they have ideas about which they would like to speak directly to himself or Director Hertel. He said it is easiest to work through him, and not to hesitate if they would like to do that.
3. Allen Jansen reported that MDHHS had received a request to review one of the proposals: a very narrow review request from for the timeline of the proposal only.
    a. A PIHP asked for a general idea of how MDHHS had responded to the timeline inquiry.
    b. Allen Jansen could say only that they had made recommendations to extend a number of the timelines.
4. A PIHP asked if there were any proposals or considerations with or by Director Hertel to reduce the number of PIHPs.
    a. Allen Jansen could only say that the idea was at least implied in some proposals, but that there was no response from Director Hertel on it.

- MDHHS is continuing to work towards resolving the litigation under the KB v. MDHHS lawsuit and is engaged in ongoing negotiations with plaintiff's counsel.

- MDHHS has identified the following key goals for the overarching MI Kids Now initiative:
    - Ensure that critical services and supports are available to children, youth, young adults and families in every community. Build on the existing service array to expand access to services, such as mobile intensive crisis stabilization services.
    - Standardize screenings, evaluations, and assessments.
    - Strengthen and expand care coordination (utilizing High Fidelity Wraparound).
    - Ensure individualized plans of care that put the unique needs and strengths of each child, youth, young adult and family first.
    - Increase children, youth, and family engagement in system design
    - Improving monitoring and accountability:
        - Collect and analyze data to (1) determine how well the system is performing and (2) identify areas for improvement.
        - Create a user-friendly dashboard to inform stakeholders about (1) the number of children, youth and young adults being served, (2) the services that they receive, and (3) the outcomes of those services.

- MDHHS has also convened a Leadership Team and several workgroups to assist with the development of the MI Kids Now Initiative. The workgroups are as follows:
    - Service Access, Array, and Care Coordination
    - Screening and Assessment
    - Workforce Development and Training
    - Data Collection and Quality Monitoring
    - Communications

- From November 8 through 17, 2021, MDHHS hosted a series of nine stakeholder engagement feedback forums with behavioral health partners and Michigan families.
    - MDHHS is working to include the voices of the stakeholders and families in this initiative. The goal of the sessions was to collect feedback regarding the current state of behavioral health services in Michigan, specifically as it relates to crisis stabilization services, Fidelity Wraparound services, and peer supports.
    - The three main themes that emerged from the forums were (1) awareness of services, (2) access and consistency in service development, and (3) resources to support service delivery including funding and workforce.

- The Michigan legislature approved $30 million in General Fund for FY 22 for addressing new commitments under the settlement agreement. MDHHS is working towards implementing proposals to improve children's behavioral health services using the funding, which includes:
    - Expanding access to key home and community-based services such as mobile crisis and intensive crisis stabilization services
    - Investing in workforce development programs such as student loan repayment
    - Establishing additional support for children and youth who are ready to transition back to the community from a state hospital or residential treatment facility
    - Expanding mental health services available through Child and Adolescent Health Centers

email correspondence

From: Alan Bolter
To: Alan Bolter
Cc: Robert Sheehan
Subject: AG Nessel Opinion: Meeting Attendance Accommodations Required under ADA
Date: Friday, February 4, 2022 2:15:45 PM

I'm sending this as an FYI – I reached out to MAC to get their thoughts on this and will send out the response once I get it.

From: Christin Nohner <NohnerC@rwca.com>
Sent: Friday, February 4, 2022 8:53 AM
To: Alan Bolter <ABolter@cmham.org>
Subject: FW: AG Nessel Opinion: Meeting Attendance Accommodations Required under ADA

FYI

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FOR IMMEDIATE RELEASE:
Friday, February 4, 2022

AG Nessel Opinion: Meeting Attendance Accommodations Required under ADA

LANSING – Michigan Attorney General Dana Nessel released a new opinion today addressing open meeting requirements and attendance accommodations.

"It is my opinion, therefore, that the Americans with Disabilities Act and Rehabilitation Act require state and local boards and commissions to provide reasonable accommodations, which could include an option to participate virtually, to qualified individuals with a disability who request an accommodation in order to fully participate as a board or commission member or as a member of the general public in meetings that are required by the Open Meetings Act to be held in a place available to the general public," the opinion's conclusion states.

Last month, Sen. Jeff Irwin and Sen. Wayne Schmidt requested an opinion on how Michigan's Open Meetings Act (OMA) intersects with federal law when a person with a disability either serves on a body subject to the OMA or desires to fully participate in the meetings of such a body and requests an accommodation for their disability.

Their request stated, "[t]his is a matter of great urgency and importance as the allowance of local governments, as well as their boards and commissions, to meet virtually in response to the COVID-19 pandemic ended on January 1, 2022...Michiganians with disabilities and specific health conditions shouldn't have to risk their wellbeing to contribute to civic life in their communities."

The opinion analyzes both the OMA and federal laws that govern access to public meetings.

"Historically, the kinds of modifications that have been requested have addressed physical or communication barriers, which have been remedied by disabled ramps, closed captioning, and the like. It is crucial that efforts aimed at removing those types of barriers continue. But medical conditions that make physical presence dangerous or impossible highlight a different but equally important need, and physical-presence requirements such as those of the OMA present an equally troubling barrier—one that potentially excludes the disabled as effectively as the lack of handicapped accessible parking or a wheelchair ramp... Determining what reasonable modifications might remedy such a barrier is, also, a heavily fact-dependent inquiry that must be determined on a

case-by-case basis, considering the nature, location, and resources of a particular board or commission. (Some municipalities might have IT challenges, for example.) But because our boards and commissions already must, under the OMA, provide remote access and allow full participation for a member of the military, and because many of these boards and commissions have successfully gone wholly or partially virtual during the COVID-19 pandemic, it seems unlikely that a request for a hybrid approach of an in-person meeting and telephonic access or a virtual platform would result in an undue administrative or financial burden or constitute a fundamental alteration of a board's or commission's meetings," the analysis found.

"While this opinion will only be binding for state boards, it is my hope that local boards will use this guidance and ensure fair access to public meetings for those who require appropriate accommodations as we continue to navigate our way through the pandemic," Nessel said. "Government participation should include everyone in our state who wants to serve, not just those who are fortunate enough not to have disabilities."

The full opinion, No. 7318, is now available on the Department of Attorney General's website.

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Michigan Integration Efforts

February 2022 Update

Overview

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

Goals

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

Opportunities for Improvement

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

Behavioral Health Homes (BHH)

Overview

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

Current Activities:

- As of January 27, 2022, there are 1048 people enrolled:
    - Age range: 7-84 years old
    - Race: 22% African American, 73% Caucasian, 1% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- The State of Michigan budget allocated funding to expand behavioral health homes into two new PIHP regions. MDHHS is working on policy documents to expand in 2022.
- Regions are continuing to enroll eligible beneficiaries and working to expand health home partners to increase capacity to serve more beneficiaries.

Questions or Comments

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

Certified Community Behavioral Health Clinics (CCBHC)

Overview

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

Current Activities

- The CCBHC Demonstration started on October 1, 2021!
- All CCBHCs are provisionally certified and have submitted applications for full certifications. MDHHS staff are reviewing the applications and anticipate full certifications to be issued by March 1.
- The final CCBHC policy (MSA 21-34) and CCBHC Demonstration Handbook can be found on the CCBHC webpage MDHHS - Provider (michigan.gov)
- All technological systems met October 1st start date requirements. As of February 2, 2022, over 13,000 people are assigned to a CCBHC in the WSA. MDHHS is working with PIHPs and CCBHCs to make pertinent updates as needed.
- Final rates and implementation procedures have been submitted to CMS for approval. The Implementation Team has been engaging in ongoing technical assistance with CMS.
- An MDHHS marketing campaign is under development with plans to launch in February. Marketing is intended to increase awareness of the CCBHC model, eligibility, and services among the public and other community providers. Marketing will target the sixteen counties with demonstration sites.

Questions or Comments

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

Opioid Health Homes (OHH)

Overview

- Medicaid Health Homes are an optional State Plan Amendment under Section 1945 of the Social Security Act.
- Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration.
- Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.
- As of October 1, 2021, OHH services are available to eligible beneficiaries in 48 Michigan counties. Service areas include PIHP region 1, 2, 6,7, 9, 10 and Calhoun and Kalamazoo counties in region 4.

Current Activities

- As of February 1, 2022, 1,970 beneficiaries enrolled in OHH services.
- MDHHS has recently expanded OHH services to an additional nine counties within PIHP region 6, 7, and 10. Existing OHH's are expanding access with new providers and growing services for more beneficiaries.
- MDHHS is working on collaborating with many state agencies such as the Maternal and Infant Health division to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

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

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

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

Current Activities

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

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

- Shiawassee County is starting to see shared patient data in Azara DRVS. Implementation of the care management module is underway and Saginaw County is continuing to integrate the system into their practice.
- Providers are delivering more in person appointments to enrollees, but telehealth is still offered and preferred by some patients.

Questions or Comments

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

Michigan Psychiatric Care Improvement Project (MPCIP)

February 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

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.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption is occurring.
- 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.
- As of 2/1/22: Adopted/Accepted by: 39 Emergency Departments, 19 Psychiatric Hospitals, 13 CMHSPs. 21 more facilities are in the process of implementing.
- In the past month, MPCIP has started partnering with the Munson Healthcare, McLaren Bay Region, and UP Health System- Marquette.

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 BHDDA 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 Spring 2022. Staff recruitment is underway.
- MiCAL and the Michigan Warmline staff have had over 41,000 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 is rolled out in LRE, Region 3. It is rolling out in Region 10 at the end of February.
- MiCAL will roll out in Northern Michigan Regional Entity at the end of March.

BHDDA Customer Relationship Management (CRM) – Internal Business Processes

Overview

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

Current Activities

- Universal Credentialing (PA 282 of 2020): After initial information gathering through stakeholder meetings, BHDDA is defining overall project scope based on the legislation. MDHHS will reengage stakeholders in the next month or two.
- ASAM Level of Care Certification Development Process is live in Detroit Wayne and the Upper Peninsula.
- CMHSP Certification: This process is almost complete. Design work continues for an upload process for current CMHSP Certification data. Rollout plans and training are being discussed.
- Business Process development is starting on certification for speciality programs: homebased, ACT, intensive crisis stabilization, drop-in centers, clubhouse, therapeutic foster care, crisis residentials, and wrapaound

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 which was funded by Vibrant. An Implementation Plan was developed.
- Stakeholders provided feedback throughout the planning process. Workgroup meetings have focused 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

- Michigan's Official 988 Plan was submitted to Vibrant and SAMHSA on January 21st.
- MDHHS applied for a 988 Implementation Grant which was submitted January 31st.
- There is ongoing stakeholder advisory engagement through monthly updates.
- Operations workgroup meetings with current NSPL centers to develop common practices around NSPL requirements for things like support callers at imminent risk, active rescues, and follow-up supports.

- Coordination meetings between 911 and 988 have started.

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

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

Current Activities

- LARA is in the process of rolling out MiCARE statewide to all the psychiatric hospitals. There are 58 facilities. 70% attended the initial orientation.
- Onboarding date: All Psychiatric Hospitals will fully participate in MiCARE by June 30,2022.
- MDHHS is outreaching to 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.

CRISIS STABILIZATION UNITS

Overview

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

Current Activities

- Michigan CSU Model for adults has been drafted and approved by Workgroup.
- The Michigan Model is being tailored to the needs of Children and Families. Stakeholder meetings will be held in March.

- A small subset of the Stakeholder group is developing draft certification criteria for adults. It will be presented to the larger workgroup in early 2022 for their feedback. There is special attention being paid to congruency with funding requirements, licensing requirements of related services, and accreditation.
- Two meetings were held with rural stakeholders to obtain feedback on the Model and certification rules. One meeting was held with law enforcement and the other with a cross sector of stakeholders.
- PSC 'extensive research on best practices in other states is being incorporated in the model.
- PSC is looking at available statewide data to help determine capacity needs.

MOBILE CRISIS SERVICES

Overview

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

Target Date: Spring 2022

Current Activities –

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

QUESTIONS OR COMMENTS?

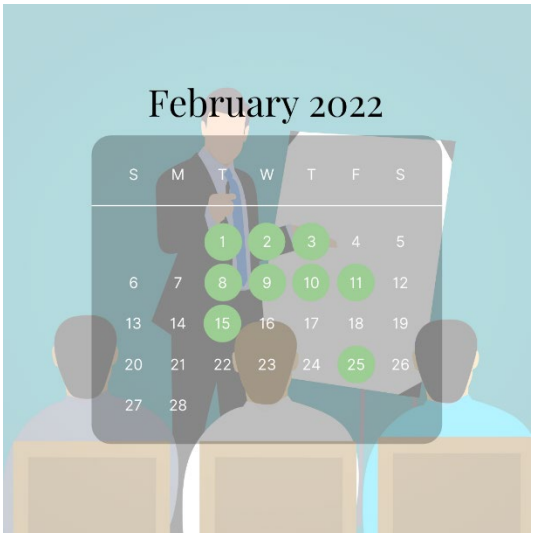
- Krista Hausermann (hausermannk@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Region 2 - MiCAL 988 Rollout Schedule

Rollout Activity	Purpose	Date	Audience
Leadership Discussion	Overview and scheduled plan for the rollout and training.	Tuesday, February 15, 2022 10:00 - 11:00 a.m.	Leadership & Key Staff
IT Administrator Guidance and Support Session	Refresh of previous training and opportunity for questions or issues.	Wednesday, March 9 3:00 - 4:00 p.m.	IT Administrators
Log-in Support Sessions	Help with accessing and navigating the CRM system.	Friday, March 11 9:00 - 10:00 a.m. Monday, March 14 10:00 - 11:00 a.m.	All staff, as needed.
Staff Training Session	Overview of the CRM system and the program requirements.	Wednesday, March 16 3:00 - 4:30 p.m.	All staff
Learning Labs	Support for those who have questions, need help in using the required components, or an opportunity to become more familiar with the system.	Thursday, March 31 10:00 - 11:00 a.m. Wednesday, April 6 3:00 - 4:00 p.m.	All staff, as needed.
Go-live Touch Base Meetings	Individual meetings with each CMHSP/PIHP to introduce the primary MiCAL contact and ensure coordination regarding afterhours procedures for activation of face-to-face crisis services.	Times will vary.	Key Contacts & primary MiCAL Contact
GO LIVE		**Thursday, March 31**	
Feedback Sessions	Gather feedback on the rollout to assist in process improvements.	Friday, April 8 11:00 a.m. - 12:00 p.m. Wednesday, April 13 3:30 - 4:30 p.m.	Leadership & Key Staff

CMHA Feb. 2022 Social Calendar

First Week:

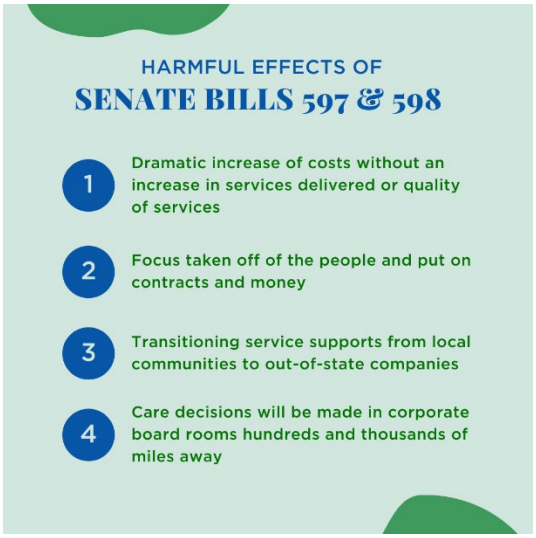


Copy: Keep up-to-date on our upcoming conferences and trainings by visiting https://www.cmham.org/education-events/conferences-training/

Second week:

Copy: Senate Bills 597 & 598 are dangerous, costly, and bad for Michigan residents. Click the link below to sign our petition opposing these harmful bills and to learn more. www.cmham.org/advocacy

Third week:



Copy: Senate Bills 597 & 598 are harmful to our local mental health communities because they put for-profit companies based outside of Michigan in charge. How do these companies know what our residents will need if they aren't based here? Learn more about these bills by visiting our website: www.cmham.org/advocacy

Fourth week:

Join CMHA and more than 100 other organizations in opposition of Senate Bills 597 & 598. Visit CMHA.org/Advocacy to learn more. You can also sign up for our action alerts to receive regular updates on policies that may impact public mental health services. #CMHA #commnitymentalhealth

Copy: Senate Bills 597 & 598 give more power to for-profit insurance companies that have limited experience in serving persons with mental health needs. To learn more about the dangers of these bills visit: www.cmham.org/advocacy

Copy: Senate Bills 597 & 598 are not right for Michiganders. Solutions must get at the root cause and address the areas of greatest need. This includes increasing overall access to care, adding more local providers, strengthening the workforce, and increasing inpatient care opportunities. To learn more, please visit www.cmham.org/advocacy

Copy: Organizations across the state of Michigan are standing up to oppose Senate Bills 597 & 598. To join in opposition, sign our petition at www.cmham.org/advocacy

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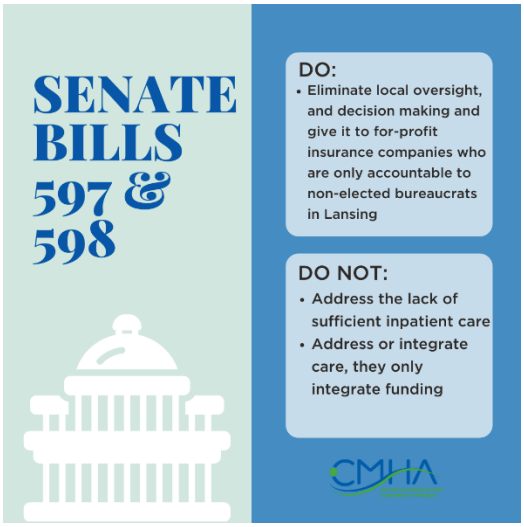
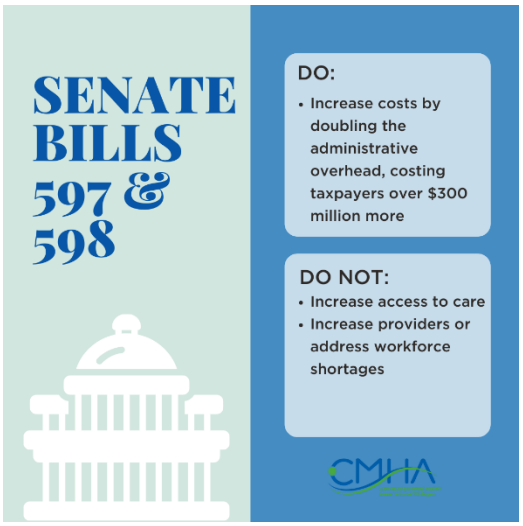


Copy: Senate Bills 597 & 598 are currently being discussed in the senate. We wanted to share some information on what these bills do and do not do. While they do integrate funding for mental health services, they also give oversight to for-profit companies based outside of Michigan. Michigan's people are important. We should make these decisions that impact mental healthcare together. Visit www.cmham.org/advocacy to learn more.



Copy: Senate Bills 597 & 598 are currently being discussed by lawmakers. While these bills may appear fine on the surface, they ultimately increase costs for Michigan taxpayers. For-profit companies involved have double the administrative costs that the public mental health service providers currently have. These bills will result in more empty pockets for Michigan residents. Visit www.cmham.org/advocacy to learn more.

email correspondence

From: Monique Francis <MFrancis@cmham.org>
Sent: Monday, February 7, 2022 3:21 PM
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Statement of CMHA, its officers and leadership, in response to recent racist hacking

To: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons; CEOs of CMHs, PIHPs, Affiliate members and Provider Alliance members
From: Board President Joe Stone, the Officers of the Board of Directors, and Robert Sheehan, CEO, CMH Association of Michigan
Re: Statement of CMHA, its officers and leadership, in response to recent racist hacking

In the fall of 2019, CMHA formed the Persons Served Advisory Group. The members of the Advisory Group are persons who are currently served or have been served by Michigan's public mental health system as well as the family members of persons served. The purposes of the Persons Served Advisory Group are to:

- Directly incorporate the voices of persons served (those with lived experiences), in addition to those on the Association's Board of Directors and on the Association's committees, into the dialogue and decision making of the Association, most notably those involving legislation, policy, and political advocacy
- Provide a venue to link, for persons served and with those with lived experience from across the state, to each other for dialogue, support, and shared wisdom

During a recent virtual meeting of this Advisory Group, an uninvited hacker intruded. CMHA shut down that virtual meeting as soon as possible but not before the intruder posted racist written statements and, in their video connection, played out the arrest and murder of George Floyd while continuing to make racist statements.

Undeterred, with courage and commitment, the members of the Persons Served Advisory Group and CMHA re-scheduled and held a meeting of the Advisory Group within a week. At that meeting Advisory Group members expressed their reactions to the earlier meeting and discussed, with first-person insight, a wide range of issues core to the work of CMHA, the vitality of the public mental health system including the wellbeing of those served. That rescheduled meeting, as will all future meetings of this group and others, was held with a number of added virtual meeting security features, implemented by CMHA, in order to reduce the risk of similar hacks in the future.

CMHA, its leadership, and its members remain **firmly** committed to the fact that all of us - regardless of our disability or ability, race, ethnicity, gender, income, gender identity, geography, age, political affiliation, gender preference, marital status, religion, or any other descriptor of any of us - will not be nor should be harmed, judged, belittled, stigmatized, segregated, nor ostracized because of these descriptors.

This event, while repugnant, has only served to strengthen the resolve of CMHA, its Board of Directors, staff, members, and the members of the Persons Served Advisory Group. We remain determined to see through and identify the false and damaging labels, images, and characterizations, and, with them, the policies, practices, and systems built upon them.

CMHA **firmly** stands with those who have been exposed to this appalling event, along with any and all who have experienced similar attacks. We choose to move forward with renewed energy and zeal to oppose all forms of hate in our society.

Onward and upward,

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
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email correspondence

From: Alan Bolter
To: Alan Bolter
Cc: Robert Sheehan
Subject: MDHHS Presents Overview of the Governor"s FY 23 Budget Recommendation in Senate Appropriations Subcommittee
Date: Tuesday, February 15, 2022 4:47:15 PM
Attachments: image001.png
FY 23 MDHHS Budget Presentation.pdf

See attached and below

From: Christin Nohner <NohnerC@rwca.com>
Sent: Tuesday, February 15, 2022 4:22 PM
To: Christin Nohner <NohnerC@rwca.com>
Subject: MDHHS Presents Overview of the Governor's FY 23 Budget Recommendation in Senate Appropriations Subcommittee

Good afternoon, All:

Today, in the Senate Appropriations Subcommittee on Health and Human Services, Michigan Department of Health and Human Services (MDHHS) Director Elizabeth Hertel gave an overview of the scope and the organizational structure of the department, as well as a briefing on the Governor's FY 2023 Budget Recommendation for MDHHS. The full presentation is attached.

Governor Whitmer's FY 2023 request for MDHHS is $33.4 billion gross, $6.4 billion General Fund (GF). That amounts to an increase of $1.5 billion Gross and $610 million GF over the original enacted budget (4.6 percent over the enacted Gross budget and 11 percent over enacted GF budget).

Director Hertel outlined the following main budgetary priorities for the department:

- Protecting the most vulnerable residents
- Cost-effective prevention programs
- Expanding access to behavioral health
- Critical COVID-19 response efforts

No proposed reductions were recommended. The following is a list of notable new investments:

- Medicaid Dental Program Redesign ($243.3 Million (M) Gross, $69.8 M GF)
    - To consolidate child and adult Medicaid and Healthy Michigan Plan dental benefit into a single managed care contract with Dental Health Plans
- Health Equity Across the Lifespan ($15.5 M Gross, $6.3 M GF)
    - End the state's Medicaid birth expenses recovery program
    - Increase access to doula care for high-risk families
    - Support additional community health workers to help migrants across health care services at the four Federally Qualified Health Centers
- Fee, Wage, and Payment Adjustments ($75.8 M Gross, $27.4 M GF)
- Behavioral Health Capacity and Access ($69.3 M gross, $55 M GF)

    - Expand behavioral health inpatient community-based treatment programs
    - Extend behavioral health and opioid health homes to additional counties
    - Fund staff and operational costs for two new units at the Hawthorne Center
    - Fund staff and operational costs for a new Center for Forensic Psychiatry satellite facility
- Occupational Health Clinics ($3.6 million gross, $3.2 million GF)
- Centralized Administrative Support for State Psychiatric Hospital Activities ($1.1 M Gross/GF)
    - Expanding staffing, infrastructure, and supervision within the department
- Foster Parent, Guardianship and Adoption Subsidy Rate Increase ($33.6 M Gross, $13.3 M GF)
    - Increase the rate provided to foster, relative, guardian, and adoptive families by 18 percent
- Child Caring Institution Rate Increase ($10.5 M Gross, $8.9 M GF)
    - $10.5 M gross to increase the contracted rates for child caring institutions to provide for improved service delivery and capacity to meet the needs of the youth that require this care
- Child Welfare Day Treatment Pilot ($2.4M Gross, $2.4M GF)
    - $2.4M to implement a pilot to provide day treatment programming for youth
- Young Child Financial Support Supplement ($8.3 M Gross)
    - Provide a $100 TANF funded monthly supplement to families receiving cash assistance for each child aged five and younger
- Child Support Pass-Through ($1.1 M Gross/GF)
    - Pass through 100 percent of child support paid to a child's caregiver when that caregiver is receiving PIP benefits.
- One-time Behavioral Health and Public Health Investments ($386.1 M GF)
    - New State Operated Psychiatric Complex ($325 M)
    - Michigan Essential Health Provider Program – Mental Health Expansion ($25 M)
    - Jail Diversion Fund ($15 M)
    - Gun Violence Prevention ($10 M)
    - Multicultural Integration Organizations ($8.6 M)
    - First Responder Mental Health Funding ($2.5 M)
- One-Time Children's Services and Economic Stability Investments ($107.5 M Gross, $106.3 M GF)
- One-Time Information Technology Investments ($33.5 M, $19.15 M GF)
- One-Time Investments for Initiatives to Address Racial Disparities ($20 M Gross, $15 M GF)
    - New incentive pool to contracted Medicaid Health Plans to address racial disparities in medical services ($10 M Gross, $5 M GF)
    - Support for expansion of the number of Centering Pregnancy sites in the state ($4.2 M Gross, $4.2 M GF)
    - New Funding for Michigan Area Health Education Centers ($4 million Gross, $4 million GF)
    - Workforce development funds to enhance and diversify Michigan's healthcare workforce ($1.3 M Gross, $1.3 M GF)
    - Education and outreach campaign on uterine fibroid disparities ($500,000 Gross, $500,000 GF)

The House Appropriations Subcommittee on DHHS is expected to hear a similar presentation on Wednesday, February 16.

In the coming weeks, we expect the appropriations subcommittees in both chambers to begin deliberations on their respective budget areas.

In the meantime, please let us know if you have any questions.

Sincerely,

Your RWC Team

RWC ADVOCACY
A Governmental Affairs Law Firm

email correspondence

From: Monique Francis <MFrancis@cmham.org>
Sent: Wednesday, February 16, 2022 1:39 PM
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Guidance related to demand for financial data by Milliman and MDHHS: View of Provider Alliance leadership and CMHA

To: CEOs of CMHA Provider Alliance members
Cc: CEOs of CMHs and PIHPs
From: Jacque Wilson, Chair, CMHA Provider Alliance; and Robert Sheehan, CEO, CMH Association of Michigan
Re: Guidance related to demand for financial data by Milliman and MDHHS: View of Provider Alliance leadership and CMHA

REQUEST OF ACTION BY YOU: You will note, at the end of this e-mail, a request that you take a moment to send your concerns, regarding this salary and wage information requirement of Milliman and MDHHS, to Milliman at BH.Provider.Survey@Milliman.com, in the next several days. Such communication would be greatly appreciated. **Your voice, from the front lines of our system, is key to Milliman and MDHHS better underscoring the flaws in this data requirement.**

Recently, you received, from your CMHSPs, PIHPs, or directly from MDHHS and Milliman (the actuarial firm leading the overhaul the financial reporting system of the state's public mental health system), a notice of a requirement to submit financial information that is both detailed and not readily accessible. The original notification from Milliman and MDHHS is provided below and attached.

CONCERNS WITH THIS REQUIREMENT: Upon review of the survey document and information requested it became clear to the leadership of the CMHA Provider Alliance leadership and CMHA that:

- The purpose of this effort, beyond gaining an understanding of the causes of cost variances, is not clear, even after repeated requests of Milliman and MDHHS, by the CMHA Provider Alliance and CMHA
- An understanding of the causes of cost variances can be gained with readily available financial data and its analysis by knowledgeable financial staff within the provider, CMH, and PIHP systems
- The detailed financial data provided in response to a similar requirement, last year, do not appear to have resulted in improvements in the Medicaid behavioral health rate setting process nor to the adequacy of the fees paid to the provider system
- The required data aligns more closely with the clinical practices of traditional physical health modalities (physician visits and services, inpatient stays) and not the clinical practices of the state's behavioral health system which is far more team- and community-based, representing both traditional and non-traditional services. This mismatch becomes clear in the misalignment of the CCBHC and Health Home financial recordkeeping with the financial reporting constructs in this data requirement
- The majority of the state's provider organizations do not have the required data nor the ability to develop the data in the format required without substantial levels of complex and expensive work. This will lead to the data that will be submitted by provider organization to be incomplete and best guesses/estimates for many of the data elements, weakening the validity and usability of these data.
- Providers working in a number of geographic regions of the state, with widely differing labor markets, making the provision of the information required not only difficult to compile but difficult to interpret in the development of a statewide standardized fee schedule.

- This requirement has very high levels of complexity, data volume, detail, and of the work required to provide the required data. Many of the providers in the CMH and PIHP system do not have the administrative staff, the expertise, nor the technology needed to provide the data required.

PREMISES FOR NEXT STEPS:

- This financial reporting requirement is based upon Medicaid bulletin MS 21-39. This bulletin, however, goes far beyond the requirements of the federal regulations upon which it claims to be based.
- Given that the Department cannot make unilateral demands of the state's PIHPs, CMHSPs, nor the provider organizations in the networks of the PIHPs or CMHSPs, whether by bulletin or any other means, if that unilateral action is not an accurate interpretation of federal nor state law.
- Rather, such requirements must be negotiated by the state's PIHPs and CMHSPs with MDHHS and reflected in the contracts between these parties.

NEXT STEPS: The CMH Negotiation Team, the PIHP Negotiation Team, the CMHA representatives on the joint MDHHS/CMHA Standard Cost Allocation Workgroup, and CMHA are meeting, later this month, to determine a course of action relative to the request that you have received and other, equally troubling components of the Standard Cost Allocation initiative. Immediately after this meeting, CMHA will let you know of the steps that this group will take related to these reporting demands and related demands.

At this point, beyond making this request for you to voice your concerns, CMHA cannot provide you, as the leaders of the state's provider network, with concrete guidance as to whether you should respond to this requirement nor how you should respond. However, we wanted you to know of the concerns of the Provider Alliance leadership and CMHA, related to this information requirement and of the steps being taken in response to this requirement and to ask that you send your concerns to Milliman at the e-mail address provided below.

REQUEST OF ACTION BY YOU: If you would take a moment to send your concerns regarding this salary and wage information requirement process to Milliman at BH.Provider.Survey@Milliman.com, in the next several days, such communication would be greatly appreciated. **Your voice, from the front lines of our system, is key to Milliman and MDHHS better underscoring the flaws in this data requirement.**

Robert Sheehan
Chief Executive Officer
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426 South Walnut Street
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517.237.3142 direct
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www.cmham.org

Subject: Release of BH 2022 Salary and Wage Survey
Importance: High

SENDING ON BEHALF OF JEREMY CUNNINGHAM –

The deadline for sending the survey to network providers has been revised to 2/4, although we encourage sending sooner if possible.

Please see the attached overview of the BH fee schedule reporting requirements. The Salary and Wage survey is for all network providers (except for hospitals who already submit cost reports to MDHHS). The $1M threshold is applicable to the Contracted BH Provider Service Expense Data Collection Tool that will be released in late February.

Jeremy Cunningham, FSA, MAAA
Principal and Consulting Actuary

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Dear CMHSPs and PIHPs—

MDHHS is releasing the required Salary and Wage survey for all contracted behavioral health network providers and CMHSPs. All behavioral health network providers (contracted and CMHSPs) participating in Michigan's Medicaid program and providing covered behavioral health services, developmental disability services, and substance use disorder services are required, per MSA 21-39, to participate in the survey. The Salary and Wage survey is due March 31, 2022 and all materials, including a pre-recorded training, have been posted to the MDHHS website under the Policy 21-39 Reporting Requirements section.

We have drafted an email for you to send to your contracted behavioral health network providers. Would you please distribute this email by the end of the week (no later than January 28, 2022)? The sooner the Salary and Wage survey is distributed, the more time your contracted behavioral health network providers will have to complete it.

Thank you.

Email to Providers (sent on behalf of CMHSPs and PIHPs)

To all contracted behavioral health network providers—

Michigan Department of Health and Human Services (MDHHS) is conducting a **required** Salary and Wage survey for all behavioral health providers (contracted and CMHSPs) participating in Michigan's Medicaid program and providing covered behavioral health services, developmental disability services, and substance use disorder services. Providers already submitting a hospital cost report to MDHHS are exempt from submitting the Salary and Wage survey. The collection of this information is necessary to develop the standardized fee schedule for Medicaid behavioral health services (per MDHHS Budget Boilerplate Section 964 of Public Act 166 of 2020) and supports the requirements within MDHHS's Medical Services Administration (MSA) Bulletin 21-39, "Beginning December 1, 2021 and required annually thereafter, CMHSP/PIHP network behavioral health service providers (providers who contract with PIHPs and CMHSPs) must provide all relevant information for the provision of covered services delivered to Medicaid beneficiaries to MDHHS using standard reporting templates that are provided by MDHHS." MSA Policy 21-39 is available here.

Your participation in this survey is required by MDHHS to understand the resources required to provide these essential behavioral health services in Michigan. The information collected through this survey will be used to understand the staffing, wage, and other provider resource requirements associated with these services. Please submit one Salary and

Wage survey for each provider tax identification number (TIN), even if you receive this request from more than one CMHSP, and include information associated with all behavioral health services.

To access the survey and training materials, visit the MDHHS website here and go to the Policy 21-39 Report Requirements section and Salary and Wage Survey area.

MDHHS requires your full participation in this important endeavor and appreciate your time and support. If you have any questions about the process or the survey tool, after reviewing the available training materials, please send them to BH.Provider.Survey@Milliman.com.

Please return the completed survey to BH.Provider.Survey@milliman by **March 31, 2022**.

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

ATTENDEES:	**Chris Bigger, Connie Cadarette, Christine Gebhard, Kevin Hartley, Chip Johnson, Nancy Kearly, Eric Kurtz, Donna Nieman, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**
ABSENT:	**Lauri Fischer, Larry Patterson**

REVIEW AGENDA & ADDITIONS
Deanna added Open HSW slots to the Agenda.

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

MOTION BY KEVIN HARTLEY TO APPROVE THE MINUTES OF THE JANUARY 12, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

MONTHLY FINANCIALS
December 2021

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

The Direct Care Wage Surplus was reported as $2,162,220. Eligibility continues to trend upward.

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

EDIT UPDATE

The minutes from the January 20th EDIT meeting were forwarded by Donna Nieman on January 21st.

- The workgroup wanted experience with working on third period FY21 EQI which was released at the end of December.
- The COB subgroup met January 21st; New COB reporting requirements will be effective FY23.
- Code Chart Changes subgroup will begin making updates to the code chart quarterly, allowing time to implement changes prior to becoming effective.
- The workgroup to develop tiered rates for inpatient psychiatric services has determined that rates should be based on staffing level (as opposed to violent behavior). The target date for implementation is FY23.
- The workgroup to develop tiered rates for licensed residential services reconvened in January; it was determined that an assessment tool, incorporated into the IPOS is needed to determine LOC and ultimately rates. Eric questioned how the Fair Hearing process will work under this standard; Donna replied that it has not yet been addressed. Chip expressed that tiered pay rates cannot be done in a capitated service model without first conducting an RFP to establish rates and staffing.
- The modifiers related to staff licensing and education levels were discussed; the need to have minimum level (such as bachelors or higher) was expressed.
- Telemedicine Update: On January 16th the Federal PHE was extended for another 90 days. COVID-19 policies will continue through April 16th. Telemedicine guidelines for the post-COVID era are being developed.
- Place of Service for Telemedicine Update: HASA has decided not to use POS 10 and to continue with POS 02; all claims and encounters should continue to come in with POS 02, even if the service is provided in the patient's home.
- Although the FQ modifier was created to distinguish services provided with only an audio component, providers are record services provided via audio only with POS 02 using the GT modifier and noting "services provided via telephone" in the comments section.
- Audio-Only E&M Codes Update: The State is looking at whether E&M codes 99441 – 99443 o be delivered by audio-only communication and billed to Medicaid.
- Some confusion was expressed regarding bundled codes and the use of modifiers for inpatient screenings; ACT should use the H0039 code with the pre-screen modifier.
- The decision was made to add 96372 for SUD services to the code chart for injectables and keep H0033 for oral medications.

The next EDIT meeting is scheduled for April 21st.

IN-REGION COFRS

Erinn requested a discussion about whether COFR Contracts will continue between Member CMHSPs. Chris voiced support for eliminating COFRs in-region. Eric voiced the need to keep the Regional Clinical Leadership Committee involved in the discussion. Christine asked under what circumstances are problems occurring. Erinn responded that contract and clinical staff are running into issues on the finance side. Erinn offered to circle back with AuSable Valley Leadership. Eric asked to be kept informed. That request was made that the paying CMHSP accept the clinical LOC determination made by the providing CMHSP.

DCW AND SALARY WAGE SURVEYS

In December, MDHHS contacted businesses, agencies, and entities that are eligible to receive the direct care worker (DCW) wage increase (also called a DCW premium payment) to complete a reporting of DCW wages and the number of DCWs in each wage range to MDHHS by February 1, 2022.

In January, MDHHS issued a Salary/Wage Survey to be completed by all behavioral health providers (contracted and CMHSPs, excludes hospitals) for calendar year 2021 with a due date of March 2022.

Eric requested an update on where the Boards are in the process of collecting these data.

- Erinn reported that AuSable Valley the information to Providers but has not done any follow-up or tracking other than for its direct-employed staff.
- Connie reported that Northeast Michigan sent the DCW memo to Providers which was a fairly straightforward process.
- Kevin reported that North Country hasn't forwarded the Salary/Wage survey to Providers to date but did provide an introduction during a recent Provider meeting.

It was noted that several Providers lack the technology to complete the Salary/Wage survey. Eric instructed the Boards to omit small "mom and pop" Providers. Donna asked whether "mom and pop" Providers should be included in the TIN worksheet in the EQI; some do not have Federal ID numbers and use SSNs. Tricia responded that, for security purposes, SSNs should not be included on the form; the fields can be left blank.

STABILITY PLANS

Eric received communication from Jeff Wieferich requesting the PIHPs provider stability plan efforts for fiscal year FY22 by close of business on March 1, 22; Eric requested the information from the CMHSPs by February 25th.

FSR & EQI DUE DATE

The due date to the NMRE was provided as February 14th; the due date to the State is February 28th. Tricia clarified (from Period 3 Instructions): "It is not required that the general fund and other fund sources tie between the EQI and the FSR, though it is anticipated that Medicaid and HMP expenditures should."

VACANT HSW SLOTS

20 vacant HSW slots have been identified region wide. Deanna asked for a status update on packets.

- Connie reported that Northeast Michigan has 3 packets pending and 6 in process.
- Donna reported that Centra Wellness has 5 packets in process.

NEXT MEETING

The next meeting was scheduled for March 9th at 10:00AM.

Chief Executive Officer Report

February 2022

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

Jan 27: Attended and participated in MDHHS PIHP/CMHSP COVID 19 call.

Jan 27: Met with MDHHS regarding Intensive Crisis Stabilization Services POC.

Jan 28: Attended and participated in MDHHS/PIHP Contract Negotiations Meeting.

Jan 31: Met with TC County Administrator regarding Liquor Tax.

Feb 1: Chaired NMRE Regional Operations Committee Meeting.

Feb 2: Attended and participated in PIHP CEO Meeting.

Feb 3: Attended and participated in MDHHS/PIHP CEO Meeting.

Feb 7: Attended NMRE Compliance Training.

Feb 8: Attended NMRE Provider Network Managers Meeting.

Feb 9: Attended NMRE Finance Committee Meeting.

Feb 10: Attended and participated in MDHHs PIHP/CMHSP COVID 19 call.

Feb 11: Meet with Bear River Health Regarding Tax Levy.

Feb 14: Sat on the ICE.

Feb 15: Chaired NMRE Operations Committee Meeting.

Feb 18: Attended and participated in Clinical Leadership Committee Meeting.

December 2021 Finance Report

December 2021 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	6,481,012	11,296,664	9,298,750
Healthy Michigan	1,895,589	5,061,832	7,059,746
	$ 8,376,601	$ 16,358,496	$ 16,358,496

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	334,802	1,230,730	2,198,851	2,114,450	767,507	1,371,974	358,286	$ 8,376,601
Direct Care Wage Estimated Surplus								(2,162,220)
Medicaid Carry Forward								16,358,496
Total Med/HMP Current Year Surplus								$ 22,572,877
Medicaid & HMP Internal Service Fund								16,358,496
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 38,931,373

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through December 31, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 47,908,865	$ 1,159,812						$ 49,068,677
CMHSP Distributions	(46,646,912)		15,537,782	12,852,297	7,838,053	6,390,158	4,028,622	0
1st/3rd Party receipts			118,960	-	172,605	-	-	291,565
Net revenue	1,261,953	1,159,812	15,656,742	12,852,297	8,010,657	6,390,158	4,028,622	49,360,242
Expense								
PIHP Admin	587,129	10,580						597,709
PIHP SUD Admin		11,299						11,299
SUD Access Center		12,552						12,552
Insurance Provider Assessment	389,318	8,059						397,377
Hospital Rate Adjuster	-							-
Services		740,995	13,534,276	11,246,462	7,367,292	5,172,482	3,798,787	41,860,293
Total expense	976,447	783,485	13,534,276	11,246,462	7,367,292	5,172,482	3,798,787	42,879,230
Net Actual Surplus (Deficit)	$ 285,507	$ 376,327	$ 2,122,466	$ 1,605,835	$ 643,366	$ 1,217,677	$ 229,835	$ 6,481,012

Notes

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

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through December 31, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 4,626,074	$ 2,756,578						$ 7,382,652
CMHSP Distributions	(4,491,650)		1,641,185	1,359,240	556,373	558,761	376,092	-
1st/3rd Party receipts			-	-	2,684	-	-	2,684
Net revenue	134,424	2,756,578	1,641,185	1,359,240	559,058	558,761	376,092	7,385,336
Expense								
PIHP Admin	50,010	25,699						75,710
PIHP SUD Admin		27,444						27,444
SUD Access Center		30,488						30,488
Insurance Provider Assessment	35,118	18,701						53,819
Hospital Rate Adjuster	-							-
Services		1,799,843	1,564,799	850,625	434,916	404,463	247,641	5,302,287
Total expense	85,128	1,902,175	1,564,799	850,625	434,916	404,463	247,641	5,489,748
Net Surplus (Deficit)	$ 49,295	$ 854,403	$ 76,386	$ 508,615	$ 124,141	$ 154,298	$ 128,451	$ 1,895,589

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

Net Surplus (Deficit) MA/HMP	**$ 334,802**	**$ 1,230,730**	**$ 2,198,851**	**$ 2,114,450**	**$ 767,507**	**$ 1,371,974**	**$ 358,286**	**$ 8,376,601**
Direct Care Wage Estimated Surplus								**$ (2,162,220)**
Medicaid & HMP Carry Forward								**16,358,496**
Total Med/HMP Current Year Surplus								$ 22,572,877
Medicaid & HMP ISF - based on Interim FSR								**16,358,496**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 38,931,373**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through December 31, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 55,456		99,325	9,827	20,356	11,231	91,603	$ 287,798
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	55,456	-	99,325	9,827	20,356	11,231	91,603	287,798
Expense								
PIHP Admin	3,318							3,318
BHH Admin	-							-
Insurance Provider Assessment	1,079							1,079
Hospital Rate Adjuster								
Services	-		99,325	9,827	20,356	11,231	91,603	232,342
Total expense	4,397	-	99,325	9,827	20,356	11,231	91,603	236,739
Net Surplus (Deficit)	$ 51,059	$ -	$ -	$ -	$ -	$ -	$ -	$ 51,059

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through December 31, 2021

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,159,812	$ 2,756,578	$ 804,407	$ 622,052	$ 521,261	$ 5,864,110
Expense						
Administration	21,879	53,143	20,195	37,911		133,128
OHH Admin			24,181	-		24,181
Access Center	12,552	30,488	-	6,422		49,462
Insurance Provider Assessment	8,059	18,701	4,793			31,553
Services:						
Treatment	740,995	1,799,843	683,943	379,105	521,261	4,125,147
Prevention	-	-	-	198,615	-	198,615
State targeted response	-	-	-	-	-	-
Total expense	783,485	1,902,175	733,112	622,053	521,261	4,562,086
PA2 Redirect			-			-
Net Surplus (Deficit)	$ 376,327	$ 854,403	$ 71,295	$ -	$ -	$ 1,302,024

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through December 31, 2021

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 47,908,865	$ 1,159,812	$ -	$ 49,068,677
Medicaid Savings	-	-	-	-
Healthy Michigan	4,626,074	2,756,578	-	7,382,652
Healthy Michigan Savings	-	-	-	-
Health Home	287,798	-	-	287,798
Opioid Health Home	-	804,407	-	804,407
Substance Use Disorder Block Grant	-	622,053	-	622,053
Public Act 2 (Liquor tax)	-	521,261	-	521,261
Affiliate local drawdown	224,900	-	-	224,900
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	36,330	-	36,330
Veteran Navigator Grant	25,358	-	-	25,358
SOR Grant Revenue	-	198,186	-	198,186
Gambling Grant Revenue	-	418	-	418
Other Revenue	-	-	1,860	1,860
Total operating revenue	53,072,995	6,099,045	1,860	59,173,900
Operating expenses				
General Administration	702,354	120,692	-	823,046
Prevention Administration	-	20,487	-	20,487
OHH Administration	-	24,181	-	24,181
BHH Administration	-	-	-	-
Insurance Provider Assessment	425,515	31,553	-	457,068
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	40,827,734	740,995	-	41,568,729
Healthy Michigan Services	3,499,760	1,799,843	-	5,299,603
Health Home Services	232,342	-	-	232,342
Opioid Health Home Services	-	683,943	-	683,943
Community Grant	-	379,105	-	379,105
Prevention	-	178,128	-	178,128
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	521,261	-	521,261
Local PBIP	-	-	-	-
Local Match Drawdown	224,900	-	-	224,900
Miscellanous Grant	-	36,330	-	36,330
Veteran Navigator Grant	25,358	-	-	25,358
SOR Grant Expenses	-	198,186	-	198,186
Gambling Grant Expenses	-	418	-	418
Total operating expenses	45,937,963	4,735,122	-	50,673,085
CY Unspent funds	7,135,032	1,363,923	1,860	8,500,815
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	7,631,776	9,263,073	14,870,057	31,764,906
Unspent funds - ending	$ 14,766,808	$ 10,626,996	$ 14,871,917	$ 40,265,721

Northern Michigan Regional Entity

Statement of Net Position

December 31, 2021

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 6,870,136	$ 10,374,172	$ 14,871,917	$ 32,116,225
Accounts Receivable	8,897,408	1,526,175	-	10,423,583
Prepaids	76,791	-	-	76,791
Total current assets	15,844,335	11,900,347	14,871,917	42,616,599
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	15,844,335	11,900,347	14,871,917	42,616,599
Liabilities				
Current liabilities				
Accounts payable	864,721	1,273,351	-	2,138,072
Accrued liabilities	212,806	-	-	212,806
Unearned revenue	-	-	-	-
Total current liabilities	1,077,527	1,273,351	-	2,350,878
Unspent funds	$ 14,766,808	$ 10,626,996	$ 14,871,917	$ 40,265,721

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 48,232,773	$ 47,908,865	$ (323,908)	(0.67%)
Carryover	11,296,664	11,296,664	-	(11,296,664)	(1)
Healthy Michigan					
Capitation	20,566,272	5,141,568	4,626,074	(515,494)	(10.03%)
Carryover	5,061,832	5,061,832	-	(5,061,832)	(100.00%)
Health Home	506,772	126,693	287,798	161,105	127.16%
Affiliate local drawdown	1,204,388	301,097	224,900	(76,197)	(25.31%)
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	27,501	25,358	(2,143)	(7.79%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	70,188,128	53,072,995	(17,115,133)	(24.38%)
Operating expenses					
General Administration	3,021,688	753,687	702,354	51,333	6.81%
BHH Administration	-	-	-	-	0.00%
Insurance Provider Assessment	1,645,387	411,347	425,515	(14,168)	(3.44%)
Hospital Rate Adjuster	4,001,228	1,000,306	-	1,000,306	100.00%
Local PBIP	1,334,531	-	-	-	0.00%
Local Match Drawdown	1,204,388	301,097	224,900	76,197	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	48,723	25,358	23,365	47.95%
Payments to Affiliates:					
Medicaid Services	173,402,120	43,350,530	40,827,734	2,522,796	5.82%
Healthy Michigan Services	15,233,944	3,808,486	3,499,760	308,726	8.11%
Health Home Services	456,768	114,192	232,342	(118,150)	(103.47%)
Total operating expenses	200,508,190	49,788,368	45,937,963	3,850,405	7.73%
CY Unspent funds	$ 32,503,361	$ 20,399,760	7,135,032	$ (13,264,728)	
Transfers in			-		
Transfers out			-	45,937,963	
Unspent funds - beginning			7,631,776		
Unspent funds - ending			$ 14,766,808	7,135,032	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 1,099,686	$ 1,159,812	$ 60,126	5.47%
Healthy Michigan	9,763,272	2,440,818	2,756,578	315,760	12.94%
Substance Use Disorder Block Grant	5,709,003	1,427,249	622,053	(805,196)	(56.42%)
Opioid Health Home	2,320,384	580,095	804,407	224,312	38.67%
Public Act 2 (Liquor tax)	1,533,979	-	521,261	521,261	0.00%
Miscellanous Grants	36,335	9,084	36,330	27,246	299.94%
SOR Grant	1,215,000	303,750	198,186	(105,564)	(34.75%)
Gambling Prevention Grant	200,000	50,000	418	(49,582)	(99.16%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	5,910,681	6,099,045	188,364	3.19%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	252,621	120,692	131,929	52.22%
Prevention Administration	90,144	22,536	20,487	2,049	9.09%
Insurance Provider Assessment	116,901	29,225	31,553	(2,328)	(7.96%)
Medicaid Services	3,387,649	846,912	740,995	105,917	12.51%
Healthy Michigan Services	7,453,459	1,863,365	1,799,843	63,522	3.41%
Community Grant	2,077,452	519,363	379,105	140,258	27.01%
Prevention	664,967	166,242	178,128	(11,886)	(7.15%)
State Disability Assistance	95,215	23,809	-	23,809	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	24,181	(24,181)	0.00%
Opioid Health Home Services	2,117,226	529,308	683,943	(154,635)	(29.21%)
Miscellanous Grants	36,335	9,084	36,330	(27,246)	(299.94%)
SOR Grant	1,215,000	303,750	198,186	105,564	34.75%
Gambling Prevention	200,000	50,000	418	49,582	99.16%
PA2	1,533,978	-	521,261	(521,261)	0.00%
Total operating expenses	20,058,810	4,616,214	4,735,122	(118,908)	(2.58%)
CY Unspent funds	$ 5,117,907	$ 1,294,467	1,363,923	$ 69,456	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			9,263,073		
Unspent funds - ending			$ 10,626,996		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 432,267	$ 398,020	$ 34,247	7.92%
Fringes	549,516	130,143	129,342	801	0.62%
Contractual	433,304	108,327	122,324	(13,997)	(12.92%)
Board expenses	16,100	4,026	4,848	(822)	(20.42%)
Day of recovery	14,000	9,000	250	8,750	97.22%
Facilities	152,700	38,175	24,505	13,670	35.81%
Other	127,000	31,749	23,065	8,684	27.35%
Total General Admin	$ 3,021,688	$ 753,687	$ 702,354	$ 51,333	6.81%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 120,552	$ 33,267	$ 87,285	72.40%
Fringes	166,800	41,700	9,651	32,049	76.86%
Access Salaries	194,484	48,621	37,822	10,799	22.21%
Access Fringes	57,588	14,397	11,640	2,757	19.15%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	24,999	24,893	106	0.42%
Board expenses	5,000	1,251	950	301	24.06%
Facilities	-	-	-	-	0.00%
Other	10,404	1,101	2,469	(1,368)	(124.25%)
Total operating expenses	$ 1,070,484	$ 252,621	$ 120,692	$ 131,929	52.22%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2021 through December 31, 2021

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	624	1,860	1,236	198.08%
Total operating revenue	2,501	624	1,860	1,236	198.08%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 624	1,860	$ 1,236	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			14,870,057		
Unspent funds - ending			$ 14,871,917		

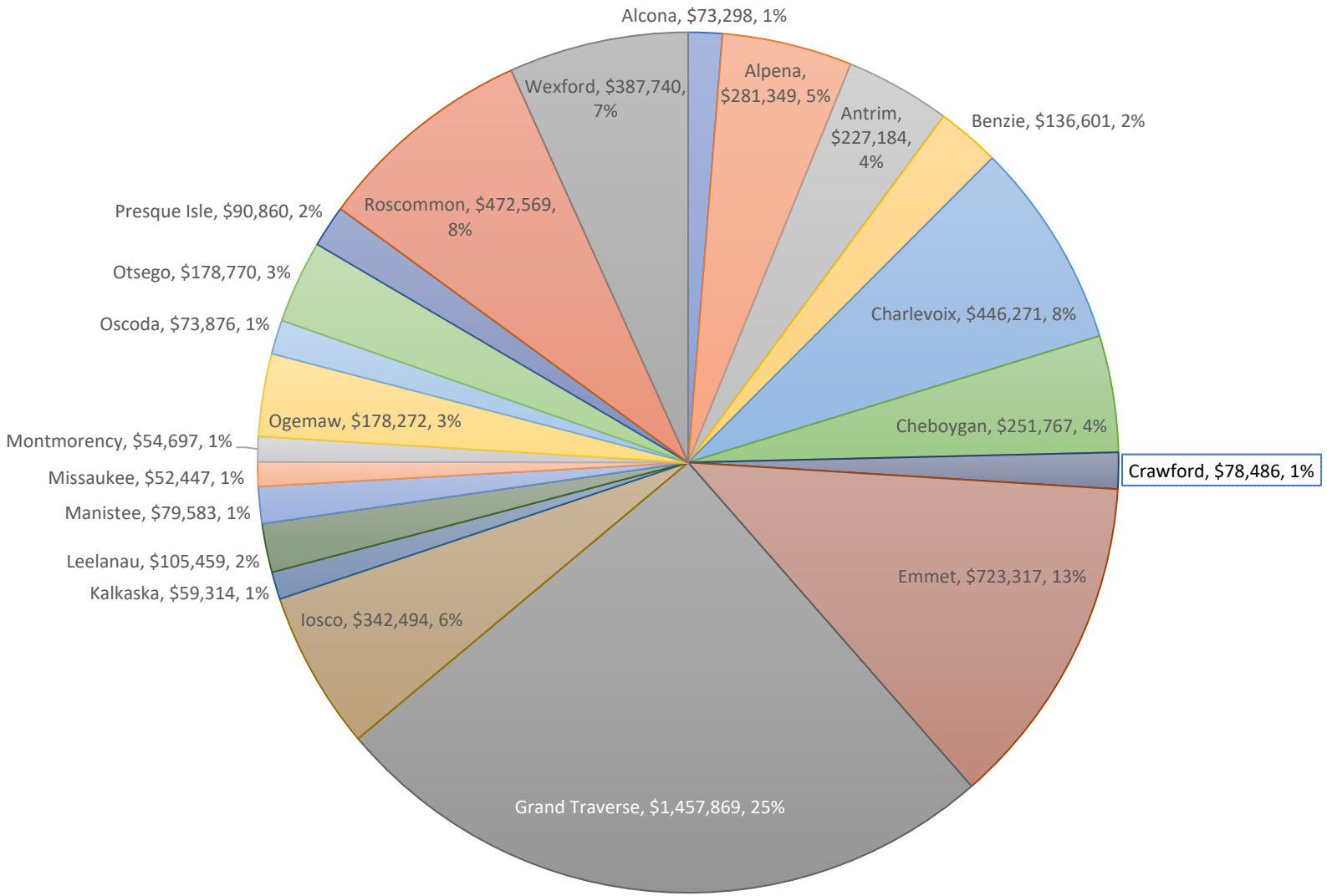
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through December 31, 2021

County	Beginning Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
Alcona	$ 83,636	$ 0	9,450	$ 888	$ 73,298
Alpena	315,554	-	31,765	2,440	281,349
Antrim	243,062	-	13,880	1,997	227,184
Benzie	144,391	-	6,283	1,507	136,601
Charlevoix	467,765	-	19,253	2,241	446,271
Cheboygan	280,756	-	26,814	2,175	251,767
Crawford	85,250	-	5,573	1,192	78,486
Emmet	754,134	-	27,971	2,846	723,317
Grand Traverse	1,615,220	-	149,480	7,872	1,457,869
Iosco	368,626	-	23,974	2,157	342,494
Kalkaska	73,813	-	12,988	1,512	59,314
Leelanau	131,773	-	24,458	1,857	105,459
Manistee	90,412	-	8,734	2,094	79,583
Missaukee	66,066	-	12,333	1,286	52,447
Montmorency	64,849	-	9,359	793	54,697
Ogemaw	193,012	-	12,941	1,799	178,272
Oscoda	81,054	-	6,467	711	73,876
Otsego	205,220	-	24,346	2,104	178,770
Presque Isle	102,301	-	10,344	1,097	90,860
Roscommon	488,633	-	14,015	2,049	472,569
Wexford	417,956	-	27,363	2,853	387,740
	6,273,483	0	477,790	43,471	5,752,223
PA2 Redirect					-
					5,752,223

PA2 Funds by County

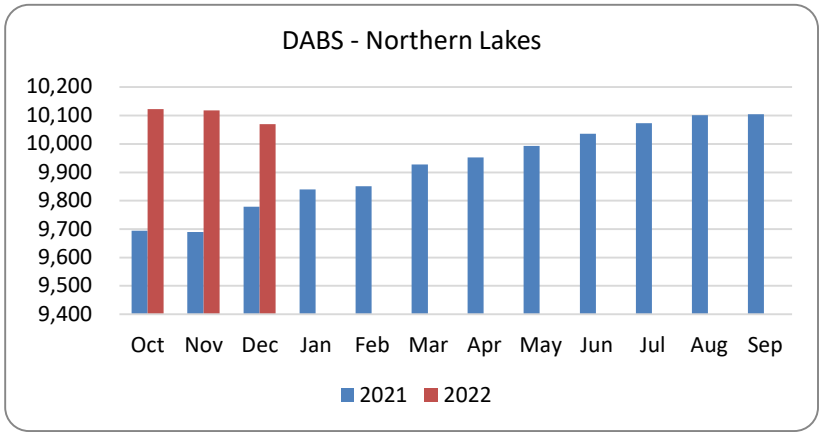


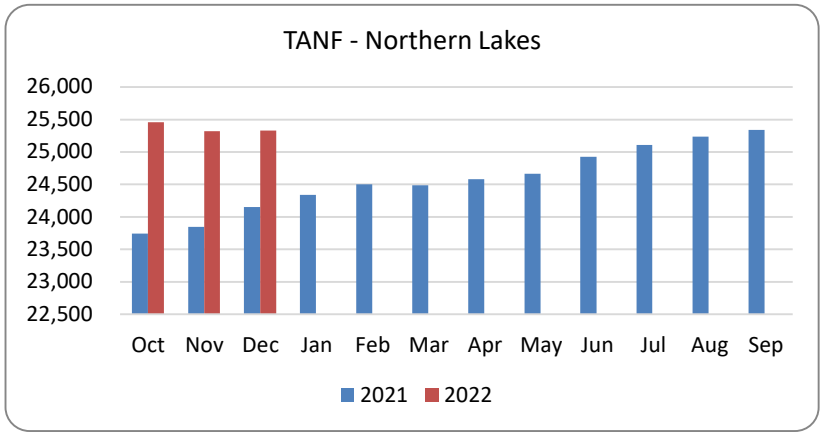
Northern Michigan Regional Entity

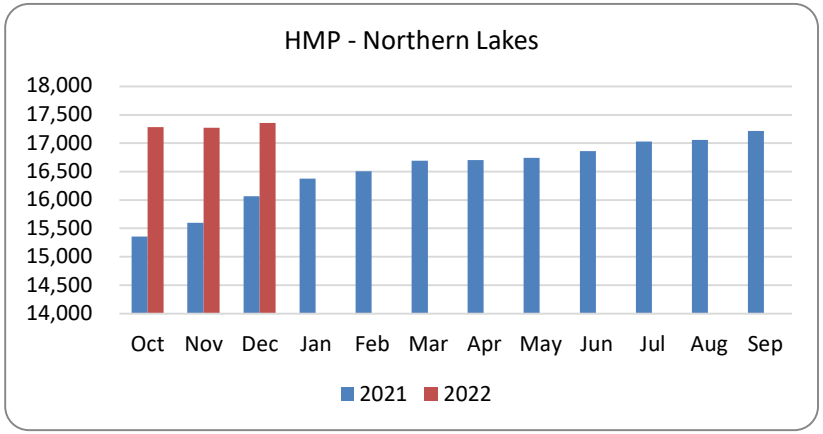
Narrative

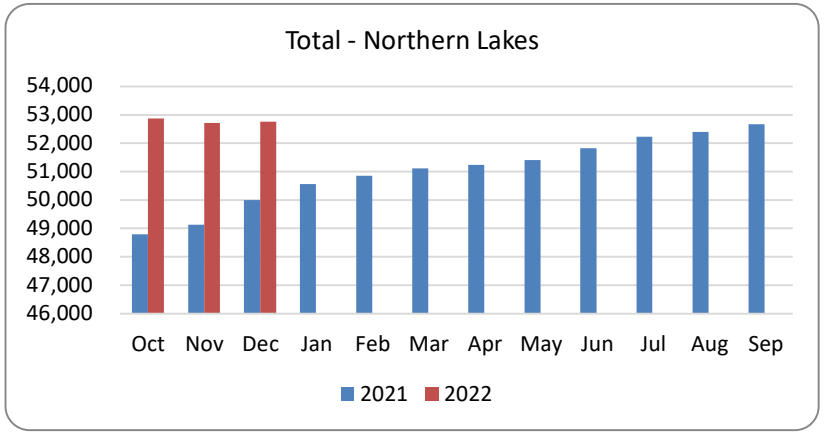
October 1, 2021 through December 31, 2021

Northern Lakes Eligible Trending







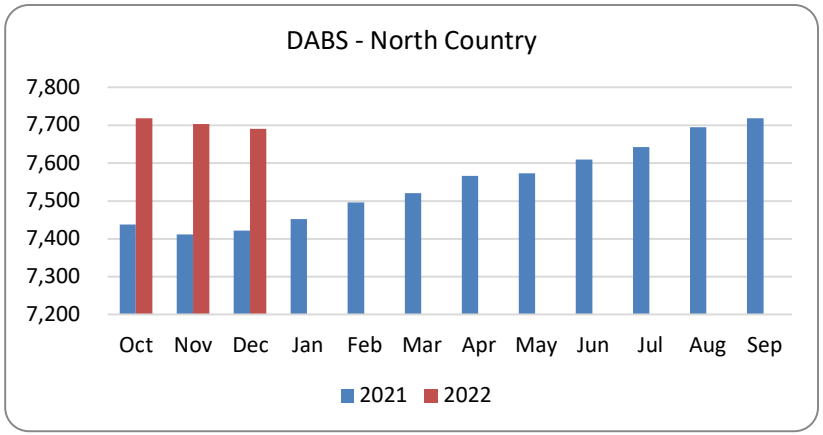


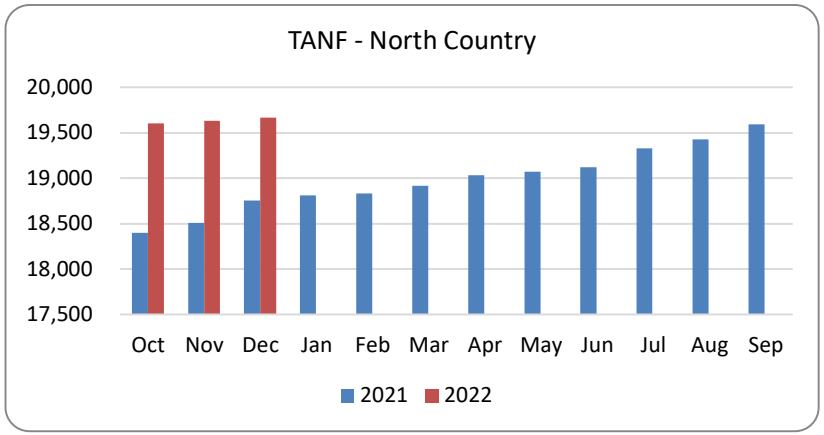
Northern Michigan Regional Entity

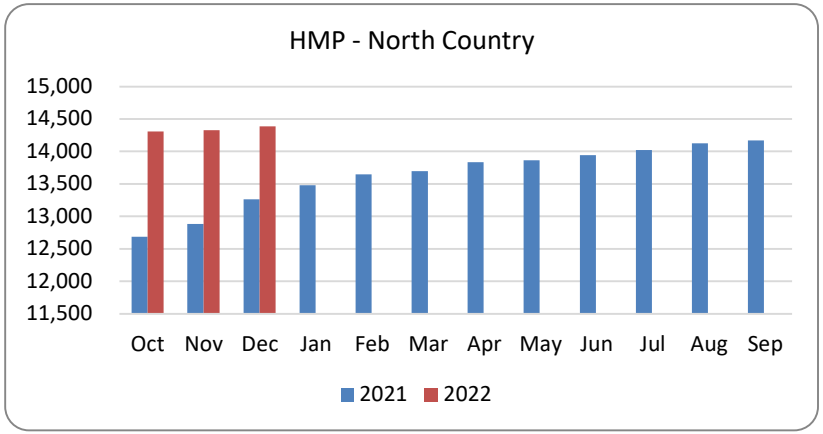
Narrative

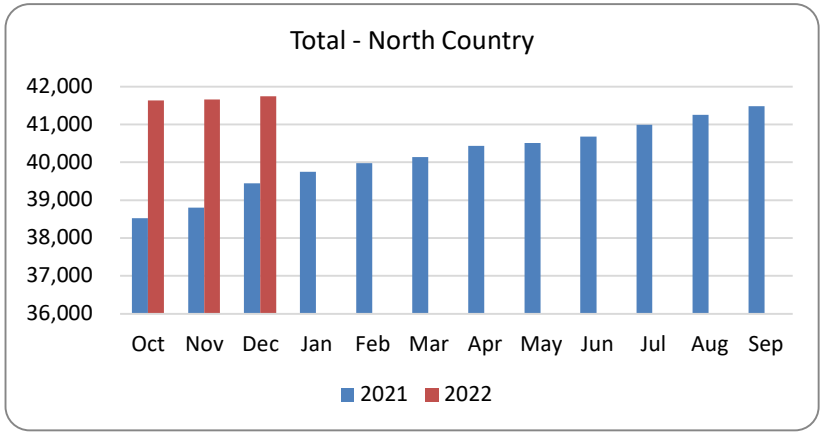
October 1, 2021 through December 31, 2021

North Country Eligible Trending







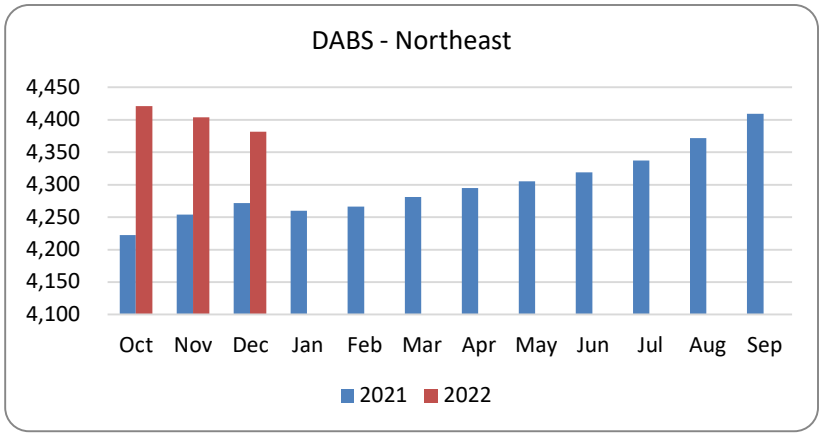


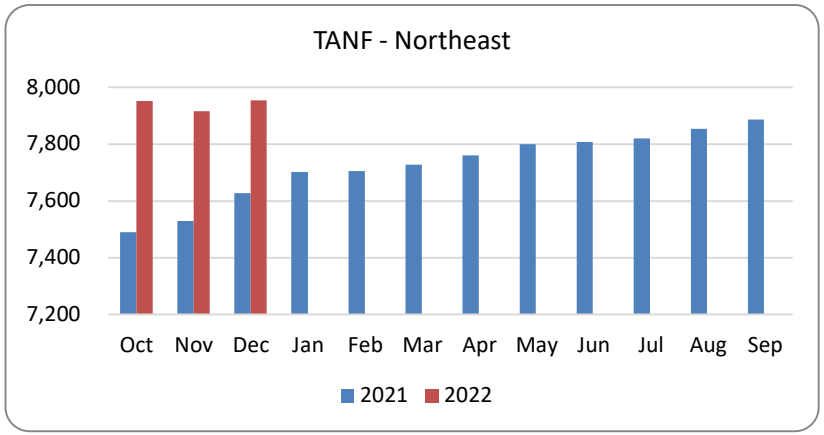
Northern Michigan Regional Entity

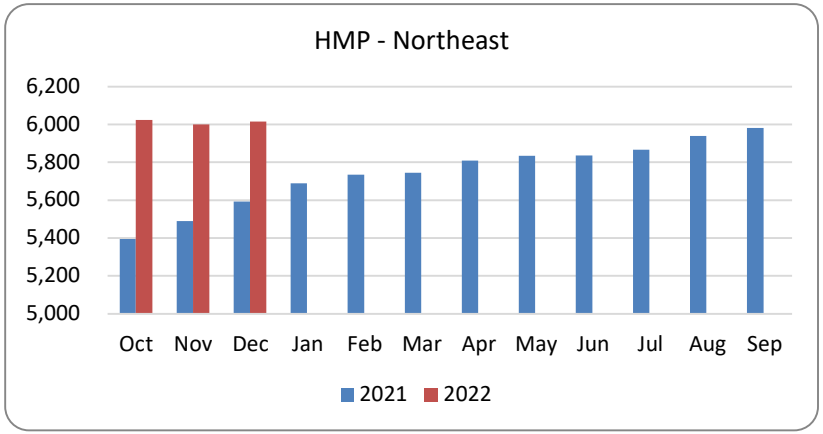
Narrative

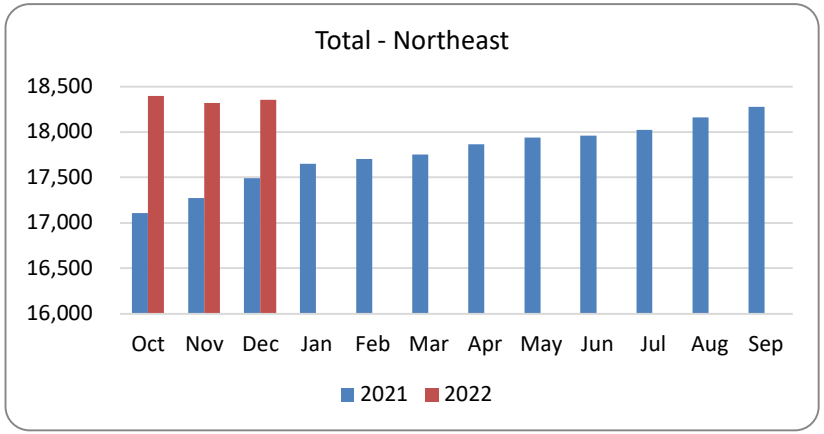
October 1, 2021 through December 31, 2021

Northeast Eligible Trending







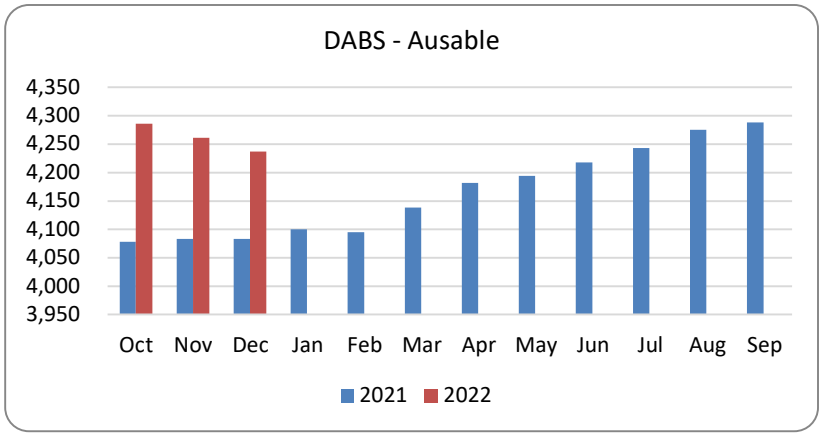


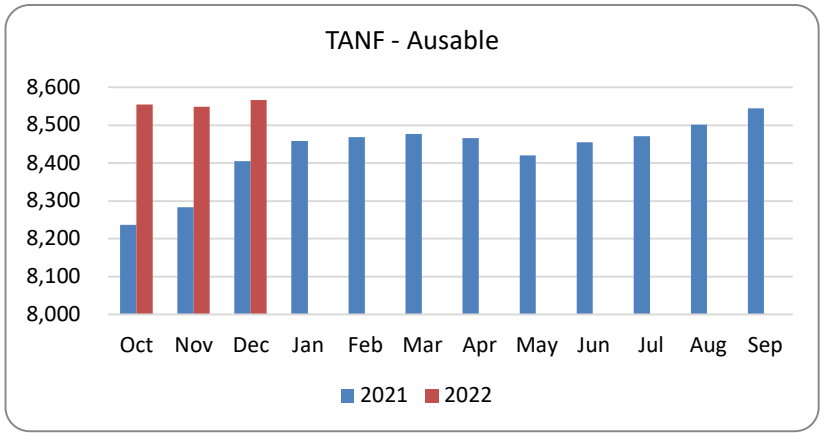
Northern Michigan Regional Entity

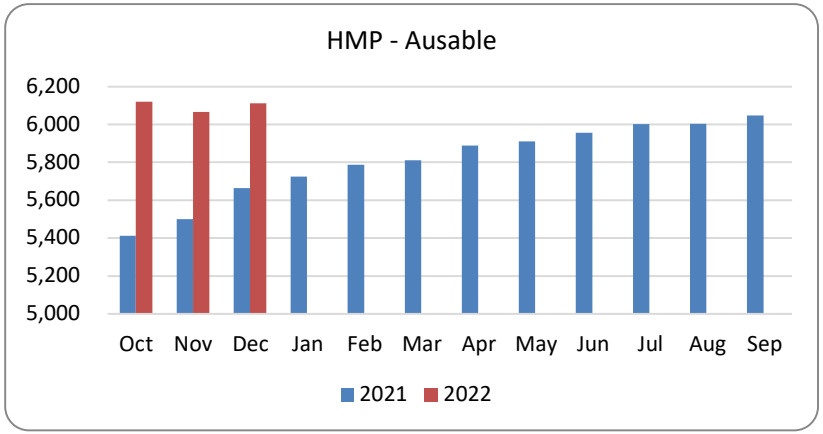
Narrative

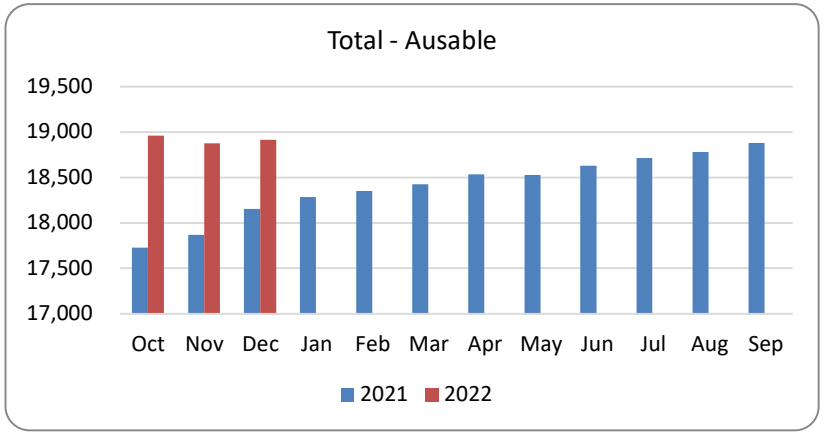
October 1, 2021 through December 31, 2021

Ausable Valley Eligible Trending







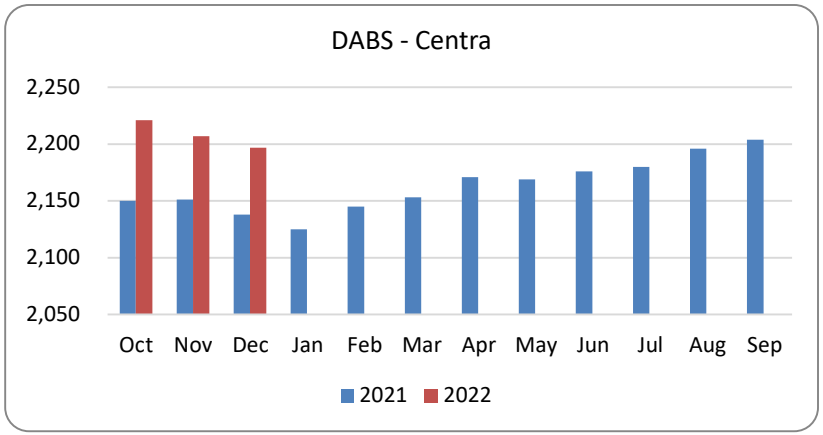


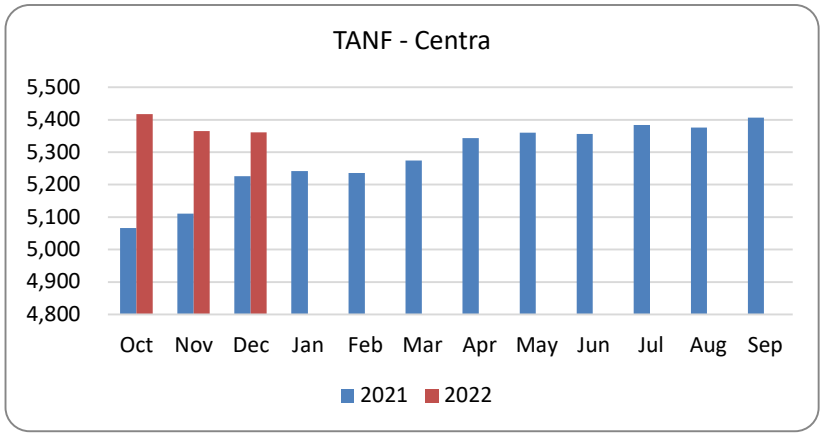
Northern Michigan Regional Entity

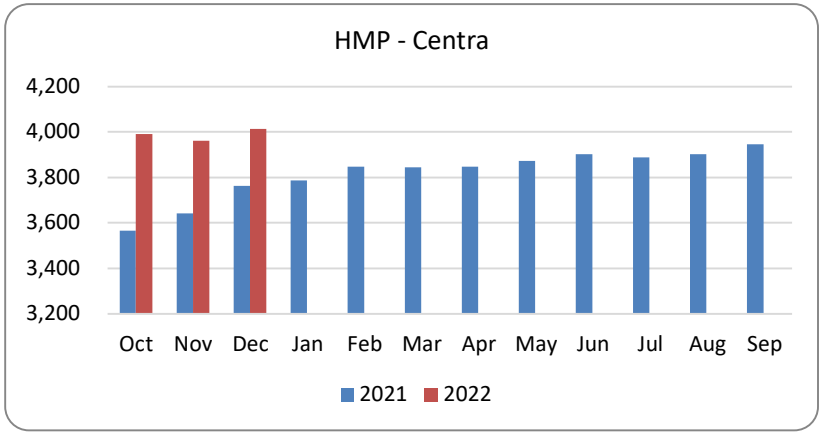
Narrative

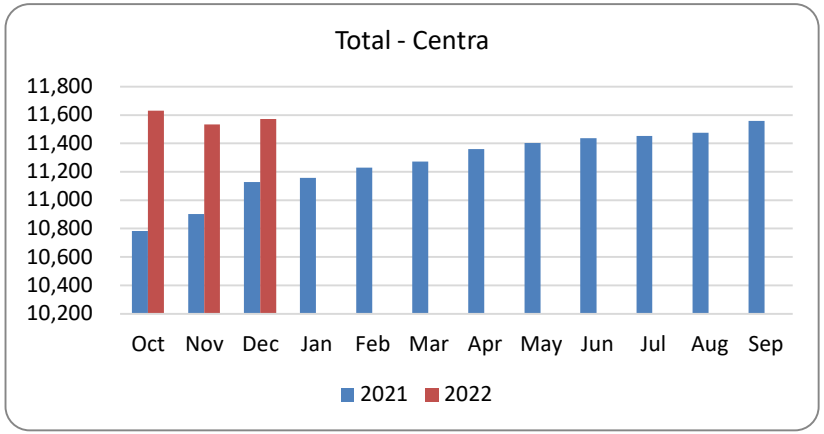
October 1, 2021 through December 31, 2021

Centra Wellness Eligible Trending







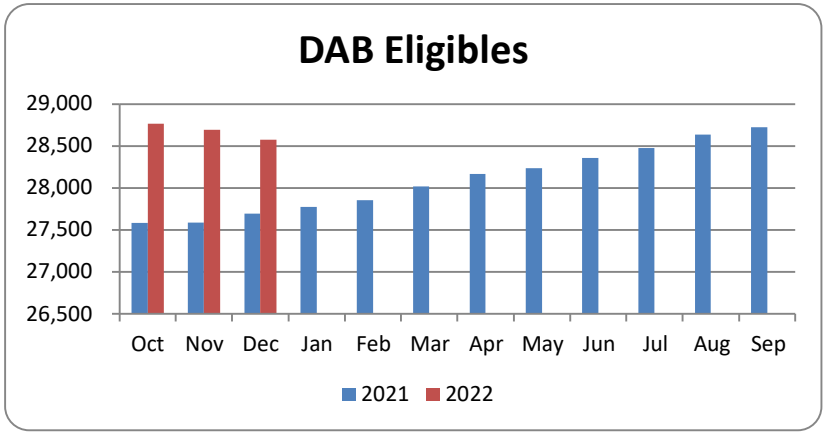


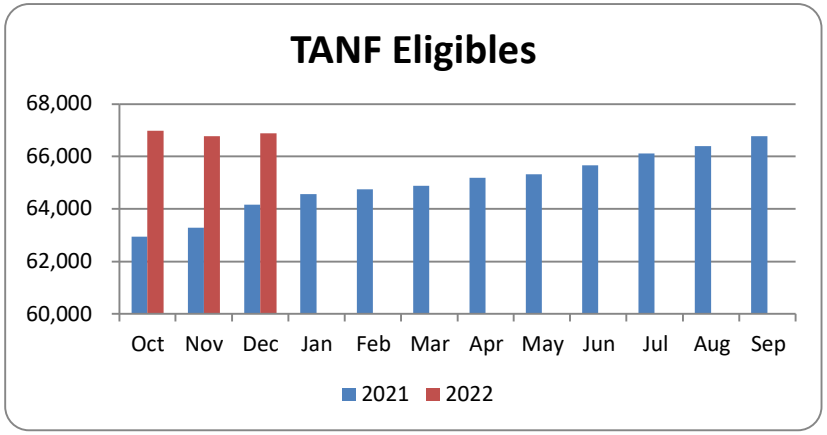
Northern Michigan Regional Entity

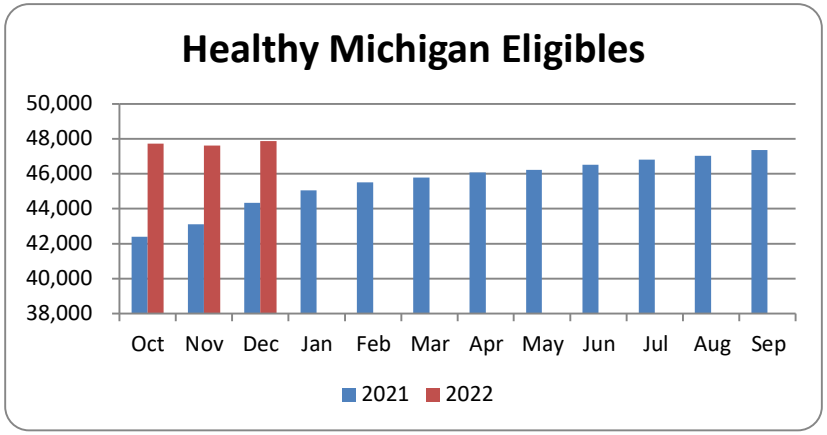
Narrative

October 1, 2021 through December 31, 2021

Regional Eligible Trending





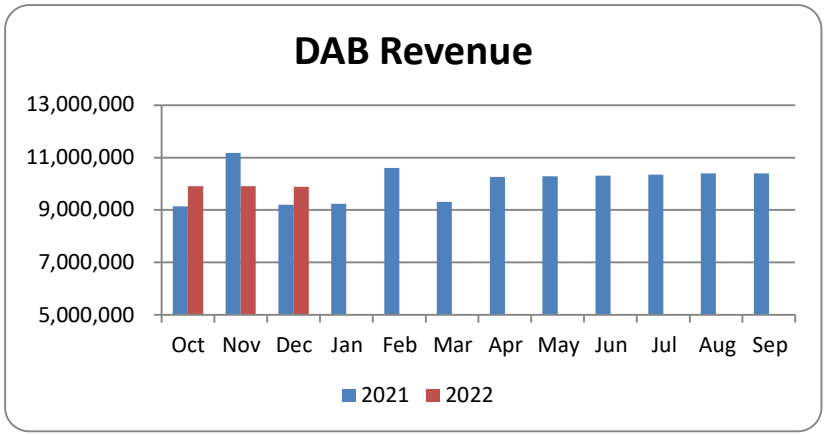


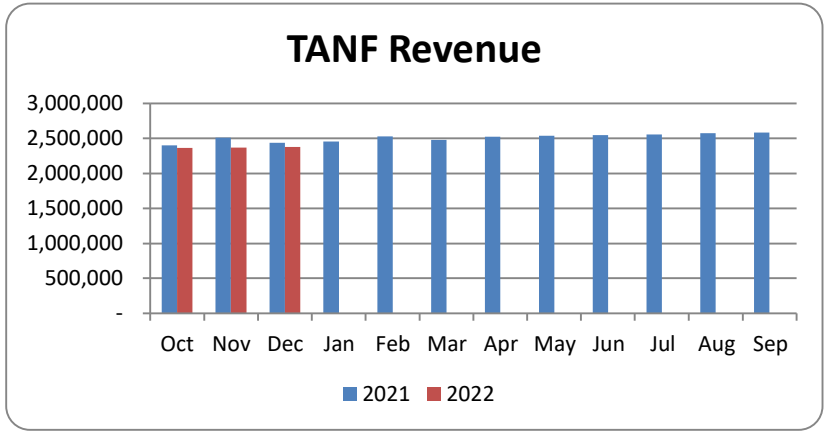
Northern Michigan Regional Entity

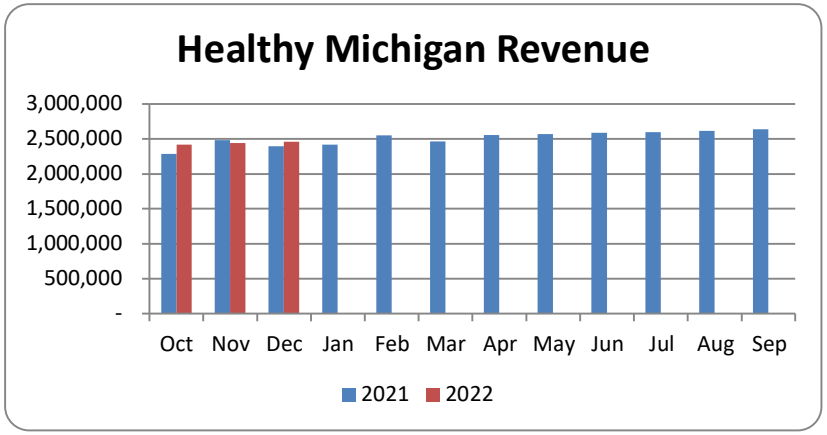
Narrative

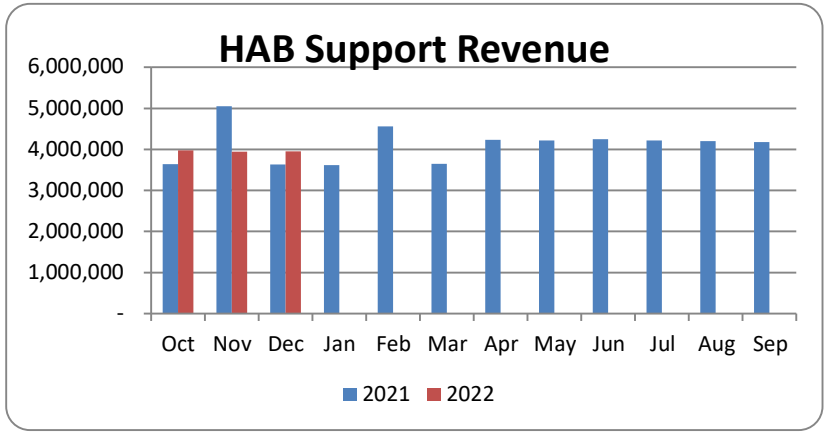
October 1, 2021 through December 31, 2021

Regional Revenue Trending









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

ATTENDEES:	**Joanie Blamer, Christine Gebhard, Chip Johnston, Eric Kurtz, Diane Pelts, Nena Sork, Carol Balousek**
GUESTS:	**Elizabeth DeJongh, Karen Everett, Krista Hausermann, Natalie McQueary**

REVIEW AGENDA & ADDITIONS
Ms. Pelts requested that a discussion about the NMRE annual site review/training & documentation tool be added to the meeting Agenda.

APPROVAL OF PREVIOUS MINUTES
The January minutes were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE MINUTES OF THE JANUARY 18, 2022 NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE MEETING; SUPPORT BY CHRISTINE GEBHARD. MOTION APPROVED BY CONSENSUS.

FINANCE COMMITTEE & RELATED
December Financials

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

MOTION BY CHRISTINE GEBHARD TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2021; SUPPORT BY DIANE PELTS. MOTION APPROVED BY CONSENSUS.

FY22 BUDGET STABILIZATION
Ms. Gebhard provided an update on the adult Crisis Residential facility planned for Gaylord; one bid has been received for the renovations and another is expected. The two bids will be presented to the North Country Board. The target date for the renovations to be completed was

given as May of this year. Ms. Gebhard and Ms. Blamer noted recent home closures due to staffing issues.

Mr. Kurtz reported that he was notified by the CMH Partnership of Southeast Michigan that the IRS placed a Notice of Levy on Bear River Health for failure to submit payroll taxes. Southeast Michigan, Network 180, and Ottawa County CMH were notified to send payments due to BRH to the IRS. Mr. Kurtz has been discussing the matter with legal counsel, Steve Burnham. Al Jansen, Jeff Wieferich and Liz Hertel was notified of the issue. A response was obtained from BRH CEO, Dan Hartman, stating that the full amount of the levy was paid on February 11th. No closures of BRH sites have occurred to date.

Ms. Gebhard asked the other Boards what they have are planning for staff COLAs.

- AuSable Valley – Is planning to request an increase of 2% - 4% in April.
- Centra Wellness – A request for an increase of 4% will be taken to the CWN Board.
- North Country – A 3% increase was included in the FY22 budget but has not been enacted yet; it will likely be retroactive to October 1st.
- Northeast Michigan – A 3% COLS was given plus an additional 2% increase to offset rising health insurance costs.
- Northern Lakes – NL, 3% added a 5% increase to help with insurance premiums (BC/BSM up 18%).
- NMRE – A 3% COLA was issued to staff for FY22 and has recently instituted longevity pay (2% of annual salary) for staff maxed at their current pay classifications.

It was noted that salary structures are also under review.

MiCAL 988

Elizabeth DeJongh, Karen Everett, Krista Hausermann, and Natalie McQueary from MDHHS joined the meeting to conduct a leadership-level discussion of the MiCAL 988 rollout.

MiCAL 988 is not intended to circumvent any current channels available to clients to contact the CMHSP but is intended to provide a point of entry to individuals who do not know where to call.

Additional training activities are planned for staff up until the GO LIVE date of March 31, 2022.

A Contact information worksheet was shared with the Boards; the due date to MDHHS was given as February 28th.

Ms. Blamer noted that NAMI is promoting 988; she is concerned that MiCAL may report ProtoCall wait times to recipient rights.

LAMBERT

A letter drafted on behalf of AuSable valley prepared by Lambert PR was included in the meeting materials. After the letter was received via email on February 7th, Mr. Kurtz contacted Ms. Pelts; Ms. Pelts had not seen the letter and was not supportive of its content. Mr. Kurtz expressed that he is overall unimpressed by the work Lambert PR has done for the NMRE to date; he is considering ending the relationship and going in a different direction.

PERFORMANCE BONUS

Mr. Kurtz reported that the NMRE scored 100% on the FY21 Pay for Performance measures resulting in a Performance Bonus Incentive Payment of $1,737,751.66 which will be sent on February 28th.

PARITY

Mr. Kurtz announced that the State is going to put parity in the FY22 audit. He stressed that we cannot be more restrictive in our process than national parity guidelines. Some aspects of parity can be integrated in PCE. Currently there is no direction regarding what the audit will include. This topic will be diverted to the Regional Clinical leadership Committee.

The CMHs taking on Face-to-Face Assessments for SUD was discussed. Staffing issues have delayed the process. Masters level staff and bachelors level staff under a MCBAB development plan will be required to perform the Assessments.

INPATIENT RATES

Inpatient Psychiatric Tiered Rates

A PowerPoint from MDHHS titled "Inpatient Psych Tiered Rate Discussions" dated February 3, 2022 was included in the meeting materials. The tiered rates were developed using a staffing ratio system instead of using violent behavior/violent incidents. Draft rate calculations are based on:

1. Relative increase of service staffing needs between rate tiers 1 – 4, starting with a Tier 1 "baseline" per diem rate.
2. Given the differentials across rate tiers, preliminary baseline per diem rates were developed under different scenarios.

Illustrative Adult Services Model

Rate Tier	Estimated Utilization	Baseline Per Diem Rate	Rate Differential	Preliminary Per Diem Rate
Baseline Tier 1	77%	$702.30	0%	$702.30
Enhanced Tier 2 (2:1)	15%	$702.30	46.1%	$1,026.06
Enhanced Tier 3 (1:1)	6%	$702.30	92.2%	$1,349.82
Enhanced Tier 4 (1:2)	2%	$702.30	184.4%	$1,997.34

Illustrative Pediatric Services Model

Rate Tier	Estimated Utilization	Baseline Per Diem Rate	Rate Differential	Preliminary Per Diem Rate
Baseline Tier 1	77%	$764.26	0%	$764.26
Enhanced Tier 2 (2:1)	15%	$764.26	46.1%	$1,116.58
Enhanced Tier 3 (1:1)	6%	$764.26	92.2%	$1,468.91
Enhanced Tier 4 (1:2)	2%	$764.26	184.4%	$2,173.56

It was noted that, if the Standard Cost Allocation (SCA) is still being pushed through the MDHHS-PIHP Contract, the NMRE will develop a regional strategy for completing it.

Hospital Rate Request

War Memorial Hospital requested a rate increase of 35% (to $1,250) for FY22. It was noted that NorthCare Network locked in a three-year rate of $925 in FY20. Member CMHSPs do not

currently have contracts in place with War Memorial; Single Case Agreement will be used for the remainder of FY22, after which War Memorial will be operating in the MyMichigan (formerly MidMichigan) health system. Mr. Johnston expressed that NMRE should not be paying more than the lowest negotiated Medicaid rate. NMRE will continue to communicate with Marla Bunker, Chief Nursing Officer/Chief Operating Officer at War Memorial.

SENATE BILLS, NORTHERN MICHIGAN COUNTY ASSOCIATION

CMHAM advocacy efforts continue. Public polling is being conducted to gauge the public's impression of the bills. Bob Sheehan and Alan Bolter plan to meet with Governor Whitmer in the near future, during which their strong opposition to SB 597 & 598 will be presented.

ANNUAL SITE REVIEW

Ms. Pelts questioned the requirements included in the NMRE staff training review tool for the upcoming audit as some of the elements seem overly rigorous. Mr. Kurtz agreed to review the tool and the basis/citations for each standard with NMRE site review staff.

Mr. Johnston questioned why deemed status is not given to organizations meeting the criteria for accreditation by a national accreditation body. Boilerplate language requires MDHHS to recognize accrediting organizations for Medicaid health plans and to consider accreditation results when reviewing health plan performance with state program review criteria or audit requirements.

NEXT MEETING

The next meeting was scheduled for March 15, 2022 at 9:30AM in Gaylord.

email correspondence

From: Jackie Wurst
To: Eric Kurtz (NMRE); Sara Sircely (NMRE); Deanna Yockey (NMRE)
Subject: IRS Levy Update
Date: Wednesday, February 16, 2022 4:48:22 PM

(Sara can you please make sure Eric and Deann receive this. I have IT looking at why they weren't receiving, but want to make sure they don't miss it)

We are writing to inform you of the updates regarding the IRS Levy that was placed on Bear River Health.

Thursday, February 12th we became aware of the Levy that notification was sent to MDHHS and several of our contractual relationships from Eric Kurtz at NMRE. On Friday February 11, 2022 the full amount of the Levy was paid in full by cashiers check, FedEx overnight through our tax attorney, resolving this issue and we are expecting written confirmation of this resolution. We will be providing the documents of discharge of tax obligation resolution when we receive them for our tax attorney.

We again would like to reassure all of our contracts that Bear River Health organization is solvent with their financials with continued support from our Board and investors. We look forward to continuing a healthy contractual relationship in the future.

Best Regards,
Daniel Hartman, Executive Director

Jackie (Wurst) Guzman, RMA, CCAR
Financial Director
Humility is not thinking less of yourself, it's thinking of yourself less. -C. S. Lewis

2329 Center Street
Boyne Falls, MI 49713
Phone: (231)535-2822
Cell Phone: (231) 758-4566
Fax: (231)535-2372

www.bearriverhealth.com

Bear River Health at Walloon Lake
2329 Center Street
Boyne Falls MI 49713
Tel 231-535-2822 Fax 231-535-2372
bearriverhealth.com

BEAR RIVER HEALTH

BRH at Walloon Lake

February 11, 2022

To all PIHP providers:

RE IRS LEVY

Dear Sir or Madam:

Prior to the current administration at BRH there was a payroll tax liability that was incurred by BRH. It was before there were even contracts with the PIHPs in 2018.

Walloon Lake Recovery Lodge, LLC, (dba Bear River Health) did make a most serious, naive, even egregious error early in its inception by prior management to not employ a payroll payment agency such as Paychex or ADP and processed payroll itself, internally. This error in judgement caused nonpayment of taxes due, not by intention, but by naivety; and, this is quite embarrassing frankly. Once the issue came to the attention of new BRH management, a meeting was held with the IRS at which time a plan was agreed upon to make payments for past due taxes over time. BRH would be considered to be in "good standing" with the IRS and its tax obligations with this payment plan in place. It was correctly determined that no malice, and no fraud was intended by BRH and as such a payment plan was satisfactory to the IRS and other taxing authorities so BRH was able to continue business as a "compliant" organization. This a settlement agreement was made in 2017 or 2018 and a significant payment made with a payment plan.

I understood as a board member the following information. BRH contracted with On Target to handle resolution and a payment agreement was made that had an automatic debit each month.

When COVID 19 disrupted normal business activities across all businesses globally, and even government operations, this regular, scheduled payment to the IRS was interrupted / suspended by the IRS (without notice or explanation to BRH). BRH contacted its legal representative of record with the IRS to resolve this "non payment" issue because of its known imperativeness and importance. Our legal representative on record with the IRS informed us that our IRS agent has been reassigned and that we had no replacement representative to communicate with to resolve this, or even discuss this interruption of payments on our payment plan. On Target communicated to us that the IRS operations were extremely negatively affected by the COVID response

directives put in place with people working from home and also being besieged by the monetary policies enacted to offset the negative effects of the COVID outbreak exacted on the economy and the IRS was extremely overworked with new efforts of supporting the economy through tax relief protocols. BRH continued repeatedly requesting communication with the IRS regarding reinstitution of the payment plan but to no avail.

When COVID-19 hit the country through no request of BRH, the IRS suspended collection and there was no method in place for us to make voluntary payments. The original payment "pin" was set up by persons no longer affiliated with the company to our knowledge and we need the pin to make voluntary payment. A requested pin was mailed to the address that was on file and not received. BRH then sent paperwork to have an address change and new pin sent which has still never arrived.

Alas, a new IRS agent was just recently assigned to the BRH IRS file and this person, without communication to our legal representative on file with the IRS or BRH itself, ordered the levies in question before us now. Our legal representative assured us that this was not proper and that it would be halted as we re-engaged with the IRS to reinstitute our payments on the agreed payment plan and maintain our good standing with the IRS. Since April of 2021 Bill Gitre was working with Eric Hoogland and On Target to reinstate the payment agreement or settle. Our calls to the IRS had gone unreturned.

The current 2017 liability is $257k. That sounds like a lot but that is less than 1/2 of a month revenue and is an amount that our principle board member stands ready and willing to pay.

Approximately two weeks ago, BRH was informed of a bank levy and notified our tax attorney. At that time BRH was told that it was being handled and that it was a mistake because we had never violated our payment plan by our attorney.
Last week BRH received a levy against our primary accounts at Fifth Third Bank and this resulted in impoundment of $57k and significant disruption. However, BRH received over $275,000 in revenue after the impoundment and was permitted to continue using the accounts. Our tax lawyer On Target reported that some form of protest was filed and that a hearing transpired on Wednesday, February 9, 2022. It was reported to me by Eric Hoogland that the hearing resulted in a favorable determination and that the IRS was going to retract all levies. Obviously that has not occurred yet and I do not have a written order. The basis for the decision at the emergency hearing and as I understand it, the levy was to be removed because we did not default on agreement.

To make matters more interesting the IRS and our attorney were close to settling in a payoff amount that included a waiver of interest and penalties in total or in part and that Eric Hoogland our board member/investor was willing to pay on our behalf and provide us a promissory note.

On Thursday, February 10, 2022 I attempted to find out the amounts impounded from Fifth Third Bank so we could factor in the amount of it could be determined that the money was sent to the IRS or being returned based on the hearing. This was deemed necessary to have a settlement.

The representative from Fifth Third bank told me basically that they did not have to share the information. BRH has a rough idea of the amount and can calculate it but 5/3rd just emptied our accounts to zero. However, there is no entry in our online bank related to the withdrawn/impounded funds as BRH did not make a notation that we can observe. Further, BHR has no information if the funds that were taken have left the bank or if the funds had been sent to the IRS or are being returned.

Regardless, I have been informed by NMRE email letter from Eric Kurtz late in the day on February 10 that several of the PIHPs and MIDHHS have received a levy and been told to withhold money. I have not received this communication from any region and have not seen the actual levy. At the very end of the day I was informed by Region 3 NW180 and Ottawa that they are closing admissions until the matter was resolved.

I have not had the opportunity to address this issue with them but it seems that if a levy is actually in place and remained in place that the solution would be to withhold payment and not admissions.

The challenge to date is that the situation has been turned over to Eric Hoogland and investor/board member and On Target attorney John Worth the tax lawyer.

Eric has set aside $1.5 million in cash in the reserve to wire to settle both the IRS and all of our payroll or liabilities. This support has is also been required as BRH has not received the requested provider support funds from December during our outbreak from NMRE as well as the contracted rate change which was effective from October 2021.

That being said, BRH is not allowing this interim issue to affect service delivery and will continue with operations with the support of our internal team and patiently wait until the IRS issue is resolved and the provider support and contract adjustment I settled.
I assure you that BRH remains both solvent and fiscally responsible and provide compliant care.

I requested a meeting yesterday with Eric Kurtz of NMRE scheduled for today at 1 pm. I will also be seeking one today with Region 3. Furthermore, I am ready and willing to meet with any region or interested party to review as needed.

Again, BRH takes our mission seriously to serve the clients and our staff. Turning Point, a major detox facility, is closed due to an outbreak and/or staffing. Per the BRH board, we will continue to maintain all services including detox regardless of authorization until the dust settles and the IRS levy is paid. This is because of the community need.

I can be reached at 231.758.4570 or Dan.Hartman@bearriverhealth.com

Sincerely,

Daniel J. Hartman

BRH Executive Director

email correspondence

From:	Monique Francis
To:	Dr. Timothy Kangas; Eric Kurtz (NMRE); Mary Marlatt Dumas; Brad Casemore; Joe Sedlock - MSHN (joseph.sedlock@midstatehealthnetwork.org); James Colaianne; Eric Doeh; Dana Lasenby; Dave Pankotai; Jim Johnson
Subject:	PIHP Representative Information you requested
Date:	Thursday, February 3, 2022 9:14:25 AM
Attachments:	image002.png

Group:
See below the information that you requested on Board of Directors Meetings (by-laws, meeting schedule, etc.) to aid in your determination of a PIHP Delegate replacement.
I hope that this information is helpful in your search. Please let me know if you have any questions!~

By-Laws Article VII:

ARTICLE VII
BOARD OF DIRECTORS

(A) The Board of Directors has the charge and authority to manage the organization and act on behalf of the organization in a manner which is consistent with the policy, goals and purpose established by the full membership in meetings of the Member Assembly. The Board of Directors shall implement and ensure the actions of the strategic plan. At the direction of the President and Board of Directors, all policies will be reviewed on an annual basis.

(B) There will be a Board of Directors consisting of: the officers of the Association; regional representatives composed of three (3) representatives from each of the regions, one of these representatives shall be an Executive Director and two (2) shall be board members; Standing Committee co-chairpersons; four (4) representatives of the PIHPs (collectively), as designated by the PIHPs, and four "at large" provider representatives, in accordance with Article III (E)3(b). Voting membership on the Board of Directors is limited to the above.

(C) Regional Representatives:

1. Regional representatives to the Board of Directors shall be elected by delegates in each region for three-year terms. One-third of the regional representatives shall be elected each year.
Note there is no term for PIHP representatives.

2. Vacancy:

The unexpired term of a regional representative to the Board of Directors shall be filled in the manner as provided in this Article. When a regional representative resigns or is removed from office before his or

her term expires, the appropriate regional alternate shall serve the remainder of the unexpired term. Should the alternate be unwilling or unable to serve, the region may elect a new regional representative to serve for the remainder of the unexpired term at its next regularly scheduled meeting or at a special regional meeting which may be called at the discretion of the regional chairperson. The new regional representative shall assume the duties of the regional representative he or she replaces immediately upon election.
The unexpired term of a PIHP representative to the Board of Directors shall be filled by the PIHPs as designated. The new PIHP representative shall assume the duties of the PIHP representative he or she replaces immediately upon designation.

3. Removal:

A regional representative may be removed from his or her position for misfeasance or nonfeasance when a two-thirds (2/3) vote of the Association decides that it would be in the best interests of the Association to do so. The Board of Directors by majority vote may remove any regional representative who has accumulated three (3) unexcused absences at Board of Directors meetings, regular or special, within the regional representative's term of office.

A PIHP representative to the Board of Directors may be removed from his or her position for misfeasance or nonfeasance when two thirds (2/3) vote of the Association decides that it would be in the best interests of the Association to do so. The Board of Directors by majority vote may remove any PIHP representative who has accumulated three (3) unexcused absences at Board of Directors meetings, regular or special, within the PIHP representative's term of office.

(D) Each region shall be represented by its designated representatives or their alternates. Each region shall select an alternate board member and an alternate Executive Director who may vote on matters before the Board of Directors in the absence of the regional representative for whom they are designated as an alternate.

(E) The co-chairpersons of all Standing Committees shall be members of the Board of Directors and shall report on the recommendations of their respective Committees at each meeting of the Board of Directors.

(F) Board of Directors Meetings:

1. Meetings:

The Board of Directors will meet at least six (6) times annually, at such time and in such place as it shall direct. Meetings of the Board of Directors may be called by the President or by written notice signed by

one-half (½) of the members of the Board of Directors. Meetings may be conducted in person, by audio or video conference, or by a combination of the above.

2. Notice:

All meetings of the Board of Directors shall be called by means of actual notice, written or oral, to each Board of Directors member, at least seven (7) days prior to a meeting, stating the time, date, place and purpose of the meeting. No action taken at such a meeting shall be invalid for want of notice if duly waived by two-thirds (2/3) of the Board of Directors.

3. Quorum:

The presence **(**including audio or video conference participation**)** of a majority of the members of the Board of Directors eligible to vote shall constitute a quorum for the transaction of business at any meeting of the Board of Directors and the members may continue to transact business until adjournment notwithstanding the withdrawal of enough members to leave less than a quorum.

2022 Meeting Schedule:

Board of Directors Meetings in 2022 (formerly known as "Executive Board")

9:30am unless otherwise indicated

- February 4, 2022 (Hybrid – Zoom and In Person options available)
- April 15, 2022 (Hybrid – Zoom and In Person options available)
- June 6, 2022 (at spring/summer conference, 4pm)
- August 5, 2022 (Hybrid – Zoom and In Person options available)
- October 23, 2022 (at fall conference, 4pm)
- December 2, 2022 (Hybrid – Zoom and In Person options available)

Downtown I-496 to close for months in both directions – This may affect your route when coming to the CMHA Office. (click link below for information)

https://lansingcitypulse.com/stories/downtown-i-496-to-close-in-both-directions-for-six-months,19536

Please be aware that I will be working from home Mondays, Wednesdays and Thursdays, and

working in the CMHA Office on Tuesdays and Fridays. This schedule is subject to change according to meetings that may be held in the office. I am returning emails regularly, and can be reached on my cell phone on days that I am working remotely. My cell number is listed below in my signature.

Monique Francis

Monique Francis, Board of Directors & Committee Clerk
Conference Exhibit Coordinator
Community Mental Health Association of Michigan
426 South Walnut Street, Lansing MI 48933
Direct Line: (517) 237-3145 Fax: (517) 374-1053
Cell: (517) 648-9258
cmham.org

"I'm trying to be totally awesome today,
But I'm exhausted from being totally awesome yesterday!"

email correspondence

From: Harrison, Julie (DHHS)
To: Eric Kurtz (NMRE); Carol Balousek (NMRE); Tema Pefok
Cc: Andrews, Debi (DHHS); Stoneburner, Brenda (DHHS)
Subject: FY21 Performance Bonus and Incentive Feedback
Date: Friday, January 28, 2022 11:58:42 AM
Attachments: image002.png
NMRE_FY21 Incentive Feedback.docx
Importance: High

SENDING ON BEHALF OF DEBI ANDREWS

Good morning,

This communication serves as the consultation draft review response to your PIHP regarding the FY2021 performance bonus, contract section 8.4.2. Scoring is based on PIHP/MHP Joint Metrics and PIHP-only deliverables.

Your PIHP has earned full points in both areas.

FY21 Total .75 Performance Bonus Incentive Pool

	Total $ Available (.75 withhold)	Total Withhold Unearned
NMRE	**$1,737,751.66**	**$0.00**

PIHP/MHP Joint Metrics

Joint metrics with the MHPs included J.1 Implementation of Joint Care Management Processes, J.2 FUH Performance Measure, and J.3 FUA Performance Measure. The final Follow-up after Hospitalization for Mental Illness within 30 Days (FUH) for the 7/1/2020-06/30/2021 measurement period and Follow-up after ED visits for Alcohol and Other Drugs (FUA) were posted in CC360 in January 2022.

Points earned are displayed in the tables below.

J.1

Joint Care Management Processes (35 points)

	Joint care mgmt processes Yes = 35, No = 0
NMRE	35

J.2

Follow-up after Hospitalization for Mental Illness within 30 days July 2020 -June 2021(20 points)

	Scored 6-20 Combos	Scored 6-20 Combos Meeting Standard	Scored 21-65 Combos	Scored 21-65 Combos Meeting Standard	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	**Score (maximum = 20)**
NMRE	2	2	4	4	6	3.33	6	**20**

Follow-up after Hospitalization for Mental Illness Disparity 2020.7-2021.6 (20 points)

	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	**Score (maximum = 20)**
NMRE	3	6.67	3	20

J.3

Follow-up after ED visits for Alcohol and Other Drugs Disparity (25 points)

	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	**Score (maximum = 25)**
NMRE	3	8.33	3	25

Joint metric results are represented below in dollar amounts.

PIHP Joint MHP Metric Score (100 points)

	Score	**Score Converted to Percentage**	**Joint Metric Total $ Available**	**Total Joint Metric Earned**
NMRE	100	100%	$ 521,325.50	$ 521,325.50

PIHP-only deliverables

PIHP-only deliverables included P.1 Quarterly Veteran Service Navigator data submissions; BHTEDS Data Quality Narrative Report, P.2 Admission Discharge and Transfer (ADT) submissions, and P.4 Narrative report on patient-centered medical home-like participation. Points earned along with dollar amounts are displayed in the table below.

PIHP-only Incentive Score (200 points)

	Total PIHP-only $ Available	P.1 & P.2 Total PIHP-only $ Earned	P.4 PIHP-Only $ Earned	Total PIHP-only $ Earned
NMRE	$1,216,426.16	$695,100.66	$521,325.50	$1,216,426.16

*See Attached FY21 Incentive Feedback for scoring.

Final FY2021 Performance Bonus Incentive Pool award notices will be sent by February 28.

Thank you,

Debi Andrews

Debi Andrews, MBA, State Administrative Manager
Data, Eligibility and Payment Section
Behavioral Health & Developmental Disabilities Administration
Michigan Department of Health and Human Services (MDHHS)
320 S. Walnut St.
Lansing, MI 48913

Michigan Department of Health & Human Services

Julie R. Harrison

Executive Secretary
Program Development, Consultation, and Contracts Division
Behavioral Health and Developmental Disabilities Administration
Michigan Department of Health and Human Services

Lansing, Michigan
Phone: 517-335-3768
Fax: 517-335-5376

Northern Michigan Regional Entity – Region 2
FY21 Pay for Performance

PIHP-only Deliverables/Narratives Score: 200

Feedback & Scoring Form

PIHPs earning 200 points will earn full incentive dollars.

PIHP-only Deliverables		
☑ REVIEW ☐ FINAL		
P.1 Veteran Service Navigator Data Submissions:	**Point Allocation**	**Submission Points**
The VSN Data Collection form will be submitted to the State by the last day of the month following the end of each quarter.	***25***	**25**
P.1 BHTEDS and VSN Comparison Narrative:	**Point Allocation**	**Submission Points**
Plans will be expected to monitor BH-TEDS records showing "not collected" on military and veteran fields Plans will submit a 1-2 page narrative report on findings and any actions taken to improve data quality.	***25***	**25**
P.2 Admission Discharge and Transfer Submissions:	**Point Allocation**	**Submission Points**
By July 31, Plan must submit, to the State, a report no longer than 2 pages listing CMHSPs sending ADT messages, and barriers for those who are not, along with remediation efforts and plans.	***50***	**50**
P.4 Patient-centered Medical Home Participation Narrative:	**Point Allocation**	**Submission Points**
Increased participation in patient-centered medical homes: • Comprehensive Care • Patient-Centered • Coordinated Care • Accessible Services • Quality & Safety	***100***	**100**
TOTAL SCORE: 200/200		

P.1 BHTEDS and VSN Comparison Narrative Review:

Report fulfills stated purpose; however, does not give specific/detailed information/results of comparisons done between BHTEDS & Veteran Navigator Report.

P.2 Admission Discharge and Transfer Report Review:

NMRE stated that work in this area was disrupted by COVID-19. Four CMHSPs have requested to enable outbound ADTs to MiHIN and NMRE will monitor to ensure progress is made. Northern Lakes Community Mental Health is currently submitting ADT notices.

P.4 Patient-centered Medical Home Participation Narrative Review:

The narrative sufficiently summarized participation in patient-centered medical homes and similar activities.

Your PIHP has earned full points in both the PIHP/MHP Joint Metrics and PIHP-only deliverables.

FY21 Total .75 Performance Bonus Incentive Pool		
	Total $ Available (.75 withhold)	**Total Withhold Unearned**
NMRE	$1,737,751.66	$0.0

ENHANCING OUR **Community Mental Health** SYSTEM

MENTAL HEALTH LISTENING TOUR
MICHIGAN HOUSE DEMOCRATS

Overview

Between September and December 2021, Michigan House Democrats held over 15 Mental Health Listening Tour stops throughout Michigan. The goal of these tours was to facilitate a guided discussion among local mental health practitioners, consumers, and their families on the current state of our Community Mental Health (CMH) system in Michigan. The tour was meant to ensure that any changes to our CMH system were consumer-centered. Consumers and families need to be actively involved in the planning and delivery of services at all levels of the system.

Through these listening tours, we were able to learn about the great work being done locally throughout our CMH system as well as identify areas for improvement. Issues such as access, workforce recruitment and retention, and funding were all common challenges across the state. Michiganders deserve and expect a strong public mental health system. By implementing key policy changes and making targeted investments, Michigan can continue to enhance the system it has built over the past 50 years and create a system that is accessible, person-centered, and community-driven.

Key Takeaways

1. **Keeping Community Mental Health in the Community:** Consumers and mental health practitioners alike support a community-based approach. Most people do not want to see services and decision-making taken out of the local setting. There are countless local partnerships that are working well and should not be disrupted. In fact, many argued that it is through local partnerships that consumers are able to get appropriate services.

2. **Elevating the CCBHC Model:** Certified Community Behavioral Health Clinics (CCBHCs) are a new provider type in Medicaid that must directly provide (or contract to provide) nine types of services. They emphasize 24-hour crisis care and integration with physical health care. CCBHCs are available to any individual in need of care, which is crucial in helping improve access to care for our mild-to-moderate population. Supporting the implementation of CCBHCs in the initial pilot sites (there are currently 36 sites in Michigan) and continuing to scale up statewide is imperative in improving access to care for all Michiganders.

3. **Constant Efforts to Restructure Creates Instability Within the System:** There have been numerous proposals over the years that would drastically alter how behavioral health care is delivered in Michigan. From drastic funding cuts to complete system overhauls, each measure (real or perceived) destabilizes the system and directly impacts consumers, their families, and workforce recruitment and retention.

Albion
Ann Arbor
Battle Creek
Detroit
Grand Rapids
Kalamazoo
Lansing
Livonia
Marquette
Novi
Saginaw
Traverse City (2)
Troy
Warren

15 Listening Tour Sessions

88 Panelists

30+ Hours Spent Listening

38 Survey Responses

450 Attendees

Report prepared by
State Representative Felicia Brabec
101st Legislature • December 2021

Key Takeaways (continued)

4. **Improving Workforce Recruitment and Retention:** The pandemic has only exacerbated already existing workforce issues. Across the state, we are seeing challenges in recruiting and maintaining a qualified workforce. Commonly cited challenges include low wages and benefits, overly burdensome documentation, increased workload, need for child care, lack of training reciprocity, and lack of professionalization of career paths – particularly for our direct care workers.

5. **Adopting a New Funding Strategy:** Over the years, a number of financing decisions have systematically restricted the ability of Michigan's public mental health system to meet the needs of Michiganders. Funding is far below what is needed to meet growing demand. General Fund cuts, the inability of the public system to retain savings, and insufficient Medicaid reimbursement rates are all issues that need to be addressed.

6. **Relieving Administrative Burdens:** In the behavioral health system, there is a tremendous amount of duplication and redundancy in the way the state reviews and audits. There needs to be oversight of the system, but we need to eliminate the duplication and non-value added requirements. These administrative burdens often take away time from helping consumers, and can create significant hurdles for those seeking care.

7. **Addressing Barriers to Access:** There are still barriers to access for consumers for a multitude of reasons. We need to continue to support the work of the system in coordinating the network of services necessary to address the range of social determinants of health: housing, employment, food access, transportation, family support, child care, etc. The shortage of acute and residential psychiatric beds and broadband capacity to access telehealth are also key to addressing access.

8. **Improving Stigma and Public Awareness:** Many people stressed the importance of destigmatization, education, and outreach. More needs to be done to lessen the impact stigma can have on seeking care. Similarly, there needs to be greater clarity in describing available services so that people know where the "front door" is.

MENTAL HEALTH LISTENING TOUR
MICHIGAN HOUSE DEMOCRATS

Conclusion

There are many aspects of the Community Mental Health system that are working well for consumers and should be celebrated. The system has demonstrated strong performance in providing a wide range of services to multiple populations in the community setting. Much of these successes can be attributed to local partnerships, a person-centered approach to care, and the system's proven ability to control costs.

These successes prove the system is working. However, it is equally important for us to recognize areas in which the system can be enhanced. Through thoughtful, responsive legislation, we can work to address barriers to access, issues with workforce recruitment and retention, better address social determinants of health, and improve funding. We can also work to revise departmental policies to reduce duplication and redundancy within the system. There is much work to be done, but we are committed to offering changes in a way that actively involves consumers and their families.