Northern Michigan Regional Entity

Board Meeting

August 24, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – July 27, 2022	Pages 2 – 7
7.	Correspondence	Pages 8 – 66
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – August 9, 2022 and August 24, 2022	Page 67
	c. CEO's Report – August 2022	Page 68
	d. Financial Report – June 2022	Pages 69 – 90
	c. Operations Committee Report – No Report	
	e. NMRE SUD Oversight Board Report – Next meeting is September 12, 2022	
11.	New Business	
12.	Old Business	
	a.. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest	
13.	Presentation/Discussion	
	NMRE FY23 Proposed Budget	Pages 91 – 99
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – September 28th at 10:00 am	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – JULY 27, 2022
GAYLORD BOARDROOM

ATTENDEES:	**Kate Dahlstrom, Ed Ginop, Gary Klacking, Gary Nowak, Jay O'Farrell, Karla Sherman, Don Smeltzer, Joe Stone, Don Tanner**
VIRTUAL ATTENDEES:	**Angie Griffis (Roscommon), Terry Larson (Rogers City)**
ABSENT:	**Roger Frye, Christian Marcus, Mary Marois, Richard Schmidt**
NMRE/CMHSP STAFF:	**Amy Christie, Lauri Fischer, Eric Kurtz, Tema Pefok, Pamela Polom, Sara Sircely, Teresa Tokarczyk, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Susan Pulaski, Sharon Vreeland, Sue Winter, Susan Wojtkowiak**

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 Roger Frye, Christian Marcus, Mary Marois, and Richard Schmidt were excused from the meeting on this date; all other NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

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

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR JULY 27, 2022; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

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

MOTION BY JAY O'FARRELL TO APPROVE THE MINUTES OF THE JUNE 22, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

CORRESPONDENCE

1) The minutes from the July 7, 2022 PIHP CEO meeting.
2) Correspondence received through the NMRE ticketing system from Kate Dahlstrom regarding Grand Traverse County and Northern Lakes CMHA.
3) A letter from Farah Hanley, Chief Deputy for Health at MDHHS dated June 30, 2022 announcing the public comment period for the Home and Community Based Services (HCBS) Program transition.
4) A memorandum from Jeff Wieferich, Director of Community Based Services at MDHHS, dated June 30, 2022 regarding request for supplemental reporting information.
5) Email correspondence from CMHAM dated July 8, 2022 urging comment on proposed Medicaid Policy (Project #2153-BH) to move all HCBS services to a 1915(i) benefit.
6) A memorandum from Jeff Wieferich at MDHHS dated July 15, 2022 regarding CMS Financial Management Review of PIHPs' use of Internal Service Funds (ISFs).
7) CMHAM review of the State's FY23 Final Budget Report.
8) NMRE Quarter 2 FY22 Performance Indicators Report.
9) Memorandum from Eric Kurtz and Don Tanner to Robert Sheehan, CEO of CMHAM, dated July 19, 2022 expressing concerns with making Certified Community Behavioral Health Clinic (CCBHC) a permanent structure through a State Plan Amendment (SPA) (or other waiver mechanism).
10) The draft minutes from the July 13th NMRE Regional Finance Committee meeting.

Mr. Kurtz drew attention to the FY22 Quarter 2 Performance Indicators Report and the memorandum to CMHAM regarding the CCBHC.

ANNOUNCEMENTS

Let the record show that Mr. Nowak called for a moment of silence for Roger Frye. Mr. Stone announced that August will be his last meeting as he is relocating. New Board Member appointed by Northern Lakes, Kate Dahlstrom, was introduced.

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 June Board Meeting.

CEOs Report

The NMRE CEO Monthly Report for July 2022 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to the June 27th meeting with the six county Administrators and six County Commission Chairpersons that comprise Northern Lakes CMHA (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford). Another meeting is scheduled for August 1st which Mr. Kurtz will attend.

May 2022 Financial Report

- Net Position showed net surplus Medicaid and HMP of $11,641,930. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $28,000,047. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $44,358,164.

- Traditional Medicaid showed $133,699,812 in revenue, and $121,972,015 in expenses, resulting in a net surplus of $11,727,797. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $21,158,296 in revenue, and $17,083,552 in expenses, resulting in a net surplus of $4,074,744. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $990,032 in revenue, and $783,025 in expenses, resulting in a net surplus of $207,007.
- SUD showed all funding source revenue of $16,726,785, and $13,980,108 in expenses, resulting in a net surplus of $2,746,677. Total PA2 funds were reported as $5,433,618.

The direct care wage surplus was estimated at $4,160,611.

Ms. Yockey is working with Mr. Kurtz on PMPM estimates by Board for FY23. The $17M carryforward will be spread by FY21 PMPM, which is likely not sustainable into FY24. It was noted that eligibles are trending up. Regionally, NMRE estimated a 4.3% reduction in revenue. Mr. Kurtz reported that he has heard rumblings that DCW surplus may be retained. Revenue projections and the FY23 budget will be presented to the Board in August.

MOTION BY JOE STONE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MAY 2022; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Operations Committee Report
The draft minutes from July 19, 2022 were included in the materials for the meeting on this date. The committee discussed developing Benefit Stabilization plans early in the next fiscal year. For FY23, the NMRE will create a separate line item to distribute Medicaid savings to the CMHSPs as benefit stabilization funds.

NMRE SUD Oversight Board Report
The draft minutes from July 11, 2022 were included in the materials for the meeting on this date. Liquor tax applications (continuations/renewals) for FY23 were due to the NMRE by June 1st; it was noted that new requests may also be submitted at any time throughout the year.

NEW BUSINESS
Liquor Tax Requests
Twenty-two liquor tax renewals for FY23 were presented to the NMRE Substance Use Disorder Oversight Board on July 11, 2022; a summary of the requests and the SUD Board's recommendations were included in the materials for the meeting on this date. Approval of one request was postponed until September pending additional information. It was noted that project budgets were uploaded to the nmre.org website on July 22nd for review.

MOTION BY GARY NOWAK TO APPROVE THE JULY 11, 2022 LIQUOR TAX USE RECOMMENDATIONS BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD TOTALING TWO MILLION THREE HUNDRED SEVENTY-SEVEN THOUSAND SIX HUNDRED EIGHTY-SIX DOLLARS ($2,377,686.00); SUPPORT BY JAY O'FARRELL. ROLL CALL VOTE.

"Yea" Votes:	**E. Ginop, G. Klacking, G. Nowak, J. O'Farrell, K. Sherman, D. Smeltzer, J. Stone, D. Tanner**
"Nay" Votes:	**Nil**
Abstentions:	**K. Dahlstrom**

MOTION CARRIED.

FY23 Prevention Contract Awards
The NMRE conducted a Request for Proposals for FY23 Prevention Services for seven of the NMRE's 21 counties. The NMRE recommended the following:

County	Provider	Amount Requested
Benzie	**No bids were received for Benzie County*	
Grand Traverse	Catholic Human Services	$119,832
Kalkaska	Catholic Human Services	$21,103
Leelanau	Catholic Human Services	$26,430
Manistee	**No bids were received for Manistee County*	
Missaukee	District Health Department 10	$17,612
Wexford	District Health Department 10	$41,828

Ms. Sircely explained that for Benzie and Manistee counties, the NMRE intends to keep the RFP open in the hopes of working with providers in neighboring counties.

MOTION BY GARY NOWAK TO APPROVE PREVENTION CONTRACT AWARDS TO CATHOLIC HUMAN SERVICES IN THE AMOUNT OF ONE HUNDRED SIXTY-SEVEN THOUSAND THREE HUNDRED SIXTY-FIVE DOLLARS ($167,365.00) FOR THE COUNTIES OF GRAND TRAVERSE, KALKASKA, AND LEELANAU AND DISTRICT HEALTH DEPARTMENT TEN (10) IN THE AMOUNT OF FIFTY-NINE THOUSAND FOUR HUNDRED FORTY DOLLARS ($59,440.00) FOR THE COUNTIES OF MISSAUKEE AND WEXFORD; SUPPORT BY JAY O'FARRELL. ROLL CALL VOTE.

"Yea" Votes:	**E. Ginop, G. Klacking, G. Nowak, J. O'Farrell, K. Sherman, D. Smeltzer, J. Stone, D. Tanner**
"Nay" Votes:	**Nil**
Abstentions:	**K. Dahlstrom**

MOTION CARRIED.

MDHHS-PIHP Contract Change Order No.5
Change Order No. 5 to the MDHHS-PIHP Contract was included in the materials for the meeting on this date. Change Order No.6 is anticipated which will correct Change Order No.5 relative to the Performance Bonus Incentive Section. Change Order No. 6 is also expected to include SCA, MLR, Definitions, and Delegation matters despite PIHP objections.

MOTION BY ED GINOP TO APPROVE CHANGE ORDER NUMBER FIVE (NO.5) TO THE CONTRACT BETWEEN THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE NORTHERN MICHIGAN REGIONAL ENTITY; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

Schedule August Executive Committee Meeting
A meeting of the NMRE Board Executive Committee is needed in August to review the CEO's performance and compensation. The decision was made to schedule a meeting of the NMRE Board Executive Committee for August 24, 2022 at 9:15AM (prior to the August Board meeting).

OLD BUSINESS

Senate Bills 597 & 598/House Bills 4925 – 4929 – The Latest
Nothing is expected for SB 597 & SB 598 until possibly later in the fall with the lame duck session.

Grand Traverse County and Northern Lakes CMHA
Mr. Kurtz will be attending the meeting of county Administrators and County Commission Chairpersons on August 1st to discuss opening the Enabling Agreement that created NLCMHA. During its meeting on July 21st, the NLCMHA voted (10-6) to launch a new search for a CEO. Nicole Miller and Justin Reed were removed from the NLCMHA Board on July 12th; they were replaced with Tom Bratton and Kate Dahlstrom. Mr. Kurtz stressed that decisions made regarding dismantling Northern Lakes affect all 21 counties in the region, not just Northern Lakes' six.

PRESENTATION

Quality Assessment and Performance Improvement Program (QAPIP) Update
NMRE Compliance and Quality Officer, Tema Pefok, was in attendance to give the Board an update on the NMRE's FY22 Compliance and Quality Workplans.

- The NMRE is engaging in a Performance Improvement Project (PIP) focusing on enrollment and retention in the Opioid Health Home. A second PIP topic will focus on either: 1) decreasing hospitalizations for medical conditions by increasing enrollment in the Behavioral health Home, or 2) decreasing no-show/missed appointments for psychiatric services through the provision of telehealth services.
- The NMRE (through its Quality Oversight and Compliance Committee) developed a standardized collection process for risk event and sentinel event data.
- The NMRE completed mental health and substance use disorder satisfaction surveys in FY22.
- The NMRE's regional Quality Oversight and Compliance Committee reviewed quarterly performance indicator data.
- The NMRE conducted an annual site review of its CMHSP providers, and a review of its substance use disorder providers' Corrective Action Plans.
- The NMRE and its CMHSP providers completed revisions to their Provider Directories to include a list of physical accommodations (ramps, restrooms, electric doors, etc.)
- The NMRE is in the process of creating a report using Microsoft Power Bi with a dashboard that will allow users to search mileage and travel time from client address to provider locations in response to Network Adequacy standards.
- The NMRE registered with the National Practitioner Data Bank (NPDB) to run monthly checks on healthcare professionals.
- The NMRE implemented DocuSign to facilitate the process of signing contracts and other documentation.

COMMENTS

Board

Ms. Sherman thanked Mr. Kurtz and Mr. Tanner for composing the CCBHC letter to CMHAM.

Ms. Dahlstrom noted that the amount of money received related to the opioid lawsuit settlement was lower than anticipated; she requested that an avenue to file a dispute or advocate for additional funds be identified. Ms. Dahlstrom suggested that a (regional) marijuana tax be established.

Staff/CMHSP CEOs

Mr. Johnston shared that rural directors around the state are annoyed about the Association's recommendation to make the CCBHC a permanent, state planned service. Mr. Johnston drafted a "white paper" detailing these concerns which will be sent to Board Members.

Mr. Johnston expressed appreciation for the support and collaboration that exists within the NMRE region.

MEETING DATES

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on August 24, 2022.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:31AM.

PIHP CEO Meeting
August 4, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

Pre-paid Inpatient Health Plans (PIHP)

Dr. Timothy Kangas (Northcare Network)	Region 1
Eric Kurtz (Northern MI Regional Entity)	Region 2
Mary Marlatt-Dumas (Lakeshore Regional Entity)	Region 3
Brad Casemore (Southwest Michigan Behavioral Health)	Region 4
Tracy Dawson (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

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie
Lisa Collins
Audrey Dick
Erin Emerson
Amy Epkey
Matthew Ellsworth
Farah Hanley
Darrell Harden
Krista Hausermann
Belinda Hawks
Leah Julian
Amy Kanouse
Brian Keisling
Phil Kurdunowicz
Lindsay McLaughlin
Dana Moore
Lindsey Naeyaert
Ernest Papke
Ashley Seeley
Jackie Sproat
Brenda Stoneburner
Scott Wamsley
Keith White
Jeff Wieferich
Amanda Zabor

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

CANS Presentation & Children's Bureau Update

1. Phil Kurdunowicz provided an update on the intent to switch to the Child and Adolescent Needs and Strengths (CANS) Assessment.
    a. This is part of the MI Kids Now initiative.
    b. MDHHS recognizes that it will take years to fully implement.
    c. Lisa Collins will be the point person for the CANS assessment, supported by Phil Kurdunowicz and Kim Bastche-McKenzie. Lisa's email address is collinsl10@michigan.gov.
    d. The target date for the child and older youth population transition to the CANS is October 1, 2024.
        i. MDHHS will engage the PIHPs in the design of the tool and the implementation process over the next year.
        ii. MDHHS is committed to supporting the CMH and PIHP system in this transition, including training supports and resources to fund training statewide and engagement in the design process.
        iii. One of the opportunities the state sees for the CANS is that it does not come with its own pre-constructed system, so MDHHS can design the technology in a way that is user-friendly for clinicians and administrators.
2. Lisa Collins provided an overview of a one-page document sent out the week of July 25, 2022.
3. Kim Bastche-McKenzie stated that nothing would change with the use of the Child And Adolescent Functional Assessment Scale (CAFAS) and Preschool And Early Childhood Functional Assessment Scale (PECFAS) tools in FY 2023. FY 2023 will be used to build a Michigan version of the CANS.
    a. Kim Bastche-McKenzie shared that MDHHS is planning to focus use of the CANS on children from 5-6 years of age up to age 21, with particular attention to the transition-aged youth.
    b. Phil Kurdunowicz stated that the intent was to implement the CANS for children and youth with intellectual and developmental disabilities, including Autism Spectrum Disorder and Serious Emotional Disturbances, so it would bring those populations together under one standardized assessment.
        i. Kim Bastche-McKenzie noted that the CANS does not replace screening tools already being used.
4. A PIHP asked what the best estimate was of the CANS administration timeframe, including preparation and post-interview efforts.
    a. Kim Batsche-McKenzie explained that there were two versions of the CANS, one briefer and one more extensive.
    b. She added that the CANS is based on the bio-psycho-social information providers would already be gathering during their information gathering process, not a separate checklist that the provider would have to run through with the family.
    c. Lakeshore Regional Entity shared that four out of five of their providers have been using the CANS for a significant length of time. Those who use it are extremely positive about it and would like to see even more populations moved into the CANS assessment.
5. Phil Kurdunowicz provided the MI Kids Now update.

a. There are two existing interagency teams: the Workforce Development Team and the Intensive Crisis Stabilization Team.
    i. The Workforce Development Team is focused on incentives and recruitment. It has successfully launched a new MI Kids Now loan repayment service. The application deadline for this was extended through August 5, 2022. MDHHS has received 900 applications already, and this is just the first year of the program. MDHHS hopes to expand this initiative as part of the next fiscal year.
    ii. The Intensive Crisis Stabilization Team is looking at funding opportunities to support expansion of services.
b. MDHHS is also establishing two additional interagency teams.
    i. The Community Behavioral Health Treatment and Placement Options Team's goal is to explore ways to offer additional options for the population when a child is in crisis or needs additional supports beyond what they might receive in their family or foster family's home.
    ii. The Community Reintegration Process Interagency Team will explore options to assist youth rejoining the community from more institutional residential placements. The intent is for this team to operate with a trauma-informed lens to expand treatment in the community.

FY 22 and FY 23 Budget

1. Amy Epkey introduced herself as the Senior Deputy Director over Financial Operations.
    a. She reported that the budget for FY 2023 was signed into law by Governor Whitmer on July 20th as Public Act 166 of 2022.
    b. Due to the volume of new funding and new requirements, it will take MDHHS some time to get the funding out as they determine who takes lead on which components.
    c. She shared several the components of the FY 2023 budget.
    d. MDHHS is already thinking about FY 2024 budget development and encourages the PIHPs' input.
    e. Funds were included for a FY 2022 supplemental budget as well, specifically $1.7 billion for the department. MDHHS is working on implementation plans.

Actuarial Update

1. Keith White provided an actuarial update.
    a. He informed the PIHPs about two upcoming meetings between PIHP representatives and Milliman staff on August 12 and August 16, 2022. He also mentioned a provider survey meeting for early September 2022 but stated there was no scheduled date for that meeting yet.
    b. The actuarial department is still in the process of working with Milliman staff to review the draft FY 2023 rates.

i. They have received feedback from multiple PIHPs about draft enrollment in the rates.
ii. For any additional feedback, he requests they send it to the actuarial inbox at mdhhs-msa-actuarial-division@michigan.gov.

HCBS Update

1. Belinda Hawks provided the update.
    a. She thanked everyone who took part in the Improving MI Practices survey; MDHHS received over 300 responses.
    b. The 1915(i) policy draft was out for public comment, with the public comment period ending on August 12, 2022. MDHHS will continue to review that feedback and develop a response as they move the policy forward.
    c. MDHHS has submitted the amendment request under the 1115 Demonstration to move the 1915(i) implementation date out a year. It would then start in October 2024 instead of October 2023.
        i. CMS has published that request for public comment at a national level for 30 days, and MDHHS expects to hear a response from CMS on that request.
    d. There will be a communication coming out from Jeff Wieferich in the next few weeks reminding the PIHPs of the need to look at transition plans for individuals in settings that are not compliant with the HCBS rule.
    e. A training to walk the PIHPs through what is intended for the new Critical Incident Reporting Platform was scheduled for August 8, 2022. Both CEOs and CIOs were invited.

Public Health Emergency Unwind

1. Jeff Wieferich reported that MDHHS was still waiting for mid-August to receive notification from CMS whether the public health emergency would be ending or not.
2. Farah Hanley reported that MDHHS is focused on mitigating the potential loss of coverage for Medicaid-eligible individuals. MDHHS is working on address verification issues and has borrowed individuals who had served as contact tracers during the start of the COVID-19 outbreak to determine where addresses were outdated and where further outreach would be required.
3. A PIHP asked if spenddown was part of the conversations about the unwind.
    a. Farah Hanley responded that right now her team is focused on a broader perspective, but there may be more nuanced conversations taking place that she is not currently privy to.
    b. Brian Keisling provided context for the PIHP's concern, noting that individuals who had a Medicaid spenddown and met that spend-down during the public health emergency would have received full Medicaid supports since that time. These individuals would likely go back onto spenddowns, but it would happen over the course of the twelve months of the unwind as each person's eligibility came up for renewal.

MPCIP & MI CAL Update

1. Krista Hausermann provided the MPCIP update via email.
    a. She shared that MDHHS will be hiring more staff over the next 4-6 weeks to help with crisis service projects.
    b. She reported that MDHHS had met with LARA about the Psychiatric Bed Registry on August 3, 2022, and that they continue to increase their partnership.
        i. She added that she did not believe the Psychiatric Bed Registry itself will have much of an impact on the individuals with the highest needs. She is not sure that those high-need beds will ever appear as vacant on the registry.
        ii. From listening sessions with the psychiatric hospitals, MDHHS has heard that the hospitals have morning meetings to discuss who is likely to be discharged that day, at which point the hospitals may already start to think about who will fill those beds. Decisions are likely made based on calls they have received from CMHs previously about individuals waiting for beds.
        iii. She still feels the registry is a good way to track referrals for people who are in high acuity, which will help MDHHS to work with stakeholders to figure out how to help those with higher needs.
        iv. A PIHP noted that they feel the intention of the bed registry is to have an inventory of where beds are available. This should reduce how many psychiatric hospitals each PIHP or CMH must call to find a bed, once it is in full use.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Erin Emerson shared that Lindsey Naeyaert has accepted a position as the State Administrative Manager for the service delivery transformation section.
2. Lindsey Naeyaert provided the update.
    a. For Opioid Health homes, Michigan had over 2300 Medicaid beneficiary enrollees as of August 3, 2022. MDHHS is also working to expand Opioid Health Homes in Region 5, Region 8, and into the rest of the six counties within Region 4 on October 1, 2022. At that point, there will be 41 sites throughout Michigan providing Opioid Health Home services.
    b. For Behavioral Health Homes, there are around 1300 individuals enrolled. MDHHS is working to expand Behavioral Health Homes into Mid-State Health Network, with an anticipated start date of April 1, 2023. MDHHS will be reaching out to Mid-State Health Network to discuss next steps and the policy process with within the next month.
    c. For PIPBHC, the participating counties continue to implement the Azara integration and are gearing up to complete their annual integration self-assessment. This is the third year Michigan counties have completed this self-assessment. As of this year there are now seven other states using that integrated self-assessment, so MDHHS hopes to be able to do comparisons with other states.
    d. For CCBHCs, many people are assigned within the Waiver Supports Application, and a lot of people are receiving services.

i. As of August 3, 2022, MDHHS has 41,515 Medicaid beneficiaries assigned in the WSA, and 6,162 without Medicaid.
ii. MDHHS is working to ensure encounter reporting is accurate and hopes to have better estimates of service utilization by October 2022.
iii. Over the next few months there will be a lot of reconciliation, cost reporting, and rate setting.

e. CMS has not communicated any changes to the demonstration other than the extension to 2027.

Sliding Fee Scales

1. Jeff Wieferich reported that MDHHS had submitted amended administrative rules to the Rules Committee. The Rules Committee has reviewed it, and no public comment period is necessary, significantly reducing the amount of time needed to get the rules in place. He anticipates that changes will be finalized within 90 days.

PIHP Contract Streamlining

1. Darrell Harden presented on contract monitoring and oversight for the PIHPs.
    a. The PowerPoint has been distributed to the group via email.
2. A PIHP noted that the reorganization had scrambled communications channels a bit and asked about a potential contact sheet for who they should be receiving information from about what topic.
    a. Darrell Harden responded that if a PIHP was receiving the same ask from two different people at MDHHS, the PIHP could reach out to him, and he would reach out across the teams to ensure MDHHS only asked the PIHPs for something once.
    b. He agreed that a list would be a good idea.

SUD Provider Discharge Support

1. Jeff Wieferich shared that he and Farah Hanley have been talking with providers and have talked about different opportunities to offer additional support.
    a. After discussion about the Michigan Department of Corrections, MDHHS will be adding $150,000 in SUD Block Grant funds to each PIHP's contract to fund a staff position that will be able to assist providers. The hope is that this role will help to address some of the administrative burden for discharge planning and improve access for SUD services.
        i. MDHHS will follow with an actual summary of what is expected of this role, but there will be a lot of leeway.
        ii. The PIHPs clarified that they heard the role is a complex care management position for the SUD side of complex cases, one that the PIHPs could use to facilitate better or smoother placements.
    b. A PIHP asked if that funding for the position was additional funding, or if it would result in a reduction in other anticipated Block Grant funds.

        i. Jeff Wieferich responded that it was additional funding.
    c. Darrell Harden shared that his team was working on amendment preparations to get that out as soon as possible.

MHP Rebid Process

1. Farah Hanley reported that this process is now being referred to as the MI Healthy Life initiative.
    a. While it is still very early in the process, MDHHS has had internal meetings and engaged outside consultants to provide support on this big lift.
    b. MDHHS hopes to get closer to what it believes are strategic pillars and objectives.
    c. A survey went out to providers, advocates, and beneficiaries to provide influence on this process.
2. A PIHP asked about timing.
    a. Farah Hanley responded that an RFP should be going out in Fall 2023, and MDHHS will be gathering information before then. Rates must be in place by October 1, 2024, for the FY 2025 budget.
    b. The consultant has been very clear that MDHHS is on a tight timeline.
    c. This project is a very high priority for Director Elizabeth Hertel.
3. A PIHP asked if MDHHS anticipated impacts on the public behavioral health system.
    a. Farah Hanley responded that MDHHS was so early in the process she could not answer.
    b. At this point, MDHHS is collecting survey input, and she suggested that the PIHPs take the opportunity to provide their input.
    c. The strategic pillars are the principles that will guide the process.

- Reorganization heightened focus on behavioral health
  - Increased resources for MDHHS staffing and operations
    - Three new analysts to be hired
  - Better monitoring and oversight
    - Ensure compliance with federal requirements
    - More support around contract monitoring

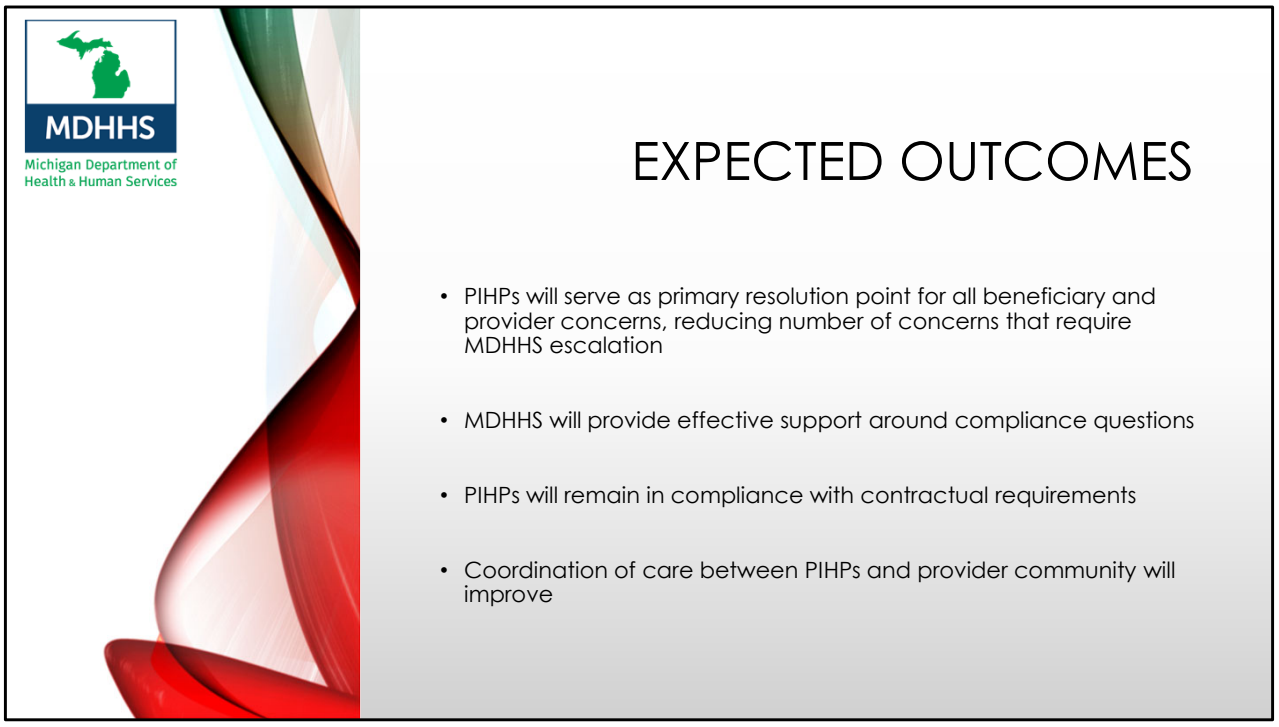
- Internal team established to work toward those objectives

- Does MDHHS receive the data needed to demonstrate compliance with federal requirements?
  - Reviews thus far on network adequacy, service denial, claims data
  - Reached out in July to solicit additional information around claims and network adequacy
- Do the reports contain information that is in other reports?
- Do the reports contain information MDHHS does not need to collect?

MDHHS
Michigan Department of Health & Human Services

NEXT STEPS

- Enhanced process for review of all data submitted to MDHHS on reports
- Review and feedback on supplemental reporting submissions
- Consistent internal process for completing compliance oversight and monitoring
- Continued engagement with PIHPs to support compliance with contractual requirements



- We're following an iterative process
  - Stopping to take deep dives as needed during our review
  - Addressing major concerns

- Moving forward expeditiously, but not rushed

Crisis Stabilization Units in Michigan

Meeting the Needs of Children, Youth, Young Adults, and Adults

Background and Purpose

Michigan Public Act (PA) 402 of 2020 added Chapter 9A (Crisis Stabilization Units) to the Mental Health Code, which requires the Michigan Department of Health and Human Services (MDHHS) to establish minimum standards and requirements and provide for certification of crisis stabilization units (CSUs). CSUs are meant to provide a short-term alternative to emergency department and psychiatric inpatient admission for people who can be stabilized through treatment and recovery coaching within 72 hours.

To develop a model for CSUs in Michigan, MDHHS engaged Public Sector Consultants (PSC) to convene and facilitate an advisory group of stakeholders for a series of statewide discussions and listening sessions on topics including rural areas, persons served, and children. The advisory group reviewed and discussed selected readings from the National Council on Behavioral Health's *Roadmap to the Ideal Crisis System* and the Substance Abuse and Mental Health Services Authority's *National Guidelines for Behavioral Health Crisis Care*. PSC and the department also consulted with other states and reviewed national guidance to identify best practices for the implementation of CSUs. The advisory group focused primarily on CSU services for adults. The model concept described below is based on their guidance as well as that of experts in children's behavioral health services.

While this document provides a high-level overview of the key concepts and stakeholder priorities for CSUs in Michigan, a set of certification rules currently under development will provide much greater detail regarding the requirements for CSU implementation and service delivery.

A Vision for CSUs in Michigan

Advisory group members were asked to imagine a future in which Michigan has established a world-class crisis response system that includes the certification of high-quality CSUs. Their vision included six main themes:

Improved access to care: There is no wrong door to access a CSU. Insurance status, transportation, childcare, and ability to pay are not barriers to accessing care at a CSU. All Michiganders will know about CSUs, have easy access to a CSU when needed, and the capacity of CSUs meet the needs of the community.

Appropriate levels of care: Children, youth, young adults, and adults are served in a community-based, noninstitutional setting, in the least restrictive environment and are triaged to the appropriate level of care to support and stabilize them quickly. There is a decrease in inappropriate psychiatric hospitalizations and emergency department use.

Coordinated care: Coordination occurs across systems and agencies, including law enforcement, 9-1-1, 9-8-8, and emergency medical services (EMS), mobile crisis responders (of any type including multidisciplinary response teams [MDRT], Mobile Crisis Stabilization Services [MCSS], intensive crisis

stabilization for children [ICSS], juvenile urgent response teams [JURT], etc.), child welfare, aging and older adult services, and behavioral health systems and supports.

When working with children, youth, and young adults, and their families, care activities are deliberately organized across systems, and information is shared among all allowed and relevant entities concerned with the child and youth's care. This means the needs and preferences of children, youth, young adults and their families are solicited upon entry and are communicated in a timely fashion to the right people and that this information is used to provide safe, appropriate, and effective care. Children and youth receive coordinated contact around their health from the initial CSU visit to community support follow-ups.

Positive individualized experience: CSUs provide high quality of care for those in crisis. All people, including children, youth, and their families feel safe, respected, and supported in comfortable spaces that maximize privacy. Service intake and discharge are seamless for individuals, children, youth, and their families, and they can expect that there will be linkage to further services beyond the period of crisis.

Family-Driven/Youth-Guided Care: Family and found family are an important, if not the most crucial, part of a youth's support network. Because of the important role of family/found family, treatment of youth optimally occurs as part of a family unit. CSUs provide family-driven/youth-guided care which involves and supports the family as well as the youth. CSUs will involve whomever the child, youth, young adult and their family identify as their supports in the recovery process and resiliency building.

Natural Supports: CSUs recognize the importance of family and friends in a person's recovery and seek to maximize positive impact through the involvement and support of a person's informal support network. CSUs will involve whomever the individual identifies as a support for their recovery.

CSU Model Concept

Eligible Provider Entities

Per PA 402 of 2020, the following entities are eligible to establish and operate a crisis stabilization unit.

- CMHSP preadmission screening units
- Psychiatric hospitals
- General hospitals (must have 24-hour access to a preadmission screening unit for crisis services and establish a formal agreement with a CMHSP or regional entity for services provided to individuals using public behavioral health funds)

Populations Served

CSUs must provide crisis stabilization services to:

- All people in crisis, regardless of behavioral health diagnosis or health care coverage
- Children, youth, and/or adults experiencing a crisis related to mental health, substance use, or both, as defined by the person and/or their family.

Meeting the needs of diverse groups

Children, youth, and young adults with their families should be treated in physically separate facilities from adults but in a parallel fashion. CSUs should ensure that all care, treatment, and coordination is offered in a culturally competent and linguistically appropriate manner. CSUs should be prepared to serve diverse populations, including Black, Indigenous, and people of color (BIPOC), people who identify as LGBTQ+, and other historically underserved groups. CSUs must also have interpreters that can speak about mental health and treatment in the preferred language of the people they serve in a culturally appropriate manner and be available on an as-needed basis to serve all populations. While CSUs are expected to serve all people presenting with a behavioral health crisis, they must be prepared to meet the needs of adults with serious mental illness (SMI), people with intellectual and developmental disabilities (IDD) or autism spectrum disorder (ASD), individuals with substance use disorders (SUD) in crisis, as well as people with co-occurring mental health and substance use issues. Those serving children must be prepared to meet the needs of children with serious emotional disturbance (SED) and their families.

Basic Requirements

CSUs must:

- Initiate assessment and treatment interventions upon arrival
- Conduct an initial psychosocial assessment and psychiatric evaluation within 24 hours
- Ensure timely access to appropriate medical services for physical health needs and provide ambulatory care level support for physical health
- Treat crises related to both mental health and substance use
- Ensure meaningful family involvement in the child, youth, young adult, and/or individual's assessment, care, treatment planning, and care coordination, which may include connecting family members to their own services and supports
- Ensure that services are inclusive and gender affirming
- Provide individualized services based on the specific needs of the child, youth, young adult, or adult. This includes determining the best treatment setting for transition age youth (ages 18-21)
- Provide treatment in the least restrictive manner possible, including providing care for individuals seeking voluntary treatment, and individuals who need involuntary treatment for up to 72 hours (consistent with Sec. 409), after which the individual must be provided with the clinically appropriate and accessible level of care, resulting in one of the following:

    - The individual is no longer a person requiring treatment.
    - Referral to outpatient or community-based services for aftercare treatment.
    - Referral to a partial hospitalization program.
    - Referral to a residential treatment center, including crisis residential services.
    - Referral to an inpatient bed.
    - An order for involuntary treatment.

Geographic and Special Population Considerations

Different CSU models may be needed for different geographic locations and populations. While basic requirements will be the same for all CSUs, the way in which requirements are met will be based on the

needs of the community. It is also critical that the needs of adults with SMI, children with SED, and adults or children with I/DD guide how CSUs are implemented within a community.

Staffing Requirements

CSUs must:

- Provide access to 24/7/365 multidisciplinary staff including psychiatrists, psychiatric nurse practitioners, nurses, other licensed and/or credentialed clinicians, and individuals with lived experience
- Ensure staffing levels and types of staff are adequate to provide required services and meet the needs of the population
- Meet staff-to-client ratios established by MDHHS

Importance of Peers

All individuals seeking help should be informed of the availability of support from certified, specially trained peers/people with relevant lived experience.[1] Individuals with lived experience should be available at each step of the process from intake and treatment to release and transportation. This type of peer support helps amplify the voice of patients, including children, youth, young adults, adults, and their families while supporting them in navigating a crisis.

Flexibility in Staffing

CSUs will be established with certain flexibilities in filling staff roles. CSU policies should not dictate CSU staff be directly employed by the CSU and should allow for or promote the use of telehealth services.

Physical Space Requirements

CSUs must:

- Provide a trauma-informed, comfortable, home-like environment
- Ensure physical space that meets the needs of special populations
- Provide waiting areas and treatment spaces for children and their families that are separated from those for adults receiving services
- Ensure individual (not shared) rooms that ensure privacy, are family- and individual-friendly, and provide a trauma-informed, comfortable, home-like setting, and are conducive to recovery and building resiliency
- Provide for individuals' and families' physical needs (e.g., food, shower facilities)

Operational Standards

General

CSUs must:

[1] Not intended to be the Parent Support Partner or Youth Peer Support Medicaid service

- Accept all referrals including self-referrals and do not require medical clearance prior to accepting them and initiating crisis response
- Assess and support medical stability throughout stay; deliver care for most minor physical health challenges; transfer to medical facility if required
- Carry out limited medical emergency receiving and evaluating functions (i.e., identify the need for medical attention in a hospital)
- Establish protocols for transfers between ED/CSU based on medical stability utilizing MI-SMART medical clearance protocols
- Establish protocols for pharmacy and medication administration, as well as safety and emergency protocols
- Establish discharge planning protocols, including referrals and warm hand-offs to clinically appropriate and accessible levels of care (see above)
- Establish protocols for both voluntary and involuntary admission consistent with Sec 409 of the Mental Health Code.

Law Enforcement, Mobile Crisis, EMS, and other First Responders

CSUs must:

- Offer walk-in and first responder drop off options
- Follow a "No-rejection" policy for all drop-offs and walk-ins
- Offer a dedicated first responder drop off area

Complaint Resolution

CSUs must:

- Afford individuals served all recipient rights under MHC Chapter 7.
- Establish complaint process separate and distinct from providers and not delegated by MDHHS to CMHSP or contractor.

System Collaboration Requirements

CSUs must:

- Ensure linkage and partnership with Michigan Crisis and Access Line (MiCAL)
- Ensure a pre-admission screening unit is available on a 24-hour basis to provide crisis services on a voluntary basis.
- Hospitals must establish a formal agreement with a CMHSP or regional entity for services provided to individuals using public behavioral health funds
- Operate within a real-time regional bed registry (e.g., OpenBeds/MiCARE)
- Establish and maintain crisis response partnerships with law enforcement, dispatch, EMS, and other mobile crisis response systems in the region
- Develop shared agency-to-agency protocols for coordination and care management that are supported by real-time electronic processes
- Participate in coordinated staff trainings such as the Behavioral Health Emergency Partnership (BHEP) training to maximize crisis continuum coordination

Data/Reporting Requirements

- CSUs must provide timely reports to MDHHS, as required. These could include:
    - Data on number served
    - Data on demographics capturing prevalence of populations served and examined related to diversity and equity
    - Whether the person is currently involved in community-based services or institutions (e.g., child welfare or juvenile justice)
    - Data on insurance types billed
    - Disposition of all individuals served
    - Percentage of law enforcement, mobile crisis, and first responder referrals and percentage not referred to emergency department for medical care and not arrested (i.e., hospital and jail diversion)
    - Law enforcement and first responder drop-off time
    - Average length of stay per person (i.e., child, youth, young adult, or adult) served
    - Percentage completing outpatient follow up
    - Readmission rate within 30 days to CSU, crisis residential facility, or inpatient psychiatric hospital.
    - Total cost per crisis episode
    - Satisfaction/exit surveys

Certification and Accreditation

CSU's must:

- Obtain accreditation from The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or similar organization accreditation by soonest of 1/12/2023 or 3 years following MDHHS certification

Questions and comments regarding the CSU model concept can be submitted to Krista Hausermann at hausermannk@michigan.gov.

Community Mental Health Association of Michigan

Concerns over specific actions, decisions, or lack of action by MDHHS

August 2022

Concerns over specific actions, decisions, or lack of action by MDHHS

During the July 2022 CMHA Directors Forum, the members of the Forum noted a number of concerns with MDHHS initiatives, delays and refusals to act on a number of fronts:

1. The recent announcement that 110 beds are being taken off-line at Michigan's state psychiatric hospitals with discharges to start immediately. (these beds are being taken off line due to high levels turnover and FMLA use - issues that need to be resolved by the state rapidly). These discharges are planned in the face of the fact that efforts to move these persons to community settings, over the last several months, have not been successful, in spite of aggressive efforts by CMHs to find community placements for these persons. This reduced capacity in the state's psychiatric hospital appears to be the result of a lack of will or ability, by MDHHS, to address this capacity-decrease (via workforce and other efforts) and the lack of understanding, by MDHHS, of the negative impact that will occur in communities across the state, by the premature discharge of state facility patients without adequate community supports.

2. The lack of residential or inpatient options for persons with IDD who have complex and challenging behaviors – and the parallel concern over the lack of movement, by MDHHS, to address this issue.

3. The need for MDHHS to assist LARA in understanding that the licensing of group homes and other facilities needs to reflect the liberty- and community-based goals of the state's HCBS efforts. The failure to help LARA understand this fact has led, with increased frequency recently, to LARA's findings Zof licensing violations at sites for behaviors and site responses that are to be expected given HCBS principles.

4. The fact that the MDHHS has been slow to take action on the concrete set a recommendations that our association and our members have provided relative to efforts to address the behavioral health work force shortage – slow action that is in sharp contrast the need for urgent action to address this deep and prolonged workforce shortage.

5. The lack of action relative to the concrete set of recommendations that our association and our members have made relative to removing unnecessary and costly administrative burdens on the system.

6. The recently expressed views of MDHHS that the Department will view the contracts between MDHHS and the state PIHPs and CMHs as akin to the state's contracts with other private sector vendors. This view ignores the fact that these contracts are the legal statutorily-based expression of a partnership between public bodies, in fulfillment of mutually held obligations, that date back to the 1980s. These are not market driven contract arrangements in which the contractor nor the state can walk away.

7. The fact that MDHHS has not underscored - in the face of Senator Shirkey's and others efforts to decimate the system- the centrality of a number of cutting edge practices implemented by the community-based system to ensuring that state retains its national prominence in mental health care. Those initiatives include: the state's CCBHCs, Behavioral Health Homes, and Opioid Health Homes; hundreds of clinical integration initiatives involving primary care practices, emergency departments, and

behavioral health resources provided by the state's CMH system; the development and implementation of sophisticated assisted outpatient treatment (AOT) efforts in communities across the state that prevent people, by intervening early, in decompensating and losing the ability to live productive lives in the community; the implementation and refinement of dozens of evidence-based and promising practices; the deep and long standing partnerships that the public mental health system has developed with local law-enforcement, first responders, homeless shelters, schools, primary care practices, and other partners in communities across the state.

8. The fact that MDHHS has not underscored, to the public, policy makers, legislators and other key stakeholders, the industry-leading implementation, by the state's public mental health system, of health-promoting components that are only now being adopted by the physical health sector. These initiatives, which could be highlighted, include: a focus on social determinants with active, hands-on efforts to support persons serve in acquiring those key resources: housing, employment, family connection; a focus on trauma in the development and implementation of treatment plans; the need for integration of the work of a number of community sectors (housing, employment, education, faith community - to name a few) ensuring the recovery of person served; the use of persons with lived experience as paid employees on treatment teams, in serving clients; and use of a range of nationally/federally-certified evidence based practices; the system's commitment and ability to continue to serve persons throughout the pandemic using telehealth modalities, extraordinary creativity, and heroic efforts of home and community-based outreach and side-by-side support with persons with mental health needs.

9. Concerns over pressure (explicit and implicit) that has existed over the past several years, and increasingly recently with the aims of the MI Kids Now initiative taking shape, for the state's CMHs to take on many of the traditional obligations and responsibilities of the state's child welfare system. This movement is out of step with the legal obligations and responsibilities of the state's child welfare system and its public mental health system. Needed are efforts to ensure that the boundaries between the obligations and responsibilities of these two systems be retained with both systems bringing their expertise and statutory obligations and responsibilities to joint efforts to serve Michigan's children.

Concerns over a number of MDHHS leadership practices

Directors Forum members also underscored a number of concerns were expressed relative to a number of the leadership approaches, of MDHHS:

1. The use of two leadership and decision-making approaches that are at the extremes of sound inclusive, dialogue-rich, transparent and action oriented leadership.

At one extreme are decisions made with little dialogue with the field, little effort to draw on the expertise of the field, and without openness to revision, refinement, nor negotiation related to draft proposals by the Department.

At the other extreme are initiatives that are so process-oriented (the workforce and administrative burden initiatives as examples) that timely and concrete actions are not taken or are so delayed as to be either inconsequential or irrelevant to the issue, that has now grown in intensity, size, or harm.

2. The lack of leadership with a passion and vision for the state's public mental health system, within the Department. This leadership has been lacking for some time, with reorganization of the Department serving to further dissipate and weaken the voice of and vision for this system, within the department.

The power ceded to Milliman to structure the financing and financial reporting of the public system is an example of the loss of one of the central leadership roles of the department.

3. It is unclear to CMHA members and many stakeholders as to whom, within the Department is responsible for a number of initiatives and issues – from large system design issues to technical mechanics related to state policy, financing, and service delivery.

4. Given the lack of staff, within the Department, with a working knowledge of the community-based system, the Department fails to involve key subject matter experts from within the community-based system in the development of new initiatives or revisions to current ones – outside of what many feel is the token involvement of CMH, PIHP, and Provider staff in workgroups in which the fundamental constructs of these initiatives cannot be questioned by these knowledgeable representatives of the community-based system/

Advocacy actions – an initial list

Finally, the Directors Forum members developed an initial list of advocacy efforts - a list to kick-off the discussion of a comprehensive and aggressive advocacy effort that will take be developed by Directors Forum members and CMHA.\

1. Development of a description of the public mental health system that captures is full set of roles and responsibilities including its safety net and community convener roles, and its unique and central place in the life and health of the community. (Building on the media and public relations work that CMHA, its members, and allies have done over the past several years)

2. Outlining concerns and recommending action to:
- Governor
- Legislative allies

(Building on the government relations work of CMHA, its members, and allies.)

3. Increase media relations to generate news coverage that point outs these issues and proposed solutions (Building on the media and public relations work that CMHA, its members, and allies have done over the past several years)

4. Direct advocacy with MDHHS leadership regarding these issues, with offers of expertise, co-leadership, and other resources to move the resolution of these issues forward. (Building on the relationships that CMHA, its members, and allies have with these leaders)

5. Legal action when statutory, regulatory, or contractual requirements or obligations are violated.

6. Purchase of additional expertise around technical issues. Work around the actuarial analysis of the Milliman-developed Medicaid rates and the use of legal counsel on issues of law, regulation, and contracts. (Building on the use contractual expertise that is carried out by CMHA, its members, and allies)

7. Join with allies to address issues of common concern regarding MDHHS practices, proposals, decisions, leadership approach (Building on the broad and diverse set of allies that CMHA and its members have developed)

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Movement around the state hospital capacity reduction issues
Date: Friday, August 12, 2022 11:24:25 AM
Attachments: image001.png

To: CEOs of CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Movement around the state hospital capacity reduction issues

As you know, MDHHS recently announced, that, due to staff shortages, 110 state psychiatric hospital beds are being taken off-line. This news caused concerns among you, this association, and our partners across the state.

Since that announcement, CMHA has taken a number of steps in response to this announcement:

1. Over the past two weeks (most recently, yesterday, August 11) CMHA met with senior leadership within the Health Administration of MDHHS (to which the State Hospital Administration (SHA) and the Behavioral and Physical Health and Aging Services Administration (BPHASA) reports) to voice concerns and make a number of recommendations designed to mitigate against the impact of this planned state facility capacity reduction.
2. Several times since the reduced capacity announcement, CMHA met with our colleagues at the Michigan Health and Hospital Association (MHA) to identify common concerns and develop a coordinated advocacy effort around this issue.
3. Today, August 12, representatives of CMHA and MHA met with the leadership of the Health Administration, SHA, and BPHASA to outline a range of options to expand the range of community and inpatient settings that could meet the needs of persons being discharged from state hospitals and those unable to access state and private/community hospitals; and to address the crisis stabilization needs of persons waiting in hospital EDs and other settings, awaiting mental health services.
4. During the last several discussions with these MDHHS leaders, the details of the Behavioral Health Access and Capacity effort that was included in the FY 23 budget, were outlined. This effort will add 60 beds – including residential and community inpatient beds – designed to address the needs of persons with challenging behaviors. This is the effort for which MDHHS has asked CMHA to organize a sounding board group to provide guidance to MDHHS on this effort. That group has been formed and stands ready to meet with MDHHS on this initiative.
5. SHA leadership announced, today, August 12, that they have been successful in obtaining written consent, from the patients in state hospitals and/or their guardians, consent to stay in the state hospitals under a voluntary status (converting their status from involuntary). These consents have dramatically reduced the size of the “ready to discharge” list and avoids Olmstead violations.

While these steps represent movement in the right direction, we remain concerned regarding this reduced state inpatient capacity. We will continue, with your help, to advocate and co-develop approaches to addressing these needs.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
507 South Grand Avenue, Lansing, MI 48933 (Note new address)
517.374.6848 main
517.237.3142 direct
517.374.1053 fax
www.cmham.org

CMHA MOVING: As of June 1, 2022, the CMHA offices will no longer be at 426 South Walnut. CMHA's new address will be 507 South Grand Avenue, Lansing, MI 48933, only several blocks eastward of our former South Walnut location. My email address and phone number will remain the same. However, because we will not be moving into our new office location until September 1st , due to renovations, my CMHA colleagues and I will be working fully remotely until then. You can, of course, continue to reach me via phone and email during this two-month transition.

Community Mental Health Association of Michigan

Michigan's State Demonstration & SPA/Permanent CCBHC initiative: Recommendations

Revised August 10, 2022 (Sections reflecting more than technical/grammatical/syntax changes from the previous version are highlighted)

FOUNDATIONAL ASSUMPTIONS

A number of assumptions formed the foundation for the development of this document:

WHY CMHA IS DEVELOPING THIS SET OF RECOMMENDATIONS:

1. **The State of Michigan**, for the reasons outlined in the next section below, **will be making Certified Behavioral Health Clinics (CCBHC) a central and permanent part of the state's mental health system.**

2. As is true in states across the country, Michigan's CCBHCs will become a central component in Michigan's public mental health system through **a Medicaid State Plan Amendment (SPA) or a Medicaid waiver.**

3**. The active involvement of CMHA, its members, and allies**, in the design of the CCBHC-centered SPA or Medicaid waiver is key to ensuring that that the CCBHC system that is established meets the needs of all of the communities in Michigan – rural, suburban, urban – and strengths the state's mental health safety net.

Without this involvement – in the form of recommendations and on-going dialogue **– the state's permanent CCBHC system is unlikely to accurately reflect the views of CMHA members, allies, and stakeholders.**

WHY THERE IS SUCH CERTAINTY THAT CCBHCS WILL BECOME A CENTRAL AND PERMANENT PART OF MICHIGAN'S MENTAL HEALTH SYSTEM.

1. **CCBHCs are seen, by policy makers and observers of the nation's mental health system, as the emerging cornerstones of the nation's mental health system** - one that provides the access, quality and range of services envisioned in the federal Community Mental Health Act of 1963.

Among those voices (with links to those views expressed by those voices) are:

- Center for Health Care Strategies
- National Council of State Legislators
- Office of the Assistant Secretary for Planning and Evaluation, HHS
- National Council for Mental Wellbeing

2. **Michigan's CCBHCs have reported greatly increased access to care** for the members of their communities, with dramatic increases in access for children, persons with mild to moderate mental health needs, and substance use disorder needs.

3. The CCBHC initiative is made possible by the **US Senator Debbie Stabenow**, Michigan's senior US Senator and a longtime advocate for and ally of Michigan's public mental health system, who **sponsored the Excellence in Mental Health Act creating the CCBHC initiative.**

4. The loss of access to care by a significant number of Michiganders if CCBHCs are not made a permanent component of Michigan's mental health system. The importance and timing of Michigan developing a Medicaid State Plan Amendment (SPA) or waiver amendment to make CCBHC permanent is underscored by two events. These importance of these two events was highlighted, a few months back, by the National Council CCBHC staff during the Michigan Rural CCBHC roundtable. Those events include:

- the end of the demonstration project period (impacting 13 Michigan communities)
- the end of the expansion grants for another 21 communities

If the SPA/waiver is not in place when either of these two events take place, these CCBHC sites would shut down with the attending loss of over $40 million dollars to the system and access to care for a large number of persons in those communities.

WHY THERE IS LIKELY TO BE A ROLE FOR PRIVATE PROVIDER ORGANIZATIONS IN MICHIGAN'S CCBHC SYSTEM

1. **Michigan's CCBHC State Demonstration effort already involves several private non-profit organizations as CCBHCs.** This fact underscores the need for CMHA, its members, and allies to work to ensure that the permanent CCBHC system **promotes a strong public mental health safety net while recognizing the unique and vital role played by the private non-profit providers essential**.

Political and policy experts have recommended that a set of standards that align with the definitions and requirements of Michigan's mental health safety net be used to promote this aim while ensuring that innovative private non-profits have a solid role in the state's CCBHC system.

PROCESS USED IN DEVELOPMENT OF THIS DOCUMENT

To ensure that the recommendations that will be reflected in the final set of CMHA recommendations related to the state's work to make CCBHC a permanent part of the state's mental health landscape, CMHA has designed a sequence of dialogues, with key parties within CMHA, in the development of these recommendations. These dialogues include:

1. Ensuring that CCBHC can meet needs of all Michigan communities: CMHA held a series of CCBHC learning sessions for CMHA members, designed to support the current operation and development of the emerging CCBHC system in Michigan. Those sessions included a **Michigan Rural CCBHC Roundtable,** in September 2021 jointly sponsored by CMHA and the National Council, with leaders of rural CCBHCs from across Michigan and Minnesota.

2. Initial draft set of recommendations developed by CMHA: Based on the issues raised in these venues and based on periodic and informal discussions with leaders within the state's CCBHC demonstration sites, CCBHC expansion sites, CMHs operating Behavioral and Opioid Health Homes, leaders of CCBHC efforts in other states, and the CCBHC Technical Assistance Center at the National Council, CMHA developed an initial set of recommendations related to what may become Michigan's CCBHC design going forward.

3. Refining initial draft with views of those with working knowledge of CCBHC – the current State Demonstration Sites: Group discussion, of the initial concept paper, with CEOs and leaders of CMHs that are CCBHC demonstration sites and CMHs with CCBHCs in their networks. Given that these leaders had the greatest familiarity with CCBHC design and operations, their views were sought to begin the dialogue with CMHA members on this draft set of recommendations. A revised draft emerged from this discussion that was distributed to the CEOs of all of the state's CMHs and PIHPs.

4. Refining draft with views of the CEOs of the state's CMHs and PIHPs:

- Group discussion of the draft document, with an invitation to the CEOs of all of the state's CMHs and PIHPs, on July 29. A revised draft emerged from this discussion that was distributed to the CEOs of all of the state's CMHs and PIHPs.

- A second group discussion of the latest draft of the document, with an invitation to the CEOs of all of the state's CMHs and PIHPs, is slated for August 10.

- If needed, a third group discussion of the draft that emerges from the August 10 session, will be held, with an with an invitation to the CEOs of all of the state's CMHs and PIHPs.

5. Legislative and Policy Committee: The draft that emerges from the venues, listed above, will be reviewed and revised by the CMHA Legislation and Policy Committee for recommendation to the CMHA Board of Directors at its September 21 meeting.

6. CMHA Board of Directors: The recommendations, reflecting the document recommended by the Legislative and Policy Committee, will reviewed, revised, and adopted by the CMHA Board of Directors at its October or November meeting.

7. Recommendations used as policy advocacy tool: CMHA, its members, and allies use the adopted set of recommendations in dialogue with MDHHS, the State Legislature, and CCBHC stakeholders

PURPOSE OF THIS DOCUMENT

This document outlines a set of foundational principles, policies, and practices, recommended by the Community Mental Health Association of Michigan (CMHA) and its members, to be applied to the design and operation of the current Michigan CCBHC State Demonstration initiative and any Medicaid State Plan Amendment (SPA) or waiver that may be developed to make the CCBHC structure a permanent and central component of Michigan's Medicaid and behavioral health landscape.

It is the intent that these recommendations will be useful to MDHHS as it crafts and operates the current Michigan CCBHC State Demonstration initiative and any Medicaid State Plan Amendment (SPA) or waiver that may be used to make the CCBHC structure a permanent part of Michigan's mental health and Medicaid landscape.

Note that these recommendations are associated with the operation of Michigan's CCBHC State Demonstration and post-State Demonstration system and as they are relevant to relate to Michigan's CCBHC Expansion sites.

1. In addition to the fundamental aim of fostering access, by all Michiganders, to high quality and comprehensive mental health services, a **core aim of the CCBHC movement in Michigan** is to ensure that **Michigan's mental health safety net** grows in its strength and ability to serve all Michiganders, **in all Michigan communities – rural, suburban, and urban**.

2. In Michigan, the **state's mental health safety net** is made up of:

- the public Community Mental Health Service Programs (CMHSP)
- the public Regional Entities/Prepaid Inpatient Health Plans (PIHPs) created and governed by the CMHSPs
- the provider networks of the CMHSPs and PIHPs (private providers when fulfilling the contractual relationship with a CMHSP or PIHP)

What defines and makes Michigan's mental health safety net system unique are the system's:

- Basis in longstanding state statute, regulation, policy, and contract
- Direct connection to local county governments, as a creation of county government to serve to fulfill each county's mental health responsibilities. - as part of the longstanding partnership between the county, state, and federal governments
- Decades of high performance in directly providing and purchasing the full range of behavioral health services, for all of the populations served by Michigan's public system and defined in state law and for all of the modalities and practices outlined in state law, regulation, Medicaid waivers, and contract across all levels of severity and need, all levels of intensity, including psychiatric inpatient care (at local and state hospitals), 24/7 crisis response services, and a wide range of non-traditional home and community-based services
- Role as the clinical risk and responsibility-bearing mental health body in every community in Michigan
- Central role in community mental health needs assessment, stakeholder involvement, and community dialogue
- Role in serving as the state's screening and admission points to state psychiatric hospitals and discharge planning and implementation from those hospitals
- Work in managing and ensuring the quality of care of comprehensive community-based service networks
- Role in serving as a highly visible convener and collaborator around a wide range of community needs and social determinants
- Leadership in the development, use, and replication of evidence-based and promising practices
- Role as a source of guidance and expertise to other healthcare and human services providers, elected officials, policy makers, the media

The full set of statutes, rules, waiver, and contractual references that define the unique safety net role of Michigan's CMHSP and PIHP system are contained in Appendix A.

3. **The CCBHC initiative** is designed to ensure that each community's mental health safety net:

- Provides a comprehensive array of mental health services
- Ensures access to mental health care regardless of severity or payer source
- Uses a well-recognized set of evidence-based and promising practices
- Meets high, uniform national standards of quality and performance
- Is funded via a method that supports this work
- Actively collaborates with community partners to ensure whole-person care
- Has a clear point of contact and guidance related to mental health needs, avoiding duplication and confusion for those seeking services and supports

4. **The private providers in the CMH and PIHP networks are key components in the safety net structure of the state's public mental health system, only when they are woven together into each community's mental health safety net** through contracts with the state's CMHSPs or PIHPs.

RECOMMENDED POLICIES AND PRACTICES TO BE REFLECTED IN CCBHC-CENTERED MEDICAID SPA OR WAIVER

Given these premises:

1. State plan for number and location of CCBHCs: The SPA/waiver that will make CCBHCs a permanent part of Michigan's mental health landscape should include the number and location of the CCBHCs that are to be certified in Michigan. The determination of the number and location of CCBHCs should be guided by the need for statewide coverage and for the prevention of duplication and confusion. This initial determine of number and location is expected to change, over time, with the state spelling out, in advance in the SPA/waiver, the method by which those changes will be made.

The method by which CCBHC Expansion sites become CCBHC during the State Demonstration period of post-Demonstration should be clearly outlined and implemented with sufficient time to allow these sites to understand and work to comply with these methods.

2. Development of clear criteria for designation as a CCBHC in the State Demonstration and permanent, post-Demonstration period. These standards should be the requirements contained in Michigan's current CCBHC State Demonstration effort, with the following refinements. These refinements are recommended, by CMHA, in pursuit of the Principles and Premises outlined earlier in this paper.

Recommended refinements to the CCBHC standards:

A. Ensure that the state's CCBHCs meet the mental health safety net definition. This definition is provided above, within the Principles and Premises section of this paper and in Appendix A.

B. Michigan's CCBHC standards must be developed to be flexible enough to meet the needs of all communities: Michigan's CCBHC certification standards should be resilient enough to be applicable to the unique needs and resources of the **urban, suburban, and rural communities** throughout Michigan and to the **unique service delivery architecture** of the mental health safety net in each community.

3. CCBHC Expansion and State Demonstration as on-ramp for post-Demonstration CCBHC system: Those organizations who were CCBHC Expansion sites and later became State Demonstration sites found the receipt of these Expansion grant dollars to be invaluable in their ability to take on the challenges of becoming CCBHC State Demonstration sites. Similarly, the Demonstration sites are finding and will find this experience helpful to them as they move into the post-demonstration era.

It is recommended that the financial support and technical assistance received by the Expansion and the State Demonstration sites **be made available to all of the state's CMSHPs who indicate an interest in becoming CCBHCs – through the provision of grant dollars to those sites and through inclusion as State Demonstration CCBHC sites.**

4. Roles for private provider organizations: The role of private provider organizations in CCBHC systems, given that they do not meet the definition of the Michigan mental health safety net, must be defined with precision. These roles may include: as Designated Collaborating Organization (DCO) of a CCBHC, as a partner of a safety net organization in fulfilling CCBHC obligations.

Additionally, the private non-profit organizations currently involved in the CCBHC State Demonstration initiative, could be grandfathered into the post-Demonstration CCBHC system with conditions that ensure that these private non-profit CCBHCs function as integral parts of the state's mental health safety net (as defined in earlier sections of this document. Those conditions would include:

- All CCBHC enrollments, for persons served by the private organization, must be done by the CMHSP serving the area in which the private organization is providing CCBHC services. This enrollment process would include the screening and initial assessment of the person's needs for CCBHC services and any other services provided by and/or funded by the CMHSP – in keeping with the CCBHC aim of strengthening and not fragmenting the mental health safety net in CCBHC communities.
- Any persons enrolled, by the CMHSP, into the CCBHC program and referred to the private CCBHC organization, must be served by the private CCBHC – in keeping with the aim of the CCBHC initiative.

5 Retain the current Medicaid capitation payment system by which the state's CMHSPs are financed (since 1997) as a core component of the financing of the state's CCBHCs, a complement to the Prospective Payment System (PPS) used to complete the state's funding of Michigan's mental health safety net.

6. All CMHSPs should be seen as eligible (but not required) to become CCBHCs: All of Michigan's CMHSPs, which meet the CCBHC certification standards, should be certified as CCBHCs – **if the CMHSP elects to be certified as a CCBHC** - under the Michigan's CCBHC State Demonstration initiative and as part of any Medicaid State Plan Amendment (SPA) or waiver.

Such voluntary participation, as a CCBHC, by a CMHSP, applies to the CMHSP's **election to become certified as a CCBHC** and to its **election to voluntarily exit from CCBHC status.**

This entre' to CCBHC eligibility, for the state's CMHSPs, is in recognition of the close alignment of the philosophy, structure, services, and operations of the state's CMHSPs – the core of Michigan's mental health safety net system - with those of the CCBHC constructs.

However, the status as an Expansion CCBHC site, by a CMHSP, does not guarantee that site's certification as a CCBHC under the State Demonstration initiative nor under a permanent CCBHC structure.

7. Foster consistency of policy and practice in the roles played by the state's PIHPs relative to CCBHC financing and operations: The use of the state's PIHP system to organize the financing of the state's CCBHCs is wise. Needed is greater guidance, from MDHHS, in the SPA/waiver, as to the standard practices that should be used by all of the state's PIHPs relative to CCBHC financing and operations. Michigan's PIHPs have demonstrated a strong willingness to work with MDHHS to develop consistent practices and policies relative to financing of and operational support to the state's CCBHCs.

8. Ensure that Michigan's CMHSP certification standards do not conflict with the state's CCBHC standards: It is key that Michigan's CMHSP certification process not hinder CMHSPs who may want to pursue CCBHC designation. It is equally important that the CMHSP certification standards not force CMHSPs not seeking CCBHC designation to meet CCBHC standards that are not relevant to the CMHSP certification process.

9. Require, over time, that a specific four of nine CCBHC services be directly provided: The aims and integrity of the nation's CCBHC initiative are founded on strong and clear requirements (Underscored in the State Demonstration constructs) that are central to: ensuring access to care (crisis and non-crisis), coordination of care, and the consistency and stability of the CCBHC benefit.

To that end, **over time**, Michigan's State Demonstration and post-demonstration CCBHC certification process should require that all of Michigan's CCBHCs provide the following four of the nine required CCBHC services:

- Screening, Assessment, Diagnosis, and Risk Assessment
- Treatment planning
- Crisis Services
- Outpatient Mental Health and Substance Use Services

Unique features of Michigan mental health safety net: Breadth of roles of Michigan's Community Mental Health and Regional Entity system - statutory, regulatory, and contractual foundation

A. Multiple roles: CMHs serve several roles in fulfilling their statutory, regulatory, and contractual obligations:

- Direct provider and purchaser of the full range of behavioral health services, across all levels of severity and need, all levels of intensity, including psychiatric inpatient care (at local and state hospitals), 24/7 crisis response services, and a wide range of non-traditional home and community-based services
- Manager and assurer of the quality of care across a comprehensive service network
- Community convener and collaborator around a wide range of community needs and social determinants
- Advocate for individual clients and for clients as a group
- Source of guidance and expertise to other healthcare and human services providers

B. Breadth of roles required in statute, regulation and contract:

1. Michigan Mental Health Code: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868-23755--,00.html

Section 206, of the code, provides a picture of the array of services for which the state's CMHSPs are responsible:

330.1206 Community mental health services program; purpose; services.

(1) The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:

(a) Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.

(b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.

(c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.

(d) Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.

(e) Recipient rights services.

(f) Mental health advocacy.

(g) Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.

(h) Any other service approved by the department.

2. Michigan Administrative Rules that apply to the public mental health system:
https://ars.apps.lara.state.mi.us/AdminCode/DeptBureauAdminCode?Department=Health%20and%20Human%20Services&Bureau=Behavioral%20Health%20and%20Developmental%20Disabilities%20Administration

Examples of the expansive role of CMH as defined by Administrative Rules:

> **R330.2007: "**Prevention services *(a set of services required by Mental Health Code and Administrative Rules, of the CMH system)* are those services of the county program directed to at-risk populations and designed to reduce the incidence of behavioral, emotional, or cognitive dysfunction and the need for individuals to become mental health recipients of treatment services." "Prevention services may be provided through individualized services, time-limited training or community/caregiver services." "Prevention services shall include...provision for responding to the mental health dimensions of community catastrophes."
>
> **R330.2014** : "Community caregiver services are those services of the county program provided to agencies and community groups on behalf of client groups and at-risk populations by means of consultation, education and collaboration, the purpose of which is to facilitate non-mental health services and reduction of demand on the county program."

3. MDHHS contract with the CMHs and PIHPs: The contract between MDHHS and the CMH and PIHP system contains requirements that underscore the expansive role expected, for the public mental health system, by the state of Michigan. These expectations go far beyond those expected of typical health care providers, public health departments, and health plans and require a unique blend of traditional clinical interventions and human services and relation-based interventions that address social determinants. The work is based on in-depth person-centered planning and self-determination processes – unlike most other healthcare systems. The work with children and youth is family driven and youth guided services, with families as part of team - unlike most other healthcare systems.

Examples of the expansive role of CMHs as defined by the MDHHS-CMH contract:

> **CMHSP Contract 6.4.3 Collaboration with Community Agencies**: "CMHSPs must work closely with local public and private community based organizations and providers to address prevalent human conditions and issues that are related to a shared consumer base."
>
> **CMHSP Contract 6.9.4 Coordination : "**The CMHSP shall.. assure that services to each individual are coordinated with primary health care providers and other service agencies in the community that serve the recipient with practices and written agreements."
>
> **CMHSP Contract 6.4.3 Collaboration with Community Agencies:** "...Local health departments, local MDHHS offices, regional PIHP for SUD, community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid waiver agents for HCBW program, school systems and Michigan Rehabilitation Services."

A subset of the attachments to the CMH and PIHP contracts with MDHHS make clear the breadth and depth of these contractual requirements and expectations:

Sample of CMH contract attachments:

C 3.1.1	Access System Standards
C 3.3.1	Person-Centered Planning
C 3.3.4	Self-Determination & Fiscal Intermediary Guideline
C 3.3.5.1	Recovery Policy & Practice Advisory
C 4.5.1	PASARR Agreement
C 4.7.1	SEDW Agreement
C 4.7.2	Technical Requirement for SED Children
C 4.9.1	Mental Health Court Pilot Projects
C 6.3.2.3A	CEU Requirements for RR Staff
C 6.3.2.3B	RR Training Standards for CMH and Provider Staff TR
C 6.3.2.4	Recipient Rights Appeal Process
C.6.8.3.1	Training for Behavior Treatment Plan Review Committees
C 6.9.1.1	Incompetent to Stand Trial and Not Guilty by Reason of Insanity Protocol
C 6.9.1.2	State Facility Contract
C 6.9.3.1	Housing Practice Guideline
C 6.9.3.2	Inclusion Practice Guideline
C 6.9.3.3	Consumerism Practice Guideline
C 6.9.5.1	Jail Diversion Practice Guideline
C 6.9.6.1	School to Community Transition Guideline
C 6.9.7.1	Family-Driven and Youth-Guided Policy & Practice Guideline
C 6.9.8.1	Employment Works! Policy
C 6.9.9.1	CMHSP Trauma Policy

Sample of PIHP contract attachments:

P.1.4.1	Technical Requirement for Behavior Treatment Plans
P.4.1.1	Access Standards
P.4.4.1.1	Person-Centered Planning Practice Guideline
P.4.7.1	Self Determination Practice & Fiscal Intermediary Guideline
P.4.7.4	Technical Requirement for SED Children
P.4.13.1	Recovery Policy & Practice Advisory
P.7.10.2.1	Inclusion Practice Guideline
P.7.10.2.2	Housing Practice Guideline
P.7.10.2.3	Consumerism Practice Guideline
P.7.10.2.4	Personal Care in Non-Specialized
P.7.10.2.5	Family-Driven and Youth-Guided Policy & Practice Guideline
P.7.10.2.6	Employment Works! Policy
P.7.10.3.1	Jail Diversion Practice Guidelines
P.7.10.4.1	School to Community Transition Planning

4. 1915 Medicaid Waiver, 1115 Medicaid Waiver, and Medicaid State Plan

Example of the expansive role of CMH as required in the Medicaid waivers:
1915b(c) Waiver Implementation Guide:

> **"**The case for preferential contracting with CMHSPs (for the Medicaid specialty benefit) rests upon their commitment to particular public policy objectives and outcomes… and upon their unique role in the community as an "integrator" of services…**Community Benefit endeavors including: Information, education, prevention and consultation activities."**

5. Application for Participation (in 2002 and subsequent AFP, ARR): Since the 1998 implementation of the Michigan Medicaid Managed Specialty Supports and Services Program and subsequent federal waiver authorities, CMHSPs were designated as Comprehensive Specialty Services Networks (CSSNs) and are expected to create and maintain Provider Specialty Services Networks (PSSNs). This has been the state's expectations for all CMHSPs and is the very foundation for Michigan's unique managed care "carve-out" sole source contractual arrangement with the public community mental health system. These roles are outlined in a number of foundational documents of Michigan's behavioral health Medicaid program, excerpts of which are provided below:

Michigan Department of Community Health; Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans; Final Version; 2000

> … CMHSPs in the affiliation would be eligible for a special provider designation – that of **"Comprehensive Specialty Service Network" (CSSN)** – that affords them special consideration in the provider network and qualifies them to receive a sub-capitation from the PHP or hub-CMHSP.

Michigan Department of Community Health; Specialty Pre-Paid Health Plan 2002 application for participation and implementation guide; January 2002:

> "This Targeted Populations /Local Management/Consolidated Funding Model has successfully concentrated community interest, stakeholder involvement, professional expertise, service delivery development, and resource deployment on the specific needs and interests of persons with mental illness, developmental disabilities and addictive disorders. The focus on local collaboration has forged necessary linkages for care coordination and cooperative community solutions to complex situations."
>
> "MDCH *(now MDHHS)* was concerned that competitive selection of Medicaid specialty Prepaid Health Plans [PIHPS] posed the risk that one of the ingredients of *a comprehensive community care system* – Medicaid Specialty Service benefits – might be split off and placed under separate governance. Such a separation would reintroduce the inefficiencies, service fragmentation and coordination problems that have historically hindered effective care for beneficiaries with serious mental illness, developmental disabilities and addictive disorders."

ARR Sec.8 Coordinating and Managing Care; 2002:

> "…Expanding the concept of "System of Care" principles across schools, DHHS, Probate/Juvenile Court…for complex and co-occurring…requiring extra outreach."

2013 AFP reinforced these principles:

"The 2002 AFP and the 2008 ARR are the foundation of the Medicaid Specialty Supports and Services program and the vision, values and public policy they addressed…are still highly regarded and….will continue to be part of the contracts between MDCH *(now MDHHS)* and the new PIHPs…"

email correspondence

From: Robert Sheehan
To: Eric Kurtz (NMRE)
Cc: Joe Stone; Don Tanner
Subject: RE: CCBHC and NMRE Board and Leadership Concerns
Date: Thursday, August 11, 2022 2:57:11 PM
Attachments: image001.png

Eric, Joe, Don,

Thank you for sharing the concerns of the NMRE Board of Directors. We share those concerns. Those concerns are those that are driving the work of CMHA and its members to ensure that our association is on record, now, relative to any work, by MDHHS, around making CCBHCs a permanent part of Michigan's mental health landscape. The recent (August 10) discussion by the large number of CMH and PIHP CEOs, during which the draft CMHA recommendations were further refined, addressed the issues that you have raised, along with many others. That revised draft will be sent to the state's CMH and PIHP CEOs, later this week.

The following, drawn, from the July 29 draft of these recommendations, may be helpful in providing the NMRE Board with the context for this effort.

Michigan's State Demonstration & SPA/Permanent CCBHC initiative: Recommendations

Revised July 29, 2022

FOUNDATIONAL ASSUMPTIONS
A number of assumptions formed the foundation for the development of this document:

WHY CMHA IS DEVELOPING THIS SET OF RECOMMENDATIONS:

1. **The State of Michigan**, for the reasons outlined in the next section below, **will be making Certified Behavioral Health Clinics (CCBHC) a central and permanent part of the state's mental health system.**

2. As is true in states across the country, Michigan's CCBHCs will become a central component in Michigan's public mental health system through **a Medicaid State Plan Amendment (SPA) or a Medicaid waiver.**

3**. The active involvement of CMHA, its members, and allies**, in the design of the CCBHC-centered SPA or Medicaid waiver is key to ensuring that that the CCBHC system that is established meets the needs of all of the communities in Michigan – rural, suburban, urban – and strengths the state's mental health safety net.

Without this involvement – in the form of recommendations and on-going dialogue **– the state's permanent CCBHC system is unlikely to accurately reflect the views of CMHA members, allies, and stakeholders.**

WHY THERE IS SUCH CERTAINTY THAT CCBHCS WILL BECOME A CENTRAL AND PERMANENT PART OF MICHIGAN'S MENTAL HEALTH SYSTEM.

1. **CCBHCs are seen, by policy makers and observers of the nation's mental health system, as the emerging cornerstones of the nation's mental health system** - one that provides the access, quality and range of services envisioned in the federal Community Mental Health Act of 1963.

Among those voices (with links to those views expressed by those voices) are:

- Center for Health Care Strategies
- National Council of State Legislators
- Office of the Assistant Secretary for Planning and Evaluation, HHS
- National Council for Mental Wellbeing

2. **Michigan's CCBHCs have reported greatly increased access to care** for the members of their communities, with dramatic increases in access for children, persons with mild to moderate mental health needs, and substance use disorder needs.

3. The CCBHC initiative is made possible by the **US Senator Debbie Stabenow**, Michigan's senior US Senator and a longtime advocate for and ally of Michigan's public mental health system, who **sponsored the Excellence in Mental Health Act creating the CCBHC initiative.**

4. The loss of access to care by a significant number of Michiganders if CCBHCs are not made a permanent component of Michigan's mental health system. The importance and timing of Michigan developing a Medicaid State Plan Amendment (SPA) or waiver amendment to make CCBHC permanent is underscored by two events. These importance of these two events was highlighted, a few months back, by the National Council CCBHC staff during the Michigan Rural CCBHC roundtable. Those events include:

- the end of the demonstration project period (impacting 13 Michigan communities)
- the end of the expansion grants for another 21 communities

If the SPA/waiver is not in place when either of these two events take place, these CCBHC sites would shut down with the attending loss of over $40 million dollars to the system and access to care for a large number of persons in those communities.

WHY THERE IS LIKELY TO BE A ROLE FOR PRIVATE PROVIDER ORGANIZATIONS IN MICHIGAN'S CCBHC SYSTEM

1. **Michigan's CCBHC State Demonstration effort already involves several private non-profit organizations as CCBHCs.** This fact underscores the need for CMHA, its members, and allies to work to ensure that the permanent CCBHC system **promotes a strong public mental health safety net while recognizing the unique and vital role played by the private non-profit providers essential**.

Political and policy experts have recommended that a set of standards that align with the definitions and requirements of Michigan's mental health safety net be used to promote this aim while ensuring that innovative private non-profits have a solid role in the state's CCBHC system.

PROCESS USED IN DEVELOPMENT OF THIS DOCUMENT

To ensure that the recommendations that will be reflected in the final set of CMHA recommendations related to the state's work to make CCBHC a permanent part of the state's mental health landscape, CMHA has designed a sequence of dialogues, with key parties within CMHA, in the development of these recommendations. These dialogues include:

1. Ensuring that CCBHC can meet needs of all Michigan communities: CMHA held a series of CCBHC learning sessions for CMHA members, designed to support the current operation and development of the emerging CCBHC system in Michigan. Those sessions included a **Michigan Rural CCBHC Roundtable,** in September 2021 jointly sponsored by CMHA and the National Council, with leaders of rural CCBHCs from across Michigan and Minnesota.

2. Initial draft set of recommendations developed by CMHA: Based on the issues raised in these venues and based on periodic and informal discussions with leaders within the state's CCBHC demonstration sites, CCBHC expansion sites, CMHs operating Behavioral and Opioid Health Homes, leaders of CCBHC efforts in other states, and the CCBHC Technical Assistance Center at the National Council, CMHA developed an initial set of recommendations related to what may become Michigan's CCBHC design going forward.

3. Refining initial draft with views of those with working knowledge of CCBHC – the current State Demonstration Sites: Group discussion, of the initial concept paper, with CEOs and leaders of CMHs that are CCBHC demonstration sites and CMHs with CCBHCs in their networks. Given that these leaders had the greatest familiarity with CCBHC design and operations, their views were sought to begin the dialogue with CMHA members on this draft set of recommendations. A revised draft emerged from this discussion that was distributed to the CEOs of all of the state's CMHs and PIHPs.

4. Refining draft with views of the CEOs of the state's CMHs and PIHPs:

- Group discussion of the draft document, with an invitation to the CEOs of all of the state's CMHs and PIHPs, on July 29.. A revised draft emerged from this discussion that was distributed to the CEOs of all of the state's CMHs and PIHPs.

- A second group discussion of the latest draft of the document, with an invitation to the CEOs of all of the state's CMHs and PIHPs, is slated for August 11.

- If needed, a third group discussion of the draft that emerges from the August 11 session, will be held, with an with an invitation to the CEOs of all of the state's CMHs and PIHPs.

5. Legislative and Policy Committee: The draft that emerges from the venues, listed above, will be reviewed and revised by the CMHA Legislation and Policy Committee for recommendation to the CMHA Board of Directors at its September 21 meeting.

6. CMHA Board of Directors: The recommendations, reflecting the document recommended by the Legislative and Policy Committee, will reviewed, revised, and adopted by the CMHA Board of Directors at its October or November meeting.

7. Recommendations used as policy advocacy tool: CMHA, its members, and allies use the adopted set of recommendations in dialogue with MDHHS, the State Legislature, and CCBHC stakeholders

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
507 South Grand Avenue, Lansing, MI 48933 (Note new address)
517.374.6848 main
517.237.3142 direct
517.374.1053 fax
www.cmham.org

CMHA MOVING: As of June 1, 2022, the CMHA offices will no longer be at 426 South Walnut. CMHA's new address will be 507 South Grand Avenue, Lansing, MI 48933, only several blocks eastward of our former South Walnut location. My email address and phone number will remain the same. However, because we will not be moving into our new office location until September 1st , due to renovations, my CMHA colleagues and I will be working fully remotely until then. You can, of course, continue to reach me via phone and email during this two-month transition.

From: Eric Kurtz (NMRE) <ekurtz@nmre.org>
Sent: Wednesday, July 20, 2022 1:26 PM
To: Robert Sheehan <rsheehan@cmham.org>
Cc: Joe Stone <stonejoe09@gmail.com>; Don Tanner <drtannerbnz@gmail.com>
Subject: CCBHC and NMRE Board and Leadership Concerns

HI Bob, as we talked last week, I indicated you would be getting a memo regarding our NMRE concerns of CCBHC expansion and it becoming a state plan service. As stated in the memo, we all agree we want to expand our services to our entire communities, but don't want that to be tied to one model. From a system perspective, I also have concerns the current requirements could open the door to numerous potential providers, which would water down the CCBHC's original intent and has the potential to undermine the CMHSP's uniqueness where it provides the whole array of services.

Thanks

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

Date: August 15, 2022

To: Prepaid Inpatient Health Plan (PIHP) Directors

From: Jeffery L. Wieferich MA, LLP JW
Director
Bureau of Community Based Services
Behavioral and Physical Health and Aging Services Administration

Re: Substance Use Disorder Discharge/Complex Care Manager

As a follow up to the discussion at the August 4, 2022, PIHP CEO meeting, the Michigan Department of Health and Human Services (MDHHS) is confirming that $150,000, in **additional** Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, is being provided to each PIHP as part of the Substance Abuse and Gambling Services grant program for Fiscal Year 2023 (SUGS-23) through the Treatment and Access Management project to establish a discharge support/complex care management position.

These funds will be available on October 1, 2022. It is the intent of MDHHS that this will be ongoing funding contingent on the federal SAPT funds continuing to be appropriated to the State in an adequate amount.

This position must be dedicated to supporting substance use disorder providers with meeting the needs of priority population individuals. Specific attention must be given to those involved with the Department of Corrections due to the additional requirements that are part of the services being provided to them.

Please provide the name and contact information of the individual who fills this position to Teri Baker at BakerT3@michigan.gov.

c: Farah Hanley
Kristen Jordan
Belinda Hawks
Jackie Sproat
Angie Smith-Butterwick
Darrell Harden

August 12, 2022

MEMORANDUM

TO: Board Chairpersons
Executive Directors
Association Delegates
Board of Directors

FROM: Dr. Carl Rice, Jr., President

RE: **Nomination and Election of Association Treasurer – 2022/2024**
Must respond by Thursday, September 1, 2022

We are continuing the process of nominating and electing an Association Treasurer for 2022/2024. A Special Election will be held at the Member Assembly Meeting during the Fall Conference on **SUNDAY, OCTOBER 23, 2022**. The process involves the following:

1. Each region must appoint a representative to the Nominating Committee. These nominations were completed at the Fall regional meetings in 2021. The Nominating Committee members are listed on page 2.

2. Boards are asked to nominate candidates for office by sending their nominations to their regional chairperson and the Association office. Discussions for the nomination process began at the Summer Regional Meetings held on June 8, 2022.

3. If the regional chairperson receives a large number of nominations, the chair may want to convene a regional meeting via Zoom or in person to recommend a roster of candidates to be nominated from their region. The nominations should be forwarded to the Association office by September 1, 2022. Each Region should nominate ONE INDIVIDUAL per office on the provided blank roster.

4. The complete slate will be sent to all boards by September 8, 2022 prior to the By-laws deadline.

5. ***The Special Election will be held during the Association Member Assembly Meeting in October.***

This memo will serve as official notification and invitation from the Association to every board to submit candidates for Treasurer to their regional chairperson and the Association office. ***You are encouraged to submit nominees as soon as possible.***

- Officers to be elected will be treasurer ONLY.
- Our By-Laws mandate that the president and first vice president must be a board member. Treasurer can be a board member or director.
- The By-Laws also state that not more than two officers shall be from the same Association region.
- Members are prohibited from serving more than 2 consecutive terms in any office.
- Boards are requested to send nominations for Association Treasurer to:
  CMHA, 507 South Grand Ave., Lansing, MI 48933 OR email to mfrancis@cmham.org

Community Mental Health Association of Michigan
2022-2024 Special Election for Treasurer
ROSTER

2022-2024 NOMINATING COMMITTEE:

Chairperson: Ed Woods (LifeWays)
Central: Connie Barber (Bay-Arenac)
Metro: Linda Busch (Macomb)
Northern: Nena Sork (Northeast)
Southeast: Kay Randolph-Back (CEI)
U.P.: Jim Moore (Hiawatha)
Western: Todd Koopmans (Newaygo)

(Below nominations were received at the 2022 Annual Summer Conference)

2022-2024 ROSTER OF NOMINEES FOR TREASURER

	President	1st VP	2nd VP	Treasurer	Secretary
Current Officers	Dr. Carl Rice, Jr. LifeWays (Southeast)	Craig Reiter Hiawatha (UP)	Cathy Kellerman Newaygo (Western)	VACANT	Wil Morris Sanilac (Central)
Eligible for re-election					
Central					
Metro				Angelo Glenn (B) Detroit Wayne *(Metro)*	
Northern				Michael Welsch (B) AuSable Valley *(Northern)*	
Southeast					
U.P.				Cathy Pullen (B) Pathways *(UP)*	
Western					

Please Note:

< Officer to be elected will be treasurer ONLY.
< Our By-Laws mandate that the president and first vice president must be board members. Treasurer can be a board member OR a director.
< The By-Laws also state that not more than two officers shall be from the same Association region.

08/12/2022

Statewide PIHP Performance Indicators Quarter 2 FY22

Indicator 1a: Percentage of Children Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours -- 95% Standard

	Percentage	Number of Emergency Referrals for Children	Number Completed in Three Hours for Children
Detroit Wayne Mental Health Authority	98.14	805	790
Lakeshore Regional Entity	98.92	369	365
Macomb Co CMH Services	99.53	213	212
Mid-State Health Network	98.00	1,002	982
NorthCare Network	98.68	76	75
Northern MI Regional Entity	97.20	214	208
Oakland Co CMH Authority	98.54	137	135
Region 10	99.73	377	376
CMH Partnership of Southeast MI	99.33	150	149
Southwest MI Behavioral Health	99.64	280	279
Statewide Total	**98.77**	**3,623**	**3,571**

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

	Percentage	Number of Emergency Referrals for Adults	Number Completed in Three Hours for Adults
Detroit Wayne Mental Health Authority	98.81	2,684	2,652
Lakeshore Regional Entity	98.51	1,338	1,318
Macomb Co CMH Services	99.91	1,160	1,159
Mid-State Health Network	98.77	2,447	2,417
NorthCare Network	100.00	218	218
Northern MI Regional Entity	98.93	747	739
Oakland Co CMH Authority	92.73	1,705	1,581
Region 10	100.00	853	853
CMH Partnership of Southeast MI	98.82	592	585
Southwest MI Behavioral Health	99.42	862	857
Statewide Total	**98.59**	**12,606**	**12,379**

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

	Percentage	# of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	59.23	3,407	2,018
Lakeshore Regional Entity	65.95	1,216	802
Macomb Co CMH Services	11.32	1,652	187
Mid-State Health Network	62.08	4,518	2,805
NorthCare Network	57.89	665	385
Northern MI Regional Entity	50.93	1,343	684
Oakland Co CMH Authority	44.78	1,083	485
Region 10	54.88	2,008	1,102
CMH Partnership of Southeast MI	61.65	1,124	693
Southwest MI Behavioral Health	72.26	1,806	1,305
Statewide Total	**54.10**	**18,822**	**10,466**

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

	Percentage	# MI Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	45.65	966	441
Lakeshore Regional Entity	66.87	495	331
Macomb Co CMH Services	9.77	532	52
Mid-State Health Network	63.78	1,549	988
NorthCare Network	58.57	251	147
Northern MI Regional Entity	50.37	409	206
Oakland Co CMH Authority	51.72	379	196
Region 10	56.97	574	327
CMH Partnership of Southeast MI	70.00	370	259
Southwest MI Behavioral Health	75.08	630	473
Statewide Total	**54.88**	**6,155**	**3,420**

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

	Percentage	# MI Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	62.94	1,959	1,233
Lakeshore Regional Entity	64.22	559	359
Macomb Co CMH Services	10.15	1,005	102
Mid-State Health Network	61.38	2,597	1,594
NorthCare Network	56.75	363	206
Northern MI Regional Entity	49.70	833	414
Oakland Co CMH Authority	42.64	645	275
Region 10	51.73	1,096	567
CMH Partnership of Southeast MI	52.91	618	327
Southwest MI Behavioral Health	69.27	1,012	701
Statewide Total	**52.17**	**10,687**	**5,778**

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

	Percentage	# DD Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	71.78	404	290
Lakeshore Regional Entity	78.49	93	73
Macomb Co CMH Services	32.89	76	25
Mid-State Health Network	58.58	268	157
NorthCare Network	66.67	27	18
Northern MI Regional Entity	66.20	71	47
Oakland Co CMH Authority	26.32	19	5
Region 10	63.71	259	165
CMH Partnership of Southeast MI	79.21	101	80
Southwest MI Behavioral Health	80.17	121	97
Statewide Total	**62.40**	**1,439**	**957**

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

	Percentage	# DD Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	69.23	78	54
Lakeshore Regional Entity	56.52	69	39
Macomb Co CMH Services	20.51	39	8
Mid-State Health Network	63.46	104	66
NorthCare Network	58.33	24	14
Northern MI Regional Entity	56.67	30	17
Oakland Co CMH Authority	22.50	40	9
Region 10	54.43	79	43
CMH Partnership of Southeast MI	77.14	35	27
Southwest MI Behavioral Health	79.07	43	34
Statewide Total	**55.79**	**541**	**311**

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

		Admissions			
	Percentage	# of Non-Urgent Admissions to a Licensed SUD Treatment Facility as reported in BH TEDS	# of Expired Requests Reported by the PIHP	Total	# of Persons Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request
Detroit Wayne Mental Health Authority	63.04	2,653	772	3,425	2,159
Lakeshore Regional Entity	67.65	1,262	203	1,465	991
Macomb Co CMH Services	77.80	1,231	188	1,419	1,104
Mid-State Health Network	77.04	2,853	392	3,245	2,500
NorthCare Network	74.75	506	84	590	441
Northern MI Regional Entity	71.73	1,004	82	1,086	779
Oakland Co CMH Authority	81.42	909	146	1,055	859
Region 10	66.87	1,654	453	2,107	1,409
CMH Partnership of Southeast MI	61.95	764	219	983	609
Southwest MI Behavioral Health	66.27	1,226	351	1,577	1,045
Statewide Total	**70.85**	**14,062**	**2,890**	**16,952**	**11,896**

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

	Percentage	# of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# of Persons Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	87.27	2,592	2,262
Lakeshore Regional Entity	59.84	889	532
Macomb Co CMH Services	72.82	710	517
Mid-State Health Network	65.53	3,235	2,120
NorthCare Network	76.31	477	364
Northern MI Regional Entity	65.22	831	542
Oakland Co CMH Authority	99.88	824	823
Region 10	84.79	1,341	1,137
CMH Partnership of Southeast MI	72.85	722	526
Southwest MI Behavioral Health	65.39	1,433	937
Statewide Total	**74.99**	**13,054**	**9,760**

Indicator 3a: The Percentage of New Children with Emotional Disturbance During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	80.73	716	578
Lakeshore Regional Entity	60.31	446	269
Macomb Co CMH Services	60.20	196	118
Mid-State Health Network	60.24	1,167	703
NorthCare Network	81.03	195	158
Northern MI Regional Entity	62.83	269	169
Oakland Co CMH Authority	100.00	308	308
Region 10	88.27	375	331
CMH Partnership of Southeast MI	67.14	280	188
Southwest MI Behavioral Health	65.41	477	312
Statewide Total	**72.62**	**4,429**	**3,134**

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

	Percentage	# MI Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	88.24	1,480	1,306
Lakeshore Regional Entity	55.59	295	164
Macomb Co CMH Services	76.97	456	351
Mid-State Health Network	67.56	1,785	1,206
NorthCare Network	73.33	240	176
Northern MI Regional Entity	65.07	481	313
Oakland Co CMH Authority	99.78	457	456
Region 10	79.25	689	546
CMH Partnership of Southeast MI	76.09	322	245
Southwest MI Behavioral Health	65.68	810	532
Statewide Total	**74.76**	**7,015**	**5,295**

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

	Percentage	# DD Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	96.36	330	318
Lakeshore Regional Entity	65.28	72	47
Macomb Co CMH Services	91.67	36	33
Mid-State Health Network	75.24	210	158
NorthCare Network	69.57	23	16
Northern MI Regional Entity	86.79	53	46
Oakland Co CMH Authority	100.00	20	20
Region 10	96.79	218	211
CMH Partnership of Southeast MI	80.23	86	69
Southwest MI Behavioral Health	57.55	106	61
Statewide Total	**81.95**	**1,154**	**979**

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

	Percentage	# DD Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	90.91	66	60
Lakeshore Regional Entity	68.42	76	52
Macomb Co CMH Services	68.18	22	15
Mid-State Health Network	72.60	73	53
NorthCare Network	73.68	19	14
Northern MI Regional Entity	50.00	28	14
Oakland Co CMH Authority	100.00	39	39
Region 10	83.05	59	49
CMH Partnership of Southeast MI	70.59	34	24
Southwest MI Behavioral Health	80.00	40	32
Statewide Total	**75.74**	**456**	**352**

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

	Percentage	# Children Discharged from Psychiatric Inpatient Unit	# Children Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	93.75	64	60
Lakeshore Regional Entity	92.11	38	35
Macomb Co CMH Services	31.94	72	23
Mid-State Health Network	98.97	97	96
NorthCare Network	100.00	21	21
Northern MI Regional Entity	100.00	28	28
Oakland Co CMH Authority	96.15	26	25
Region 10	97.30	74	72
CMH Partnership of Southeast MI	92.86	28	26
Southwest MI Behavioral Health	100.00	27	27
Statewide Total	**90.31**	**475**	**413**

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

	Percentage	# Adults Discharged from Psychiatric Inpatient Unit	# Adults Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	95.94	566	543
Lakeshore Regional Entity	95.05	222	211
Macomb Co CMH Services	32.44	524	170
Mid-State Health Network	95.75	471	451
NorthCare Network	98.53	68	67
Northern MI Regional Entity	97.81	137	134
Oakland Co CMH Authority	86.75	249	216
Region 10	95.67	254	243
CMH Partnership of Southeast MI	93.79	161	151
Southwest MI Behavioral Health	97.60	250	244
Statewide Total	**88.93**	**2,902**	**2,430**

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

	Percentage	# SA Discharged from Substance Abuse Detox Unit	# SA Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	99.37	474	471
Lakeshore Regional Entity	94.79	96	91
Macomb Co CMH Services	99.60	252	251
Mid-State Health Network	99.37	159	158
NorthCare Network	.	0	0
Northern MI Regional Entity	96.64	119	115
Oakland Co CMH Authority	100.00	150	150
Region 10	85.71	70	60
CMH Partnership of Southeast MI	96.46	113	109
Southwest MI Behavioral Health	94.65	187	177
Statewide Total	**96.29**	**1,620**	**1,582**

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

	Percentage	Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients
Detroit Wayne Mental Health Authority	6.09	48,360	793,539
Lakeshore Regional Entity	5.36	17,754	331,290
Macomb Co CMH Services	4.61	11,416	247,719
Mid-State Health Network	7.49	35,288	470,904
NorthCare Network	6.93	5,488	79,168
Northern MI Regional Entity	7.74	11,464	148,062
Oakland Co CMH Authority	7.15	16,330	228,373
Region 10	6.87	16,384	238,625
CMH Partnership of Southeast MI	6.18	9,334	151,139
Southwest MI Behavioral Health	6.63	16,840	253,873
Statewide Total	**6.51**	**188,658**	**2,942,692**

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

	Percentage	# of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	Total Number of HSW Enrollees
Detroit Wayne Mental Health Authority	92.91	930	1,001
Lakeshore Regional Entity	90.61	560	618
Macomb Co CMH Services	92.77	398	429
Mid-State Health Network	94.25	1,426	1,513
NorthCare Network	95.79	341	356
Northern MI Regional Entity	91.40	595	651
Oakland Co CMH Authority	92.86	767	826
Region 10	93.59	569	608
CMH Partnership of Southeast MI	88.68	611	689
Southwest MI Behavioral Health	88.90	617	694
Statewide Total	**92.18**	**6,814**	**7,385**

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

	Percentage	Number of Children Discharged from Inpatient Care	# Children Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	7.69	130	10
Lakeshore Regional Entity	18.33	60	11
Macomb Co CMH Services	5.19	77	4
Mid-State Health Network	5.60	125	7
NorthCare Network	10.00	20	2
Northern MI Regional Entity	10.26	39	4
Oakland Co CMH Authority	2.86	35	1
Region 10	5.26	95	5
CMH Partnership of Southeast MI	0.00	33	0
Southwest MI Behavioral Health	5.36	56	3
Statewide Total	**7.06**	**670**	**47**

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

	Percentage	Number of Adults Discharged from Inpatient Care	# Adults Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	16.31	1,527	249
Lakeshore Regional Entity	7.37	339	25
Macomb Co CMH Services	18.21	582	106
Mid-State Health Network	10.42	787	82
NorthCare Network	12.36	89	11
Northern MI Regional Entity	10.43	211	22
Oakland Co CMH Authority	8.50	400	34
Region 10	11.46	419	48
CMH Partnership of Southeast MI	8.81	227	20
Southwest MI Behavioral Health	9.61	437	42
Statewide Total	**11.35**	**5,018**	**639**

Funding agency to oversee Northern Lakes CMH

By Patti Brandt Burgess pburgess@record-eagle.com

TRAVERSE CITY — The Northern Michigan Regional Entity will provide oversight to Northern Lakes Community Mental Health Authority, a move that includes naming an interim CEO and being the point of contact in the search for a new CEO.

Oversight also could include a review of audits where plans of correction were identified, such as in customer services, quality management and reporting, and grievance or appeals processes, according to a letter from Eric Kurtz, CEO of NMRE, and Don Tanner, chair of the NMRE board.

The NMRE board met earlier this month to talk about contractual oversight in the wake of a May decision by the Grand Traverse County Commission to part ways with Northern Lakes, as well as possible instability caused by unsuccessful efforts by the Northern Lakes board to name a new CEO.

Northern Lakes has been without a permanent CEO for more than a year and oversight by NMRE will make sure services continue to be delivered, the letter states.

NMRE manages about $80 million in Medicaid funding for behavioral health treatment in five CMHs covering 21 counties in northern lower Michigan.

"I feel it's wise to accept their help," said GTC Commissioner Penny Morris, who sits on the Northern Lakes board. "The last time the CEO search process did not go as well as it should. We all need to trust the process."

NMRE will appoint an interim CEO that would report to Kurtz, as well as to the Northern Lakes board. Joanie Blamer is currently the interim CEO.

Blamer said the letter from Kurtz appears to show concerns about the board's decision-making.

"The letter is not a reflection of NLCMA's operations or quality of services provided to people we serve," Blamer said. "All state and NMRE audits, as well as CARF [Commission on Accreditation of Rehabilitation Facilities] international accreditation reviews confirm that the quality of NLCMH services remains high, as always."

NMRE also will provide administrative support for the CEO search by managing the process or working with a search firm, receiving all applications and logging them before turning them over to the Northern Lakes search committee to review. NMRE will not vet the candidates.

"It is also strongly our recommendation that no current NLCMHA staff should be involved in this process," the letter states.

Kurtz could not be reached for comment.

During a CEO search done at the end of 2021, at least one resume was lost — that of Dave Pankotai, who was offered the job but declined when salary negotiations hit an impasse.

Leelanau County Commission Chair Ty Wessell, who represents that county on the Northern Lakes board, sees the move as a good one.

"I think it's a positive way to move forward, to make sure we get some help in a search for a new CEO and some additional oversight while that search takes place," Wessell said.

Wessell said the issue will likely be discussed at the regular Northern Lakes board meeting at 2 p.m. Thursday at the Leelanau government center. A Committee of the Whole meeting takes place at noon.

Blamer was a final candidate for the CEO post and was named to the post twice, with the offer rescinded twice, the latest time in July when a majority of Northern Lakes board members voted to restart the CEO search. The board had not yet approved a contract for Blamer.

Blamer has said she will not reapply for the post.

The vote came after two sitting members, Justin Reed and Nicole Miller, were removed from the Northern Lakes board by the GTC commission after Chair Rob Hentschel and Commissioner Morris claimed they violated their official duties by allowing Blamer to violate Northern Lakes board rules.

New members Kate Dahlstrom and Tom Bratton were appointed nine days later — one day before the Northern Lakes meeting — with both voting to rescind the offer.

The GTC board in May voted to dissolve an Enabling Agreement that in 2003 created the Northern Lakes authority that also includes Crawford, Leelanau, Missaukee, Roscommon and Wexford counties. Dissolving the agreement would mean the NLCMHA would no longer exist.

Several commissioners have said the agency has delivered insufficient mental health services for decades.

The county has hired a consultant to explore the process of forming its own authority or one with Leelanau, though Hentschel and county Administrator Nate Alger recently said they would be open to sitting down with representatives from the other five counties to revise the agreement.

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – AUGUST 10, 2020
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Connie Cadarette, Lauri Fischer, Ann Friend, Nancy Kearly, Eric Kurtz, Donna Nieman, Larry Patterson, Brandon, Rhue, Jennifer Warner, Deanna Yockey, Tricia Wurn, Carol Balousek**
ABSENT:	**Erinn Trask**

REVIEW AGENDA & ADDITIONS
Jennifer requested a discussion of COLAs and provider rate increases projected for FY23. Brandon requested a discussion about the use of the 97151 service code.

REVIEW PREVIOUS MEETING MINUTES
The July minutes were included in the materials packet for the meeting

MOTION BY DONNA NIEMAN TO APPROVE THE MINUTES OF THE JULY 13, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY LAURI FISCHER. MOTION APPROVED.

MONTHLY FINANCIALS
June 2022

- Net Position showed net surplus Medicaid and HMP of $10,402,465. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $26,760,582. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $43,118,699.
- Traditional Medicaid showed $150,850,088 in revenue, and $139,113,673 in expenses, resulting in a net surplus of $11,736,415. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $23,767,920 in revenue, and $19,752,513 in expenses, resulting in a net surplus of $4,015,407. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,113,539 in revenue, and $892,402 in expenses, resulting in a net surplus of $221,137.
- SUD showed all funding source revenue of $18,837,111, and $15,824,090 in expenses, resulting in a net surplus of $3,013,021. Total PA2 funds were reported as $4,888,310.

The direct care wage surplus was estimated at $5,349,357.

Deanna reported that $10-$14M lapse anticipated for FY22.

Connie indicated that the numbers for Northeast Michigan look off; she noted that she resent the June numbers. Deanna agreed to take another look. Deanna noted that the difference wasn't material.

Lauri asked whether the surplus health home funds are sitting with NMRE. Deanna responded that the NMRE considering a health home distribution to the Boards. It was noted that surplus health home funds from FY21 turn into local for FY2; these funds will be dispersed, likely yet in FY22.

MOTION BY LAURI FISCHER TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JUNE 2022 WITH THE CAVEAT THAT NUMBERS FOR NORTHEAST MICHIGAN WILL BE REVIEWED; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

EDIT UPDATE

The minutes of the July 21st were included in the meeting materials; discussion topics included:

- Rounding rules are relaxed through the PHE. The April 7th communication remains current.
- At the end of the PHE telemedicine place of service codes will be "02" if not in the beneficiary home and "10" if in the beneficiary home.
- The EQI Workgroup continues to meet monthly. A validation exercise comparing the Milliman master eligibility file with PIHP eligibility data is planned.
- A COB Fee-for-Service Subgroup will be forming in FY23.
- Efforts on the development of tiered rates for inpatient psychiatric services are currently on hold
- Efforts on the development of tiered rates for licensed residential services are moving forward. The workgroup is currently interviewing providers and reviewing assessment tools.
- The 837 Companion Guide was updated in June; COB and reporting requirements were added.
- A new Housing Assistance policy is out for comment. Feedback has been requested on the new housing support benefit (T2038). This service is intended to support consumers to find their own housing.
- The Code Chart Changes Subgroup is reviewing the mental health lines.
- The Code Chart and Provider Qualifications Chart was updated on July 1st.
- Lifeways requested that biofeedback/neurofeedback be added as an allowable modality for therapy which was not approved pending additional information
- West Michigan requested that 96158, 96159, and 99409 be added as allowable services in the code chart which was not approved.

The next EDIT meeting is scheduled for October 20th.

97151 CODE

Brandon stated that he received communication from MDHHS indicating that there has been some confusion and limits set on the use of the 97151, Behavior Identification Assessment, as well as some additional confusion on the maximum number of units allowed to be billed for this service per day, at two Member CMHSPs.

> *97151: Behavior identification assessment, administered by a physician, ABA, or other qualified health care professional, each 15 minutes of the physician's or other health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and*

recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.

Clarification was made that CMS has a Medically Unlikely Edit (MUE) of 32 per day set for 97151; this would allow for a maximum of 8 hours to be billed per day of this service if medically appropriate.

Brandon noted that this topic will also be presented to the regional QOC committee for discussion (and any other billing/coding groups). The Boards were advised to review with staff and providers and a follow-up conversation will occur in September.

CLAIMS TIMELINESS REPORT

Brandon referred to an email dated August 2nd from Teri Baker indicating that the NMRE was failed to submit supplemental reporting information by the August 1st due date. Eric responded to the email on August 4th stating that this information needed to be obtained from the CMHSPs which he hoped to have by early in the week beginning August 8th (North Country's report was received.)

Eric noted that the State's contract division is overseeing timeliness and accuracy of managed care reporting. The Boards discussed using the "Claims Timeliness report in PCE to obtain the needed information; Donna shared a screenshot with the group. Connie indicated that the information should also be available in the "AP Claims Detail Report".

Brandon expressed that the NMRE looking to revive the Regional IT group with an initial focus on PCE functionality.

EQI UPDATE

Period 2 EQI (October 1st – May 31st) is due to the State September 30th; templates were distributed on July 29th. September 6th was selected as the data pull date. Reports will be due to the NMRE by September 22nd. Lauri asked whether the DCW will be included; Deanna agreed to seek clarification.

FY23 PROPOSED BUDGET

The NMRE's Proposed Budget for FY23 was included in the meeting materials. Deanna reviewed the "assumptions" which included:

- A 4.3% decrease in revenue for Medicaid and HMP due to rates with a minor increase in eligibles
- Fully funded ISF at the close of FY22
- SUD costs based on projected current year utilization
- Autism revenue included in capitation methodology
- SUD Block Grant revenue based on current year actual MDHHS allocation
- PA2 revenue anticipated to stay consistent with the current year
- Affiliate local match and local match drawdown based on actual historical amounts

NMRE expenditures were updated to reflect staffing and benefit changes. The "Contractual" line increased as anticipated use is likely to increase in the coming year. The HRA was trended forward.

	Proposed FY23	Projected FY22	Proposed Increase (Decrease)
NMRE Operating Revenue	**$253,706,301**	$261,505,776	($7,799,475)
NMRE Expenses	**$233,033,954**	$224,176,938	$8,857,016
Anticipated Surplus	**$20,672,347**	37,328,838	(16,656,491)

Payments to Providers were calculated using revenue minus the anticipated decrease; this does not include any carry-forward expenditures. Health Home amounts were trended from Q3 FY22. CMHSP Projected PM/PM using actual July revenue was summarized as:

	AuSable Valley	Centra Wellness	North Country	Northeast Michigan	Northern Lakes
FY23 Total PMPM	$26,977,163	$16,979,116	$53,208,812	$31,941,812	$65,197,930
FY22 Carry forward	$1,955,236	$1,247,903	$4,095,691	$2,272,462	$4,919,342
FY23 Projections	**$28,932,399**	**$18,227,019**	**$57,304,503**	**$34,214,274**	**$70,117,272**

Clarification was made that the DCW is included in the PM/PM; attestations will be needed for FY23 until MDHHS advises otherwise.

A benefit stabilization line was added for one-time expenses.

MOTION BY DONNA NIEMAN TO FORWARD THE NORTHERN MICHIGAN REGIONAL ENTITY PROPOSED BUDGET FOR FISCAL YEAR 2023 TO THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS FOR APPROVAL; SUPPORT BY LAURI FISCHER. MOTION CARRIED.

Following the meeting, an amended NMRE Proposed Budget for FY23 and revised CMHSP Projected PM/PM were distributed to the committee.

	Proposed FY23	Projected FY22	Proposed Increase (Decrease)
NMRE Operating Revenue	**$253,705,885**	$261,505,776	($7,799,891)
NMRE Expenses	**233,033,957**	$224,176,938	$8,857,019
Anticipated Surplus	**20,671,928**	$37,328,838	($16,656,910)

	AuSable Valley	Centra Wellness	North Country	Northeast Michigan	Northern Lakes
FY23 Total PMPM	$26,177,469	$16,828,829	$54,749,254	31,699,369	$64,803,616
FY22 Carry forward	$1,955,236	$1,247,903	$4,095,591	$2,272,462	$4,919,342
FY23 Projections	**$28,132,705**	**$18,076,732**	**$58,844945**	**$33,971,831**	**$69,722,958**

A motion to approve the amended NMRE FY23 Budget was requested.

MOTION BY BRIAN BABBITT TO FORWARD THE AMENDED NORTHERN MICHIGAN REGIONAL ENTITY PROPOSED BUDGET FOR FISCAL YEAR 2023 TO THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS FOR APPROVAL; SUPPORT BY DONNA NIEMAN. MOTION CARRIED.

FY23 COLAS AND PROVIDER RATE INCREASES

Jennifer asked the Boards what they have planned in terms of COLAs and provider rate increases for FY23.

- **AuSable Valley** – Jennifer reported that a 4% Cola planned, potentially with an additional 3% increase in April. Providers are receiving a 3%-5% rate increase (closer to 5%).
- **Centra Wellness** – Donna reported that a salary study was conducted last year, and adjustments were made accordingly for internal staff. Providers received roughly a 13% increase throughout FY22, which will remain consistent going into FY23.
- **North Country** – Ann reported that a 4% COLA is planned. Provider rates are still being developed. North Country's budget goes to its Board for approval in September.
- **Northeast Michigan** – Connie reported there has been no discussions of a COLA for internal staff yet, though she anticipates there will be some increase. Northeast Michigan's budget does not go to its Board for approval until October. Mom & Pop providers are getting 100% of DCW +3%. Larger provider requests are coming in for review.
- **Northern Lakes** – Lauri reported that providers will receive 100% of the DCW + 4.15% = an hourly rate of $24.21. Agency staff received a 5% COLA in January (a 3.75% increase for ¾ of the year). Four union negotiations must be completed by December 31st; she is hoping to hold at a 5% increase. Lauri noted that PA 152 set the limit on the amount that a public employer may contribute to a medical benefit at 1.3% for 2023.

NEXT MEETING

The next meeting was scheduled for September 14th at 10:00AM.

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD EXECUTIVE COMMITTEE MEETING
1:00PM – AUGUST 9, 2022

EXECUTIVE COMMITTEE MEMBERS:	**Don Tanner, Ed Ginop (Levering), Gary Nowak, Mary Marois, Joe Stone**
NMRE STAFF:	**Eric Kurtz, Carol Balousek**

Mr. Tanner stated that the meeting was called to discuss Northern Lakes CMHA. He and Mr. Kurtz have been discussing some concerns, one of which is the numerous unsuccessful efforts to secure a permanent CEO and what could be the NMRE's role with regard to assisting in that process as well as assuring that NLCMHA continues to meet its contractual obligations with the NMRE and the state.

Mr. Kurtz spoke briefly about the August 1st meeting with the six county administrators (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford) and six county commission chairpersons (which he also attended). A central purpose of the meeting was to create a Memorandum of Understanding (MOU) to reauthor the Enabling Agreement that formed NLCMHA.

Given that the NMRE is strongly committed to keeping the NLCMHA intact and a full participating member of the NMRE Board, the Board Executive Committee directed Mr. Kurtz to draft a contractual oversight memo to the NLCMHA Board and the respective six county commission chairs and administrators requesting the NMRE be allowed to appoint an interim CEO and provide administrative support related to the CEO search process. Mr. Kurtz noted that the NMRE will not be involved in vetting potential candidates for the position but will act as a point of contact to receive all applications, log, and archive them, and provide them to the full NLCMHA Board and/or a Board appointed Search Committee. Mr. Tanner also indicated that as the contractor with the state that the memo needs to ensure contractual obligations continue to be met through enhanced NMRE oversight.

NMRE Board Executive Committee Members authorized Mr. Kurtz to send the memo to the NLCMHA Board as soon as possible.

Mr. Kurtz was directed to contact the state regarding the issues.

The NLCMHA Board governance structure was discussed. Ms. Marois expressed that the current governance model has impeded the hiring of a CEO.

Chief Executive Officer Report

August 2022

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

Aug 1: Attended and participated in NLCMHA six county administrators meeting.

Aug 4: Attended and participated in in MDHHS/PIHP CEO Meeting.

Aug 9: Attended and participated in NMRE Executive Committee Meeting.

Aug 10: Attended and participated in NMRE Regional Finance Committee Meeting.

Aug 16: Met with GT County Administrator regarding community input/needs.

Aug 18: Met with NLCMHA Board.

Aug 23: Attended and participated in CMHAM Advocacy Meeting.

June 2022 Finance Report

June 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	11,736,415	11,296,867	9,298,368
Healthy Michigan	4,015,407	5,061,250	7,059,749
	$ 15,751,822	$ 16,358,117	$ 16,358,117

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	900,262	2,233,420	1,823,148	2,299,830	697,463	1,873,575	574,768	$ 10,402,465
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 26,760,582
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 43,118,699

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through June 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 146,534,937	$ 3,535,906						$ 150,070,843
CMHSP Distributions	(141,393,732)		46,978,678	38,886,963	23,718,726	19,468,829	12,340,536	-
1st/3rd Party receipts			337,624	-	441,621	-	-	779,245
Net revenue	5,141,205	3,535,906	47,316,302	38,886,963	24,160,347	19,468,829	12,340,536	150,850,088
Expense								
PIHP Admin	1,847,774	35,931						1,883,705
PIHP SUD Admin		43,404						43,404
SUD Access Center		42,395						42,395
Insurance Provider Assessment	1,204,981	24,384						1,229,365
Hospital Rate Adjuster	1,262,492							1,262,492
Services		2,568,441	43,385,272	36,754,285	23,467,110	16,808,076	11,669,128	134,652,312
Total expense	4,315,247	2,714,555	43,385,272	36,754,285	23,467,110	16,808,076	11,669,128	139,113,673
Net Actual Surplus (Deficit)	$ 825,958	$ 821,351	$ 3,931,030	$ 2,132,678	$ 693,237	$ 2,660,753	$ 671,408	$ 11,736,415

Notes

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

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through June 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 15,278,134	$ 8,484,908						$ 23,763,042
CMHSP Distributions	(13,906,836)		5,062,941	4,222,002	1,728,378	1,728,606	1,164,909	-
1st/3rd Party receipts			-	-	4,878	-	-	4,878
Net revenue	1,371,298	8,484,908	5,062,941	4,222,002	1,733,256	1,728,606	1,164,909	23,767,920
Expense								
PIHP Admin	166,149	87,100						253,249
PIHP SUD Admin		105,215						105,215
SUD Access Center		102,769						102,769
Insurance Provider Assessment	107,668	57,539						165,207
Hospital Rate Adjuster	1,023,176							1,023,176
Services		6,226,113	5,377,467	3,321,956	860,840	1,533,612	782,909	18,102,897
Total expense	1,296,993	6,578,736	5,377,467	3,321,956	860,840	1,533,612	782,909	19,752,513
Net Surplus (Deficit)	$ 74,305	$ 1,906,172	$ (314,526)	$ 900,046	$ 872,416	$ 194,994	$ 382,000	$ 4,015,407

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

Direct Care Wage Estimated Surplus	**(494,103)**	**(1,793,356)**	**(732,895)**	**(868,190)**	**(982,173)**	**(478,640)**	**$ (5,349,357)**
Net Surplus (Deficit) MA/HMP/DCW	**$ 900,262**	**$ 2,233,420**	**$ 1,823,148**	**$ 2,299,830**	**$ 697,463**	**$ 1,873,575**	**$ 574,768**	**$ 10,402,465**
Medicaid & HMP Carry Forward								**16,358,117**
Total Med/HMP Current Year Surplus								$ 26,760,582
Medicaid & HMP ISF - based on unaudited FSR								**16,358,117**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 43,118,699**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through June 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 238,991		349,185	92,130	66,509	44,289	322,435	$ 1,113,539
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	238,991	-	349,185	92,130	66,509	44,289	322,435	1,113,539
Expense								
PIHP Admin	12,234							12,234
BHH Admin	593							593
Insurance Provider Assessment	5,027							5,027
Hospital Rate Adjuster								
Services	-		349,185	92,130	66,509	44,289	322,435	874,548
Total expense	17,854	-	349,185	92,130	66,509	44,289	322,435	892,402
Net Surplus (Deficit)	$ 221,136	$ -	$ (0)	$ 0	$ 0	$ (0)	$ -	$ 221,137

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through June 30, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 3,535,906	$ 8,484,908	$ 2,864,916	$ 2,302,173	$ 1,649,208	$ 18,837,111
Expense						
Administration	79,335	192,315	73,903	140,304		485,856
OHH Admin			95,614	-		95,614
Access Center	42,395	102,769	-	23,159		168,322
Insurance Provider Assessment	24,384	57,539	17,323			99,246
Services:						
Treatment	2,568,441	6,226,113	2,392,580	1,403,037	1,649,208	14,239,379
Prevention	-	-	-	735,673	-	735,673
State targeted response	-	-	-	-	-	-
Total expense	2,714,555	6,578,736	2,579,420	2,302,173	1,649,208	15,824,090
PA2 Redirect			-	(0)	0	-
Net Surplus (Deficit)	$ 821,351	$ 1,906,172	$ 285,496	$ -	$ 0	$ 3,013,021

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through June 30, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 146,534,937	$ 3,535,906	$ -	$ 150,070,843
Medicaid Savings	11,296,867	-	-	11,296,867
Healthy Michigan	15,278,134	8,484,908	-	23,763,042
Healthy Michigan Savings	5,061,250	-	-	5,061,250
Health Home	1,113,539	-	-	1,113,539
Opioid Health Home	-	2,864,916	-	2,864,916
Substance Use Disorder Block Grant	-	2,302,173	-	2,302,173
Public Act 2 (Liquor tax)	-	1,649,208	-	1,649,208
Affiliate local drawdown	674,700	-	-	674,700
Performance Incentive Bonus	1,363,500	-	-	1,363,500
Miscellanous Grant Revenue	-	21,087	-	21,087
Veteran Navigator Grant	83,600	-	-	83,600
SOR Grant Revenue	-	804,421	-	804,421
Gambling Grant Revenue	-	116,375	-	116,375
Other Revenue	-	-	5,522	5,522
Total operating revenue	181,406,527	19,778,994	5,522	201,191,043
Operating expenses				
General Administration	2,236,216	444,120	-	2,680,336
Prevention Administration	-	64,001	-	64,001
OHH Administration	-	95,614	-	95,614
BHH Administration	593	-	-	593
Insurance Provider Assessment	1,317,676	99,246	-	1,416,922
Hospital Rate Adjuster	2,285,668	-	-	2,285,668
Payments to Affiliates:				
Medicaid Services	131,304,626	2,568,441	-	133,873,067
Healthy Michigan Services	11,871,906	6,226,113	-	18,098,019
Health Home Services	874,548	-	-	874,548
Opioid Health Home Services	-	2,392,580	-	2,392,580
Community Grant	-	1,403,037	-	1,403,037
Prevention	-	671,672	-	671,672
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	1,649,208	-	1,649,208
Local PBIP	2,801,252	-	-	2,801,252
Local Match Drawdown	674,700	-	-	674,700
Miscellanous Grant	-	21,087	-	21,087
Veteran Navigator Grant	83,600	-	-	83,600
SOR Grant Expenses	-	804,421	-	804,421
Gambling Grant Expenses	-	116,375	-	116,375
Total operating expenses	153,450,785	16,555,915	-	170,006,700
CY Unspent funds	27,955,742	3,223,079	5,522	31,184,343
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,254,458	6,231,624	16,358,117	24,844,199
Unspent funds - ending	$ 30,210,200	$ 9,454,703	$ 16,363,639	$ 56,028,542

Northern Michigan Regional Entity

Statement of Net Position

June 30, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 9,944,268	$ 7,546,252	$ 16,363,639	$ 33,854,159
Accounts Receivable	37,572,927	2,869,289	-	40,442,216
Prepaids	65,491	-	-	65,491
Total current assets	47,582,686	10,415,541	16,363,639	74,361,866
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	47,582,686	10,415,541	16,363,639	74,361,866
Liabilities				
Current liabilities				
Accounts payable	17,144,662	960,838	-	18,105,500
Accrued liabilities	227,824	-	-	227,824
Unearned revenue	-	-	-	-
Total current liabilities	17,372,486	960,838	-	18,333,324
Unspent funds	$ 30,210,200	$ 9,454,703	$ 16,363,639	$ 56,028,542

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2021 through June 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 144,698,319	$ 146,534,937	$ 1,836,618	1.27%
Carryover	11,296,664	11,296,664	11,296,867	203	0
Healthy Michigan					
Capitation	20,566,272	15,424,704	15,278,134	(146,570)	(0.95%)
Carryover	5,061,832	5,061,832	5,061,250	(582)	(0.01%)
Health Home	506,772	380,079	1,113,539	733,460	192.98%
Affiliate local drawdown	1,204,388	903,291	674,700	(228,591)	(25.31%)
Performance Bonus Incentive	1,334,531	1,334,531	1,363,500	28,969	2.17%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	82,503	83,600	1,097	1.33%
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	179,181,923	181,406,527	2,224,604	1.24%
Operating expenses					
General Administration	3,021,688	2,248,061	2,236,216	11,845	0.53%
BHH Administration	-	-	593	(593)	0.00%
Insurance Provider Assessment	1,645,387	1,234,040	1,317,676	(83,636)	(6.78%)
Hospital Rate Adjuster	4,001,228	3,000,918	2,285,668	715,250	23.83%
Local PBIP	1,334,531	-	2,801,252	(2,801,252)	0.00%
Local Match Drawdown	1,204,388	903,291	674,700	228,591	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	146,169	83,600	62,569	42.81%
Payments to Affiliates:					
Medicaid Services	173,402,120	130,051,590	131,304,626	(1,253,036)	(0.96%)
Healthy Michigan Services	15,233,944	11,425,458	11,871,906	(446,448)	(3.91%)
Health Home Services	456,768	342,576	874,548	(531,972)	(155.29%)
Total operating expenses	200,508,190	149,352,103	153,450,785	(4,098,682)	(2.74%)
CY Unspent funds	$ 32,503,361	$ 29,829,820	27,955,742	$ (1,874,078)	
Transfers in			-		
Transfers out			-	153,450,785	
Unspent funds - beginning			2,254,458		
Unspent funds - ending			$ 30,210,200	27,955,742	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2021 through June 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 3,299,058	$ 3,535,906	$ 236,848	7.18%
Healthy Michigan	9,763,272	7,322,454	8,484,908	1,162,454	15.88%
Substance Use Disorder Block Grant	5,709,003	4,281,750	2,302,173	(1,979,577)	(46.23%)
Opioid Health Home	2,320,384	1,740,285	2,864,916	1,124,631	64.62%
Public Act 2 (Liquor tax)	1,533,979	511,326	1,649,208	1,137,882	222.54%
Miscellanous Grants	36,335	27,251	21,087	(6,164)	(22.62%)
SOR Grant	1,215,000	911,250	804,421	(106,829)	(11.72%)
Gambling Prevention Grant	200,000	150,000	116,375	(33,625)	(22.42%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	18,243,374	19,778,994	1,535,620	8.42%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	757,863	444,120	313,743	41.40%
Prevention Administration	90,144	67,608	64,001	3,607	5.34%
Insurance Provider Assessment	116,901	87,676	99,246	(11,570)	(13.20%)
Medicaid Services	3,387,649	2,540,737	2,568,441	(27,704)	(1.09%)
Healthy Michigan Services	7,453,459	5,590,094	6,226,113	(636,019)	(11.38%)
Community Grant	2,077,452	1,558,089	1,403,037	155,052	9.95%
Prevention	664,967	498,725	671,672	(172,947)	(34.68%)
State Disability Assistance	95,215	71,413	-	71,413	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	95,614	(95,614)	0.00%
Opioid Health Home Services	2,117,226	1,587,924	2,392,580	(804,656)	(50.67%)
Miscellanous Grants	36,335	27,251	21,087	6,164	22.62%
SOR Grant	1,215,000	911,250	804,421	106,829	11.72%
Gambling Prevention	200,000	150,000	116,375	33,625	22.42%
PA2	1,533,978	511,326	1,649,208	(1,137,882)	(222.54%)
Total operating expenses	20,058,810	14,359,956	16,555,915	(2,195,959)	(15.29%)
CY Unspent funds	$ 5,117,907	$ 3,883,418	3,223,079	$ (660,339)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,231,624		
Unspent funds - ending			$ 9,454,703		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2021 through June 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 1,296,801	$ 1,173,555	$ 123,246	9.50%
Fringes	549,516	390,429	384,290	6,139	1.57%
Contractual	433,304	324,981	503,589	(178,608)	(54.96%)
Board expenses	16,100	12,078	14,511	(2,433)	(20.14%)
Day of recovery	14,000	14,000	4,917	9,083	64.88%
Facilities	152,700	114,525	92,461	22,064	19.27%
Other	127,000	95,247	62,893	32,354	33.97%
Total General Admin	$ 3,021,688	$ 2,248,061	$ 2,236,216	$ 11,845	0.53%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2021 through June 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 361,656	$ 160,101	$ 201,555	55.73%
Fringes	166,800	125,100	39,621	85,479	68.33%
Access Salaries	194,484	145,863	129,473	16,390	11.24%
Access Fringes	57,588	43,191	38,849	4,342	10.05%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	74,997	67,230	7,767	10.36%
Board expenses	5,000	3,753	2,240	1,513	40.31%
Facilities	-	-	-	-	0.00%
Other	10,404	3,303	6,606	(3,303)	(100.00%)
Total operating expenses	$ 1,070,484	$ 757,863	$ 444,120	$ 313,743	41.40%

Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through June 30, 2022

County	Beginning Balance	FY22 Projected Revenue	Current Receipts	FY22 Approved Projects	County Specific Projects	Region Wide Projects by Population	Ending Balance
					Actual Expenditures by County		
Alcona	$ 83,635	$ 19,313	$ 19,260	$ 38,301	29,965	$ 888	$ 76,241
Alpena	315,554	66,080	65,235	160,005	87,683	2,440	246,517
Antrim	243,061	53,592	54,992	95,690	57,243	1,997	205,212
Benzie	144,391	49,804	51,000	27,891	13,316	1,507	130,127
Charlevoix	467,765	82,100	84,999	262,209	112,775	2,241	317,673
Cheboygan	280,756	68,778	71,908	176,925	121,953	2,175	224,829
Crawford	85,250	28,559	31,195	32,978	16,699	1,192	67,528
Emmet	754,134	145,253	157,175	278,987	131,554	2,846	597,625
Grand Traverse	1,615,220	376,032	383,335	909,582	446,963	7,872	1,153,171
Iosco	359,368	70,274	69,753	160,492	70,824	2,157	272,379
Kalkaska	73,813	33,023	33,605	42,665	24,804	1,512	56,882
Leelanau	131,774	48,924	52,996	97,254	65,594	1,857	97,898
Manistee	90,411	63,745	67,391	36,315	18,860	2,094	71,405
Missaukee	66,066	18,058	17,775	50,287	33,235	1,286	50,584
Montmorency	64,849	26,456	25,952	36,920	26,194	793	55,421
Ogemaw	164,571	54,659	50,933	80,483	47,683	1,799	137,296
Oscoda	76,895	17,086	17,185	43,817	22,145	711	55,836
Otsego	205,220	86,909	86,927	210,283	142,651	2,104	139,675
Presque Isle	102,301	20,617	20,148	47,065	33,846	1,097	90,648
Roscommon	488,633	75,491	73,418	63,178	27,337	2,049	456,913
Wexford	417,956	82,829	82,014	111,588	74,411	2,853	384,448
	6,231,626	1,487,584	1,517,189	2,962,916	1,605,734	43,471	4,888,310
PA2 Redirect							-
							4,888,310

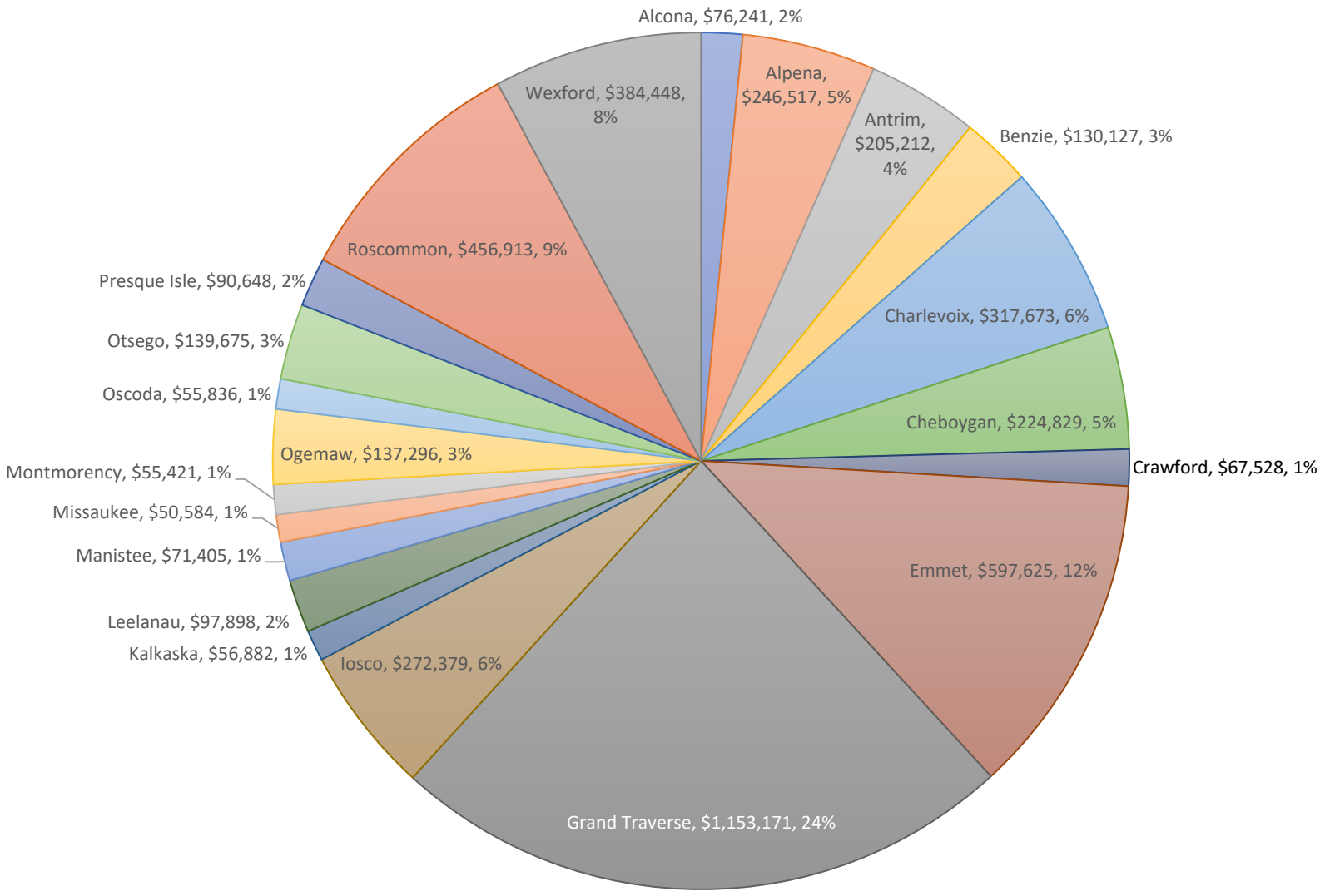
Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2021 through June 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	1,872	5,522	3,650	194.98%
Total operating revenue	2,501	1,872	5,522	3,650	194.98%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 1,872	5,522	$ 3,650	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,358,117		
Unspent funds - ending			$ 16,363,639		

PA2 Funds by County

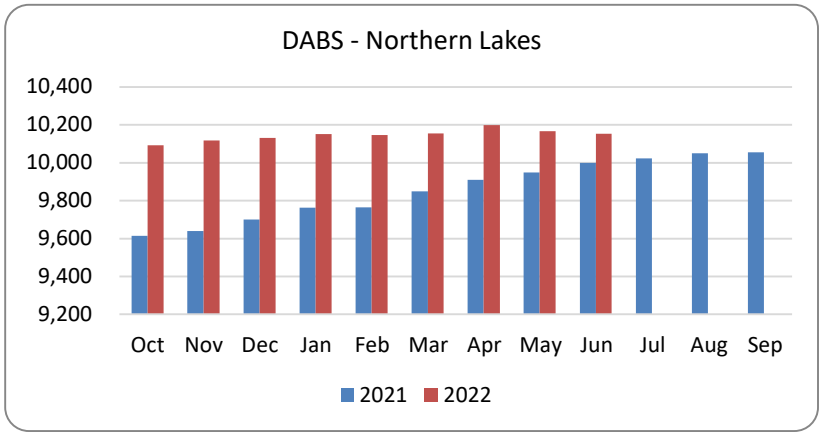


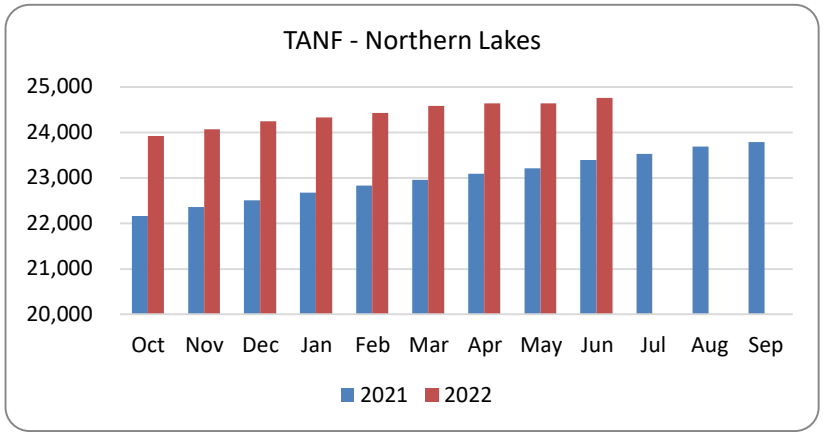
Northern Michigan Regional Entity

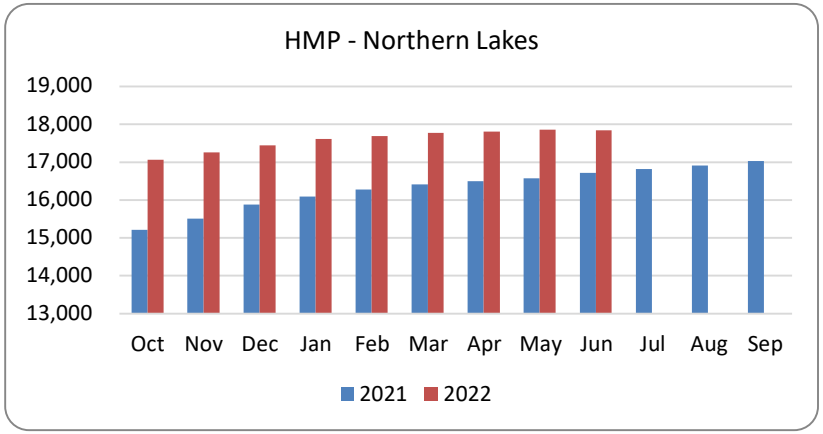
Narrative

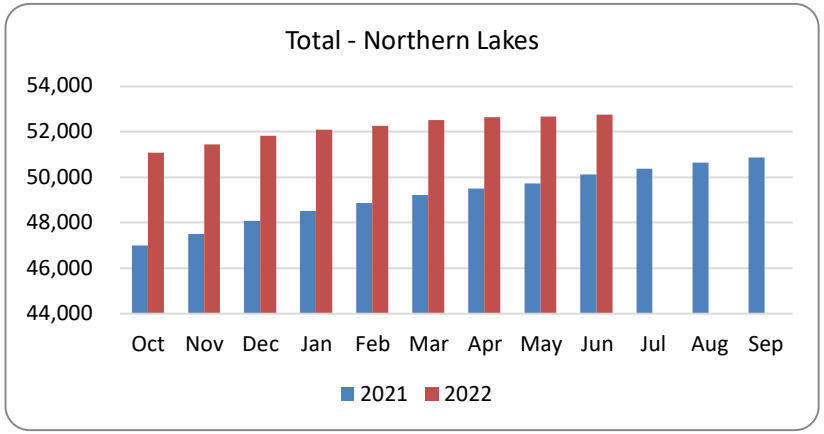
October 1, 2021 through June 30, 2022

Northern Lakes Eligible Trending - based on payment files







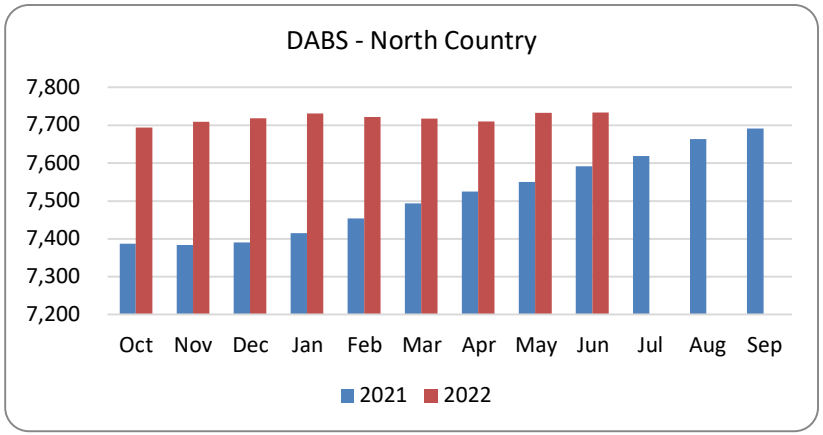


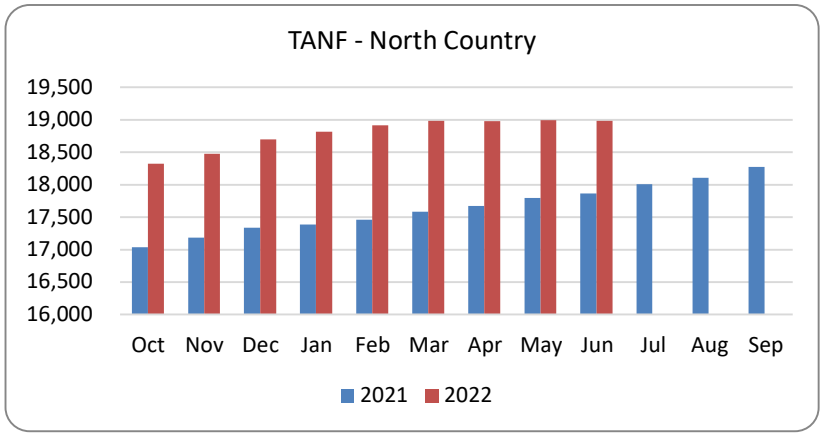
Northern Michigan Regional Entity

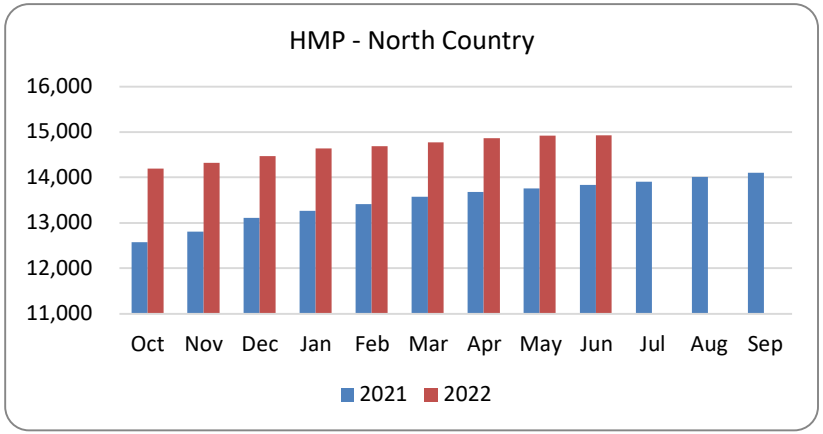
Narrative

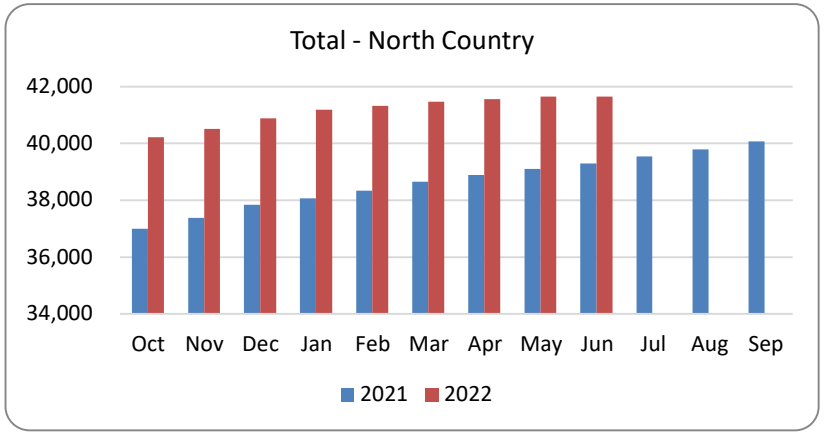
October 1, 2021 through June 30, 2022

North Country Eligible Trending - based on payment files







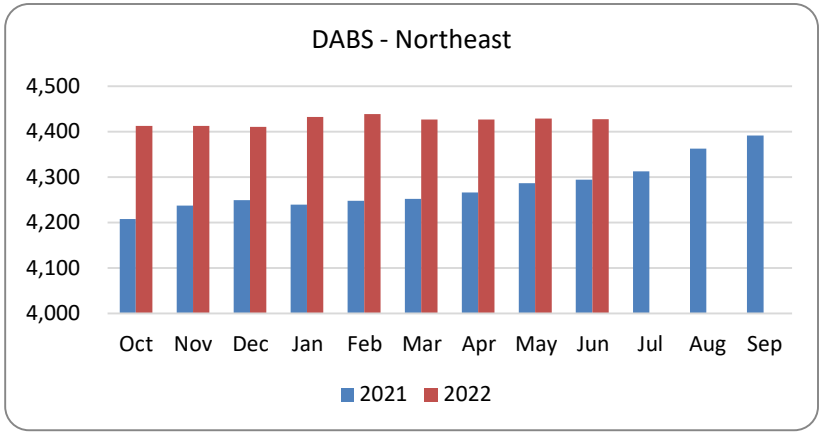


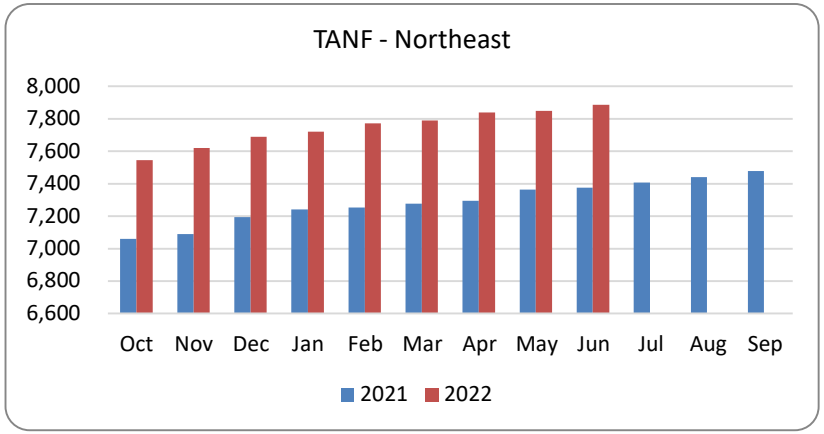
Northern Michigan Regional Entity

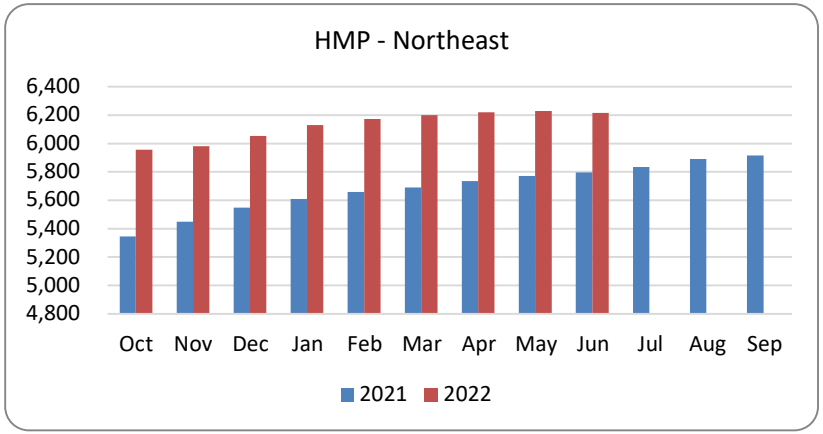
Narrative

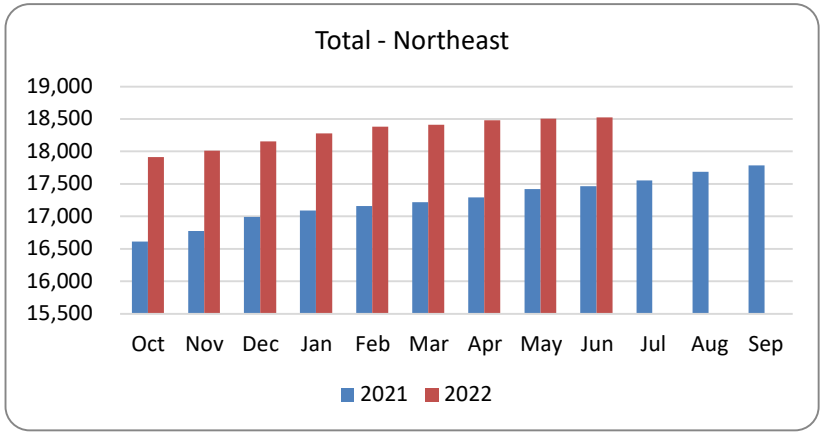
October 1, 2021 through June 30, 2022

Northeast Eligible Trending - based on payment files







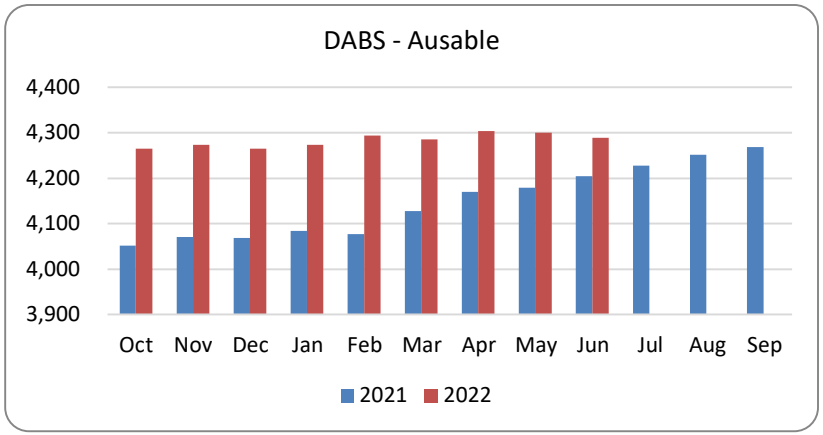


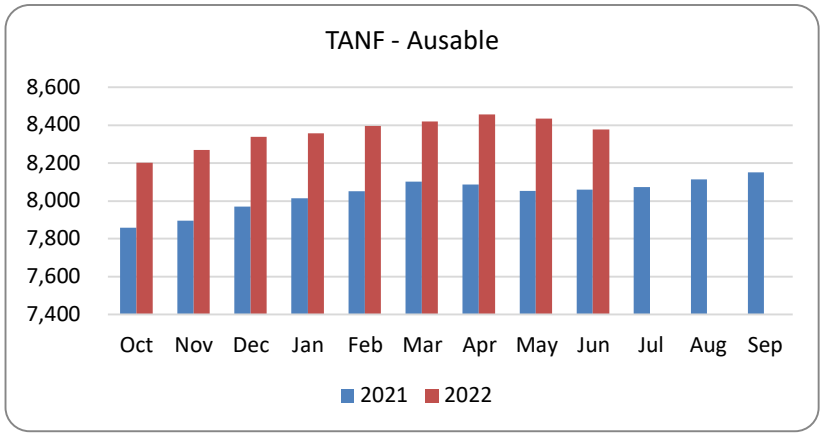
Northern Michigan Regional Entity

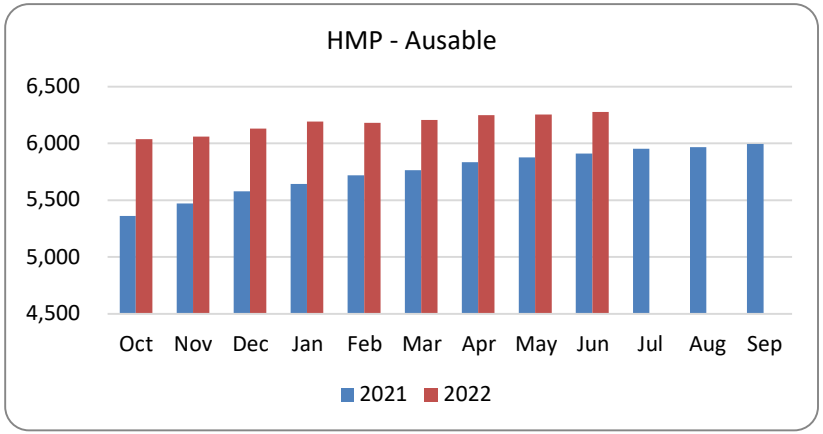
Narrative

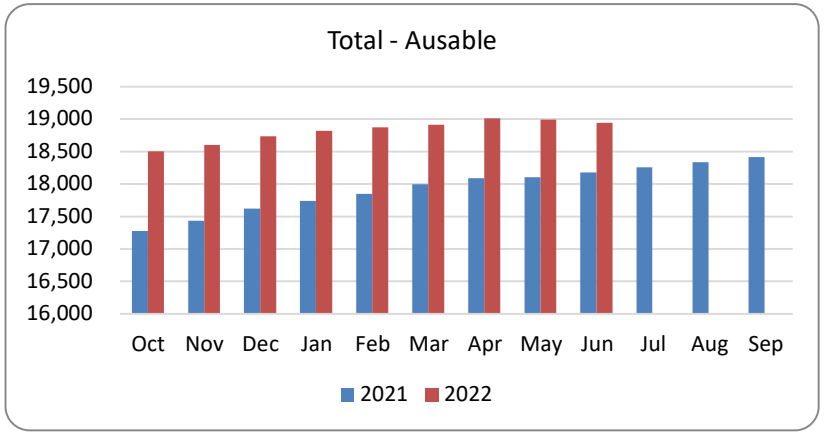
October 1, 2021 through June 30, 2022

Ausable Valley Eligibles Trending - based on payment files







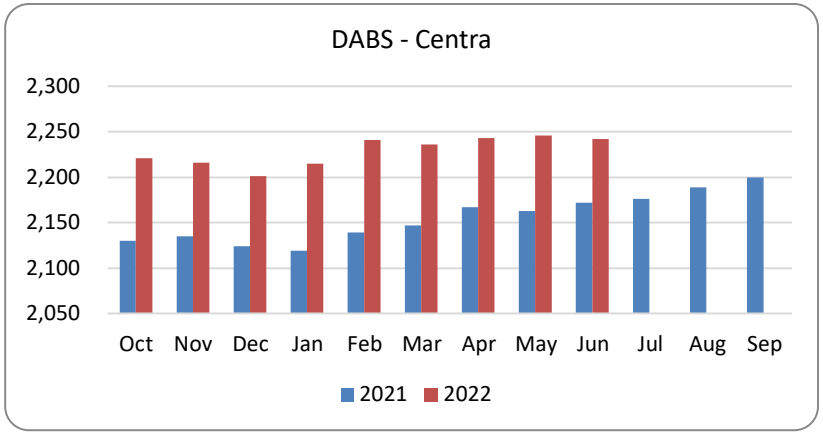


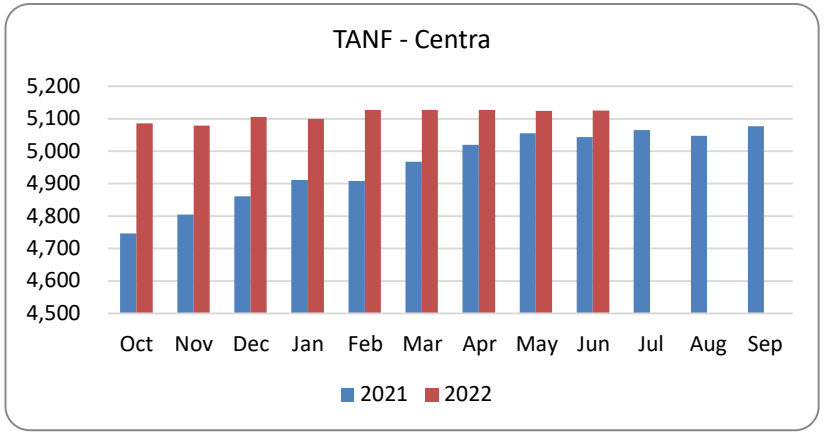
Northern Michigan Regional Entity

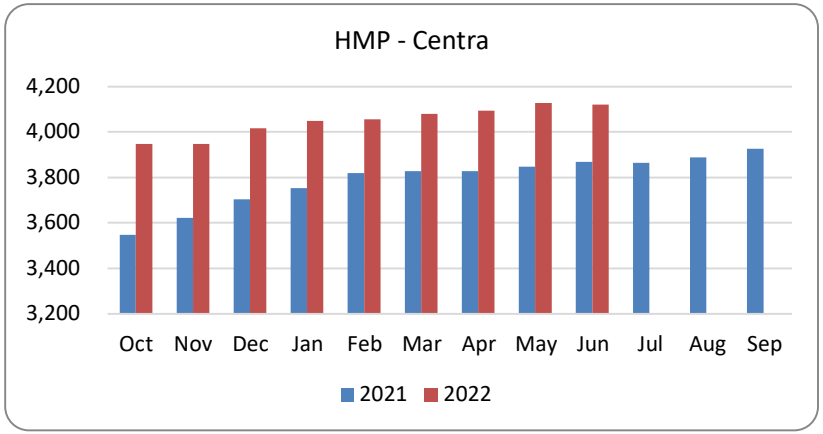
Narrative

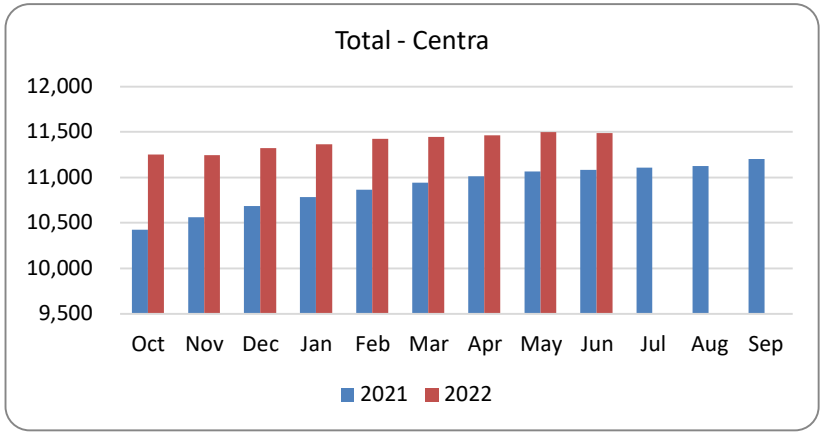
October 1, 2021 through June 30, 2022

Centra Wellness Eligibles Trending - based on payment files







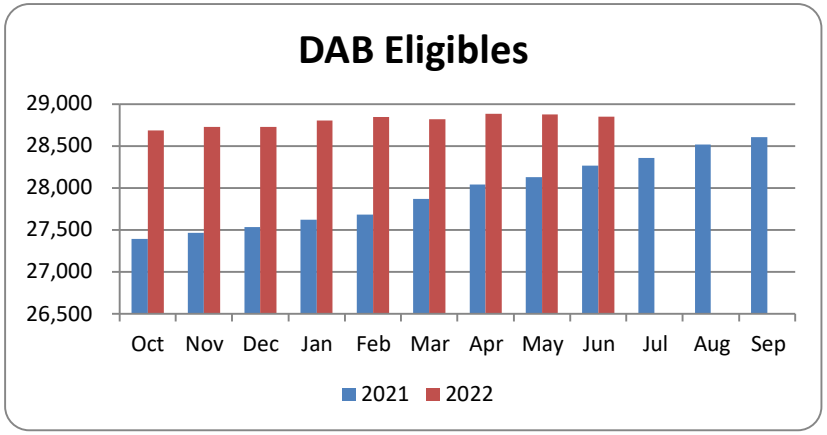


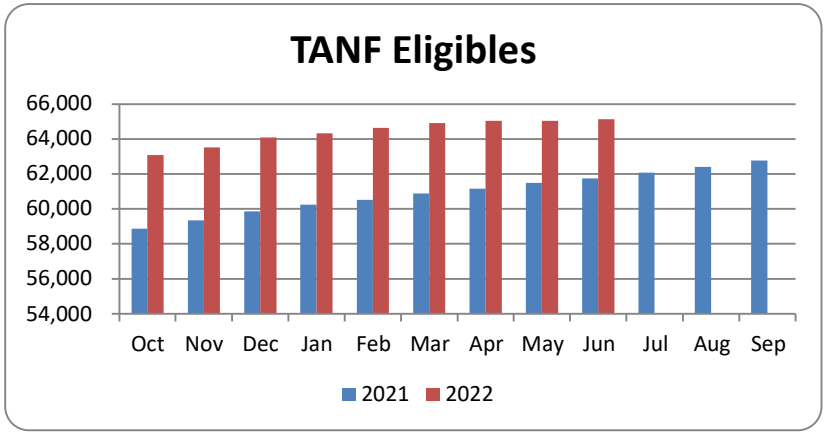
Northern Michigan Regional Entity

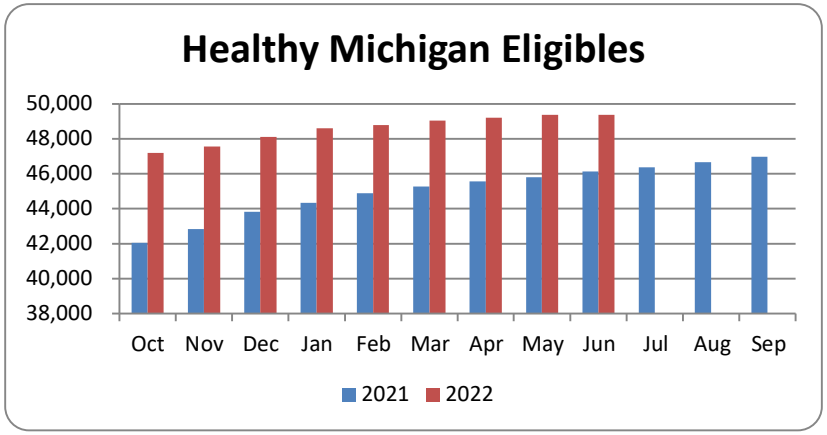
Narrative

October 1, 2021 through June 30, 2022

Regional Eligible Trending





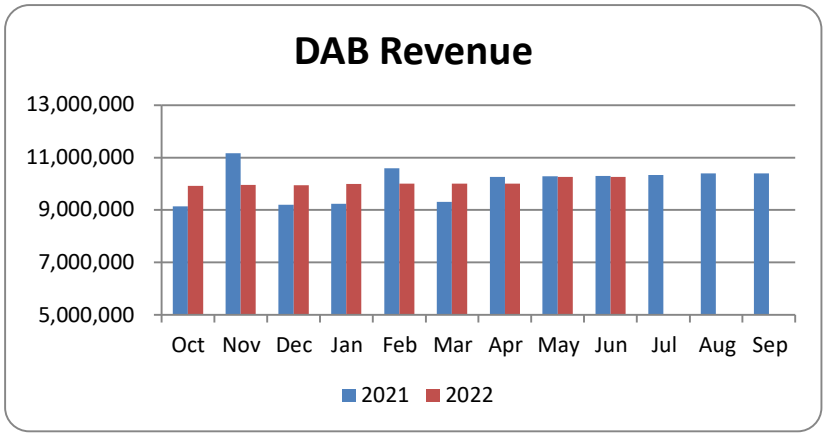


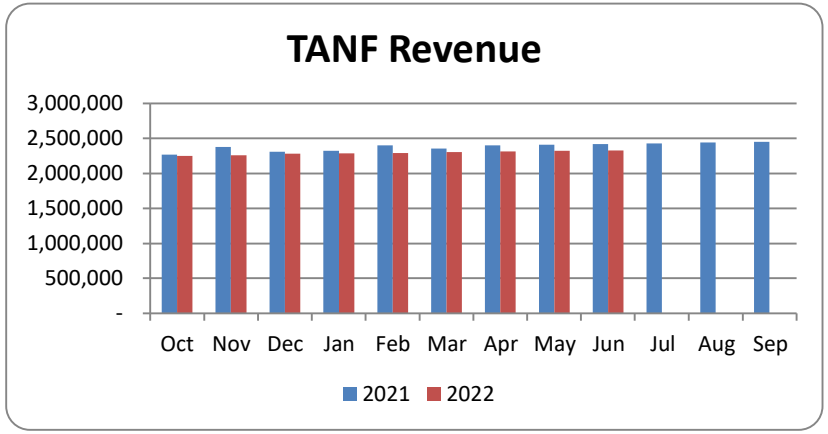
Northern Michigan Regional Entity

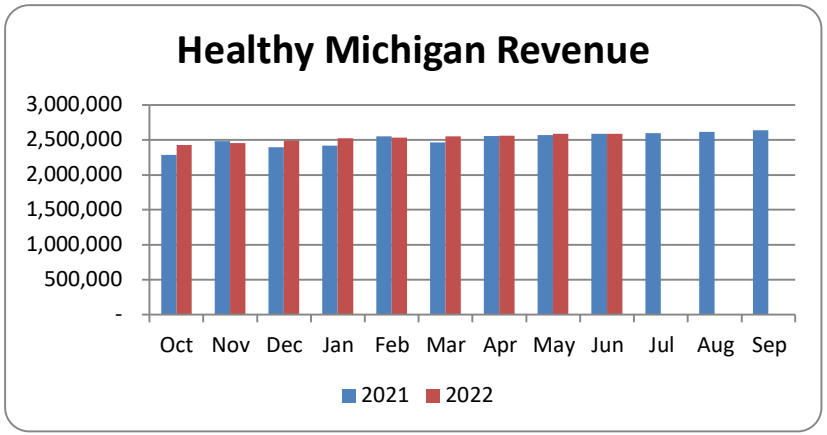
Narrative

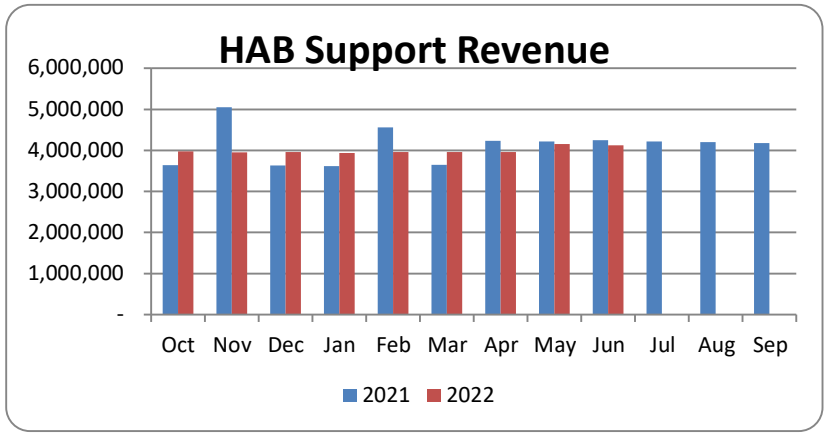
October 1, 2021 through June 30, 2022

Regional Revenue Trending









2023

Proposed Budget

Northern Michigan Regional Entity

Fiscal Year 2023 Budget

Significant Assumptions and Key Points

I. Medicaid and Healthy Michigan (HMP) 4.3% revenue decrease due to rates with a minor increase in eligibles.

- The ISF is anticipated to be fully funded at close of fiscal year 2022

II. Medicaid and Healthy Michigan (HMP) - Expenses

- Substance Abuse costs based on projected current year utilization.

III. Autism program - revenue is included in capitation methodology.

IV. Substance Abuse Prevention and Treatment Block Grant - revenue based on current year actual MDHHS allocation.

- Block grant allocation is broken down into separate programs with distinct allowable uses (Treatment, Prevention, and SDA).

- All services expected to be provided through NMRE's provider network.

V. Public Act 2 (PA2) funding - revenue anticipated to stay consistent with current year.

- PA2 funds must be used in the county from which they originated for prevention or treatment but may not be used on administration.

VI. Affiliate local match and local match drawdown - based on actual historical amounts.

Northern Michigan Regional Entity

Fiscal Year 2023 Budget

	MH Proposed Budget	SUD Proposed Budget	ISF Proposed Budget	Proposed FY 2023 Budget	Projected FY 2022	Proposed Increase (Decrease)
Operating revenue						
Medicaid:						
Medicaid Capitation	$ 187,752,705	$ 4,678,634	$ -	$ 192,431,339	$ 200,094,457	$ (7,663,118)
Carry Forward	11,400,000	-	-	11,400,000	11,296,664	103,336
HMP Capitation	19,683,377	11,196,405	-	30,879,782	31,684,056	(804,274)
Carry Forward	5,100,000	-	-	5,100,000	5,061,832	38,168
Health Home	1,451,271	-	-	1,451,271	1,200,000	251,271
SUD Block Grant	-	3,105,145	-	3,105,145	3,105,145	-
Interest Revenue	-	-	7,500	7,500	7,283	217
PA 2 - Liquor Tax Revenue	-	1,533,979	-	1,533,979	1,533,979	-
Opioid Health Home	-	3,424,509	-	3,424,509	3,150,000	274,509
Grant Revenue	110,000	3,362,760	-	3,472,760	3,472,760	-
Affiliate Local Drawdown	899,600	-	-	899,600	899,600	-
Total operating revenue	226,396,953	27,301,432	7,500	253,705,885	261,505,776	(7,799,891)
Operating expenses						
General Administration						
Salaries	2,013,524	587,160	-	2,600,684	2,375,616	225,068
Fringes	685,800	179,484	-	865,284	740,256	125,028
Access salaries	-	220,620	-	220,620	194,484	26,136
Access fringes	-	67,140	-	67,140	57,588	9,552
Contractual	683,300	129,000	-	812,300	612,300	200,000
Board expenses	18,000	5,000	-	23,000	21,100	1,900
Day of recovery	14,000	-	-	14,000	14,000	-
Facilities	152,700	-	-	152,700	152,700	-
Other	135,800	12,600	-	148,400	137,400	11,000
IPA Tax	1,866,584	144,549	-	2,011,133	1,919,705	91,428
Hospital Rate Adjuster	4,571,336	-	-	4,571,336	4,571,336	-
Grant Expenses	-	3,312,760	-	3,312,760	3,312,760	-
Local Match Drawdown	899,600	-	-	899,600	899,600	-
Payments to Providers:						
Medicaid Services	176,618,608	3,931,559	-	180,550,167	176,725,108	3,825,059
Healthy Michigan Services	17,639,931	10,226,006	-	27,865,937	24,111,036	3,754,901
Health Home Services	1,415,201	-	-	1,415,201	1,150,000	265,201
Opioid Health Home Services	-	3,165,000	-	3,165,000	2,843,254	321,746
PA2 Services	-	1,533,978	-	1,533,978	1,533,978	-
Comunity Grant	-	2,075,447	-	2,075,447	2,075,447	-
Prevention	-	634,055	-	634,055	634,055	-
State Disability Assistance	-	95,215	-	95,215	95,215	-
Total operating expenses	206,714,384	26,319,573	-	233,033,957	224,176,938	8,857,019
Revenue over (under) expenses	$ 19,682,569	$ 981,859	$ 7,500	$ 20,671,928	$ 37,328,838	$ (16,656,910)

Note: Payments to providers are based on the actual projected PMPM by CMH.

Northern Michigan Regional Entity

2023 Proposed Budget

By Funding Source

	Medicaid	Healthy Michigan	Health Home/ OHH	SAPT Block Grant/ PA2 Funds	Total
Mental Health/Developmental Disability					
Operating revenue	$ 199,152,705 *	$ 24,783,377 *	$ 1,451,271	$ -	$ 225,387,353
Operating expenses					
General Administration	2,654,606	265,131	21,271	-	2,831,008
MH Admin	414,843	41,433	3,324	-	459,600
IPA Tax	1,705,382	149,727	11,475	-	1,866,584
Hospital Rate Adjuster	2,524,984	2,046,352	-	-	4,571,336
Payments to Providers	176,618,608	17,639,931	1,415,201	-	195,673,740
Total operating expenses	183,918,423	20,142,574	1,451,271	-	205,402,268
Unspent (Overspent) MH/DD Funds	$ 15,234,282	$ 4,640,803	$ 0	$ -	$ 19,985,085
Substance Use Disorder					
Operating revenue	$ 4,678,634	$ 11,196,405	$ 3,424,509	$ 4,639,124	$ 23,938,672
Operating expenses					
General Administration	59,092	153,699	47,570	42,155	302,516
SUD Admin	168,622	341,073	135,744	218,174	863,244
SUD Access Admin	56,210	146,201	45,250	40,099	287,760
IPA Tax	33,060	80,545	30,944	-	144,549
PA2 Expenditures	-	-	-	1,533,978	1,533,978
Payments to Providers	3,931,559	10,226,006	3,165,000	2,804,717	20,127,282
Total operating expenses	4,248,542	10,947,524	3,424,509	4,639,124	23,259,329
Unspent SUD (Overspent) Funds	430,092	248,881	0	0	679,343
Total Unspent (Overspent) Funds	$ 15,664,374	$ 4,889,685	$ 0	$ 0	$ 20,664,428

* Medicaid and HMP Revenue includes FY22 Carryforward flowing into FY23

Northern Michigan Regional Entity

Fiscal Year 2023 Budget

Summary of Revenue Contracts

Revenue Source (Grantor/Payor)	Contract Type	Amount
MDHHS/PIHP Master Contract	Service	241,262,392
MDHHS/Substance Abuse Prevention and Treatment (Community Grant)	Grant-SUD	3,105,145
Detail for Grant Revenue:		
MDHHS/Veteran Navigator	Grant-PIHP	110,000
MDHHS/State Opioid Response (SOR II)	Grant-SUD	2,015,455
MDHHS/Michigan Gambling Disorder Prevention Project	Grant-SUD	200,000
MDHHS/Substance Use Disorder - Tobacco	Grant-SUD	4,000
MDHHS/COVID	Grant-SUD	1,168,900
MDHHS/Pregnant and Postpartum Women	Grant-SUD	174,405

Northern Michigan Regional Entity

Fiscal Year 2023 Budget

Summary of Admin Contracts over $10,000

Vendor	Contract Type/Department	Amount
Behavioral Medicine Associates PLLC	Medical Director	10,000
Roslund, Prestage & Company	Audit/Finance	26,000
General Consulting	Miscellaneous Contracts	200,000
Electronic Health Record	Data - IT	150,000
Legal	Legal	50,000
Paychex	HR/Payroll	27,712
United Training	Training/Regional	10,000
Wellness Center	NMRE Office Lease	117,870

Northern Michigan Regional Entity

Fiscal Year 2023 Budget

Summary of Substance Use Treatment Contracts

Vendor	Outpatient	Residential	Withdrawl Management	Recovery Homes	Access
Addiction Treatment Centers	X	X	X	X	
BASES	X				
Bear River Health	X	X	X	X	
Catholic Human Services	X				
DOT Caring Center	X	X	X		
Grace Center	X				
Great Lakes Recovery		X	X		
Harbor Hall	X	X	X	X	
Holy Cross		X	X		
Meridian		X	X		
Michigan Therapeutic Consult	X				
Munson	X				
NMSAS	X				
Recovery Pathways	X				
Sacred Heart	X	X	X		
Sunrise	X	X	X		
Ten Sixteen Recovery Network		X			
ProtoCall					X
Wedgwood		X			

Northern Michigan Regional Entity

Fiscal Year 2023 Budget

Summary of Program Contracts

Vendor	Contract Type/Department	Amount
Northeast CMH	Service/Mental Health	$ 31,699,370
North Country CMH	Service/Mental Health	54,749,254
Northern Lakes CMH	Service/Mental Health	64,803,617
Ausable Valley CMH	Service/Mental Health	26,177,469
Centra Wellness	Service/Mental Health	16,828,829
Catholic Human Services	Prevention/Substance Abuse	521,892
District Health Department #10	Prevention/Substance Abuse	64,326
Northwest MI Health Department	Prevention/Substance Abuse	110,471
ProtoCall	Prevention/Substance Abuse	43,200

FY23 Projected PMPM	NMRE - SUD	NL	NC	NE	AV	CW	Total
Medicaid							
FY22 Projected PMPM - Medicaid	4,483,586	63,100,089	52,245,537	31,863,483	26,272,228	16,585,365	194,550,287
DCW Surplus	(260,539)	(2,362,161)	(949,195)	(1,272,378)	(1,338,187)	(646,659)	(6,829,118)
FY23 Projected Rate Decrease		(2,575,450)	(2,098,235)	(1,254,232)	(1,054,716)	(650,485)	(7,633,118)
FY23 Eligibles - projected increase	17,578	250,067	208,594	125,642	103,933	65,368	771,181
Total Projected Medicaid FY23 PMPM	**4,240,625**	**58,412,546**	**49,406,701**	**29,462,515**	**23,983,257**	**15,353,589**	**180,859,232**
Benefits Stabilization - Medicaid	259,728	3,694,950	3,082,151	1,856,463	1,535,693	965,866	11,394,851
FY23 Projected PMPM - Medicaid - including benefits stabilization spend	4,500,353	62,107,495	52,488,852	31,318,978	25,518,950	16,319,455	192,254,083
HMP							
FY22 Projected PMPM - HMP	10,788,226	6,798,243	5,689,042	2,322,246	2,326,986	1,567,533	29,492,276
DCW Surplus	33,270	(142,865)	(125,053)	4,946	(42,313)	(31,343)	(303,358)
FY23 Projected Rate Decrease		(292,324)	(244,629)	(99,857)	(100,060)	(67,404)	(804,274)
FY23 Eligibles - projected increase	40,036	28,017	23,192	9,519	9,600	6,454	116,819
Total Projected HMP FY23 PMPM	**10,861,531**	**6,391,071**	**5,342,553**	**2,236,855**	**2,194,212**	**1,475,240**	**28,501,462**
Benefits Stabilization - HMP	1,749,638	1,224,392	1,013,540	415,999	419,543	282,037	5,105,149
FY23 Projected PMPM - HMP - including benefits stabilization spend	12,611,169	7,615,463	6,356,093	2,652,854	2,613,756	1,757,277	33,606,611
Total Projected Medicaid & HMP FY23 PMPM	**15,102,157**	**64,803,616**	**54,749,254**	**31,699,369**	**26,177,469**	**16,828,829**	**209,360,694**
Including Benefits Stabilization	17,111,523	69,722,958	58,844,945	33,971,831	28,132,706	18,076,732	225,860,694