**Northern Michigan Regional Entity**

**Board Meeting**

**October 27, 2021**

**1999 Walden Drive, Gaylord**

**10:00AM**

**Agenda**

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| 1. | Call to Order | |
| 2. | Roll Call | |
| 3. | Pledge of Allegiance | |
| 4. | Acknowledgement of Conflict of Interest | |
| 5. | Approval of Agenda | |
| 6. | Approval of Past Minutes – September 22, 2021 | Pages 2 – 8 |
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| | e. NMRE SUD Oversight Board Report – Next Meeting November 8, 2021 | |
| 11. | New Business | |
| | a. Engagement Letter with Feldsman, Tucker, Liefer, Fidell, LLP | |
| | b. NMRE ICSS Plan of Correction | Pages 81 – 82 |
| | c. CMHAM Fall Conference Debrief | |
| 12. | Old Business | |
| | a. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest | |
| 13. | Presentation/Discussion | |
| | Veteran Navigator Update | |
| 14. | Comments | |
| | a. Board | |
| | b. Staff/CMHSP CEOs | |
| | c. Public | |
| 15. | Next Meeting Date – November 24, 2021 | |
| 16. | Adjourn | |

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

| | |
|---|---|
| **ATTENDEES:** | **Roger Frye, Ed Ginop, Randy Kamps, Terry Larson, Gary Nowak, Jay O'Farrell, Richard Schmidt, Karla Sherman, Don Smeltzer, Joe Stone, Don Tanner** |
| **VIRTUAL ATTENDEES:** | **Gary Klacking (West Branch), Mary Marois (Traverse City)** |
| **ABSENT:** | **Christian Marcus** |
| **NMRE/CMHSP STAFF:** | **Brian Babbitt, Joanie Blamer, Eugene Branigan, Eric Kurtz, Pamela Polom, Brandon Rhue, Sara Sircely, Teresa Tokarczyk, Deanna Yockey, Carol Balousek, Lisa Hartley** |
| **PUBLIC:** | **Anja Angel, Chip Cieslinski, Chris Frasz, Kassondra Glenister, Sue Winter, Jackie Wurst** |

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

ROLL CALL
Let the record show that Christian Marcus was absent for the meeting on this date; all Board Members were in attendance either virtually or in person.

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 expressed.

APPROVAL OF AGENDA
Let the record show that Chairman Tanner called for any additions or corrections to the meeting Agenda; none were proposed.

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

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

**MOTION BY ROGER FRYE TO APPROVE THE MINUTES OF THE AUGUST 25, 2021 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY RANDY KAMPS. MOTION CARRIED.**

CORRESPONDENCE

1) The minutes from the September 2, 2021 PIHP CEO Meeting.
2) Michigan Psychiatric Care Improvement Project (MPCIP) Update dated August 2021.
3) "Stakeholder Update KB vs. MDHHS Lawsuit" presentation slides dated August 2021.
4) "Michigan Behavioral Health Delivery System Redesign: presentation slides from Rep. Mary Whiteford.
5) "SB 597 and SB 598" presentation slides from the Michigan Association of Health Plans (MAHP) dated August 31, 2021.
6) Document titled "Why We Oppose SBs 597 & 598" from the Community Mental Health Association of Michigan (CMHAM).
7) SFY 2022 Behavioral Health Capitation Rates draft presentation from Milliman dated August 31, 2021.
8) The minutes from the September 8, 2021 Regional Finance Committee Meeting in draft form.

Mr. Kurtz drew attention to the KB Lawsuit update that was presented to PIHP CEOs in August. The lawsuit alleges that the State of Michigan failed to provide adequate behavioral health services and supports to children eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT). During an investigation into the allegations the "current PIHP and CMHPS structure" was identified as an underlying issue.

Attention was next drawn to Rep. Whiteford's system redesign slides regarding House Bill 4925, in which she calls for a "managed fee-for-service delivery system through a contract with a single public or nonprofit administrative services organization" to replace the 10 PIHPs. Mr. Tanner spoke about Rep. Whiteford's visit to Centra Wellness Network, calling it a good discussion and exchange of ideas. Michigan's 101st District Representative Jack O'Malley was in attendance and confessed to knowing nothing about the issue. Mr. Stone responded that CMHAM needs to do a better job of informing legislators. Ms. Sherman remarked that she has met with Rep. Whiteford three times; she and 107th District Representative John Damoose appear to be "all ears."

Mr. Kamps spoke about Rep. Whiteford's visit to Northern Lakes; he expressed that she didn't seem receptive to push back about rural vs. urban, local input, or further modifications to the bills. Mr. Kurtz responded that his perception is that Rep. Whiteford is listening but not really changing the approach. Mr. Kamps voiced that he is pleased that Region 2 partners are delivering a consistent message.

ANNOUNCEMENTS

Let the record show that Mr. Stone reminded the Board about the CMHAM Fall Conference taking place October 25th – 26th in Traverse City; a reception is planned for the evening of October 24th.

PUBLIC COMMENTS

Let the record show that the members of the public attending the meeting virtually were recognized. Chris Frasz, Outreach Director for Bear River Health, expressed that he had some comments regarding liquor tax requests. Mr. Tanner responded that he may bring those up as the requests are presented under "New Business."

REPORTS

**Executive Committee Report**

Let the record show that the NMRE Board Executive Committee met earlier on this date; a report will be given under "New Business."

**CEOs Report**

The NMRE CEO Monthly Report for September 2021 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to a meeting he attended on September 2nd regarding Behavioral Health home services and Targeted Case Management. Oakland County's Medical Director raised questions with the Department that targeted case management and care management are duplicative services and cannot be billed within the same month. MDHHS then contacted MSA which agreed. Mr. Kurtz has drafted an opinion outlining the differences in services. Current guidance is to continue to provide both services until a final determination is received in writing.

Mr. Kurtz also referenced issues concerning the Standard Cost Allocation (SCA). In September, CFI, CMH Contract Negotiation Team, the PIHP Contract Negotiation Team, and several CMH and PIHP staff with expertise in cost allocation, financial management, state policy, statutes, and Medicaid waivers, met with representatives of Milliman and MDHHS to negotiate the contract language, in both the CMH and PIHP contracts, related to the MDHHS/Milliman proposed Standard Cost Allocation (SCA) initiative. More meetings are scheduled. CMHSP administrative cost reporting remains a primary issue (Network Provider vs. Subcontractor). Mr. Kurtz explained how the SCA is tied to the PIHP's Medical Loss Ratio. Mr. Kamps questioned whether the SCA is intended to improve the provision of services or just add additional administrative burden.

**July 2021 Financial Report**

- Traditional Medicaid showed $169,683,683 in revenue, and $146,422,957 in expenses, resulting in a net surplus of $23,260,726. Medicaid ISF was reported as $7,738,320 based on the unaudited final FSR. Medicaid Savings was reported as $4,515,675.
- Healthy Michigan Plan showed $26,312,497 in revenue, and $20,406,986 in expenses, resulting in a net surplus of $5,905,511. HMP ISF was reported as $7,058,552 based on the unaudited Final FSR. HMP savings was reported as $0.
- Net Position* showed net surplus Medicaid and HMP of $29,166,237. Medicaid carry forward was reported as $4,515,675. The total Medicaid and HMP Current Year Surplus was reported as $27,911,912. Medicaid and HMP combined ISF was reported as $14,796,872; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $42,708,784.
- Health Home showed $422,310 in revenue, and $351,433 in expenses, resulting in a net surplus of $70,877.
- SUD showed all funding source revenue of $17,347,217, and $14,286,596 in expenses, resulting in a net surplus of $3,060,621. Total PA2 funds were reported as $6,491,685.

Ms. Yockey reported that a FY21 lapse is currently projected at approximately $18M. Mr. Stone asked what can be done to reduce the risk of future lapse. Mr. Kurtz responded that not much can be done for FY21; however, Operations committee is discussing benefit stabilization initiatives to undertake in FY22; crisis and residential services for both mental health and SUD were identified as key target areas, though staffing issues continue to be problematic. It was noted that much of the surplus is due to Medicaid enrollees not being dropped during the

pandemic; there remains a level of uncertainty regarding revenue amounts when Medicaid redeterminations and spenddowns resume.

Ms. Yockey stated that an additional PA2 payment is expected by the end of the year.

Mr. Tanner remarked that in the past CMHSPs were able to retain Medicaid savings to use as local. Ms. Sherman spoke about the benefit of serving the mild/moderate population under the public system.

**MOTION BY RANDY KAMPS TO RECEIVE AND FILE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JULY 2021; SUPPORT BY JOE STONE. ROLL CALL VOTE.**

| | |
|---|---|
| **"Yea" Votes:** | **R. Frye, R. Schmidt, R. Kamps, K. Sherman, J. Stone, E. Ginop, T. Larson, G. Klacking, J. O'Farrell, D. Smeltzer, G. Nowak, D. Tanner** |
| **"Nay" Votes:** | **Nil** |

**MOTION CARRIED.**

**Operations Committee**
The minutes from August 21, 2021 were distributed during the meeting on this date in draft form. Mr. Kamps asked about the NMRE's decision to pass on applying for the Veteran Navigator Peer Support grant. Mr. Kurtz responded that the NMRE's Veteran Navigator, Brian Martinus, is not ready at this time to bring on a peer nor is the region seeing the need; this will be explored more in the future. Mr. Martinus will report his activities during a upcoming Board meeting.

Ms. Sherman asked about the intent of the Behavioral Health fee screen developed by the Department/Milliman. Mr. Kurtz responded that the cover letter indicated that it is not to be used to set rates but likely to satisfy a legislative requirement. Mr. Kamps noted Rep. Whiteford's support of issuing an RFP to procure the Department's actuarial firm.

**NMRE SUD Oversight Board Report**
The minutes of the September 13, 2021 meeting of the NMRE Substance Use Disorder Oversight Board were included in the meeting materials in draft form. Liquor tax requests will be presented under "New Business."

NEW BUSINESS
**PA2 Requests**
1) Michigan Rehabilitation Services – $35,000 (split between all 21-counties)
2) Child & Family Services of Northwestern Michigan – $23,889 (Grand Traverse, Leelanau)
3) Catholic Human Services – $94,382 (Missaukee, Wexford)
4) Catholic Human Services – $58,850 (Leelanau)
5) Catholic Human Services $149,691 (Grand Traverse, Kalkaska, Leelanau)
6) District Health Department #2 – $58,880 (Alcona, Alpena, Cheboygan, Iosco, Oscoda, Presque Isle)
7) Health Department of Northwest Michigan - $132,500 (split between participating schools in the NMRE 21-county region)
8) Catholic Human Services – $196,529 (Cheboygan, Crawford, Iosco, Oscoda, Roscommon)
9) Community Recovery Alliance – $125,830 (Antrim, Charlevoix, Cheboygan, Emmet)

10) Catholic Human Services – $15,873 (Alpena, Antrim, Benzie, Grand Traverse, Iosco, Kalkaska, Manistee, Missaukee, Montmorency, Ogemaw, Roscommon, Wexford)
11) Catholic Human Services – $139,041 (Alpena, Antrim, Benzie, Grand Traverse, Iosco, Kalkaska, Manistee, Missaukee, Montmorency, Ogemaw, Roscommon, Wexford)
12) Catholic Human Services – $66,000 (Grand Traverse)
13) Catholic Human Services - $174,486 (Alcona, Alpena, Antrim, Benzie, Crawford, Grand Traverse, Iosco, Kalkaska, Manistee, Missaukee, Montmorency, Otsego, Presque Isle, Wexford)
14) Bear River Health - $92,738 (Emmet)
15) Bear River Health – $49,509 (Emmet

The NMRE noted instances where the PA2 request would put a county's fund balance below the recommended level equivalent of one year's receipts. The budgets associated with the PA2 requests were posted to the nmre.org website per prior request.

The total amount approved by the NMRE SUD Oversight Board on September 13, 2021was reported as $1,413,198.

**MOTION BY GARY NOWAK TO APPROVE THE LIQUOR TAX REQUESTS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD ON SEPTEMBER 13, 2021 FOR A TOTAL AMOUNT OF ONE MILLION FOUR HUNDRED THIRTEEN THOUSAND, ONE HUNDREED NINETY-EIGHT DOLLARS ($1,413,198.00) FOR FISCAL YEAR 2022; SECOND BY ED GINOP.**

Discussion:
Mr. Schmidt voiced that the NMRE SUD Oversight Board approved the spending of $37K Manistee County PA2 funds without him (the NMRE SUD Board representative for Manistee County) being in attendance. Ms. Yockey emphasized that block grant funds are used whenever possible to reduce the impact on PA2.

Chris Frasz, Outreach Director for Bear River Health, reported that the provision of MAT services to individuals in county jails has bene very successful. The program began with SOR and PA2 funds and continued in FY21 using SOR funds only; SOR funds were not allocated to support the program in FY22, which led to the application for PA2. Without funding, the program will end September 30th. Mr. Schmidt suggested reducing the ask to allow the program to be funded for a few months and reapplying mid-year. The decision was made to fund one-third of the requested amount of $68,556, or $22,623.

**MOTIN BY GARY NOWAK TO AMEND HIS PRIOR MOTION TO INCLUDE AN APPROVAL OF THE REQUEST BY BEAR RIVER HEALTH FOR $22,623 OTSEGO COUNTY LIQUOR TAX DOLLARS FOR JAIL MAT SERVICES; SUPPORT BY JOE STONE. ROLL CALL VOTE.**

| | |
|---|---|
| **"Yea" Votes:** | **E. Ginop, D. Smeltzer, G. Klacking, G. Nowak, R. Schmidt, J. O'Farrell, R. Kamps, K. Sherman, T. Larson, R. Frye, J. Stone, D. Tanner** |
| **"Nay" Votes:** | **Nil** |

**MOTION CARRIED.**

**ROLL CALL VOTING TOOK PLACE ON THE MAIN MOTION.**

**"Yea" Votes:** **D. Smeltzer, T. Larson, J. Stone, R. Frye, J. O'Farrell, E. Ginop, K. Sherman, G. Klacking, G. Nowak, R. Kamps, D. Tanner**

**"Nay" Votes:** **R. Schmidt**

**MOTION CARRIED.**

Let the record show that the total amount of PA2 funds approved on this date was $1,435,821**.**

**NMRE CEO Contract and Compensation**
Let the record show that the NMRE Board Executive Committee met at 9:15 on this date to discuss the CEO's contract and compensation for FY22. A salary increases of 10.37% was proposed in addition to extending the contract term through FY26.

**MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY EXECUTIVE COMMITTEE'S SALARY RECOMMENDATION FOR THE CHIEF EXECUTIVE OFFICER FOR FISCAL YEAR 2022 AND EXTEND THE CONTRACT TERM THROUGH FISCAL YEAR 2026; SUPPORT BY ROGER FRYE**.

Discussion:
Mr. Stone expressed that the NMRE is fortunate to have Mr. Kurtz as its CEO.

**ROLL CALL VOTING TOOK PLACE ON MR. NOWAK'S MOTION.**

**"Yea" Votes:** **J. Stone, G. Klacking, K. Sherman, R. Kamps, G. Nowak, E. Ginop, D. Smeltzer, J. O'Farrell, R. Frye, R. Schmidt, T. Larson, D. Tanner**

**"Nay" Votes:** **Nil**

**MOTION CARRIED.**

**Proposed FY22 NMRE Board Meeting Schedule**
The proposed NMRE Board Meeting schedule for FY22 was included in the materials for the meeting on this date.

**MOTION BY RANDY KAMPS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING SCHEDULE FOR FISCAL YEAR 2022; SUPPORT BY JOE STONE. MOTION CARRIED.**

OLD BUSINESS
**Senate Bills 597 & 598/House Bills 4925-4929 – The Latest**
This topic was addressed under the "Correspondence" portion of the meeting Agenda.

PRESENTATION
**NMRE Proposed FY22 Budget**
The NMRE's proposed budget for FY22 was included in the materials for the meeting on this date. Milliman projected a 7.5% increase in the state for $2.00 DCW increase. The Statewide effective increase was reported as 1.2%.

NMRE rates showed an increase of (<1%). The NMRE used FY21 actual revenue as a basis for revenue less the anticipated DCW lapse and a neutral revenue projection for the FY22 budget.

The NMRE Operating Revenue included a 3% cola for staff, fully accrued PTO, and current vacant positions at full year.

Lambert PR will be added to the list of Administrative Contracts.

**MOTION BY JOE STONE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BUDGET FOR FISCAL YEAR 2022 AS PRESENTED AND REVIEWED ON THIS DATE; SUPPORT BY GARY NOWAK. ROLL CALL VOTE.**

| | |
|---|---|
| **"Yea" Votes:** | **G. Klacking, D. Smeltzer, K. Sherman, R. Schmidt, E. Ginop, T. Larson, R. Kamps, R. Frye, J. O'Farrell, G. Nowak, J. Stone, D. Tanner** |
| **"Nay" Votes:** | **Nil** |

**MOTION CARRIED.**

COMMENTS
Mr. Nowak announced that the Northeast Michigan Board of Directors voted to contract with Straley, Kamp, and Kraenzlein, PC as its financial auding firm.

MEETING DATES
The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on October 27, 2021.

ADJOURN
Let the record show that Mr. Tanner adjourned the meeting at 11:50AM.

# PIHP CEO Meeting
# October 7, 2021
# 9:00AM – 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 |
| Mila Todd (Sackett) (Southwest Michigan Behavioral Health) | Region 4 |
| Joe Sedlock (Mid-State Health Network) | Region 5 |
| James Colaianne (CMH Partnership of Southeast Michigan) | Region 6 |
| Eric Doeh (Detroit Wayne Mental Health Authority) | Region 7 |
| Dana Lasenby (Oakland Community Health Network) | Region 8 |
| Dave Pankotai (Macomb County CMH Services) | Region 9 |
| Jim Johnson | Region 10 |

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie
Audrey Dick
Larry Scott
Jackie Sproat
Jeff Wieferich
Carrie Rheingans
Brenda Stoneburner
Matthew Seager
Price Pullins
Jody Lewis
Lindsay McLaughlin

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

## MI Kids Now Update

1. Phil Kurdunowicz reported that Chief Deputy Director David Knezek had sent out a communication.
    a. The original deadline for completion of the settlement agreement was September 1, 2021. At the mutual agreement of the plaintiff's counsel, the attorney general's office, and MDHHS legal counsel, that deadline has been extended 90 days. December 1, 2021 is the new operational deadline for the settlement agreement. That process is still underway.
    b. The six workgroups continue to meet internally at MDHHS. Those six workgroups are:
        i. Service array and care coordination.
        ii. Service access.
        iii. Screening and assessment.
        iv. Workforce development and training.
        v. Data collection and quality monitoring.
        vi. Communications.
2. Phil Kurdunowicz reported that funding for the MI Kids Now initiative was included in the FY 2022 budget, in the amount of $30 million in the general fund, with various estimates on the federal match.
    a. MDHHS was authorized to use $30 million general fund to support the implementation of the MI Kids Now initiative. Department leadership has been examining immediate priorities for that spending, and the focus is helping to provide immediate relief to the field to increase access to services for children and youth.
    b. MDHHS is working on a couple of proposals now and plans to engage the PIHPs in that work going forward.
3. Phil Kurdunowicz shared that there has been interest in launching a process like the talent pipeline management program in the behavioral health workforce.
    a. MDHHS recognizes the seriousness of the crisis in the behavioral health workforce and is looking at opportunities to strengthen the behavioral health workforce.
    b. MDHHS also wants to ensure the PIHPs and CMHs and their providers are involved in the process.

## Status of Afghan Nationals Coming to MI

1. Jody Lewis and Price Pullins shared the information they have on the Afghan nationals that will be resettled in Michigan.
    a. At last count the anticipated number of Afghan nationals coming to Michigan would be around 1300. These estimated numbers do change frequently.
    b. These individuals will be eligible for Medicaid and WIC. Some refugee agencies will be helping with the initial adjustment for settlement.
    c. The counties receiving people have been identified as Wayne, Ingham, and Kent. People will be able to settle from those counties to other places, but those are the initial settlement locations.

        i. Other counties were also included on the list, but people have not necessarily arrived there yet; these locations were flagged for temporary housing or later settlement.
    d. The agencies that assist with the initial settlement will be doing initial medical screening, including some behavioral health screening to identify what needs people may have initially. Given that the people are coming from an area that has been at war, they will likely need trauma counseling.
        i. A trauma screening tool has been translated into the Dari, Pashto, and Farsi languages to make the tools more accessible to the new arrivals.
        ii. The PIHPs said they would look into having translators available for those languages.
    e. Currently, the new arrivals are at a military base while they receive their first round of vaccines. They will remain there for 21 days following their first vaccines. Local health departments will be helping them complete their vaccinations afterwards.
    f. Once the refugee organizations do their work, the new residents will need to be integrated into the system for behavioral health services, Medicaid, and other human services as needed.
2. A PIHP asked if the state would be providing any cultural competency training for providers on this population, as it is one the PIHPs are less likely to be familiar with.
    a. Jody Lewis responded that they would investigate this.

**MPCIP & MI CAL Update**

1. Krista Hausermann provided the MPCIP update. This update has been distributed to the group via email.
    a. One area she highlighted was the universal credentialling crosswalk. MDHHS is taking an in-depth look at the legislation and any related business processes to develop a crosswalk of all those requirements to ensure MDHHS is not requesting the same information from the PIHPs twice.
    b. A PIHP reminded the group that the requirements for accreditations remain and that the PIHPs must comply with those; thus, MDHHS needs to continue to consider those requirements.
        i. Krista Hausermann agreed and thanked the PIHP, stating that MDHHS would be relying on the PIHPs to provide them with that feedback as well; MDHHS fully expects the PIHPs to help add to the crosswalk.

**Strategic Behavioral Health Integration and Coordination Initiatives**

1. The update for this section was sent to the group via email.

**SUD Capacity 1003 Demonstration Update**

1. Carrie Rheingans provided the SUD Capacity 1003 Demonstration Update.

a. Michigan is now in its third and final year of the grant; Michigan officially received the 12-month no-cost extension. The extension will last until September 29, 2022.
b. MDHHS will be continuing their work with the Michigan Public Health Institute and the Inter-Tribal Council of Michigan.
    i. Her team is reviewing the data the Inter-Tribal Council has collected over a decade about the access to recovery programs. After this quantitative study is done, her team will be able to share what could be replicated or advanced with the Inter-Tribal Council and the tribal health providers.
    ii. Her team is also continuing interviews with tribal providers and beneficiaries.
c. Carrie's team is gearing up to do interviews with court drug coordinators and with beneficiaries that have experienced the court and incarceration systems to see what can be learned from both perspectives. Her team has heard from PIHPs and SUD providers that there are sometimes complications working between the justice system and the SUD care system.
d. The 1003 Demonstration team has worked with a few PIHPs already in 2021 to map out the SUD intake process, looking for possible process improvement locations. There is still funding to complete this process with any of the PIHPs that would like to participate.
    i. A handout was sent to the group via email; any PIHPs interested in participating in this free process were to respond by Friday, October 15, 2021.

2. Carrie Rheingans reported that her colleagues in the Medical Services Administration (MSA) are targeting Hepatitis C for elimination in Michigan.
    a. The MSA is curious how PIHP providers screen for Hepatitis C and what processes surround that.
    b. The MSA wants to put together a couple of questions to email to the PIHPs for written responses; nothing extensive, only asking if the PIHPs screen for Hepatitis C, and then if so, what the referrals and linkages are for treatment.

**National Core Indicators Survey Advisory Council**

1. Matt Seager invited the PIHPs to participate in the National Core Indicators (NCI) Survey Advisory Council.
    a. One PIHP is participating already, but he wanted to invite all the PIHPs to see if they would like to send a representative to participate in that meeting.
    b. The next NCI meeting will be in January 2022 and will focus on COVID-19 surveys gathered in 2020. Invitations will go out the first week of December 2021.
    c. If the PIHPs would like to send a representative, they can contact Matt Seager via email at seagerm@michigan.gov.
2. A PIHP asked what percentage of the IDD population MDHHS was surveying.
    a. Matt Seager responded that it was a representative sample; for 2020, MDHHS has surveyed around 665 individuals. It is a sample small enough that the results must be statewide and cannot be parceled out by region.

3. A PIHP requested more background information on the group be sent to them, and possibly minutes from the last few meetings.
    a. Matt Seager provided background that the survey itself focuses on the experience of individuals with IDD in Michigan. It surveys a variety of things, from feelings of loneliness to access to things in their environment like phone and internet.
    b. Survey results have previously been presented to the CMHs for the CMHs to determine how to address them. The Quality Management and Planning Division would like to take a more proactive approach to this data, developing a concerted effort to get a conversation going with both CMHs and PIHPs about what works and what does not.
4. A PIHP asked if MDHHS was comparing Michigan's results with other states or using it to drive quality improvement.
    a. Matt Seager answered that a third-party vendor compiles the data at a national website, and that the data is compared to other states. Historically, MDHHS has provided the data to the CMHs to use as they would, but MDHHS feels that moving forward they would like to be more tactical about identifying areas for improvement and workshopping that in partnership with both the CMHs and PIHPs.

**DCW Reporting and Accounting in FY 22**

1. The PIHPs asked where MDHHS is headed with the administrative structure laid out for Direct Care Worker (DCW) premium pay.
    a. The PIHPs commented that a notice issued by MDHHS indicated that the funds for the DCW premium pay must be kept track of separately and be in addition to wages that were established in April of 2020.
    b. The PIHPs asked what, if any, flexibilities the department may be planning to incorporate, and what the requirements will be moving forward about accounting for the DCW premium pay separately.
    c. The PIHPs expressed concern about what figures they would be cost settling against, and the cost settlement process when the revenue cannot be specifically identified in the Milliman rates certification letter.
2. MDHHS responded that this was an issue they had discussed internally. MDHHS wants to give the correct guidance, and so has consulted with the State Budget Office about the intent and information MDHHS will need to organize. Once MDHHS receives guidance from the State Budget Office, they will communicate it to the PIHPs via L-Letter.
    a. If MDHHS finds out the intent is for this to be permanent, they will look into how to change the reporting requirements.
3. The PIHPs asked if there was anything they could contribute to help.
    a. MDHHS responded that an email with the items the PIHPs talked about would be helpful and allow MDHHS to share the concerns upstream.
4. A PIHP asked if the increase was meant to go towards hours worked or towards hours total.
    a. MDHHS responded that that was another question MDHHS had to ask of the State Budget Office, and that MDHHS would clarify when they received an answer.

## 1915(i) Implementation Planning Questions/Concerns

1. A PIHP noted that some of the PIHPs are beginning the rollout to the 1915(i) eligibility and program work. From what the PIHP had heard, it looked as though the 1915(i) were beginning to roll out through the Habilitation Supports Waiver and enrollment teams. To the PIHP, the 1915(i) work seems larger than that, and the PIHP would recommend a broader group for implementation given the crossover of those services with other waivers.
    a. The PIHPs still have a lot of questions around eligibility and mechanics for enrolling that large of a population with the 1915(i) criteria are still being developed.
    b. Matt Seager pledged to take the PIHPs' concerns back to the team as the team worked to come up with the most seamless transition possible.

## Action Items

| *#* | *Date Added* | *Action Item* | *Assigned To* | *Status* |
|---|---|---|---|---|
| 1. | 01/07/2021 | H2015 Follow-up. | MDHHS | In Progress |

*FY2021 Q3 PIHP Final PI Numbers*

# CMHSP Medicaid Only & SUD All-Funding

*04/01/2021 – 06/30/2021*

# FY2021 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2021 – 06/30/2021

## NORTHERN MICHIGAN REGIONAL ENTITY

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 217 | 217 | **100.00%** |
| **Adults** | 660 | 654 | **99.09%** |
| **Total** | **877** | **871** | **99.32%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 412 | 286 | **69.42%** |
| **MIA** | 699 | 439 | **62.80%** |
| **DDC** | 75 | 53 | **70.67%** |
| **DDA** | 37 | 23 | **62.16%** |
| **Total** | **1,223** | **801** | **65.49%** |

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

| Population | Admissions | Expired | In 14 Days | % In 14 Days |
|---|---|---|---|---|
| **SA** | Calculated | 167 | Calculated | Calculated **%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 327 | 226 | **69.11%** |
| **MIA** | 443 | 326 | **73.59%** |
| **DDC** | 65 | 50 | **76.92%** |
| **DDA** | 24 | 19 | **79.17%** |
| **Total** | **859** | **621** | **72.29%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 71 | 14 | 57 | 54 | **94.74%** |
| **Adults** | 265 | 79 | 186 | 182 | **97.85%** |
| **Total** | **336** | **93** | **243** | **236** | **97.12%** |

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

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **SA** | 225 | 121 | 104 | 99 | **95.19%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 71 | 1 | 70 | 6 | **8.57%** |
| **Adults** | 265 | 5 | 260 | 31 | **11.92%** |
| **Total** | **336** | **6** | **330** | **37** | **11.21%** |

Produced by: Valerie McBain

# FY2021 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2021 – 06/30/2021

## AVCMH - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 40 | 40 | **100.00%** |
| **Adults** | 113 | 113 | **100.00%** |
| **Total** | **153** | **153** | **100.00%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 84 | 57 | **67.86%** |
| **MIA** | 131 | 85 | **64.89%** |
| **DDC** | 17 | 10 | **58.82%** |
| **DDA** | 3 | 2 | **66.67%** |
| **Total** | **235** | **154** | **65.53%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 66 | 47 | **71.21%** |
| **MIA** | 84 | 61 | **72.62%** |
| **DDC** | 15 | 10 | **66.67%** |
| **DDA** | 3 | 2 | **66.67%** |
| **Total** | **168** | **120** | **71.43%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 7 | 0 | 7 | 6 | **85.71%** |
| **Adults** | 18 | 2 | 16 | 16 | **100.00%** |
| **Total** | **25** | **2** | **23** | **22** | **95.65%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 7 | 0 | 7 | 1 | **14.29%** |
| **Adults** | 18 | 0 | 18 | 0 | **0.00%** |
| **Total** | **25** | **0** | **25** | **1** | **4.00%** |

# FY2021 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2021 – 06/30/2021

## CWN - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 5 | 5 | **100.00%** |
| **Adults** | 10 | 10 | **100.00%** |
| **Total** | **15** | **15** | **100.00%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 46 | 43 | **93.48%** |
| **MIA** | 69 | 59 | **85.51%** |
| **DDC** | 5 | 4 | **80.00%** |
| **DDA** | 4 | 4 | **100.00%** |
| **Total** | **124** | **110** | **88.71%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 40 | 28 | **70.00%** |
| **MIA** | 46 | 36 | **78.26%** |
| **DDC** | 3 | 2 | **66.67%** |
| **DDA** | 3 | 2 | **66.67%** |
| **Total** | **92** | **68** | **73.91%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 4 | 2 | 2 | 2 | **100.00%** |
| **Adults** | 12 | 7 | 5 | 5 | **100.00%** |
| **Total** | **16** | **9** | **7** | **7** | **100.00%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 4 | 0 | 4 | 0 | **0.00%** |
| **Adults** | 12 | 0 | 12 | 1 | **8.33%** |
| **Total** | **16** | **0** | **16** | **1** | **6.25%** |

# FY2021 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2021 – 06/30/2021

## NCCMH - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 25 | 25 | **100.00%** |
| **Adults** | 134 | 134 | **100.00%** |
| **Total** | **159** | **159** | **100.00%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 111 | 84 | **75.68%** |
| **MIA** | 167 | 120 | **71.86%** |
| **DDC** | 27 | 26 | **96.30%** |
| **DDA** | 8 | 6 | **75.00%** |
| **Total** | **313** | **236** | **75.40%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 91 | 62 | **68.13%** |
| **MIA** | 119 | 86 | **72.27%** |
| **DDC** | 26 | 20 | **76.92%** |
| **DDA** | 8 | 6 | **75.00%** |
| **Total** | **244** | **174** | **71.31%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 12 | 0 | 12 | 11 | **91.67%** |
| **Adults** | 65 | 7 | 58 | 58 | **100.00%** |
| **Total** | **77** | **7** | **70** | **69** | **98.57%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 12 | 0 | 12 | 1 | **8.33%** |
| **Adults** | 65 | 0 | 65 | 10 | **15.38%** |
| **Total** | **77** | **0** | **77** | **11** | **14.29%** |

# FY2021 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2021 – 06/30/2021

## NEMCMH - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 71 | 71 | **100.00%** |
| **Adults** | 116 | 115 | **99.14%** |
| **Total** | **187** | **186** | **99.47%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 46 | 28 | **60.87%** |
| **MIA** | 61 | 40 | **65.57%** |
| **DDC** | 0 | 0 | **0.00%** |
| **DDA** | 6 | 5 | **83.33%** |
| **Total** | **113** | **73** | **64.60%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 36 | 30 | **83.33%** |
| **MIA** | 46 | 40 | **86.96%** |
| **DDC** | 0 | 0 | **0.00%** |
| **DDA** | 3 | 2 | **66.67%** |
| **Total** | **85** | **72** | **84.71%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 12 | 1 | 11 | 11 | **100.00%** |
| **Adults** | 22 | 2 | 20 | 18 | **90.00%** |
| **Total** | **34** | **3** | **31** | **29** | **93.55%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 12 | 0 | 12 | 0 | **0.00%** |
| **Adults** | 22 | 0 | 22 | 4 | **18.18%** |
| **Total** | **34** | **0** | **34** | **4** | **11.76%** |

# FY2021 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2021 – 06/30/2021

## NLCMH - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 76 | 76 | **100.00%** |
| **Adults** | 287 | 282 | **98.26%** |
| **Total** | **363** | **358** | **98.62%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 125 | 74 | **59.20%** |
| **MIA** | 271 | 135 | **49.82%** |
| **DDC** | 26 | 13 | **50.00%** |
| **DDA** | 16 | 6 | **37.50%** |
| **Total** | **438** | **228** | **52.05%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 94 | 59 | **62.77%** |
| **MIA** | 148 | 103 | **69.59%** |
| **DDC** | 21 | 18 | **85.71%** |
| **DDA** | 7 | 7 | **100.00%** |
| **Total** | **270** | **187** | **69.26%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 36 | 11 | 25 | 24 | **96.00%** |
| **Adults** | 148 | 61 | 87 | 85 | **97.70%** |
| **Total** | **184** | **72** | **112** | **109** | **97.32%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 36 | 1 | 35 | 4 | **11.43%** |
| **Adults** | 148 | 5 | 143 | 16 | **11.19%** |
| **Total** | **184** | **6** | **178** | **20** | **11.24%** |

# FY2021 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2021 – 06/30/2021

## Substance Use Disorder

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

| Population | Expired |
|---|---|
| **SA** | 167 |

### Table 4b – Access – Continuity of Care

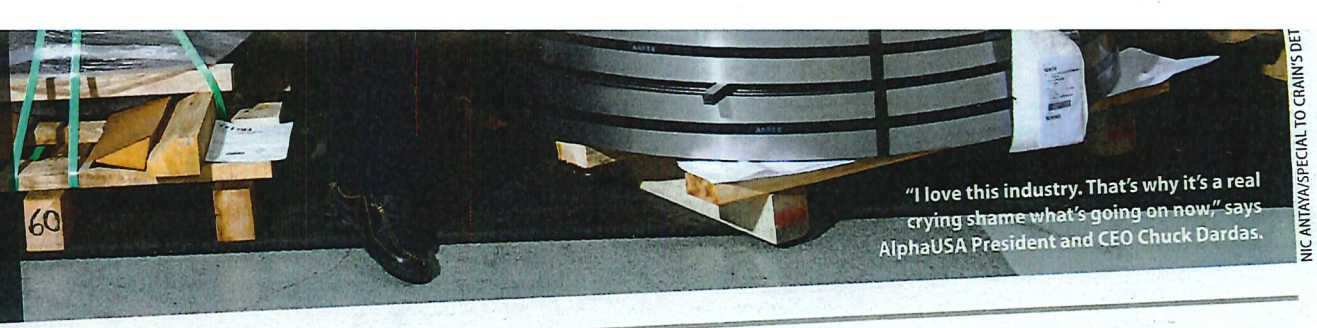
| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **SA** | 225 | 121 | 104 | 99 | **95.19%** |

of the soaring prices. "It's not just inflationary to us, it's hyperinflationary. It's a tax on us that we can't afford."

Manufacturers better get over the sticker shock, said Lourenco Goncalves, chairman, president and CEO of Cleveland-Cliffs Inc.

It's the best of days for the Ohio-based steel giant, which hauled in a record $795 million profit in the second quarter, joining fellow domestic steel companies capitalizing on unprecedented demand.

See **STEEL** on Page 17



"I love this industry. That's why it's a real crying shame what's going on now," says AlphaUSA President and CEO Chuck Dardas.

NIC ANTAYA/SPECIAL TO CRAIN'S DET

# Staffing woes leave those in dire need waiting

## Long haulers: Rural hospital patients hampered by ambulance service shortage

**BY DUSTIN WALSH**

Heart attack patients rushed to War Memorial Hospital in Sault Ste. Marie are quickly stabilized and prepared for transfer to a hospital with a heart catheterization lab. The Upper Peninsula hospital, like most in rural Michigan, is not equipped to handle interventional cardiac or neurological care.

But right now War Memorial is short-staffed — only 36 of its 49 licensed beds are open because of staffing — and it's near capacity with 33 patients filling beds last week. Patient transfers are more critical now than ever.

Yet the ambulances aren't coming.

Nursing managers are calling upwards of 20 ambulance services

See **AMBULANCES** on Page 20


**War Memorial Hospital in Sault Ste. Marie has struggled to get transport for patients.** | CRAIN'S DETROIT BUSINESS

## Group-home beds go unused as agencies struggle to pay enough to lure workers

**BY SHERRI WELCH**

Only half of the 100 residential treatment beds at Vista Maria's Dearborn campus are full.

Yet 20 girls, many a danger to themselves or others, are on a waiting list to get in.

And providers aren't sure where those girls and other children waiting to get into residential treatment are referred until they have a bed and staff to take them in.

Like other employers, human-service providers of residential care and treatment for children are facing staffing shortages. But they are limited in their ability to compete for employees, given the need to pay more than the state reimburses and the tough nature of the jobs they seek to fill.

See **GROUP HOMES** on Page 21

# GROUP HOMES

From Page 1

Exacerbating the staff shortages is a policy shift in Michigan this year to comply with federal requirements. Aimed at keeping more troubled youth in their family homes with added supports, the changes are lowering the total number of children coming through state and juvenile justice referrals to providers by referring only those with most accute mental health issues for residential treatment.

The higher percentages of youth with the most severe issues require one-to-one staffing, putting even more pressure on providers' staffing issues.

"The need for additional staff to care for youth suffering from acute mental health disorders, many of whom require a 1:1 (caregiver) ratio, is the main reason we currently have a wait list at Vista Maria," President and CEO Angela Aufdemberge said.

"We can't take them in because we don't have enough staff to fill those beds. ... I cannot recruit and train people fast enough to meet the needs of the children."

The staffing woes come with a human cost. Providers are questioning where the children in dire need of treatment are waiting to get into a residential site. Some say the state is referring them to youth crisis shelters for extended periods of time, but even those sites, which are designed for short-term stays, have limited beds.

"We have to pay for it now or pay for it later," said Kevin Roach, president and CEO of Methodist Children's Home Society.

"Costs to taxpayers, ER visits, we can talk about all of those, but the bigger cost is the cost to that child," Roach said.

and failure to make needed investments are not contributing to a happy and healthy future for them, he said.

"Paying for it later is going to come at a significantly higher cost."

The Michigan Health and Human Services Department recognizes the staffing challenges, and its Children's Services Agency and others within the department are working daily to address the challenge, said Bob Wheaton, public information officer, in an email.

Efforts include networking to share successful staffing strategies, such as shift premiums, bonuses and raises that are working to help attract caregivers.

"In addition, we have adjusted ratio requirements in some cases to accommodate staffing issues," Wheaton said.

"This exception has to be approved with an understanding youth will still have adequate supervision and keep safe."

The department's goal is to place children in the most family-like setting available appropriate to meet the child's needs, he said. It is working with residential treatment providers to find suitable placement as close to children's home communities as possible.

The department does contract with private agencies who offer temporary, short-term housing that MDHHS occasionally uses while it searches for a more long-term placement able to meet a child's needs," Wheaton said.

Contrary to reports in other parts of the country and rumblings locally, "Children are not permitted to stay overnight in hotels or in state offices," Wheaton said. "We are 100 percent committed to the well-being of (these) children providing them with appropriate care."

**Only half of the 100 mental health treatment are full due to the staffing shortage group h**

## Policy change

Early this year, the state shifted to a placement approach that seeks to keep more troubled children in their homes with enhanced support services rather than sending them to residential treatment sites, in compliance with the federal Family First Prevention Services Act passed in 2018.

Under the revised approach, only children with the most intensive mental health needs are removed from homes and placed in residential care.

The change is bringing new staffing realities for residential treatment providers. For every child that comes into care, providers must maintain prescribed staffing levels based on the severity of their mental health issues. Typically, one staff member cares for four children. But children with more acute issues require their own dedicated caregiver, Aufdemberge said.

"These are kids that are self-harming or a harm to others. To create a safe placement, they need one-to-one care."

In the past, five or six of the girls ages

11-18 in treatment at Vista Maria might have needed that level of care. But now, more than half of the girls on the agency's waiting list require an individual caregiver, she said. For every child with the most severe mental health issues, Vista Maria has to hire 3.5 employees to provide 24-hour, seven-day-a-week care.

Vista Maria offers full health coverage, including dental and vision, an employee assistance program, and a referral bonus program for employees, along with competitive rates, it said. But it's still struggling to recruit enough caregivers, given heightened levels of care needed for the girls coming to its campus through the judicial system and state referrals.

"That, coupled with the labor shortage, makes it almost impossible to take young people right now into our programs," Aufdemberge said.

Before the pandemic about 990 children were in treatment and care at residential sites throughout the state; in September, that was down to 482, according to numbers shared by the Michigan Department of Health and Human Services, said Judith Wollack, CEO of Wolverine Human Services.

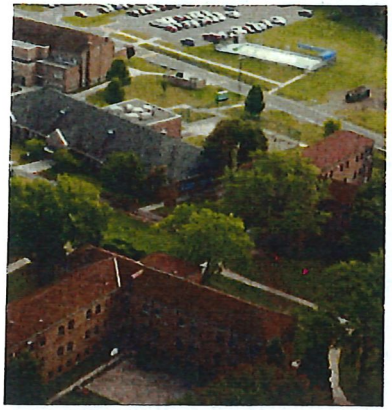
"The children we're getting into care have much more significant issues than they've had in the past" and are much more destructive, she said, pointing to incidences of children breaking windows and tearing down fire alarms and security cameras.

The issues children are dealing with "has a lot less to do with the pandemic and everything to do with the disintegration of society," said Wollack, who's worked for over 40 years with children.

"There's an increase in child abuse, domestic violence, substance abuse ... all of that filters down to children."

Many of the children need psychiatric intervention, but hospitals do not have beds to take them, she said.

Wolverine provides residential treat-



t beds at Vista Maria's Dearborn campus omes for children are seeing. | VISTA MARIA

ment and care at sites in Detroit and Vassar, just outside of Frankenmuth. It's operating at about 50-percent capacity with a total of 84 children and youth age 12-19 referred to it through the county, state or courts in its care. A large majority came through the juvenile justice system; the rest are awaiting foster placements, Wollack said.

Operating on a $14 million budget this year, down from $35 million before the pandemic, Wolverine pays caregivers at its Vassar campus $12.50 an hour. In Detroit, where the cost of living is higher and competition is steeper, it's paying $17 per hour. But the organization still hasn't seen a significant number of people applying for open positions, Wollack said.

"This is a hard job. ... Kids are spitting at you, cussing at you, threatening your life, (being) physically aggressive."

With unemployment benefits running out, Wolverine is hoping the number of employees in the market and compassionate enough to work with those kids will improve, she said.

"As a nonprofit, we can't raise our prices. We're not Walmart. (And) we can't reduce our staff."

The state has asked Wolverine to open up more emergency shelter beds for kids pulled out of their homes, "but we can't because we don't have enough staff," Wollack said.

"The state has no place to put them. We can't take them."

## Competing for employees

To compete with McDonald's, Walmart, Amazon and other employers, many care providers have raised wages to $15 or higher for entry-level caregivers. But at that rate, they are losing money for every child they treat, given that state reimbursement rates aren't covering those costs, they said. Fundraising has to make up the difference.

The state pays residential treatment providers a per diem based on the level of care a child needs. Those levels have not been increased to account for COVID costs such as PPE, cleaning and hazard pay, Aufdemberge said.

The reimbursements assume a rate of $12-$12.50 per hour, she said, far shy of the $15 or more providers are paying hourly to attract employees.

"I lose money for every child I take into care. We can't fundraise fast enough to get out of the hole," Aufdemberge said.

Vista Maria is projecting a $20 million budget this year, down from $25 million last year when it saw a $1 million loss.

Vista Maria and other providers initially refused to sign new contracts with the state in April, she said.

"The state asked us to do it in good faith and said it would make rate changes. But that has not happened yet."

The state's 2022 budget includes a $2/hour reimbursement of hazard pay for employees. But that is not a permanent increase that addresses the more difficult cases organizations are facing or ongoing COVID-related expenses, Aufdemberge said.

"It's not a fix to the problem; it's a Band-Aid."

The Michigan Health and Human Services Department "contracts with private agencies at a rate commensurate with the service array they provide," Wheaton said.

"Each agency is entitled to determine what rate they pay their staff."

He did not comment on whether there is consideration to permanently increase the rates the state pays.

## Increasing benefits

Meanwhile, Methodist Children's Home Society in Redford Township, an agency formed during the last major global pandemic over 100 years ago, has seen a less severe impact from the talent shortages, thanks to moves it made last year that helped improve retention and competitiveness.

It's been able to retain most of its staff and maintain services for 50 children on its campus, down only slightly from 55 last year.

"I think we're paying more and have stronger benefits," Roach said, pointing to a $15-per-hour minimum wage, 401(k) with a 3 percent match, increased paid time off and two additional staff holidays instituted last fall at an added cost of about $500,000 annually paid for through increased fundraising.

Methodist Children's Home also provides health, dental and vision insurance with full coverage for families, and tuition reimbursement.

The pandemic and "long-overdue reckoning on race and equity" spurred the nonprofit — named a Crain's Best-Managed Nonprofit in 2020 — to look at compensation for its employees last fall, he said.

"I recognized for our central caregiver staff, who were the essential employees, yet the lowest paid ... we had to confront that as an organization."

"The turnover of direct care staff has a direct impact on the health, safety and well-being of children in care."

*Contact: swelch@crain.com*
*(313) 446-1694; @SherriWelch*

# BEHAVIORAL HEALTH 1915(i) STATE PLAN BENEFIT
## FREQUENTLY ASKED QUESTIONS

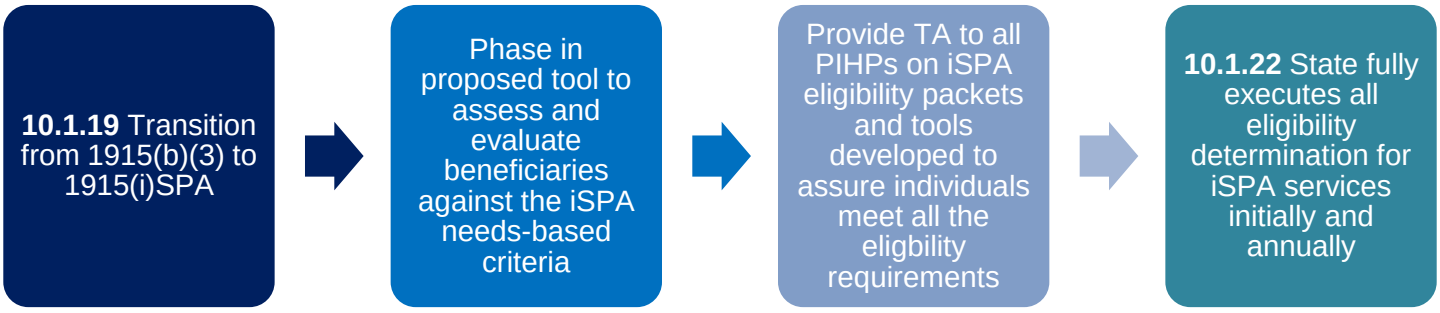
## General Information

**What is the background for the transition from (b3) waiver services to 1915(i) State Plan Amendment (SPA) services?**

Following CMS's guidance, Michigan will transition all the specialty behavioral health services and supports currently covered under 1915(b)(3) authority to a 1115 Behavioral Health Demonstration and 1915(i) HCBS state plan benefit effective October 1, 2019. Michigan developed the HCBS benefit to meet the specific needs of its behavioral health and developmental disabilities priority populations that were previously served through the Managed Specialty Services & Supports 1915(b1)(b3) waiver authorities within Federal guidelines.

The 1915(i) State Plan will operate concurrently with the 1115 Demonstration, which establishes the provision of behavioral health community-based services AND evaluation/re-evaluation of eligibility function through Michigan's managed-care contract with the regional Prepaid Inpatient Health Plans (PIHP).

**What is the timeframe for transition of eligibility determination of this benefit to the MDHHS/BHDDA ?**




**Is the expectation that the PIHP to be reviewing every (b3)/1915(i) State Plan case in order to determine eligibility effective 10/1/2019?**

The expectation of the PIHP and their networks will be to work as partners with MDHHS/BHDDA to develop systems with tools to evaluate "needs-based criteria" for the benefit in accordance with the State's approved 1115 special terms and conditions to fully transition the administrative function of eligibility evaluation back to MDHHS/BHDDA. It is recommended that prior or on 10/1/19 that all PIHPs/CMHSP's familiarize themselves with the iSPA target group, evaluation/re-evaluation of eligibility process, and the needs-based criteria that is available now on the MDHHS website.

**How can I stay up to date with the changes related to the 1915(i)SPA implementation and progress?**

MDHHS will be hold regular meetings with the identified 1915(i)SPA PIHP Leads to provide updates regarding implementation and progress. Please email all 1915(i)SPA questions to QMP-Federal-Compliance@michigan.gov, noting 1915(i)SPA in the subject line.

**Does the PIHP need to have a work plan for how they will implement establishing eligibility for the next two years?**

MDHHS has does not have pre-established PIHP expectation of a "work-plan" but will partner with PIHP's and their current systems to stand up or "phase in" the key components that will be required in evaluating eligibility of the iSPA benefit. We also recommend that you evaluate the scope of beneficiaries receiving B3 services regionally and locally, so you can start thoughtfully planning and projecting future staffing/admin resources this switch in authority may require. PIHP's should begin to evaluate/re-evaluate individuals beginning 10/1/19 based upon the needs-based criteria in preparation for meeting CMS milestones for process change.

## Coverage

**What services are covered under this benefit?**

The 1915(i)SPA benefit includes Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support & Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment & Supplies (formerly known as Assistive Technology), Supported/Integrated Employment, and Vehicle Modification (formerly known as Assistive Technology). The 1915(i)SPA benefit does not include Goods and Services.

**Do children under 21 need to be enroll in the 1915(i)SPA benefit?**

Children under 21 would need to be evaluated and enroll in the benefit if there is an assessed need for respite services. The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services, or EPSDT. EPSDT provides a comprehensive array of services for children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

**What services that were provided through the 1915(b3) waiver authority are not included under the 1915(i) benefit?**

No services have been eliminated, but some services were moved to the State Plan or EPDST authority instead of being included in the 1915(i) benefit. One service labeled as Assistive Technology remains, but the State was instructed to separate the large definition into two separate services, that contain the same coverage, services, and providers.

**Where will Prevention-Direct services be covered now?**

These services will be covered under EPSDT for children up to age 21. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

## Eligibility

**Will there be a limit on the number of individuals eligible for the 1915(i)SPA benefit?**

The 1915(i) SPA benefit does not have a cap to the number of eligible beneficiaries it enrolls.

**What will the eligibility criteria for the 1915(i) benefit?**

The 1915(i)SPA target groups include individual beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability.

To be eligible for 1915(i) services, an individual must meet the following needs-based criteria:

A. Have a substantial functional limitation in 1 or more of the following areas of major life activity:
    1. Self-care
    2. Communication
    3. Learning
    4. Mobility
    5. Self-direction
    6. Capacity for independent living
    7. Economic self-sufficiency; and
B. Without 1915(i) services the beneficiary is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity or community inclusion and participation.

**In the 1915(i)SPA benefit, who is responsible for the individual face-to-face assessments to determine eligibility?**

The PIHP provider network will perform the face-to face assessments. The PIHP's network will conduct assessments that identifies the beneficiary meets all the eligibility requirements for 1915(i) benefit. This network will assist in identifying level of need, administer assessments related to the individual's functional abilities and identify services and supports required to reach the expected outcomes of community inclusion and participation.

**In the webinar I heard you say that establishing eligibility could not be delegated, however we currently delegate this function. Does that need to change effective 10/1/19?**

In a 1915(i) State plan authority the State Medicaid Agency (SMA)/MDHHS cannot delegate the responsibility for performing evaluations/reevaluations of eligibility for the benefit to the PIHP's and must retain this line of authority. This differs from how service eligibility is determined currently under the 1915(b)(b3) authority. If you currently delegate this authority that does not need to change immediately, but again PIHP and their network will want to start looking at your system and start to phase in new expectations in preparation of looking at this eligibility requirement for the (i)SPA benefit, so you and the network are ready to fully execute the responsibility in accordance with our 1115 STC's milestones that bestows authority for a three year period, for the process change to come into compliance with the eligibility determination requirements for the Medicaid 1915(i) HCBS state plan benefit, which will sunset effective 10/1/22.

**Annual eligibility determination for (b)(3) waiver services (now 1915(i)SPA services) is a significant change. What will this look like from the PIHPs to MDHHS/BHDDA?**

The process for annual eligibility determination will be similar to the current HSW/SEDW/ABA WSA eligibility, certifications, recertifications, re-evaluations, etc.

We also recommend that you evaluate the scope of beneficiaries receiving B3 services regionally and locally, so you can start thoughtfully planning and projecting future staffing/admin resources this switch in authority may require. You should begin to evaluate/re-evaluate individuals beginning 10/1/19 based upon the needs-based criteria in preparation for meeting CMS milestones for process change.

**Does the 1915(i)SPA benefit eligibility need to be determined for each individual service covered under the benefit?**

Each beneficiary's eligibility is evaluated annually to determine they meet the needs-based criteria for the 1915(i) benefit**,** which includes an array of services. Each individual service within the benefit will be based on the unique needs of the beneficiary in order to achieve their individual goals of independence, recovery, productivity or community inclusion and participation

**Who is responsible for conducting the 1915(i) benefit independent evaluation of eligibility?**

Currently, Michigan authorizes a managed care arrangement with the PIHP. This arrangement allows the PIHP network to perform eligibility evaluations and determinations for beneficiaries receiving 1915(b)(3) services. Following CMS's guidance, Michigan will transition all of the specialty behavioral health services and supports currently covered under 1915(b)(3) authority to a 1115 Demonstration and 1915(i) HCBS state plan benefit effective October 1, 2019. Michigan's PIHP will not be able to function in the same manner under this new authority due to not being a "separate agency of the state" nor will the state have sufficient time to move this currently delegated function back to the administration of the state agency.

CMS has granted MDHHS/BHDDA time for process change through established milestones to complete all evaluations and re-evaluations of beneficiaries enrolled in and/or seeking 1915(i) HCBS state plan service benefits by October 1, 2022. At that time MDHHS/BHDDA will determine 1915(i)SPA eligibility and the PIHP provider network will be responsible for perform face-to-face assessments, compile required documentation, and submit findings to the MDHHS/BHDDA. The MDHHS/BHDDA will make the determination of needs-based criteria through an independent evaluation and re-evaluation.

**On or before 10/1/22 how will the PIHP be notified by MDHHS/BHDDA once eligibility has been determined for the 1915(i)SPA benefit?**

Once the WSA application is functional for the 1915(i), the PIHP will receive notification electronically through the WSA. This is similar to the current notification process for HSW/SEDW/ABA WSA applications.

It is recommended that prior or on 10/1/19 that all PIHPs/CMHSP's familiarize themselves with the 1915(i) HCBS state plan service benefit's target group, evaluation/re-evaluation eligibility process, and the needs-based criteria that is available now to the public on MDHHS's website. MDHHS will be pulling together additional resources with key information and tools, so the PIHP network can start to focus on the eligibility evaluation process with clear expectations of what will be required by MDHHS in

the form of data, evidence, and documentation in order to make annual needs-based eligibility determination for the 1915(i) HCBS state plan service benefit.

## Provider Qualifications

**What are the qualifications needed for Qualified Intellectual Disability Professional (QIDP)/Qualified Mental Health Professional (QMHP) providers under the 1915(i) benefit?**

Effective 10/1/19 the definition of a QIDP and QMHP are as follows:

**QIDP**: Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) **OR** one year experience in treating or working with a person who has intellectual disability; **AND** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, **OR** a human services professional with at least a bachelor's degree or higher in a human services field.

**QMHP**: Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) **OR** one year experience in treating or working with a person who has mental illness; **AND** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant **OR** a human services professional with at least a bachelor's degree or higher

# Michigan Psychiatric Care Improvement Project (MPCIP)

October 2021 Update

## Overview

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

**Two Part Crisis System**

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

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

**Opportunities for improvement**

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

## MI-SMART (MEDICAL CLEARANCE PROTOCOL)

### Overview

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

### Current Activities:

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- Two free MiSMART trainings with CMEs were held in July with good turnout.
- CSUs will be required to accept the MiSMART form from EDs as proof of medical clearance as part of certification.
- As of 10/14/21: Adopted/Accepted by: 30 Emergency Departments, 14 Psychiatric Hospitals, 13 CMHSPs. 19 more facilities are in the process of implementing.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption

### Michigan Crisis and Access Line (MiCAL)

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

### CALL SIDE

### Overview

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

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

### Current Activities

- MiCAL Pilot is active in Upper Peninsula and Oakland County on April 19th.
- Warmline is active statewide.
- First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development.
- MiCAL and the Michigan Warmline staff have had over 21,000 encounters since April 19th (MiCAL go live); mostly calls. Over half the encounters have been on the Warmline.
- Pilot is focused on streamlining and routinizing care coordination process with CMHSPs and ensuring that CRM technology supports these processes.
- MiCAL Rollout: MiCAL will rollout statewide in two phases.
    - Phase 1 FY 22: MiCAL will rollout statewide one to two PIHP regions at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time.
    - Phase 2 FY 23: CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout will occur one PIHP at a time.
- In early December, PIHPs, CMHSPs will be asked to provide BHDDA access and crisis services information in the CRM. This will be used for crisis services planning and in preparation for MiCAL referrals. We will host a couple of trainings which will cover the requirements and talk about 988 coordination requirements.

## BHDDA Customer Relationship Management (CRM) – Internal Business Processes

### Overview

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

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

### Current Activities

- Universal Credentialing (PA 282 of 2020): BHDDA is taking an in-depth look at the legislation and related business processes so we can ensure that the Universal Credentialing meets the requirements of the legislation and other process such as PIHP credentialing without having our partners enter the same information multiple times. They are designing a requirements cross walk which will be shared with stakeholders. BHDDA has already sent out an email soliciting participation from stakeholders and received a great response.
- Customer Service Inquiry and Contract Management Processes are rolled out statewide.
- ASAM Level of Care Certification Development is occurring now and will is estimated to be ready for rollout in December 2021.
- CMHSP Certification: Design work is still being done on this process. We are also working on rollout plans which will likely be a gradual rollout. Please stay tuned.

## 988 COALITION

### Overview

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

### Current Activities

- Michigan's Draft Plan has two phases based on implementation time frames. Phase 1 focuses primarily on ensuring adequate call coverage statewide. Phase 2 will focus on metrics, operations requirements, and marketing. Note: Vibrant is still developing requirements so they suggested the "Phase" planning approach.
- Stakeholders have provided feedback throughout the planning process. Workgroup meetings have focused on topics such as vision, follow up care, and resources. Upcoming topics are metrics, communications, and funding.
- Official 988 Draft Plan was approved by the Workgroup and BHDDA Leadership and has been submitted to Vibrant and SAMHSA for their review. We expect feedback from them in November which we will incorporate into the final plan.
- We are starting implementation. We have scheduled meetings with existing NSPL centers to standardize processes as much as possible.

- We are also developing an email list to keep Workgroup members up to date and to solicit their help as needed on topics such as marketing.

## PSYCHIATRIC BED TREATMENT REGISTRY

### Overview

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

### Current Activities

- LARA is rolling out MiCARE regionally with a statewide completion date by early 2022.
- LARA is in the process of rolling out MiCARE statewide to all the psychiatric hospitals which was strongly supported by Workgroup members at the August meeting.
- The Psychiatric Bed Advisory Workgroup will meet on Friday, October 22nd to support rollout and to focus on streamlining the referral process.

## CRISIS STABILIZATION UNITS

### Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
- MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders.
- Timing: Current to December 2021

### Current Activities

- MDHHS is contracting with PSC/HMA to help develop a Michigan model and certification process.
- There will be a model for both children and adults. The adult model should be complete 12-1-2021.
- PSC is facilitating twice monthly stakeholder groups with the initial focus on setting high level standards, determining capacity needs, and a thorough assessment of existing CSU like facilities in Michigan.
- Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.

- The most recent workgroup focused on CSU services for children. A sub workgroup will meet to develop a family driven, youth guided CSU model.
- The Michigan model needs to work effectively in all regions. An initial listening session with rural CMHSPs was held to start work on developing a rural model for CSUs. More meetings will be held.
- PSC is also doing extensive research on best practices in other states as well as in Michigan. They have interviewed several other states.
- PSC is looking at available statewide data to help determine capacity needs.

## MOBILE CRISIS SERVICES

### Overview

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

Target Date: Spring 2022

### Current Activities

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

## SMI/SED 1115 WAIVER APPLICATION

### Current Activities

- MDHHS has determined that there is no need to pursue a SMI/SED 1115 Waiver for crisis services at this point in time as the current priorities can be accomplished through other means. MDHHS might pursue a waiver in the future if needs arise.

## QUESTIONS OR COMMENTS?

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

# Michigan Integration Efforts

October 2021 Update

## Overview

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

**Goals**

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

**Opportunities for Improvement**

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

## Behavioral Health Homes (BHH)

### Overview

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

### Current Activities:

- As of October 5, 2021, there are 881 people enrolled:
    - Age range: 7-84 years old
    - Race: 21% African American, 73% Caucasian, 1% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- Regions are continuing to enroll eligible beneficiaries and working to expand health home partners to increase capacity to serve more beneficiaries.

### Questions or Comments


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

## Certified Community Behavioral Health Clinics (CCBHC)

### Overview

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

### Current Activities

- The CCBHC Demonstration started on October 1, 2021!
- CCBHC's are working on their certification application in the BHDDA CRM and MDHHS staff are beginning to review the applications. Ten CCBHCs were provisionally certified on October 1, 2021 as the rest continue to submit the required documentation.
- The final CCBHC policy (MSA 21-34) was distributed on September 1, 2021.
- The operational companion to the policy, the CCBHC Demonstration Handbook, has been developed and was distributed to PIHPs and CCBHCs.
- All technological systems met October 1st start date.
- The PPS rates have been finalized and sent to CMS for approval. They were also shared with PIHPs and CCBHCs.
- BHDDA staff hosted a CCBHC kickoff on September 20 and 21, 2021. The National Council for Mental Wellbeing kicked off the event with an overview of the national landscape of CCBHCs. The rest of the training focused on program requirements, CCBHC and PIHP roles and responsibilities, payment, and DCO arrangements. 176 participants attended each day of the event.
- We will be scheduling technical assistance calls with the PIHPs and CCBHCs in October to discuss implementation challenges and successes and provide technical assistance.
- Final rates and implementation procedures have been submitted to CMS for approval. The Implementation Team has been engaging in ongoing technical assistance with CMS.
- An MDHHS marketing request has been submitted to begin a public marketing campaign. Marketing is intended to increase awareness of the CCBHC model, eligibility, and services among the public and other community providers. Marketing will target the eighteen counties with demonstration sites.

### Questions or Comments

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

## Opioid Health Homes (OHH)

### Overview

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

### Current Activities

- As of October 5, 2021, 1,616 beneficiaries are enrolled in OHH services.
- MDHHS has recently expanded OHH services to an additional nine counties within PIHP region 6, 7, and 10.
- MDHHS is working on collaborating with many state agencies such as the Maternal and Infant Health division to ensure OHH beneficiaries have wraparound support services through their recovery journey.

### Questions or Comments

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

## Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

### Overview

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

- Shiawassee County: Shiawassee County Community Mental Health and Great Lakes Bay Health Centers to increase primary care

## Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.
- Providers are starting to deliver more in person appointments to enrollees, but telehealth is still offered and preferred by some patients.
- CMH's and FQHC's are partnering to provide COVID-19 vaccination clinics to CMH recipients.
- Analysis of the FY21 Integration Self-Assessment has been completed for all grantees. Results show that grantees are increasing levels of integration when compared to the FY20 Integration Self-Assessment.

## Questions or Comments

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

October 11, 2021

Senate Majority Leader Shirkey & Members of the Senate Government Operations Committee,

We are writing to express opposition and concern to SB 597 – 598, the recent legislative proposal that would dramatically change the public mental system in Michigan. These bills would privatize the system and threaten to eliminate key components of care at the local community level.

Thousands of families across the State of Michigan depend on the public mental health system for affordable, accessible care. The changes being suggested at the legislative level do very little to improve care and access for people with a mental illness or addiction. The proposal focuses solely on the administrative / managed care level, not the direct service level, and the suggested changes could in fact hurt individuals receiving the care they need at a time when so many across our state are struggling, vulnerable and in need of support.

Our organizations want to express our support for Michigan's public mental health system and its strong local collaboration and problem-solving approach. Local law enforcement, judiciary, and prosecutors across Michigan have been in partnership with the Community Mental Health centers (CMHSPs and PIHPs) in their communities for years. Those partnerships include:

- CIT and other crisis response training for law enforcement personnel
- Wide range of jail diversion efforts (along the full intercept continuum from first encounter with law enforcement through re-entry into the community after incarceration)
- In-jail mental health and substance use disorder treatment
- Crisis response partnerships in which local law enforcement and CMHs work together to address mental health crises
- Mental health and substance use disorder/recovery courts

Community stakeholders have come together to form partnerships to promote care in the community and divert persons with serious mental illness from the criminal justice system. The civil justice system is being modified to provide for court-ordered outpatient treatment to help persons with serious mental illness recover. Commonly known as Assisted Outpatient Treatment or AOT, this system of care reduces homelessness, criminal justice involvement and hospitalization while promoting recovery.

Because the consequences of untreated mental illness have consequences across the criminal and civil justice system as well as education and child protection, managing the problem requires community partnerships and the most important partner is the system that delivers mental health care. **Law enforcement, prosecutors, judges, child protection services, hospitals, emergency rooms, crisis**

**centers and healthcare providers and others have to come together to implement the sequential intercept model. <u>The private sector can be a partner in this endeavor. It cannot be the owner. This would destroy the partnerships that the public sector has created to provide a system of community treatment.</u>**

**Court-ordered outpatient treatment can be the community-based system of care promised by the supporters of closing mental hospitals. Currently, courts can order the public community mental health system to provide that care. Courts have no authority to order the private sector to provide that care or pay for that care. While, the private sector can be an important partner in providing care in the community control of the system of payment is critical to assuring that that care will actually occur.**

The benefits of these community partnerships are just now being realized. Reforms to the Mental Health Code over the last four years have opened the door to an improved system of community treatment. We are finally, after nearly 50 years, seeing the emergence of a system of community care. We urge policy makers to give the system a chance to grow by encouraging additional collaboration to focus on integrating care at the level of the person being served, increasing access to the system, and focusing on prevention and diversion. Now is not the time to make drastic, unproven changes to the system.

Sincerely,

Stephan Currie
Executive Director, Michigan Assoc. of Counties

Matthew M. Saxton FBINA #230
Executive Director, Michigan Sheriffs' Assoc.

*Martha Anderson*

Hon. Martha Anderson
President, Michigan Judges Assoc.

*Merissa Kovach*

Merissa Kovach
American Civil Liberties Union of Michigan

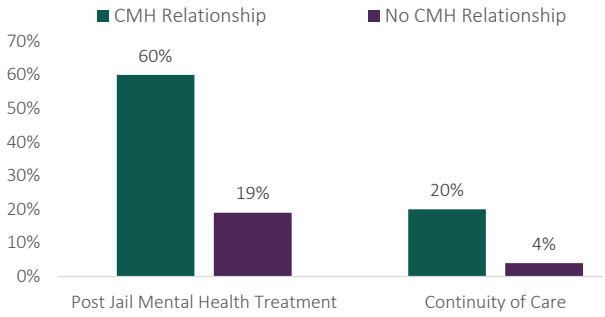
Thom Lattig
President, MI Assoc for Family Court Adminstration

CC; Governor Whitmer & the Michigan Senate

# The Impact of Community Mental Health (CMH) on Michigan's Jails

Since 2015, the Center for Behavioral Health and Justice (CBHJ) has evaluated programs and practices for individuals with serious mental illness (SMI) in 26 Michigan jails. Using interviews and data from county- and state-level databases, and across multiple evaluation projects, the following results show that CMHs have significant and positive impacts on individuals with SMI who have been in jail.

## The Impact of Community Mental Health (CMH) on Michigan's Jails




In 2019, 3,797 individuals were screened for SMI at jail booking. Thirty-six percent screened positive for SMI. Of those with SMI, 53% had a CMH relationship in the prior year1. Individuals with a CMH relationship were:

- Significantly more likely to engage with mental health treatment after jail release (60%) compared to those with no CMH relationship (19%).
- More likely to receive care within two weeks of jail release (20%) compared to those with no CMH relationship (4%) - this two week period holds higher risk period for suicide and overdose[2].

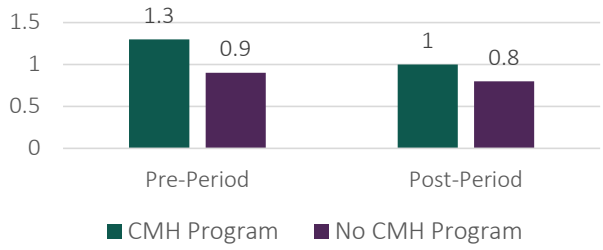
## Impact of CMH on Recidivism

In 2019, 135 individuals with SMI participated in a CMH jail diversion program. Their outcomes were compared to others with SMI in jail[2].

Though those who participated in the diversion program were higher risk, there was a significant decrease in the number of jail stays in the year after the CMH program (1.0) compared to the year before (1.3). The number of jail stays did significantly decrease for those with SMI who did not participate in a CMH diversion program.

CMH jail providers are more likely to provide mental health services (73%), than non-CMH providers (40%).[4]

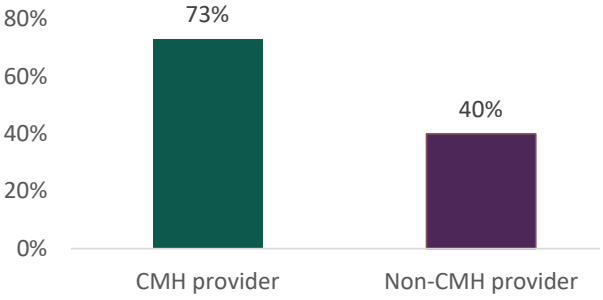
*Average Number of Jail Stays*




## CMH Effectively Serves Individuals in Jails

- CMH plays a key role in serving individuals with SMI in Michigan's jails by increasing treatment engagement and reducing recidivism.
- CMH provides in-reach and post-jail follow-up services unlike private mental health providers.
- Current House (H.B. 4925-4929) and Senate (S.B. 597-598) bills would restructure or remove CMH for behavioral healthcare at the community level. This would lead to poor outcomes for this population and create a void on local, collaborative boards seeking to problem-solve and improve deflection and diversion efforts.

*Jail-Based Services Provided*




The Center for Behavioral Health envisions communities in which research, data, and best practices are used by multiple stakeholders to enhance the optimal well-being of individuals with mental illness and/or substance use disorders who come in contact with the criminal/legal system.

[1]Found in Medicaid Encounter Data, Michigan Department of Health and Human Services; [2] Lim, et al, (2012). Risks of Drug-Related Death, Suicide, and Homicide During the Immediate Post-Release Period Among People Released From New York City Jails, 2001–2005, American Journal of Epidemiology, 175(6), 519-526; [3]County Jail Data; [4]Comartin, et al (2021). Comparing For-Profit and Nonprofit Mental Health Services in County Jails. The Journal of Behavioral Health Services & Research, 48(2), 320-329.

# SB 597 & 598: The Wrong Step At The Wrong Time

# Dangerous, Costly & Bad for Michigan

We MUST broaden the conversation beyond Medicaid. Mental illness and addiction impact millions of individuals and families across the state of Michigan regardless of their insurance.

Solutions MUST be BROAD BASED, get at the root cause and address the areas of greatest need – **increasing overall access to care, adding providers and strengthening the workforce, and increasing inpatient care.**

Don't be fooled: SBs 597 & 598 are a shell game, just shifting who pays the bills for a small fraction of people in the Medicaid program.

## The DO & DON'Ts ABOUT SBs 597 & 598

### THE DOs

- SBs 597 & 598 DO increase costs by doubling the administrative overhead costing taxpayers over $300 million more. [1]
- SBs 597 & 598 DO eliminate local control, local decision making by the CMH and give it to for-profit insurance companies who are only accountable to non-elected bureaucrats in Lansing via contracts.
- SBs 597 & 598 DO turn over control to for profit insurance companies that had record profits in 2020 – over $550 million. [2]
- SBs 597 & 598 DO give control to for profit insurance companies that have no experience in serving persons with complex mental health needs and poor track record on mild to moderate mental health services – lack of date & outcomes. [3]

### THE DO NOTs

- SBs 597 & 598 DO NOT increase access to care
- SBs 597 & 598 DO NOT Increase providers or address workforce shortages
- SBs 597 & 598 DO NOT address the lack of sufficient inpatient care
- SBs 597 & 598 DO NOT address or integrate care, they only integrate funding
- SBs 579 & 598 DO NOT improve or guarantee better outcomes

## JOIN THE FOLLOWING GROUPS IN OPPOSING SBs 597 & 598

Michigan Probate Judges Association

The Arc Michigan

Michigan Judges Association

Michigan Association for Family Court Administration

NAMI Michigan
National Alliance on Mental Illness

MAC
Michigan Association of Counties

CMHA
Community Mental Health Association of Michigan

1. FY19 Medicaid Utilization Net Cost (MUNC) report & https://www.milliman.com/-/media/milliman/pdfs/2021-articles/7-7-21-medicaid_managed_care_financial_results.ashx
2. https://www.crainsdetroit.com/health-care/michigan-health-plans-post-rosy-profits-first-half-2020-blues-cross-income-lower-2019
3. Altarum_Behavioral-Health-Access_Final-Report.pdf

# JOIN THE FOLLOWING GROUPS IN OPPOSING SBs 597 & 598

**Disability and other Consumer Advocate Groups**
- The Arc Michigan
- Association for Children's Mental Health
- Michigan Developmental Disabilities Council
- Michigan Developmental Disabilities Institute
- Michigan Disability Rights Coalition
- Michigan United Cerebral Palsy
- National Alliance on Mental Illness

**Health Care Professional Organizations**
- National Association of Social Workers Michigan Chapter

**Human Rights Organizations**
- American Civil Liberties Union

**Judiciary**
- Michigan Association for Family Court Administration
- Michigan Judges Association
- Michigan Probate Judges Association

**Labor**
- American Federation of Labor and Congress of Industrial Organizations
- American Federation of State, County, and
- Municipal Employees
- Michigan Corrections Organization
- Service Employees International Union

**Law Enforcement**
- Michigan Sheriffs' Association

**Local Government Leaders**
- Clinton County Board of Commissioners
- Eaton County Board of Commissioners
- Gratiot County Board of Commissioners
- Kalamazoo County Board of Commissioners
- Mason County Board of Commissioners
- Michigan Association of Counties
- Upper Peninsula Association of County Commissioners
- Wayne County Commission

**Mental Health Services Administrators and Providers**
- Allegan County Community Mental Health Services
- AuSable Valley Community Mental Health Authority
- Barry County Community Mental Health Authority
- Bay-Arenac Behavioral Health Authority
- Berrien Mental Health Authority
- Centra Wellness Network
- Community Living Services, Inc.
- Community Mental Health Authority of Clinton-Eaton-Ingham Counties
- Community Mental Health for Central Michigan
- Community Mental Health of Ottawa County
- Community Mental Health Partnership of Southeast Michigan
- Community Mental Health & Substance Abuse Services of St. Joseph County
- Copper Country Community Mental Health Services
- Detroit Wayne Integrated Health Network
- Freedom Work Opportunities of Genesee County, Inc (FWOGC)
- Genesee Health System
- Gogebic Community Mental Health Authority
- Gratiot Integrated Health Network
- HealthWest
- Hiawatha Behavioral Health
- Huron Behavioral Health
- Integrated Services of Kalamazoo
- Lakeshore Regional Entity
- Lapeer County Community Mental Health Services
- Lenawee Community Mental Health Authority
- LifeWays Community Mental Health
- Livingston County Community Mental Health Authority
- Macomb County Community Mental Health Services
- Mid-State Health Network
- Monroe Community Mental Health Authority
- Montcalm Care Network
- Network180
- Newago County Mental Health Center
- NorthCare Network
- North Country Community Mental Health Authority
- Northeast Michigan Community Mental Health Authority
- Northern Lakes Community Mental Health Authority
- Northern Michigan Regional Entity
- Northpointe Behavioral Healthcare Systems
- Oakland Community Health Network
- Pathways Community Mental Health
- Pines Behavioral Health Services
- Region 10 PIHP
- Saginaw County Community Mental Health Authority
- Sanilac County Community Mental Health
- Shiawassee Health & Wellness
- Southwest Michigan Behavioral Health
- St. Clair County Community Mental Health Services
- Summit Point
- Ten16 Recovery Network
- The Right Door for Hope, Recovery and Wellness
- Training & Treatment Innovations
- Tuscola Behavioral Health Systems
- VanBuren Community Mental Health Authority
- Washtenaw County Community Mental Health
- West Michigan Community Mental Health System
- Woodlands Behavioral Healthcare Network

**Statewide and Regional Services Administrators and Providers**
- Community Mental Health Association of Michigan

Medicaid Reform

# MYTH vs. FACT

| THEY SAY... | TRUTH IS... |
|---|---|
| Health plans "run from risk." | **JUST THE OPPOSITE.** Health Plans will assume all risk required to treat/serve all enrollees, for all the care they need. |
| Health plans will deny access to providers and will not have enough providers to offer services. | **NOT TRUE.** Health plans will be required to contract with all Community Mental Health Service Providers (CMHSPs) and prove adequate numbers of providers in every region they operate. Health plans will offer consumers more choices and expanded networks of providers both within and outside their county of residence. |
| Consumers will lose appeal rights. | **FALSE.** Consumers will have expanded appellate rights for grievances and disputes through third party entities. |
| Health plans cannot serve populations needing behavioral services. | **YES, THEY CAN AND DO.** Health plans have proven they can meet the needs of unique populations and provide services under programs such as:<br>• Services for Disabled<br>• Children's Special Health Care Services<br>• Foster Care<br>• MI Health Link (Medicaid & Medicare Dual Eligible Demonstration)<br>• Special Needs Plans for Seniors |
| No further savings are possible. | **WE DISAGREE.** Health plans have already saved the state of Michigan millions by focusing on performance-based patient outcomes in the populations they serve. The state can use those savings to reinvest in additional behavioral supports. |
| For-profit Health Plan will profiteer off our most vulnerable populations. | **WRONG:** Health plans are non-profit and for-profits entities that are subject contractual rates set by the state each year and all costs are subject to state oversight and policing. |



mahp
Michigan Association of Health Plans

# Medicaid Reform: What Opponents of SB 597 & 598 **Say** and What They Really **Mean** are Two Different Things

Integrating physical and behavioral healthcare services in Medicaid has been discussed for over three decades. Attempts by some opposition groups to silence this discussion, divert attention, and throw arrows at meaningful reform is like listening to a broken record. What they **say** and what they really **mean** are two completely different things.

What they SAY: *"SB 597 & 598 is a money grab by health plans"*

What they MEAN: "Health plans can provide more services than we do today for a better price."

- **FACT:** Michigan health plans will be contractually required to provide all the services now provided by PIHPs at the same or higher levels of quality for a better price. And if they don't, they will take the risk of losses.

- **FACT:** Nine out of Michigan's 10 Prepaid Inpatient Health Plans (PIHPs) that oversee mental health services had structural deficits of nearly $93 million in 2018. These regional PIHPs are another administrative layer of the state – they're unlicensed public insurance and care entities created by statute over a decade ago.

- **FACT:** Today's ten PHIPs and the 46 CMHs don't compete to provide behavioral health services. They are direct recipients of state and federal dollars.

- **FACT:** PHIPs have received legislatively appropriated financial bailouts while Medicaid health plans bear all the financial risk under competitively-bid contracts with MDHHS.

- **FACT:** Because PHIPs and CMHs don't have performance-based contacts, they don't have to report administrative costs. Health plans have performance-based contracts, and they publicly report detailed metrics, including administrative costs.

- **FACT:** Managed care health plans have saved the state hundreds of millions of dollars by providing more efficient care and early care that reduces expensive procedures that come when care is ignored. Each plan has a contract with the state that limits profits.

- **FACT:** Health plans have administrative rates below typical government programs and their profits – which average under 3% – are subject to state review and oversight. There is no "21%" administrative costs taken by Medicaid health plans. Plans also pay taxes on their 3 percent margins.

What they SAY: *"Integration isn't working in other states"*

What they MEAN: *"Integration may be providing more and better services to patients in other states, but PIHP bureaucrats don't want to risk losing their jobs."*

- **FACT:** 33 states have already or are starting to integrate care for Medicaid consumers and satisfaction rates have increased.

- **FACT:** Arizona integrated care nearly a decade ago. An evaluation found improvement in all measures of patient experience, ambulatory care, preventive care, and chronic disease management.

- **FACT:** Washington integrated care in 2015. An evaluation of integration efforts for adult populations and found statistically significant improvement in 10 out of 19 enrollee outcomes in 2016 and 11 out of 19 enrollee outcomes in 2017, including access to preventive/ambulatory health services, SUD treatment penetration, and mental health treatment penetration.

What they SAY: *"These bills don't integrate care – they only integrate funding"*

What they MEAN: *"We want the status quo"*

- **FACT:** Page 21, Section 109F, Subsection (3) of SB 597 says "By June 1, 2022, the department shall develop and begin implementation of a plan to fully integrate the administration of physical health care services and behavioral health specialty services and supports for eligible Medicaid beneficiaries"

- **FACT:** Under the bills, DHHS sets the terms and conditions for providing integrated care, not the health plans, PIHPs or CMHs.

- **FACT:** The Substance Abuse and Mental Health Services Administration (SAMSHA) defines the highest level of integrated care as one that has integrated systems and collaborative communications at the system, team and individual level which is exactly what this legislation provides for.

What they SAY: *"The legislation will remove government oversight"*

What they MEAN: *"We want the system to remain siloed."*

- **FACT:** The 46 CMH boards across the state are not going away – the bills require the best plans (managed care or PHIPs) selected by DHHS through a competitive contract process to contract with each CMH to deliver behavioral health services for consumers. (Page 22, Section 109f, Subsection 4(b) of SB 597)

- **FACT:** The legislation expressly permits DHHS (a.k.a. government) to issue contracts setting the terms and conditions for specialty integrated plan contacts.

- **FACT:** The legislation provides a gradual phased-in approach to integrated care by populations allowing the Legislature and DHHS to monitor results and make recommendations to for continuation, delay, or modification. (Page 26, Section 109f, Subsection (8) of SB 597).

- **FACT**: Newly created Specialty Integrated Plans (SIPs) would be regulated by CMS (federal), MDHHS and DIFS (state) clearly ensuring that SIPs are accountable to the public.

- **FACT:** Medicaid health plans are required to have at least a third of its governing body be representatives of its membership. Plans must also have a Consumer Advisory Council that reports to its governing body.

What they SAY: *"Health plans can't provide behavior health care services"*

What they MEAN: *"We don't want you to know that health plans already oversee behavioral care to virtually all persons with employer-sponsored health plans, as well as mild to moderate mental health services to Medicaid patients."*

- **FACT:** Health plans provide behavioral healthcare services to millions of Michiganders right now in the commercial market.

- **FACT:** Health plans already deliver mild to moderate behavioral healthcare services to Medicaid patients.

- **FACT:** Old data is being provided by PIHPs from a period when Medicaid health plans were required to provide a set number of outpatient mild-to-moderate health care visits. Today, DHHS contracts requires plans to provide unlimited mild-to-moderate visits with no authorization requirements.

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**NORTHERN MICHIGAN REGIONAL ENTITY**
**FINANCE COMMITTEE MEETING**
**10:00AM – OCTOBER 13, 2021**
**VIA TEAMS**

| | |
|---|---|
| **ATTENDEES:** | **Connie Cadarette, Lauri Fischer, Kevin Hartley, Chip Johnston, Eric Kurtz, Donna Nieman, Larry Patterson, Brandon Rhue, Amy Rottman, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek** |

REVIEW AGENDA & ADDITIONS
FY22 DCW and Local Match were added to the meeting agenda.

APPROVE PRIOR MEETING MINUTES
The September minutes were included in the materials packet for the meeting.

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

MONTHLY FINANCIALS
**August 2021**

- Traditional Medicaid showed $187,025,444 in revenue, and $161,484,230 in expenses, resulting in a net surplus of $25,541,214. Medicaid ISF was reported as $7,738,320 based on the unaudited final FSR. Medicaid Savings was reported as $4,515,675.
- Healthy Michigan Plan showed $28,929,794 in revenue, and $23,511,665 in expenses, resulting in a net surplus of $5,418,129. HMP ISF was reported as $7,058,552 based on the unaudited Final FSR. HMP savings was reported as $0.
- Net Position* showed net surplus Medicaid and HMP of $30,959,343. Medicaid carry forward was reported as $4,515,675. The total Medicaid and HMP Current Year Surplus was reported as $29,128,018. Medicaid and HMP combined ISF was reported as $14,796,872; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $43,924,890.
- Health Home showed $473,786 in revenue, and $418,739 in expenses, resulting in a net surplus of $55,047.
- SUD showed all funding source revenue of $19,357,458, and $17,454,194 in expenses, resulting in a net surplus of $1,903,264. Total PA2 funds were reported as $6,339,469.

Deanna reported the potential lapse as of August 31, 2021 as $19M. Unspent DCW was stated as $6,347,000. Deanna clarified that health home surplus in FY20 was used to fund potential future deficits. A third PA2 payment is expected for FY21 in December. In July 2021, the NMRE Board recommended that a balance equivalent to one year's liquor tax receipts be maintained for each county.

**MOTION BY CONNIE CADARETTE TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR AUGUST 2021; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.**

NON-RECURRING BENEFIT STABILIZATION EXPENSES

Given FY22 projections, Eric is pushing for budget stabilization plans early in the year to make the greatest impact. Operations Committee was unsure how to spend the full amount of anticipated excess funds, though it did place priority on crisis treatment and residential services. Chip noted that West Michigan CMH has expressed interest in utilizing a crisis unit housed in the NMRE region. Eric added that Region 1 would likely use it too, depending on the location.

EDIT UPDATE

The next EDIT meeting is scheduled for October 21st; Donna shared the meeting agenda with the group. Donna noted a meeting was held with the State about MLR calculations and delegated functions; negotiations continue.

New codes/modifiers rolled out October 1st. Lauri reported that the greatest struggle has been with the H0031 code change. Donna explained that when the LOCUS is administered during the Assessment, the 90791 code is used for the Assessment portion and H0031HN/HO is used for the LOCUS portion (both encounter codes).

Lauri asked about Edit Agenda items, "Update on development of tiered rate for inpatient psychiatric services" and "Update on status of tiered rate for licensed residential services." Eric commented that he doesn't think either has been completed, though workgroups have been formed. Access to psychiatric units was identified as the bigger issue. Barriers to establishing residential tiered rates were discussed.

FY22 CODE & MODIFIER CHANGES

This item was discussed under the previous topic.

EQI UPDATE

The decision was made in September to run the data pull on October 14th. The CMHSPs' reports are due to the NMRE on October 21st so that the NMRE can submit the full report to the Department by the November 5th due date. Clarification was made that no costing is required (unit-based only) for October 1, 2020 – May 31, 2021. For the last report, Tricia noted variances in the direct run vs. contracted services with two of the Boards (Centra Wellness for S5199 and T1999 and Northeast Michigan for 90832, 90834, 90837, 90847, 97803, and H0031); according to Brandon, the issue has to do with the use of NPI numbers.

Brandon explained that NPI numbers are taken from the 837 payments files; that is now the State determines who provided the service. If the CMH's organizational NPI number is used, the State sees that as a direct run service. The variance is occurring when PCE brings in billings from third-party providers and is changes the NPI numbers in the 837 files. Brandon forwarded an email sent from Kathy Haines in February 2021 to the Committee and suggested the CFOs discuss the matter with their internal IT departments. Eric emphasized that providers who directly enter services into the CMHSP's EHR will likely show with the CMHSP's organizational NPI, otherwise the NPI is identified in the 837; in some cases, PCE systems at the CMHSP-level have been flipping those to the CMHSP's NPI. In order for this to be corrected in the eyes of the State, the CMHSPs would have to make the changes in their systems and generate correction billings to send to the NMRE; NMRE would need to accept them and submit them to the State. This will mainly be an issue for the year-end submission which includes costs.

SCA

Lauri asked whether there has been any traction at the State-level regarding the request to stall. Eric responded that negotiations are occurring in a very long and drawn-out manner. An edited PIHP Contract document was sent to the State. Between CFI and the PIHPs, work is in process. Lauri noted that the CMHSP General Fund Contract still references the standard forms (FSR). Chip confirmed that there is no reference to the Standard Cost Allocation in the CMHSP GF Contract. Lauri questioned what would happen if the State issues an RFP for an actuarial firm (as has been suggested by Rep. Whiteford) and Milliman is not selected. Eric clarified that the State must have an actuary, though its responsibility should be confined to certifying the rates.

FY22 DCW

No L-letter has been issued to date. A $2.35 permanent increase was approved in the FY22 budget (likely with the addition of 12% admin.) It was noted that Milliman would then need to re-certify the rates as they currently reflect $2.00 DCW plus $.24 admin load.

LOCAL MATCH FY22

Due to Department November 16th. Eric reported that the total was reduced by an additional 1/5th (60%) for FY22.

OTHER

Deanna reminded the Group that the CMH Interim FSR is due to the NMRE by close of business on November 9th.

NEXT MEETING

The next meeting was scheduled for 10:00AM on November 10, 2021.

## Chief Executive Officer Report

## October 2021

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

**Sept 23:** Attended and participated in CMHAM Directors Forum.

**Sept 28:** Chaired NMRE Internal Operations Committee Meeting.

**Oct 5:** Attended and participated in NMRE regional QOC Meeting.

**Oct 6**: Attended and participated in PIHP CEO Meeting.

**Oct 7:** Attended and participated in MDHHS/PIHP CEO Meeting.

**Oct 12:** Attended and participated in NMRE Network Management Committee Meeting.

**Oct 12:** Chaired NMRE Internal Operations Committee Meeting.

**Oct 13:** Attended and participated in NMRE Regional Finance Committee Meeting.

**Oct 14**: Attended and participated in MDHHS PIHP/CMHSP Covid 19 call.

**Oct 19**: Chaired NMRE Operations Committee Meeting.

**Oct 21**: Participated in Management Agreement Review regarding Managed Care Contracts with Adam Falone and Assoc.

**Oct 24**: Plan to attend CMHAM Fall Conference.


August 2021

# Monthly Finance Report

# August 2021 Financial Summary

| Funding Source | YTD Net Surplus (Deficit) | Carry Forward | ISF |
|---|---|---|---|
| Medicaid | 25,541,214 | 4,515,675 | 7,738,320 |
| Healthy Michigan | 5,418,129 | | 7,058,552 |
| | $ 30,959,343 | $ 4,515,675 | $ 14,796,872 |

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Ausable Valley | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| Net Surplus (Deficit) MA/HMP | 1,792,260 | 1,865,681 | 7,647,765 | 8,703,111 | 3,215,499 | 5,132,702 | 2,602,325 | $ 30,959,343 |
| Direct Care Wage Estimated Surplus | | | | | | | | (6,347,000) |
| Medicaid Carry Forward | | | | | | | | 4,515,675 |
| Total Med/HMP Current Year Surplus | | | | | | | | $ 29,128,018 |
| Medicaid & HMP Internal Service Fund | | | | | | | | 14,796,872 |
| Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF | | | | | | | | $ 43,924,890 |

# Northern Michigan Regional Entity

## Funding Source Report - PIHP

Mental Health

October 1, 2020 through August 31, 2021

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Ausable Valley | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| **Traditional Medicaid (inc Autism)** | | | | | | | | |
| **Revenue** | | | | | | | | |
| Revenue Capitation (PEPM) | $ 181,831,300 | $ 4,130,904 | | | | | | $ 185,962,204 |
| CMHSP Distributions | (175,383,405) | | 58,156,799 | 48,562,528 | 29,247,419 | 24,192,027 | 15,224,631 | - |
| 1st/3rd Party receipts | | | 467,063 | - | 596,177 | - | - | 1,063,240 |
| **Net revenue** | 6,447,895 | 4,130,904 | 58,623,862 | 48,562,528 | 29,843,596 | 24,192,027 | 15,224,631 | 187,025,444 |
| **Expense** | | | | | | | | |
| PIHP Admin | 2,018,577 | 43,730 | | | | | | 2,062,307 |
| PIHP SUD Admin | | 70,137 | | | | | | 70,137 |
| SUD Access Center | | 47,144 | | | | | | 47,144 |
| Insurance Provider Assessment | 1,113,075 | 23,525 | | | | | | 1,136,600 |
| Hospital Rate Adjuster | 1,642,256 | | | | | | | 1,642,256 |
| Services | | 3,319,059 | 51,721,338 | 42,003,564 | 27,344,194 | 19,394,628 | 12,743,003 | 156,525,786 |
| **Total expense** | 4,773,908 | 3,503,595 | 51,721,338 | 42,003,564 | 27,344,194 | 19,394,628 | 12,743,003 | 161,484,230 |
| **Net Actual Surplus (Deficit)** | $ 1,673,988 | $ 627,309 | $ 6,902,524 | $ 6,558,964 | $ 2,499,402 | $ 4,797,399 | $ 2,481,628 | $ 25,541,214 |

**Notes**

**Medicaid ISF - $7,738,320 - based on unaudited final FSR**

**Medicaid Savings - $4,515,675**

# Northern Michigan Regional Entity

## Funding Source Report - PIHP

Mental Health

October 1, 2020 through August 31, 2021

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Ausable Valley | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| **Healthy Michigan** | | | | | | | | |
| **Revenue** | | | | | | | | |
| Revenue Capitation (PEPM) | $ 19,533,858 | $ 9,392,244 | | | | | | $ 28,926,102 |
| CMHSP Distributions | (17,847,093) | | 6,511,545 | 5,387,796 | 2,212,834 | 2,233,242 | 1,501,675 | (0) |
| 1st/3rd Party receipts | | | - | - | 3,692 | - | - | 3,692 |
| **Net revenue** | 1,686,765 | 9,392,244 | 6,511,545 | 5,387,796 | 2,216,526 | 2,233,242 | 1,501,675 | 28,929,794 |
| **Expense** | | | | | | | | |
| PIHP Admin | 181,681 | 101,810 | | | | | | 283,491 |
| PIHP SUD Admin | | 163,287 | | | | | | 163,287 |
| SUD Access Center | | 109,756 | | | | | | 109,756 |
| Insurance Provider Assessment | 102,452 | 51,838 | | | | | | 154,290 |
| Hospital Rate Adjuster | 1,284,360 | | | | | | | 1,284,360 |
| Services | | 7,727,181 | 5,766,303 | 3,243,649 | 1,500,429 | 1,897,940 | 1,380,979 | 21,516,481 |
| **Total expense** | 1,568,493 | 8,153,872 | 5,766,303 | 3,243,649 | 1,500,429 | 1,897,940 | 1,380,979 | 23,511,665 |
| **Net Surplus (Deficit)** | $ 118,272 | $ 1,238,372 | $ 745,242 | $ 2,144,147 | $ 716,097 | $ 335,302 | $ 120,696 | $ 5,418,129 |

**Notes**

**HMP ISF - $7,058,552 - based on unaudited final FSR**

**HMP Savings - $0**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Net Surplus (Deficit) MA/HMP** | **$ 1,792,260** | **$ 1,865,681** | **$ 7,647,765** | **$ 8,703,111** | **$ 3,215,499** | **$ 5,132,702** | **$2,602,325** | **$ 30,959,343** |
| **Direct Care Wage Estimated Surplus** | | | | | | | | **$ (6,347,000)** |
| **Medicaid Carry Forward** | | | | | | | | **4,515,675** |
| **Total Med/HMP Current Year Surplus** | | | | | | | | **$ 29,128,018** |
| **Medicaid & HMP ISF - based on unaudited Final FSR** | | | | | | | | **14,796,872** |
| **Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF** | | | | | | | | **$ 43,924,890** |

# Northern Michigan Regional Entity

## Funding Source Report - PIHP

Mental Health
October 1, 2020 through August 31, 2021

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Ausable Valley | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| **Health Home** | | | | | | | | |
| **Revenue** | | | | | | | | |
| Revenue Capitation (PEPM) | $ 62,800 | | 153,374 | 26,323 | 24,568 | 6,668 | 200,053 | $ 473,786 |
| CMHSP Distributions | - | | | | | | | - |
| 1st/3rd Party receipts | | | | | | | | - |
| **Net revenue** | 62,800 | - | 153,374 | 26,323 | 24,568 | 6,668 | 200,053 | 473,786 |
| **Expense** | | | | | | | | |
| PIHP Admin | 5,415 | | | | | | | 5,415 |
| Insurance Provider Assessment | 2,338 | | | | | | | 2,338 |
| Hospital Rate Adjuster | | | | | | | | |
| Services | - | | 153,374 | 26,323 | 24,568 | 6,668 | 200,053 | 410,986 |
| **Total expense** | 7,753 | - | 153,374 | 26,323 | 24,568 | 6,668 | 200,053 | 418,739 |
| **Net Surplus (Deficit)** | $ 55,047 | $ - | $ - | $ - | $ - | $ - | $ - | $ 55,047 |

## Northern Michigan Regional Entity

### Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2020 through August 31, 2021

| | PIHP MH | PIHP SUD | PIHP ISF | Total PIHP |
|---|---|---|---|---|
| **Operating revenue** | | | | |
| Medicaid | $ 181,831,300 | $ 4,130,904 | $ - | $ 185,962,204 |
| Medicaid Savings | 4,515,675 | - | - | 4,515,675 |
| Healthy Michigan | 19,533,858 | 9,392,244 | - | 28,926,102 |
| Healthy Michigan Savings | - | - | - | - |
| Health Home | 473,786 | - | - | 473,786 |
| Opioid Health Home | - | 2,065,144 | - | 2,065,144 |
| Substance Use Disorder Block Grant | - | 2,501,381 | - | 2,501,381 |
| Public Act 2 (Liquor tax) | - | 1,267,785 | - | 1,267,785 |
| Affiliate local drawdown | 1,204,388 | - | - | 1,204,388 |
| Performance Incentive Bonus | - | - | - | - |
| Miscellanous Grant Revenue | - | 33,640 | - | 33,640 |
| Veteran Navigator Grant | 56,911 | - | - | 56,911 |
| SOR Grant Revenue | - | 1,259,812 | - | 1,259,812 |
| Gambling Grant Revenue | - | 155,365 | - | 155,365 |
| Other Revenue | - | - | 2,302 | 2,302 |
| **Total operating revenue** | 207,615,918 | 20,806,275 | 2,302 | 228,424,495 |
| **Operating expenses** | | | | |
| General Administration | 2,423,717 | 570,196 | - | 2,993,913 |
| Prevention Administration | - | 77,556 | - | 77,556 |
| OHH Administration | - | 64,709 | - | 64,709 |
| Insurance Provider Assessment | 1,217,865 | 87,353 | - | 1,305,218 |
| Hospital Rate Adjuster | 2,926,616 | - | - | 2,926,616 |
| Payments to Affiliates: | | | | |
| Medicaid Services | 152,143,487 | 3,319,059 | - | 155,462,546 |
| Healthy Michigan Services | 13,785,608 | 7,727,181 | - | 21,512,789 |
| Health Home Services | 410,986 | - | - | 410,986 |
| Opioid Health Home Services | - | 1,886,155 | - | 1,886,155 |
| Community Grant | - | 1,643,275 | - | 1,643,275 |
| Prevention | - | 592,881 | - | 592,881 |
| State Disability Assistance | - | - | - | - |
| State Targeted Response | - | - | - | - |
| Public Act 2 (Liquor tax) | - | 1,267,785 | - | 1,267,785 |
| Local PBIP | 1,334,530 | - | - | 1,334,530 |
| Local Match Drawdown | 1,039,183 | - | - | 1,039,183 |
| Miscellanous Grant | - | 33,640 | - | 33,640 |
| Veteran Navigator Grant | 56,911 | - | - | 56,911 |
| SOR Grant Expenses | - | 1,259,812 | - | 1,259,812 |
| Gambling Grant Expenses | - | 155,365 | - | 155,365 |
| **Total operating expenses** | 175,338,903 | 18,684,967 | - | 194,023,870 |
| **CY Unspent funds** | 32,277,015 | 2,121,308 | 2,302 | 34,400,625 |
| **Transfers In** | - | - | - | - |
| **Transfers out** | - | - | - | - |
| Unspent funds - beginning | 1,293,901 | 6,840,165 | 14,796,872 | 22,930,938 |
| **Unspent funds - ending** | $ 33,570,916 | $ 8,961,473 | $ 14,799,174 | $ 57,331,563 |

# Northern Michigan Regional Entity

## Funding Source Report - SUD

Mental Health

October 1, 2020 through August 31, 2021

| | Medicaid | Healthy Michigan | Opioid Health Home | SAPT Block Grant | PA2 Liquor Tax | Total SUD |
|---|---|---|---|---|---|---|
| **Substance Abuse Prevention & Treatment** | | | | | | |
| **Revenue** | $ 4,130,904 | $ 9,392,244 | $ 2,065,144 | $ 2,501,381 | $ 1,267,785 | $ 19,357,458 |
| **Expense** | | | | | | |
| Administration | 113,867 | 265,097 | 64,708 | 164,328 | | 607,999 |
| OHH Admin | - | - | 64,709 | - | | 64,709 |
| Access Center | 47,144 | 109,756 | - | 23,341 | | 180,241 |
| Insurance Provider Assessment | 23,525 | 51,838 | 11,990 | | | 87,353 |
| Services: | | | | | | |
| Treatment | 3,319,059 | 7,727,181 | 1,886,155 | 1,643,275 | 1,267,785 | 15,843,455 |
| Prevention | - | - | - | 670,437 | - | 670,437 |
| State targeted response | - | - | - | - | - | - |
| **Total expense** | 3,503,595 | 8,153,872 | 2,027,562 | 2,501,381 | 1,267,785 | 17,454,194 |
| **PA2 Redirect** | | | - | | | - |
| **Net Surplus (Deficit)** | $ 627,309 | $ 1,238,372 | $ 37,582 | $ - | | $ 1,903,264 |

# Northern Michigan Regional Entity

## Statement of Net Position

August 31, 2021

| | PIHP MH | PIHP SUD | PIHP ISF | Total PIHP |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current Assets** | | | | |
| Cash Position | $ 11,282,350 | $ 9,619,725 | $ 5,212,591 | $ 26,114,666 |
| Accounts Receivable | 32,088,428 | 2,044,176 | 9,586,583 | 43,719,187 |
| Prepaids | 57,980 | - | - | 57,980 |
| **Total current assets** | 43,428,758 | 11,663,901 | 14,799,174 | 69,891,833 |
| **Noncurrent Assets** | | | | |
| Capital assets | - | - | - | - |
| **Total Assets** | 43,428,758 | 11,663,901 | 14,799,174 | 69,891,833 |
| **Liabilities** | | | | |
| **Current liabilities** | | | | |
| Accounts payable | 9,653,105 | 2,702,428 | - | 12,355,533 |
| Accrued liabilities | 204,737 | - | - | 204,737 |
| Unearned revenue | - | - | - | - |
| **Total current liabilities** | 9,857,842 | 2,702,428 | - | 12,560,270 |
| **Unspent funds** | $ 33,570,916 | $ 8,961,473 | $ 14,799,174 | $ 57,331,563 |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health

October 1, 2020 through August 31, 2021

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **Operating revenue** | | | | | |
| Medicaid | | | | | |
| * Capitation | $ 174,071,340 | $ 159,565,395 | $ 181,831,300 | $ 22,265,905 | 13.95% |
| Carryover | 6,600,000 | 6,600,000 | 4,515,675 | (2,084,325) | (0) |
| Healthy Michigan | | | | | |
| Capitation | 16,832,844 | 15,430,107 | 19,533,858 | 4,103,751 | 26.60% |
| Carryover | - | - | - | - | 0.00% |
| Health Home | 160,664 | 147,267 | 473,786 | 326,519 | 221.72% |
| Affiliate local drawdown | 1,324,156 | 1,307,524 | 1,204,388 | (103,136) | (7.89%) |
| Performance Bonus Incentive | 1,229,649 | - | - | - | 0.00% |
| Miscellanous Grants | - | - | - | - | 0.00% |
| Veteran Navigator Grant | 100,000 | 91,667 | 56,911 | (34,756) | (37.92%) |
| Other Revenue | - | - | - | - | 0.00% |
| Total operating revenue | 200,318,653 | 183,141,960 | 207,615,918 | 24,473,958 | 13.36% |
| **Operating expenses** | | | | | |
| General Administration | 3,144,865 | 2,859,279 | 2,423,717 | 435,562 | 15.23% |
| Insurance Provider Assessment | 1,600,452 | 1,467,081 | 1,217,865 | 249,216 | 16.99% |
| Hospital Rate Adjuster | 3,834,600 | 3,515,050 | 2,926,616 | 588,434 | 16.74% |
| Local PBIP | 1,229,649 | - | 1,334,530 | (1,334,530) | 0.00% |
| Local Match Drawdown | 1,324,152 | 1,324,152 | 1,039,183 | 284,969 | 21.52% |
| Miscellanous Grants | - | - | - | - | 0.00% |
| Veteran Navigator Grant | 100,000 | 91,663 | 56,911 | 34,752 | 37.91% |
| Payments to Affiliates: | | | | | |
| Medicaid Services | 167,358,096 | 153,411,588 | 152,143,487 | 1,268,101 | 0.83% |
| Healthy Michigan Services | 15,049,128 | 13,795,034 | 13,785,608 | 9,426 | 0.07% |
| Health Home Services | 157,008 | 143,924 | 410,986 | (267,062) | (185.56%) |
| Total operating expenses | 193,797,950 | 176,607,771 | 175,338,903 | 1,268,868 | 0.72% |
| **CY Unspent funds** | $ 6,520,703 | $ 6,534,188 | 32,277,015 | $ 25,742,827 | |
| **Transfers in** | | | - | | |
| **Transfers out** | | | - | 175,338,903 | |
| Unspent funds - beginning | | | 1,293,901 | | |
| **Unspent funds - ending** | | | $ 33,570,916 | 32,277,015 | |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse

October 1, 2020 through August 31, 2021

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **Operating revenue** | | | | | |
| Medicaid | $ 4,546,404 | $ 4,167,537 | $ 4,130,904 | $ (36,633) | (0.88%) |
| Healthy Michigan | 8,615,688 | 7,897,714 | 9,392,244 | 1,494,530 | 18.92% |
| Substance Use Disorder Block Grant | 3,105,145 | 2,846,383 | 2,501,381 | (345,002) | (12.12%) |
| Opioid Health Home | 963,264 | 882,992 | 2,065,144 | 1,182,152 | 133.88% |
| Public Act 2 (Liquor tax) | 1,533,979 | 1,022,653 | 1,267,785 | 245,132 | 23.97% |
| Miscellanous Grants | 36,335 | 33,307 | 33,640 | 333 | 1.00% |
| SOR Grant | 2,298,500 | 2,106,958 | 1,259,812 | (847,146) | (40.21%) |
| Gambling Prevention Grant | 200,000 | 183,333 | 155,365 | (27,968) | (15.26%) |
| Other Revenue | - | - | - | - | 0.00% |
| Total operating revenue | 21,299,315 | 19,140,877 | 20,806,275 | 1,665,398 | 8.70% |
| **Operating expenses** | | | | | |
| Substance Use Disorder: | | | | | |
| SUD Administration | 773,328 | 703,384 | 570,196 | 133,188 | 18.94% |
| Prevention Administration | 87,516 | 80,223 | 77,556 | 2,667 | 3.32% |
| Insurance Provider Assessment | 89,052 | 81,631 | 87,353 | (5,722) | (7.01%) |
| Medicaid Services | 3,187,188 | 2,921,589 | 3,319,059 | (397,470) | (13.60%) |
| Healthy Michigan Services | 6,894,144 | 6,319,632 | 7,727,181 | (1,407,549) | (22.27%) |
| Community Grant | 2,075,447 | 1,902,493 | 1,643,275 | 259,218 | 13.63% |
| Prevention | 664,967 | 609,553 | 592,881 | 16,672 | 2.74% |
| State Disability Assistance | 95,215 | 87,281 | - | 87,281 | 100.00% |
| State Targeted Response | - | - | - | - | 0.00% |
| Opioid Health Home Admin | - | - | 64,709 | (64,709) | 0.00% |
| Opioid Health Home Services | 810,000 | 742,500 | 1,886,155 | (1,143,655) | (154.03%) |
| Miscellanous Grants | 36,335 | 33,307 | 33,640 | (333) | (1.00%) |
| SOR Grant | 2,298,500 | 2,106,958 | 1,259,812 | 847,146 | 40.21% |
| Gambling Prevention | 200,000 | 183,333 | 155,365 | 27,968 | 15.26% |
| PA2 | 1,533,978 | 1,022,652 | 1,267,785 | (245,133) | (23.97%) |
| Total operating expenses | 18,745,670 | 16,794,537 | 18,684,967 | (1,890,430) | (11.26%) |
| **CY Unspent funds** | $ 2,553,645 | $ 2,346,340 | 2,121,308 | $ (225,032) | |
| Transfers in | | | - | | |
| Transfers out | | | - | | |
| Unspent funds - beginning | | | 6,840,165 | | |
| **Unspent funds - ending** | | | $ 8,961,473 | | |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration

October 1, 2020 through August 31, 2021

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **General Admin** | | | | | |
| Salaries | $ 1,721,088 | $ 1,577,664 | $ 1,335,236 | $ 242,428 | 15.37% |
| Fringes | 623,856 | 547,184 | 453,821 | 93,363 | 17.06% |
| Contractual | 461,441 | 422,991 | 347,610 | 75,381 | 17.82% |
| Board expenses | 21,600 | 19,800 | 15,185 | 4,615 | 23.31% |
| Day of recovery | 14,000 | 14,000 | 243 | 13,757 | 98.26% |
| Facilities | 166,884 | 152,977 | 123,116 | 29,861 | 19.52% |
| Other | 135,996 | 124,663 | 148,506 | (23,843) | (19.13%) |
| Total General Admin | $ 3,144,865 | $ 2,859,279 | $ 2,423,717 | $ 435,562 | 15.23% |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration

October 1, 2020 through August 31, 2021

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **SUD Administration** | | | | | |
| Salaries | $ 318,624 | $ 292,072 | $ 181,324 | $ 110,748 | 37.92% |
| Fringes | 115,560 | 105,930 | 79,095 | 26,835 | 25.33% |
| Access Salaries | 133,320 | 122,210 | 140,876 | (18,666) | (15.27%) |
| Access Fringes | 28,188 | 25,839 | 39,365 | (13,526) | (52.35%) |
| Access Contractual | - | - | - | - | 0.00% |
| Contractual | 159,996 | 146,663 | 119,456 | 27,207 | 18.55% |
| Board expenses | 8,400 | 7,700 | 3,340 | 4,360 | 56.62% |
| Facilities | - | - | - | - | 0.00% |
| Other | 9,240 | 2,970 | 6,740 | (3,770) | (126.94%) |
| Total operating expenses | $ 773,328 | $ 703,384 | $ 570,196 | $ 133,188 | 18.94% |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2020 through August 31, 2021

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **Operating revenue** | | | | | |
| Charges for services | $ - | $ - | $ - | $ - | 0.00% |
| Interest and Dividends | 6,000 | 5,500 | 2,302 | (3,198) | (58.15%) |
| Total operating revenue | 6,000 | 5,500 | 2,302 | (3,198) | (58.15%) |
| **Operating expenses** | | | | | |
| Medicaid Services | - | - | - | - | 0.00% |
| Healthy Michigan Services | - | - | - | - | 0.00% |
| Total operating expenses | - | - | - | - | 0.00% |
| **CY Unspent funds** | $ 6,000 | $ 5,500 | 2,302 | $ (3,198) | |
| Transfers in | | | - | | |
| Transfers out | | | - | - | |
| Unspent funds - beginning | | | 14,796,872 | | |
| **Unspent funds - ending** | | | $ 14,799,174 | | |

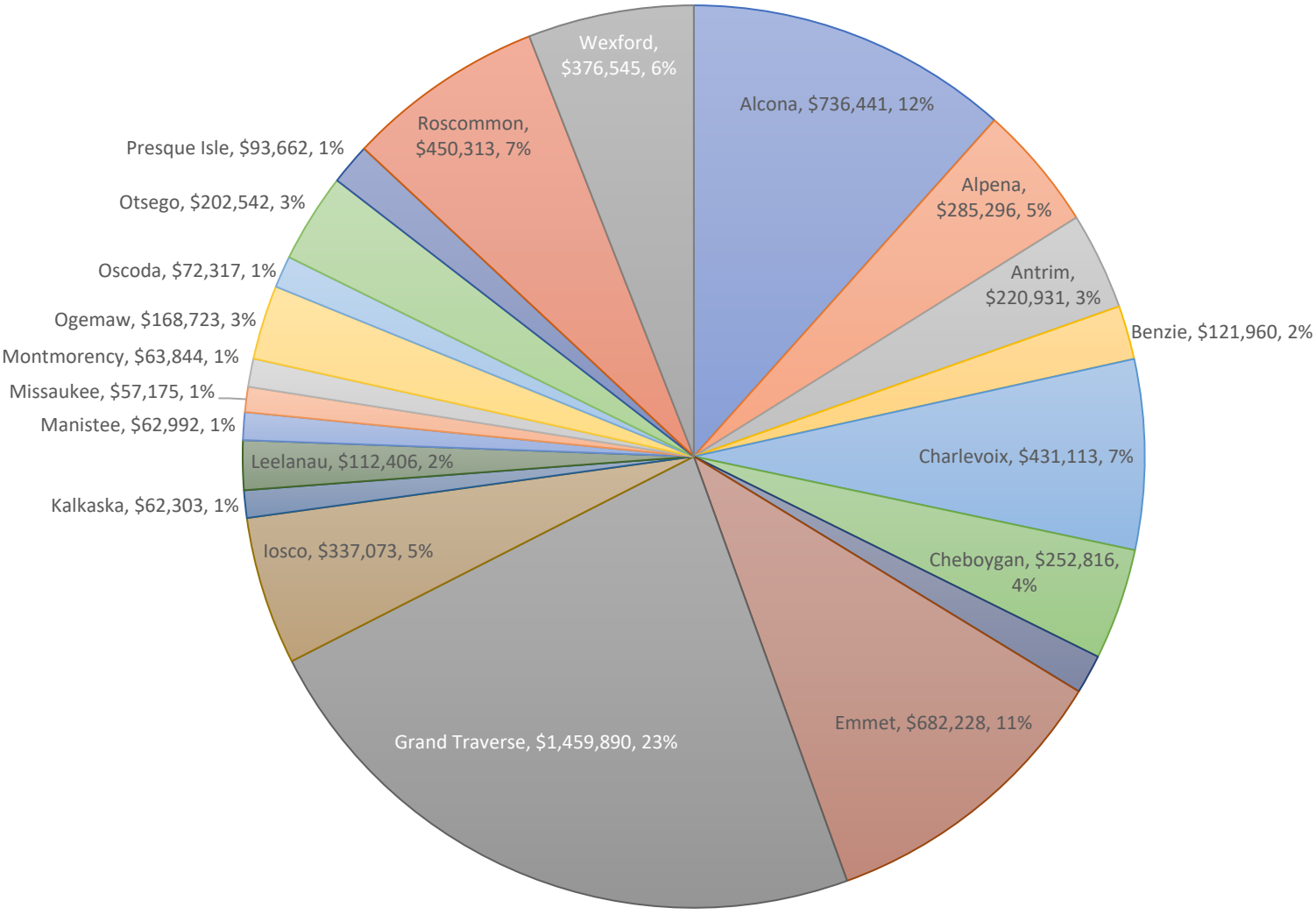
# Northern Michigan Regional Entity

## Schedule of PA2 by County

October 1, 2020 through August 31, 2021

| County | Beginning Balance | Current Receipts | County Specific Projects | Region Wide Projects by Population | Ending Balance |
|---|---|---|---|---|---|
| Alcona | $ 88,107 | $ 669,908 | 17,597 | $ 3,977 | $ 736,441 |
| Alpena | 326,729 | 29,632 | 60,130 | 10,935 | 285,296 |
| Antrim | 218,487 | 24,032 | 12,639 | 8,948 | 220,931 |
| Benzie | 118,479 | 22,333 | 12,101 | 6,751 | 121,960 |
| Charlevoix | 432,993 | 36,815 | 28,653 | 10,042 | 431,113 |
| Cheboygan | 303,118 | 30,842 | 71,398 | 9,746 | 252,816 |
| Crawford | 121,414 | 12,807 | 39,976 | 5,343 | 88,902 |
| Emmet | 648,645 | 65,134 | 18,799 | 12,752 | 682,228 |
| Grand Traverse | 1,612,893 | 168,619 | 286,351 | 35,271 | 1,459,890 |
| Iosco | 401,902 | 31,512 | 86,674 | 9,667 | 337,073 |
| Kalkaska | 109,739 | 14,808 | 55,469 | 6,775 | 62,303 |
| Leelanau | 162,144 | 21,938 | 63,357 | 8,320 | 112,406 |
| Manistee | 84,324 | 28,585 | 40,533 | 9,384 | 62,992 |
| Missaukee | 63,191 | 8,098 | 8,352 | 5,762 | 57,175 |
| Montmorency | 96,078 | 11,863 | 40,542 | 3,554 | 63,844 |
| Ogemaw | 228,036 | 24,510 | 75,761 | 8,061 | 168,723 |
| Oscoda | 78,291 | 7,662 | 10,451 | 3,184 | 72,317 |
| Otsego | 257,837 | 38,972 | 84,840 | 9,427 | 202,542 |
| Presque Isle | 111,192 | 9,245 | 21,861 | 4,914 | 93,662 |
| Roscommon | 442,922 | 33,852 | 17,281 | 9,180 | 450,313 |
| Wexford | 372,430 | 37,142 | 20,243 | 12,784 | 376,545 |
| | 6,278,950 | 1,328,303 | 1,073,006 | 194,776 | 6,339,469 |
| PA2 Redirect | | | | | (1) |
| | | | | | 6,339,469 |

# PA2 Funds by County

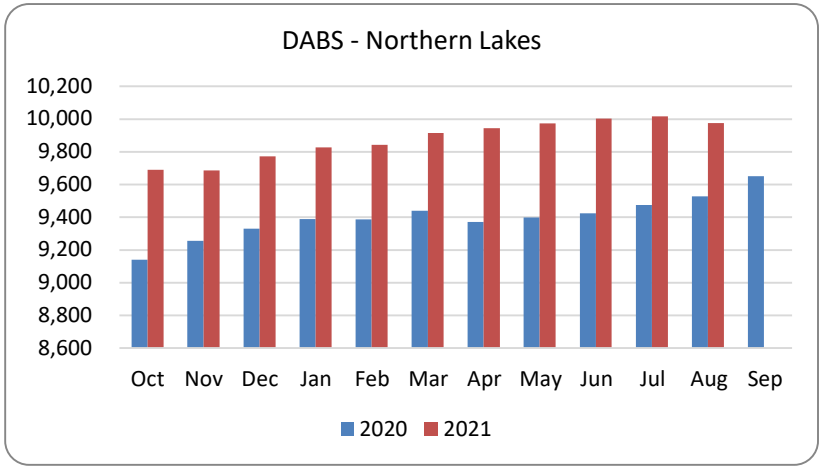


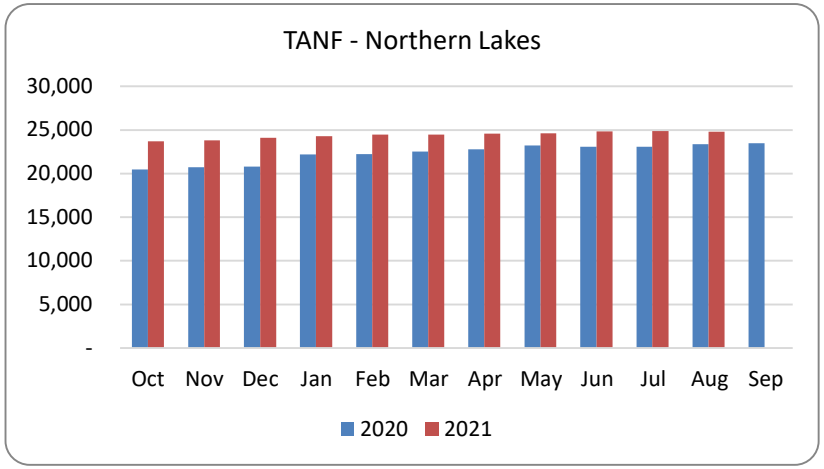
# Northern Michigan Regional Entity

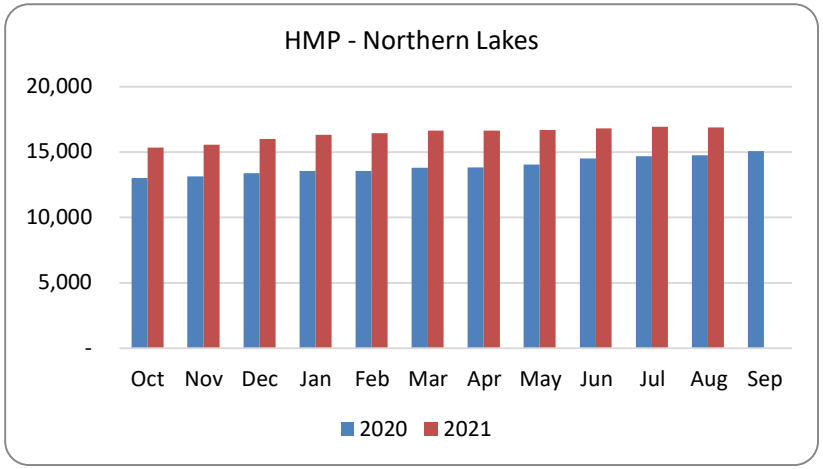
## Narrative

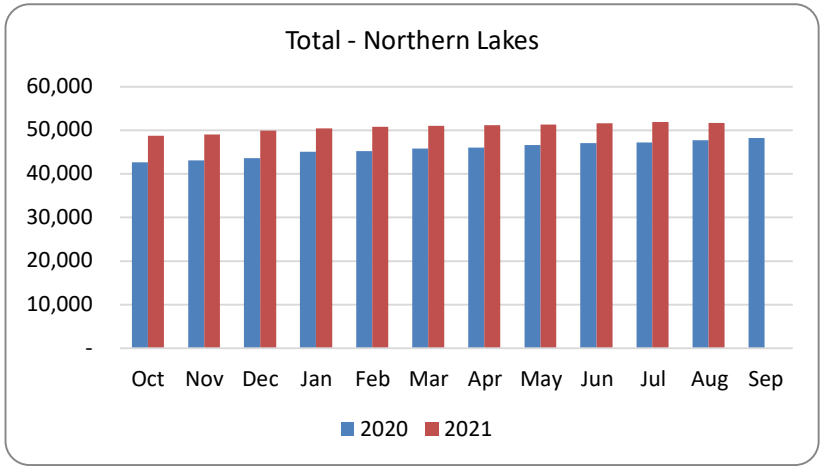
October 1, 2020 through August 31, 2021

## Northern Lakes Eligible Trending



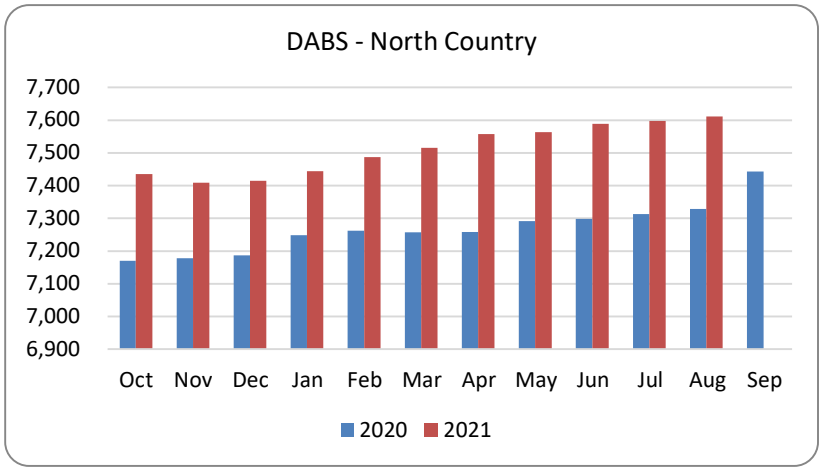



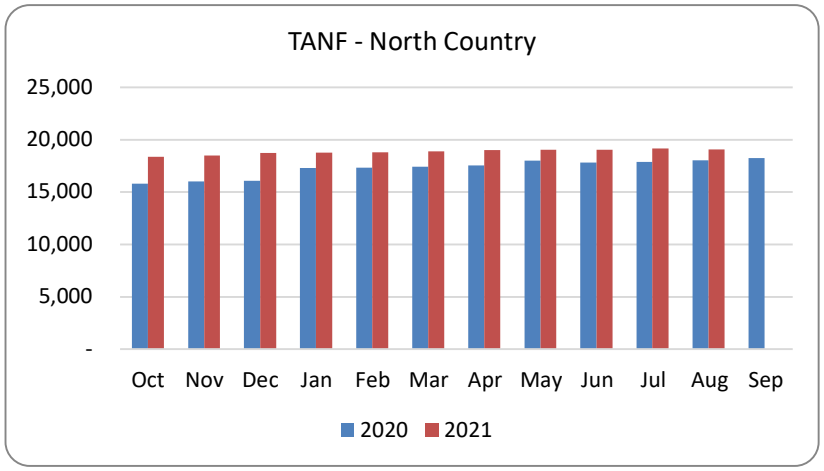
# Northern Michigan Regional Entity

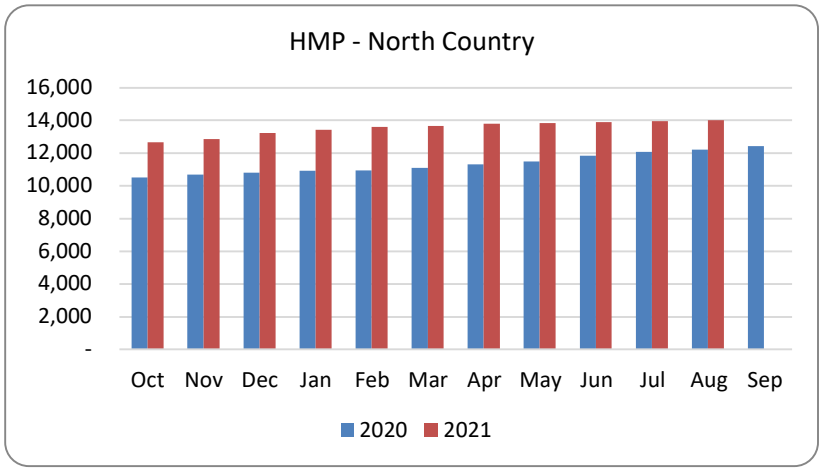
## Narrative

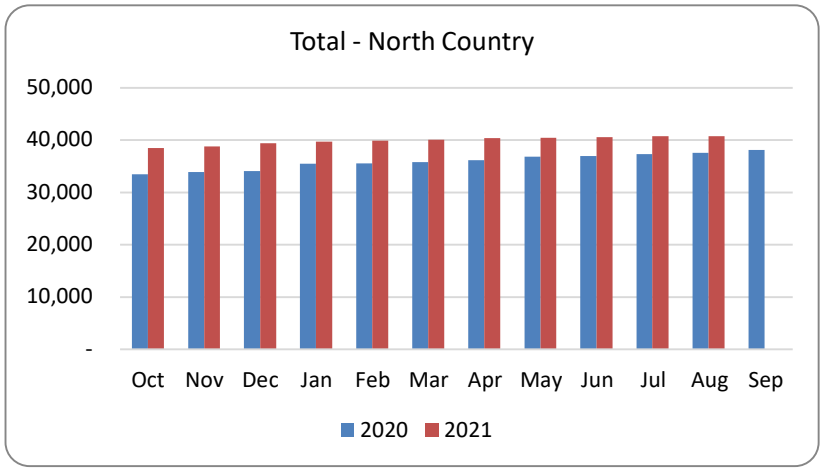
October 1, 2020 through August 31, 2021

## North Country Eligible Trending



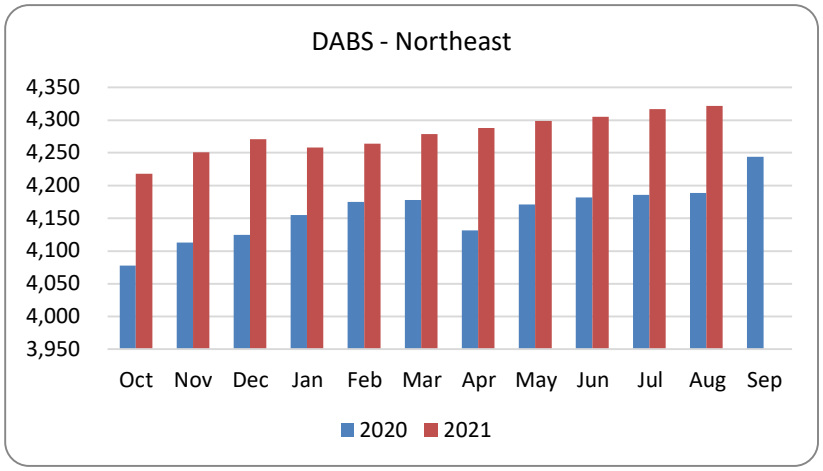



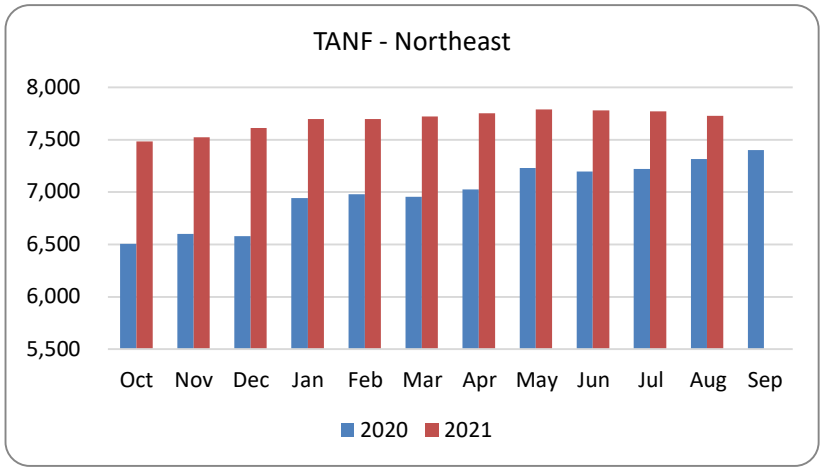
# Northern Michigan Regional Entity

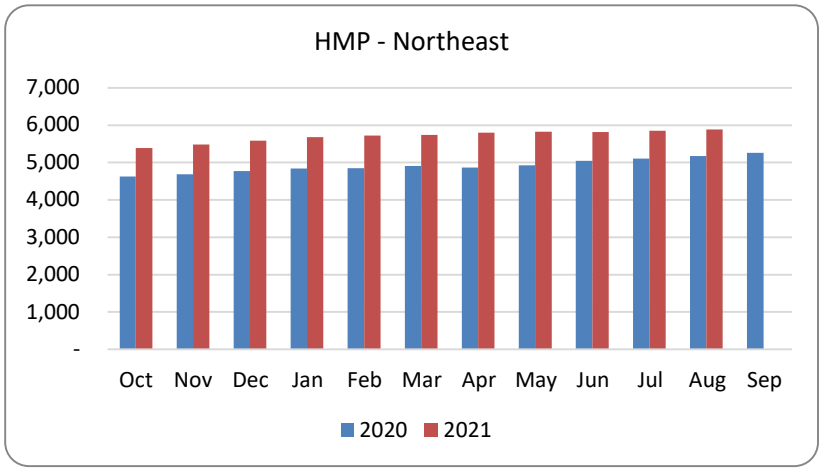
## Narrative

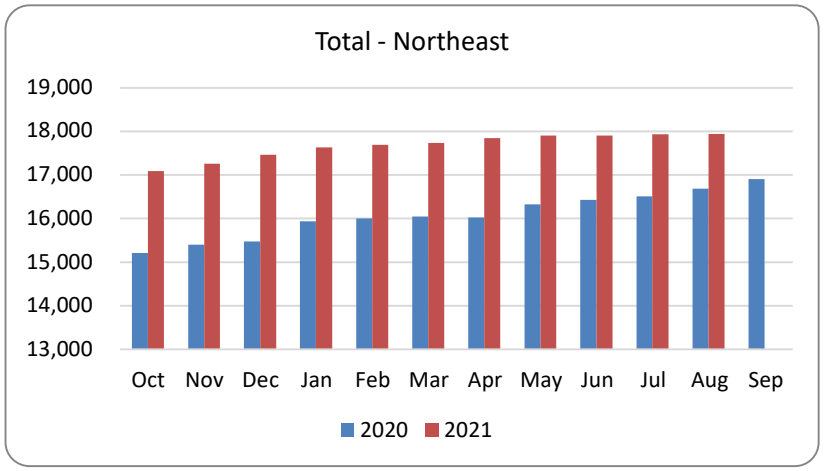
October 1, 2020 through August 31, 2021

## Northeast Eligible Trending



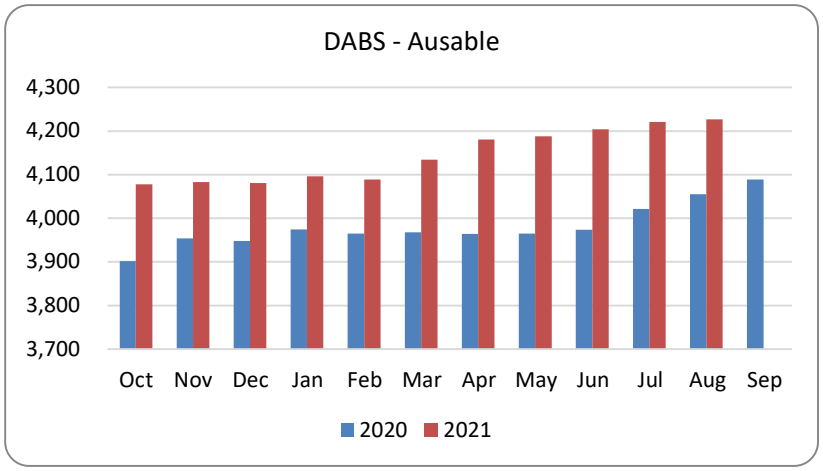



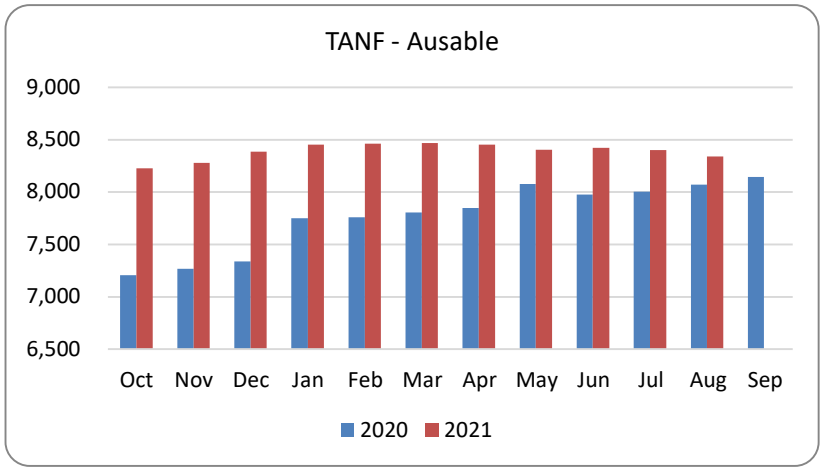
# Northern Michigan Regional Entity

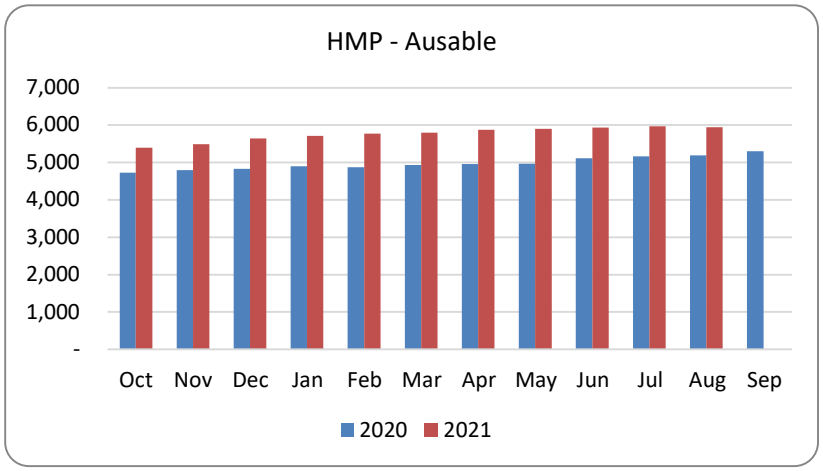
## Narrative

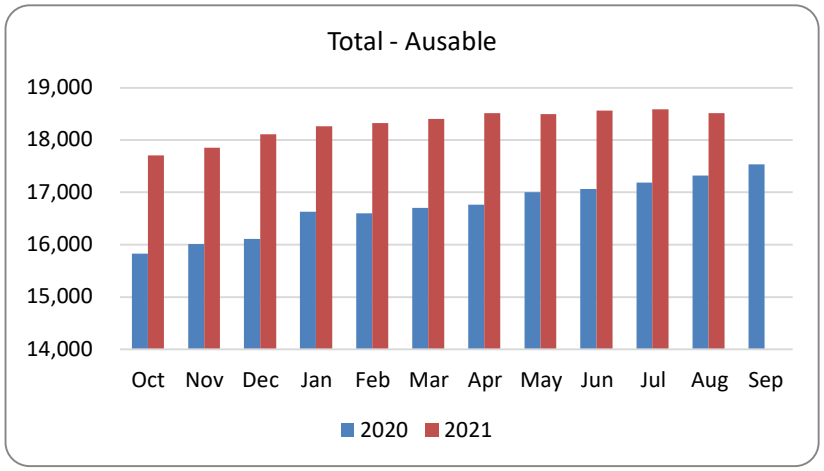
October 1, 2020 through August 31, 2021

## Ausable Valley Eligible Trending



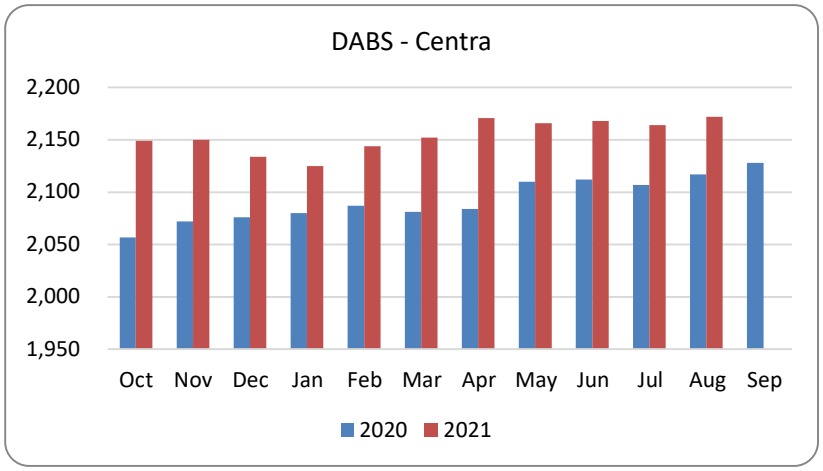



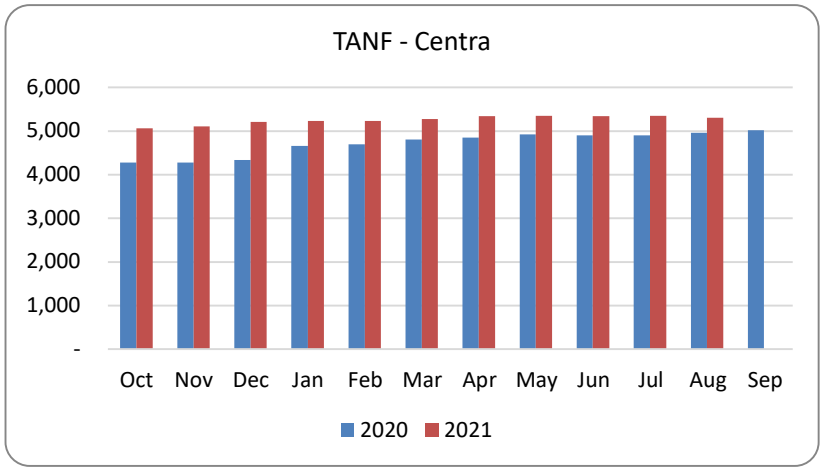
# Northern Michigan Regional Entity

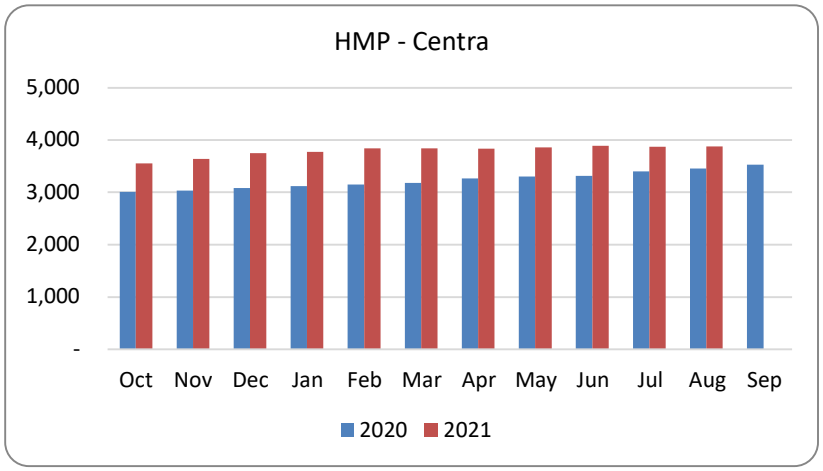
## Narrative

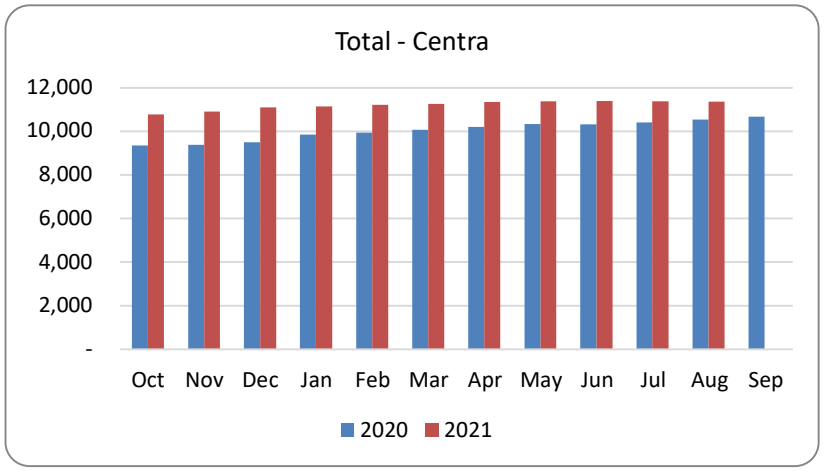
October 1, 2020 through August 31, 2021

## Centra Wellness Eligible Trending



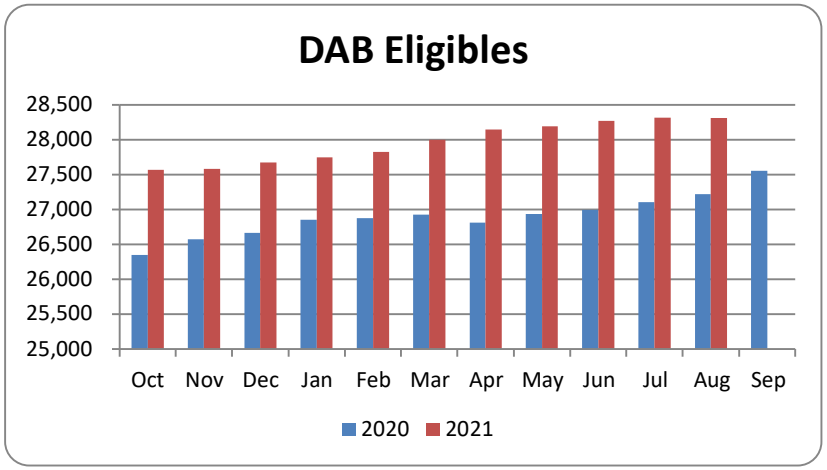



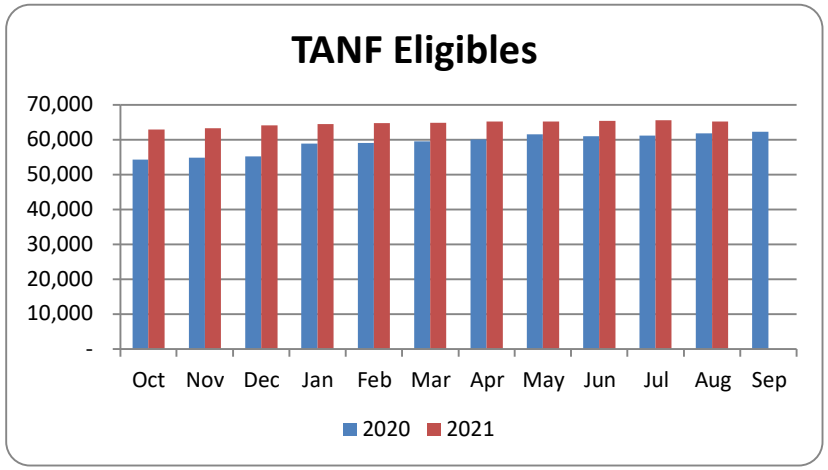
## Northern Michigan Regional Entity

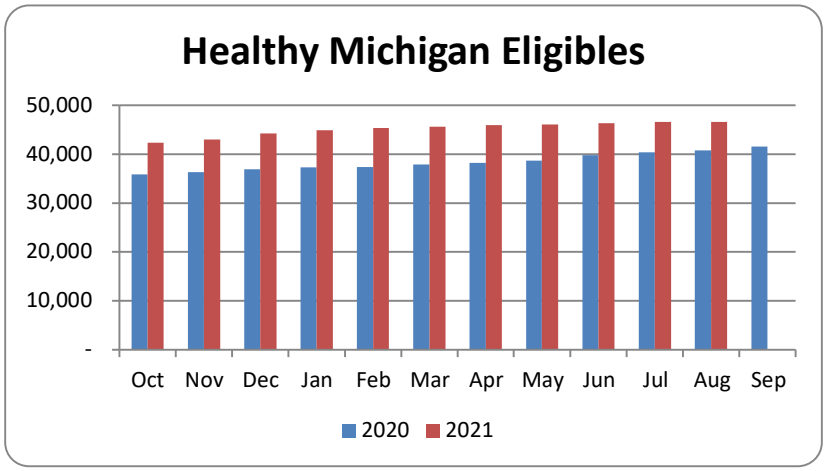
### Narrative

October 1, 2020 through August 31, 2021

### Regional Eligible Trending



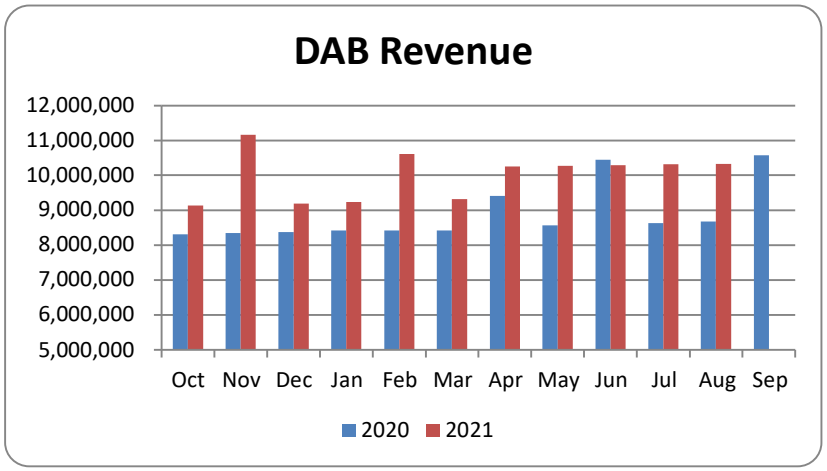



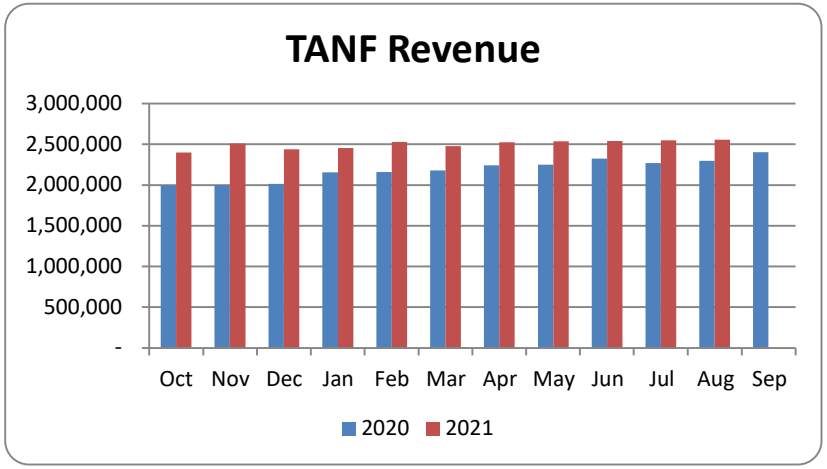
## Northern Michigan Regional Entity

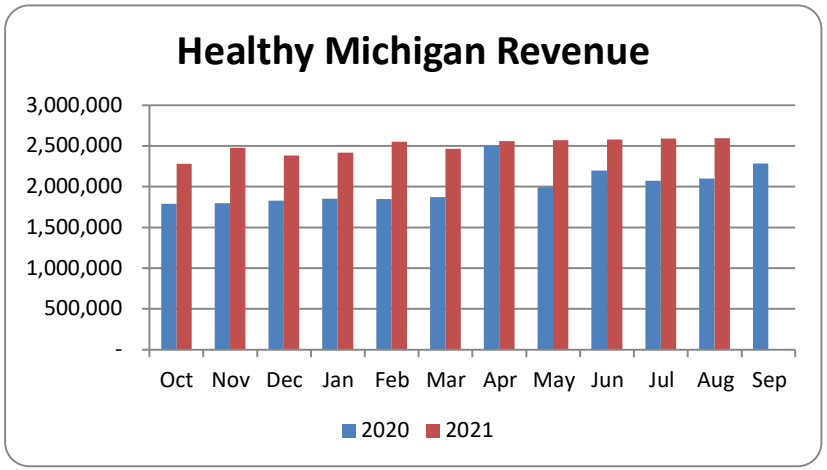
### Narrative

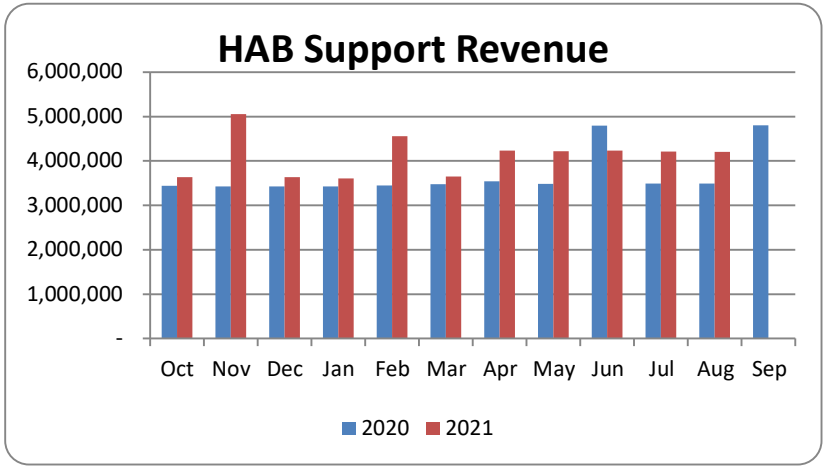
October 1, 2020 through August 31, 2021

### Regional Revenue Trending



**NORTHERN MICHIGAN REGIONAL ENTITY**
**OPERATIONS COMMITTEE MEETING**
**9:30AM – OCTOBER 19, 2021**
**GAYLORD CONFERENCE ROOM**

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

REVIEW AGENDA & ADDITIONS
Ms. Gebhard asked to add Crisis Stabilization Units in rural areas; it will be addressed under the ICSS discussion.

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

**MOTION BY DIANE PELTS TO APPROVE THE SEPTEMBER 21, 2021 MEETING MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SECOND BY JOANIE BLAMER. MOTION APPROVED BY CONSENSUS.**

FINANCE COMMITTEE & RELATED
**August 2021 Financials**

- Traditional Medicaid showed $187,025,444 in revenue, and $161,484,230 in expenses, resulting in a net surplus of $25,541,214. Medicaid ISF was reported as $7,738,320 based on the unaudited final FSR. Medicaid Savings was reported as $4,515,675.
- Healthy Michigan Plan showed $28,929,794 in revenue, and $23,511,665 in expenses, resulting in a net surplus of $5,418,129. HMP ISF was reported as $7,058,552 based on the unaudited Final FSR. HMP savings was reported as $0.
- Net Position* showed net surplus Medicaid and HMP of $30,959,343. Medicaid carry forward was reported as $4,515,675. The total Medicaid and HMP Current Year Surplus was reported as $29,128,018. Medicaid and HMP combined ISF was reported as $14,796,872; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $43,924,890.
- Health Home showed $473,786 in revenue, and $418,739 in expenses, resulting in a net surplus of $55,047.
- SUD showed all funding source revenue of $19,357,458, and $17,454,194 in expenses, resulting in a net surplus of $1,903,264. Total PA2 funds were reported as $6,339,469.

Unspent DCW was reported as $6,347,000. The potential FY22 lapse was discussed. Ms. Pelts asked whether there are any Rescue Funds available regionally as AuSable Valley is looking to evaluate its HVAC/air filtration systems. Mr. Kurtz responded that there are some COVID funds and some American Rescue Plan Act (ARPA) funds coming in for SUD; he advised moving forward with the improvements. Mr. Johnston asked to have the Health Home revenue/expenses by CMHSP; these will be added prior to sending the report to the Board.

**MOTION BY CHIP JOHNSTON TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR AUGUST 2021; SUPPORT BY DIANE PELTS. MOTION APPROVED BY CONSENSUS.**

**FY22 Budget Stabilization**
Operations Committee discussed FY22 Budget Stabilization efforts in September; the regional Finance Committee also discussed the topic on October 13th.

Ms. Sork asked about the possibility of the CMHSPs transferring General Funds to the NMRE in FY22 (236 transfer); NMRE would act as a repository and set the funds aside for CMHSP use. Mr. Kurtz responded that he believes it is allowed under the 2013 AFP. Mr. Johnston suggested that Mobile Crisis Units could be a potential use of the funds in the future.

**MOTION BY CHIP JOHNSTON TO EXPLORE THE OPTION OF ALLOWING THE MEMBER COMMUNITY MENTAL HEALTH SERVICES PROGRAMS TO TRANSFER UNSPENT GENERAL FUNDS TO THE NORTHERN MICHIGAN REGIONAL ENTITY TO HOLD FOR FUTURE USE; SUPPORT BY NENA SORK. MOTION APPROVED BY CONSENSUS.**

Mr. Kurtz agreed to draft a General Funds Transfer policy if allowed.

**DCW**
Mr. Kurtz announced that an L-letter will not be released until November, but a permanent increase of $2.35 + 12% admin load was approved in the Executive budget. The increase applies to the same services codes as previously determined. Tracking may be achieved via attestation rather than the current method.

**Local Match**
Mr. Kurtz reported that the legislature reduced the local match contribution by an additional $^1/_5$, resulting in $^2/_5$ payment, or 60% of the total. Mr. Kurtz has requested that the language be removed from the MDHHS/PIHP Contract.

NMRE Finance Committee also discussed the development of tiered rates for inpatient psychiatric and licensed residential services which would be tied to the IPOS.

Ms. Gebhard asked about the about H2015 CLS code (modifiers, preponderance rule, etc.) Mr. Kurtz responded that efforts to halt the change from H0043 to H2015 have been unsuccessful. Mr. Kurtz expressed that he would be interested in reviewing the year-end EQI report to see how many codes are actually being used.

It was noted that a meeting of the SCA joint workgroup is scheduled for November 4th.

<u>HSW RATES</u>
Mr. Kurtz reported that the October payment for HSW was $138 per person less; this was likely due to an error in the CHAMPS system. Other PIHPs also noted the decrease.

<u>ICSS</u>
A letter dated October 14th from Kendra Binkley was distributed on this date. MDHHS and BHDDA found Northeast Michigan CMHA had only one contact for the Intensive Crisis Stabilization Services (mobile crisis) in FY20 resulting in “contract noncompliance.” A Plan of Correction is due to MDHHS by November 24, 2021. Ms. Sork responded that Northeast Michigan has a schedule and a team in place. Mr. Kurtz spoke with other PIHPs that had similar findings. Mr. Kurtz expressed that he may request a delay of the POC so that further discussions and information gathering can occur. Mr. Johnston noted that this is receiving increased scrutiny due to the KB lawsuit. Mr. Johnston referenced the article, “Group-home

beds go unused as agencies struggle to pay enough to lure workers" by Sherri Welch in the October 11, 2021 edition of Crain's; he read aloud from the article.

COFR

Mr. Kurtz discussed a current issue in which Oakland County is attempting to send an individual to the Northeast Michigan service area. Oakland Community Health Network requested that Mr. Kurtz attest, on behalf of the NMRE, that Northeast Michigan is in "good credentialing standing." Mr. Kurtz responded that Northeast Michigan is a certified CMHSP and a Medicaid provider under contract with the PIHP; there is no need for an attestation (NMRE is not a party to the COFR). Several weeks later, Mr. Kurtz received an email from Audrey Parsons at the State stating disappointment that the NMRE is not accepting reciprocity. After emails back and forth, clarification was made that Oakland Community Health Network requested the attestation as part of its Plan of Correction with the Health Services Advisory Group's Compliance Audit.

REGIONAL CRISIS RESIDENTIAL

During the September Operations Committee meeting, as part of the region's benefit stabilization efforts, emergency/crisis services were identified as a need. TBD Solutions conducted a crisis assessment for North Country and Northern Lakes; Ms. Blamer shared the Statement of Work with the Committee.

Ms. Gebhard shared that Beacon is opening a crisis residential facility for adolescents in Fife Lake on November 1st. Dr. Ibrahim reached out to Ms. Gebhard about creating an adult CRU in northern Michigan. Ms. Gebhard requested FY21 crisis residential utilization numbers from the CMHSPs; these data were shared with the Committee on this date. Dr. Ibrahim has asked that the NMRE financially support four beds at both Northshore (Oscoda) and a new facility (possibly in Gaylord) to be cost settled at the end of the year.

Mr. Kurtz added that he is looking to do something similar with a residential detox facility.

Ms. Blamer suggested that Munson be approached about allocating a portion of its SUD unit for individuals with cooccurring SUD/MI with regional support.

**MOTION BY CHIP JOHNSTON TO FINANCIALLY SUPPORT THE CREATION OF AN ADULT CRISIS RESIDENTIAL UNIT IN THE NORTHERN MICHIGAN REGIONAL ENTITY REGION AT A COST OF UP TO TWO MILLION DOLLARS ($2,000,000.00) OVER TWO YEARS.**

Discussion:

Mr. Kurz recommended stressed the need for the facility to accept children and individuals with autism diagnoses.

Mr. Johnston revised his motion.

**MOTION BY CHIP JOHNSTON TO AUTHORIZE THE NORTHERN MICHIGAN REGIONAL ENTITY TO EXPLORE OPENING A CRISIS HOME IN NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY'S CATCHMENT AREA TO ACCEPT ALL ADULT POPULATIONS SERVED UNDER THE NORTHERN MICHIGAN REGIONAL ENTITY'S CONTRACT WITH THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES AT A COST OF UP TO TWO MILLION DOLLARS ($2,000,000.00) OVER TWO YEARS; SECOND BY DIANE PELTS. MOTION APPROVED BY CONSENSUS.**

Ms. Gebhard agreed to reach out to Dr. Ibrahim to measure his interest in opening a crisis facility for adolescents/children. The Boards will pursue a licensed home that could be used as children/adolescent CSU.

Ms. Gebhard stated that she has a meeting scheduled with Todd Burch, McLaren Northern Michigan President/CEO. McLaren is looking to develop the Cheboygan hospital into a Behavioral Health Campus. Utilizing a licensed home in Cheboygan for an adolescent/children CSU would be ideal. Mr. Kurtz discussed the struggle to get an approved inpatient hospital contract with McLaren.

Ms. Blamer spoke about Northern Lakes' efforts to partner with Munson to allocate some crisis beds for individuals with mental illness. Ms. Blamer was notified that Northern Lakes was included in the SAMHSA grant appropriation dollars for $1.8M. Mr. Kurtz suggested that the unit provide intensive services to move people out of the emergency department. Ms. Blamer will schedule a meeting with Terry Kelty and invite Mr. Kurtz.

**MOTION BY CHIP JOHNSTON TO AUTHORIZE THE NORTHERN MICHIGAN REGIONAL ENTITY TO PERSUE A PARTNERSHIP WITH MUNSON MEDICAL CENTER TO CREATE A CRISIS CENTER OPEN TO INDIVIDUALS SERVED UNDER THE NORTHERN MICHIGAN REGIONAL ENTITY'S CONTRACT WITH THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES AT A COST OF UP TO TWO MILLION DOLLARS ($2,000,000.00) OVER TWO YEARS; SECOND BY JOANIE BLAMER. MOTION APPROVED BY CONSENSUS.**

Ms. Blamer agreed to reach out to TBD Solutions with a response on behalf of the region to not pursue their assessment at this time.

SENATE BILLS, HOUSE BILLS, & LISTENING TOURS

New language was added to the bills; a bulleted list was distributed by Alan Bolter. Mr. Kurtz is working with Lambert PR on an educational document to send to courts, sheriffs, legislators, etc. in response to system redesign efforts.

(i)SPA

Mr. Kurtz reported that, prior to COVID the Department held a meeting to discuss the enrollment process for b(3) services now being converted to the 1915(i) Waiver. The State is in favor of a full enrollment model, though Mr. Kurtz asserted that additional individuals need to be involved in the conversation. Mr. Johnston noted that the enrollment form references the SIS and GAIN Assessments.

OTHER

Ms. Gebhard announced that she is part of a statewide workgroup to develop CSU certification criteria; a session is scheduled during the Fall Conference (October 25th – 26th) during which she plans to address rural challenges. She asked the group what works best in rural/frontier areas. Ms. Blamer responded that there is a reliance on regional partnerships (schools, law enforcement, hospitals/emergency departments, etc.) She added that resources are limited. Staff recruitment and retention was also identified as problematic as was the sustainability of the unit. Mr. Johnston noted that fewer philanthropic organizations are available in rural areas. Low use/high-cost services are not supported in rural environments.

NEXT MEETING

The next meeting was scheduled for 9:30AM on November 23, 2021.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

October 14, 2021

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

Dear Mr. Kurtz:

The Michigan Department of Health and Human Services (MDHHS) and Behavioral Health and Developmental Disabilities Administration (BHDDA) has completed a thorough review of the annual report that Northeast Community Mental Health Service Program (CMHSP) provided regarding the Intensive Crisis Stabilization Service (mobile crisis) for FY20. The review resulted in the following findings:

- There is evidence that the mobile crisis for children is not being provided in one CMHSP in your region because it was reported that "clinicians take care of crisis in the individuals they serve." There was only one contact last year. This is a contract noncompliance issue given this is a Medicaid covered service and must be included in the array of services provided by the Prepaid Inpatient Health Plan (PIHP).

Based on these findings, the MDHHS is requiring a plan of correction to address the contract compliance concerns noted above. The plan must indicate how you plan to raise awareness and educate your community of this service, including marketing and outreach strategies for families who are not yet open to CMH services.

**The plan of correction is due by November 24, 2021, and must include the following information and evidence of completion:**

- Information must be present on the CMHSPs website for parents, youth, and community members about the service and how to access it
- Must provide Access and Emergency Services policy or written process that supports referrals to the program
- Evidence of outreach materials for the community
- Monthly data on service use including quotes or satisfaction data from families who have received the service. Please provide until April 1, 2022, to contact individuals listed below.
- Reports provided by the CMHSPs indicate that this crisis service is alternatively being provided by Home-based and case management staff. Please provide evidence that the response occurred within the two hours rural timeframe and 24:7 in nature.

Section D, General Requirements, of the MDHHS and PIHP Contract describes a process for contract remedies and sanctions (Section D is included with this correspondence for your reference). Please be advised that the required plan of correction and corrective actions will now become part of the CMH Partnership of Southeast Michigan's contract with the MDHHS as a contract performance objective. **This correspondence serves as notice that if the plan of correction does not sufficiently address the areas of concern and/or these areas are found to be out of compliance by November 24, 2021, the MDHHS will *move* to step B, which allows the MDHHS to impose a direct dollar penalty.**

Please send the plan of correction via e-mail to me at binkleyk@michigan.gov and Kim Batsche-McKenzie at batsche-mckenziek@michigan.gov. If you have any questions, please contact me.

Sincerely,

Kendra Binkley

Kendra Binkley, MPA, Manager

Attachment: PIHP Contract Sanction Language Excerpt

c: Jeff Wieferich
Jackie Sproat
David Waldo-Levesque
Kim Batsche-McKenzie
Justin Tate