Northern Michigan Regional Entity

Board Meeting

June 26, 2024

1999 Walden Drive, Gaylord

10:00AM

Agenda

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	e. NMRE SUD Oversight Board Report – The Next Meeting is July 8, 2024	
11.	New Business	
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	a. Northern Lakes Update	
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13.	Presentation	
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14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – July 24, 2024 at 10:00AM	
16.	Adjourn	

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – MAY 22, 2024
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Ed Ginop, Eric Lawson, Mary Marois, Michael Newman, Gary Nowak, Jay O'Farrell, Ruth Pilon, Richard Schmidt, Don Smeltzer, Don Tanner, Chuck Varner**
ABSENT:	**Tom Bratton, Gary Klacking, Karla Sherman**
NMRE/CMHSP STAFF:	**Bea Arsenov, Carol Balousek, Amy Christie, Eric Kurtz, Brian Martinus, Diane Pelts, Brandon Rhue, Nena Sork, Deanna Yockey**
PUBLIC:	**Samantha Borowiak, Chip Cieslinski, Tiffany Fewins, Dave Freedman, Stacy Maiville, Neil Rojas**
GUESTS:	**Kerreen Conley, Derek Miller**

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

ROLL CALL
Let the record show that Tom Bratton, Gary Klacking, and Karla Sherman were excused from the meeting on this date; all other NMRE Board Members were in attendance in Gaylord.

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

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

APPROVAL OF AGENDA
Let the record show that FY24 Audit Firm selection and draft Board Resolution related to conflict-free access and planning were added to the agenda under "New Business."

MOTION BY CHUCK VARNER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR MAY 22, 2024 AS AMENDED; SUPPORT BY GARY NOWAK. MOTION CARRIED.

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

MOTION BY GARY NOWAK TO APPROVE THE MINUTES OF THE APRIL 24, 2024 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

CORRESPONDENCE

1) PIHP CEO meeting minutes dated April 4, 2024.
2) Medicaid Provider L-Letter 24-29 regarding FY23 Direct Care Worker Wage Increase.
3) Michigan House Bill 5725 which would amend PA 267, "The Open Meetings Act" to permit remote participation at public meetings in certain circumstances.
4) Communication from the Community Mental Health Association of Michigan (CMHAM) dated May 2024 titled, "Purposes and roles within Michigan's public mental health system: State of Michigan and the state's CMHSPs and PIHPs."
5) Communication dated May 7, 2024 from Roslund, Prestage, and Co. to NMRE Board of Directors members providing them the opportunity to share any concerns or ask any questions regarding the NMRE compliance audit.
6) An Action Alert from CMHAM dated May 10, 2024 requesting that legislators (House & Senate) and the Governor be urged to push MDHHS to halt the implementation of its approach to meeting the federal Conflict-Free Access and Panning (CFA&P) requirements.
7) An infographic supplied by CMHAM outlining the approaches proposed by MDHHS to meet Federal CFA&P requirements.
8) Email correspondence from CMHAM dated May 15, 2024 to CEOs of CMHSPs/PIHPs and Provider Alliance Members Urging Boards of Directors to pass resolutions against the implementation of MDHHS' approach to CFA&P.
9) A sample Board Resolution opposing the implementation of MDHHS' approach to CFA&P.
10) The draft minutes of the May 8, 2024 regional Finance Committee meeting.

Mr. Kurtz explained that if House Bill 5725 passes, a formal resolution will be required of the Board.

Discussion of the correspondence related to Conflict-Free Access and Planning (CFAP) was moved to "New Business."

ANNOUNCEMENTS

Let the record show that Mary Marois was welcomed back to the NMRE as a representative from Northern Lakes CMHA. Ms. Marois replaces Greg McMorrow who resigned from the NMRE Board to take the position of Northern Lakes CMHA Board Chair.

PUBLIC COMMENT

Let the record show that the members of the public attending the meeting virtually were recognized. North Country CMHA Chief Clinical Officer, Amy Christie, was sitting in for Brian Babbitt. NMSAS Recovery Center Executive Director, Samantha Borowiak, was introduced to the Board.

PRESENTATION

NMRE FY23 Financial Audit

Derek Miller, CPA with Roslund, Prestage & Co., PC (RPC) was in attendance to present the findings of the NMRE's FY23 Financial Audit. Although RPC completes three audits for the NMRE annually (Financial, Compliance, and Single Audit), the presentation focused on the Financial Audit.

Mr. Miller reported the following:

- Total Assets were down .76% from FY22.
- Total Liabilities were down 8.3% from FY22.

- Net Position was up 16.8% from FY22.
- Total Operating Revenue was up 10% from FY22.
- Total Operating Expenses were up 8% from FY22.
- Change in Net Position was up 246% from FY22.
- A Prior Year Adjustment was reported as $33,997 due to the Direct Care Wage increase.

It was noted that Governmental Accounting Standards Board (GASB) Statement No. 100, *Accounting Changes and Error Corrections*, was issued by the GASB in June 2022and will be effective for the PIHP's fiscal year ending September 30, 2024. Statement No, 101, *Compensated Absences*, was issued by GASB in June 2022 and will be effective for the PIHP's fiscal year ending September 30, 2025.

Mr. Miller thanked the NMRE Team for their work and assistance in completing the audit.

MOTION BY ERIC LAWSON TO ACCEPT THE NORTHERN MICHIGAN REGIONAL ENTITY FISCAL YEAR 2023 FINANCIAL AUDIT REPORT BY ROSLUND, PRESTAGE, AND COMPANY; SUPPORT BY CHUCK VARNER. MOTION CARRIED.

REPORTS

Executive Committee Report

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

CEO Report

The NMRE CEO Monthly Report for May 2024 was included in the materials for the meeting on this date. Mr. Kurtz thanked Northeast Michigan CMHA for including him in their Strategic Planning meeting on May 9th. Mr. Kurtz noted that the PIHP Contract Negotiations meeting scheduled for May 21st and included in his report was cancelled.

Mr. Kurtz and Mr. Johnston are engaged in efforts to eliminate $10M local drawdown and match which essentially makes the PIHP a "taxing entity" as arm of the state without constitutional authority. A five-year plan to reduce the local match to zero by 2024 was implemented in 2019 and has since stalled; by Federal mandate, it must end by 2027.

March 2024 Financial Report

- Net Position showed net surplus Medicaid and HMP of $1,407,732. Carry forward was reported as $11,624,171. The total Medicaid and HMP Current Year Surplus was reported as $13,031,903. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $33,608,059.
- Traditional Medicaid showed $103,421,851 in revenue, and $99,619,787 in expenses, resulting in a net surplus of $3,802,064. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $845,073.
- Healthy Michigan Plan showed $14,052,940 in revenue, and $16,447,272 in expenses, resulting in a net deficit of $2,394,332. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $10,779,098.
- Health Home showed $1,435,090 in revenue, and $1,231,467 in expenses, resulting in a net surplus of $221,623.

- SUD showed all funding source revenue of $15,196,893 and $13,642,380 in expenses, resulting in a net surplus of $1,554,513. Total PA2 funds were reported as $5,132,294.

The region currently has four open HSW slots with four packets pending approval. Communication has been received from MDHHS indicating that packets will be scrutinized related to Home and Community Based Services (HCBS) compliance. NMRE will work with CMHSP staff on packet submissions, but this will slow down the process. Eligibility issues in CHAMPS have caused a payment gap for approximately 30 enrolled individuals in the region. Data is being collected and provided to MDHHS. This results in an estimated revenue loss of over $7K per month per enrollee. The increase in HSW rates in addition to the NMRE filling vacant slots has enabled HSW revenue to offset the shortfall in DAB, TANF, and HMP.

The Board has approved PA2 funded projects amounting to $2.6M for FY24. Some of this may be diverted, however, as the NMRE is being creative in trying to utilize other funding to conserve PA2 resources. The NMSAS Recovery Coaching program has moved to American Rescue Plan Act (ARPA) grant funding. SUD Block Grant usage is 36% higher than it was in the same period in FY22. Liquor tax funds may been to be used for treatment deficits if SUD Block Grant funding is depleted.

MOTION BY DON SMELTZER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2024; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Operations Committee Report
Let the record show that no meetings of the NMRE Regional Operations Committee have occurred since the April Board Meeting.

NMRE SUD Oversight Committee Report
The minutes from the May 6th NMRE Substance Use Disorder Oversight Committee meeting were included in the materials for the meeting on this date. A Liquor tax request will be reviewed under the next agenda topic. The NMRE's liquor tax application will be revised to align with the parameters for liquor tax use approved by the Board in April.

NEW BUSINESS

Liquor Tax Requests
One liquor tax request was presented to the NMRE Substance Use Disorder Oversight Committee and moved for approval of NMRE Board of Directors on May 6, 2024.

217 Recovery	Recovery Stories – Part III	Grand Traverse	New Request	$4,783

MOTION BY JAY O'FARRELL TO APPROVE THE REQUEST FROM 217 RECOVERY CENTER FOR GRAND TRAVERSE COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF FOUR THOUSAND SEVEN HUNDRED EIGHTY-THREE DOLLARS TO FUND PART THREE (III) OF THE MESSAGE OF HOPE RECOVERY STORIES PROGRAM; SUPPORT BY MARY MAROIS. MOTION CARRIED.

Audit for FY24
The selection of Roslund, Prestage, and Company, PC (RPC) for financial auditing services was approved in August 2021. The NMRE was scheduled to issue an RFP for an auditing firm for fiscal years 2024, 2025, and 2026, however the regional Finance Committee recommended that the Agreement with RPC be extended for an additional year. A bid proposal from RPC was distributed during the meeting.

MOTION BY CHUCK VARNER TO APPROVE A CONTRACT EXTENSION WITH ROSLUND, PRESTAGE, AND COMPANY THROUGH FISCAL YEAR 2024 FOR AUSABLE VALLEY COMMUNITY MENTAL HEALTH AUTHORITY, CENTRA WELLNESS NETWORK, NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY, NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY, AND NORTHERN MICHIGAN REGIONAL ENTITY WITH COSTS FOR NORTHERN MICHIGAN REGIONAL ENTITY NOT TO EXCEED THIRTY THOUSAND DOLLARS ($30,000.00); SUPPORT BY JAY O'FARRELL. ROLL CALL VOTE.

"Yea" Votes:	R. Adrian, E. Ginop, E. Lawson, M. Marois, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, R. Schmidt, D. Smeltzer, D. Tanner, C. Varner
"Nay" Votes:	Nil

MOTION CARRIED.

Conflict-Free Access & Planning
At the urging of the Community Mental Health Association of Michigan (CMHAM), a resolution expressing concerns with the MDHHS' proposed approach to meeting the federal Conflict-Free standards was drafted and include in the meeting materials under "Correspondence."

MOTION BY CHUCK VARNER TO ADOPT A RESOLUTION OPPOSING THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES' DECISIONS TO IMPLEMENT CONFLICT FREE ACCESS AND PLANNING IN MICHIGAN; SUPPORT BY MARY MAROIS. ROLL CALL VOTE.

"Yea" Votes:	R. Adrian, E. Ginop, E. Lawson, M. Marois, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, R. Schmidt, D. Smeltzer, D. Tanner, C. Varner
"Nay" Votes:	Nil

Motion Carried.

The full resolution is attached to these meeting minutes and incorporated herein.

OLD BUSINESS
Northern Lakes CMHA Update
The Human Resources Assessment Report of Northern Lakes Community Mental Health Authority by Rehmann was included in the materials for the meeting on this date. Kerreen Conley, Principal with Rehmann was in attendance to present the report to the Board.

Ms. Connelly acknowledged that Chief Human Resources Officer, Neil Rojas, was not in place during the period covered by the assessment. The current HR Team was extremely cooperative and is moving in the right direction.

The main areas of focus for the assessment were:
- Fair Labor Standards Act (FLSA), I-9, and Policy Compliance
- Recruiting, Selection, and Onboarding Processes
- Employment Practices
- HR Policies and Procedures
- Employee Handbook Review
- HR Documents and Forms
- Employee Relations

Recommendations were made in the areas of:
- Policy Compliance
- Record Keeping
- Training
- Employment and Pre-Employment Practices
- Compensation
- Performance Management
- Career Development and Succession Planning
- Health and Safety
- Employee Relations

Throughout the assessment, more than 40 interviews were conducted resulting in the following feedback regarding Northern Lakes CMHA:
- Inconsistent and unfair treatment
- Lack of trust
- Fear of retaliation
- Unbalanced workloads
- Unavailable Supervisors
- Lack of leadership response to critical safety concerns
- Lack of overall response to safety concerns
- Job security and the future trajectory of the organization

The lack of clear expectations and standardized operational norms contributed to many of these issues, leading to a negative impact on employees across the organization.

The percent of engaged employees was reported as:

Responses	Engaged	Not Engaged	Actively Disengaged
233	39%	47%	14%

It was noted that the assessment did not include contracted employees.

Ms. Marois asked whether there was any indication of altered credentials. Ms. Connelly responded that there was one instance involving a job description being altered and not reposted.

Ms. Marois asked how the previous Interim CEO was able to be paid overtime. Ms. Connelly responded that salaried employees can be either salary exempt or salary non-exempt. A staff classified as salary exempt is not eligible to receive overtime pay. It would all depend on how the employee was set up in the payroll system.

COMMENTS

Board

- Ms. Marois expressed thanks to Rehmann for bringing issues that needed addressing to light during its compliance examination of Northern Lakes CMHA
- Mr. Smeltzer advised the Northern Lakes CMHA Board to focus on communication and transparency as it moves forward.

Staff/CEOs

- It was noted that the NMRE Day of Education was held at Treetops Resort on May 17th with over 120 regional consumers and staff in attendance.
- Ms. Arsenov reported that the NMRE received $83,110 for meeting the Pay-for Performance metrics for the Behavioral Health Home program.
- Ms. Pelts stated that Rehmann runs Human Resources for AuSable Valley CMHA and Northern Lakes CMHA can be confident it the assessment and recommendations provided on this date.
- Ms. Pelts reported that Governor Whitmer signed the first mental health parity law on May 21st.
- Ms. Pelts spoke to the previous Interim CEO of Northern Lakes CMHS receiving overtime pay.

MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on June 26, 2024.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:53AM.

Northern Michigan Regional Entity
1999 Walden Drive, Gaylord, MI 49735
p: 231.487.9144 • f: 989.448.7078

RESOLUTION OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS OPPOSING MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES DECISIONS TO IMPLEMENT CONFLICT FREE ACCESS AND PLANNING IN MICHIGAN

WHEREAS the Northern Michigan Regional Entity (NMRE) is a regional entity created in 2014 by the five Community Mental Health Services Programs (CMHSPs) of AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health Authority, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority and functions as the Prepaid Inpatient Health Plan (PIHP) for twenty-one Michigan counties under a master Medicaid Specialty Supports and Services Contract with the State of Michigan. The NMRE Board of Directors is comprised of three appointees from each of the CMHSPs in the NMRE region, at least one of whom is a primary or secondary consumer of behavioral health services.

WHEREAS MDHHS has announced its decision to require CMHSPs to separate service assessment and planning from service delivery, requiring beneficiaries to receive the assessment and planning services from one entity and ongoing direct services from another, separate entity by October 1, 2024.

WHEREAS after careful review the conclusions of the NMRE Board are that the current decision:

- Is in conflict with the statutory responsibilities of CMHSPs under Michigan Law;
- Erroneously implies profit drive or undue enrichment motives on the part of governmental entities (CMHSPs and PIHPs) instead of recognizing what is actually a formal transfer of governmental responsibility from the State to the Counties for the delivery of public behavioral health services;
- Ignores the capitation-based financing of the Michigan public behavioral health system, which is constant and does not vary by volume of individuals served negating any conflicts of interest in service planning and service delivery;
- Ignores Michigan's current shared risk (with MDHHS) financing system which already mitigates against conflict and self-interest;
- Is in conflict with the Certified Community Behavioral Health Clinic (CCBHC) model currently being implemented and expanded in Michigan;
- Ignores, at best, and disregards, at worst, input from persons with lived experience that have consistently stated that the available procedural safeguards are preferrable to systemic/structural upheaval inherent In MDHHS announced decisions.

THEREFORE, BE IT UNANIMOUSLY RESOLVED THAT, in the strongest possible terms, and for the reasons noted herein, the NMRE Board of Directors opposes the MDHHS announced structural strategies for compliance with the federal Conflict Free Access and Planning Rules.

BE IT FURTHER UNANIMOUSLY RESOLVED THAT, the NMRE Board of Directors requests MDHHS reconsideration of its current decisions and to honor CMS waiver approval for procedural mitigation of conflict, and to pursue CMH approval of strengthened procedural safeguards against conflict of interest in Michigan.

ON BEHALF OF THE NORTHERN MICHIGAN REGINAL ENTITY BOARD OF DIRECTORS MAY 22, 2024

Gary Klacking, Chairperson (AuSable Valley CMHA)
Don Tanner, Vice-Chairperson (Centra Wellness Network)
Karla Sherman, Secretary (North Country CMHA)

PIHP CEO Meeting
June 6, 2024
9:30 a.m. – 12:00 p.m.
Microsoft Teams Meeting

Contents

MDHHS Attendees:

Kristen Jordan
Michelle Mills
Michelle Hill
Ashley Seeley
Meghan Groen
Leah Julian
Jackie Sproat
Kasi Hunziger
Audrey Dick
Herve Mukuna
Brian Keisling
Angela Smith-Butterwick
Allison Beaudouin
Crystal Williams
Keith White
Erin Emerson
Lindsey Naeyaert
Ernest Papke
Lyndia Deromedi
Alexandra Kruger
Nicole Hudson
Belinda Hawks
Dana Moore
Krista Hausermann
Scott Wamsley

PIHP Attendees:

Jim Johnson
Eric Doeh
James Colaianne
Brad Casemore
Joe Sedlock
Morgan Osaer
Dana Lasenby
Mary Marlatt-Dumas
Traci Smith
Amanda Ittner

CCBHC

a. Lindsey Naeyaert provided updates.
    1. We do have our new certification manager, Jen Ruff, who is overseeing our certification process for CHC.
    2. We also expanded our team with two other folks who are certification specialists for CHC and they're really going to be focusing on UMM, doing certification recertification for the existing and any potential expansions and ongoing monitoring and support for CCHC's and the certification process and working on site visits as well.
    3. Our team is working on reviewing recertification applications for our current CBHC demonstration sites. We're doing the recertification for the current demonstration sites right now and recertifying the demonstration sites that started in October to the new criteria.
        i. All of our potential expansion sites must submit their application and cost reports by July 1, and that expansion is contingent on what's included in the final budget.
        ii. We have been offering technical assistance training.
        iii. We've been meeting individually with those organizations that did submit an intent to apply for certification survey back in March, and we did have 13 organizations who are interested in joining the demonstration.
    4. For the behavioral health home, just wanted to let folks know quickly that we are expanding, or we plan to submit a state plan amendment to expand the BH to PIHP regions 3/4 and 9, and that policy is currently out for public comment.
        i. We do plan to submit the SPA hopefully in the next couple weeks, which will include an update to those geographic regions.
        ii. We are adding two additional eligibility codes F91 which is conduct disorder and F98 which is other behavioral emotional disorders.
        iii. Those two codes, along with a youth peer support specialist kind of geared to supporting youth and adolescence in the BH model, and that was based on feedback that we received from our current BHH regions.

Crisis Services

a. Krista Hausermann provides updates for Crisis Services
    1. We are expecting a new quarterly crisis update to be coming out any day.
    2. We've had a group that's been working on developing a crisis model and high-level model.

i. It has 988 and there are crisis hubs that will be operated like the local CMHSP and then out of that crisis hub there will be kind of the air traffic controller for an array of crisis services which will fall under the ICS benefit.
ii. We have drafted some language around the ICSS policy.
iii. Hopefully will come out in the next month or so to share with everyone we have floated this model by.
iv. We've also shared that model with the CCHCS and we'll be presenting this model in some of the concepts and at the Board Association Conference next week talking about some of those pieces.
v. Where we're headed is a gentle move more in the direction of providing 24/7 crisis services outside of the ER.
vi. Having the crisis hub availability, somebody to pick up the phone and dispatch some type of crisis service 24/7 outside of the ER, it could be a telehealth response.
vii. There is an emphasis on building out more of that two-person response or building out at somewhere in that array of 24/7 crisis services.
viii. We are getting much closer to looking at the requirements for staffing and really building out a requirement for a certified crisis professional.
ix. We hope to formally certify to create some type of certification. We are still working out how to go about it and we have the training that we've been working with Wayne State and there's a lot of excitement from providers around that training.
x. We have an advisory group to give us good feedback and hopefully each of the members of the advisory group are keeping the CMH on and the PIHP's updated because there's supposed to go back and have conversations with them where we're headed. W
xi. What we're doing with the initiation of this crisis training and with crisis training requirements, the focus will be more on them having trained and having skills, certain skills to provide crisis services rather than requiring very specific degrees.

3. CSU- We've got 2C issues that are finishing up provisional certification so that they can start to operate a little earlier.
    i. Network 180 is already operating, and Detroit Wayne should be starting to operate sometime this month.
    ii. We are also working very hard with Milliman on the bundled rate, develop a bundled rate for CSU.
    iii. We need to wait to submit the rules to the legislature because there's a component in there where we need to include some cost information.
4. Hopefully in the next month or two there will be an RFP that will be issued for community based mobile crisis and it will be an opportunity for in particular rural areas to develop some creative some creative response, mobile crisis response for their communities.
5. As we build out these and have the new requirements, we're also looking to support and work with rural areas because we know that's more challenging for them and in particular areas where there isn't a state demo CBHC. We look forward to getting

feedback from the rural caucus on the proposed rules and also to talk about potential funding and how we can initially help them with some funding to get things set up.

Public Health Emergency Unwind

a. Nicole Hudson provided the Public Health Emergency Unwind updates.
    1. The May 2024 Cohort is our final Cohort, and we are in the final month with the one-month procedural, the one month pause, and procedural terminations for the May 2024 Cohort.
        i. Once that finishes, at the end of this month, we have completed our full 12-month cycle for CMS and will be sort of finished so to speak with the pH unwind.
        ii. However, about a month or six weeks ago, CMS indicated to states that they would be extending all of the E 14 waivers and special flexibilities until the end of the 2024 calendar year.
        iii. Then CMS again indicated to states that they would actually be extending all of the E 14 waivers and special flexibilities through June 30th, 2025.
        iv. While we are now starting in with our kind of regular, so to speak, cohort of renewals, we actually still have the ability to use our E 14 waivers that we had in place during the pH unwind that were supposed to expire but are now not expiring.
        v. We will be a updating the operations plan.
        vi. Even though our pH unwind cohort is over many of these waivers will be remaining in place for at least in the next year.
        vii. We will be building out some of these more systematic pieces of our systems, so as we process renewals moving forward, they will just become part of our regular processes.
        viii. We will also be looking at some more systematic changes so that we can streamline and make that process more efficient.
        ix. Partnering with enrollment brokers to update our in state beneficiary contact information again will be continuing that one reinstating eligibility affective on an individual's prior termination date for individuals who are disenrolled based on a procedural reason and are subsequently redetermined eligible for Medicaid during a 90 day reconsideration period.(simply put, folks who are procedurally disenrolled and submit their renewal paperwork within 90 days, they will be reinstated back).
        x. Termination date extension is also part of the new eligibility rule.
        xi. Nicole shared a link in the meeting chat regarding her presentation.

    2. Medicaid eligibility for those with stable income or assets when no useful data is returned, we will be continuing that through 6/30/2025, delaying procedural terminations for beneficiaries for one month while the state conducts targeted renewal outreach.
        i. We have been able to determine that on average, every month we have been able, through this policy alone, to renew on average 21,230 additional

beneficiaries every month simply by delaying those procedural terminations by one month. This is a policy that we will get to continue for at least another year.

ii. We will be continuing to send list to our managed care plans to and other providers of individuals who are going to be up for renewal on through our 837 files and then those who do not respond or are being either procedurally terminated or closed for eligibility reasons to allow for some outreach. We are continuing to allow plans to do outreach, through phone, email, text message to contact those who either haven't returned their forms etc.

iii. We will continue to extend the amount of time managed care plans have to conduct outreach to individuals who have been terminated for procedural reasons, but we will be rescinding the extra time we've provided managed care plans to do outreach to individuals who have been terminated for eligibility reasons. We had given an extra 30 days, so from 30 days to 60 days during the unwind, again, just as we're moving back into some normal operations, we are going to move that back from 60 days to 30 days. However, they will have extended time to do outreach to individuals.

HIDE SNP/PIHP

a. Updates provided by Allison Beaudouin
    1. As a reminder, the MyLink program is currently geographically limited to four regions throughout Michigan, and we will be transitioning to a model starting in 2026 that integrates long term care services and supports or LTSS and it will become a statewide model.
        i. While we're not integrating behavioral health in this model, we recognize duly eligible beneficiaries often have many physical and behavioral health needs.
        ii. We work to draft a coordinating agreement similar to that that's used in the comprehensive Health care program between the PIPS and the MHPS, and we want this to be used as a baseline for coordination criteria between the payers and this model, similar to how it's being used in the other program, we circulated a draft of the coordinating agreement that we created based on the CHCP template, and we solicited your input for feedback and we are very happy that we have received quite a few ideas and suggestions for improving the draft, many of which we are able to incorporate into the template.
        iii. A final draft of the template with the Q&A document that provides responses to some of the questions we received, will circulate sometime in the next week.
            i. It will also highlight the changes that we made based on your feedback in the Q &A.
            ii. Many of the edits that we made added clarity to what was already included in the agreement.
            iii. Some of the changes were a little bit more substantial than others and they addressed some gaps in the agreement that you all had identified for us.
            iv. We added some language around the roles and the responsibilities of the PIHP and the HIDE SNP as well as our expectations for coordination for the mutually served beneficiaries.

v. We also added some out letter citations for payment responsibility grids and the behavioral health consent form.
vi. We added a statement to allow additional collaboration above and beyond what is outlined in the agreement to give broad flexibility for innovations between payers.
vii. Where it was appropriate to require written documentation, specifically around plan contacts, to make sure that you all have written contact information for each.
viii. We incorporated language around the exchange of information on how to identify mutually served enrollees, including use of care, Connect 360 and other available systems.
ix. We added an expectation for disputes to be resolved in accordance with expectations outlined later in the agreement.
x. We added in the referral section some language about encouraging plan to plan and PCP communication and collaboration and requirement to address the needs of beneficiaries as quickly as their needs require.
xi. We added language to assure necessary communication about referrals including the sharing of social determinants of health screenings and language around tracking referrals and monitoring referrals.
xii. In the Care coordination section, we added some broad flexibility to establish performance improvement projects to measure improved outcomes and then also processes to monitor and report and intervene to improve individual metrics including headers, metrics.

CFAP Update

a. Updates provided by Belinda Hawks
    1. Conflict free access and planning.
        i. Metting with beneficiaries is scheduled for the 20th and the 24th and you'll be getting an invitation sent to you today related to that invitation.
        ii. It's an open webinar for people served and their families and you folks are welcome to attend and listen in.
        iii. We have also been quickly developing the necessary resources for you to be able to submit an implementation plan to the department and those things include the implementation.
        iv. Q&A documents that are as a result of all those subsequent stakeholder meetings and future ones with individual served, we will create separately so that people served can have a reference point as well.
        v. We're working with Wayne State an effort to have them help and assist the department in developing resource materials for those individuals and families so that they have additional information related to this rule and how it applies to their services and supports.
        vi. We have an implementation strategy, billing code chart or table that we've created which better understand what service codes are in and which ones are not within the rule requirements.

vii. The template that you will be using in order to submit an implementation plan to the department is a survey style template that will come out to you and subsequently have links attached to that survey for your CMH's to complete.

viii. We're hoping to have final approval of those templates very soon and out to you.

ix. Timelines moved to July from May submission and we're likely to be adjusting that timeline because we've continued to receive feedback in our stakeholder meetings and from all of you, we want make sure that we're implementing this strategy and this timeline in such a way that makes sense for the information you need to receive, understand, have an opportunity to talk with the department.

x. There's an application process that we again are finalizing and hope to have out to you soon and perhaps even with the rest of the materials that have already reviewed and discussed here today.

xi. we want to move away from a PowerPoint presentation to one that would be a technical requirement document that would then be something that could be referenced as a part of the contract, so we're working with our division related to our contract and our policy work.

HCBS Update

a. Lyndia Deromedi provided updates.

1. We had an HCBS provider training last week.
    i. We will be sharing that PowerPoint with those that attended will also be posting it on our HTTPS web page.
2. As many of you are aware, CMS is coming for their on-site review and that will begin on July the 15th.
    i. We are just finalizing details with CMS right now in terms of and their selection of sites that they're going to visit. We do know that there are five sites that they have tentatively selected, but we need to finalize that confirmation and then once we get that finalization, we will alert the PIHPs.
3. We've been working with our MSU partners to come up with a case management training regarding HCBS compliance.
    ii. Ideally, we would be training the HCBS PHP leads and then there would be implementation across the regions we are working to see if we can get that training on our improving my practices page so that it could be available to everybody.
    iii. The intention is that that would be a required training for case managers just because we think the information is so important and we also recognize that we have a fairly new, in terms of case management, staffing, case managers who are working in the system.

WHODAS Tool

a. Lyndia Deromedi provided updates.
    i. As part of the planning process for the implementation of WHODAS, we are going to get a web page updated.
    ii. When we got the work group together, we split the work group into four different work group panels, and we assign them each and assessment and we asked them to look at five key areas. We wanted them to look at the assessment to determine the scientific acceptability.
    iii. So ultimately once we got through the scoring, we narrowed it down to two assessments and this process took us longer than we anticipated because the two assessments, we narrowed it down to both had both were very different, but they both had equal pros and cons.

DHHS Policy Conflicts for HCBS based on Behavior Treatment Plans

a. Mary Marlatt-Dumas requested discussion.

HSW Applications in WSA for CFAP- Related Issues

a. Joe Sedlock requested discussion.

PRTF Update

a. Alex Kruger provided update.
    1. There is going to be a revised PRTF policy coming out shortly.
    2. We're in the final steps of adding another provider to our youth array, so we will be having a provider over in the Livonia area. They will be adding an additional 6 beds this summer and are in the final steps of some construction and CCI licensure, but we're in the process of getting them on board and credentialed and contracted and to start providing services for youth and the ages of 9 to 12 years old.

EVV Update

a. Michelle Hill provided updates.
    1. Reminder, that the lens for which behavioral health is operating within in based upon the guidelines and expectations by CMS.
        i. We have a go live date of September 3, 2024
        ii. Welcome letters went out on May 14th to agency providers and fiscal intermediaries, to help them to understand next steps, welcoming them to the Ajax team, and understanding what to expect moving forward.
        iii. Phase two is going be looking at broadening assessments.
        iv. The Get Ready webinars are our first step towards the phase three launch and those will happen on June 10th, June 13th and June 18th. You do need to register to attend.

v. The link Michigan is up and running and has been for a few months where it shows information about the different pieces connected to EVV.
vi. After the webinar, there will be a survey collection process.
vii. There is a technical go live milestone date of mid-August that is targeted to help support that formal official go live on September 3rd and in between the technical go live and the official goal live there will still be ongoing training events for preparing your caregivers how to use the system with regard to scheduling all of those really key pieces so that folks that need to use the system feel confident and comfortable with.

EVV Update from DHHS and EVV Discussion

a. James Colaianne requested discussion.

Mi Healthy Life/Mental Health Framework

a. Kristen Jordan provided updates.
    1. The mental health framework we've been working on as part of the My Healthy Life initiative.
        i. The high-level information has been shared on our website.
        ii. We are currently connecting some targeted interviews with a few of the Medicaid health plans and PIHPs around the current state of information sharing and joint care planning.

Governor Signs SB 27 – Codifying Federal Parity Legislation

This week, Governor Gretchen Whitmer signed bipartisan legislation that requires insurers to cover treatments for mental health and substance use disorder at the same level as physical health services. This new law aims to close existing loopholes, ensuring that Michigan residents have necessary access to the treatments they need.

Senate Bill 27**,** sponsored by state Senator Sarah Anthony (D-Lansing), simply codifies the federal mental health and substance use disorder law and puts it into Michigan statute.

“Every person in Michigan deserves access to mental and physical health care," said Governor Whitmer**.** “Today, I am proud to be signing a commonsense, bipartisan bill to require insurers to provide equal coverage for mental health and substance use disorder treatments, just as they do for physical health treatments. Getting this done will ensure Michiganders get the care they need and close loopholes that have allowed providers to avoid covering these essential services. Let’s keep working together to help every Michigander get the help they need to get better.”

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Analysis of FY 24 Medicaid Behavioral Health revenue picture; recommendation to meet
Date: Friday, June 14, 2024 10:12:07 AM
Attachments: image001.png
Copy of Actual Funding to Projected Comparison as of May 31st.pdf

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To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Analysis of FY 24 Medicaid Behavioral Health revenue picture; recommendation to meet

Below is a recent correspondence with MDHHS and Milliman regarding the revenue gap that many of the state's PIHPs and CMHSPs are experiencing, this year, in spite of the recent Medicaid rate increase.

We will keep you posted as our work with MDHHS and Milliman progresses.

_____

MDHHS and Milliman colleagues,

Over the past several weeks, since the implementation of the new Medicaid Behavioral Health rates, our PIHP and CMHSP members have indicated that the Medicaid revenues coming to the state's PIHPs, since April 2024, have not been sufficient, for most of the state's PIHPs, to close the revenue gap that they projected prior to the rate increase. What was to be $116 million in additional revenue – sufficient to close the projected revenue gap - as a result of the increased rates (as outlined in the slides that accompanied that rate increase), is projected to be closer to $40 million, based on the April and May 2024 payments.

The key take-aways from the analysis, attached, include:

1. As seen in the first table at the top of the page, the new rates, when applied to the October through March period, close the gap experienced during that period, with a modest difference of $150,000 between the projected revenues and the actual revenues received. So, you, Milliman and MDHHS, were accurate in developing the rate increase needed for the first six months of the year.

2. However, after the first six months of the year, when the actual enrollment totals and age/gender breakdown was known, the actual revenues received for April and May are significantly below the revenues that were expected from the new rates. These differences - $12,355,955 for April and $13,832,007 for May (the second and third table in the attached) – leave a gap of $13.09 million per month, totaling a gap of over $78.5 million from what was expected to be a $116 increase in Medicaid payments to the state's PIHPs.

3. There appears to be several factors at work in relation to this gap:
    a. The statewide actual DAB, HMP, and HSW enrollments (the bottom table in the attached) are below what was projected when the new rates were developed. DAB is 1.8% below, HMP is 1.6% below, and HSW 2.8% below; while the TANF enrollment is slightly higher than projected, at 0.4% above the

projection.

While the actual enrollment, statewide, is not far from the projected enrollment, the enrollment patterns widely vary from PIHP to PIHP and CMSHP to CMHSP.

b. While the actual enrollments, statewide are slightly below the projected enrollment (with some parts of the state, as noted above, with much deeper enrollment losses), the revenue losses by each population are much greater, as the table below illustrates. This difference is typically due to the actual pattern of enrollment, re-enrollment, and disenrollment, by age and gender, being significantly different from that contained in the projection.

April 2024

Medicaid Populations	% Difference is to Projected Enrollment	% Difference in revenues	
		BH	SUD
DAB Population Count	-1.0%	-3.9%	-3.5%
TANF Population Count	0.2%	-2.6%	-7.3%
HMP Population Count	-1.0%	-4.8%	-4.4%

May 2024

Medicaid Populations	% Difference is to Projected Enrollment	% Difference in revenues	
		BH	SUD
DAB Population Count	-1.8%	-4.7%	-4.1%
TANF Population Count	0.4%	-2.3%	-7.2%
HMP Population Count	-1.6%	-5.1%	-4.7%

RECOMMENDATION: Given this revenue gap, of $78 million, from what all of us had hoped would be a gap-filling rate increase, we would like to have your shop, the state's PIHPs, and CMHA get together, soon, to work to revise the rates to close this gap. If you would send dates that work for you, we can then, as a group, nail down a time and date to meeting.

Thank you, in advance, for your work on this front.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
507 South Grand Avenue
2nd Floor
Lansing, MI 48933
517.237.3142 (direct)
www.cmham.org

Community Mental Health Association of Michigan Comparison of Actuarial Projected Funding and Funding Received

	October of 23 through March of 24 Revised Funding Comparison			
Funding Category	**Revised Actuarial Projected Funding**	**Actual Funding Reported**	**Difference**	**% Difference is to Projected**
DAB Capitation Behavioral Health	$ 1,040,800,000	$ 1,040,781,694	($18,306)	0.0%
DAB Capitation Substance Use Disorder	$ 20,500,000	$ 20,476,189	($23,811)	-0.1%
TANF Capitation Behavioral Health	$ 189,000,000	$ 189,038,335	$38,335	0.0%
TANF Capitation Substance Use Disorder	$ 24,000,000	$ 24,032,138	$32,138	0.1%
HSW,CWP, & SED Payments	$ 319,300,000	$ 319,122,821	($177,179)	-0.1%
HMP Capitation Behavioral Health	$ 151,700,000	$ 151,690,523	($9,477)	0.0%
HMP Capitation Substance Use Disorder	$ 69,900,000	$ 69,861,724	($38,276)	-0.1%
Autism all Populations	$ 150,700,000	$ 150,746,569	$46,569	0.0%
Total:	$ 1,965,900,000	$ 1,965,749,994	($150,006)	0.0%

Comparison of Projected Funding versus Actual Funding for April and May of 2024

	30-Apr-24			
Funding Category	**Actuarial Projected Funding**	**Actual Funding Reported**	**Difference**	**% Difference is to Projected**
DAB Capitation Behavioral Health	$ 183,630,000	$ 176,556,134	($7,073,866)	-3.9%
DAB Capitation Substance Use Disorder	$ 3,540,000	$ 3,415,108	($124,892)	-3.5%
TANF Capitation Behavioral Health	$ 33,080,000	$ 32,214,027	($865,973)	-2.6%
TANF Capitation Substance Use Disorder	$ 4,040,000	$ 3,745,070	($294,930)	-7.3%
HSW,CWP, & SED Payments	$ 57,030,000	$ 54,814,615	($2,215,385)	-3.9%
HMP Capitation Behavioral Health	$ 25,810,000	$ 24,563,864	($1,246,136)	-4.8%
HMP Capitation Substance Use Disorder	$ 11,900,000	$ 11,374,170	($525,830)	-4.4%
Autism all Populations	$ 27,110,000	$ 27,101,059	($8,941)	0.0%
Total:	$ 346,140,000	$ 333,784,045	($12,355,955)	-3.6%

Medicaid Populations	**Actuarial Projected ***	**Actual Reported**	**Difference**	**% Difference is to Projected**
DAB Population Count	503,500	498,361	(5,139)	-1.0%
TANF Population Count	1,296,500	1,299,173	2,673	0.2%
HMP Population Count	780,500	773,052	(7,448)	-1.0%
HSW Paid Person Count	7,457	7,249	(208)	-2.8%

	31-May-24			
Funding Category	**Actuarial Projected Funding**	**Actual Funding Reported**	**Difference**	**% Difference is to Projected**
DAB Capitation Behavioral Health	$ 182,350,000	$ 173,819,440	($8,530,560)	-4.7%
DAB Capitation Substance Use Disorder	$ 3,510,000	$ 3,366,333	($143,667)	-4.1%
TANF Capitation Behavioral Health	$ 32,440,000	$ 31,683,590	($756,410)	-2.3%
TANF Capitation Substance Use Disorder	$ 3,960,000	$ 3,675,266	($284,734)	-7.2%
HSW,CWP, & SED Payments	$ 57,030,000	$ 54,625,857	($2,404,143)	-4.2%
HMP Capitation Behavioral Health	$ 24,800,000	$ 23,544,409	($1,255,591)	-5.1%
HMP Capitation Substance Use Disorder	$ 11,430,000	$ 10,897,855	($532,145)	-4.7%
Autism all Populations	$ 26,780,000	$ 26,855,244	$75,244	0.3%
Total:	$ 342,300,000	$ 328,467,993	($13,832,007)	-4.0%

Medicaid Populations	**Actuarial Projected ***	**Actual Reported**	**Difference**	**% Difference is to Projected**
DAB Population Count	499,900	490,794	(9,106)	-1.8%
TANF Population Count	1,271,500	1,276,993	5,493	0.4%
HMP Population Count	750,800	739,031	(11,769)	-1.6%
HSW Paid Person Count	7,457	7,249	(208)	-2.8%

** Does not include Adjustment factor from Certification Document*

DATE: May 17, 2024

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Belinda Hawks, MPA
Director
Adult Home and Community Based Services Division

SUBJECT: Home and Community Based Services (HCBS) Final Rule Requirements Regarding use of Restrictions and Modification of Rights

The purpose of the communication is to clarify the position of the Michigan Department of Health and Human Services (MDHHS) related to the requirements of the Home and Community Based Services (HCBS) Final Rule regarding the use of restrictions or the modification of a Medicaid beneficiary's rights. The rule identifies that Medicaid beneficiaries shall enjoy the same rights and freedoms as non-Medicaid beneficiaries.

It is our intent to ensure that any restriction of a person's rights is supported through the adherence to a person-centered planning process and is present in the Individual Plan of Service (IPOS).

The following criteria will assure compliance with these requirements:

- Any restriction of a person's rights is identified through the adherence to a person-centered planning process.
- The restriction is being instituted as the last resort when less restrictive measures have been unsuccessful.
- The IPOS shall include justification that the restriction is needed to ensure the health or safety of the person or those around them,
- Restrictions placed upon a person shall be the minimum that can be expected to be effective.
- Document that any modifications of the HCB settings requirements are based upon a specific assessed health and safety need and justified in the person-centered service plan including the following:

    - Identify the specific assessed need(s),
    - Document the positive interventions and supports used previously,
    - Document less intrusive methods that were tried and did not work, including how and why they did not work,
    - A clear description of the condition that is directly proportionate to the assessed need,
    - Identify the services and supports that will be in place to reduce the need for the restriction,

- Regular collection and review of data to measure the effectiveness of the modification,
- Established time limits for periodic review of the modification,
- Informed consent of the individual and,
- Assurances that the modifications will cause no harm to the individual.

Additionally, it is important to note that:

- All settings providing an HCBS service have a current, signed copy of the IPOS.
- HCBS Providers will be trained on any restrictions or modifications present in the individual IPOS. Please note that the Behavior Treatment Plan (BTP) is not a substitute for the IPOS. An updated IPOS with the approved restriction in place must be provided to the setting prior to implementing the restriction.

Please see attachment A for supplementary detail related to the applicable policies and additional resources.

Questions related to the HCBS rule may be directed to the HCBS team at HCBSTransition@michigan.gov .

Thank for your continued support in our successful implementation of the HCBS Final Rule.

c: Kristen Jordan, Director, Bureau of Specialty Behavioral Health Services
Lyndia Deromedi, Federal Compliance Section, Manager
Millie Shepherd, HCBS Specialist

Attachment A: Links to Home and Community Based Services Policy Requirements

Michigan Medicaid Provider Manual Link:
See Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter under
Section 3- Covered Services; 3.4 Behavioral Treatment Plan and
MedicaidProviderManual.pdf (state.mi.us)

MDHHS Person-Centered Planning Policy
https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder17/Folder3/Folder117/Folder2/Folder217/Folder1/Folder317/Person-Centered_Planning_Practice_Guideline.pdf?rev=ffea3bb64407413bac68814ffcb1bf6e&hash=7CFC27549579F3C147E3417B188A8E8A

Behavior Treatment Plan Technical Requirements:
https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines/behavior-treatment-plans

The Behavior Treatment Technical Requirement revised 7.31.2023 states

A. *The PCP process used in the development of a written IPOS will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical, or environmental causes of the target behavior, and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.*

B. *Behavior treatment plans must be developed through the PCP process and written special consent must be given by the individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan that includes intrusive or restrictive interventions.*

Administrative Rule R330.7199- b. 2018 Administrative Rules (michigan.gov)

R 330.7199 Written plan of services. Rule 7199. (1)The individualized written plan of services is the fundamental document in the recipient's record. A provider shall retain all periodic reviews, modifications, and revisions of the plan in the recipient's record
(ii) Any limitation shall be justified, time-limited, and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid limitations, as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the limitations in the future.

Additional clarification of the PIHPs contractual obligations is provided in the policies and practices section of the MDHHS webpage.
HCBS_Monitoring_Compliance_Technical_Advisory.pdf (michigan.gov)

V. The Contractor must ensure that all HCBS Final Rule requirements are met, as described in the Michigan Medicaid Provider Manual.
The Contractor will review any restrictions placed upon the individual to ensure that they are consistent with the HCBS modification requirements and Behavior Treatment Plan Review Committee Technical Requirements as outlined in the Michigan Medicaid Provider Manual.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

MEMORANDUM

DATE: May 28, 2024

TO: Executive Directors of Prepaid Inpatient Health Plans

FROM: Jackie Sproat, Director JS
Division of Contracts and Quality Management

SUBJECT: Psychiatric Inpatient Tiered Rates

In FY19, the legislature put forth language that was signed into law to move towards a tiered rate system for psychiatric inpatient care. PA 27 2019, Sec. 1513. (1) The department shall participate in a workgroup to determine an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care. Since then, legislative and executive branches have continued to support this effort each year. In FY24, House bill 4437 Section 1815 continued support and provided $8M GF to fund tiered rates.

MDHHS is providing this memorandum as notice to PIHPs regarding the implementation of Psychiatric Inpatient Tiered Rates. MDHHS expects tiered rate modifiers will begin to be reported on encounters starting July 1, 2024, in preparation for paying tiered rates starting October 1, 2024, pending federal review and approval.

Psychiatric Inpatient Tiered Rate Modifiers:

Effective July 1, 2024, there will be four new modifiers for inpatient psychiatric stays; these can be reported as early as April 1, 2024, but will not be required until July 1, 2024. For contracts where physician services are unbundled (i.e., not using 0100 revenue code), reporting will be required starting at a later date.

Modifier	Description
V1	Demonstration Modifier: Tier 1 – Normal staffing level
V2	Demonstration Modifier: Tier 2 – 2:1 staffing ratio
V3	Demonstration Modifier: Tier 3 – 1:1 staffing ratio
V4	Demonstration Modifier: Tier 4 – 1:2 staffing ratio

Staffing ratios represent Patients:Hospital Staff

Which code/service would these modifiers be reported on?

- Revenue Code 0100.
  - Revenue code 0100 is an all-inclusive rate for room and board plus ancillary services, including payment for both the hospital and physician service.
  - The bundling of physician services is required beginning at a later date, which may lead to some other IP Psych revenue codes being removed from the code sets.

Purpose/Goal of Psychiatric Inpatient Tiered Rates:

The goal of the proposed tiered rate methodology is to provide a standardized approach to payment increases that incentivize the provision of inpatient psychiatric services with enhanced staffing levels and improved access to care.

Tier assignment:

- Tiered rates will be assigned to each patient day without an hours threshold. Multiple days can be reported on the same claim line if staffing ratios are consistent during the span. Encounter claims should include multiple claim lines if multiple rate tiers are needed.

Covered days:

- The number of covered days applicable for each tiered rate would be based on the service to date less the service from date (subject to payor approval).
- Covered days would be reported at the claim detail line level, along with revenue code, revenue code modifier (V1-V4), and service date to allow for multiple per diem rate tiers to be billed for the same patient stay.

Validation:

- MDHHS proposes that the PIHP/CMHSP payor validate the initial placement of patients into tiers:
  - Patients can move to higher or lower rate tiers based on a physician order, with the physician order being used as documentation.
  - MDHHS continues to propose PIHPs and CMHSPs validate the initial placement of patients into higher rate tiers and maintaining the concurrent review process with current policies.

Psychiatric Inpatient Tiered Rates:

Psychiatric Inpatient Tiered Rates will not be implemented until October 1, 2024, pending federal review and approval. MDHHS intends to share the tiered rate fee schedule later this month. Effective October 1, 2024, PIHP (or subcontracted CMHSP) must pay no less than the state defined minimum rates for inpatient psychiatric services. Additionally, MDHHS has received questions regarding 3rd party payors. The tiered rates minimums apply to Medicaid only.

cc: Kristen Jordan, MDHHS
Keith White, MDHHS
Kasi Hunziger, MDHHS

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

MEMORANDUM

To: Executive Directors of Pre-Paid Inpatient Health Plans (PIHPs) and Community Mental Health Service Providers (CMHSPs) and Assessment Panel Members and Community Partners

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

Date: June 5, 2024

RE: Introduction of new Intellectual and Developmental Disability (I/DD) Assessment/Screening Tool

The Michigan Department of Health and Human Service (MDHHS) is excited about the opportunity to introduce a new assessment/screening tool for Medicaid beneficiaries who are 21 and older with I/DD which will be used to determine eligibility for 1915(i) State Plan Application (iSPA) services and to screen individuals who may be eligible for the Habilitation Supports Waiver (HSW). MDHHS has made the decision to use the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) as the assessment/ screening tool to replace the Support Intensity Scale (SIS-A).

In March of 2023, MDHHS concluded the contract to utilize the SIS-A assessment tool for adults with I/DD. In the fall of 2023, the MDHHS developed an assessment panel workgroup that included clinical and administrative professionals from PIHPs and CMHSPs, Medicaid beneficiaries, advocates, and family members of Medicaid beneficiaries from across the State of Michigan to support the selection of a replacement for the SIS-A. Panel Members reviewed four candidate assessments and provided a recommendation to MDHHS. The four candidate assessments reviewed were Functional Assessment Standardized Items (FAS*), Adult Needs and Strengths Assessment (ANSA), Adaptive Behavioral Assessment System (ABAS3) and WHODAS 2.0.

MDHHS recognizes t hat the implementation of a new assessment tool requires the time necessary to ensure success. Included below is a proposed timeline of implementation. Keep in mind, this timeline is proposed and is subject to change to include additional implementation activities.

General Tentative Timeline for WHODAS 2.0 Implementation:

- MDHHS defining implementation details (current)
- Begin gathering steering committee members (fall 2024)
- Steering Committee launched (winter 2025)
- Training (Spring 2025)
- Implementation (Fall 2026)

If you have any questions, please email Alana Blaha at BlahaA1@michigan.gov and include I/DD Assessment/Screening Tool in the subject line. Further information regarding the WHODAS 2.0 can be found on the following webpage: WHO Disability Assessment Schedule (WHODAS 2.0)

c: Belinda Hawks, Director, Adult Home and Community Based Services Division
Lyndia Deromedi, Federal Compliance Section Manager
Patricia Neitman, Director, Bureau of Children's Coordinated Health Policy and Supports

From: Deromedi, Lyndia (DHHS)

Subject: Excellent Work by PIHP HCBS Leads
Date: Monday, June 10, 2024 4:59:42 PM

Good afternoon,

I am writing this email to extend my gratitude and appreciation for the excellent work done by the PIHP HCBS leads gathering and verifying the provider email contacts to get the HCBS Setting surveys out last week. I wanted to let you know that we had very few email bounce backs, with one PIHP having zero and many having less than 10. I know a significant amount of work was asked of all the leads to complete this task timely but also accurately, which needs to be recognized. Your hard work has paid off as there will be little time spent on verifying emails and instead can be spent with providers to address questions about the survey and to encourage completion.

I know it is not much but thank you for your dedication to ensure this task was completed with accuracy and by the deadline provided so we could meet our timelines. It is valued and recognized.

Sincerely,

Lyndia Deromedi MBA, LBSW
Manager of Federal Compliance Section
Division of Adult Home and Community Based Services
Bureau of Specialty Behavioral Health Services
Behavioral and Physical Health and Aging Services Administration
Cell: 517-243-4944
deromedil@michigan.gov

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Advocacy generated by recent action alert
Date: Monday, May 20, 2024 9:52:02 AM

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Advocacy generated by recent action alert

As you know, CMHA and you, its members, and our allies are involved in an advocacy effort to urge the state of Michigan to adopt a sound approach to meeting the federal conflict free requirements.

Several days ago, CMHA issued an action alert, urging you and our allies to contact their state legislators and the Governor.

As of Friday afternoon, May 17, over 900 emails have been generated to those elected officials; and this effort has only begun. Bravo.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
507 South Grand Avenue Lansing MI 48933
517.374.6848 main
517.237.3142 direct
517.374.1053 fax
cmham.org

COUNTY OF OSCODA
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Ms. Libby Marsh

Mr. Tom McCauley, Vice Chair
Mr. Ted Handrich

Telephone (989) 826-1130

Fax Line (989) 826-1173

Oscoda County Government Center, 311 S. Morenci Ave, P.O. Box 399, Mio, MI 48647

June 11, 2024

Northern Michigan Regional Entity
1999 Walden Drive
Gaylord, MI 49735

Re: Letter of Support

Mr. Gary Klacking,

On behalf of the Oscoda County Board of Commissioners, we are writing this letter of support to the Northern Michigan Regional Entity in their decision to implement a Resolution Opposing MDHHS' Decision to Implement Conflict Free Access and Planning in Michigan.

Sincerely,

Charles E. Varner, Jr., Chair

Cc: Rep. Ken Borton
Rep. Cameron Cavitt
Senator Michelle Hoitenga

March 5, 2024

Centers for Medicare and Medicaid Services
ATTN: Keri Toback, CMS
keri.toback@cms.hhs.gov.

RE: Concerns about the proliferation of conflict of interest in the Michigan Community Mental Health System

Dear Ms. Toback:

We represent three of Michigan's oldest, statewide disability rights organizations and we write to share our concerns regarding the conflict of interest that is present in the public mental health system in our state. The Arc Michigan, Disability Rights Michigan and the Mental Health Association in Michigan have over 160 years of combined experience advocating for individuals with developmental and intellectual disabilities; mental health and substance use disorders and children with serious emotional disturbance. In our work with persons who receive services from the community mental health system in Michigan, we are uniquely positioned to observe the problems that have been created by the lack of accountability and oversight that is endemic in our state mental health system.

The main driver behind the lack of accountability and oversight is the blatant conflict of interest that is woven into the governance boards of the managed care organizations or Prepaid Inpatient Health Plans (PIHPS). We have been perplexed and confused by the way in which the PIHP boards have been allowed to be structured and cannot understand it. We have wondered if it is allowed under Federal rules for a managed care organization's board to be populated with the entities that contract with it, thus allowing the contracted entities to control the managed care organization. This seems, at least to us, to be problematic, particularly if the MCO is charged with monitoring the members of its provider network.

As advocates, we listen to beneficiaries, to beneficiaries' families and to those who support beneficiaries as they explain their frustrations trying to access specialty supports and services from community mental health services providers or CMHSPs. We and our staff provide direct advocacy assistance to beneficiaries and have witnessed the challenges that they experience. Problems include:

- Being told that home and community-based services and supports are not available due to a lack of providers
- That there is not enough money to pay for supports and services that are needed
- That the beneficiary does not meet "medical necessity criteria" but the rationale for making the determination lacks specificity.
- The failure to provide beneficiaries with notice of their rights to due process when there is an adverse benefit determination is an ongoing problem.

Person-centered planning is virtually non-existent, and beneficiaries are rarely offered the opportunity to have an independent facilitator during the planning process. Adults with serious mental illness and children with serious emotional disturbance (SED) are rarely offered the chance to participate in a self-determination arrangement. These are only a few of the problems that are ongoing in our state. At the same time, one of the solutions that MDHHS proposes to eliminate the conflict of interest is to have independent facilitation and self-determination available.

We have made concerted efforts to meet with leadership from the Michigan Department of Health and Human Services (MDHHS) to voice our concerns about the conflicts of interest and how that conflict of interest interferes with the ability of persons served to access and select Medicaid-covered services and support, but our concerns have gone unanswered. Additionally, we have met with MDHHS leadership on three separate occasions: August 7, 2023; October 31, 2023, and December 19, 2023. Despite these conversations, our statement of concerns which includes not only the conflict of interest on the PIHP boards but also the fact that the MDHHS is not following its own 2019 1915(i) waiver application with respect to addressing the conflict free access and planning that is required by the revisions to the HCBS rules that occurred in 2014. Therefore, we have decided to bring our concerns to you, the Centers for Medicare and Medicaid (CMS), with the hope that you will actively address the problems that we will outline in this correspondence with the state of Michigan.

We were also told by officials in MDHHS that there is "no way to hold the PIHPs/CMHSPs accountable." In light of the conversations that we had with state officials, we believe that the only way to address these ongoing systemic failures is to seek your help. Unfortunately, despite the multiple meetings with the state, the most outstanding obstacle in the system has gone unaddressed: the lack of accountability and oversight by the PIHPs and the MDHHS.

As it stands right now, the CMHSPs have absolute control of the boards of directors of the PIHPs and yet, the CMHSPS also contract with those same PIHPS. We cannot understand how this arrangement was allowed in light of the role of the PIHP. The PIHP has two functions: 1. To write the check to the CMHSPs for Medicaid and 2. To hold the CMHSPs accountable under myriad federal and state statutes, rules, and regulations for public dollars. When the state decided to reduce the number of PIHPS from 18 to 10 in 2014, the CMHSPs became owners/members of the PIHPs. [i] For example, the Application for Participation (AFP) that was issues by the state of Michigan Behavioral Health and Developmental Disabilities Administration on February 6, 2013, provided this guidance regarding the governance of the PIHPs:

The AFP affords initial consideration for specialty prepaid inpatient health plan designation to qualified single county or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act). Therefore, the first and most basic requirement is that the organization submitting an application, be comprised of and jointly, representatively governed

by all CMHSPs in the region pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

The boards of directors of the PIHPs became populated with and controlled by the board members from the CMHSPs boards of directors. It is not possible for the board member of a CMHSP to sit on the board of a PIHP and remain fully objective and unbiased regarding the activities of its own CMHSP. As advocates, we have plenty of anecdotal evidence to support our knowledge of the fact that the PIHPs are ineffective in ensuring that the CMHSPs are following the terms of the master PIHP/CMHSP contract. We believe that most of the difficulties that beneficiaries and their families and those who love/support them experience are related to the inability of the PIHPs to ensure that the CMHSPs are abiding by their contractual obligations.

The 2013 Application for Participation that was issued by the state made it clear that the CMHSPs are to be part of the governance structure of the PIHPs.

The only acceptable legal arrangements for affiliation going forward will be either UCA agreements or creation of a regional entity under Section 1204b of the Mental Health Code. In either case, such intergovernmental affiliation formations result in the creation of a new legal entity jointly "owned" and governed by the sponsoring CMHSPs. It is this entity that will be considered, recognized, and designated as the PIHP (for a region consisting of more than one CMHSP).[ii]

Additionally, we are bringing to the attention of CMS the problems created by the governance structure of the PIHPs in light of the MDHHS' efforts to implement conflict free access and planning in accordance with its 2019 1915(i)spa application. In its 1915(i)-spa waiver application, the MDHHS gave assurances to CMS that the MDHHS will "maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the state HCBS benefit." MDHHS/BHDDA contracts with regional managed care Pre-Paid Inpatient Health Plans (PIHP) as the other contracted entity, to assist in monitoring functions of the HCBS benefit." [iii] We believe that the MDHHS and the PIHPs have been unable to keep this commitment to CMS.

The MDHHS assured CMS that certain safeguards would be implemented to allow beneficiaries to have freedom of access to home and community-based services through the elimination of conflict of interest. The state responded***, "MDHHS/BHDDA as the state Medicaid agency will deliver 1915(i) SPA services through contracted arrangements with its managed care PIHPs regions. The PIHPs have responsibility for monitoring person-centered service plans and the network's implementation of the 1915 (i) SPA services, which require additional conflict of interest protections including separation of entity and provider functions within provider entities.***" [iv] Our concern is that, as long as the CMHSPs control the governing boards of the PIHPs, then it is not possible for the PIHPs to effectively monitor the implementation of the 1915(i) SPA services. In our state, CMHSPs have functioned as both payer and provider for years. If Michigan is going to address the structural conflict of interest in the system, then changes

must be made to the board governance of the PIHPS. Despite the ongoing work that was undertaken by a workgroup convened by the MDHHS to address conflict free access and planning, Michigan still has not met the requirements as dictated by the changes in the HCBS rules in 2014.

On Pages 3-4 of the 1915 (1) waiver application that was submitted by the state of Michigan in 2019, Michigan made certain assertions that it was going to assure that certain administrative functions are carried out by either the state Medicaid Agency or by the contracted entities or PIHPs. The waiver application alleges that the state or the PIHPs will carry out the review of participant plans of service; prior authorization of State Plan HCBS; Utilization Management; Qualified provider enrollment and execution of the Medicaid provider agreements. Unfortunately, we can provide the CMS with information that demonstrates that the PIHPs DO NOT monitor the person-centered services plans of beneficiaries and that the PIHPs DO NOT implement utilization management. We believe that this information should be of concern to the federal government.

In accordance with the language from the 2019 waiver application, Michigan checked the box and made these assurances (see below) on page 2:

(By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.

We request the opportunity to meet with CMS at its earliest convenience so that we can discuss our concerns and provide representatives with anecdotal evidence that supports the concerns that have been raised in this correspondence. We are also asking that CMS inquire with the state of Michigan about the conflict of interest that has been identified in this correspondence. We remain baffled by the understanding that the current structure of the PIHP system in Michigan has been allowed under the Federal rules. We quite simply don't understand how it was or has been approved. We are seeking not only verification of the fact that such an arrangement has been undertaken with the full knowledge of the Centers for Medicare and Medicaid Services, but we would like to have a greater understanding of why this has been allowed.

Finally, we would like to include some persons served and their families in a meeting with representatives from CMS. We believe that you would benefit from hearing directly from those

who have found it necessary to fight the system in order to get what is needed for themselves and/or their loved ones. Given the fact that the community mental health system has had three federal lawsuits filed against it with and on behalf of individuals served by the system—with one filed against the MDHHS and two against CMHSPS—we believe that CMS might be interested in hearing more about "how" Michigan is underperforming in the public mental health arena.

Thank you for your attention and assistance. We look forward to hearing from you. Our contact information is: Sherri Boyd, Executive Director, Arc Michigan (sherri@arcmi.org and (517) 487-5426); Michelle Roberts, Executive Director, Disability Rights Michigan (mroberts@drm.org and (517) 487-1755); Marianne Huff, Executive Director, Mental Health Association in Michigan (mhuff@mha-mi.com and (517) 898-3907).

Sincerely,

Sherri Boyd

Michelle Roberts

Marianne Huff

Cc: Meghan Groen, Kristin Jordan, Erin Emerson, Belinda Hawks, Jackie Sproat

[i] On 2/6/13, the Michigan Department of Health and Human Services issued the Application for Participation for Specialty Prepaid Inpatient Health Plans which describes the process that those entities desiring to become or remain PIHPS must follow. Application for Participation for Specialty Prepaid Inpatient Health Plans.

[ii] IBID. Page 4.

[iii]C: MI 1915i for Behavioral Health State Plan Amendment (SPA) #: 19-0006. "Contracted Entity: MDHHS/BHDDA, as the Medicaid State Agency, will maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the state plan HCBS benefit. MDHHS local field offices establish Medicaid eligibility (function 2) as the other state agency and MDHHS/BHDDA contracts with regional managed care Pre-paid Inpatient Health Plans (PIHP), as the other contracted entity, to assist in monitoring functions of the HCBS benefit (functions 1, 3, 4, 5, 6, 7, and 10). MDHHS/BHDDA, the PIHP, an EQR Vendor, and local nonstate entities/Community Mental Health Service Programs (CMHSP) will all be actively involved in assuring quality and implementation of identified quality improvement activities (function 10).

[iv] MI 1915i for Behavioral Health State Plan Amendment (SPA) #: 19-0006. State's response to section 5/conflict of interest.

Join us!

Input Session on Mental Health

In-person or virtual

Learn and be heard

July 9, 2024 • 9-11 AM

NLCMHA Office, 105 Hall Street, Traverse City PLUS VIRTUAL

See "Recent News" at northernlakescmh.org
or scan the QR Code for the virtual meeting link

Each July we hold a Public Hearing to share information on funding and improvement projects and receive input from the community to help us assess the needs and gaps of service in our local communities.

We welcome you to provide your input in writing if you are unable to attend. Please email your input to Stacy.Maiville@nlcmh.org or mail to Stacy Maiville at NLCMHA, 105 Hall St, Ste A, Traverse City, MI 49684.

We invite you to participate and share your input with us!

Northern Lakes
COMMUNITY MENTAL HEALTH AUTHORITY

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – JUNE 12, 2024
VIA TEAMS

ATTENDEES:	**Laura Argyle, Brian Babbitt, Connie Cadarette, Ann Friend, Nancy Kearly, Inna Mason, Allison Nicholson, Brandon Rhue, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

REVIEW AGENDA & ADDITIONS
Brandon requested that a discussion about HSW payments be added to the meeting agenda.

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE MAY 8, 2024 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY LAURA ARGYLE. MOTION APPROVED.

MONTHLY FINANCIALS
April 2024

- Net Position showed net surplus Medicaid and HMP of $67,302. Carry forward was reported as $11,624,171. The total Medicaid and HMP Current Year Surplus was reported as $11,691,473. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $32,267,629.
- Traditional Medicaid showed $121,054,836 in revenue, and $117,378,208 in expenses, resulting in a net surplus of $3,676,628. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $845,073.
- Healthy Michigan Plan showed $16,150,559 in revenue, and $19,759,885 in expenses, resulting in a net deficit of $3,609,326. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $10,779,098.
- Health Home showed $1,428,070 in revenue, and $1,484,801 in expenses, resulting in a net deficit of $56,731.
- SUD showed all funding source revenue of $17,567,743 and $16,033,218 in expenses, resulting in a net surplus of $1,534,525. Total PA2 funds were reported as $4,908,762.

PA2/Liquor Tax was summarized as follows:

Projected FY24 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$5,220,509	$1,794,492	$2,595,550	$4,419,450

Actual FY24 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,220,509	$656,798	$968,545	$4,908,762

The NMRE continues to monitor revenue closely.

Clarification was made that if a Board overspends beyond the PMPM, regional smoothing will occur. The regional Operations Committee (Ops) makes these decisions. The NMRE's $11M carry forward would be exhausted before any dipping into the ISF occurs. Rates are likely still not where they should be. Ops will decide whether any Boards need to implement cost containment plans.

Laura remarked that Northern Lakes is looking at Utilization Management practices, specifically for costly out-of-network placements. Connie said that Northeast Michigan is doing the same. Laura noted that staffing ratios are often not reconsidered after a behavioral incident that necessitated a higher staffing level. Brian agreed, adding that some residential costs are similar to hospital stays.

Laura questioned whether a possible solution might be to convert a home in the region to place individuals with high behavioral needs.

MOTION BY CONNIE CADARETTE TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR APRIL 2024; SUPPORT BY ALLISON NICHOLSON. MOTION APPROVED.

EDIT UPDATE
The next EDIT meeting is scheduled for July 18th at 10:00AM.

EQI UPDATE
The Period 1 (October 1, 2023 through January 31, 2024) EQI was submitted to MDHHS May 31st. Period 2 (October 1, 2023 through May 31, 2024 is due September 30th.

Tricia reported that the Period 1 process went smoother than anticipated. The Variance report has not been received to date.

ELECTRONIC VISIT VERIFICATION (EVV)
Weekly EVV Project Discovery and Status meetings continue to occur with MDHHS and HHAX; representatives from PCE have been in attendance. Brandon noted that PIHP involvement is minimal; CMHSPs will be the central point of contact. The PIHP will act mainly as a conduit for information flow. A PCE training session took place on May 15th. A system demonstration for cases in which the CMHSP is both the service provider and the funding agency is scheduled for later in the month. Provider trainings will be scheduled once the system is established.

Allison referenced a "next steps" email which she agreed to share with the group.

LOCAL MATCH
The Quarter 4 local match payment is due to MDHHS August 16th.

HSW UPDATE
The NMRE is in need of packets from the CMHSPs. All previous packets have been submitted to MDHHS.

PLAN FIRST UPDATE
There was no update provided on this topic during the meeting.

FY24 REVENUE

Deanna shared a summary of the impact of the April rate adjustment on PMPM. Regional data was supplied as:

Total PMPM FY24 Projections

MA/SED/CWP	HMP	HSW	Total	
$68,813,531	$7,151,871	$27,560,089	$103,525,491	October – March Actual
$11,776,454	$1,135,596	$4,811,262	$17,723,313	April Actual
$11,533,697	$1,091,952	$4,618,333	$17,243,983	May Actual
$45,558,105	$4,313,211	$18,342,825	$68,214,141	June – September Projected
$137,681,787	$13,692,631	$55,332,631	$206,706,928	Total Revised as of May 2024
			$204,895,685	Original FY24 PMPM Budget
			$1,811,243	Increase

Actual PMPM Paid to All Boards

	MA	Incur (Decr)	HMP	inch (Decr)	HSW	Incr (Decr)	Total	Overall Incur (Decr)
FY23 Last 8 Months	91,885,188		13,497,275		30,691,078		136,073,541	
FY24 First 8 Months	91,401,771	(483,418)	9,379,420	(4,117,855)	36,989,684	6,298,606	137,770,875	1,697,334
Totals	183,286,959	(483,418)	22,876,695	(4,117,855)	67,680,762	6,298,606	273,844,416	

The decline in DAB, TANF, and HMP revenue has been greater than anticipated. The increase in HSW revenue is buffering the shortfall. Deanna plans to reach out to the PIHP CFO group to inquire about whether the April rate adjustment was satisfactory. Deanna will continue to trend data through FY24.

AUDIT FIRM RFP

During the May meeting, Deanna noted that the three-year cycle to select a firm for the financial audits ended FY23. Instead of issuing an RFP for FY24 – FY26, the decision was made to obtain a quote from Roslund, Prestage, and Company (RPC) to extend its contract through FY24.

A bid proposal was received from RPC on May 16th stating the following:

			Single Audit	
	Financial Audit	Compliance Audit	1st Program	Each Additional Program
NMRE	$13,000	$10,000	$4,500	$2,500
AuSable Valley	$15,000	$9,500		
Centra Wellness	$13,700	$9,500		
North Country	$16,250	$9,500		
Northeast MI	$17,500	$9,500	$4,500	$2,500

The NMRE Board approved the contract extension and the proposed costs for the NMRE audits on May 22, 2024.

HSW PAYMENT STATUS

The NNRE has identified clients enrolled in HSW for whom payments are not being received; specifics information has been sent to MDHHS.

Initially, the problem was thought to be related to individuals being placed on Plan First during the Medicaid redetermination process but has since been identified as a separate issue.

The issue was then thought to be related to spenddowns. Communication from MDHHD on May 4th, May 28th, and June 3rd advised CMHSPs to follow up with DHS case workers to be sure spenddown paperwork was submitted timely. It was clarified that spenddown payments can be retroactive for 6 months. If delays in spenddown are not recorded beyond six months, there is the potential of payments not being received at all. The NMRE is looking at specific instances. MDHHS hasn't indicated whether payments beyond six months will be considered. Eric got involved in the matter and suggested raising the issue with Kristen Jordan. MDHHS is reaching out to CMHAMPs to try to figure out where the issue lies. Brandon confirmed that the NMRE is not receiving payment for individuals even when spenddowns are met.

Deanna reviewed the June 12th data file. The NMRE should be paid for 654 HSW slots but was only paid for 629. At $7K per month each, this equates to $175K in lost revenue for the month of June alone. The importance of HSW revenue was highlighted considering the decline in DAB, TANF, and HMP.

NEXT MEETING

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

Chief Executive Officer Report

June 2024

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

May 29: Attended and participated in NMRE Internal Operations Committee Meeting (IOC).

May 31: Attended and participated in AG discussion with Emmet County regarding OUD funding.

June 4: Attended and participated in PIHP CEO Meeting.

June 7: Received legal update from Waskul lawsuit/settlement.

June 11: Attended and participated in CMHAM Spring Conference.

June 18: Chaired NMRE Regional Operations Committee Meeting.

June 20: Plan to attend Sec. 928 (local match) discussion with MDHHS.

June 21: Plan to attend MDHHS Rate Setting discussion.

April 2024 Finance Report

April 2024 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	3,676,628	845,073	13,510,136
Healthy Michigan	(3,609,326)	10,779,098	7,066,020
	$ 67,302	$ 11,624,171	$ 20,576,156

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	275,969	1,307,899	(1,198,225)	(2,031,053)	627,241	1,480,247	(394,777)	$ 67,302
Carry Forward		-	-	-	-	-	-	11,624,171
Total Med/HMP Current Year Surplus	275,969	1,307,899	(1,198,225)	(2,031,053)	627,241	1,480,247	(394,777)	$ 11,691,473
Medicaid & HMP Internal Service Fund								20,576,156
Total Medicaid & HMP Net Surplus								$ 32,267,629

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2023 through April 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 116,934,814	$ 4,120,022						$ 121,054,836
CMHSP Distributions	(112,961,336)		37,346,516	30,229,000	18,890,732	16,388,932	10,106,155	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	3,973,478	4,120,022	37,346,516	30,229,000	18,890,732	16,388,932	10,106,155	121,054,836
Expense								
PIHP Admin	1,571,526	36,695						1,608,221
PIHP SUD Admin		46,797						46,797
SUD Access Center		22,265						22,265
Insurance Provider Assessment	1,041,929	24,252						1,066,181
Hospital Rate Adjuster	1,067,352							1,067,352
Services		2,591,292	36,883,075	31,208,270	18,210,753	14,467,737	10,206,265	113,567,392
Total expense	3,680,807	2,721,301	36,883,075	31,208,270	18,210,753	14,467,737	10,206,265	117,378,208
Net Actual Surplus (Deficit)	$ 292,670	$ 1,398,721	$ 463,441	$ (979,270)	$ 679,979	$ 1,921,195	$ (100,110)	$ 3,676,628

Notes

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

Medicaid Savings - $845,073

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2023 through April 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 9,488,845	$ 6,661,714						$ 16,150,559
CMHSP Distributions	(8,287,468)		3,017,492	2,462,149	1,043,936	1,082,046	681,844	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	1,201,377	6,661,714	3,017,492	2,462,149	1,043,936	1,082,046	681,844	16,150,559
Expense								
PIHP Admin	166,947	91,066						258,014
PIHP SUD Admin		116,136						116,136
SUD Access Center		55,256						55,256
Insurance Provider Assessment	108,179	59,263						167,442
Hospital Rate Adjuster	942,952							942,952
Services		6,430,815	4,679,158	3,513,933	1,096,674	1,522,994	976,512	18,220,086
Total expense	1,218,078	6,752,536	4,679,158	3,513,933	1,096,674	1,522,994	976,512	19,759,885
Net Surplus (Deficit)	$ (16,701)	$ (90,822)	$ (1,661,666)	$ (1,051,784)	$ (52,738)	$ (440,948)	$ (294,667)	$ (3,609,326)

Notes
HMP ISF - $7,066,020 - based on current FSR
HMP Savings - $10,779,098

Net Surplus (Deficit) MA/HMP	**$ 275,969**	**$ 1,307,899**	**$ (1,198,225)**	**$ (2,031,053)**	**$ 627,241**	**$ 1,480,247**	**$ (394,777)**	**$ 67,302**
Medicaid/HMP Carry Forward								**11,624,171**
Total Med/HMP Current Year Surplus								$ 11,691,473
Medicaid & HMP ISF - based on current FSR								**20,576,156**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 32,267,629**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2023 through April 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 162,471		373,081	226,727	167,764	153,725	344,302	$ 1,428,070
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	162,471	-	373,081	226,727	167,764	153,725	344,302	1,428,070
Expense								
PIHP Admin	20,437							20,437
BHH Admin	21,176							21,176
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	177,589		373,081	226,727	167,764	153,725	344,302	1,443,188
Total expense	219,202	-	373,081	226,727	167,764	153,725	344,302	1,484,801
Net Surplus (Deficit)	$ (56,731)	$ -	$ -	$ -	$ -	$ -	$ -	$ (56,731)

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2023 through April 30, 2024

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 4,120,022	$ 6,661,714	$ 2,122,732	$ 3,694,733	$ 968,542	$ 17,567,743
Expense						
Administration	83,492	207,202	57,644	133,491		481,829
OHH Admin			49,399	-		49,399
Access Center	22,265	55,256	-	20,883		98,404
Insurance Provider Assessment	24,252	59,263	-			83,515
Services:						
Treatment	2,591,292	6,430,815	1,789,063	2,430,435	968,542	14,210,147
Prevention	-	-	-	696,053	-	696,053
ARPA Grant	-	-	-	413,871	-	413,871
Total expense	2,721,301	6,752,536	1,896,106	3,694,733	968,542	16,033,218
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 1,398,721	$ (90,822)	$ 226,626	$ -	$ -	$ 1,534,525

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2023 through April 30, 2024

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 116,934,814	$ 4,120,022	$ -	$ 121,054,836
Medicaid Savings	845,073	-	-	845,073
Healthy Michigan	9,488,845	6,661,714	-	16,150,559
Healthy Michigan Savings	10,779,098	-	-	10,779,098
Health Home	1,428,070	-	-	1,428,070
Opioid Health Home	-	2,122,732	-	2,122,732
Substance Use Disorder Block Grant	-	3,694,733	-	3,694,733
Public Act 2 (Liquor tax)	-	968,542	-	968,542
Affiliate local drawdown	410,692	-	-	410,692
Performance Incentive Bonus	478,660	-	-	478,660
Miscellanous Grant Revenue	-	3,335	-	3,335
Veteran Navigator Grant	39,368	-	-	39,368
SOR Grant Revenue	-	1,112,349	-	1,112,349
Gambling Grant Revenue	-	34,543	-	34,543
Other Revenue	35	-	4,767	4,802
Total operating revenue	140,404,655	18,717,970	4,767	159,127,392
Operating expenses				
General Administration	1,970,292	368,851	-	2,339,143
Prevention Administration	-	68,533	-	68,533
OHH Administration	-	49,399	-	49,399
BHH Administration	21,176	-	-	21,176
Insurance Provider Assessment	1,150,108	83,515	-	1,233,623
Hospital Rate Adjuster	2,010,304	-	-	2,010,304
Payments to Affiliates:				
Medicaid Services	110,851,862	2,591,292	-	113,443,154
Healthy Michigan Services	11,718,741	6,430,815	-	18,149,556
Health Home Services	1,443,188	-	-	1,443,188
Opioid Health Home Services	-	1,789,063	-	1,789,063
Community Grant	-	2,430,435	-	2,430,435
Prevention	-	627,520	-	627,520
State Disability Assistance	-	-	-	-
ARPA Grant	-	413,871	-	413,871
Public Act 2 (Liquor tax)	-	968,542	-	968,542
Local PBIP	2,011,358	-	-	2,011,358
Local Match Drawdown	297,408	-	-	297,408
Miscellanous Grant	-	3,335	-	3,335
Veteran Navigator Grant	39,368	-	-	39,368
SOR Grant Expenses	-	1,112,349	-	1,112,349
Gambling Grant Expenses	-	34,543	-	34,543
Total operating expenses	131,513,805	16,972,063	-	148,485,868
CY Unspent funds	8,890,850	1,745,907	4,767	10,641,524
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	714,375	5,220,509	20,576,156	26,511,040
Unspent funds - ending	$ 9,605,225	$ 6,966,416	$ 20,580,923	$ 37,152,564

Northern Michigan Regional Entity

Statement of Net Position

April 30, 2024

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 52,529,649	$ 4,141,517	$ 20,580,923	$ 77,252,089
Accounts Receivable	4,173,804	4,316,865	-	8,490,669
Prepaids	106,007	-	-	106,007
Total current assets	56,809,460	8,458,382	20,580,923	85,848,765
Noncurrent Assets				
Capital assets	9,615	-	-	9,615
Total Assets	56,819,075	8,458,382	20,580,923	85,858,380
Liabilities				
Current liabilities				
Accounts payable	46,978,583	1,491,966	-	48,470,549
Accrued liabilities	235,233	-	-	235,233
Unearned revenue	34	-	-	34
Total current liabilities	47,213,850	1,491,966	-	48,705,816
Unspent funds	$ 9,605,225	$ 6,966,416	$ 20,580,923	$ 37,152,564

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2023 through April 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 109,522,413	$ 116,934,814	$ 7,412,401	6.77%
Carryover	11,400,000	-	845,073	845,073	-
Healthy Michigan					
Capitation	19,683,372	11,481,967	9,488,845	(1,993,122)	(17.36%)
Carryover	5,100,000	-	10,779,098	10,779,098	0.00%
Health Home	1,451,268	846,573	1,428,070	581,497	68.69%
Affiliate local drawdown	594,816	297,408	410,692	113,284	38.09%
Performance Bonus Incentive	1,334,531	1,334,531	478,660	(855,871)	(64.13%)
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	64,169	39,368	(24,801)	(38.65%)
Other Revenue	-	-	35	35	0.00%
Total operating revenue	227,426,695	123,547,061	140,404,655	16,857,594	13.64%
Operating expenses					
General Administration	3,591,836	2,077,066	1,970,292	106,774	5.14%
BHH Administration	-	-	21,176	(21,176)	0.00%
Insurance Provider Assessment	1,897,524	1,106,889	1,150,108	(43,219)	(3.90%)
Hospital Rate Adjuster	4,571,328	2,666,608	2,010,304	656,304	24.61%
Local PBIP	1,737,753	-	2,011,358	(2,011,358)	0.00%
Local Match Drawdown	594,816	297,408	297,408	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	53,501	39,368	14,133	26.42%
Payments to Affiliates:					
Medicaid Services	176,618,616	103,027,526	110,851,862	(7,824,336)	(7.59%)
Healthy Michigan Services	17,639,940	10,289,965	11,718,741	(1,428,776)	(13.89%)
Health Home Services	1,415,196	825,531	1,443,188	(617,657)	(74.82%)
Total operating expenses	208,177,013	120,344,494	131,513,805	(11,169,311)	(9.28%)
CY Unspent funds	$ 19,249,682	$ 3,202,567	8,890,850	$ 5,688,283	
Transfers in			-		
Transfers out			-	131,513,805	
Unspent funds - beginning			714,375		
Unspent funds - ending			$ 9,605,225	8,890,850	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2023 through April 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 2,729,202	$ 4,120,022	$ 1,390,820	50.96%
Healthy Michigan	11,196,408	6,531,238	6,661,714	130,476	2.00%
Substance Use Disorder Block Grant	6,467,905	3,772,943	3,694,733	(78,209)	(2.07%)
Opioid Health Home	3,419,928	1,994,958	2,122,732	127,774	6.40%
Public Act 2 (Liquor tax)	1,533,979	511,326	968,542	457,216	89.42%
Miscellanous Grants	4,000	2,333	3,335	1,002	42.93%
SOR Grant	2,043,984	1,192,324	1,112,349	(79,975)	(6.71%)
Gambling Prevention Grant	200,000	116,667	34,543	(82,124)	(70.39%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	16,850,991	18,717,970	1,866,979	11.08%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	596,505	368,851	227,654	38.16%
Prevention Administration	118,428	69,083	68,533	550	0.80%
Insurance Provider Assessment	113,604	66,269	83,515	(17,246)	(26.02%)
Medicaid Services	3,931,560	2,293,410	2,591,292	(297,882)	(12.99%)
Healthy Michigan Services	10,226,004	5,965,169	6,430,815	(465,646)	(7.81%)
Community Grant	2,074,248	1,209,978	2,430,435	(1,220,457)	(100.87%)
Prevention	634,056	369,866	627,520	(257,654)	(69.66%)
State Disability Assistance	95,215	55,545	-	55,545	100.00%
ARPA Grant	-	-	413,871	(413,871)	0.00%
Opioid Health Home Admin	-	-	49,399	(49,399)	0.00%
Opioid Health Home Services	3,165,000	1,846,250	1,789,063	57,187	3.10%
Miscellanous Grants	4,000	2,333	3,335	(1,002)	(42.93%)
SOR Grant	2,043,984	1,192,324	1,112,349	79,975	6.71%
Gambling Prevention	200,000	116,667	34,543	82,124	70.39%
PA2	1,533,978	511,326	968,542	(457,216)	(89.42%)
Total operating expenses	25,222,653	14,294,725	16,972,063	(2,677,338)	(18.73%)
CY Unspent funds	$ 4,322,183	$ 2,556,266	1,745,907	$ (810,359)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			5,220,509		
Unspent funds - ending			$ 6,966,416		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2023 through April 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 1,121,057	$ 1,060,878	$ 60,179	5.37%
Fringes	666,212	369,614	344,060	25,554	6.91%
Contractual	683,308	398,601	338,486	60,115	15.08%
Board expenses	18,000	10,500	11,761	(1,261)	(12.01%)
Day of recovery	14,000	9,000	1,316	7,684	85.38%
Facilities	152,700	89,075	84,113	4,962	5.57%
Other	135,804	79,219	129,678	(50,459)	(63.70%)
Total General Admin	$ 3,591,836	$ 2,077,066	$ 1,970,292	$ 106,774	5.14%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2023 through April 30, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 502,752	$ 293,272	$ 154,613	$ 138,659	47.28%
Fringes	145,464	84,854	33,211	51,643	60.86%
Access Salaries	220,620	128,695	73,684	55,011	42.75%
Access Fringes	67,140	39,165	24,720	14,445	36.88%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	43,750	65,227	(21,477)	(49.09%)
Board expenses	5,000	2,919	3,105	(186)	(6.37%)
Day of Recover	-	-	-	-	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	3,850	14,291	(10,441)	(271.19%)
Total operating expenses	$ 1,082,576	$ 596,505	$ 368,851	$ 227,654	38.16%

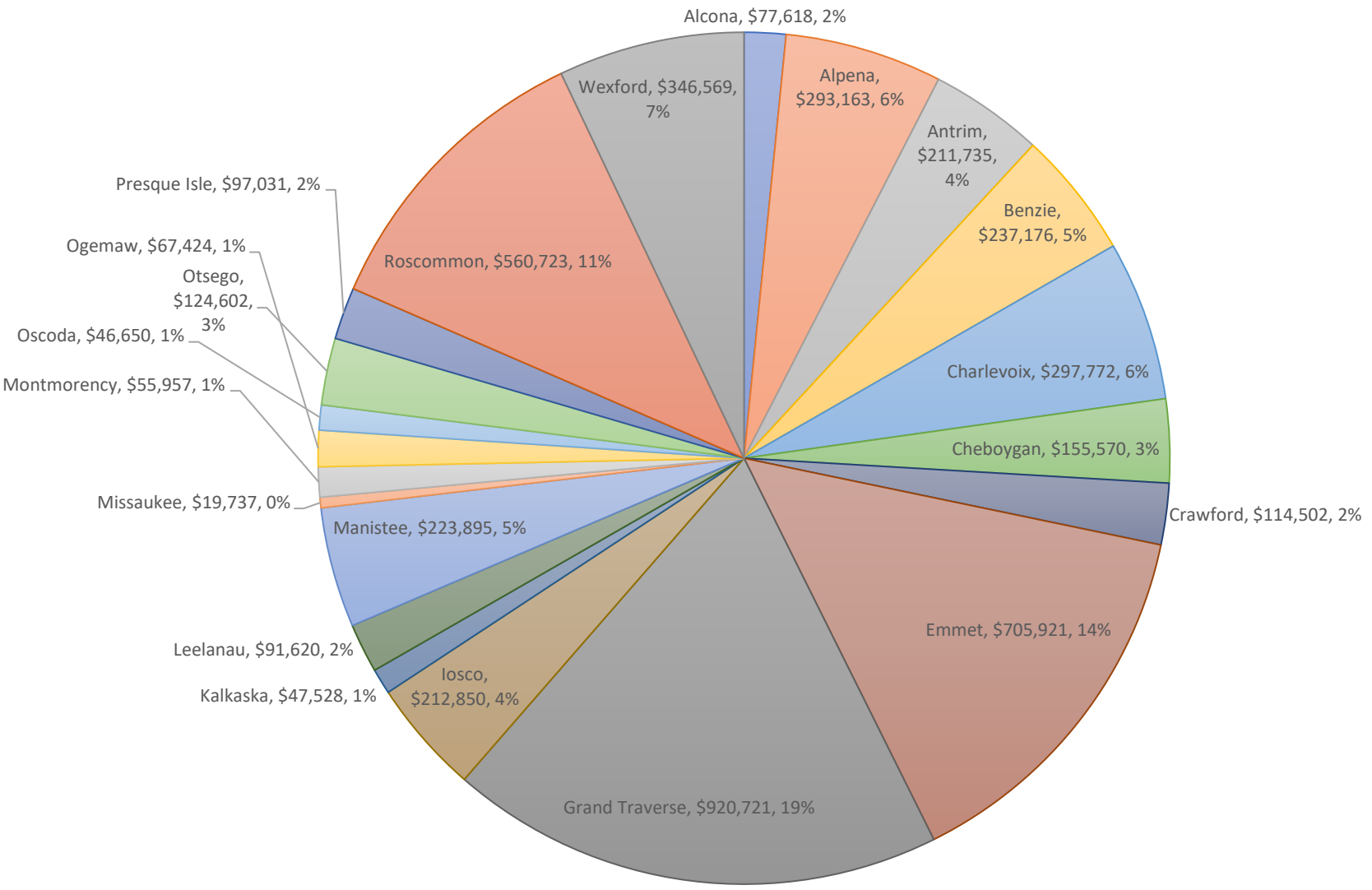
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2023 through April 30, 2024

	Projected FY24 Activity				Actual FY24 Activity			
	Beginning Balance	FY24 Projected Revenue	FY24 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 79,250	$ 23,184	$ 47,690	$ 54,744	$ 8,183	9,100	$ 715	$ 77,618
Alpena	302,452	80,118	115,089	267,482	28,891	36,215	1,965	293,163
Antrim	212,068	66,004	72,490	205,582	25,399	24,124	1,608	211,735
Benzie	224,046	59,078	21,930	261,194	22,765	8,421	1,213	237,176
Charlevoix	336,031	101,224	272,367	164,889	38,039	74,493	1,805	297,772
Cheboygan	163,153	84,123	141,260	106,016	30,405	36,237	1,751	155,570
Crawford	107,533	36,525	20,706	123,352	12,874	4,945	960	114,502
Emmet	771,608	181,672	478,053	475,227	65,054	128,450	2,291	705,921
Grand Traverse	1,035,890	440,668	524,017	952,541	165,048	273,879	6,338	920,721
Iosco	253,083	83,616	190,357	146,341	29,982	68,479	1,737	212,850
Kalkaska	42,471	41,470	34,179	49,762	14,862	8,588	1,217	47,528
Leelanau	86,055	62,190	51,029	97,215	22,690	15,630	1,495	91,620
Manistee	204,938	83,138	24,985	263,090	29,328	8,685	1,686	223,895
Missaukee	17,521	21,128	5,832	32,818	7,948	4,697	1,035	19,737
Montmorency	51,302	31,822	21,810	61,313	10,780	5,486	639	55,957
Ogemaw	96,797	74,251	96,041	75,006	24,460	52,384	1,448	67,424
Oscoda	55,406	20,578	38,064	37,920	7,705	15,889	572	46,650
Otsego	125,550	96,172	101,106	120,616	37,360	36,614	1,694	124,602
Presque Isle	96,731	25,177	85,120	36,788	8,881	7,698	883	97,031
Roscommon	559,806	82,157	87,287	554,676	31,048	28,482	1,650	560,723
Wexford	398,819	100,198	166,138	332,880	35,095	85,047	2,297	346,569
	5,220,509	1,794,492	2,595,550	4,419,450	656,798	933,545	35,000	4,908,762
PA2 Redirect								-
								4,908,762

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2023 through April 30, 2024

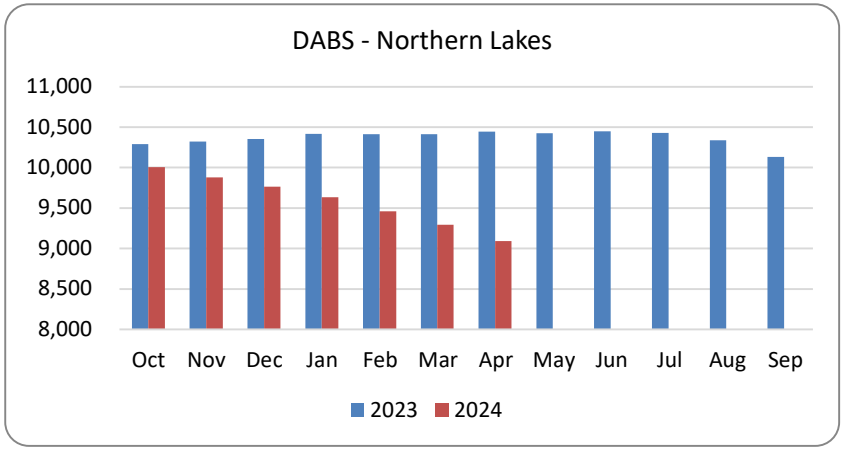
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	4,375	4,767	392	8.96%
Total operating revenue	7,500	4,375	4,767	392	8.96%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 4,375	4,767	$ 392	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,576,156		
Unspent funds - ending			$ 20,580,923		

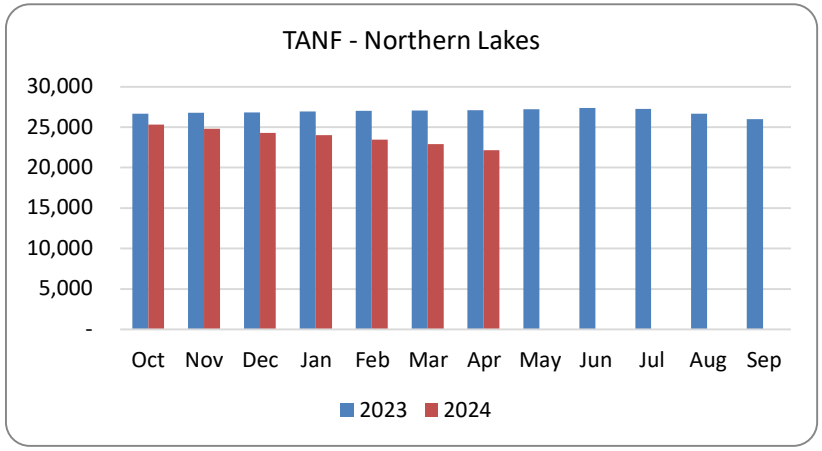
Northern Michigan Regional Entity

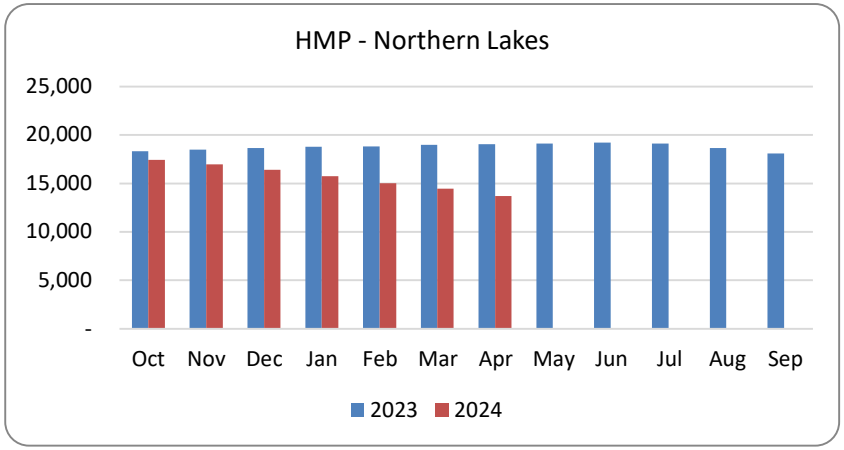
Narrative

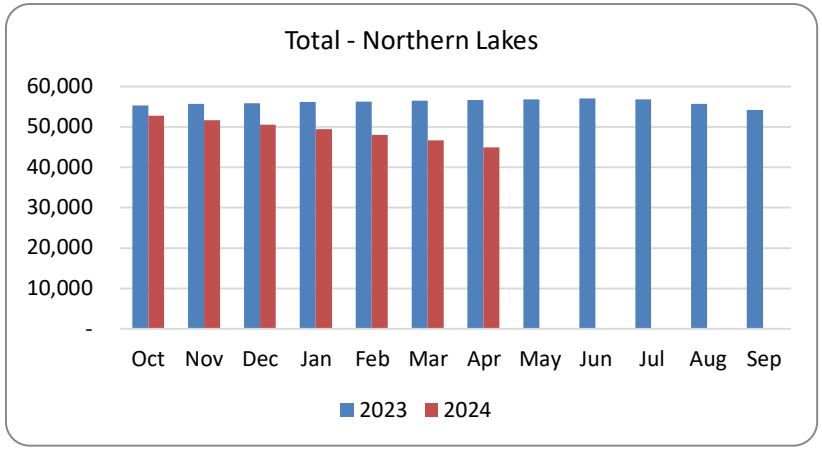
October 1, 2023 through April 30, 2024

Northern Lakes Eligible Members Trending - based on payment files







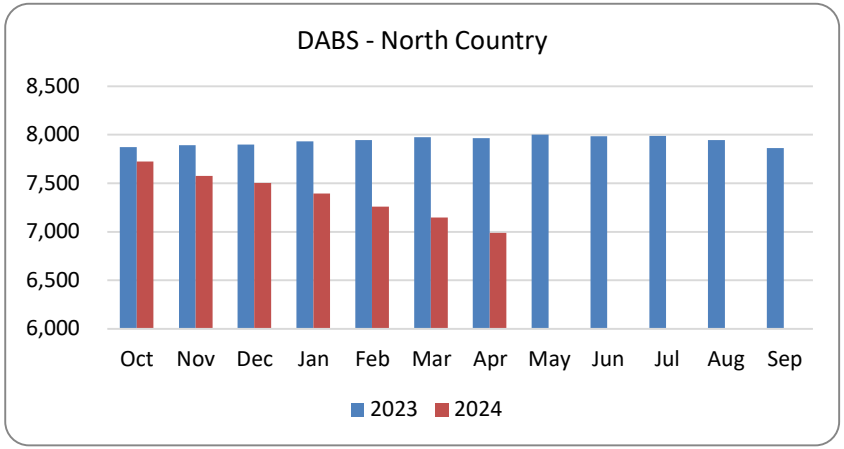


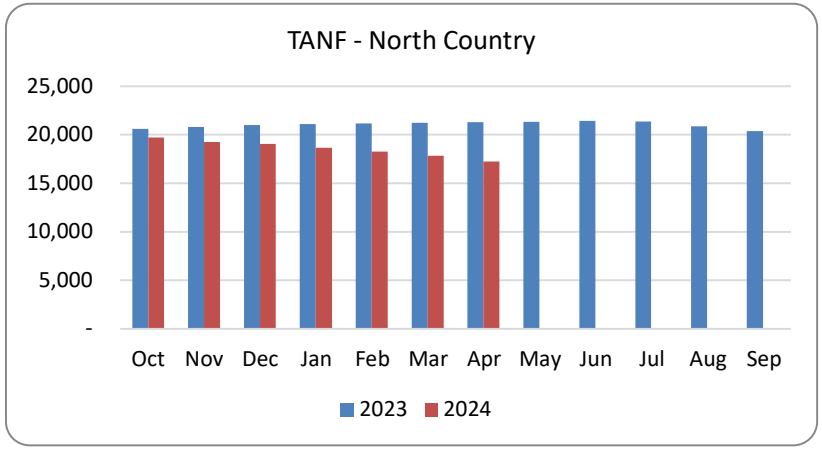
Northern Michigan Regional Entity

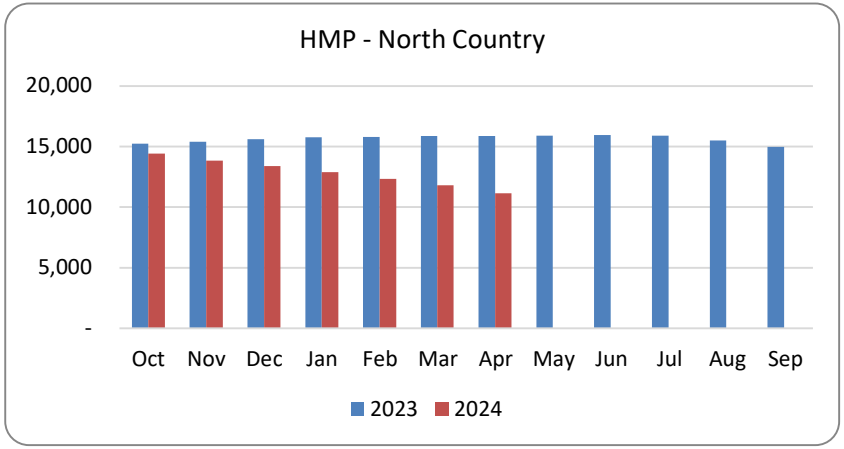
Narrative

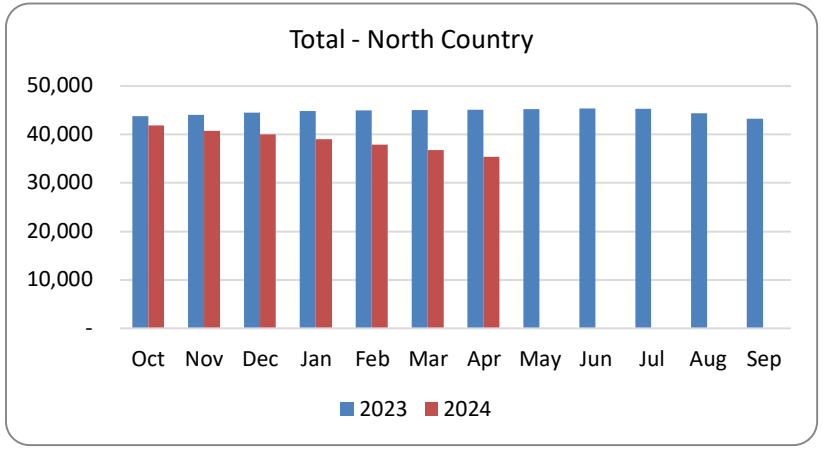
October 1, 2023 through April 30, 2024

North Country Eligible Members Trending - based on payment files







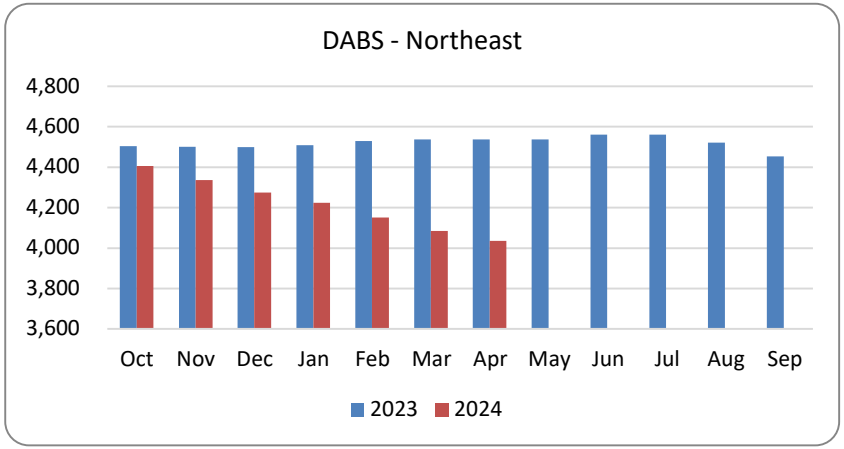


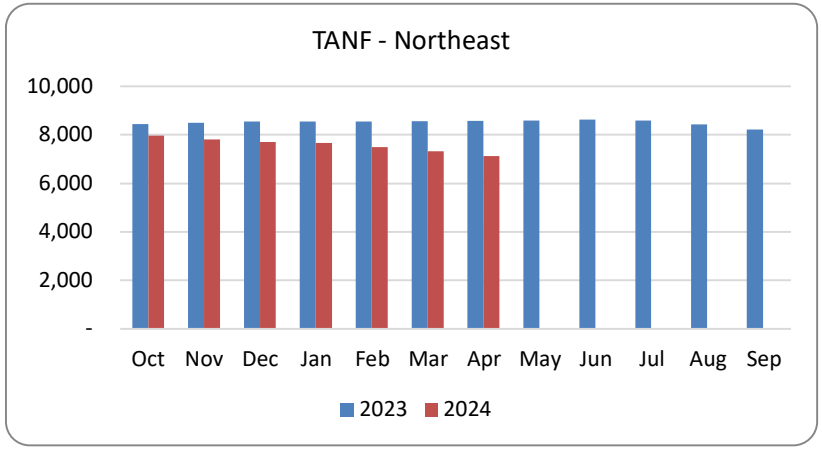
Northern Michigan Regional Entity

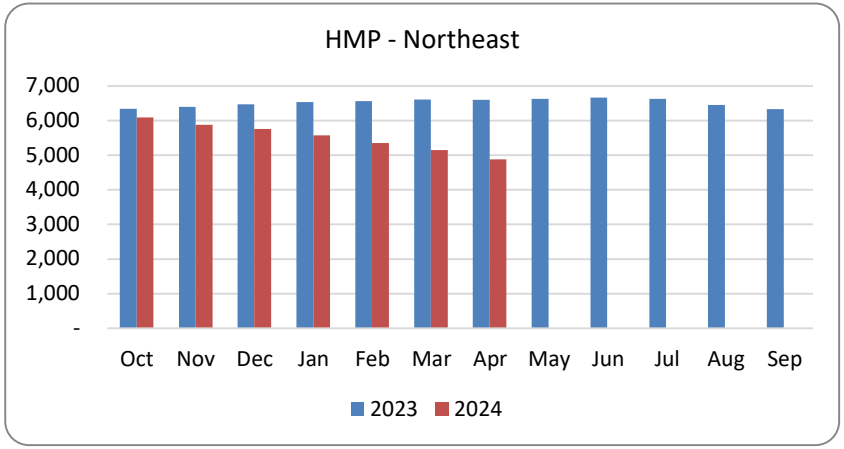
Narrative

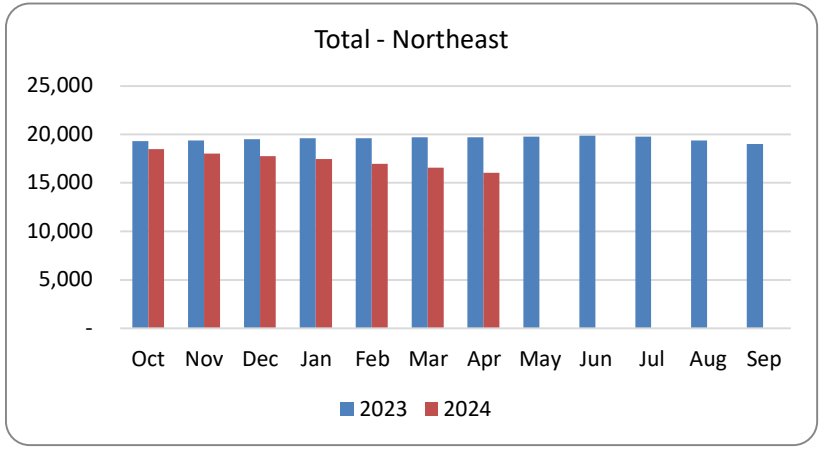
October 1, 2023 through April 30, 2024

Northeast Eligible Members Trending - based on payment files







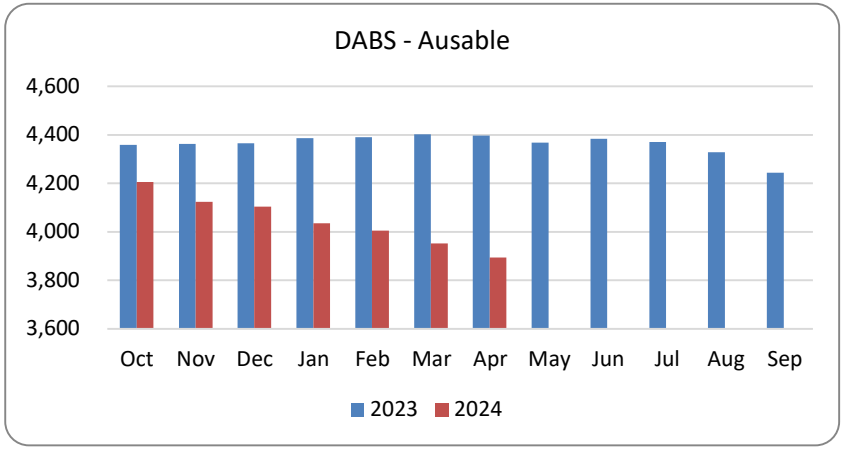


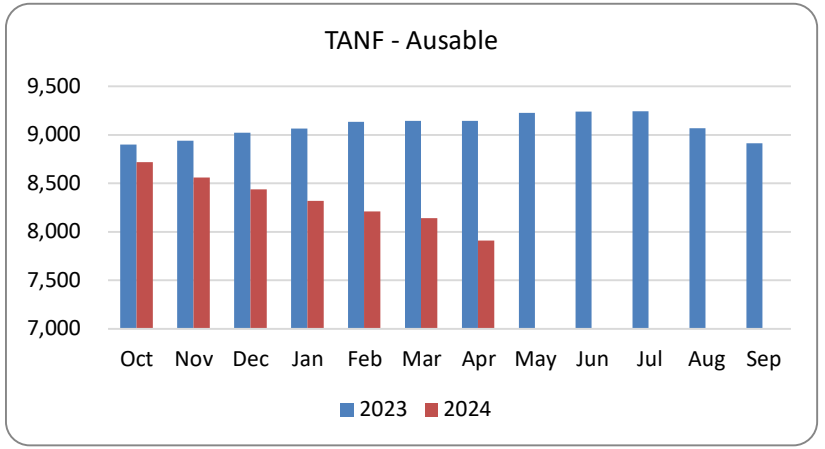
Northern Michigan Regional Entity

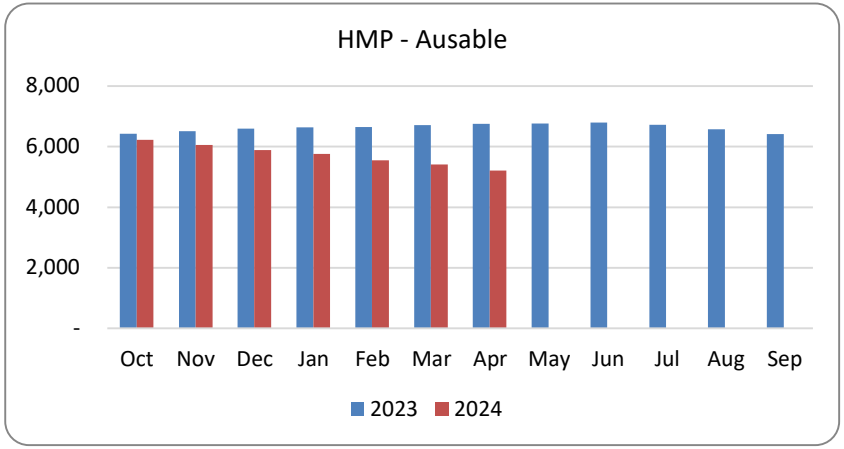
Narrative

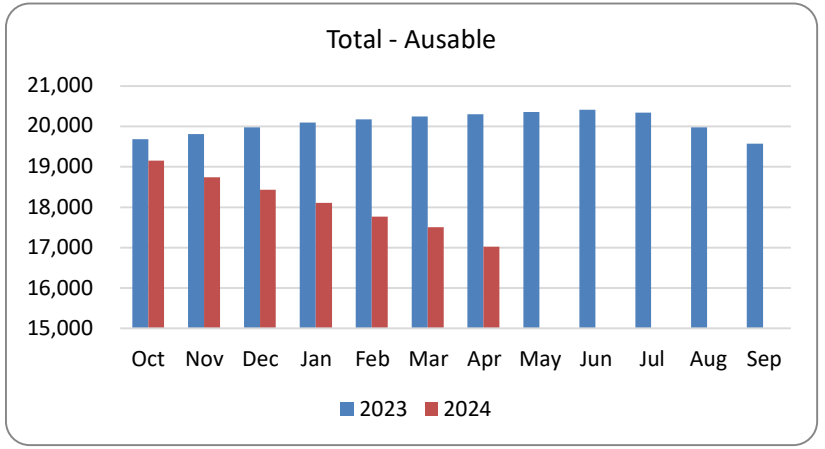
October 1, 2023 through April 30, 2024

Ausable Valley Eligible Members Trending - based on payment files







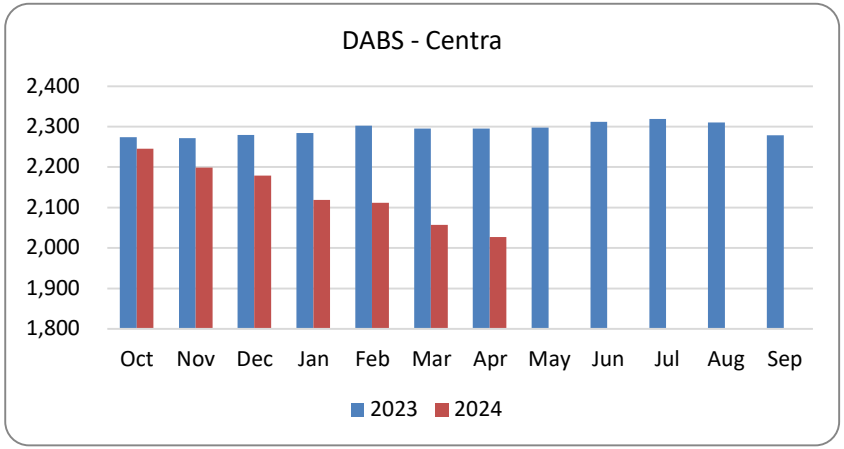


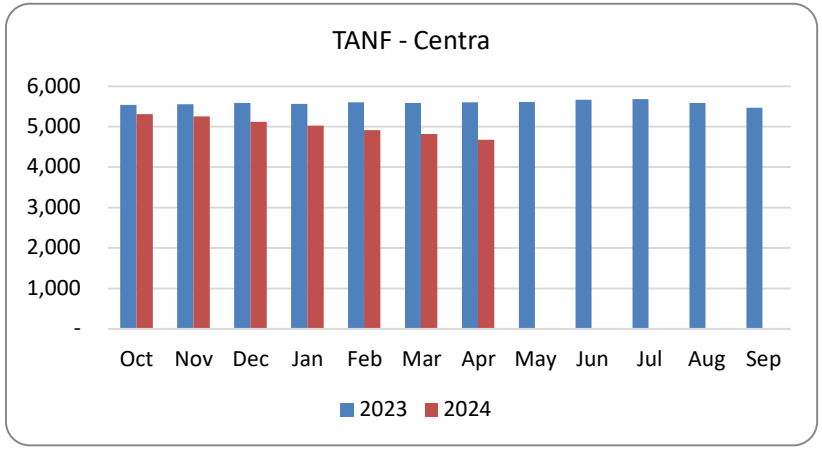
Northern Michigan Regional Entity

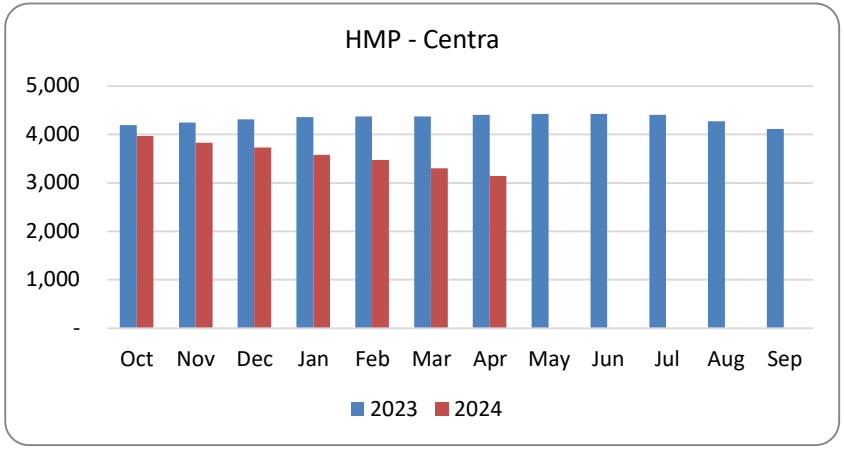
Narrative

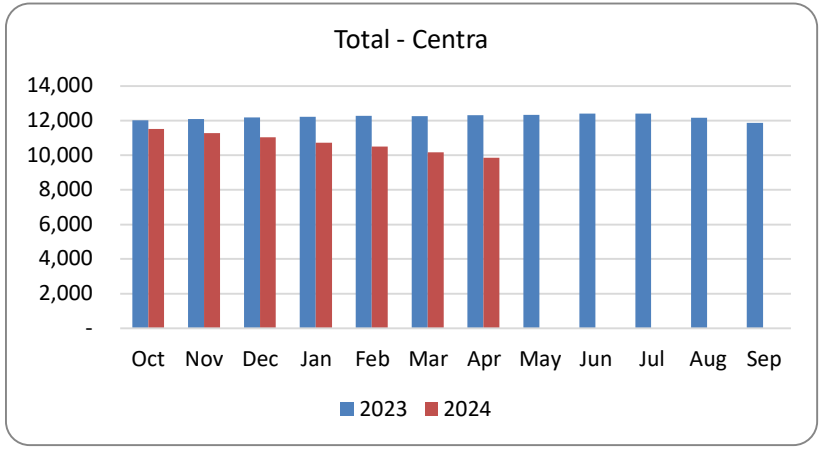
October 1, 2023 through April 30, 2024

Centra Wellness Eligible Members Trending - based on payment files







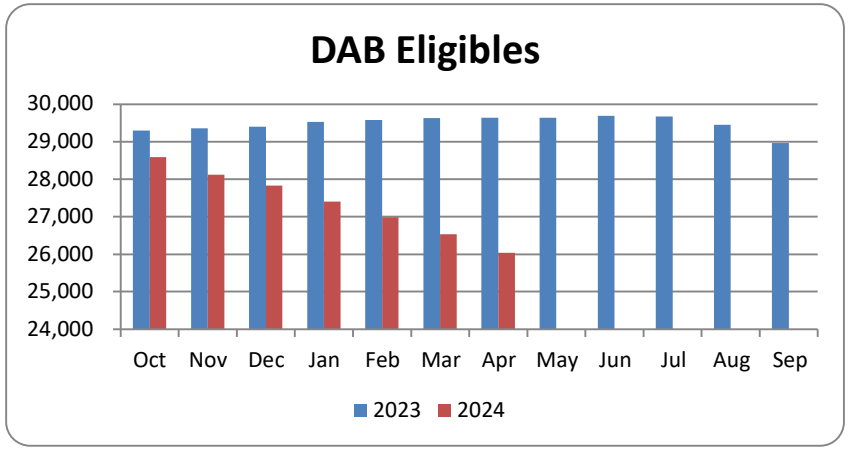


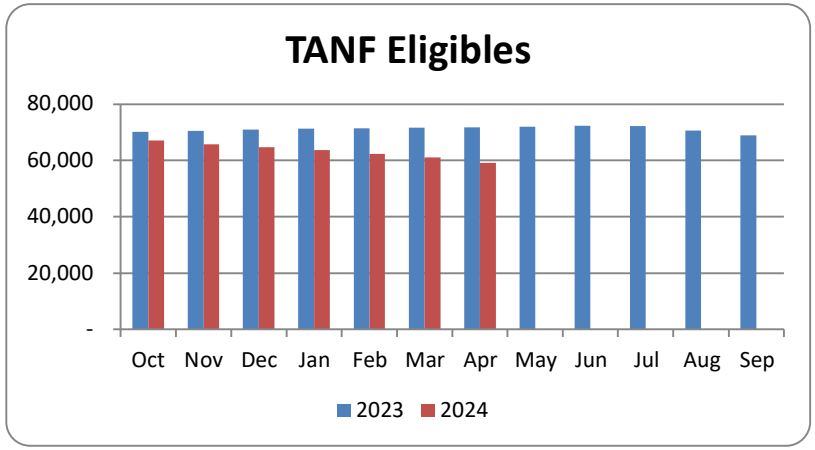
Northern Michigan Regional Entity

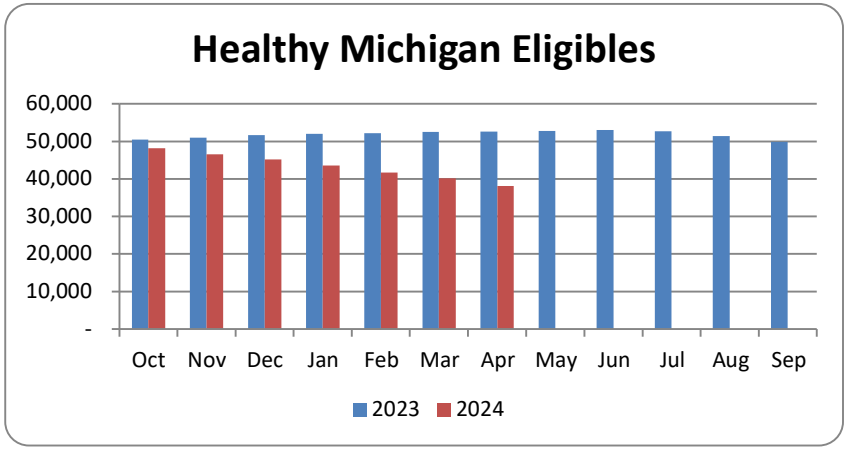
Narrative

October 1, 2023 through April 30, 2024

Regional Eligible Trending





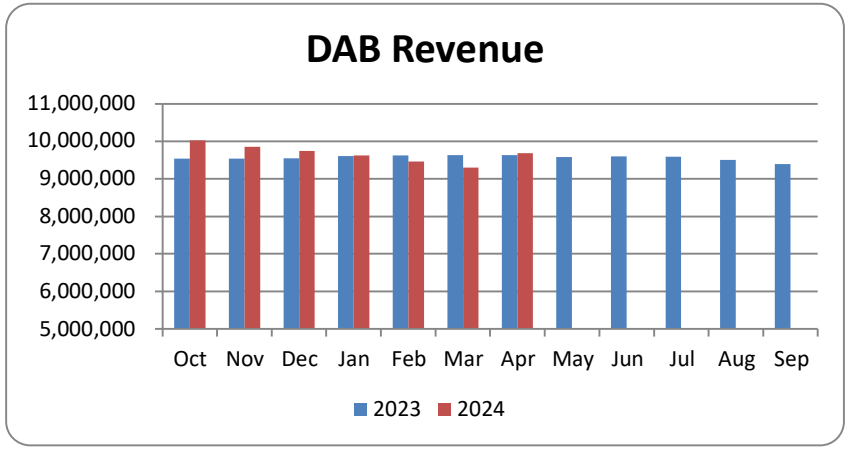


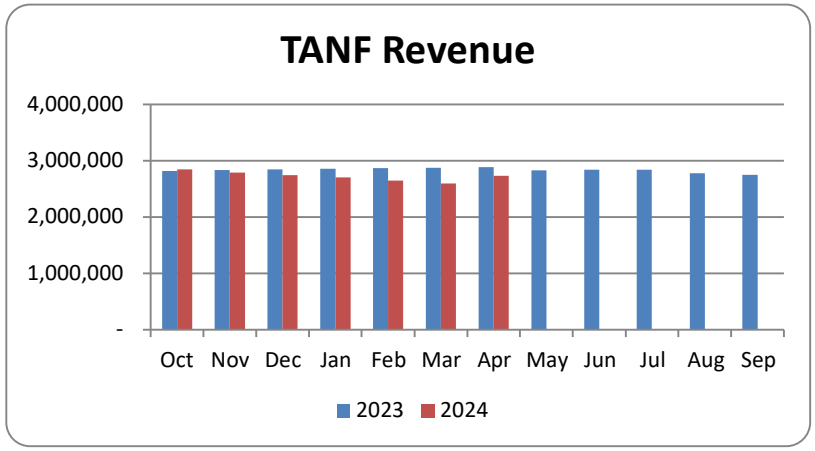
Northern Michigan Regional Entity

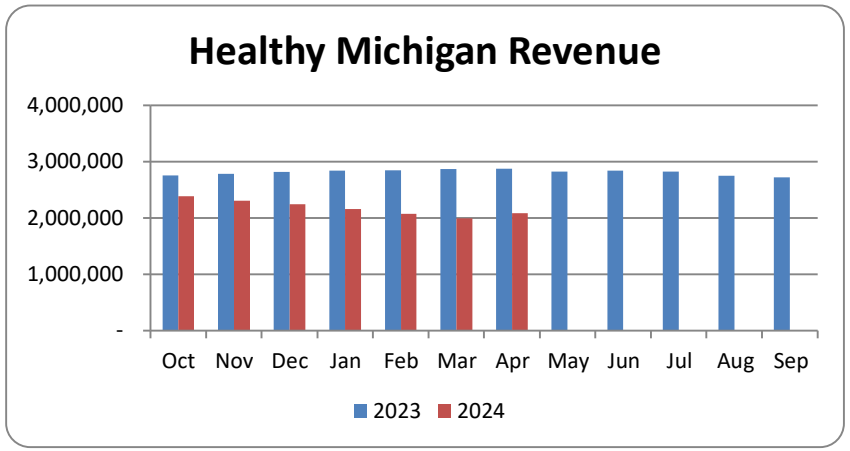
Narrative

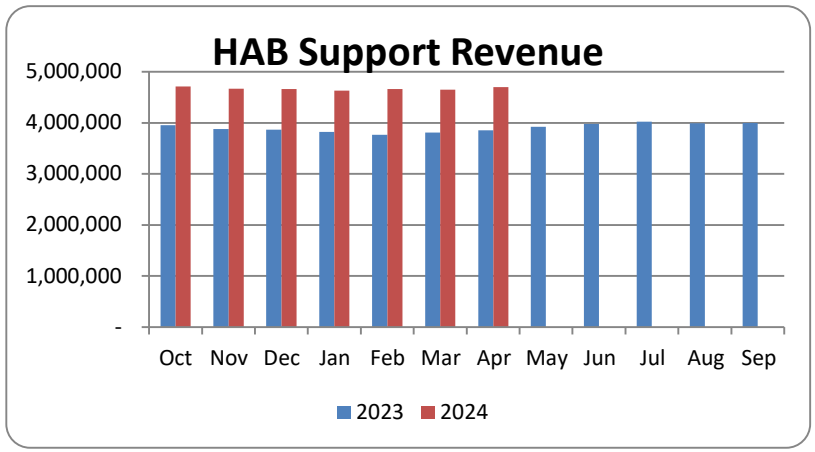
October 1, 2023 through April 30, 2024

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – JUNE 18, 2024
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Brian Babbitt, Chip Johnston, Eric Kurtz, Brian Martinus, Nena Sork, Teresa Tokarczyk, Carol Balousek**

REVIEW OF AGENDA AND ADDITIONS

Ms. Sork requested that discussions about the Electronic Visit Verification (EVV) and the regional Business Intelligence and Technology (BIT) Committee be added to the meeting agenda.

APPROVAL OF PREVIOUS MINUTES

The minutes from April 16th were included in the meeting materials.

MOTION BY NENA SORK TO APPROVE THE APRIL 16, 2024 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY CHIP JOHNSTON. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

April 2024

- Net Position showed net surplus Medicaid and HMP of $67,302. Carry forward was reported as $11,624,171. The total Medicaid and HMP Current Year Surplus was reported as $11,691,473. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $32,267,629.
- Traditional Medicaid showed $121,054,836 in revenue, and $117,378,208 in expenses, resulting in a net surplus of $3,676,628. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $845,073.
- Healthy Michigan Plan showed $16,150,559 in revenue, and $19,759,885 in expenses, resulting in a net deficit of $3,609,326. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $10,779,098.
- Health Home showed $1,428,070 in revenue, and $1,484,801 in expenses, resulting in a net deficit of $56,731.
- SUD showed all funding source revenue of $17,567,743 and $16,033,218 in expenses, resulting in a net surplus of $1,534,525. Total PA2 funds were reported as $4,908,762.

Ms. Sork asked the others how their CMHSPs are positioned with General Funds. Northeast Michigan is overspent, mainly due to individuals who meet Medicaid criteria but have not been enrolled. Mr. Johnston responded that Centra Wellness is stable with GF. Mr. Kurtz acknowledged that there are current issues with CHAMPS, Bridges, and payment files that are resulting in PIHPs not being paid for individuals on spenddowns (once met). Information on specific individuals has been sent to Kristen Jordan.

Additionally, the June 12th data file showed that the NMRE was paid for 629 HSW placements, which should have been 654. At $7K per month each, this equates to $175K in lost revenue for the month of June alone. The importance of HSW revenue was highlighted considering the decline in DAB, TANF, and HMP.

Clarification was made that Coronavirus Aid, Relief, and Economic Security (CARES) Act funds banked during the public health emergency are not intended to count as income that makes a person ineligible for Medicaid.

It was noted that all Boards have cut discretionary spending.

MOTION BY CHIP JOHNSTON TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR APRIL 2024; SUPPORT BY BRIAN BABBITT. MOTION APPROVED.

FY24 Revenue Outlook

A summary showing the impact of the April rate adjustment on PMPM was included in the meeting materials. Regional data was supplied as:

Total PMPM FY24 Projections

MA/SED/CWP	HMP	HSW	Total	
$68,813,531	$7,151,871	$27,560,089	$103,525,491	October – March Actual
$11,776,454	$1,135,596	$4,811,262	$17,723,313	April Actual
$11,533,697	$1,091,952	$4,618,333	$17,243,983	May Actual
$45,558,105	$4,313,211	$18,342,825	$68,214,141	June – September Projected
$137,681,787	$13,692,631	$55,332,631	$206,706,928	Total Revised as of May 2024
			$204,895,685	Original FY24 PMPM Budget
			$1,811,243	Increase

Actual PMPM Paid to All Boards

	MA	Incr (Decr)	HMP	Incr (Decr)	HSW	Incr (Decr)	Total	Overall Incur (Decr)
FY23 Last 8 Months	91,885,188		13,497,275		30,691,078		136,073,541	
FY24 First 8 Months	91,401,771	(483,418)	9,379,420	(4,117,855)	36,989,684	6,298,606	137,770,875	1,697,334
Totals	183,286,959	(483,418)	22,876,695	(4,117,855)	67,680,762	6,298,606	273,844,416	

The decline in DAB, TANF, and HMP revenue has been greater than anticipated. The increase in HSW revenue is buffering the shortfall.

CONFLICT FREE ACCESS & PLANNING (CFA&P)

The CMHSP Boards of Directors have passed or will be passing resolutions opposing MDHHS's approach to meeting CFA&P Requirements. The NMRE's Resolution was sent to the 21 county Boards of Commissioners, legislators, and the Governor and Lieutenant Governor. CMHAM advocacy efforts continue.

A letter from Marianne Huff (Mental Health Association in Michigan), Michelle Roberts (Disability Rights Michigan), and Sherri Boyd (The Arc Michigan) dated March 5, 2024 to Keri Toback at CMS and Meghan Groen, Kristin Jordan, Erin Emerson, Belinda Hawks, and Jackie Sproat at MDHHS expressed concerns about the proliferation of conflict of interest in the Michigan Community Mental Health System.

Mr. Kurtz suggested that CLS (and Respite) be removed from the 1915(i) waver and added to the State Plan. Mr. Babitt noted that CMHAM recently submitted a Freedom of Information Act (FOIA) request for communications between MDHHS and CMS regarding CFA&P.

Mr. Kurtz offered to write a memorandum to MDHHS stating how Region 2 currently meets the federal CFA&P requirements.

PIHP CONTRACT AMENDMENT NO.2

A summary of the changes included in Amendment No.2 to the PIHP Specialty Supports and Services Contract with the State was distributed during the meeting.

The predominant change is the addition in Schedule A – Statement of Work, Section 1, General Requirements, Subsection R, Program Integrity. This section requires:

1) Maintenance of a Regulatory Compliance Committee comprised of Board of the Directors and senior management charged with overseeing the PIHP's compliance program and its compliance with the requirements of the Specialty Supports and Services Contract. The Committee must be chaired by the PIHP Compliance Officer and meet at least quarterly.

2) The PIHP must have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the PIHP in preventing and detecting potential Fraud, Waste, and Abuse activities.

    a) The PIHP must operate a distinct "Special Investigations Unit" to prevent and detect Fraud, Waste, and Abuse led by a Special Investigation Unit (SIU) manager/liaison.

Mr. Kurtz noted that Amendment No.2 also includes language related to the April 1, 2024 rate adjustment.

MOTION BY NENA SORK TO RECOMMEND THAT THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUTIVE OFFICER SIGN AMENDMENT NUMBER TWO (NO. 2) TO THE SPECIALTY SUPPORTS AND SERVICES CONTRACT WITH THE STATE OF MICHIGAN; SUPPORT BY CHIP JOHNSTON. MOTION APPROVED.

ISF RESOLUTION

An email dated June 6th from Region 10 CEO, Jim Johnson, shared a Board Resolution opposing proposed contract language which would limit internal service fund (ISF) balances to amounts well below actuarially sound levels.

Region 10's resolution language was updated for adoption by the NMRE Board of Directors and included in the meeting materials.

It is likely that no changes to the contract will occur until FY26.

MOTION BY BRIAN BABBITT TO MOVE THE PROPOSED RESOLUTION OPPOSING PROPOSED CONTRACT LANGUAGE LIMITING INTERNAL SERVICE FUND BALANCES TO AMOUNTS BELOW ACTUARILY SOUND LEVELS TO THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY BRIAN MARTINUS. MOTION APPROVED.

TIERED INPATIENT RATES

A memorandum dated March 28, 2024 from Jackie Sproat (MDHHS) to PIHP CEOs and slides from a May 30, 2024 MDHHS PowerPoint Presentation on Psychiatric Inpatient Tiered Rates was included in the meeting materials.

Effective July 1, 2024, there will be four new modifiers (V1 – V4) for revenue code 0100 (all-inclusive room & board) for inpatient psychiatric stays.

Psychiatric Inpatient Tiered Rates will not be implemented until October 1, 2024, pending federal review and approval. Effective October 1, 2024, PIHP (or subcontracted CMHSP) must pay no less than the state defined minimum rates for inpatient psychiatric services to Medicaid beneficiaries.

Preliminary Modeled Per Diem Rates without Hospital Rate Adjustment (HRA) add-on payments were provided as:

Proposed Rate Tier	Staffing Ratio Threshold	Tier Adjustment Factor	Preliminary Modeled Per Diem Rate - Adult	Preliminary Modeled Per Diem Rate - Pediatric
Baseline Rate Tier	No set threshold (assumed average of 4 patients:1 hospital staff)	100%	$771.41	$804.30
Enhanced Tier 1	2 patients:1 hospital staff	139.5%	$1,076.12	$1,122.00
Enhanced Tier 2	1 patient:1 hospital staff	178.9%	$1,380.05	$1,438.89
Enhanced Tier 3	1 patient:2 hospital staff	257.9%	$1.989.47	$2,074.29

LOCAL MATCH 928

Mr. Kurtz, Mr. Johnston, and Steve Burnham are again working toward eliminating the $10M local drawdown and match which essentially makes the PIHP a "taxing entity" as arm of the state

without constitutional authority. A five-year plan to reduce the local match to zero by 2024 was implemented in 2019 and has since stalled; by Federal mandate, it must end by 2027.

HSW SLOTS
The importance of HSW revenue was stated under the FY24 revenue discussion. Due to this fact and ongoing need, the NMRE has requested up to 45 additional slots from the State.

MI WORKS NORTHEAST CONSORTIUM
NMRE Provider Network Manager, Chris VanWagoner was recently contacted by Michigan Works Northeast Consortium about entering into a Memorandum of Understanding (MOU) with the NMRE to access Workforce Innovation Opportunity Act (WIOA) grant funding to refer individuals in the counties of Alcona, Alpena, Cheboygan, Crawford, Montmorency, Otsego, Oscoda, and Presque Isle to the appropriate CMHSP for services.

After discussion, it was determined that neither the CMHSPs nor the NMRE are interested in pursuing a MOU at this time.

NLCMHA UPDATE
Mr. Martinus announced that Kevin Hartly will be starting as Northern Lakes' Chief Financial Officer on July 2nd.

The MIChoice waiver divestment will be complete by October 1. Relias out of Grand Rapids (90%), and Area Agency on Aging (10%) are taking over the benefit. Relias has agreed to take on any NLCMHA staff that want to transition.

The Rehmann forensic investigation of Northern Lakes CMHA's finances is still underway.

Mr. Martinus referenced the Department of Defense (DOD) SkillBridge Program a staffing resource. More information may be found by visiting: DOD SkillBridge Program (osd.mil).

ELECTRONIC VISIT VERIFICATION (EVV)
For Behavioral Health, the EVV applies to codes H2015 (Community Living Supports) and T1005 (Respite Care) with location code 12 (Home Location, other than a hospital or other facility, where the patient receives care in a private residence).

Weekly EVV Project Discovery and Status meetings continue to occur with MDHHS and HHAX; representatives from PCE have been in attendance. PIHP involvement is minimal; CMHSPs have been identified as the points of contact for all their providers and will need to assist providers with understanding and getting access to and using the HHAX system. The PIHP will act mainly as a conduit for information flow.

Mr. Johnston reported that, according to Centra Wellness Network CFO/CIO Donna Nieman, the HHAX software is not working with 837 files. Due to this, the State is moving to a retrospective payment review process.

Providers will be required to use the phone app to enter activity as well as enter activity into the PCE system (double work). Mr. Babbit noted that the EVV is not needed in cases where more than one resident is in a home; family respite providers are also exempt from the EVV/.

BIT MEETINGS

In June 2013, a regional Business Intelligence & Technology (BIT) Committee was formed to share collaborative efforts around data reporting and PCE enhancements (including a backlog of enhancement requests at PCE). Ms. Sork expressed that the committee has veered from its intended purpose. It was noted that the BIT Committee includes CMHSP representation several disciplines including, clinical, finance, quality and compliance, in addition to information technology. A discussion about clinical forms has yet to occur. Mr. Kurtz responded that the original intent was for subgroups of the main BIT Committee to form to address specific projects; one of these could be a regional Clinical Forms Committee. Mr. Kurtz will follow up with the BIT chair and the PCE representatives regarding the original intent and where we may need to redirect the group and the PCE efforts.

It was also noted that the BIT Committee Charter may need to be revised to more clearly state its mission.

OTHER

Ms. Sork announced that Northeast Michigan CMHA's Medical Director, Dr. Anastasia Banicki-Hoffman, is moving to Florida. Although she will remain as a telehealth psychiatrist, a new Medical Director is needed. Mr. Martinus suggested that Ms. Sork reach out to Northern Lakes CMHA and NMRE Medical Director, Dr. Curt Cummins.

NEXT MEETING

The next meeting was scheduled for July 16th at 9:30AM in Gaylord.

FY 24 PIHP Contract Amendment 2

Summary Update

1. Schedule A, Statement of Work
   Customer Service Handbook Requirements, item k. ii. 5. Transition of Care Policy is hereby added.

2. Schedule A, Statement of Work
Network Requirements, item c is hereby deleted and replaced with:
Contractor must provide documentation on which the State bases its certification that Contractor complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network as referenced in 42 CFR Parts 438.604(a)(5); 438.606; 438.207(b) and 438.206. Submission of documentation will take place as specified by the State but no less frequently than the following: i. At the time Contractor enters into a contract with the State.
   ii. On an annual basis.
   iii. Anytime there has been significant change (as defined by the State) in Contractor that would affect adequacy of capacity and services, including changes in services, benefits, geographic service area, composition of or payments to its provider networks, or at the enrollment of a new population

3. Schedule A, Statement of Work
Out of Network Providers, items a. and c. are hereby deleted and replaced with:
a. Contractor must provide adequate and timely access to and authorize and reimburse Out-of-Network providers and cover Medically Necessary services for beneficiaries if such services could not reasonably be obtained by a Network Provider on a timely basis inside or outside the State of Michigan. Contractor must cover such out-of-Network services for as long as Contractor's Provider Network is unable to provide adequate access to covered Medically Necessary services for the identified beneficiary(ies) as referenced in 42 CFR 438.206(b)(4).
c. Contractor must coordinate with Out-of-Network providers with respect to payment and follow all applicable MDHHS policies to ensure the beneficiary is not liable for costs greater than would be expected for in network services including a prohibition on balance billing in compliance with 42 CFR 438.106, 42 CFR 438.116, 42 CFR 438.206(b)(5) and the Medicaid Provider Manual.

4. Schedule A, Statement of Work: Choice, item a. is hereby deleted and replaced with:
a. In accordance with 42 CFR 438.3(l), Contractor must assure that the beneficiary is allowed to choose his or her health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate.

5. Schedule A, Statement of Work: Transition of Care, first paragraph is hereby deleted and replace with: Transition of Care
Contractor must develop and implement a transition of care policy consistent with 42 CFR 438.62 and the MDHHS Transition of Care Technical Requirement to ensure continuity of care for its enrollees. The Contractor transition of care policy must be included in the enrollee handbook.

6. Schedule A, Statement of Work: Institution for Mental Disease (IMD) Services is hereby deleted and replaced in its entirety with:
   7. Institution for Mental Disease (IMD) Services
   a. As per 42 CFR 438.3(e)(2)(iii), the covered services in an IMD will be offered to enrollees at the option of the Contractor and with agreement from the enrollee up to 15 days per month per individual if the following conditions are met: i. The IMD stay is a medically appropriate substitute for the covered setting under the State plan.
      ii. The IMD stay is a cost-effective substitute for the setting under the State plan.
      iii. The beneficiary is not required to use the alternative setting.

7. Schedule A, Statement of Work: Grievance and Appeals Process for Beneficiaries, Item 1. e., vi, 1-3 are hereby deleted and replaced with following:
   1) Make reasonable efforts to give the beneficiary prompt oral notice of the delay.
   2) Within two (2) calendar days, provide the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a Grievance if he or she disagrees with that decision.
   3) Issue and carry out its determination as expeditiously as the beneficiaries' health condition requires and no later than the date the extension expires. (Per 42 CFR 438.404(c)(4); 42 CFR 438.408(c)(2); 438.410(c)(2))

8. Schedule A, Statement of Work: Grievance and Appeals Process for Beneficiaries, Item 6.d., is deleted and replaced with:
   d. In accordance with 42 CFR 438.420(d), if the final resolution of the appeal or State Fair Hearing is adverse to the beneficiary, that is, upholds Contractor's adverse benefit determination, Contractor may, consistent with the State's usual.

9. Schedule A, Statement of Work: Additional Information Requirements, item ii. 3 is hereby delated and replaced with:
   3) Contractor must make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider as defined in 42 CFR 438.10(f)(1). Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.

10. Schedule A, Statement of Work: Section 1. General Requirements, Q. Observance of State and Federal Laws and Regulations, Items 18 and 19 are hereby added, existing item 18. Programs or Activities No Longer Authorized by Law is hereby renumbered to 20.
   18. Application Programming Interface (API)
      a. In accordance with 42 CFR 438.242(b)(5), Contractor must implement an Application Programming Interface (API) as specified in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the Contractor.
      b. In accordance with 42 CFR 438.242(b)(6), Contractor must implement and maintain a publicly accessible standards-based API described in 42 CFR 431.70 (access to published provider directory information), which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2).

   19. Methadone

a. Pursuant to 2023 PA 119 Section 965 and any properly promulgated successor guidance issued, Contractor shall maintain a bundled rate at not less than $19.00 per unit for the administration and services of methadone (procedure code H0020).

11. Schedule A, Statement of Work

Section 1. General Requirements, R. Program Integrity is hereby deleted and replaced with: This whole section was replaced although not all rewritten. New requirements for the NMRE include:

1. Maintenance of a Regulatory Compliance Committee comprised of the Board of Directors and senior management charged with overseeing the Contractor's compliance program and its compliance with requirements under the Contract. a) Contractor must establish a Regulatory Compliance Committee that will advise the compliance officer and assists in the maintenance of the compliance program.
b) The Regulatory Compliance Committee must not have the authority to block or interfere with any actions taken or proposed to be taken by the compliance officer.
c) The compliance officer will remain duty-bound to report on and correct alleged fraud and other misconduct.
d) The compliance officer must chair the Regulatory Compliance Committee.
e) The Regulatory Compliance Committee must meet no less than quarterly.

2. Contractor must have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential Fraud, Waste, and Abuse activities.

a) Special Investigations Unit – The Contractor must operate a distinct Fraud, Waste, and Abuse Unit, Special Investigations Unit (SIU).

i) The investigators in the unit must detect and investigate Fraud, Waste, and Abuse by its Michigan Medicaid Enrollees and providers. It must be separate from the Contractor's utilization review and quality of care functions. The unit can either be a part of the Contractor's corporate structure or operate under contract with the Contractor.

ii) On a yearly basis, the Contractor's SIU must conduct program integrity training to improve information sharing between departments within the Contractor, such as Provider Credentialing, Payment Integrity, Customer Service, Human Resources, and the General Counsel, and to enhance referrals to the SIU regarding Fraud, Waste, and Abuse within the Contractor's Medicaid program. 1. The yearly training must include a component specific to Michigan Medicaid and the Contractor's approach to address current Fraud, Waste and Abuse within the program.

12. Schedule A, Statement of Work: Key Personnel, B. Administrative Personnel Requirements, item h. is hereby added:

h. Special investigations unit (SIU) manager/liaison

13. Schedule A, Statement of Work: Contract Financing item 3 is hereby added:

3. As per 42 CFR 438.608(c)(3) the Contractor and any subcontractor must report to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

14. Schedule A, Statement of Work: State Funding first paragraph is hereby deleted and replaced with:

The State's funding includes MMSSSP and the Flint 1115 Waiver. The financing in this Contract is always contingent on the annual Appropriation Act. CMHSPs within a PIHP may, but are not required to, use General Funds to provide services not covered under MMSSSP or underwrite a portion of the cost of covered services to these beneficiaries. The State reserves the right to disallow such use of General Funds if it believes that the CMHSP was not appropriately assigning costs in order to maximize the savings allowed within the risk corridors. Specific financial detail regarding the State funding is provided in Schedules G and H. As per 42 CFR 438.608(c)(3), the Contractor and any subcontractors must report to the state within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the Contract.

15. Schedule A, Statement of Work: Serious Emotional Disturbance Waiver Payments, item b. is deleted and replaced with:

b. Encounters must be processed and submitted on time, as defined in Section N. Provider Services, 7. Claims Management System and the Reporting Requirements in order to assure timely SEDW service verification.

16. Schedule A, Statement of Work: MDHHS Incentive Payments, item a. is deleted and replaced with:

a. The MDHHS Incentive Payment (DHIP) has been established to support program initiatives as specified in the MDHHS Medicaid Quality Strategy, including ensuring high quality and high levels of access to care. For the PIHPs to be eligible for an incentive payment, the child must meet the following requirements:

i. To receive the MDHHS Incentive Payment, the child must meet the following eligibility criteria:

1) Have a Serious Emotional Disturbance as defined by Michigan Law.
2) Eligible for Medicaid.
3) Between the ages of 0 to 18.
4) Be served in the MDHHS Foster Care System or Child Protective Services (Risk Categories I and II)
5) Meet one of the following criteria:

a) Service Criteria 1: At least one of the following services was provided in the eligible month:

1. H2021 – Wraparound Services
2. H0036 – Home Based Services
3. H2033 - Multi-Systemic Therapy (MST) for juveniles

b) Service Criteria 2: Two or more state plan behavioral health services covered under the 1115 Demonstration Waiver, excluding one-time assessments, were provided in the eligible month.

ii. Incentive Payments: The incentive payment will occur quarterly. Each incentive payment will be determined by comparing the PIHP's identified eligible children with the encounter data submitted. Valid encounters must be submitted within 90 days of the provision of the service regardless of the claim adjudication status in order to assure timely incentive payment verification. Once the incentive payment has taken place there will not be any opportunities for submission of eligible children for a quarterly payment already completed.

iii. Quarterly incentive payments will occur as follows:

1) April: Based on eligible children and the supporting encounter data submitted for October 1 – December 31.

2) July: Based on eligible children and the supporting encounter data submitted for January 1 – March 31.

3) October: Based on eligible children and the supporting encounter data submitted for April 1 – June 30.

4) January: Based on eligible children and the supporting encounter data submitted for July 1 –September 30.

iv. The State will provide access to an electronic copy of the names of those individuals eligible for incentive payments, which incentive payment amount they are to receive, and the COFR.

v. PIHPS are expected to provide a one-page annual narrative report by each CMHSP in their Region summarizing how the MDHHS incentive payment is directly supporting mental health services for children involved in child welfare. This report will be due at the same time as the CAFAS/PECFAS annual reporting for the MDHHS Incentive. The PIHP shall also include the total amount of annual MDHHS DHIP incentive funding they received and total amount and percentage that they passed down to CMHSPs. If the amount was less than 85% of the total amount received, please provide an explanation.

17. Schedule C, the following definition is hereby added:

Excluded: Individuals or entities that have been excluded from participating in the Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions for program related fraud, patient abuse, licensing board actions, and/or default on Health Education Assistance loans.

18. Schedule E, Reporting is deleted and replaced with:

Separate Attachment:

19. Schedule H - Behavioral Health Capitation Rate Certification Rate narrative is deleted and replaced with:

The Medicaid PEPM rates effective October 1 are included as follows. The actual number of Medicaid beneficiaries will be determined monthly, and Contractor will be notified of the beneficiaries in their service area via the pre-payment process.

Attachments to Schedule H: Behavioral Health Capitation Rate Certification include:

a. State Fiscal Year 2024 Behavioral Health Capitation Rate Certification

b. SFY 2024 Behavioral Health Entity Specific Factor Development
c. SFY 2024 Behavioral Health Capitation Rate Certification Amendment
d. April to September 2024 BH Capitation Rate Methodology

20. The following attachments are added to Schedule H: c. SFY 2024 Behavioral Health Capitation Rate Certification Amendment
d. April to September 2024 BH Capitation Rate Methodology

Northern Michigan Regional Entity
1999 Walden Drive, Gaylord, MI 49735
p: 231.487.9144 • f: 989.448.7078

Resolution of the Northern Michigan Regional Entity Board of Directors Opposing the Michigan Department of Health and Human Services Proposed Language for Fiscal Year 2025 Limiting the Funding and Use of the Internal Service Fund

WHEREAS the Northern Michigan Regional Entity (NMRE) is a regional entity created in 2014 by AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health Authority, North Country Community Mental Health Authority, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority in accordance with section 204(b) of Michigan's Mental Health Code to function as the Prepaid Inpatient Health Plan (PIHP) under a master Medicaid specialty supports and services contract with the Michigan Department of Health and Human Services (MDHHS) for Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, and Wexford Counties. The NMRE Board of Directors is comprised of three appointees from each of the five participating CMHSP Boards.

WHEREAS, under federal regulation as a managed care entity, the PIHP is responsible to ensure solvency to adequately ensure that its Medicaid enrollees will not be liable should the PIHP become insolvent.

WHEREAS, the master Medicaid specialty supports and services contract provides for the establishment of an Internal Service Fund (ISF) as the mechanism by which a PIHP may retain adequate funds to ensure solvency.

WHEREAS, MDHHS has proposed language in the master Medicaid specialty supports and services contract for fiscal year 2025 that would arbitrarily cap the amount of funding allowed to be retained by the PIHP and inappropriately shift the current risk sharing arrangement between the parties to the financial benefit of MDHHS.

WHEREAS, the proposed change represents a material change in the operation of the Medicaid State Plan in that the risk sharing arrangement approved by the Center for Medicare and Medicaid Services would be fundamentally altered.

WHEREAS, after careful review, the conclusions of the NMRE Board are that the proposed contract language:

- Limits the funding of the ISF to an amount that is less than what is actuarily sound;
- Limits the funding of the ISF to an amount that is less that what is considered best practice for operating reserves of governmental entities as proposed by the Government Finance Officers Association (GFOA);
- Overreaches and attempts to contractually limit the NMRE's ability to operate as a PIHP and appropriately manage its risk;

- Would (if enforceable) require the NMRE to return funding rightfully earned and retained from a prior contractual period.

THEREFORE, BE IT UNANIMOUSLY RESOLVED THAT, in the strongest possible terms, and for the reasons noted herein, the NMRE Board of Directors opposes the MDHHS proposed language for fiscal year 2025.

BE IT FURTHER UNANIMOUSLY RESOLVED THAT, the NMRE Board of Directors requests MDHHS to remove the language limiting the funding and use of the ISF and to honor:

- The PIHP's right to manage its business operations including the management of its contractual risk through an appropriately funding ISF;
- Generally Accepted Accounting Principles (GAAP) that already provide appropriate limitations on the establishment, purpose, and accounting for an ISF;
- Generally Accepted Actuarial Principles and Methodologies (GAAPM) that already provide appropriate limitations on determining adequate funding for an ISF;
- Federal Regulations codified in 2 CFR and 42 CFR that already provide appropriate limitation on allowable costs and utilization of ISF funding.

ON BEHALF OF THE REGION 2 PIHP BOARD OF DIRECTORS BY ITS OFFICERS ON <DATE>

_____

Gary Klacking
Chairperson of the NMRE Board of Directors

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

May 29, 2024

Dear Interested Party:

RE: Waskul Settlement Agreement

The purpose of this letter and enclosed documents is to notify the public of the Settlement Agreement and Notice of Proposed Settlement Agreement in the case of *Waskul, et al. v. Washtenaw County Community Mental Health, et al*. Please find the enclosed items below. A copy of the enclosed is available online at the following MDHHS web address https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth.

Sincerely,

Meghan E. Groen, Senior Deputy Director
Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health and Human Services

Enclosures

Settlement Agreement
Notice of Proposed Settlement Agreement

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DEREK WASKUL, *et al.*, Plaintiffs, v. WASHTENAW COUNTY COMMUNITY MENTAL HEALTH, *et al.*, Defendants.	No. 2:16-cv-10936-LVP-EAS Hon. Linda V. Parker Hon. Elizabeth A. Stafford

NOTICE OF PROPOSED SETTLEMENT AGREEMENT AND HEARING

PLEASE TAKE NOTICE that a proposed Settlement Agreement (the "Agreement") has been reached between Plaintiffs and the Michigan Department of Health and Human Services ("MDHHS") and its Director in the above captioned case. The Court will hold a hearing on September 23, 2024 at 10:00 am ET before deciding whether to approve the Agreement.

A copy of the Agreement is on file with the Court (document #300-1) and is posted at https://www.drmich.org/wp-content/uploads/2023/12/ECF300-1-executed-settlement.pdf. The Agreement is also available on MDHHS's website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth.

You should read the Agreement in its entirety, as this Notice presents only certain salient features of the Agreement. If there are any discrepancies in the content of this notice and the terms of the Agreement, the terms of the Agreement are controlling.

> ***This Notice is provided to you because your legal rights may be affected.*** If your legal rights are affected, you may have the right to formally object to the settlement. Anyone may comment on the Agreement to the Court, either favorably or unfavorably. *See procedures for objecting and commenting below.*

WHAT IS THIS CASE ABOUT?

This action, filed in March 2016, alleges that a 2015 change in budgeting procedure for Habilitation Supports Waiver ("HSW") self-determination ("SD") Community Living Support ("CLS") services implemented by the Washtenaw Community Health Organization, a predecessor to Defendant Washtenaw County Community Mental Health ("WCCMH"), caused Plaintiffs to be unable to pay for the staff and other CLS services provided for in their Individual Plans of Service ("IPOSs"). The change and its consequences are asserted to violate various federal laws, the Michigan Mental Health Code, and the HSW itself. Defendants deny these claims.

HOW AND TO WHOM DOES THE AGREEMENT APPLY?

To Fully Understand The Agreement, You Should Read The Full Agreement. This Is Only a Summary.

Contingencies

- The Agreement is subject to certain contingencies (§ D(1)), which will determine the path by which the Agreement will be implemented.
    - If the contingencies are met, the "Minimum Fee Provisions" for HSW CLS SD budgets will take effect, as described below.
    - If the contingencies are *not* met, then the Minimum Fee Provisions will not take effect but certain other provisions (the "Costing Out Provisions") will govern the HSW CLS SD budget process instead.
    - The contingencies that will determine whether the Minimum Fees Provisions or the Costing Out Provisions will take effect are:
        - approval and appropriations by the Michigan Legislature;
        - approval by the federal Medicaid authority, the Centers for Medicare and Medicaid Services; and

- execution of an appropriate contract amendment by Community Mental Health Partnership of Southeast Michigan ("CMHPSM").

- If these contingencies are met by June 1, 2025 (the "Drop Dead Date"), or an extended Drop Dead Date as laid out in the Agreement, then the Minimum Fee Provisions will take effect. Otherwise the Costing Out Provisions will take effect.

The Minimum Fee Provisions

- If the contingencies (which include appropriations necessary to fund the Minimum Fee Provisions statewide) are met, not only Plaintiffs but *all* SD CLS recipients under the HSW will have their CLS services budgeted and paid for at the the rate of $31 per service hour. (§ C(2)).
- Subject to the contingencies described above, the HSW statewide rate for Overnight Health, Safety, and Support ("OHSS") will be 70% of the CLS rate, that is, $21.70 per service hour.
- Both rates will be adjusted yearly for inflation, and both will be in effect at least until September 2029 (§§ E(6), C(10)).

Costing Out Provisions

- If the minimum rate contingencies are not met by the "Drop Dead Date," or an extended Drop Dead Date as laid out in the Agreement, then MDHHS shall begin and complete within a certain timeframe the process necessary to amend the Medicaid Provider Manual to reflect the contents of "Attachment C."
- Attachment C is a "costing out" procedure designed to ensure that each component of the CLS budget (*e.g.*, staff wage, community activities, transportation) is built up separately based on each recipient's IPOS to create a total, individualized HSW SD CLS rate.

Procedural and Process Relief

- Regardless of whether the settlement is implemented via the "Minimum Fee" provisions or the "Costing Out" provisions, certain procedural relief will start to be implemented 30 days after approval of the Agreement by the Court.

- This procedural relief will include a notification to the Michigan Office of Administrative Hearings and Rules that it is MDHHS policy for Administrative Law Judges to grant effective relief in cases involving budget or service authorization disputes. (§ C(8)).
- The procedural relief also includes clarification of the process of forming IPOSs and their related budgets for certain recipients, including:
    - Clarification of "medical necessity." (§ C(9)(a) & Attachment B).
    - Requiring discussion during the person-centered-planning process of the various components of CLS services in relation to a beneficiary's specific needs. (§ C(9)(b)).
    - Protections against Prepaid Inpatient Health Plans ("PIHPs") or Community Mental Health Service Providers ("CMHSPs") delegating to fiscal intermediaries the final determination on the amount, scope, and duration of services or any aspect of creating self-determination budgets. (§ C(9)(c)).
    - Requiring CMHPSM to offer recipients the option to self-determine (§ C(7)).
    - Protections against termination of self-determination arrangements. (§§ C(9)(d), C(8)(d)).
    - Requiring PIHPs, or CMHSPs acting on a PIHP's behalf, to provide notice of budget or service reductions. (§ C(9)(f, g)).

No Provision for Damages

The Agreement does not provide for any monetary damages.

Attorneys' Fees

Plaintiffs have asserted that by reason of the Agreement, they are "prevailing parties" who are entitled to attorneys' fees and costs under 42 U.S.C. § 1988 and related statutes. MDHHS has not yet taken a position on the amount or entitlement to fees. Fees and costs will be negotiated separate and apart from the Agreement, and Plaintiffs may file a motion for attorneys' fees and costs if they are unable to reach an agreement with MDHHS. (§ F(1), (2)).

Plaintiffs have moved to have the Agreement determined to be binding on the Local Defendants (WCCMH and CMHPSM). If that occurs, Plaintiffs will also seek fees from these Defendants.

POSITION OF THE PLAINTIFFS AND THE STATE DEFENDANTS REGARDING THE SETTLEMENT

The Plaintiffs support the Agreement and have moved for its approval, together with certain related relief regarding enforcement of the Agreement against the Local Defendants. The State Defendants (MDHHS and its Director, Elizabeth Hertel) support the motion for approval and take no position on the related relief sought by Plaintiffs. Persons who wish to learn more about the Agreement may reach out to counsel for the Plaintiffs and/or counsel for the State Defendants, who are:

Kyle Williams
Nicholas A. Gable
Simon Zagata
DISABILITY RIGHTS MICHIGAN
Attorneys for Plaintiffs
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OFFICE OF THE ATTORNEY GENERAL OF THE STATE OF MICHIGAN
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Attorneys for State Defendants
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(517) 335-7603
services3@michigan.gov
hallorank1@michigan.gov
beachb@michigan.gov

POSITION OF THE LOCAL DEFENDANTS REGARDING THE SETTLEMENT

The "Local Defendants"—WCCMH and CMHPSM—support the idea of the State providing additional funding to the public behavioral health system and oppose approval of the Agreement for various reasons. They invite persons interested in learning more about their position to reach out to their counsel, who are:

Neil J. Marchand
Robert M. Harding
MILLER, JOHNSON, SNELL & CUMMISKEY P.L.C.
Counsel for Defendant WCCMH
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marchandn@millerjohnson.com
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(616) 831-1700

Margaret T. Debler
Andrew J. Brege
ROSATI SCHULTZ JOPPICH & AMTSBUECHLER, PC
Counsel for Defendant CMHPSM
27555 Executive Drive
Suite 250
Farmington Hills, MI 48331
mdebler@rsjalaw.com
abrege@rsjalaw.com
(248) 489-4100

WHAT ARE THE NEXT STEPS?

If your legal rights are affected, you may have the right to formally object to the Agreement. Your objection should set forth (1) a detailed description of how you expect the Agreement to affect your interests, and (2) the basis and reasons for the objection.

Anyone may comment on the Agreement to the Court, either favorably or unfavorably.

Any such objection or comment (which must include the case number, 16-10936) must be ***actually delivered to the Clerk's Office***, by hand, by mail, or by overnight delivery, with copies to each of the four sets of counsel identified above, on or before ***July 15, 2024***. Objections or comments should be addressed "Attn: Honorable Linda V. Parker" and delivered to 231 W. Lafayette Blvd., Detroit, MI 48226.

The Local Defendants will file their responses to the Agreement by June 24, 2024. You are encouraged to review the papers on file with the Court and incorporate portions of them by reference. The parties will file supplemental briefs addressing any objections and comments by August 15, 2024.

HEARING

On September 23, 2024 at 10:00 am ET, the Court will hold an in-person hearing in the Courtroom of the Honorable Linda Parker of the United States District Court for the Eastern District of Michigan, Theodore Levin U.S. Courthouse, Courtroom 206,

231 W. Lafayette Blvd., Detroit, MI 48226, to determine whether the Agreement is fair, reasonable, adequate, and in the public interest.

You may attend this hearing. If you filed a formal objection with the Court as described above, the Court may allow you to speak at this hearing.

If you have any questions, please contact one of the counsel listed above.

PLEASE DO NOT CONTACT THE CLERK'S OFFICE

By Order of the Court
United States District Court
Eastern District of Michigan
May 17, 2024

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

Derek Waskul, *et al.*,	)	
	)	
Plaintiffs,	)	
v.	)	Case No. 16-cv-10936
	)	
Washtenaw County Community Mental Health, *et al.*,	)	
	)	
Defendants.	)	

SETTLEMENT AGREEMENT

This Settlement Agreement is entered into by Defendants Michigan Department of Health and Human Services and Elizabeth Hertel, in her official capacity as Director of the Michigan Department of Health and Human Services (hereafter collectively referred to as "DHHS"); and Plaintiffs Derek Waskul (guardian Cynthia Waskul), Cory Schneider (guardians Martha Schneider and Wendy Schneider), Kevin Wiesner (guardian Patrick Wiesner), Hannah Ernst (guardian Susan Ernst), and Washtenaw Association for Community Advocacy ("WACA") (hereafter "Plaintiffs").

W I T N E S S E T H :

WHEREAS, on March 15, 2016, and February 11, 2019, Plaintiffs filed their Complaint and Amended Complaint, respectively, in the captioned proceeding (the "Action") in the United States District Court for the Eastern District of Michigan, and

WHEREAS, the Complaint and Amended Complaint allege a number of violations of state and federal law arising out of the operation of the Habilitation Supports Waiver in Washtenaw County, Michigan, and

WHEREAS, DHHS denies these claims, and,

WHEREAS, the Parties mutually desire to resolve Plaintiffs' claims against DHHS without the need for further litigation, and without any admission of liability by any party.

NOW, THEREFORE, the Parties hereby enter into this Settlement Agreement to compromise, settle, and resolve all of the claims asserted by Plaintiffs against DHHS on the following terms and conditions:

A. Retention of Jurisdiction; Enforcement; Interim Payments to Plaintiffs Waskul, Wiesner, Schneider, and Ernst

1) This Settlement Agreement is subject to approval by the Court, and the terms hereof shall be incorporated in the order of approval.

   a) The Plaintiffs shall file a Motion for Approval, which may include requests for related relief against WCCMH and CMHPSM, no later than 30 days after execution hereof.

   b) DHHS shall join in the request for approval but need not join in Plaintiffs' specific arguments or the request for additional relief and may file its own papers in support of approval. The Parties shall coordinate their filings to the extent feasible.

   c) If the Court does not approve the Settlement Agreement, the Parties shall work in good faith to make modifications to address the Court's concerns, *provided* that no Party is obligated to agree to anything not already agreed-to herein.

d) If the Parties are unable to obtain approval from the Court despite good faith efforts, this Settlement Agreement shall become null and void.

2) ***Stay of Action***:

a) The Parties shall further request that the Action as a whole be stayed pending the Court's approval of this Settlement Agreement, which stay shall continue as between Plaintiffs and DHHS (except as set forth in Section A(4) below) until the Sunset Date set out in Section E(6) below.

b) Following the Merger Date set forth in Section G(1) below, the provisions of Section G shall govern as between the Plaintiffs and DHHS, but Plaintiffs shall be free to seek the lifting of the stay vis-à-vis WCCMH and CMHPSM, so that Plaintiffs may pursue their claims against those Defendants.

3) The Court's order of approval shall specify that the Court retains jurisdiction of this Action for purposes of enforcing this

Settlement Agreement until the Sunset Date described in Section E.

4) Enforcement of this Settlement Agreement shall be sought by motion in this Action (to which the stay in Section A(2)(a) shall not apply) and shall be subject to the following procedures:

a) No less than 30 days prior to filing any motion related to enforcement of this Settlement Agreement, the moving Party shall notify the non-moving Party of the alleged noncompliance and request a meeting for the purpose of attempting to resolve the alleged noncompliance.

b) If the Parties fail to resolve the allegation of noncompliance raised in the informal consultation described in Section A(4)(a), either Party may file a motion with the Court seeking a judicial determination on the issue.

c) Motions relating to alleged noncompliance will not seek to hold DHHS in criminal contempt of court.

d) Motions relating to alleged noncompliance will not seek to hold DHHS in civil contempt of court except based on

an allegation of DHHS's willful noncompliance with a previous order of enforcement on the same subject matter. If Plaintiffs do bring a motion to hold DHHS in civil contempt of court under the limitations in this Section A(4)(d), the Court may only hold DHHS in civil contempt of court if the Court makes a finding of DHHS's willful noncompliance with a previous order of enforcement on the same subject matter. Nothing in this Section A(4)(d) shall preclude Plaintiffs from seeking attorneys' fees and costs on a motion to enforce, whether under 42 U.S.C. § 1988 or otherwise.

e) For so long as the Minimum Fee Schedule Provisions hereof are in effect, Plaintiffs shall not bring enforcement actions against DHHS alleging that Plaintiffs' IPOSs need to be "costed out" to create an HSW SD CLS and/or HSW SD OHSS budget, or that a budget created in accordance with Sections C(2) and C(3) is not sufficient to implement the IPOS.

f) During any time for which DHHS is required by this Settlement Agreement to place the contents of Attachment C in the Medicaid Provider Manual, any enforcement actions brought by Plaintiffs against DHHS related to "costing out" of an HSW SD CLS and/or HSW SD OHSS budget, or the sufficiency of such budget to implement the IPOS, are limited to whether DHHS complied with the requirements in this Settlement Agreement to place the contents of Attachment C in the Medicaid Provider Manual. For the avoidance of doubt, Plaintiffs' forbearance of enforcement directly against DHHS in this Section A(4)(f) shall not limit the right of Plaintiffs to seek enforcement of Attachment C, including without limitation the costing out and sufficiency provisions thereof, against WCCMH or CMHPSM.

5) As soon as practicable after execution of this Settlement Agreement, but no later than 60 days after such execution, and without regard to any of the Contingencies set forth in Section D, DHHS shall cause Plaintiffs Derek Waskul, Kevin

Wiesner, Cory Schneider, and Hannah Ernst to have available going forward, through their Fiscal Intermediaries, funding for their HSW SD CLS and HSW SD OHSS budgets (including such changes in authorized hours as may be effected from time to time) at $31 per hour for HSW SD CLS and $21.70 per hour for HSW SD OHSS.

a) Such funding shall be revocable only in the circumstances described in Sections E(2) and E(5) below or if the Court does not approve this Settlement Agreement, and the funding shall in any event not be subject to recoupment on any basis other than for hours not yet expended.

b) The interim payments shall be treated as made in partial settlement of disputed claims in this Action and are separate and apart from any other terms of this Settlement Agreement.

B. Definitions

1) The Action: Case No. 2:16-cv-10936-PDB-EAS in the United States District Court for the Eastern District of Michigan.

2) "Amendment," or "amend," in the context of amendments to the contract between DHHS and CMHPSM, includes: (1) amending an existing contract during a fiscal year to include the relevant terms, or (2) executing a new contract or contract renewal in advance of a new fiscal year that includes the relevant terms.

3) The Centers for Medicare & Medicaid Services ("CMS"): the agency within the U.S. Department of Health and Human Services that administers the Medicaid program.

4) "CLS" means the Community Living Supports service.

5) "CLS Self-Determination Minimum Fee Schedule" refers to the minimum fee schedule described herein for HSW SD CLS.

6) "CMHSP" is a Community Mental Health Services Program, as that term is defined in M.C.L. 330.1100a(18).

7) The Defendants: DHHS (as defined in the preamble); Community Mental Health Partnership of Southeast Michigan ("CMHPSM"); and Washtenaw County Community Mental Health ("WCCMH").

8) The Plaintiffs: as set forth in the preamble.

9) The Parties: the Plaintiffs and DHHS. Only the Plaintiffs and DHHS are parties to this Settlement Agreement.

10) Habilitation Supports Waiver ("HSW"): the Medicaid program of home-and-community-based services administered by DHHS pursuant to Section 1915(c) of the Social Security Act, the terms of which are in a waiver document filed with and approved by CMS.

    a) The current Habilitation Supports Waiver expires on September 30, 2024. The terms "Habilitation Supports Waiver" and "HSW" in this Settlement Agreement encompass any renewals or modifications of the current waiver in effect before the Sunset Date (as defined in Section E(6)) unless DHHS demonstrates, on a fact-based motion that shall, as appropriate, be subject to discovery in aid of its resolution, that such renewal or modification fundamentally changes the overall concept of Self-Determination CLS services that are the subject matter of the Action.

b) DHHS represents that, as of the date this Settlement Agreement is executed, no such fundamental change is contemplated.

11) Prepaid Inpatient Health Plans ("PIHPs"): the Prepaid Inpatient Health Plans responsible for managing and paying claims for HSW services and other services pursuant to a managed care contract with DHHS. There are 10 Prepaid Inpatient Health Plans: Community Mental Health Partnership of Southeast Michigan; Detroit Wayne Integrated Health Network; Lakeshore Regional Entity; Macomb County Mental Health Services; Mid-State Health Network; NorthCare Network; Northern Michigan Regional Entity; Oakland Community Health Network; Region 10 PIHP; and Southwest Michigan Behavioral Health.

12) HSW Self-Determination Community Living Supports ("HSW SD CLS"): Community Living Supports covered through and defined by the Habilitation Supports Waiver document filed with and approved by CMS and provided via a self-determination arrangement. This term does not include CLS that is

not covered through the Habilitation Supports Waiver, nor does it include CLS covered through the Habilitation Supports Waiver provided via any arrangement other than a self-determination arrangement (for example, an agency arrangement).

13) HSW Self-Determination Overnight Health and Safety Supports ("HSW SD OHSS"). Overnight Health and Safety Supports covered through and defined by the Habilitation Supports Waiver document filed with and approved by CMS and provided via a self-determination arrangement. This term does not include OHSS that is not covered through the Habilitation Supports Waiver, nor does it include OHSS covered through the Habilitation Supports Waiver provided via any arrangement other than a self-determination arrangement (for example, an agency arrangement).

14) "IPOS" means the Individual Plan of Service.

15) The "Minimum Fee Schedule Provisions" of this Settlement Agreement are Sections C(2), C(3), C(5), C(6), and C(10) below.

16) "OHSS Self-Determination Minimum Fee Schedule" refers to the minimum fee schedule described herein for HSW SD OHSS.

17) "Policy," when referring to DHHS, means the Medicaid Provider Manual.

18) "Self Determination" includes both (1) participant direction of services as described in Appendix E of the HSW, and (2) "self direction" as that term is used in DHHS's Self-Direction Technical Requirements.

C. Terms

1) The Minimum Fee Schedule Provisions are subject to the Contingencies described in Section D(1). DHHS is not required to implement the Minimum Fee Schedule Provisions unless and until all such Contingencies are satisfied.

2) Subject to the contingencies described in Section D(1), DHHS shall amend its contract with CMHPSM so that:

   a) For each HSW SD CLS participant, the self-determination budget created jointly by CMHSPM (or a subcontractor to which CMHPSM delegates this function) and the

participant pursuant to Appendix E of the HSW shall provide for no less than the amounts set forth in the CLS Self-Determination Minimum Fee Schedule (Table 1) below (as adjusted pursuant to Section C(10)) for each authorized unit of HSW SD CLS in the participant's IPOS.

Table 1	
Service code	Unit (.25 hour) rate per participant
H2015	$7.75
H2015UN (2 participants)	$3.87
H2015UP (3 participants)	$2.59
H2015UQ (4 participants)	$1.94
H2015UR (5 participants)	$1.56
H2015US (6+ participants)	$1.10

This means, for example, that if an IPOS provides that the HSW SD CLS participant will receive 100 units per month of one-on-one HSW SD CLS (Service Code H2015, with a unit being a 15-minute increment), the funding in the associated budget for that HSW SD CLS must be equal to or greater than $775/month (100 units x $7.75 minimum rate). For the avoidance of doubt, it is

understood and agreed that if an IPOS specifies 2-on-1 (or greater) CLS staffing in certain circumstances, then the budget shall be calculated, and CMHPSM shall pay, separately at the 1-on-1 rate for each staffer associated with the multiple staffing.

b) CMHPSM shall reimburse to the fiscal intermediary the amount determined by the approved budget (which shall be at least the amount determined by the CLS and OHSS Self-Determination Minimum Fee Schedules) for HSW SD CLS and HSW SD OHSS units, respectively, actually performed during the term of the IPOS. Nothing in this Section C(2)(b) shall prohibit CMHPSM from advancing funds to the fiscal intermediary in anticipation of such actual performance.

3) Subject to the contingencies in Section D(1), DHHS shall amend its contract with CMHPSM to require that a minimum fee schedule (the "OHSS Self-Determination Minimum Fee Schedule") likewise apply to self-directed HSW SD OHSS

services, with the table entries for OHSS in effect from time to time being 70% of those for HSW SD CLS then in effect.

4) DHHS shall amend the Medicaid Provider Manual to reflect the content of Attachment A, titled "Costs Included in Community Living Supports Code H2015," to the extent DHHS determines that it does not already do so.

5) Subject to the contingencies in Section D(1), and subject to the adjustments set forth in Section C(10) below, the CLS and OHSS Self-Determination Minimum Fee Schedules and the associated funding for each of them described in Sections C(2), C(3), and C(6), shall be the totality of the funding provided to cover all costs for the HSW SD CLS participant's HSW SD CLS and HSW SD OHSS (*e.g.,* staff wages, transportation, employer costs, training, and activity fees).

6) Subject to the contingencies in Section D(1), DHHS shall increase the actuarially sound capitation rates for CMHPSM to account for the CLS and OHSS Self-Determination Minimum Fee Schedules.

a) The amount of this capitation rate increase will be at the sole discretion of DHHS, but it will be subject to CMS's annual approval of the amended capitation rates as actuarially sound, as required by federal Medicaid law.

b) The requirements of this Section C(6) will be deemed satisfied when CMS approves, as actuarially sound, the capitation rates applicable to CMHPSM.

c) In addition, DHHS shall ensure that the actuary employed by or under contract with DHHS to certify annual capitation rates also certifies, at least annually, that the HSW CLS rate cell(s) of DHHS's capitation matrix for CMHPSM are not cross-subsidized by any other rate cell and are "actuarially sound," as that term is defined in 42 C.F. R. § 438.4.

7) Subject to the Contingencies described in Section D(2), DHHS shall amend its contract with CMHPSM to require CMHPSM to offer new and existing beneficiaries who receive CLS services under the HSW (other than those previously terminated from self-determination) the choice to self-determine CLS

services. To the extent the Contingencies described in Section D(2) have not been met by September 30, 2025 with respect to this Section C(7), DHHS shall promptly commence, and diligently pursue to completion, the process of adopting such provision as Policy.

8) DHHS shall instruct the Michigan Office of Administrative Hearings and Rules ("MOAHR") that it is DHHS policy that, after the participant has exhausted the participant's internal appeal to the PIHP/CMHSP consistent with 42 C.F.R. §§ 438.402, 438.408(f):

   a) Administrative Law Judges ("ALJs") in Medicaid Fair Hearings have the authority in hearings challenging the CLS and/or OHSS portions of an HSW SD CLS participant's self-determination budget:

      i) To review HSW SD CLS participants' assertions that an insufficient number of units of HSW SD CLS or HSW SD OHSS was authorized and issue orders, as specified in Sections C(8)(b) and C(8)(c) below. For the avoidance of doubt, this includes an assertion by

the HSW SD CLS participant regarding the proper allocation between HSW SD CLS and HSW SD OHSS, as those services are defined in the Medicaid Provider Manual; and

ii) To review the budget attached to an HSW SD CLS participant's IPOS and issue orders, as specified in Sections C(8)(b) and C(8)(c) below.

b) When reviewing the CLS and/or OHSS portions of an HSW SD CLS recipient's self-determination budget, or the number of units of HSW SD CLS or HSW SD OHSS that have been authorized, ALJs have authority to issue an order, if appropriate based on the proofs presented on the record at the hearing, to:

i) reverse the determination and require a specific budget or authorization as described in paragraph (c)(i) below, ***or***

ii) reverse the determination and remand to the PIHP/CMHPSM for further evidence or assessment as described in paragraph (c)(ii) below, ***or***

iii) affirm the determination as described in paragraph (c)(iii) below.

c) Specifically,

i) If the ALJ concludes that the proofs presented on the record at the hearing establish that the PIHP/ CMHSP's decision with respect to the HSW SD CLS and/or HSW SD OHSS portions of an HSW SD CLS participant's self-determination budget and/or the number of authorized units of HSW SD CLS or HSW SD OHSS was inconsistent with medical necessity as set forth in the Medicaid Provider Manual *and* that such proofs establish that a specific budget level or authorization requested by the participant is: (1) medically necessary, (2) otherwise consistent with state and federal law and policy, and (3) necessary to implement the IPOS, then the ALJ shall reverse the determination and direct entry of the specific budget level or number of authorized units of HSW SD CLS or HSW SD OHSS requested by the participant.

ii) If the ALJ concludes that the proofs presented on the record at the hearing establish that the PIHP/ CMHSP's decision with respect to the CLS and/or OHSS portions of an HSW SD CLS participant's self-determination budget and/or the number of authorized units of HSW SD CLS or HSW SD OHSS was inconsistent with medical necessity as set forth in the Medicaid Provider Manual but that such proofs do not establish that a specific budget level or number of authorized units is (1) medically necessary, (2) otherwise consistent with state or federal law and policy, and (3) necessary to implement the IPOS, then the ALJ shall reverse the determination and remand to the PIHP/CMHSP for reconsideration based on the ALJ's findings and order, specifying to the extent reasonably possible the parameters of such reconsideration.

iii) If the ALJ concludes that the proofs presented on the record at the hearing do not establish that the PIHP/

CMHSP's decision was inconsistent with medical necessity as set forth in the Medicaid Provider Manual or otherwise inconsistent with state or federal law or policy, then the ALJ shall uphold the determination.

d) ALJs in Medicaid Fair Hearings have the authority to review PIHPs'/CMHSPs' decisions to terminate a self-determination arrangement.

i) In such a Medicaid Fair Hearing, if the ALJ determines that the evidence presented on the record at the hearing does not establish that there was good cause to terminate the self-determination arrangement, then the ALJ will reverse the PIHP/CMHSP's decision to terminate the self-determination arrangement and direct the continuation of such arrangement, rather than remand to the PIHP/ CMHSP for reconsideration.

ii) This Section C(8)(d) shall be implemented as Policy notwithstanding any provision of existing DHHS Policy or guidance stating that termination of self-

determination is not the subject of a Medicaid Fair Hearing.

e) DHHS shall supply to counsel for Plaintiffs a copy of the instruction to MOAHR required by this Section C(8).

f) Notwithstanding such instruction to MOAHR, DHHS may reserve to itself, as opposed to the ALJ, the final decision as to the authorized budget, the service authorization level, or the termination of self-determination arrangements, *provided*, *however*, that the ultimate determination be made within the timeframe for "final administrative action" as set forth in 42 C.F.R. § 431.244(f).

9) DHHS shall:

a) Amend the Medicaid Provider Manual to reflect the content of Attachment B, to the extent DHHS determines that it does not already do so.

b) Amend the Medicaid Provider Manual to require that PIHPs (or CMHSPs acting on their behalf) discuss with the HSW SD CLS participant during the person-centered planning process various components of CLS, such as

transportation, activities, staff wages, employer costs, training time, and similar topics, as well as, if relevant, the amount, scope, and frequency of each such component that may be medically necessary for the participant, as defined by Attachment B.

c) Amend the Medicaid Provider Manual to require that PIHPs (or CMHSPs acting on their behalf) ensure that the fiscal intermediary does not make a final determination on the amount, scope, or duration of services and that the PIHP (or its CMHSP subcontractor) does not delegate any aspect of creating the budget to fiscal intermediary personnel.

d) Amend the Medicaid Provider Manual to require a PIHP (or a CMHSP acting on a PIHP's behalf) to notify in writing any HSW SD CLS participant whose self-determination arrangement is at risk of termination that such risk exists.

    i) The notice shall specify in such detail as is reasonably practicable the issues that have led to the risk of

termination, and shall provide opportunities for meaningful problem solving that involve the HSW SD CLS participant.

ii) If, notwithstanding the problem-solving efforts, the PIHP (or the CMHSP as its subcontractor) believes that termination is necessary, then it shall issue an **Advance Action Notice**, with appeal rights consistent with those provided in 42 C.F.R. § 438.400 *et seq*.

e) Subject to the Contingencies described in Section D(2), amend the Contract with CMHPSM to add a new sentence to paragraph 1(Q) (General Requirements in Schedule A – Statement of Work) to read: "c. The Contractor shall comply with any decision issued by an Administrative Law Judge in a Medicaid Fair Hearing."

f) Subject to the Contingencies described in Section D(2), amend the contract with CMHPSM to require that, when CMHPSM reduces an HSW SD CLS participant's self-determination budget at an annual renewal or otherwise,

CMHPSM provide, in writing, a specific justification for the reduction, which shall explain why CMHPSM believes the participant does not need the same amount, duration, and scope of HSW services that the participant was previously assessed to need. To the extent the Contingencies described in Section D(2) have not been met by September 30, 2025 with respect to this Section C(9)(f), DHHS shall promptly commence, and diligently pursue to completion, the process of adopting such provision as Policy. For the avoidance of doubt:

i) A budget reduction or termination during the term of an IPOS shall be treated as a "reduction, suspension, or termination" for purposes of internal appeal and Fair Hearing rules (including advance Adverse Benefit Determination notice and continuation of benefits, when applicable), and

ii) A budget reduction or termination at annual renewal shall be treated as a denial of a requested service, but CMHPSM shall, in the absence of exigent

circumstances, provide the written justification required by this Section C(9)(f) as soon as practicable and, in any event, no later than 14 days before the PCP meeting for the renewal.

g) Subject to the Contingencies described in Section D(2), amend the contract with CMHPSM to require that, when WCCMH does not approve, or approves a limited authorization of, a request for inclusion in the IPOS of: (i) a service, or (ii) one or more specific aspects of the amount, scope, or duration of a service, CMHPSM shall ensure that:

i) the item is listed in a separate section of the IPOS titled "Requests Not Approved," and

ii) WCCMH provides an adverse benefit determination that briefly but concretely sets forth its reasoning for not approving the request.

This Section C(9)(g) shall apply regardless of whether the non-approval or limited approval takes place during the person-centered planning process or after its

conclusion. To the extent the Contingencies described in Section D(2) have not been met by September 30, 2025 with respect to this Section C(9)(g), DHHS shall promptly commence, and diligently pursue to completion, the process of adopting such provision as Policy.

10) Effective for the rates applicable to SFY 2026 (beginning October 1, 2025) and thereafter, the rates in the CLS Self-Determination Minimum Fee Schedule in each fiscal year, if the CLS Self-Determination Minimum Fee Schedule is in effect as required herein, shall be the rate set forth in Table 1 (the "Base Rates") adjusted by the cumulative percentage change in the nationwide Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for the period beginning March 31, 2024 and ending on the March 31 preceding the start of the fiscal year in question (that is, the rates for SFY 2027 shall be the Base Rates adjusted by the percentage change in the CPI-W from March 31, 2024 to March 31, 2026), *provided, however*, that the rates in the CLS Self-

Determination Minimum Fee Schedule in any fiscal year, shall not be less than the Base Rates set forth in Table 1. For example:

- If the CPI-W increases by 3 percent from March 31, 2024 to March 31, 2025, the rates applicable for SFY 2026 shall be the Base Rates increased by 3 percent.
- If the CPI-W decreases by 3 percent from March 31, 2024 to March 31, 2025, the rates applicable for SFY 2026 shall be the Base Rates without any adjustment.
- If the CPI-W increases by 5 percent from March 31, 2024 to March 31, 2026, the rates applicable for SFY 2027 shall be the Base Rates increased by 5 percent.

11) ***Providing Non-Binding Guidance***

a) DHHS shall provide to PIHPs and CMHSPs non-binding guidance containing examples illustrating the operation of the contract and Policy amendments effected hereby that DHHS, in its sole discretion, deems appropriate.

b) If Attachment C takes effect, then no later than 90 days after it does so, DHHS shall provide to PIHPs and CMH-SPs non-binding guidance containing examples illustrating the operation of Attachment C that DHHS, in its sole discretion, deems appropriate.

c) DHHS shall consult with counsel for Plaintiffs concerning such non-binding guidance, but the form and content thereof remain in DHHS's sole discretion.

D. Contingencies

1) DHHS is required to implement the Minimum Fee Schedule Provisions only if each of the contingencies in Sections D(1)(a) through D(1)(e) below has been met:

a) The Michigan legislature appropriates sufficient funds to pay for capitation rate increases to implement the CLS and OHSS Self-Determination Minimum Fee Schedules for HSW SD CLS and HSW SD OHSS, respectively, for all PIHPs statewide. For the avoidance of doubt, this Settlement Agreement only requires DHHS to implement the CLS and OHSS Self-Determination Minimum Fee

Schedules for CMHPSM, if the contingencies in Section D(1) are satisfied, because the Plaintiffs in this Action are served only by CMHPSM and not by any other PIHPs. But DHHS has determined it will not implement the CLS and OHSS Self-Determination Minimum Fee Schedules for CMHPSM unless DHHS is able to implement them consistently statewide. Accordingly, the Minimum Fee Schedule Provisions of this Settlement Agreement are contingent on DHHS securing necessary funding and approvals for statewide implementation.

b) CMHPSM executes a contract amendment agreeing to the Minimum Fee Schedule Provisions.

c) CMS approves the contract amendment and capitation rate increases to account for the CLS and OHSS Self-Determination Minimum Fee Schedules for all PIHPs statewide.

d) CMS approves any amendments to Michigan's Section 1115 demonstration waivers and Michigan's Section 1915(c) Habilitation Supports Waiver that CMS deems

necessary to implement the CLS and OHSS Self-Determination Minimum Fee Schedules for all PIHPs statewide.

e) CMS issues any other approvals that CMS deems necessary for implementation of the CLS and OHSS Self-Determination Minimum Fee Schedules for all PIHPs statewide, including directed payment approval (*see* 42 C.F.R. § 438.6(c)), if CMS determines that any such approvals are necessary to implement the CLS and OHSS Self-Determination Minimum Fee Schedules for all PIHPs statewide.

2) DHHS's requirements to amend its contract with CMHPSM with respect to the non-Minimum Fee Schedule Provisions of this Settlement Agreement are contingent on CMHPSM signing a contract amendment(s) containing the relevant provisions and CMS approving the contract amendment(s).

3) DHHS shall request from the Michigan legislature that an appropriation to fund the CLS and OHSS Self-Determination Minimum Fee Schedules be included in the ongoing and base

part of DHHS's budget, rather than included as a one-time appropriation.

4) DHHS will provide Plaintiffs an opportunity to comment on DHHS's draft applications to CMS for approval of any applicable state plan amendments, waiver amendments, or state-directed payments required to implement this Settlement Agreement, and DHHS will consider Plaintiffs' comments.

E. Effective Dates; Failure of CLS and OHSS Self-Determination Minimum Fee Schedules to Take Effect; Sunset; Consequences of Failure to Take Effect or Sunset

1) All provisions of this Settlement Agreement except the Minimum Fee Schedule Provisions shall become effective 30 days after the Court approves this Settlement Agreement, and all provisions of this Settlement Agreement shall remain in effect thereafter until the Sunset Date described in Section E(6) below, at which point all provisions of this Settlement Agreement shall no longer be enforceable and the obligations herein shall cease to exist, except for the provisions of Section G.

a) It is understood that some of the Terms in this Settlement Agreement (for example, contract amendments and

Medicaid Provider Manual modifications) will take DHHS more than 30 days to complete after Court approval. Accordingly, DHHS will not be deemed in violation of this Settlement Agreement so long as it continues to make diligent, good faith efforts to finalize what is required to implement these Terms.

2) On the date 10 calendar days after Director Hertel or her successor certifies to Plaintiffs and the Court that all of the Contingencies in Section D(1) have been met:

   (a) the Minimum Fee Schedule Provisions of this Settlement Agreement shall become operative, and

   (b) the interim funding for Plaintiffs Derek Waskul, Kevin Wiesner, Cory Schneider, and Hannah Ernst set forth in Section A(5) above shall be terminated and shall be supplanted by such Minimum Fee Schedule Provisions.

3) Recognizing that the interim financial relief hereunder will not extend to persons other than the four named individual Plaintiffs, DHHS shall make good faith efforts to satisfy the Contingencies set forth in Section D(1) as promptly as

reasonably practicable given the nature of the Contingencies. If any such Contingencies set forth in Section D(1) have not been met within eighteen (18) months of the date of execution of this Settlement Agreement (the "Drop Dead Date"), and there has not by that time been express written consent of all Parties to an extension of the Drop Dead Date, then the Minimum Fee Schedule Provisions of this Settlement Agreement shall not come into effect. Notwithstanding this Section E(3), if the only uncompleted Contingencies as of the Drop Dead Date are PIHP contract amendments, CMS approvals thereof, and/or CMS approvals of the new capitated rates, then the Drop Dead Date shall be deemed extended by six months as to those uncompleted amendments and approvals only.

4) If the Minimum Fee Schedule Provisions of this Settlement Agreement have not come into effect by the date that is 30 days before the Drop Dead Date, DHHS shall at that time begin, and shall complete by 120 days after the Drop Dead Date or, if applicable, the extended Drop Dead Date, the process for making amendments to the Medicaid Provider

Manual that are necessary to reflect the contents of Attachment C.

5) Sixty (60) days after the Drop Dead Date, or, if applicable, the extended Drop Dead Date, the obligation of DHHS to make the payments to or on behalf of the individual Plaintiffs as described in Section A(5) above shall expire.

6) On September 30, 2029 ("Sunset Date"), all provisions of this Settlement Agreement shall expire, except for Section G.

   a) In anticipation of such expiration, DHHS shall begin no later than April 1, 2029, and shall complete before June 30, 2029, the process for making amendments to the Medicaid Provider Manual to reflect the content of Attachment C.

   b) Any motion to enforce DHHS's obligation to promulgate the amendments described in the foregoing Section E(6)(a) shall not be subject to the informal consultation obligations of Section A(4) above and shall be filed before the Sunset Date. Such motion shall remain within the

Court's jurisdiction, including after the Sunset Date as described in Section E(6)(c)(i) below.

c) Upon the Sunset Date, excepting only Section G below and Section E(6)(b) above, all provisions of this Settlement Agreement shall no longer be enforceable against DHHS and the obligations of DHHS herein shall cease to exist.

i) Upon the later of the Sunset Date or, if a motion is filed pursuant to Section E(6)(b) above then 90 days after the entry of a court order that fully adjudicates such a motion, the Action may, upon motion, be dismissed as against DHHS.

ii) Such dismissal as against DHHS shall be with prejudice as to any claims accruing prior to the Sunset Date and without prejudice as to any claims accruing thereafter.

iii) Upon such dismissal, the Court's continuing jurisdiction over this Settlement Agreement shall cease.

iv) Neither such dismissal, nor the expiration of DHHS's obligations under this Settlement Agreement, shall by itself effect the modification or vacatur of any Policies, guidance, or other actions implemented by DHHS pursuant hereto, but such Policies, guidance, or other actions shall upon such expiration and dismissal be subject to ordinary regulatory processes of amendment, vacatur, or modification.

F. Attorneys' Fees and Costs

1) Attorneys' fees and costs for Plaintiffs' counsel will be negotiated separate and apart from this Settlement Agreement.

2) If the Parties cannot agree on attorneys' fees and costs, Plaintiffs may file a motion for attorneys' fees and costs, and DHHS may oppose the motion or the amount of the fees and costs sought.

3) Plaintiffs reserve the right to move for attorneys' fees and costs for work performed after this Settlement Agreement is executed, and DHHS reserves the right to oppose such a motion or the amount of the fees and costs sought.

G. Merger of Claims into Settlement Agreement

1) Thirty-one (31) days after the date the Court approves this Settlement Agreement (the "Merger Date"), but effective as of the date of such approval, all claims that Plaintiffs brought or could have brought against DHHS in this Action shall be extinguished as separate claims and shall merge into this Settlement Agreement.

2) From and after the Merger Date, Plaintiffs shall have no further recourse against DHHS in respect of such merged and extinguished claims except pursuant to the terms hereof.

3) The claims compromised, settled, and resolved by this Settlement Agreement, and merged into and extinguished by this Settlement Agreement pursuant to paragraph (1) above, include all claims that were raised in the Complaint or Amended Complaint, and all claims that could have been raised in the Complaint or Amended Complaint, on behalf of all Plaintiffs. As of the Merger Date, in consideration of the commitments contained herein, and the benefits provided or to be provided hereunder, this Settlement Agreement shall

fully resolve, extinguish, and finally and forever bar, and the Plaintiffs hereby give up, all claims described in this Section G.

4) The extinguishment of such claims, and/or their merger into this Settlement Agreement, shall be limited to DHHS and shall not preclude claims against any other person or entity, including without limitation WCCMH and/or CMHPSM.

5) Nothing herein shall preclude a Plaintiff from asserting in a Fair Hearing that the authorized CLS units are insufficient to meet that Plaintiff's needs.

6) Nothing herein shall prevent Plaintiffs from continuing to prosecute the Action against either or both CMHPSM or WCCMH, and nothing herein shall limit the relief Plaintiffs may seek against those Defendants.

7) Nothing herein shall preclude a Plaintiff from asserting claims against DHHS that accrue after the Sunset Date in a new lawsuit.

H. Miscellaneous

1) This Settlement Agreement may not be changed or amended except by written agreement of the Parties.

2) By entering into and complying with this Settlement Agreement, no party makes any concession as to the merits of the case, or of the opposing Party's claims or defenses.

3) This Settlement Agreement is a compromise of disputed claims and is not to be construed as an admission of liability on the part of DHHS.

Agreed to on this 1st day of December, 2023.

[**Signatures follow**]

ATTACHMENT A:
COMMUNITY LIVING SUPPORTS CODE H2015

Community Living Supports (CLS) are defined as services that "facilitate an individual's independence, productivity, and promote community inclusion and participation," including:

- Assisting, reminding, observing, guiding or training the participant with: meal preparation; laundry; routine, seasonal, and heavy household care and maintenance; Activities of Daily Living (ADLs), such as bathing, eating, dressing, personal hygiene; and shopping for food and other necessities of daily living.
- Assisting, supporting, and/or training the participant with: money management; non-medical care (not requiring nurse or physician intervention); socialization and relationship building; transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the participant's residence to community activities, among community activities, and from community activities back to the participant's residence; leisure choice and participation in regular community activities; attendance at medical appointments; and acquiring goods and services other than those listed under shopping.
- Reminding, observing, and/or monitoring of medication administration.

See Habilitation Supports Waiver.

Whether a service may be covered as CLS depends on whether it is described in the above definition and is determined through the person-centered planning process to "facilitate an individual's independence, productivity, and promote community inclusion and participation," for the particular individual. This basic coverage criteria are fleshed out in the "medical necessity criteria" (see Attachment B), which include services and supports:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Costs that may be covered for self-determination CLS (and thus are reimbursed through the CLS unit rate) include, but are not limited to, the following, *if* they are: (1) not already covered by another Medicaid service provided to the participant, (2) medically necessary for a particular CLS participant, as set forth in Attachment B, and (3) related to the participant's IPOS goals of facilitating independence and productivity or of promoting community inclusion and participation:

- CLS staff compensation (wages, benefits, payroll taxes) for time spent on any activities covered by CLS, including CLS staff time spent on delivering CLS services in the participant's residence, required training, planning meetings, supervision, travel with the participant, and attendance at community activities with the participant.
- Transportation (*i.e.*, mileage) to and from community activities (*not* to and from medical appointments, so long as the transportation costs for those appointments are covered by the State Plan).
- Fees and other charges for a community activity for a CLS participant and for the CLS worker to accompany the participant in the community activity, including, for example, gym fee, movie ticket, theme park admission, meal at a restaurant, fee for bowling, fee for horseback riding.
- Membership fees for organizations that support the identified CLS objectives.

Costs for the following are not covered as CLS under any circumstances:

- Room and board
- Fiscal intermediary services
- Purchase or rental of a vehicle
- In-home entertainment subscription
- Any payments to spouses or parents of minor children or to a legal guardian. Note, however, that payments to a non-guardian parent of an adult, or to a spouse of a legal guardian, *are* permitted so long as they are for work actually performed by that individual.

ATTACHMENT B
MEDICAL NECESSITY CRITERIA

This Attachment B is intended to resolve areas where disputes have arisen.

The specific definition of medical necessity and the criteria for determining it are set forth in the current version (in effect on December 1, 2023) of Section 2.5 of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual and include supports, services, and treatments that are:

- Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Medical necessity determinations are made in the person-centered planning process by a combination of assessments by professional(s), with input from the individual and their support system. Medical necessity determinations are made in terms of amount, scope, and duration. The determination of whether a given activity is medically necessary, and whether an alternative would accomplish the same goals, is inherently and always must be a determination specific to the individual.

If a particular activity, put in the IPOS through the person-centered planning process, meets the above definition of medical necessity and the definition of CLS in Attachment A, then it is part of the "scope" of the CLS services. UM will not replace the person-centered planning process. For example, UM review may not remove or change the participant's goals. It may provide for less costly alternatives that accomplish the same goals.

This does not prohibit a supervisor from changing a goal that the case manager agreed to at the person-centered planning meeting, provided the person-centered planning meeting is re-opened.

ATTACHMENT C

PERSON-CENTERED PLANNING, COSTING OUT, AND PREPARING THE IPOS AND THE BUDGET RELATED TO COMMUNITY LIVING SUPPORTS

Costing Out Procedures

(1) In accordance with Appendix E of the HSW, both the IPOS and the individual budget are developed in conjunction with one another through the person-centered planning process.

(a) The Home and Community Based Services Rule (42 C.F.R. Part 441, Subpart G), Appendix D-1 of the HSW, Michigan Mental Health Code, and Michigan Medicaid Provider Manual provisions implementing Appendix D-1 of the HSW, govern the person-centered-planning process.

(b) Both the participant and the PIHP/CMHSP must agree, during the person-centered planning process, to the amounts in the individual budget before the budget is authorized for the participant's use.

(c) If the person-centered planning process does not result in an agreed budget, the PIHP/CMHSP shall set the budget and, pending resolution through any internal appeal and Fair Hearing that the participant may pursue, the budget shall be set equal to the immediately preceding budget.

(2) The IPOS must set forth, in detail and with specificity, the amount, scope, and duration (see Attachments A and B) of the recipient's CLS services. The activities and tasks constituting the "scope" of the services, for example, should be set forth in enough detail for their anticipated individual and cumulative costs to be ascertained.

(3) The amount of the recipient's CLS budget is determined by costing out the medically necessary services and supports set forth in the IPOS. Specifically:

(a) The staff wage component of the budget shall:

(i) Consist of staff wages in an amount sufficient to provide the medically necessary services identified in the beneficiary's IPOS but that shall not exceed the staff wage necessary to do so, multiplied by the number of authorized units that staff member is expected to fill; and

(ii) Include Worker's Compensation, Unemployment Insurance, and taxes.

(b) Considerations for determining an appropriate staff wage may include, but are not limited to, CLS staff wages charged by self-determination providers in the community for similarly-situated CLS recipients; staff wages for the CLS recipient's self-determination providers for other services; staff wages the CLS recipient has previously paid to CLS self-determination staff; staff wages requested by CLS self-determination staff the CLS recipient wishes to hire; staff wages requested by CLS self-determination staff that have responded to job advertisements posted by the CLS recipient; and the CLS recipient's efforts to locate staff at any given staff wage.

(c) The anticipated costs of the activities and tasks determined to be part of the CLS services' "scope" (as set forth in Attachments A and B) shall be costed out separately.

(d) The recipient's anticipated transportation costs related to the CLS activities and tasks in the IPOS are likewise costed out separately, it being understood that staff transportation cost does not include home-to-workplace or work-place-to-home transportation time or expense for the staff member.

(4) The CLS budget must be sufficient to implement the IPOS.

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