Northern Michigan Regional Entity

Board Meeting

September 28, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
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3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
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12.	Old Business	
	a. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest	
	b. Grand Traverse County and Northern Lakes CMHA	
13.	Presentation/Discussion	
	Behavioral Health Home and Opioid Health Home Update	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – September 28th at 10:00 am	
16.	Adjourn	

Join Microsoft Teams Meeting

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – AUGUST 24, 2022
GAYLORD BOARDROOM

ATTENDEES:	**Kate Dahlstrom, Gary Klacking, Terry Larson, Christian Marcus, Mary Marois, Gary Nowak, Jay O'Farrell, Joe Stone, Don Tanner**
VIRTUAL ATTENDEES:	**Richard Schmidt (Kaleva), Karla Sherman (Wilson, WY), Don Smeltzer (Frankfort)**
ABSENT:	**Ed Ginop, Angie Griffis**
NMRE/CMHSP STAFF:	**Brian Babbitt, Joanie Blamer, Chip Johnston, Eric Kurtz, Diane Pelts, Sara Sircely, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Dave Freedman**

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

ROLL CALL
Let the record show that Ed Ginop and Angie Griffis were excused from the meeting on this date; all other NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

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

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR AUGUST 24, 2022; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

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

MOTION BY JOE STONE TO APPROVE THE MINUTES OF THE JULY 27, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY CHRISTIAN MARCUS. MOTION CARRIED.

CORRESPONDENCE
1) The minutes from the August 4, 2022 PIHP CEO meeting.
2) Slides from a "Contract Monitoring and Oversight" presentation by Darrell Harden at MDHHS dated August 4, 2022.

3) "Crisis Stabilization Units in Michigan" document from MDHHS.
4) CMHAM "Concerns over specific actions, decisions, or lack of action by MDHHS" document dated August 2022.
5) Email correspondence dated August 12, 2022 from CMHAM to PIHP and CMHSP CEOs and Provider Alliance Members regarding state hospital capacity reduction issues.
6) CMHAM "Michigan's State Demonstration & SPA/Permanent CCBHC Initiative: Recommendations" document revised August 10, 2022.
7) Email correspondence dated August 11, 2022 from Bob Sheehan to Eric Kurtz, Don Tanner, and Joe Stone regarding concerns expressed by the NMRE Board related to the CCBHC becoming a permanent state plan service.
8) A memorandum from Jeff Wieferich at MDHHS dated August 15, 2022 to PIHP Directors regarding the availability of additional Substance Abuse Prevention and Treatment (SAPT) Block Grant funds effective October 1, 2022 to establish a discharge support/complex care management position.
9) A memorandum from Carl Rice, President of CMHAM Board of Directors dated August 12, 2022 announcing the calling for nominations for Association Treasurer for the 2022-2024 term; an election will be held during the Fall Conference on October 23, 2022.
10) The Statewide Performance Indicator Report for Quarter 2 of Fiscal Year 2022.
11) Traverse City Record Eagle article titled, "Funding Agency to Oversee Northern Lakes CMH" by Patti Brandt Burgess dated August 17, 2022.
12) Traverse City Record Eagle article titled, "Northern Lakes Accepts Oversight, Blamer Declines to give Report" by Patti Brandt Burgess dated August 20, 2022.
13) The draft minutes from the August 10th NMRE Regional Finance Committee meeting.

Mr. Kurtz drew attention to the Contract Oversight PowerPoint slides. MDHHS has reached out to PIHPs to request additional data reports, testing PIHP compliance. MDHHS is looking for PIHPs to be the primary resolution point for all beneficiary and provider concerns.

The August memorandum from CMHAM was discussed. During the July Directors Forum, participants noted several concerns with MDHHS initiatives, delays, lack of action, and leadership approaches; a list of advocacy efforts was developed by Directors Forum members and CMHAM.

It was noted that a meeting is scheduled later this date to review the recommendations by CMHAM regarding a Certified Community Behavioral Health Clinic (CCBHC) State Demonstration initiative. Mr. Johnston asserted that making the CCBHC a permanent part of the public mental health system would be damaging to rural areas across the state. Additionally, most of the CCBHC's aims are achievable within the current system.

An additional $150,000 in Substance Abuse Prevention and Treatment (SAPT) Block Grant funds is being provided to PIHPs to establish a discharge support/complex care management position. The position "must be dedicated to supporting substance use disorder providers with meeting the needs of priority population individuals but the use of the position is somewhat flexible.

ANNOUNCEMENTS

Let the record show that Joe Stone announced that Chuck Varner will be replacing him on the NMRE Board. Mr. Varner is a member of the Oscoda County Board of Commissioners, the AuSable Valley CMHA Board of Directors, and the NMRE Substance Use Disorder Oversight Board.

PUBLIC COMMENTS

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

REPORTS

Executive Committee Report

Northern Lakes CMHA

The minutes of the August 9, 2022 Executive Committee meeting were included in the materials and approved by the Executive Committee earlier on this date. On August 9th, the Executive Committee met and authorized Mr. Kurtz to send a memorandum to Northern Lakes CMHA Board Chair Dan Dekorse offering enhanced contractual oversight by the NMRE; the memorandum was copied to the six county administrators and six county commission chairpersons within the NLCMHA region. During the meeting on August 18th, the NLCMHA Board voted (7:4) to accept the offer. Mr. Kurtz stated that he will not act as the permanent Interim CEO of NLCMHA but does have a current NMRE staff in mind for the position, who he will work with closely. He noted that a Board Search Committee needs to be formed to secure a permanent CEO.

Mr. Dekorse has requested a meeting with Mr. Kurtz but has not been responsive to recent communications.

NMRE CEO Contract

Let the record show that the NMRE Board Executive Committee met at 9:15AM on this date. Responses to the CEO evaluation were summarized and shared with the Board.

The NMRE Board Executive Committee provided a salary recommendation to the Board as well as an additional one-year extension to the CEO's current contract. The salary recommendation would put the CEO's salary commensurate with others in his peer group. It was noted that the CEO currently opts out of NMRE sponsored health benefits.

MOTION BY MARY MAROIS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD EXECUTIVE COMMITTEE RECOMMENDED SALARY AMOUNT FOR THE CHIEF EXECUTIVE OFFICE FOR FISCAL YEAR 2023 ALONG WITH AN EXTENSION OF ONE YEAR TO THE CONTRACT TERM; SUPPORT BY GARY NOWAK. ROLL CALL VOTE.

"Yea" Votes: K. Dahlstrom, G. Klacking, T. Larson, C. Marcus, M. Marois, G. Nowak, J. O'Farrell, J. Stone, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

CEOs Report

The NMRE CEO Monthly Report for August 2022 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to the August 1st meeting of the six county administrators and six county commission chairpersons within the NLCMHA region. Meetings will continue to occur, and Mr. Kurtz will keep the counties informed about the contractual oversight provided to NLCMHA by the NMRE.

June 2022 Financial Report

- Net Position showed net surplus Medicaid and HMP of $10,402,465. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $26,760,582. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $43,118,699.

- Traditional Medicaid showed $150,850,088 in revenue, and $139,113,673 in expenses, resulting in a net surplus of $11,736,415. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $23,767,920 in revenue, and $19,752,513 in expenses, resulting in a net surplus of $4,015,407. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,113,539 in revenue, and $892,402 in expenses, resulting in a net surplus of $221,137.
- SUD showed all funding source revenue of $18,837,111, and $15,824,090 in expenses, resulting in a net surplus of $3,013,021. Total PA2 funds were reported as $4,888,310.

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

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

Operations Committee Report
Let the record show that the Operations Committee did not meet in August. The next meeting is scheduled for September 20, 2022.

NMRE SUD Oversight Board Report
Let the record show that the next meeting of the NMRE Substance Use Disorder Oversight Board is scheduled for September 12, 2022. Vice-Chair Carolyn Brummund will run the September meeting and nominations for Chair will be requested.

NEW BUSINESS
NMRE CEO Contract
Let the record show that this topic was discussed under the Executive Committee report.

OLD BUSINESS
Senate Bills 597 & 598/House Bills 4925 – 4929 – The Latest
Nothing is expected for SB 597 & SB 598 until possibly later in the fall. Mr. Kurtz met on August 23rd with members of CMHAM and ARC; ACR is opposed to any plan that moves toward privatization of the mental health system. It was reported that Sen. Shirkey and Rep. Whiteford are still interested in pursuing "something."

PRESENTATION
NMRE FY23 Proposed Budget
The NMRE's proposed budget for FY23 was included in the materials for the meeting on this date. Ms. Yockey reviewed the "assumptions" which included:

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

NMRE expenditures were updated to reflect staffing and benefit changes (4% employee pension increase) and a 3% employee cost of living increase (COLA) effective October 1, 2022.

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

Mr. Kurtz noted that the end of the public health emergency (PHE) will affect eligibles and ultimately revenue.

MOTION BY MARY MAROIS TO APPROVE THE PROPOSED BUDGET FOR THE NORTHERN MICHIGAN REGIONAL ENTITY FOR FISCAL YEAR 2023 AS REVIEWED ON THIS DATE; SUPPORT BY CHRISTIAN MARCUS. ROLL CALL VOTE.

"Yea" Votes: **K. Dahlstrom, G. Klacking, T. Larson, C. Marcus, M. Marois, G. Nowak, J. O'Farrell, J. Stone, D. Tanner**

"Nay" Votes: **Nil**

MOTION CARRIED.

The suggestion was made that the NMRE review the Board per diem rates. Ms. Yockey agreed to survey the Member CMHSPs and provide a report in September.

COMMENTS

Board

Ms. Dahlstrom distributed a brochure for the Grand Traverse chapter of the National Alliance on Mental Illness (NAMI). She noted that a NAMI Navigator has been hired to support individuals and their families living with mental illness.

Ms. Dahlstrom shared a flyer for an Open House at the Traverse House Clubhouse, 105 Hall Street in Traverse City, on August 31st at 11:00AM.

Mr. Stone thanked the Board for allowing him to serve as a member of "the best PIHP in the State." He noted that the Board has matured, and trust has developed throughout the years.

Staff/CMHSP CEOs

Ms. Pelts reported that the remaining Carter Kits (1600) were delivered to AuSable Valley CMHA for distribution. The Carter Kits Board of Directors is working to schedule some regional trainings. Carter Kits will be a presentation topic during the Fall Board Conference taking place October 24th–25th.

MEETING DATES

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on September 28, 2022.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:10AM.

PIHP CEO Meeting
September 1, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

Pre-paid Inpatient Health Plans (PIHP)

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

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie	Phil Kurdunowicz
Lisa Collins	Dana Moore
Lisa Coleman	Lindsey Naeyaert
Lyndia Deromedi	Patricia Neitman
Audrey Dick	Ernest Papke
Erin Emerson	Carrie Rheingans
Matthew Ellsworth	Ashley Seeley
Farah Hanley	Angie Smith-Butterwick
Darrell Harden	Jackie Sproat
Krista Hausermann	Brenda Stoneburner
Belinda Hawks	Scott Wamsley
Kristen Jordan	Keith White
Leah Julian	Jeff Wieferich
Amy Kanouse	Amanda Zabor
Brian Keisling	

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente

Krystalle Double

Strategic Behavioral Health Integration and Coordination Initiatives

1. Lindsey Naeyaert provided the update.
    a. For Opioid Health Homes, MDHHS has been getting new regions up to speed. These regions will be getting started in October.
        i. Once that is implemented in FY 2023, the Opioid Health Homes will cover 76 counties in Michigan.
        ii. The team is working to move the state policy forward and submit the state plan amendment.
        iii. The Opioid Health Home Kickoff took place on August 23, 2022, welcoming both new and existing health home partners.
        iv. MDHHS will continue to hold monthly meetings with the new regions and meet with them as frequently as needed to discuss implementation questions and concerns.
    b. For Behavioral Health Homes, over 200 people enrolled during the month of August 2022.
        i. Behavioral health homes will be expanding to Mid-State Health Network, with an anticipated start date of April 2023. Currently, this involves policy work and getting the state plan amended to include that region.
        ii. MDHHS met with every current Behavioral Health Home region in August 2022 to learn about successes and challenges. Staffing and workforce shortages were noted as the largest challenge to effectively providing services. The largest successes were listed as improving the relationship with primary care and the overall support of the health home model from the staff and regions MDHHS spoke to.
    c. The PIPBHC grant is in its fifth and final year, and the PIPBHC sites are focusing on sustaining their staff and the integrated care work they plan to continue after the grant. The sites are also completing the PIPBHC Self-Integration Assessment Survey.
    d. For CCBHCs, as of August 30th MDHHS had 42,905 Medicaid beneficiaries assigned in the Waiver Supports Application (WSA) and 6,827 individuals without Medicaid assigned.
        i. MDHHS has seen approximately 552,000 Medicaid daily visits, and 31,000 non-Medicaid daily visits occur from October 2021 through July 2022.
        ii. MDHHS is meeting with CMS to discuss the expectations for the end of Demonstration Year One, and to finalize more plans for Demonstration Year Two.
2. A PIHP asked if MDHHS intended to expand the number of CCBHCs in the state now that the federal government has made that an option.
    a. Erin Emerson answered that wants to see what the expected additional guidance looks like before making a decision.
    b. The federal agencies have solicited feedback from the states on what that possible expansion should look like, and MDHHS would love to hear any feedback that the group feels Michigan and the federal agencies should be aware of.

Children's Bureau Update

1. Phil Kurdunowicz reported that intensive crisis stabilization services (ICSS) work was ongoing under the MI Kids Now initiative. ICSS for children is one of the key services the Children's Bureau wants to expand on a statewide basis. The service was originally launched in 2017 as part of the Medicaid program, which has been supported with the block grant for children.
    a. MDHHS wants to expand where and how ICSS is delivered.
    b. Because ICSS has been implemented through the public mental health system, it has historically been restricted. MDHHS still intends to implement ICSS through the public mental health system, but MDHHS wants to broaden the number of children who qualify for this service. Children with less intensive needs may still have crises where they can benefit from this service.
    c. The mechanism is a new grant opportunity to all CMHs for to expand this service on a statewide basis.
        i. The grant would run for several years to help support capacity-building at the local level, and then eventually translate those outcomes into Medicaid policy in a more permanent way.
        ii. He hopes to provide more information about this the week of September 5, 2022.
2. Lisa Collins provided a brief update on the CANS.
    a. MDHHS is in the process of building its brief and comprehensive versions of the CANS.
    b. The initial thought is for the brief version to be used at the access intake centers to guide the screening, assessment, and referral for behavioral health services. The plan is to eventually also use the brief version for the mobile intensive crisis stabilization services team for children to promote access, identify immediate needs, and to guide stabilization techniques.
    c. MDHHS hopes to have the brief version of the CANS ready for rollout in October 2023 and the comprehensive version completed by October 2024.
    d. MDHHS aims to have the preliminary draft of the brief and comprehensive versions complete by mid-October 2022.
    e. Kim Batsche-McKenzie shared that MDHHS looks forward to getting input from the CMH Children's Administrators on September 9, 2022.
3. Kim Batsche-McKenzie shared the following language about the monthly payment for family support subsidy:

    "Sec. 996. From the funds appropriated in part 1 for family support subsidy, the department shall make monthly payments of ~~$229.31~~ $300.36 to the parents or legal guardians of children approved for the family support subsidy by a CMHSP."

    a. A PIHP asked when the date of the new rate would begin.
        i. Kim Batsche-McKenzie reported that the rate increase will go into effect October 1, 2022, with the new fiscal year. Families will see this increase on or about October 19, which is what the October checks will be dated.

4. Phil Kurdunowicz updated the group on the Waiver Supports Application (WSA) and Database Security Application (DSA) for Autism.
    a. Discussions have carried on about decommissioning these programs for use for Autism diagnoses.
    b. MDHHS is proceeding with decommissioning the full use of the WSA and DSA for autism programming. MDHHS plans to make that change near April 1, 2023.
    c. The current submission requirements for the WSA and DSA create a large administrative burden and may be duplicative of other systems. MDHHS believes it is beneficial to move away from requiring this.
    d. MDHHS is aware that there may need to be changes on a local level to adapt to the decommissioning of the WSA. MDHHS is looking at a timeframe in which to slow the use of the WSA at the statewide level to support that.
    e. MDHHS is still working towards exploring new reporting requirements for encounter and authorization data; the thought currently is to do so twice a year at a very high level.
5. Patricia Neitman, the Division Director in the newly created Office of the Advocate for Children, Youth, and Families, shared the progress her office is making.
    a. Currently, MDHHS is increasing staffing to address the responsibilities of the new office.
    b. Her office is:
        i. Formalizing a process for joint clinical review with child welfare partners and the Children's Services Agency. Specifically, this process is for youth who have complex behavioral health needs and are involved in child welfare and/or the juvenile justice system.
        ii. Working on a process to provide clinical consultation and technical assistance to for complex clinical situations that involve those specialty behavioral health services and needs. More will be forthcoming on these as they are formalized.
        iii. Working on a process to coordinate and collaborate with state hospital administration to ensure access to appropriate community-based services for youth who are transitioning out of state hospitals and returning to the community.
        iv. Working with BPHASA to map out a shared review process when inquiries reach them that involve access and service needs. She hopes to share that information and process with this group soon.
6. Kim Batsche-McKenzie added that the Children's Bureau is setting up email inboxes specific to different areas within the Bureau to ensure that the information or inquiry reaches an inbox that is checked daily by the relevant staff from the Bureau.

2022 Coverage Study

1. Lisa Coleman reminded the group about an initiative MDHHS must complete yearly that involves randomly selected tobacco compliance checks for retailers across the state.

a. Every three years Michigan must do a coverage study. This coverage study involves a master retailer list that the PIHPs keep updated on a yearly basis. Every three years MDHHS must ensure that all the retailers throughout the state are included on the list.
b. The coverage study was initially scheduled for August, but due to amendment issues, it has been rescheduled for October 1, 2022.
c. MDHHS will need that information from the PIHPs by November 1, 2022.

2. The amendment for funding for this study will go into place in January 2023. It will be retroactive to October 2022 so that the PIHPs will have the funds to reimburse for the coverage study.

HCBS Update

1. Belinda Hawks provided the HCBS update.
    a. MDHHS is working to put the critical incident reporting system under MI CAL. This will take effect for the critical incident reporting process in October 2022. Test users have come in to get training on navigating the new system, and those test users had questions that MDHHS is working to answer as they come in. MDHHS appreciates the feedback.
        i. MDHHS is discussing how to maintain the current critical incident reporting platform by MPHI through the transition to the new system. There are reporting needs that both the PIHPs and MDHHS have that require access to that data into the next year.
    b. The conflict-free access planning workgroup continues to meet. There were two sessions this summer. The groups are now moving to listen to and have sessions with individuals served to better understand their perspective and how the process will impact their services and supports.
    c. MDHHS will shortly send out a list of providers that fall into the non-responder group for the HCBS survey and the beneficiaries impacted by those settings being on the list. This list will go out by September 9, 2022.
        i. A PIHP expressed concern that they cannot afford to lose more providers and asked if there would be any way for those providers to rejoin the network.
        ii. Belinda Hawks shared that the providers in this situation will have an opportunity to come back into the network after March 2023.

Public Health Emergency Unwind

1. Jeff Wieferich shared that MDHHS did not receive the promised 60-day advanced notice from the federal government during August, which means that the public health emergency will be continued.
    a. MDHHS continues its internal work preparing for the eventual unwind and has a website with information on the topic that the PIHPs can refer to.
2. A PIHP noted that CMS had proposed a Medicaid rule relating to reenrollment on August 31, 2022.

MPCIP & MI CAL Update

1. Krista Hausermann provided the MI CAL update. MI CAL and 988 continue to roll out coordinated coverage.
    a. MDHHS is partnering with Detroit Wayne Integrated Health Network (DWIHN) right now to coordinate with their crisis services.
    b. MDHHS has begun discussions with Southwest Michigan Behavioral Health. The last region MDHHS will be moving into in October is Macomb County Community Mental Health.
    c. There have been increased volumes on all crisis lines in August when compared to July. Despite this increase in volume, MI CAL's answer rate only dropped 1%, with an average answer time of 23 seconds.
        i. The technology is set up so that calls from 988 and CMH after-hours calls have the same priority in the system.
    d. MDHHS continues coordination with 911 around people that need emergency interventions.
        i. Some of the public believe that the new 988 number would force intervention on individuals.
        ii. Out of the 4,508 calls in July 2022 for the National Suicide Prevention Lifeline, there were only 7 voluntary and 10 involuntary interventions.
        iii. MDHHS does a retrospective review of each of those calls to see if there was anything that could have been done to better engage with the caller to avoid the need to send out an involuntary intervention.
    e. Frontline Strong Together is a crisis line operated under the MI CAL umbrella that focuses on assisting first responders; each of the staff that answers have specialty first responder training.
    f. MDHHS plans to expand after-hours coverage for PIHP access lines and CMH crisis lines in FY 2023. MDHHS will send out written information shortly and is looking for volunteer regions or CMHs to take part.
    g. MDHHS has sent out invitations to the PIHPs and CMHs to send representatives to help streamline the CRM technology that supports the after-hours coverage.
2. Krista Hausermann reported that the legislature allocated funding for nine Crisis Stabilization Units (CSUs) in Michigan in the FY 2023 budget. MDHHS has been having informal discussions with entities interested in setting up CSUs to ensure that they are in alignment with the draft certification roles MDHHS has been working on.
    a. For the physical structure of a CSU, it is important to consider that people may stay there up to 72 hours. There must be a place for them to sleep, shower, and food for them to eat.
    b. These CSUs will only have single rooms for overnight stays, not shared rooms. It has been harder to find space for individuals who cannot share rooms, and MDHHS does not want to duplicate that difficulty at the CSUs.
    c. The model was updated to include children and families.
3. Krista Hausermann provided an update on the Psychiatric Bed Registry.
    a. MDHHS is working to enhance their coordination with LARA.

b. MDHHS has held small group discussions with the CMHs and psychiatric hospitals and received useful feedback.
c. LARA is developing a web page to help communicate with stakeholders.

4. A formal written update will be provided in October.

Opioid Advisory Commission Update

1. Brad Casemore of Southwest Michigan Behavioral Health shared the updates from the Opioid Advisory Commission.
    a. The Opioid Advisory Commission is related to the opioid settlement and was founded by the legislation PA 84 of 2022. It is a 12-member advisory commission.
    b. The group first met August 31, 2022, and plans to meet monthly. It is run through the Legislative Council and the Legislative Services Bureau, not MDHHS.
    c. The Commission elected Dr. Cara Poland as Chair and Mr. Patrick Patterson as Vice Chair; both are three-year appointees of Senate Majority Leader Shirkey.
    d. In its first meeting, the group approved bylaws, approved a job description and posting for a full-time coordinator assigned to the Legislative Council and the Commission, and empowered a workgroup.

H223 to H225 Conversion Code

1. Dr. Timothy Kangas provided an update.
    a. Something may have been missed in the rollout from H223 to the H225 and associated modifiers. These codes are attached to supportive employment.
    b. There was a proposed change sometime in January that just came out in a list of changes with a go-live date in January 2023.
    c. It may be a significant lift for some of the PIHPs with larger providers to implement that coding change.
    d. His basic understanding is that they are all good changes, but there might have been a communication breakdown about those changes, and he wanted the PIHPs and MDHHS to be aware.
2. Jeff Wieferich answered that MDHHS does have people tracking those changes, and he encourages any PIHP with concerns to send an email to let MDHHS know what is going on.

Community Mental Health Association of Michigan

Advocacy around addressing MDHHS action and inaction on key policy and practice issues

August 2022

This document outlines concerns regarding, and provides recommendations to improve, the leadership and management of the Michigan Department of Health and Human Services relative to the state's behavioral health services and system. Its contents are drawn from the discussion, on this topic, held as part of the July 2022 Directors Forum and the follow-up discussion, in August 2022, to further flesh out this issue. The video recording of that August session is found at: https://us02web.zoom.us/rec/share/X6UMKgx_NJP83sOn95mJT4MzibYZoTKMwaz4z-oqmYifbZam1vnVPJSjKMHj0z6i.BXdd6bww7X7POcs7?startTime=1661530167000

Defining the problem

This problem statement captures the themes that underlie the events that have caused concern, among the state's CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks, related to the leadership and management of the Michigan Department of Health and Human Services relative to the state's behavioral health services and system. When helpful in fleshing out an issue, examples – not an exhaustive list - of those events are provided beneath each of the components of the problem statement, below.

1. The Department seems to lack an understanding or sense of gravity of the issues impacting the community system. As a result, issues of urgency and centrality to service delivery are left unaddressed.

   Examples:

   - The sense of urgency and a concrete understanding of the impact, by community-based system, to address workforce issues is not shared by MDHHS. The response to this issue is fragmented, slow, and unorganized. The lack of policy, funding, structure, support, and back-up (public expression of the impact of the workforce shortage) from MDHHS leaves the community system alone in working to resolve this issue.
   - The need for a significant reduction in the administrative burden on the community system, for which the community system has developed a concrete set of solutions, has seen no action by MDHHS. In fact, the administrative burden has increased in the fact of this call for change
     - The addition of 15-minute recording, by the state's direct care workforce, of services that were previously a once-per-day requirement, the administrative burden has grown.
     - The financial recordkeeping and reporting requirements that have been place on the community system have grown dramatically over the past few years, with little benefit to the system and those it serves

2. There appears to be a misunderstanding, by a number of Department staff, of the fact that the MDHHS relationship with the CMHSPs and PIHPs is a government-to-government partnership relationship – one intentionally designed to be a system with each party playing a key role - and not a payer-to-vendor relationship. This relationship is the foundation of the system and has been for been for the past fifty years. In addition to the description of this relationship in statute, this government-to-government relationship has been reiterated, since 1997, in the Medicaid

managed care waivers that undergird the state's Medicaid managed behavioral healthcare system.

Examples:

- The lack of understanding of this government-to-government relationship has been at the heart of disagreements around contract negotiations, reporting requirements, and the development and issuance of a number of policies.
- Not seeing the partnership as a system caused the announced reduction in state hospital beds, without co-development of that plan, and without the recognition that the General Fund (GF) dollars that were taken from community system, to fund state facilities, is now not available for community-based services nor for assuring access to state inpatient care - as was the hope/promise behind the movement of these dollars.
- MDHHS ordering, directly to IT and other vendors of the community system, changes in practices without working with community system to coordinate nor prioritize this work.

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

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

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

   Additionally, when co-development appears to be the aim of a MDHHS-sponsored workgroup, the representatives of the community system often experience token involvement in those workgroups in which the fundamental constructs of these initiatives cannot be questioned by these knowledgeable representatives of the community-based system.

4. Policies proposed by the Department staff often lack a link grasp of the legal and conceptual base of the system, the waivers on which the system is built, and the federal requirements that guide the work of the community system.

   Example:

   - MDHHS's Standard Cost Allocation (SCA) initiative requires financial recordkeeping and reporting that violates GASB and other federal accounting standards and requirements.
   - Use of 1915i waiver to structure the b(3) services – which will involve the enrollment and certification, by the CMHs, PIHPs, and MDHHS of tens of thousands of persons served into the 1915i plan - when, with a greater knowledge of and experience with Michigan's 1115 and State Plan, this waiver and State Plan could have been used for these services and avoided this administratively heavy enrollment process.

5. For a number of issues, there appears to be no final decision makers and leaders nor clear decision-making process, within the Department, around a number of areas for which leadership, clarity, cooperative development, and timely decision making are needed. This leads to:
    - Indecisiveness, by the Department, on issues of significance and time sensitivity – causing the issues to grow in their complexity and size.
    - Delays in the prompt resolution of issues, once dialogue between MDHHS and the field have identified sound solutions to those issues.
    - Lack of a reliable source for the provision of answers to questions, from the field, on policy or initiative development and implementation.
    - Lack of decisions, once made, being put in writing.
    - Once MDHHS recognizes a need for a correction to state policy, bulletins, or communications, it appears that it is unclear, within the Department, is charged with making and issuing the correction.

      Examples:
        - The need for an administrative rule change, to align the state's ability to pay scale with that of the federal government, went unaddressed for over a year. This change was necessary to ensure CMHs who have lost their National Health Service Corps status can regain that status, thus ensuring that the loan forgiveness benefit of NHSC can be used to recruit and retain staff.
        - The Workforce Flexibility effort appeared to result in no tangible results due to the need for the approval of the proposals that were discussed by staff or Department units outside of the authority of the Department staff involved in this effort
        - There has been no formal announcement, in writing, of the Department's recent decision to reduce the number of state psychiatric hospital beds and the Department's effort to discharge patients for whom discharge to an appropriate community setting has been difficult.

6. Several policy initiatives within MDHHS conflict with each other – appearing to be developed in isolation from each other.

    Examples:
    - Draft concepts related to Conflict free assessment and planning are in conflict with some of the core constructs of the Mi Kids Now and CCBHC initiatives
    - Proposed Medicaid telehealth policies that prohibit audio-only telehealth services are at odds with access-promoting work of MDHHS and the community system that recognizes the vital importance that audio-only telehealth plays in ensuring access to persons without access to broadband service (due to lack of broadband infrastructure or the cost of data/video plans)
    - Freedom of movement aims of HCBS rules and the initiatives to find community-based settings for persons with challenging behaviors

7. There appears to be a lack of an articulated plan for a strong and vibrant public mental health system - a plan co-developed by the key members and stakeholders of that system, MDHHS, the state's CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks, and the state's major advocacy groups. The resulting vision vacuum leads to:

- The legislature, induced by this vision vacuum, developing system change and redesign proposals that are often well-intended but not linked to sound practice, financing, nor structure. Such proposals lead to fragmentation, a sense of continual system threat or erosion, or inaction

  Example:
  - Proposals by Senator Shirkey and Representative Whiteford
  - CARES Committee report

- The lack of integration of system strengthening proposals into the appropriations process.

  Example:
  - Lack of MDHHS budget proposals that parallel, for the community-based system, the financial incentives proposals proposed by MDE related to school-based mental health services

- A number of initiatives that are in conflict with each other

  Example: (Noted above)

8. The Department's risk averse approach has led to the growing administrative and compliance burden borne by the community system while drawing scarce Department and community system resources away from innovation and system advancement.

   As a result, Department requirements are often focused on ensuring that community system is complying with reporting and recordkeeping details (often tangential to service delivery), without a sense of where those compliance requirements fit within the range of demands on the system and without a sense of what the pursuit of such details does to hinder efforts to address the system's greatest risk management issues:
   - the deep and prolonged workforce shortage
   - the need to focus scarce staff time on direct service delivery, sound supervision, and system management and away from unnecessary administrative and reporting demands
   - the need to continue to build and maintain community partnerships
   - clinical, financing, human resources, and administrative innovation

9. Lack of understanding, by many in the Department, of expertise and working knowledge that exists in the community system – leading to the development of policies and approaches not informed by those with the deepest knowledge and experience base in the areas impacted by these policies and approaches.

   Examples:
   - Proposed Medicaid telehealth policies that prohibit audio-only telehealth services are at odds with access-promoting work of MDHHS and the community system that recognizes the vital importance that audio-only telehealth plays in ensuring access to persons without access to broadband service (due to lack of broadband infrastructure or the cost of data/video plans)
   - Not drawing on the accounting expertise in the community system, leading MDHHS's Standard Cost Allocation (SCA) initiative to require financial recordkeeping and reporting that violates GASB and other federal accounting standards and requirements.

10. The absence of an effort, within MDHHS, that ensures that Michiganders, policy makers, and stakeholders know of the positive impact of Michigan's public mental health system, its successes, and its cutting-edge work.

11. Lack of ability of MDHHS to influence other state departments in ways that support the state's public mental health system.
    Examples include:
    a. The inability to cooperatively work with the Michigan Department of Education (MDE) to develop a joint approach to the behavioral healthcare workforce to avoid the development of recruitment efforts, by MDE, that draw clinicians from the community mental health system.
    b. The need for MDHHS to assist LARA in understanding that the licensing of group homes and other facilities needs to reflect the liberty- and community-based goals of the state's HCBS efforts. The failure to help LARA understand this fact has led, with increased frequency recently, to LARA's findings of licensing violations at sites for behaviors and site responses that are to be expected given HCBS principles.

Solutions

1. MDHHS to prioritize its major initiatives, relative to the community system, to focus on a smaller number of issues and initiatives – prioritizing those of central importance to the work of that system and those with the greatest potential positive and negative on the system and those served by the system. Recognize that the scarce staff and time resources must be focused on core issues and not fragmented and depleted with the pursuit of more minor, less central issues.

2. The Department to reduce its risk aversion around items with low risk and focus on the issues that hold significant risk to the system and to those served by the system. (The prolonged and deep behavioral health workforce, the administrative burden borne by the system that diverts resources from service delivery, and the Mi Kids Now initiative as examples of sources of significant risk)

3. Assign staff and apply urgency to those prioritized issues, leaving other initiatives, with lower priority, in abeyance until significant progress has been made on the high priority issues and projects.

4. Based on the view that MDHHS and the community-based mental health system are partners, pursue a co-development approach to policy and practice development and implementation. This approach avoids the use of two leadership and decision-making approaches that are at the extremes of sound inclusive, dialogue-rich, transparent and action oriented leadership – decisions made with little dialogue with the field, little effort to draw on the expertise of the field, and without openness to revision, refinement, nor negotiation related to draft proposals by the Department; at the other extreme are initiatives that are so process-oriented (the workforce and administrative burden initiatives as examples) that timely and concrete actions are not taken or are so delayed as to be either inconsequential or irrelevant to the issue, that has now grown in intensity, size, or harm.

    Several parallel principles guide the co-development of a number of efforts:
    a. MDHHS holds the final responsibility, authority, and expertise for a range of issues
    b. The community system holds a parallel set of responsibilities, authorities, and expertise on many if not all of these issues

c. Integrating these responsibilities, authorities, and expertise into the decision making process

Co-development components:

d. Draw in subject matter expertise, from the community system, through the appointment to MDHHS workgroups of staff identified by CMHA and its members, with those representatives of the system being seen as active participants (not merely advisors) of these workgroups with a dual role: providing subject matter expertise and representing the broader system – recognizing that the latter role is limited, given the role and perspective of these representatives.
e. Regularly discuss, with CMHA and the leaders of the state's CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks, the progress of these co-development efforts, seeking the views of this leadership on the content of the emerging policies and practices – views that only leaders can provide, given their organization-wide and system-wide perspective.

5. Clearly identify the MDHHS lead on a project and ensure that this MDHHS lead has the responsibility and authority to make decisions, related to the project, in concert with the community system members of the co-development effort.

6. Retain the expertise and authority of MDHHS, even when outside consultants are used to provide technical expertise. The authority ceded to Milliman to structure the financing and financial reporting of the public system is an example of the loss of one of the central leadership roles of the department.

7. raw on the expertise and archival/memory resources in the field on a range of issues that are foundational to the work of MDHHS and the community system. These issues would include: the unique nature of Michigan's state-county mental health partnership, the history and context of the state's Medicaid waivers, the formation of the state's PIHP system, the breadth of roles played by the CMHSP and PIHP systems (beyond service delivery), the modern/pioneering capitation payment system that is at the heart of the financing of the state's community system.

8. Develop cross-project communication and coordination systems to ensure that MDHHS-led initiatives are working complementarily and not at cross purposes.

9. MDHHS, CMHA and its members and allies to plan and carry out joint legislative, public, and media advocacy on a range of issues.

10. Deploy some of the available ARPA dollars to draw in consultants to strengthen the project management, cross-project communication, and co-development skills of MDHHS staff.

11. Provide written clarity as to the roles of MDHHS staff, in light of the reorganization, so that the community system knows to whom to communicate regarding issues that they face.

12. Develop, jointly with CMHA, its members, and allies, a public education/media relations effort that highlights the performance, cutting edge practices, and positive impact of the state's public mental health system.

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

13. Develop the relations and the political influence to impact the decisions, by other state departments, that directly impact Michigan's public mental health system.

Advocacy methods to be used by CMHA, its members, and allies to promote the adoption of these solutions

1. Dialogue with MDHHS leadership
    a. Accepting Farah Hanley's offer to hear of concerns relative to MDHHS management and leadership.
    b. Develop a workgroup on MDHHS management, leadership, communication and the co-development of solutions (using Lynne Doyle's leadership of a joint workgroup on behavioral treatment planning as a model for the formation and operation of such a group)
    c. Regular dialogue with Farah Hanley and others regarding these issues - with a group of community system representatives. (David Knezek, too)
    d. Reconnect with David Knezek – in follow up to our earlier concerns expressed to him.

2. Outreach to CMS to request that CMS prompt MDHHS to take action on the most pressing issues facing the public mental health system.

3. Federal and state legislative and media advocacy
    a. Dialogue with the Governor's office
    b. Advocacy with state legislators underscoring key concerns unaddressed by MDHHS
    c. Outreach to Senator Stabenow
    d. Identify legislators, with relationship with Governor and those, without Governor connection yet allies of our system, who will be in office next session, to make these points.
4. Media relations
    a. A statewide coordinated media effort to express concerns regarding workforce and its impact on vulnerable Michiganders
    b. Individual CMHs and PIHPs to act, independently, to raise concerns, in media and with community partners

5. Legal action when statutory, regulatory, or contractual requirements or obligations are violated.
    a. Involve allies in these issues (as plaintiff in lawsuit, media message).
    b. Class action lawsuit against MDHHS regarding state hospital capacity reduction and related discharges
    c. Contact USDOJ with recommendation around lawsuit to address lack of capacity due to workforce shortage

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

7. Provide list, to MDHHS, of issues to which we cannot respond given staff shortage. Foster a uniform commitment to not fulfill some requests/demands by MDHHS and, instead, focus on core issues.

8. Build a structure by which representatives of the community system offer education and training, on our system, to newer (and more seasoned) MDHHS staff.

9. Develop a white paper (or one-pager) around the importance of behavioral health in a community, due to the pandemic

Below are two items related to the development of CMHA's CCBHC recommendations:

TIMEFRAME FOR RECOMMENDATION SUBMISSION TO MDHHS: As noted in the most recent draft of the CMHA CCBHC recommendations (8.24.22), the CCBHC team within MDHHS has indicated that they are looking forward to seeing CMHA's recommendations on the CCBHC State Demonstration initiative and post-demonstration design. They see these recommendations as critical, given that they are drawn from a diverse group of CMHs and PIHPs - those currently involved in the demonstration, those with SAMHSA expansion grants, those involved in Behavioral and Opioid Health Homes, and those not involved in CCBHC work.

During discussions with the team, the timeframe by which the Department can best use the Association's recommendations was determined.

Given the work that the MDHHS CCBHC team has to do to wrap-up and reconcile the first year of the Demonstration (ending September 30); the work needed to determine what, if anything, this team must do to address the removal of the cap on the number of sites that a state can enroll during the CCBHC Demonstration period (which, for Michigan, extends through FY 2027); and the project refinement-related knowledge gained during the demonstration, the CCBHC team within MDHHS indicated that they would find these recommendations most helpful if submitted by and no later than mid-April 2023.

ADDITIONAL THOUGHTS ON ADDITIONS TO RECOMMENDATIONS DOCUMENT FOR DISCUSSION AT SEPTEMBER 7 SESSION: Since last week's revision-development session related to CMHA's CCBHC recommendations, a number of you provided suggested additions to the recommendations document. Those recommendations, listed below, will be raised for consideration by the group during the next document review and revision session slated for September 7. (The announcement of that session, the revised document, National Council and MDHHS updates were contained in an earlier email, attached for ease of retrieval.

If Michigan does move to make CCBHC a permanent part of the state's healthcare landscape:

1. An 1115 waiver, rather than a State Plan Amendment (SPA) should be used. Many of the features in Michigan's 1115 waiver that are fundamental to Michigan's Medicaid behavioral health system (county-based sole source arrangement with the state's CMHs and PIHPs, as one example) would be retained and enhanced through the use of an 1115 waiver rather than a SPA.
2. When the state develops a plan for the location and number of CCBHCs, this plan should be one that looks at three clinical structures into that plan - incorporating the state's existing and emerging Behavioral Health Homes (BHH) and Opioid Health Homes (OHH) as well as CCBHCs as part of the that plan. For some communities, BHHs and OHHs have proven to be sound approaches to improved access, comprehensiveness of services, and primary/behavioral health integration for the residents of those communities – achieving many of the aims of the CCBHC initiative.
3. The timing and content of Michigan's CCBHC certification process must recognize and be tailored around the deep and prolonged behavioral health workforce shortage being experienced in communities across the state. To fail to do so will set up CCBHCs for failure or discourage participation, in the CCBHC initiative, by organizations experiencing, now and for the next several years, a substantial workforce shortage.

4. Require that CCBHCs certified in the State Demonstration and post-demonstration CCBHCs directly provide all nine CCBHC services. (Moving to all 9 from the current recommendation of 4 of the 9 prevents the certification of organizations who are not working to fulfill the spirit and philosophy of the CCBHC movement – that of serving as the provider of a comprehensive set of proven behavioral health services.)

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan

Community Mental Health Association of Michigan

Michigan's State Demonstration, Demonstration growth, & initiatives to make CCBHC a permanent part of Michigan's healthcare landscape

Revised through discussion session of September 7, 2022 and the CMHA Legislative and Policy Committee on September 21, 2022 (September 7 changes reflecting more than technical/grammatical/syntax changes from the previous version are highlighted in yellow; the September 21 changes are highlighted in green.)

FOUNDATIONAL ASSUMPTIONS

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

WHY CMHA IS DEVELOPING THIS SET OF RECOMMENDATIONS:

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

2. As is true in states across the country, Michigan's CCBHCs will become a central component in Michigan's public mental health system through **a Medicaid State Plan Amendment (SPA) or a Medicaid waiver. A number of state's – red and blue states – have already submitted, and CMS has approved, Medicaid State Plan Amendments (SPA)** to make CCBHCs a permanent part of their health care landscape. These states – **all with large rural and urban communities**, are Minnesota, Missouri, Oklahoma, Nevada, Kansas.

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

Without this involvement – in the form of recommendations and on-going dialogue **– the state's CCBHC State Demonstration nor its permanent CCBHC system is unlikely to accurately reflect the views of CMHA members, allies, and stakeholders.**

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

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

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

- Center for Health Care Strategies

[1] To simplify terminology, the term "mental health system" when used in this document, refers to the system that serves persons with mental illness, emotional disturbance, intellectual/developmental disabilities, or substance use disorders.

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

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

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

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

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

If the SPA/waiver is not in place when either of these two events take place, integrated care initiatives would be harmed and services would be severely decreased, especially for persons with mild-to-moderate mental health needs, those without Medicaid or in non-Medicaid settings, and to those receiving broader array of services made possible by CCBHC funding - with the attending loss of $200 million dollars to the system and access to care for a large number of persons in those communities.

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

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

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

PROCESS USED IN DEVELOPMENT OF THIS DOCUMENT

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

1. **June - September 2021: Fostering understanding of CCBHC by the leadership of Michigan's CMHSPs and PIHPs:** CMHA held a series of CCBHC learning sessions for CMHA members, designed to support the current operation and development of the emerging CCBHC system in Michigan.

   September 2021: The CCBHC series included a **Michigan Rural CCBHC Roundtable,** in September 2021 jointly sponsored by CMHA and the National Council, with **leaders of rural CCBHCs from across Michigan and Minnesota.**

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

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

4. Four sessions with the CEOs of the state's CMHs and PIHPs to revise the recommendations: Discussions of the draft document, with an invitation to the CEOs of all of the state's CMHs and PIHPs, were held on:

- July 29, 2022
- August 10, 2022
- August 24, 2022
- September 7, 2022

Attendance has high at all of these sessions, to date, with the draft set of recommendations being substantially revised and refined with each discussion.

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

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

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

PURPOSE OF THIS DOCUMENT

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

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

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

PRINCIPLES AND PREMISES

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

2. In Michigan, the **state's mental health safety net** is made up of:
- the public Community Mental Health Service Programs (CMHSP)
- the public Regional Entities/Prepaid Inpatient Health Plans (PIHPs) created and governed by the CMHSPs
- the provider networks of the CMHSPs and PIHPs (private providers **when fulfilling the contractual relationship with a CMHSP or PIHP**)

What defines and makes Michigan's mental health safety net system unique are the system's:
- Basis in longstanding state statute, regulation, policy, and contract
- Direct connection to local county governments, as a creation of county government to serve to fulfill each county's mental health responsibilities. - as part of the longstanding partnership between the county, state, and federal governments
- Decades of high performance in directly providing and purchasing the full range of behavioral health and intellectual/developmental disability services, for all of the populations served by Michigan's public system and defined in state law (adults with mental illness, children and adolescents with emotional disturbance, persons with intellectual and/or developmental disabilities, and persons with substance use disorders) and for all of the modalities and practices outlined in state law, regulation, Medicaid waivers, and contract across all levels of severity and need, all levels of intensity, including psychiatric inpatient care (at local and state hospitals), 24/7 crisis response services, and a wide range of non-traditional home and community-based services
- Role as the clinical risk and responsibility-bearing mental health body in every community in Michigan
- Central role in community mental health needs assessment, stakeholder involvement, and community dialogue
- Role in serving as the state's screening and admission points to state psychiatric hospitals and discharge planning and implementation from those hospitals

- Work in managing and ensuring the quality of care of comprehensive community-based service networks
- Role in serving as a highly visible convener and collaborator around a wide range of community needs and social determinants
- Leadership in the development, use, and replication of evidence-based and promising practices
- Role as a source of guidance and expertise to other healthcare and human services providers, elected officials, policy makers, the media

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

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

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

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

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

Given these premises:

1. State to use 1115 waiver – and not a State Plan Amendment - as vehicle to make CCBHCs permanent: Given that much of the financing, service delivery, and community collaboration concepts and design that are fundamental to Michigan's public mental health system are contained in the state's 1115 waiver, this waiver should be used as the vehicle by which Michigan will make CCBHC a permanent part of the state's health care landscape – and not a State Plan Amendment (SPA)

Given Michigan's innovation over the past twenty years in the development of its waiver and Medicaid State Plan, CCBHC services are already included in the State Plan – thus eliminating the need for a SPA.

2. State to develop a plan that outlines the number and location of CCBHCs, BHHs, and OHHs and method by which sites will be certified and added: The State Demonstration initiative and the 1115 waiver that will make CCBHCs a permanent part of Michigan's mental health landscape should include the number and location of the CCBHCs, Behavioral Health Homes (BHH), and Opioid Health Homes (OHH) that are to be certified in Michigan. This plan would serve as the blue print for the development and certification of these three foundational clinical structures - incorporating the state's existing and emerging Behavioral Health Homes (BHH) and Opioid Health Homes (OHH) as well as CCBHCs as part of the that plan.

For many communities, BHHs and OHHs have proven to be sound approaches to improved access, comprehensiveness of services, and primary/behavioral health integration for the residents of those communities – achieving many of the aims of the CCBHC initiative and successfully meeting all of the needs of the identified risk population in these communities.

The determination of the number and location of CCBHCs, BHHs, and OHHs should be guided by the need for statewide coverage and for the prevention of duplication and confusion. This initial determine of number and location is expected to change, over time, with the state spelling out, in advance in the waiver, the method by which those changes will be made.

This plan should outline the method by which other sites, including CCBHC Expansion sites, become CCBHCs during the State Demonstration period or post-Demonstration with sufficient notice time to allow these sites to understand and work to comply with these methods.

Additionally, this plan would provide clarity as to how the CCBHC State Demonstration and other state demonstration initiatives and similar efforts relate. An example is the need to outline, in writing, the clarification provided by MDHHS that a Medicaid enrollee can be enrolled simultaneously into a Behavioral Health Home, an Opioid Health Home, and a CCHBC

3. CCBHC certification process to be tailored to account for deep and prolonged behavioral health workforce shortage: The timing and content of Michigan's CCBHC certification process must recognize and be tailored to accommodate the deep and prolonged behavioral health workforce shortage being experienced in communities across the state. To fail to do so will set up CCBHCs for failure or discourage participation, in the CCBHC initiative, by organizations experiencing, now and for the next several years, a substantial workforce shortage.

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

Recommended refinements to the CCBHC standards:

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

   An example of standards tailored to meet the unique needs of Michigan communities include revisions to the **mobile crisis team requirements** and others that would provide CCBHC services to rural communities **through methods appropriate to needs, geography, transportation, capability of community partners, population density, and available workforce of each community**.

B. **The criteria must ensure that the state's CCBHCs – under the State Demonstration and in post-demonstration period - meet Michigan's mental health safety net definition or are included via a grandfathered status or those specifically designated by the CMHSP**

as the community's CCBHC (see discussion below). The definition of the Michigan mental health safety net is provided above, within the Principles and Premises section of this paper and, in greater depth, in Appendix A.

This link of CCBHC eligibility to an organization's role as one of the state's CMHSPs, is in recognition of the **close alignment of the philosophy, structure, services, and operations of the state's CMHSPs – the core of Michigan's mental health safety net system - with those of the CCBHC constructs.**

The need for grandfathering into CCBHC State Demonstration or post-demonstration CCBHC status, for a small number of private organization sites that do not meet Michigan's mental health safety net definition, is described in a subsequent section of this document.

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

It is recommended that the **financial support and technical assistance,** currently received by the Expansion and the State Demonstration sites, **be made available to all of the state's CMSHPs who indicate an interest in becoming CCBHCs.**

6. Roles for private provider organizations as Designate Collaborating Organizations (DCO): Except for those "grandfathered CCBHC sites" or "CMHSP-designated sites", the role of private provider organizations in CCBHC systems, given that they do not meet the definition of the Michigan mental health safety net, would be, in the main, that of Designated Collaborating Organizations (DCO) of a CMH serving as the community's CCBHC. As part of a comprehensive and coordinated BHIDD system. Except for grandfathered sites.

7. Roles for private provider organizations as "grandfathered" or "CMHSP-designated" CCBHC sites: Grandfathered CCBHC status would be granted to the three private organizations that are part of Michigan's initial CCBHC State Designation list.

Additionally, a small number of private organization sites that do not meet Michigan's mental health safety net definition (above), but work in communities in which the CMHSP desires to have a CCBHC presence in their community and the CMHSP supports the CCBHC designation for that private provider organization.

Recognizing that the service areas of CCBHCs are not limited to any traditional boundary, a CMHA serving a community with a significant population density may support the designation of one or more CCBHCs to serve, in the main, specific catchment areas.

Grandfathered and CMHSP-designated private organization sites would need to adhere to a number of conditions, including:

- **All CCBHC enrollments, for persons served by the private grandfathered CCBHC site, must be done by the CMHSP** serving the community in which the private organization is providing CCBHC services. This enrollment process would include the screening and initial assessment of the person's needs for CCBHC services, and any other services provided by and/or funded by the

CMHSP – in keeping with the CCBHC aim of strengthening and not fragmenting the mental health safety net in CCBHC communities.

- **Any persons enrolled**, by the CMHSP, into the CCBHC program and **referred to the grandfathered or CMHSP-designated CCBHC organization, must be served by the private CCBHC** – in keeping with the aim of the CCBHC initiative.

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

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

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

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

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

10. Foster consistency of policy and practice in the roles played by the state's PIHPs relative to CCBHC financing and operations: The use of the state's PIHP system to organize the financing of the state's CCBHCs is wise. Needed is greater guidance, from MDHHS, in the 1115 waiver, as to the standard practices that should be used by all of the state's PIHPs relative to CCBHC financing and operations. Michigan's PIHPs have demonstrated a strong willingness to work with MDHHS to develop consistent practices and policies relative to financing of and operational support to the state's CCBHCs.

11. Ensure that Michigan's CMHSP certification standards do not conflict with the state's CCBHC standards: It is key that Michigan's CMHSP certification process not hinder CMHSPs who may want to pursue CCBHC designation.

It is equally important that the CMHSP certification standards not force CMHSPs who are not seeking CCBHC designation to meet CCBHC standards that are not relevant to the CMHSP certification process.

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

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

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

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

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

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

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

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

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

330.1206 Community mental health services program; purpose; services.

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

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

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

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

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

(e) Recipient rights services.

(f) Mental health advocacy.

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

(h) Any other service approved by the department.

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

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

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

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

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

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

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

Sample of CMH contract attachments:

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

Sample of PIHP contract attachments:

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

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

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

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

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

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

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

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

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

ARR Sec.8 Coordinating and Managing Care; 2002:

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

2013 AFP reinforced these principles:

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

Michigan Department of Health and Human Services
Program Policy Division PO Box 30809
Lansing MI 48909

Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

September 20, 2022

<Provider Name>
<Provider Address 1>
<City> <State> zipcode5-zipcode4

Dear Interested Party:

RE: Michigan's Revised Statewide Transition Plan for Home and Community-Based Services Waiver Programs.

The Michigan Department of Health and Human Services (MDHHS) provides Home and Community-Based Services (HCBS) to individuals in the Medicaid program. These services help Michigan citizens with disabilities or other health issues to live at home or in the community. MDHHS offers many of these services through "waivers" which were approved by the Centers for Medicare & Medicaid Services (CMS).

CMS released a new rule for HCBS waivers. MDHHS has six waivers that are impacted by the Final Rule. They are as follows:

- §1915(c) Children's Waiver Program
- §1915(c) Habilitation Supports Waiver Program
- §1915(c) MI Choice Waiver Program
- §1915(c) MI Health Link HCBS Waiver Program
- §1915(c) Waiver for Children with Serious Emotional Disturbances
- §1915 (i) under the 1115 Behavioral Health Demonstration

MDHHS developed a Statewide Transition Plan to outline the implementation process for this rule. Since the MI Health Link HCBS Waiver Program was approved by CMS after March 2014, all settings are required to be in immediate compliance with the Final Rule and are not included in the Statewide Transition Plan.

MDHHS recently revised its Statewide Transition Plan based on feedback from CMS. The revised Statewide Transition Plan can be found online at www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Home and Community-Based Services Program Transition >> Revised Statewide Transition Plan. Any comments regarding the revised Statewide Transition Plan, or requests for a written copy, may be submitted to HCBSTransition@michigan.gov.

MDHHS will be accepting comments until October 27, 2022. All comments on this topic should include a "Statewide Transition Plan Comment" reference in the subject line of the e-mail.

Stakeholders should only submit comments related to the content of the revised plan. MDHHS will prepare a consultation summary based on these comments which will be made available at the above website following the end of the comment period. There is no public hearing scheduled for this Statewide Transition Plan.

The revised Statewide Transition Plan will be submitted to CMS for final approval October 27, 2022. At this time, it will also be posted online. Upon approval from CMS, the approval letter and the approved version of the plan will be posted online.

We thank you in advance for your participation.

Sincerely,

Farah Hanley
Chief Deputy for Health

Written comments for the House Health Policy Committee
September 22, 2022

Chairman Kahle and Members of the Committee:

My name is Alan Bolter, Associate Director of the Community Mental Health Association of Michigan (CMHA). Our association represents Michigan's public mental health system which includes the 46 community mental health boards, 10 Prepaid Inpatient Health Plans, and over 100 provider organizations that deliver mental health, substance use disorder, and developmental disabilities services in every community across the state.

Thank you for your interest in this important topic. While we certainly appreciate and applaud Rep. Filler's passion for this issue, we do have several concerns regarding HB 6355.

- HB 6355 is a solution without a problem. **The most recent MDHHS-published MMBPIS Report for state-wide performance on this measure #1 is 98.59% completion within 3 hours for adults and 98.77% for children.** The system of CMHs and PIHPs have exceeded the required standard of 95% for years. The three-hour requirement for pre-screens has long been the expected contractual standard for the public mental health system. HB 6355 only codifies it into statute and adds intrusive terms and conditions.

- The example used as basis for the need for the statute refers to a 42-day emergency department boarding of a 16-year-old with an autism spectrum disorder. While regrettable, tragic, and unfortunately all too common that event had nothing to do with the speed of the pre-screen medical necessity determination process; the problem in that instance and the vast majority of similar situations was lack of placement options for public behavioral health patients.

- The real problem which CMHs and PIHPs and others have pointed out for years is too few private and state hospital inpatient psychiatric beds and too few alternatives such as Crisis Stabilization, Crisis Residential and semi-secure Crisis Residential facilities. State hospitals have been taking beds offline due to inability to staff and per MDHHS a high preponderance of staff Leaves and thus vacancies without an ability to fill those positions. Private inpatient psychiatric hospitals and alternatives have also struggled with staffing for years. The direct care wage funds infusion has helped but needs to be directly built into the PIHP capitation payments and not subject to legislative action and the resultant uncertainty for PIHPs, CMHSPs, Provider and Staff.

- Another documentable problem is the too common inpatient psychiatric hospital refusals to admit with such statements as "inappropriate for milieu," "previously left against medical

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advice," "behaviorally disordered," "medically fragile," "too high acuity," and the like. Placements for persons with Intellectual and Developmental Disorders with or without co-occurring serious mental illness or serious emotional disturbance are particularly challenging.

- Permitting persons not authorized by the CMHSPs and PIHPs to make medical necessity decisions whether to their own facility or another 1. Is contrary to Medicaid Provider Manual, 2. Is contrary to PIHP-MDHHS Specialty Supports and Services Contract, 3. Is arguably in violation of federal Medicaid managed care regulations on delegation of functions, 4. Opens the hospitals to financial liability for the services they authorize, and 5. Will certainly create Payer Disputes for hospitals and the attendant administrative burdens.

    - Further the process violates the letter and spirit of conflict free case management also known and Conflict Free Access and Planning.

    - HB 6355 could raise potential scope of practice and state licensure issues if it allows other professionals who are not currently qualified or licensed to offer a behavioral health diagnosis.

- While HB 6355 claims to make the process "more efficient" it will in fact burden the process with time-keeping, clock-watching and probable differential decisions resulting in client confusion, client grievances and appeals, and administrative agency to agency payment complications and conflicts. It also obligates a CMH and/or PIHP to make payment to a hospital they have no pre-screen Contract with; public funds cannot flow without a written contract.

- The bill reads as if the person served has free reign decision authority over which hospital they choose (rarely are there two or more options) and seems to bind both PIHPs and hospitals to that persons' decision.

- It is stated by proponents of the Bill that "This legislation should help shorten the *difficult wait times* ***between the evaluation and beginning services***" that rationale explicitly says the "problem" is the period "between the evaluation and the services," a different problem with different solutions underway on many fronts.

- Logistically how will the start and stop times of the three-hour clock occur and be communicated properly? How will payers, patients and referral sources be informed.

For the reasons stated above CMHA opposes HB 6355 and respectfully requests that it not be approved by this committee. Again, thank you for your time and consideration of our remarks.

Respectfully submitted,

Alan Bolter
Associate Director

Michigan House Candidates

District	GOP Candidate	Dem Candidate	GOP Base %	Dem Base %	Incumbent/Open			Democrat Leaning
1	Paula Campbell	(Inc.) Tyrone Carter	7.4	92.6	Incumbent			Republican Leaning
2	Michael Joseph D'Onofrio	(Inc.) Tullio Liberati Jr	40.1	59.9	Incumbent			Competetive
3	Ginger Shearer	Alabas Farhat	21.5	78.5	Open		(Inc.)	Incumbent Representative
4	Tonya Renay Wells	(Inc.) Karen Whitsett	5.7	94.3	Incumbent		(Sen)	Currently a Senator
5	Paul Taros	Natalie Price	22.3	77.7	Open			
6	Charles Villerot	(Inc.) Regina Weiss	17.8	82.2	Incumbent			
7	N/A	(Inc.) Helena Scott	18	82	Incumbent			
8	Robert Noble	Mike McFall	20.6	79.4	Open			
9	Michele Lundgren	(Inc.) Abraham Aiyash	5.3	94.7	Incumbent			
10	Mark Corcoran	(Inc.) Joe Tate	35.1	64.9	Incumbent			
11	Mark Foster	Veronica Paiz	32.3	67.7	Open			
12	Diane Saber	Kimberly Edwards	28.6	71.4	Incumbent			
13	Ronald Singer	(Inc.) Lori Stone	32.2	67.8	Open			
14	Wendy Waters	Donavan McKinney	25.5	74.5	Open			
15	Steven Mackie	Erin Byrnes	39	61	Open			
16	Keith Jones	(Inc.) Stephanie Young	23.3	76.7	Incumbent			
17	Penny Crider	(Inc.) Laurie Pohutsky	31.4	68.6	Incumbent			
18	Wendy Webster Jackson	Jason Hoskins	20.5	79.5	Open			
19	Anthony Paesano	(Inc.) Samantha Steckloff	36.3	63.7	Incumbent			
20	Albert Mansour	Noah Arbit	39	61	Open			
21	David Staudt	(Inc.) Kelly Breen	48.3	51.7	Incumbent			
22	Cathryn Neracher	(Inc.) Matt Koleszar	52.3	47.7	Incumbent			
23	Richard Sharland	Jason Morgan	39.1	60.9	Open			
24	John Anthony	(Inc.) Ranjeev Puri	42.2	57.8	Incumbent			
25	Scott Barlow	(Inc.) Kevin Coleman	38	62	Incumbent			
26	James Townsend	Dylan Wegela	29.4	70.6	Open			
27	Bob Howey	Jamie Churhes	49.1	50.9	Open			
28	Jamie Thompson	Robert Kull		52.3	Open			
29	James DeSana	(Inc.) Alex Garza	52.1	47.9	Incumbent			
30	William Bruck	Suzanne Jennens	55.8	44.2	Open			
31	Dale Biniecki	Reggie Miller	46.1	53.9	Open			
32	Martin Church	Jimmie Wilson	23.1	76.9	Open			
33	Robert Borer	(Inc.) Felicia Brabec	28.5	71.5	Incumbent			

District	GOP Candidate	Dem Candidate	GOP Base %	Dem Base %	Incumbent/Open			Democrat Leaning
34	(Sen) Dale Zorn	John Dahlgren	56.4	43.6	Open			
35	(Inc.) Andrew Fink	Andrew Watkins	67.3	32.7	Incumbent			
36	(Inc.) Steve Carra	Roger Williams	63.3	36.7	Incumbent			
37	(Inc.) Brad Paquette	Naomi Ludman	60.5	39.5	Incumbent			
38	Kevin Whiteford	Joey Andrews	48.2	51.8	Open			
39	(Inc.) Pauline Wendzel	Jared Polonowski	58.3	41.7	Incumbent			
40	Kelly Sackett	(Inc.) Christine Morse	46	54	Incumbent			
41	Terry Haines	(Inc.) Julie Rogers	25.5	74.5	Incumbent			
42	(Inc.) Matt Hall	Justin Mendoza	54.5	45.5	Incumbent			
43	Rachelle Smit	Mark Lugwig	68.4	31.6	Open			
44	Dave Morgan	Jim Haadsma	48	52	Incumbent			
45	(Inc.) Sarah Lightner	Ron Hawkins	63.6	36.4	Incumbent			
46	Kathy Schmaltz	Maurice Imhoff	48.2	51.8	Open			
47	Tina Bednarski-Lynch	Carrie Rheingans	38.4	61.6	Open			
48	Jason Woolford	Jennifer Conlin	49.5	50.5	Open			
49	(Inc.) Ann Bollin	Christina Kafkakis	56.3	43.7	Incumbent			
50	(Inc.) Robert Bezotte	Glen Miller	64.7	35.3	Incumbent			
51	(Inc.) Matt Maddock	Sarah May-Seward	61.2	38.8	Incumbent			
52	(Inc.) Mike Harris	Robin McGregor	59	41	Incumbent			
53	Anthony Bartolotta	(Inc.) Brenda Carter	29.7	70.3	Incumbent			
54	Donni Steele	Shadia Martini	53.7	46.3	Open			
55	(Inc.) Mark Tisdel	Patricia Bernard	53.4	46.6	Incumbent			
56	Mark Gunn	Sharon MacDonell	47.6	52.4	Open			
57	Thomas Kuhn	Aisha Farooqi	51.5	48.5	Open			
58	Michelle Smith	(Inc.) Nate Shannon	50.3	49.7	Incumbent			
59	(Sen) Douglas Wozniak	James Diez	62.3	37.7	Open			
60	Joseph Aragona	Linda Clor	56.1	43.9	Open			
61	Mike Aiella	Denise Mentzer	48	52	Open			
62	Alicia St. Germaine	Michael Brooks	49.9	50.1	Open			
63	Jay DeBoyer	Kelly Nolan	60.3	39.7	Open			
64	(Inc.) Andrew Beeler	Charles Howell	54.7	45.3	Incumbent			
65	Jaime Greene	Mark Lingeman	65.7	34.3	Open			
66	Josh Schriver	Emily Busch	65.1	34.9	Open			

District	GOP Candidate	Dem Candidate	GOP Base %	Dem Base %	Incumbent/Open			Democrat Leaning
67	(Inc.) Phil Green	Brian LaJoie	53.9	46.1	Incumbent			
68	(Inc.) David Martin	Cheri Hardmon	50.2	49.8	Incumbent			
69	Jesse Couch	Jasper Ryan Martus	38.6	61.4	Open			
70	Tim Butler	(Inc.) Cynthia Neeley	15.1	84.9	Incumbent			
71	Brian BeGole	Mark Zacharda	54.6	45.4	Open			
72	(Inc.) Mike Mueller	Stacy Taylor	53.9	46.1	Incumbent			
73	Norm Shinkle	(Inc.) Julie Brixie	45	55	Incumbent			
74	Jennifer Sokol	(Inc.) Kara Hope	32	68	Incumbent			
75	Chris Stewart	Penelope Tsernohlou	41	59	Open			
76	Jeremy Whittum	(Inc.) Angela Witwer	48.3	51.7	Incumbent			
77	John Magoola	Emily Dievendorf	38.5	61.5	Open			
78	Gina Johnsen	Leah Groves	62.2	37.8	Open			
79	Angela Rigas	Kimberly Kennedy-Barrington	68.8	31.2	Open			
80	Jeffery Johnson	Phil Skaggs	48.5	51.5	Open			
81	Lynn Afendoulis	(Inc.) Rachel Hood	49.6	50.4	Incumbent			
82	Ryan Malinoski	Kristian Grant	28.3	71.7	Open			
83	Lisa DeKryger	John Fitzgerald	49.4	50.6	Open			
84	Mike Milanowski	(Inc.) Carol Glanville	50.5	49.5	Incumbent			
85	(Inc.) Bradley Slagh	Todd Avery	74.6	25.4	Incumbent			
86	Nancy De Boer	Larry Jackson	57.1	42.9	Open			
87	Michael Haueisen	Will Snyder	36.9	63.1	Open			
88	(Inc.) Greg VanWoerkom	Christine Baker	57	43	Incumbent			
89	(Inc.) Luke Meerman	Sharon McConnon	66.2	33.8	Incumbent			
90	(Inc.) Bryan Posthumus	Meagan Hintz	62.8	37.2	Incumbent			
91	(Inc.) Pat Outman	Tammy DeVries	63	37	Incumbent			
92	Jerry Neyer	Anthony Feig	50.6	49.4	Open			
93	(Inc.) Graham Filler	Jeffery Lockwood	60.6	39.4	Incumbent			
94	James Shepler	(Inc.) Amos O'Neal	30.6	69.4	Incumbent			
95	Bill Schuette	Matthew Dawson	58.4	41.6	Open			
96	(Inc.) Timothy Beson	Kim Coonan	49.7	50.3	Incumbent			
97	Matthew Bierlein	Paul Whitney	60.1	39.9	Open			
98	Gregory Alexander	Robert Mroczek	65.2	34.8	Open			
99	Mike Hoadley	Kenneth Kish	60	40	Open			

District	GOP Candidate	Dem Candidate	GOP Base %	Dem Base %	Incumbent/Open			Democrat Leaning
100	Tom Kunse	Nate Bailey	62.1	37.9	Open			
101	Joseph Fox	Amanda Siggins	63.6	36.4	Open			
102	(Sen) Curt VanderWall	Brian Hosticka	56.2	43.8	Open			
103	(Inc.) Jack O'Malley	Betsy Coffia	51.8	48.2	Incumbent			
104	(Inc.) John Roth	Cathy Albro	61.2	38.8	Incumbent			
105	(Inc.) Ken Borton	Adam Wojdan	64	36	Incumbent			
106	Cam Cavitt	Marie Fielder	61.1	38.9	Open			
107	Neil Friske	Jodi Decker	57.8	42.2	Open			
108	David Prestin	Chris Lopez	59.5	40.5	Open			
109	Melody Wagner	Jenn Hill	47.1	52.9	Open			
110	(Inc.) Gregory Markkanen	Casey VerBerkmoes	57.1	42.9	Incumbent			

Michigan Senate Candidates

District	GOP Candidate	Dem Candidate	GOP Base %	Dem Base %	Incumbent/Open		Democrat Leaning
1	Erik Soderquist	(Inc.) Erika Geiss	25.6	74.4	Incumbent		Republican Leaning
2	Harry Sawicki	(Inc.) Syliva Santana	25.8	74.2	Incumbent		Competetive
3	N/A	(Inc.) Stephanie Chang	19.2	80.8	Incumbent	(Inc.)	Incumbent Senator
4	Houston James	(Rep) Darrin Camilleri	44.1	55.9	Open	(Rep)	Currently a Representative
5	Emily Bauman	(Inc.) Dayna Polehanki	39.5	60.5	Incumbent		
6	Ken Crider	(Rep) Mary Cavanagh	31.6	68.4	Open		
7	Corinne Khederian	(Inc.) Jeremy Moss	27	73	Incumbent		
8	Brandon Simpson	(Inc.) Mallory McMorrow	23.9	76.1	Incumbent		
9	Mike Webber	(Rep) Padma Kuppa	52.4	47.6	Open		
10	Paul Smith	(Inc.) Paul Wojno	31.5	68.5	Incumbent		
11	(Inc.) Michael MacDonald	Veronica Klinefelt	46.1	53.9	Incumbent		
12	(Rep) Pam Hornberger	(Rep) Kevin Hertel	50.9	49.1	Open		
13	Jason Rhines	(Inc.) Rosemary Bayer	46.4	53.6	Incumbent		
14	Tim Golding	Sue Shink	44.9	55.1	Open		
15	Scott Price	(Inc.) Jeff Irwin	29.2	70.8	Incumbent		
16	(Rep) Joe Bellino	Katybeth Davis	58.1	41.9	Open		
17	Jonathan Lindsey	Scott Starr	61.6	38.4	Open		
18	(Rep) Thomas Albert	Kai De Graaf	59.7	40.3	Open		
19	Tamara Mitchell	(Inc.) Sean McCann	43.4	56.6	Incumbent		
20	(Inc.) Aric Nesbitt	Kimberly Gane	59	41	Incumbent		
21	Nkenge Roberston	(Rep) Sarah Anthony	41.7	58.3	Open		
22	(Inc.) Lana Theis	Jordan Genso	61.5	38.5	Incumbent		
23	(Inc.) Jim Runestad	Une Hepburn	58.1	41.9	Incumbent		
24	(Inc.) Ruth Johnson	Theresa Fougnie	63.3	36.7	Incumbent		
25	(Inc.) Dan Lauwers	Bert Van Dyke	61.1	38.9	Incumbent		
26	(Inc.) Kevin Daley	Charles Stadler	61.1	38.9	Incumbent		
27	Aaron Gardner	(Rep) John Cherry	33.9	66.1	Open		
28	Daylen Howard	Sam Singh	45.5	55.5	Open		
29	(Rep) Tommy Brann	(Inc.) Winnie Brinks	41.6	58.4	Incumbent		
30	(Inc.) Mark Huizenga	(Rep) David LaGrand	53.7	46.3	Incumbent		
31	(Inc.) Roger Victory	Kim Nagy	65.5	34.5	Incumbent		
32	(Inc.) Jon Bumstead	(Rep) Terry Sabo	49.8	50.2	Incumbent		
33	(Inc.) Rick Outman	Mark Bignell	63.8	36.2	Incumbent		

District	GOP Candidate	Dem Candidate	GOP Base %	Dem Base %	Incumbent/Open		Democrat Leaning
34	(Rep) Roger Hauck	Christine Gerace	58.5	41.5	Open		
35	(Rep) Annette Glenn	Kristin McDonald Rivet	46.9	53.1	Open		
36	(Rep) Michele Hoitenga	Joel Sheltrown	62.1	37.9	Open		
37	(Rep) John Damoose	Barbara Conley	56.8	43.2	Open		
38	(Inc.) Ed McBroom	John Braamse	54.3	45.7	Incumbent		

Northern Michigan Regional Entity

1999 WALDEN DRIVE ♦ GAYLORD, MI 49735 231.383.6123 ♦ OFC 989.448.7078 ♦ FAX NMRE.ORG

TO: NLCMHA Board of Directors

FROM: Eric Kurtz, NMRE CEO and Don Tanner, NMRE Board Chair

RE: NLCMHA Interim CEO, Search Process, and Contractual Oversight

Overview:

Below is a summary of an email from Dan Dekorse , NLCMHA Board Chair, sent on 9-4-22, asking that I present at the 9-15 -22 NLCMHA Board Committee of the Whole meeting to provide the following information based on NLCMHA's acceptance of the NMRE's enhanced Contractual Oversight memo sent on 8-11-22:

1. Name and credentials of proposed interim CEO.
2. An identified appointment limit for the Interim CEO that could be extended with Board approval if a CEO has not been found. (i.e. start date and end date)
3. An identified limited period for the appointed Interim CEO to work with the current Interim CEO to meet with employees, be made aware of current projects and internal policies. (Maybe two weeks)
4. If and how the NMRE would assist the Board with identifying recruitment companies or practices to expedite finding a permanent CEO, so that process may be started ASAP.

This information should be presented so that the whole board receives the information at the same time.

If information was presented at our Committee of the Whole and I would have an item on agenda to vote on the specifics.

I would request that information presented to the Committee of the Whole be placed as an agenda item for the full NLCMHA Board to vote on the specifics.

Response:

This response is based on the assumptions that the NLCMHA vote on August 18, 2022, to accept the NMRE offer of enhanced contractual oversight stands and this response is to explain the process moving forward.

1. As early as today, I will personally assume the role of NLCMHA Interim CEO until the end of September at which time, Brain Martinus, currently the NMRE Veterans Services Navigator and who is a resident of Traverse City would assume the role as NLCMHA Interim CEO.

Brain's brief bio is attached, and he will be working directly under my supervision, in conjunction with the NLCMHA Board as we move forward collectively. Both he and I will be available to NLCMHA staff to provide support, direction, and oversight, as needed.

2. The term of this appointment will be six months or until such time as a permanent CEO is in place.

3. With the temporary appointment of myself and my familiarity with several NLCMHA staff, getting up to speed on current projects and internal policies should be seamless. With that said, I am interested in getting all NLCMHA Board governance policies and bylaws ASAP, as I feel we need a timelier process of getting things to, and decisions from, the Board as we move through this transition.

4. As stated in the Contractual Oversight Memo from 8-11-22, the NMRE is willing to take on the search process itself ASAP or is willing to use a search firm in conjunction with the NLCMHA Board. Given the ideal candidate would have Michigan experience due to the unique nature of Michigan's behavioral health system, the NMRE could start this process and if it does not bear out qualified applicants, then engage a firm to target a broader national search. I have been in contact with two search firms already and, as of today, received a draft proposal for consideration, depending on how we choose to proceed. As I am sure you are aware, these firms do come with a cost.

I appreciate the Board granting me time today and hope we can immediately begin to move forward.

Eric Kurtz, NMRE CEO

Meet Brian Martinus

Brian has been a resident of Traverse City Michigan for over 8 years has been an employee of Northern Michigan Regional Entity for over 5 years serving as a Veteran Service Navigator.

As the Northern Michigan Regional Entity's Veterans Navigator, Brian was tasked to create and maintain an effective environment to increase capacity in the publicly funded behavioral health care system to encourage a proactive approach to the delivery of quality behavioral health service to Veterans, members of the Military, and their families. Brian has worked directly with all five Community Mental Health Service Programs and the 21 county regions substance use disorder providers to coordinate these needed services.

Brian has had a military career spanning over 20 years in multiple positions as a Military Chaplain.

Most recently, Brian was deployed for 19 months as the Command Chaplain on a Title 10 Deployment (March 2020 thru October 2021) for TF-46th/TF-C/W on Operation COVID-19 Response working between 38 different states and 6 FEMA Regions. Brian was responsible of coordinating all religious support and behavioral health assets going into COVID-19 hospitals throughout the United States. Brian directly managed over 350 Chaplains, Religious Affairs Specialists, and Behavioral Health Specialists. Brian worked in the inner agency process setting up support to over 57 COVID-19 Field Hospitals, 43 CVC sites throughout the United States.

Brian was also deployed as a Task Force Chaplain in support of Operation Iraq Freedom/Operation New Dawn 2010-2011 to Kuwait and Iraq. As a Task Force Chaplain for TF-119th Field Artillery BN, Brain was responsible for the religious support in direct combat operations for 597 Soldiers throughout and Southern Iraq.

Other relevant work history:

Brian served 7 years as the Senior Pastor of Dice Wesleyan Church in Freeland Michigan and worked Fulltime for the Michigan Army National Guard as the Yellow Ribbon Support Chaplain.

Before becoming NMRE's Veterans Navigator, Brian served 3 years on Title 10 running the Casualty Operations/Military Funeral Honors program for the Michigan Army National Guard.

Brian has held many Chaplain positions throughout the Michigan National Guard ranging from Battalion Chaplain, Brigade Chaplain, and Command Chaplain on a Division Staff for the 46th Military Police Command out of Lansing Michigan.

Brian is currently holding the rank of COL. Brian has served a total of 12 years 6 months and on Active Duty out of his 20 total years of service within the Michigan National

Guard. Brian's currently holds the position of State Chaplain of the Michigan National Gurad.

Brian's education includes:

2001 Bachelor's Degree, Bachelor of Fine Arts Degree, Adrian College
2006 Master's Degree, Grand Rapids Theological Seminary, MA Religious Education
2008 Master's Degree, Grand Rapids Theological Seminary, MA Counseling
2021 Master's Degree, United States Army War College, MSS Strategic Studies

Brian resides in Traverse City Michigan with his wife, son, and two daughters'.

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – SEPTEMBER 14, 2020
VIA TEAMS

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

REVIEW AGENDA & ADDITIONS
Donna requested adding court appointed guardian funding to the meeting agenda.

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

MOTION BY LAURI FISCHER TO APPROVE THE MINUTES OF THE AUGUST 10, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

MONTHLY FINANCIALS
July 2022

- Net Position showed net surplus Medicaid and HMP of $12,117,012. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $28,475,129. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $44,833,246.
- Traditional Medicaid showed $168,681,306 in revenue, and $154,712,217 in expenses, resulting in a net surplus of $13,969,089. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $26,812,584 in revenue, and $22,720,930 in expenses, resulting in a net surplus of $4,091,653. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,216,598 in revenue, and $1,016,957 in expenses, resulting in a net surplus of $199,641.
- SUD showed all funding source revenue of $20,997,804, and $17,899,716 in expenses, resulting in a net surplus of $3,098,088. Total PA2 funds were reported as $5,149,752.

The direct care wage surplus was estimated at $5,943,730. Potential lapse of $11M.

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JULY 2022; SUPPORT BY LAURI FISCHER. MOTION APPROVED.

EDIT UPDATE

Donna forwarded an email from Kasi Hunziger dated August 11th regarding 97153 97154 codes.

HCPCS Codes	*Reporting and Costing Considerations*
97153	Adaptive behavior treatment by protocol, administered by a technician under the direction of a BCBA or other qualified professional, face-to-face with one beneficiary, every 15 minutes. May involve a BCBA, BCaBA, LP/LLP, or QBHP, to deliver this service as well but the primary provider is the behavior technician. Encounter needs to be reported under the BCBA and not the BT. Need to use the NPI of the BCBA.
97154	Group adaptive behavior treatment by protocol, administered by a technician under the direction of a BCBA or other qualified professional, face-to-face with two or more beneficiaries (maximum of 8 individuals), every 15 minutes. Encounter needs to be reported under the BCBA and not the BT. Need to use the NPI of the BCBA.

The next EDIT meeting is scheduled for October 20th.

EQI UPDATE

Period 2 EQI (October – May) is due to the State October 21, 2022. Milliman will use the October 3rd encounter extract for comparison to the EQI. NMRE requested reports from the Boards by close of business on October 13th.

Eric noted that a meeting took place September 13th with NMRE staff, Julie Harrison, Kathy Haines, and Milliman regarding Non-Fee-for-Service Contracts. The State was under the impression that Region 2 offered itself as a pilot. He questioned who may have made the offer and whether it is even applicable to Region 2. Eric asked the State to double-check that they aren't confusing Region 2 with Region 1 (NorthCare Network).

EQI BENEFICIARY-LEVEL FILE

Donna reported that the EQI Beneficiary-level file was an agenda topic of for the September 8th EQI Workgroup meeting. Brandon noted that the NMRE reviews the reconciliation file monthly; the beneficiary-level file may benefit PIHPs that do not.

The contracted vs. direct-run variance report was discussed. Tricia indicated that the last EQI was smooth, other than updated rates. Brandon confirmed that there will always be a difference between encounter reporting (837) and EQI reporting.

COURT APPOINTED GUARDIAN FUNDING

Pursuant to Section 950 of the FY23 Michigan state budget, funds have been appropriated to court appointed guardians.

> "Sec. 950. From the funds appropriated in part 1 for court-appointed guardian reimbursement, the department shall allocate $5,000,000.00 to reimburse court-appointed public guardians for recipients who also receive CMHSP services, at a reimbursement of $50.00 per month. The department shall make these funds available to the CMHSPs to reimburse for court-appointed public guardians for

those recipients receiving CMHSP services through the CMHSP. It is the intent of the legislature that these funds be used in addition to any other funds currently paid to court-appointed public guardians, but a court-appointed public guardian shall not be compensated more than $83.00 per month for any CMHSP-eligible recipient regardless of funding source. By September 15 of the current fiscal year, each CMHSP that has provided reimbursement to a court-appointed public guardian shall provide the department a report that shall be shared with the house and senate appropriations subcommittees on the department budget department, the house and senate fiscal agencies, the house and senate policy offices, and the senate budget office on the number of court-appointed public guardians who were reimbursed, the amount of reimbursement for each court-appointed public guardian, and the number of court-appointed public guardians who received these funds, the number of court-appointed public guardians who were also reimbursed by the counties, and the per-month reimbursement rates provided by the counties."

Donna asked the Boards whether anyone is receiving these funds; the Boards responded that they are not.

HCBS

Providers that have been unresponsive to the HCBS survey process have been considered noncompliant with the HCBS rule and will not be eligible for funding to provide services to HCBS waiver participants after March 17, 2023. PIHPs have been tasked with addressing settings that were unresponsive. A meeting is taking place with NMRE staff and the CMHSPs today at 2:00PM to discuss providers that never responded to the HCBS survey (34 individuals regionally). Exactly who is on the list has been difficult to ascertain, though it has been obtained recently and shared with Boards. Brian expressed that there is a disconnect between MSU and the State. Eric offered to email Belinda Hawks for clarification and additional information.

BHH SUMMIT

A Behavioral Health Home Summit is taking place on September 23rd from 9:30AM – 3:00PM at Treetops Resort in Gaylord; a Teams link is also available for remote attendance. Eric stressed that the goal of the event is to increase BHH enrollment. Billers were encouraged to attend. The meeting invitation and the agenda will be sent to the Finance Committee later on this date.

NEXT MEETING

The next meeting was scheduled for October 12th at 10:00AM.

Chief Executive Officer Report

September 2022

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

Aug 25: Participated in NEMCMHA CARF Interview.

Aug 26: Attended and participated CMHAM meeting to impact MDHHS policy.

Aug 30: Attended and participated GT County Behavioral Health Services Community Input.

Aug 31: Attended and participated in CMHAM independent actuary discussion.

Sept 1: Attended and Participated in MDHHS PIHP/CEO Meeting.

Sept 2: Attended and participated in CMHAM advocacy meeting around MDHHS leadership.

Sept 6: Attended and participated in PIHP CEO Meeting.

Sept 7: Attended and participated in CMHAM CCBHC Discussion.

Sept 12: Attended (remotely) and participated in NMRE SUD Oversight Board meeting.

Sept 12: Attended and participated in NL county administrators meeting.

Sept 13: Attended and participated in MDHHS EQI discussion.

Sept 14: Attended NMRE Regional Finance Committee meeting.

Sept 15: Attended and presented to NL CMHA Board.

Sept 20: Chaired NMRE Operations Committee meeting.

July 2022 Finance Report

July 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	13,969,089	11,296,867	9,298,368
Healthy Michigan	4,091,653	5,061,250	7,059,749
	$ 18,060,742	$ 16,358,117	$ 16,358,117

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	993,145	2,345,607	3,183,594	2,794,231	(69,244)	2,347,473	522,206	$ 12,117,012
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 28,475,129
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 44,833,246

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through July 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 163,809,749	$ 3,940,393						$ 167,750,142
CMHSP Distributions	(157,591,775)		52,334,345	43,307,779	26,471,060	21,735,324	13,743,266	-
1st/3rd Party receipts			379,322	-	551,842	-	-	931,164
Net revenue	6,217,974	3,940,393	52,713,667	43,307,779	27,022,902	21,735,324	13,743,266	168,681,306
Expense								
PIHP Admin	2,063,365	41,027						2,104,392
PIHP SUD Admin		50,538						50,538
SUD Access Center		47,741						47,741
Insurance Provider Assessment	1,330,411	26,984						1,357,395
Hospital Rate Adjuster	1,905,288							1,905,288
Services		2,909,692	47,272,536	40,725,261	26,792,334	18,426,460	13,120,580	149,246,863
Total expense	5,299,064	3,075,982	47,272,536	40,725,261	26,792,334	18,426,460	13,120,580	154,712,217
Net Actual Surplus (Deficit)	$ 918,910	$ 864,411	$ 5,441,131	$ 2,582,518	$ 230,568	$ 3,308,864	$ 622,686	$ 13,969,089

Notes

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

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through July 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 17,338,066	$ 9,468,763						$ 26,806,829
CMHSP Distributions	(15,512,518)		5,645,643	4,712,441	1,926,274	1,928,312	1,299,849	0
1st/3rd Party receipts			-	-	5,755	-	-	5,755
Net revenue	1,825,548	9,468,763	5,645,643	4,712,441	1,932,029	1,928,312	1,299,849	26,812,584
Expense								
PIHP Admin	190,789	99,241						290,030
PIHP SUD Admin		122,247						122,247
SUD Access Center		115,481						115,481
Insurance Provider Assessment	119,084	63,288						182,372
Hospital Rate Adjuster	1,441,440							1,441,440
Services		7,038,307	5,910,562	3,686,400	1,267,185	1,798,400	868,507	20,569,361
Total expense	1,751,313	7,438,564	5,910,562	3,686,400	1,267,185	1,798,400	868,507	22,720,930
Net Surplus (Deficit)	$ 74,235	$ 2,030,199	$ (264,919)	$ 1,026,041	$ 664,844	$ 129,912	$ 431,342	$ 4,091,653

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

Direct Care Wage Estimated Surplus	**(549,003)**	**(1,992,618)**	**(814,328)**	**(964,656)**	**(1,091,303)**	**(531,822)**	**$ (5,943,730)**
Net Surplus (Deficit) MA/HMP/DCW	**$ 993,145**	**$ 2,345,607**	**$ 3,183,594**	**$ 2,794,231**	**$ (69,244)**	**$ 2,347,473**	**$ 522,206**	**$ 12,117,012**
Medicaid & HMP Carry Forward								**16,358,117**
Total Med/HMP Current Year Surplus								$ 28,475,129
Medicaid & HMP ISF - based on unaudited FSR								**16,358,117**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 44,833,246**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through July 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 222,017		395,864	108,977	80,548	51,309	357,882	$ 1,216,598
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	222,017	-	395,864	108,977	80,548	51,309	357,882	1,216,598
Expense								
PIHP Admin	14,024							14,024
BHH Admin	3,056							3,056
Insurance Provider Assessment	5,297							5,297
Hospital Rate Adjuster								
Services	-		395,864	108,977	80,548	51,309	357,882	994,580
Total expense	22,377	-	395,864	108,977	80,548	51,309	357,882	1,016,957
Net Surplus (Deficit)	$ 199,641	$ -	$ (0)	$ 0	$ 0	$ (0)	$ 0	$ 199,641

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through July 31, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 3,940,393	$ 9,468,763	$ 3,096,851	$ 2,581,151	$ 1,910,646	$ 20,997,804
Expense						
Administration	91,565	221,488	84,490	156,846		554,388
OHH Admin			105,310	-		105,310
Access Center	47,741	115,481	-	25,734		188,956
Insurance Provider Assessment	26,984	63,288	18,715			108,987
Services:						
Treatment	2,909,692	7,038,307	2,684,859	1,568,458	1,910,646	16,111,962
Prevention	-	-	-	830,113	-	830,113
State targeted response	-	-	-	-	-	-
Total expense	3,075,982	7,438,564	2,893,374	2,581,151	1,910,646	17,899,716
PA2 Redirect			-	(0)	0	-
Net Surplus (Deficit)	$ 864,411	$ 2,030,199	$ 203,477	$ -	$ 0	$ 3,098,088

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through July 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 163,809,749	$ 3,940,393	$ -	$ 167,750,142
Medicaid Savings	11,296,867	-	-	11,296,867
Healthy Michigan	17,338,066	9,468,763	-	26,806,829
Healthy Michigan Savings	5,061,250	-	-	5,061,250
Health Home	1,216,598	-	-	1,216,598
Opioid Health Home	-	3,096,851	-	3,096,851
Substance Use Disorder Block Grant	-	2,581,151	-	2,581,151
Public Act 2 (Liquor tax)	-	1,910,646	-	1,910,646
Affiliate local drawdown	674,700	-	-	674,700
Performance Incentive Bonus	1,363,500	-	-	1,363,500
Miscellanous Grant Revenue	-	21,087	-	21,087
Veteran Navigator Grant	91,482	-	-	91,482
SOR Grant Revenue	-	972,738	-	972,738
Gambling Grant Revenue	-	139,500	-	139,500
Other Revenue	-	-	6,108	6,108
Total operating revenue	200,852,212	22,131,129	6,108	222,989,449
Operating expenses				
General Administration	2,507,689	503,833	-	3,011,522
Prevention Administration	-	71,699	-	71,699
OHH Administration	-	105,310	-	105,310
BHH Administration	3,056	-	-	3,056
Insurance Provider Assessment	1,454,792	108,987	-	1,563,779
Hospital Rate Adjuster	3,346,728	-	-	3,346,728
Payments to Affiliates:				
Medicaid Services	145,406,007	2,909,692	-	148,315,699
Healthy Michigan Services	13,525,299	7,038,307	-	20,563,606
Health Home Services	994,580	-	-	994,580
Opioid Health Home Services	-	2,684,859	-	2,684,859
Community Grant	-	1,568,458	-	1,568,458
Prevention	-	758,414	-	758,414
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	1,910,646	-	1,910,646
Local PBIP	2,801,252	-	-	2,801,252
Local Match Drawdown	674,700	-	-	674,700
Miscellanous Grant	-	21,087	-	21,087
Veteran Navigator Grant	91,482	-	-	91,482
SOR Grant Expenses	-	972,738	-	972,738
Gambling Grant Expenses	-	139,500	-	139,500
Total operating expenses	170,805,585	18,793,530	-	189,599,115
CY Unspent funds	30,046,627	3,337,599	6,108	33,390,334
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,254,458	6,231,624	16,358,117	24,844,199
Unspent funds - ending	$ 32,301,085	$ 9,569,223	$ 16,364,225	$ 58,234,533

Northern Michigan Regional Entity

Statement of Net Position

July 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 40,666,732	$ 8,008,663	$ 16,364,225	$ 65,039,620
Accounts Receivable	23,266,873	2,817,585	-	26,084,458
Prepaids	74,818	-	-	74,818
Total current assets	64,008,423	10,826,248	16,364,225	91,198,896
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	64,008,423	10,826,248	16,364,225	91,198,896
Liabilities				
Current liabilities				
Accounts payable	31,471,839	1,257,025	-	32,728,864
Accrued liabilities	235,499	-	-	235,499
Unearned revenue	-	-	-	-
Total current liabilities	31,707,338	1,257,025	-	32,964,363
Unspent funds	$ 32,301,085	$ 9,569,223	$ 16,364,225	$ 58,234,533

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2021 through July 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 160,775,910	$ 163,809,749	$ 3,033,839	1.89%
Carryover	11,296,664	11,296,664	11,296,867	203	0
Healthy Michigan					
Capitation	20,566,272	17,138,560	17,338,066	199,506	1.16%
Carryover	5,061,832	5,061,832	5,061,250	(582)	(0.01%)
Health Home	506,772	422,310	1,216,598	794,288	188.08%
Affiliate local drawdown	1,204,388	903,291	674,700	(228,591)	(25.31%)
Performance Bonus Incentive	1,334,531	1,334,531	1,363,500	28,969	2.17%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	91,670	91,482	(188)	(0.21%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	197,024,768	200,852,212	3,827,444	1.94%
Operating expenses					
General Administration	3,021,688	2,496,290	2,507,689	(11,399)	(0.46%)
BHH Administration	-	-	3,056	(3,056)	0.00%
Insurance Provider Assessment	1,645,387	1,371,156	1,454,792	(83,636)	(6.10%)
Hospital Rate Adjuster	4,001,228	3,334,353	3,346,728	(12,375)	(0.37%)
Local PBIP	1,334,531	-	2,801,252	(2,801,252)	0.00%
Local Match Drawdown	1,204,388	903,291	674,700	228,591	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	162,410	91,482	70,928	43.67%
Payments to Affiliates:					
Medicaid Services	173,402,120	144,501,767	145,406,007	(904,240)	(0.63%)
Healthy Michigan Services	15,233,944	12,694,953	13,525,299	(830,346)	(6.54%)
Health Home Services	456,768	380,640	994,580	(613,940)	(161.29%)
Total operating expenses	200,508,190	165,844,860	170,805,585	(4,960,725)	(2.99%)
CY Unspent funds	$ 32,503,361	$ 31,179,908	30,046,627	$ (1,133,281)	
Transfers in			-		
Transfers out			-	170,805,585	
Unspent funds - beginning			2,254,458		
Unspent funds - ending			$ 32,301,085	30,046,627	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2021 through July 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 3,665,620	$ 3,940,393	$ 274,773	7.50%
Healthy Michigan	9,763,272	8,136,060	9,468,763	1,332,703	16.38%
Substance Use Disorder Block Grant	5,709,003	4,757,500	2,581,151	(2,176,349)	(45.75%)
Opioid Health Home	2,320,384	1,933,650	3,096,851	1,163,201	60.16%
Public Act 2 (Liquor tax)	1,533,979	1,022,653	1,910,646	887,993	86.83%
Miscellanous Grants	36,335	30,279	21,087	(9,192)	(30.36%)
SOR Grant	1,215,000	1,012,500	972,738	(39,762)	(3.93%)
Gambling Prevention Grant	200,000	166,667	139,500	(27,167)	(16.30%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	20,724,929	22,131,129	1,406,201	6.79%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	842,070	503,833	338,237	40.17%
Prevention Administration	90,144	75,120	71,699	3,421	4.55%
Insurance Provider Assessment	116,901	97,418	108,987	(11,570)	(11.88%)
Medicaid Services	3,387,649	2,823,041	2,909,692	(86,651)	(3.07%)
Healthy Michigan Services	7,453,459	6,211,216	7,038,307	(827,091)	(13.32%)
Community Grant	2,077,452	1,731,210	1,568,458	162,752	9.40%
Prevention	664,967	554,139	758,414	(204,275)	(36.86%)
State Disability Assistance	95,215	79,347	-	79,347	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	105,310	(105,310)	0.00%
Opioid Health Home Services	2,117,226	1,764,360	2,684,859	(920,499)	(52.17%)
Miscellanous Grants	36,335	30,279	21,087	9,192	30.36%
SOR Grant	1,215,000	1,012,500	972,738	39,762	3.93%
Gambling Prevention	200,000	166,667	139,500	27,167	16.30%
PA2	1,533,978	1,022,652	1,910,646	(887,994)	(86.83%)
Total operating expenses	20,058,810	16,410,018	18,793,530	(2,383,512)	(14.52%)
CY Unspent funds	$ 5,117,907	$ 4,314,911	3,337,599	$ (977,312)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,231,624		
Unspent funds - ending			$ 9,569,223		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2021 through July 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 1,440,890	$ 1,302,265	$ 138,625	9.62%
Fringes	549,516	433,810	424,666	9,144	2.11%
Contractual	433,304	361,090	549,167	(188,077)	(52.09%)
Board expenses	16,100	13,420	15,726	(2,306)	(17.18%)
Day of recovery	14,000	14,000	4,917	9,083	64.88%
Facilities	152,700	127,250	113,879	13,371	10.51%
Other	127,000	105,830	97,069	8,761	8.28%
Total General Admin	$ 3,021,688	$ 2,496,290	$ 2,507,689	$ (11,399)	(0.46%)

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2021 through July 31, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 401,840	$ 181,120	$ 220,720	54.93%
Fringes	166,800	139,000	46,882	92,118	66.27%
Access Salaries	194,484	162,070	145,591	16,479	10.17%
Access Fringes	57,588	47,990	43,365	4,625	9.64%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	83,330	75,460	7,870	9.44%
Board expenses	5,000	4,170	3,295	875	20.98%
Facilities	-	-	-	-	0.00%
Other	10,404	3,670	8,120	(4,450)	(121.25%)
Total operating expenses	$ 1,070,484	$ 842,070	$ 503,833	$ 338,237	40.17%

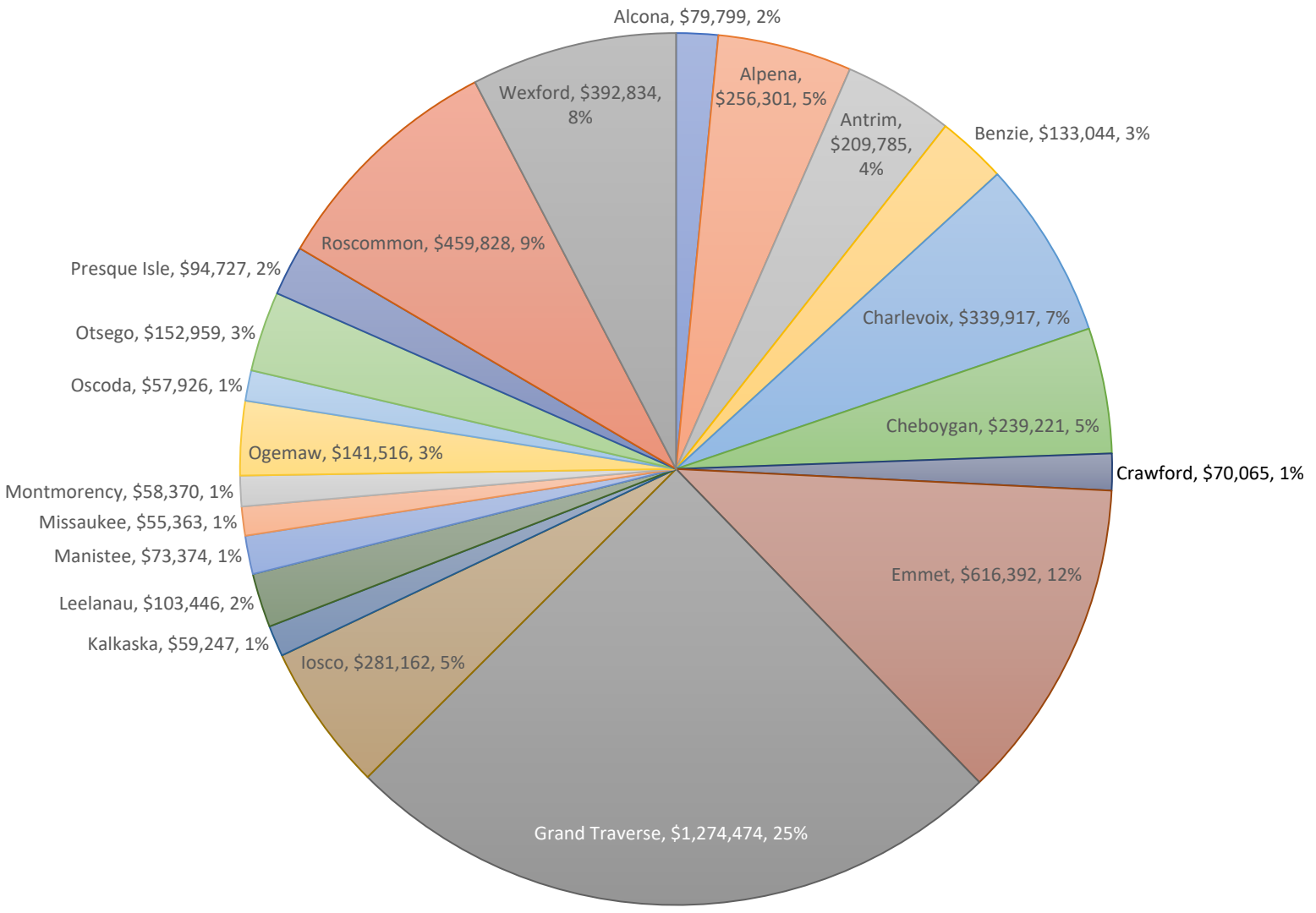
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through July 31, 2022

County	Beginning Balance	FY22 Projected Revenue	Current Receipts	FY22 Approved Projects	County Specific Projects	Region Wide Projects by Population	Ending Balance
					Actual Expenditures by County		
Alcona	$ 83,635	$ 19,313	$ 19,260	$ 38,301	33,523	$ 888	$ 79,799
Alpena	315,554	66,080	65,235	160,005	97,466	2,440	256,301
Antrim	243,061	53,592	54,992	95,690	61,815	1,997	209,785
Benzie	144,391	49,804	51,000	27,891	16,232	1,507	133,044
Charlevoix	467,765	82,100	84,999	262,209	135,019	2,241	339,917
Cheboygan	280,756	68,778	71,908	176,925	136,345	2,175	239,221
Crawford	85,250	28,559	31,195	32,978	19,236	1,192	70,065
Emmet	754,134	145,253	157,175	278,987	150,322	2,846	616,392
Grand Traverse	1,615,220	376,032	383,335	909,582	568,266	7,872	1,274,474
Iosco	359,368	70,274	69,753	160,492	79,608	2,157	281,162
Kalkaska	73,813	33,023	33,605	42,665	27,168	1,512	59,247
Leelanau	131,774	48,924	52,996	97,254	71,142	1,857	103,446
Manistee	90,411	63,745	67,391	36,315	20,829	2,094	73,374
Missaukee	66,066	18,058	17,775	50,287	38,015	1,286	55,363
Montmorency	64,849	26,456	25,952	36,920	29,144	793	58,370
Ogemaw	164,571	54,659	50,933	80,483	51,903	1,799	141,516
Oscoda	76,895	17,086	17,185	43,817	24,236	711	57,926
Otsego	205,220	86,909	86,927	210,283	155,935	2,104	152,959
Presque Isle	102,301	20,617	20,148	47,065	37,924	1,097	94,727
Roscommon	488,633	75,491	73,418	63,178	30,252	2,049	459,828
Wexford	417,956	82,829	82,014	111,588	82,796	2,853	392,834
	6,231,626	1,487,584	1,517,189	2,962,916	1,867,176	43,471	5,149,752
PA2 Redirect							-
							5,149,752

PA2 Funds by County



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2021 through July 31, 2022

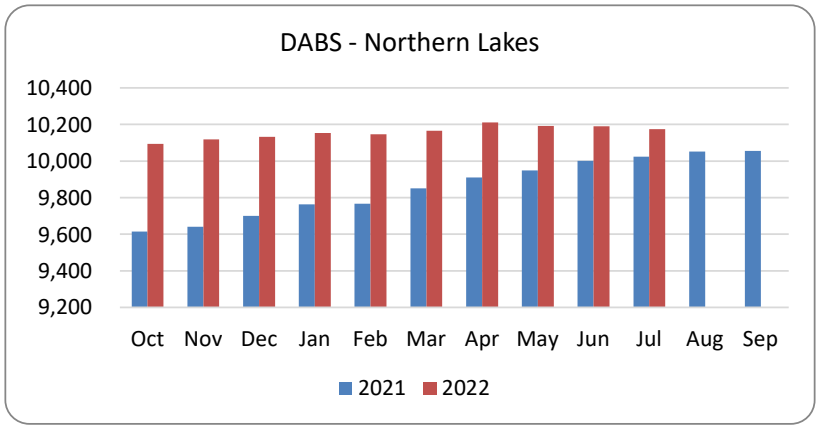
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	2,080	6,108	4,028	193.65%
Total operating revenue	2,501	2,080	6,108	4,028	193.65%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 2,080	6,108	$ 4,028	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,358,117		
Unspent funds - ending			$ 16,364,225		

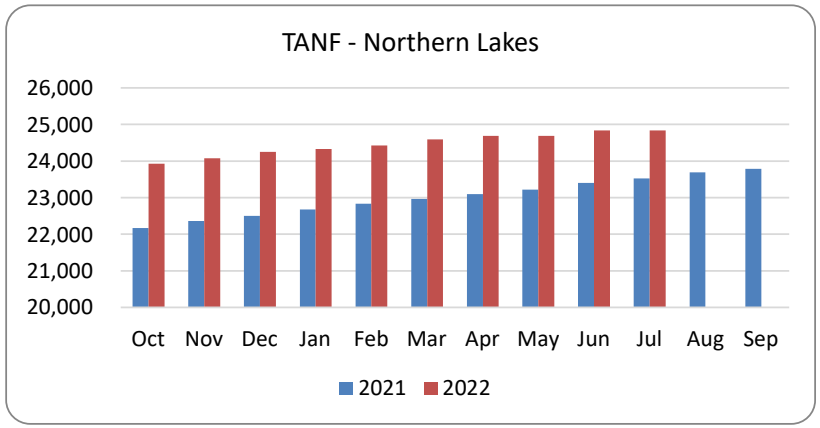
Northern Michigan Regional Entity

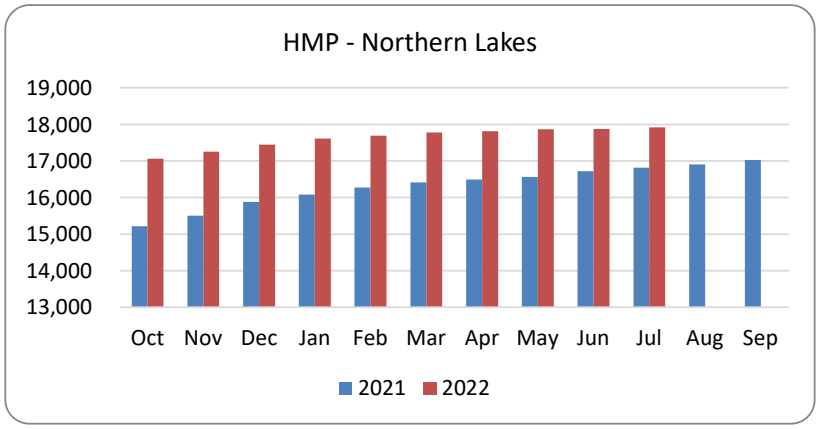
Narrative

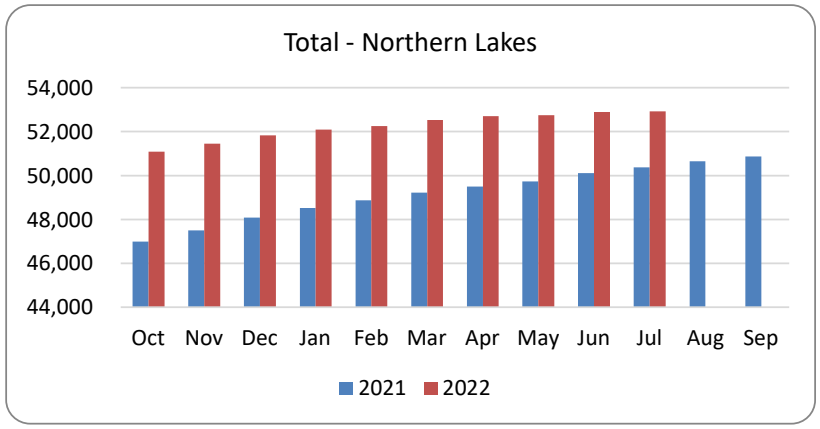
October 1, 2021 through July 31, 2022

Northern Lakes Eligible Trending - based on payment files







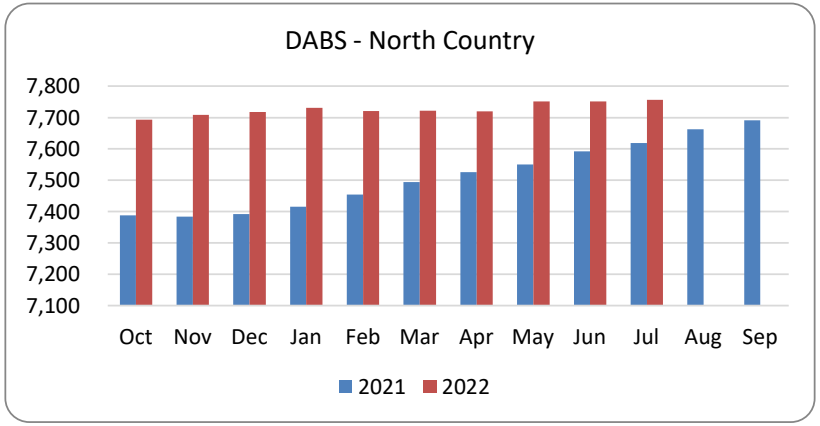


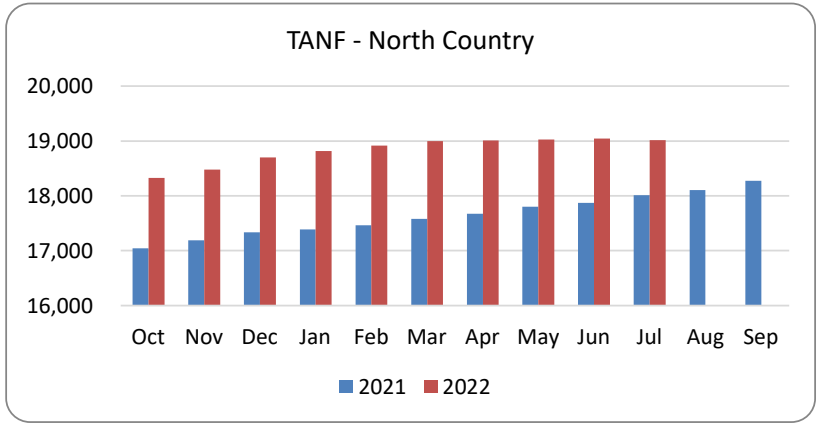
Northern Michigan Regional Entity

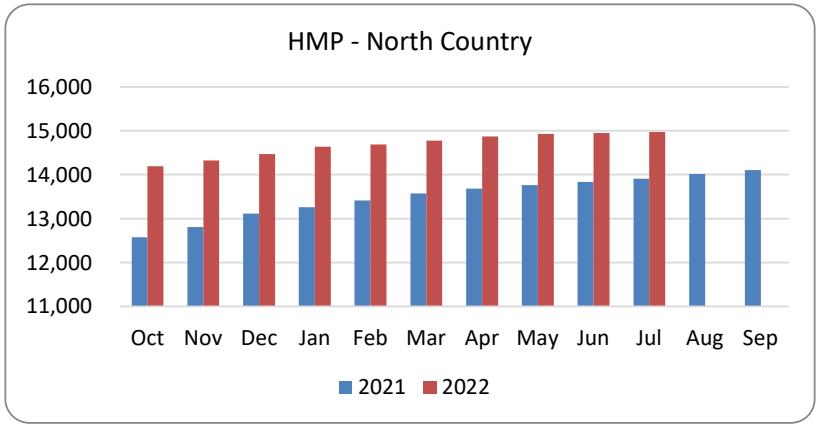
Narrative

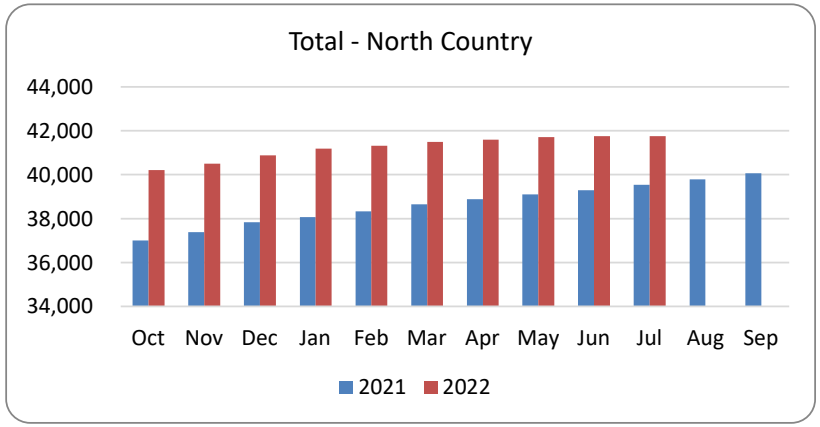
October 1, 2021 through July 31, 2022

North Country Eligible Trending - based on payment files







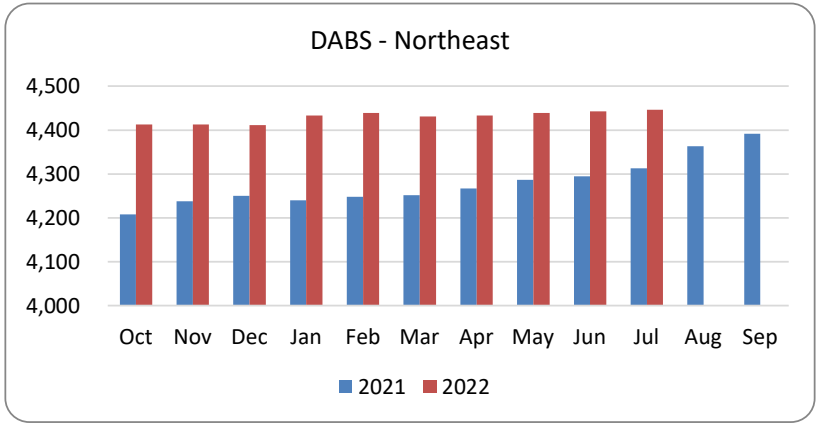


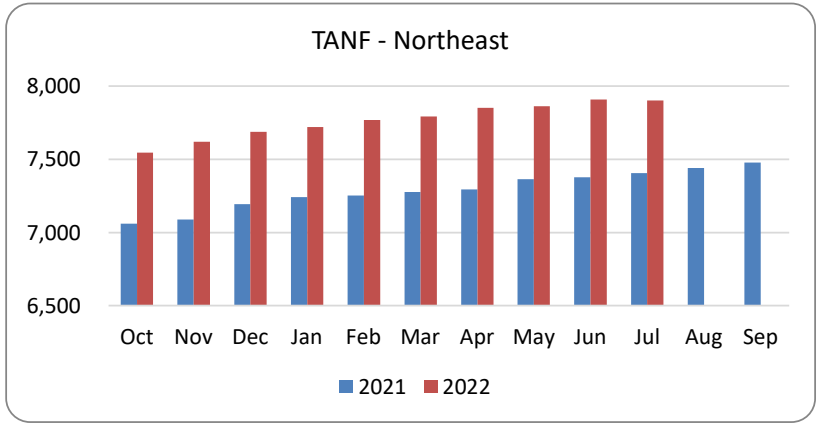
Northern Michigan Regional Entity

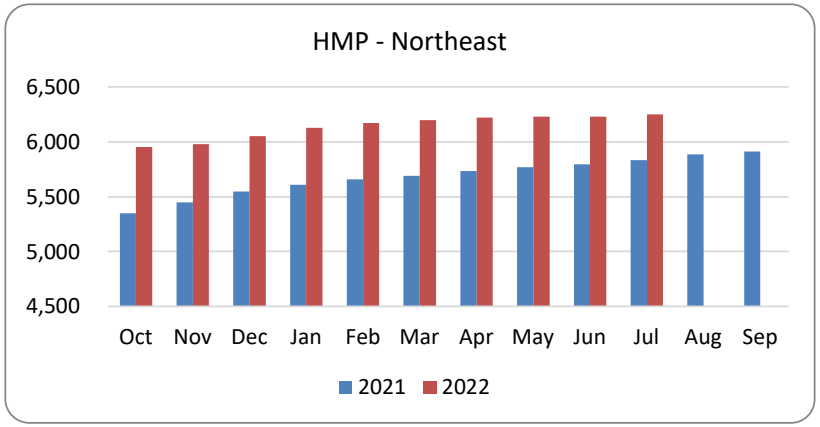
Narrative

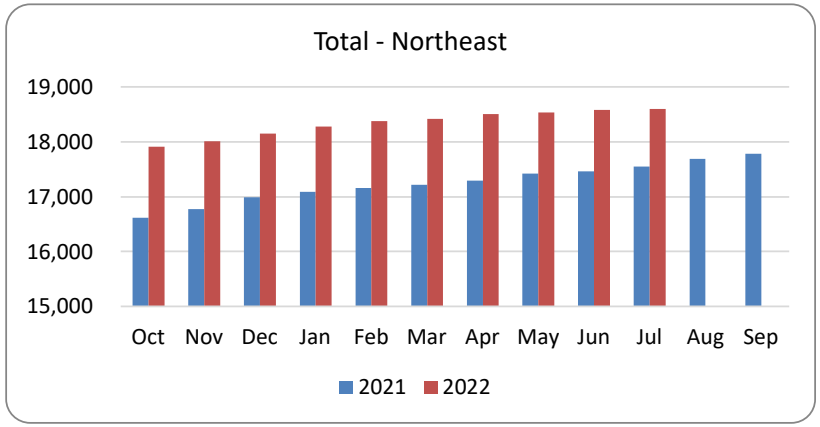
October 1, 2021 through July 31, 2022

Northeast Eligible Trending - based on payment files







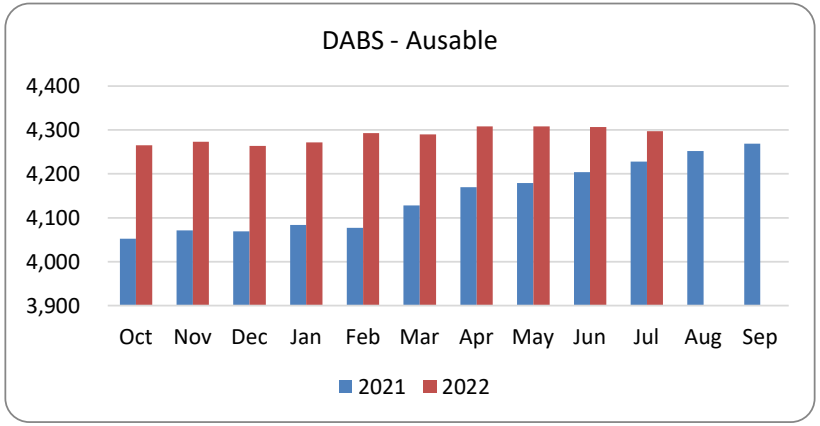


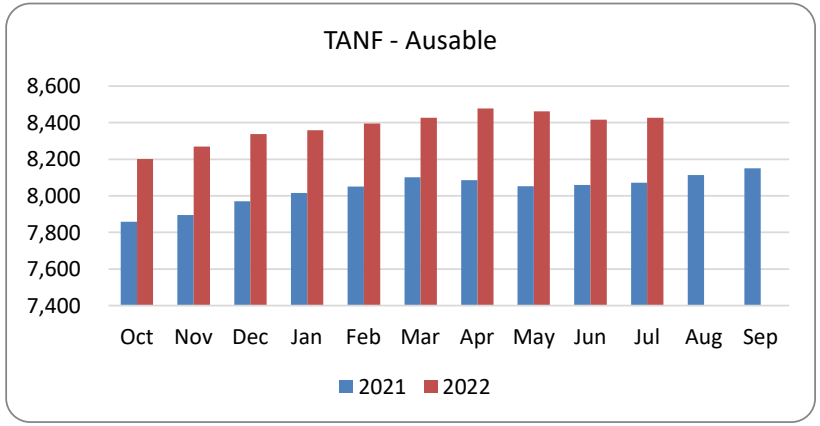
Northern Michigan Regional Entity

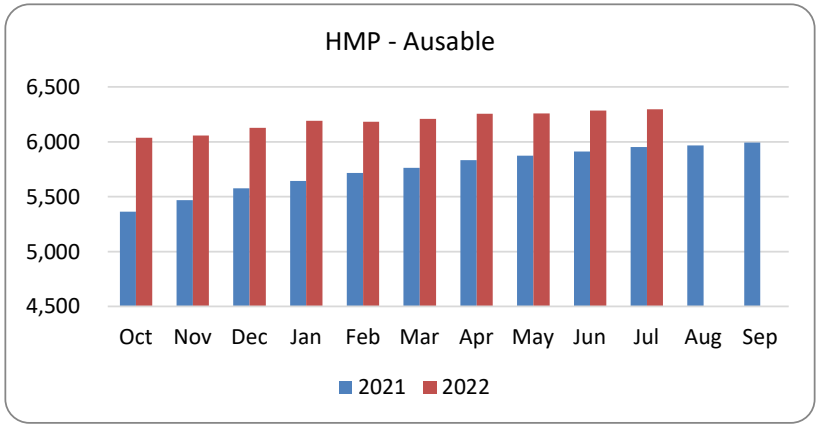
Narrative

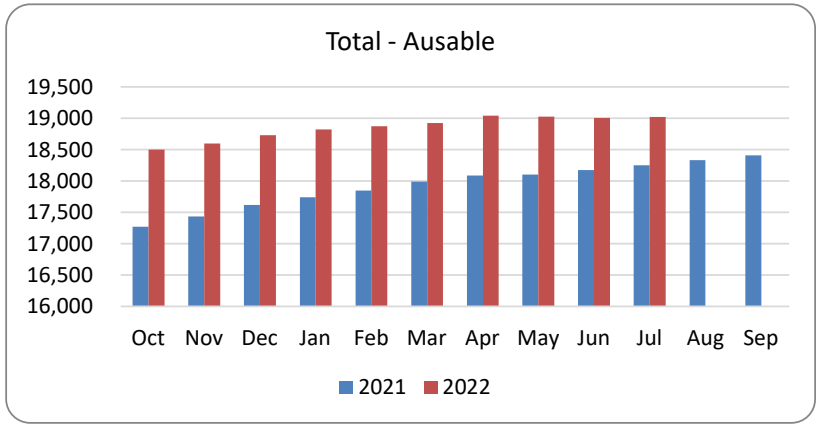
October 1, 2021 through July 31, 2022

Ausable Valley Eligibles Trending - based on payment files







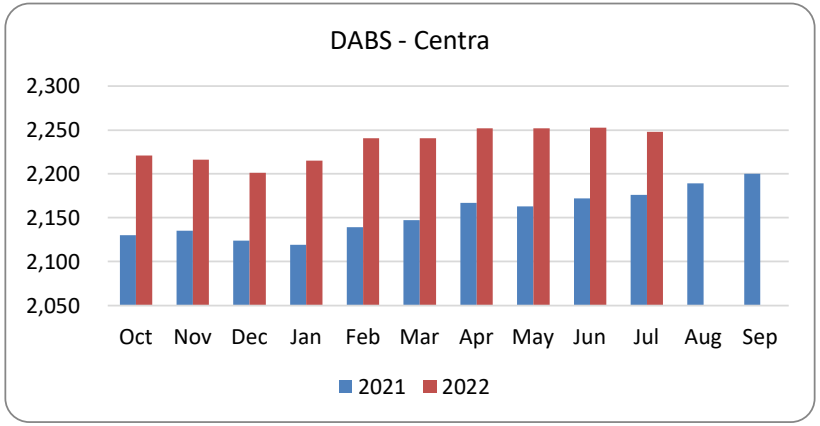


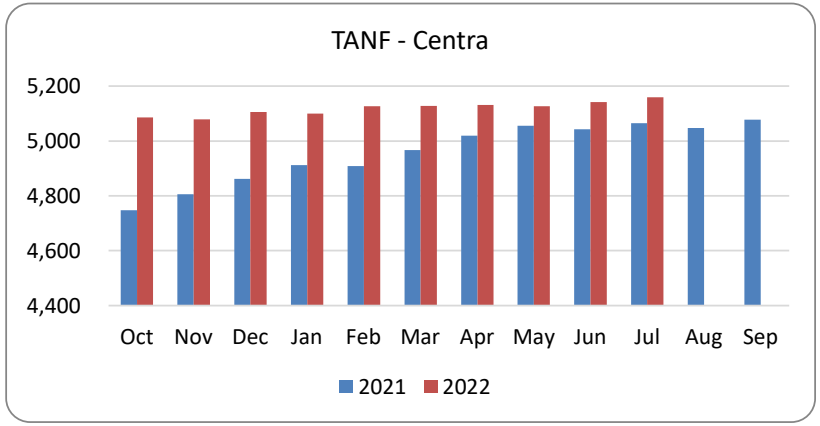
Northern Michigan Regional Entity

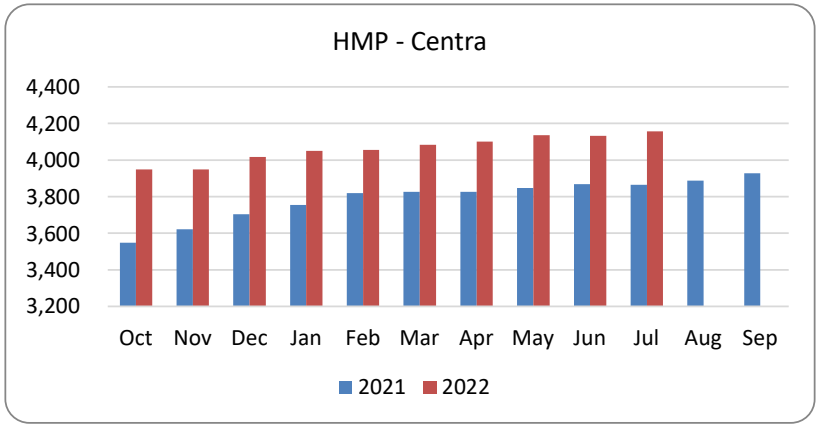
Narrative

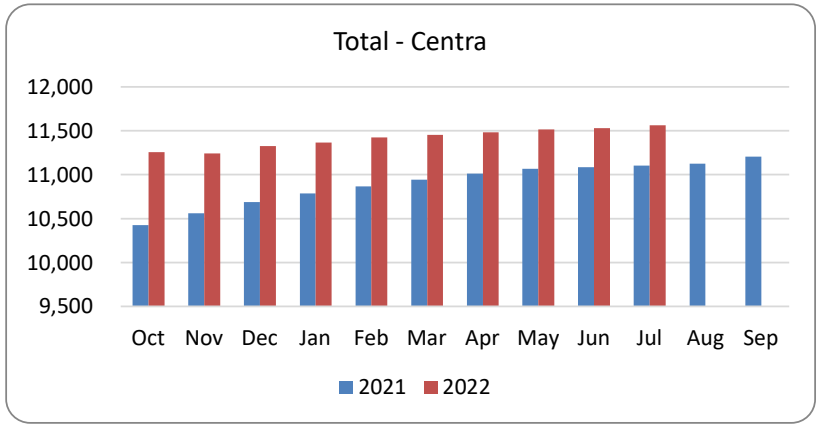
October 1, 2021 through July 31, 2022

Centra Wellness Eligibles Trending - based on payment files







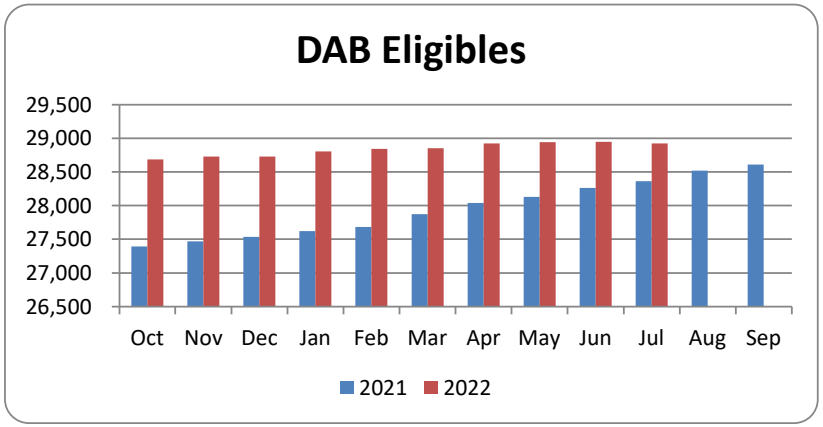


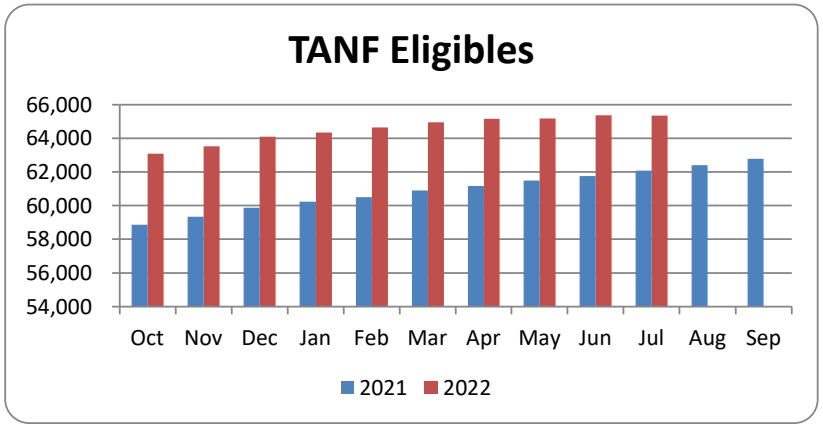
Northern Michigan Regional Entity

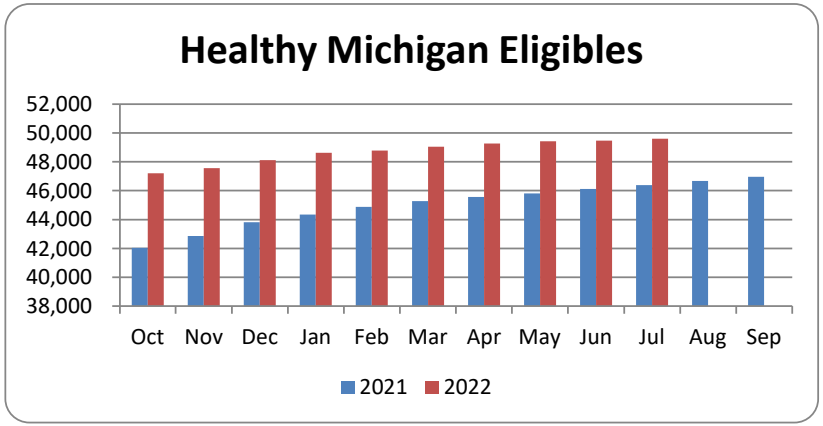
Narrative

October 1, 2021 through July 31, 2022

Regional Eligible Trending





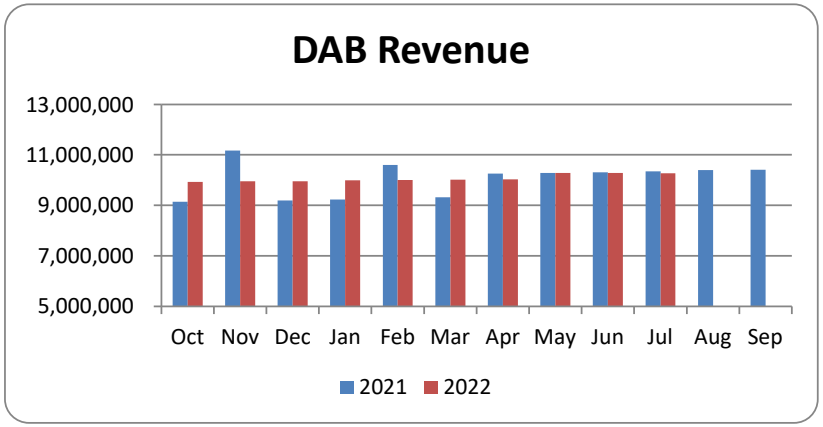


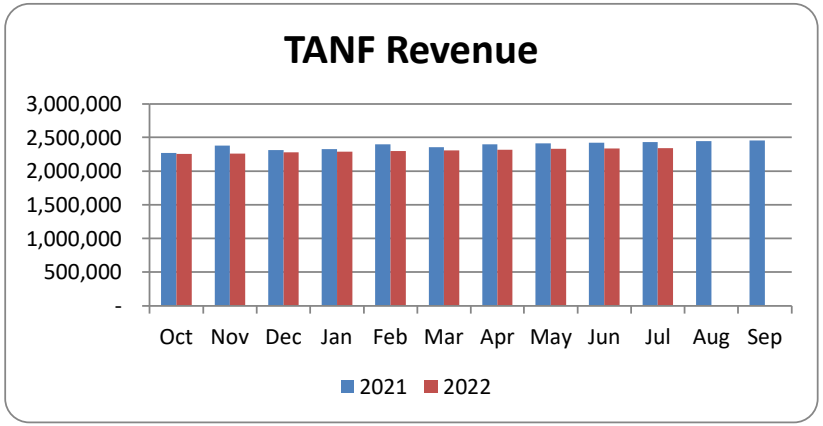
Northern Michigan Regional Entity

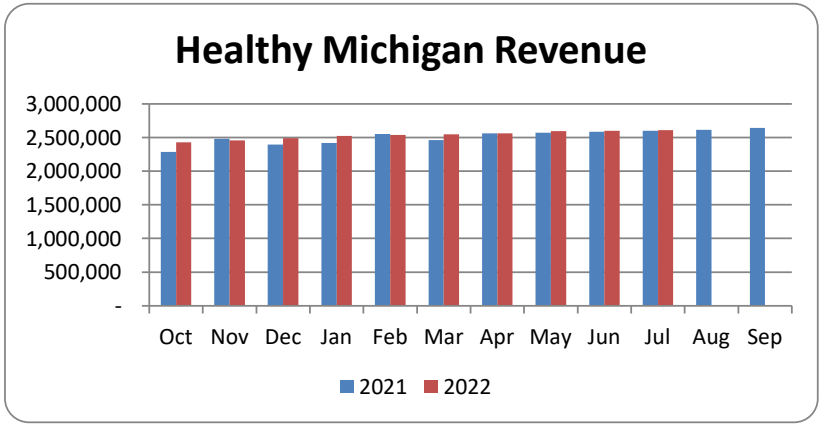
Narrative

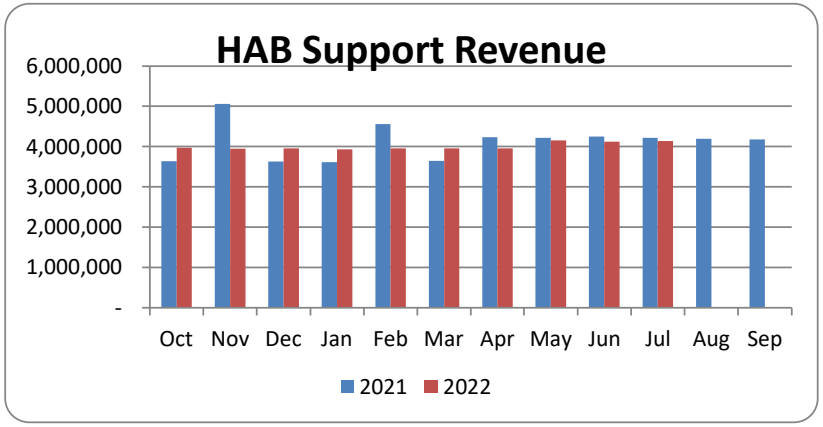
October 1, 2021 through July 31, 2022

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – SEPTEMBER 20, 2022
GAYLORD CONFERENCE ROOM

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

REVIEW AGENDA & ADDITIONS

Mr. Kurtz added REP Committee membership and T1020 Personal Care in non-specialized residential settings to the meeting agenda.

APPROVAL OF PREVIOUS MINUTES

The minutes from July 19th were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE MINUTES OF THE JULY 19, 2022 NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE MEETING; SUPPORT BY CHIP JOHNSTON. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

July Financials

- Net Position showed net surplus Medicaid and HMP of $12,117,012. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $28,475,129. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $44,833,246.
- Traditional Medicaid showed $168,681,306 in revenue, and $154,712,217 in expenses, resulting in a net surplus of $13,969,089. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $26,812,584 in revenue, and $22,720,930 in expenses, resulting in a net surplus of $4,091,653. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,216,598 in revenue, and $1,016,957 in expenses, resulting in a net surplus of $199,641.
- SUD showed all funding source revenue of $20,997,804, and $17,899,716 in expenses, resulting in a net surplus of $3,098,088. Total PA2 funds were reported as $5,149,752.

The direct care wage surplus was estimated at $5,943,730. A potential lapse of $11M for FY22 was reported. Ms. Sork questioned the $69K net deficit reported for Northeast Michigan CMHA; Northeast Michigan CFO, Connie Cadarette will reach out to Deanna Yockey for clarification.

MOTION BY DIANE PELTS TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JULY 2022; SUPPORT BY BRIAN BABBITT. MOTION CARRIED.

FY22 Budget Stabilization
Mr. Babbitt shared that North Country will show some provider stability spending yet for FY22.

SCA News
Mr. Kurtz wrote a memorandum to Jeff Wieferich and Al Jansen in March outlining some of the issues with the Standard Cost Allocation (SCA). One of the concerns identified was the Model Delegation Agreement embedded as Schedule I of the MDHHS-PIHP Contract. Recently, Schedule I was removed and just made a reference (best practice).

A PDF of the SCA methodology has been made available, which appears to be 80% correct in conversations with Richard Carpenter and others who have been part of the SCA group. Use of the template is optional. Ultimately, a review of the NMRE-CMHSP Contract will be reviewed to limit the administrative functions to only those done on behalf of the PIHP (CFR requirements). The regional CFOs will be charged with coordinating the completion of the SCA.

MDHHS-PIHP CONTRACT CHANGE NOTICE #6
A summary of the adjustments made to the MDHHS-PIHP Contract in Change Order #6 was included in the meeting materials. Added language includes, "The Contractor must comply with the Standard Cost Allocation (SCA) methodology established by MDHHS when assigning the fund source and ensure subcontractor compliance with the SCA methodology." Additional language was also added related to the use of Subcontractors, though it was noted that the term "subcontractor" does not include network provider agreements that are limited in scope to the provision of covered services to enrollees (i.e, the actual delivery of clinical care).

Mr. Kurtz noted that Change Order #6 will result in some edits to the FY23 PIHP-CMHSP Network Agreements; these will be implemented as timely as possible.

MOTION BY CHIP JOHNSTON TO MOVE APPROVAL OF CHANGE ORDER NUMBER SIX (NO. 6) TO THE CONTRACT BETWEEN THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE NORTHERN MICHIGAN REGIONAL ENTITY TO THE NMRE BOARD OF DIRECTORS; SUPPORT BY NENA SORK. MOTION CARRIED.

GRAND TRAVERSE COUNTY AND NORTHERN LAKES
Mr. Kurtz met with the NLCMHA board on September 15th and presented next steps. Brian Martinus will be named Interim CEO and a search for a permanent CEO will commence; Mary Marois will lead the Board Search Committee. Engaging with a search firm is being considered. A Lease Agreement for Mr. Martinus is being reviewed by NLCMHA legal representation. The six NLCMHA County Administrators and Board of Commission Chairpersons continue to meet monthly.

CARTER KITS AND REGIONAL TRAINING
Carter Kits Chief Operating Officer, Sam Mishra, DO is also the Emergency Medical Services Coordinator for children's programs at MDHHS; she is coordinating the trainings for EMS/Fire/Law enforcement. Ms. Pelts stated that Carter Kits received grant funding and will be offering a pediatric EMS Summit. Mr. Kurtz agreed to help sponsor the event. A training for community organizations has been developed and will be shared once approved by the Carter Kits Board.

HCBS

Providers that have been unresponsive to the HCBS survey process have been considered noncompliant with the HCBS rule and will not be eligible for Medicaid funding to provide services to HCBS waiver participants after March 17, 2023. PIHPs have been tasked with addressing settings that were unresponsive. NMRE is working with the Boards to complete this (34 individuals regionally). It was noted that some of the individuals listed reside in private residences; previous communication from MDHHS indicated that private homes were presumed to "not be non-compliant."

INPATIENT STAY CONFLICT

Email correspondence from NMRE Provider Network Manager, Chris VanWagoner, and a Chris's email and letter dated June 27th from Leah Werth, Case Coordinator with MyMichgan Health was distributed to the committee. The correspondence related to a beneficiary who was petitioned for inpatient psychiatric treatment out of the Presque Isle County jail. The individual was reported as homeless, with last known address in Otsego County. The question of which Board (North Country or Northeast Michigan) was responsible for payment for the 11-day hospital stay was discussed. Agreement was reached that North Country would compensate MyMichigan Health for the inpatient stay.

It was noted that War Memorial Hospital has been added to the MyMichigan Health network. Mr. Kurtz informed the Boards that, although the NMRE has negotiated rates for the four MyMichigan Health sites, due to the reciprocity agreement that the NMRE has with NorthCare Network, the rate for the former War Memorial (Ste. Saint Marie) location has not been finalized.

FARAH HANLEY VISIT

Kristen Jordan reached out to Mr. Kurtz. She and Farah Hanley will be traveling to the UP and would like to stop at NMRE on October 6th at approximately 2:00PM on their way home. Mr. Kurtz invited the other CEOs to attend. An agenda will be distributed prior to the meeting.

MiCAL AND ES SERVICES

Phase 2 of the MiCAL rollout is scheduled to begin after the successful rollout of the 988 National Suicide Prevention Lifeline, which went live in July 2022. MiCAL will become the after-hours crisis line for most CMHSPs in the state, meaning that most CMHSPs will forward their crisis lines to MiCAL (staffed by Common Ground) instead of a contract provider. The CEOs voiced strong opposition to this plan, preferring to keep the existing relationships with ProtoCall.

REP COMMITTEE

Mr. Kurtz noted that members are needed on the regional consumer council, the Regional Entity Partners (REP). Members are appointed by the CMHSP CEOs. Members are intended to represent all four populations: 1) Adults with a Mental Illness (MI), 2) Children with a Serious Emotional Disturbance (SED), 3) Children and Adults with an Intellectual and/or Developmental Disability (IDD), and 4) Adults with Substance Use Disorders. Each of the CMHSPs is allowed to appoint up to four members. A list of current members and the REP Guidelines/Charter will be shared following the meeting.

T1020 PERSONAL CARE IN NON-SPECIALIZED RESIDENTIAL SETTINGS

Mr. Johnston reported that he was recently at NorthPoint in the UP assisting with contracts and was made aware of some issues around using the T1020 Personal Care code in "Type A" residential settings. Mr. Johnston clarified that this should not be done. MDHHS uses the Adult Services Authorized Payments (ASAP) application (formerly Model Payment Program) as the claims entry system for personal care services authorized through MDHHS or CMHSP. Billing should be for CLS only, not Personal Care and CLS. The lost ASAP should be built into the CLS rate. A personal care supplemental payment may be paid to the residential provider if the beneficiary:

1) Is eligible for Medicaid
2) Lives in a Michigan licensed Adult Foster Care Home or Home for the Aged
3) Scores 2 or above on the Personal Care Assessment for activities of daily living.

Enrollees participating in the MI Health Link Home and Community Based Services WAIVER are not eligible to receive the Personal Care Supplement if they live in an AFC or HFA.

DEPARTMENT OF CORRECTIONS

Ms. Sork indicated that she has received communication from Jeff Wieferich at MDHHS that Northeast Michigan is not bringing individuals released from DOC into the community. Ms. Sork confirmed that Northeast Michigan has had zero contact from DOC regarding these individuals. Mr. Babbitt revealed that North Country has had similar correspondence from MDHHS.

OTHER

Mr. Kurtz explained that he and Don Tanner have been discussing the sharing of draft NMRE Board meeting minutes within the region. The decision has been made to share NMRE Board minutes only after they have been reviewed and approved by the Board. This will cause a one-month lag in the distribution of meeting minutes.

Ms. Sork announced Alpena Community College is working with Western Michigan University to offer a BSW and MSW program.

Ms. Sork announced that Eric Lawson was appointed to the NMRE Board of Directors to represent Northeast Michigan CMHA.

NEXT MEETING

The next meeting was scheduled for October 18th at 9:30AM.

NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING
10:00AM – SEPTEMBER 12, 2022
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Carolyn Brummund (Alcona), Robert Adrian (Alpena), John Wallace (Cheboygan), Dave Freedman (Grand Traverse), Richard Schmidt (Manistee), Don Edwards (Montmorency), Ron Quackenbush (Ogemaw), Chuck Varner (Oscoda), Doug Johnson (Otsego), Terry Larson (Presque Isle), Tim Muckenthaler (Roscommon), Gary Taylor (Wexford)**
VIRTUAL ATTENDEES:	**Tim Markey (Benzie), Robert Draves (Charlevoix), Sherry Powers (Crawford)**
ABSENT:	**Melissa Zelenak (Antrim), David Comai (Kalkaska), Jay O'Farrell (Iosco), Greg McMorrow (Leelanau)**
STAFF:	**Eric Kurtz, Pamela Polom, Sara Sircely, Carol Balousek**
PUBLIC:	**Joanie Blamer, Chip Cieslinski, Donna Hardies, Caitlin Koucky, Susan Pulaski, Kara Steinke**

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

ROLL CALL
Let the record show that David Comai, Greg McMorrow, Jay O'Farrell, and Melissa Zelenak were absent with notice for the meeting on this date; all remaining Substance Use Disorder Oversight Board Members were in attendance either in Gaylord or remotely.

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

APPROVAL OF PAST MINUTES
The July minutes were included in the materials for the meeting on this date.

MOTION BY TERRY LARSON TO APPROVE THE MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD FOR JULY 11, 2022; SUPPORT BY CHUCK VARNER. MOTION CARRIED.

APPROVAL OF AGENDA
Let the record show that no additions or revisions to the meeting Agenda were proposed.

MOTION BY DOUG JOHNSON TO APPROVE THE AGENDA FOR THE SEPTEMBER 12, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD; SUPPORT BY JOHN WALLACE. MOTION CARRIED.

CORRESPONDENCE

1) A memorandum from Jeff Wieferich at MDHHS dated August 15, 2022 to PIHP Directors regarding the availability of additional Substance Abuse Prevention and Treatment (SAPT) Block Grant funds effective October 1, 2022 to establish a discharge support/complex care management position.
2) The SUD portion of the NMRE's FY23 budget.

Correspondence items were shared for informational purposes.

ANNOUNCEMENTS

Don Edwards, new appointee to the NMRE SUD Oversight Board by the Montmorency County Board of Commissioners, was introduced to the group.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST

Let the record show that Ms. Brummund called for any conflicts of interest to any of the meeting agenda items; none were declared.

ELECTION OF BOARD CHAIRPERSON

The Bylaws of the Northern Michigan Regional Entity Substance Use Disorder Oversight Board were included in the materials for the meeting on this date. Pursuant to Section 5.4 of the Bylaws, " In the event of the death, resignation, removal or other inability to serve of any officer, the Board shall elect a successor who shall serve until the expiration of the normal term of such officer or until his or her successor has been elected."

Call for Nominations

Board Chair

MOTION BY TERRY LARSON TO NOMINATE CAROLYN BRUMMUND AS NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD CHAIR; SECOND BY CHUCK VARNER.

Ms. Brummund called three times for additional nominations; none were brought forward.

MOTION MADE BY DOUG JOHNSON TO CLOSE NOMINATIONS; SUPPORT BY ROBERT ADRIAN. MOTION CARRIED.

VOTING TOOK PLACE ON MR. LARSON'S MOTION. MOTION CARRIED.

Vice-Chair

MOTION BY JOHN WALLACE TO NOMINATE RICHARD SCHMIDT AS NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD VICE-CHAIR; SECOND BY GARY TAYLOR.

Ms. Brummund called three times for additional nominations; none were brought forward.

MOTION MADE BY TERRY LARSON TO CLOSE NOMINATIONS; SUPPORT BY JOHN WALLACE. MOTION CARRIED.

NOMINATIONS WERE CLOSED AND VOTING TOOK PLACE ON MR. WALLACE'S MOTION. MOTION CARRIED.

Let the record show that the Northern Michigan Regional Entity Substance Use Disorder Oversight Board Officers shall be:

- Carolyn Brummund – Chair
- Richard Schmidt – Vice Chair

INFORMATIONAL REPORTS

Admissions

The admissions report through August 31, 2022 was included in the materials for the meeting on this date. Overall admissions were down 4.83% from August of 2021. The data showed that outpatient was the highest level of treatment admissions at 47%, and alcohol was the most prevalent primary substance at 54% (heroin was second at 16%). Ms. Sircely noted that methamphetamine use is rising throughout the region reported as 15% vs. 12.6% in FY21.

Admissions data by county was requested which Ms. Sircely agreed to provide.

Opioid settlement funds were discussed. Counties have been encouraged to work with local coalitions to assess areas of need. Mr. Kurtz noted that PIHPs are loosely connected to the Opioid Advisory Commission; he offered to send a memorandum offering input regarding how opioid settlement funds may best be allocated in the region.

Finance

June 2022 Monthly Report

SUD services through June 30, 2022 showed all funding source revenue of $18,837,111 and $15,824,090 in expenses, resulting in a net surplus of $3,013,021. Total PA2 funds were reported as $4,888,310.

RECOMMENDATION ITEMS

FY23 Grant Recommendations

A summary of SUD grants for FY23 was included in the meeting materials.

American Rescue Plan Act Substance Abuse Block Grant (ARPA SABG)	$	354,060
Pregnant and Postpartum Grant (PPW)	$	174,405
Gambling Disorder Prevention	$	200,000
Tobacco	$	4,000
COVID Substance Abuse Block Grant (COVID SABG)	$	814,840
State Opioid Response (SOR) 3	$	2,043,989
Total	**$**	**3,591,294**

Clarification was made that the ARPA grant is active through FY25; the amount presented represents FY23 funding.

It was noted that the COVID Grant ends March 14, 2023. The amount of $405,242 under "Treatment Services" will be used to implement a regional Alcohol Health Home program.

MOTION BY ROBERT ADRIAN TO APPROVE FISCAL YEAR 2023 GRANT FUNDING AS PRESENTED AND REVIEWED ON THIS DATE; SUPPORT BY JOHN WALLACE. ROLL CALL VOTE.

"Yea" Votes: **R. Adrian, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace**

"Nay" Votes: **Nil**

Abstentions: **C. Brummund**

MOTION CARRIED.

FY23 Liquor Tax Request Recommendations

A summary of the liquor tax requests that will be presented for review and approval on this date, including NMRE staff recommendations, was included in the meeting materials.

PA2 Fund Use Requests

1) Addiction Treatment Services – Recovery Month Event

Grand Traverse	$	10,000.00

The recommendation by NMRE was to approve.

MOTION BY DAVE FREEDMAN TO APPROVE THE REQUEST FROM ADDICTION TREATMENT SERVICES FOR LIQUOR TAX FUNDS IN THE AMOUNT OF TEN THOUSAND DOLLARS ($10,000.00) TO SUPPORT A RECOVERY MONTH EVENT IN GRAND TRAVERSE COUNTY; SUPPORT BY RON QUACKENBUSH. ROLL CALL VOTE.

"Yea" Votes: **R. Adrian, C. Brummund, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace**

"Nay" Votes: **Nil**

MOTION CARRIED.

2) Bear River Health – SOR 2 Coverage for September 30, 2022

Cheboygan	$	71.44
Otsego	$	480.00
Total	**$**	**551.44**

The recommendation by NMRE was to approve.

MOTION BY RON QUACKENBUSH TO APPROVE THE REQUEST FROM BEAR RIVER HEALTH FOR LIQUOR TAX FUNDS IN THE AMOUNT OF FIVE HUNDRED FIFTY-ONE DOLLARS AND FORTY-FOUR CENTS ($551.44) TO FUND STATE OPIOID RESPONSE TWO (SOR 2) SERVICES ON SEPTEMBER 30, 2022; SUPPORT BY TERRY LARSON. ROLL CALL VOTE.

"Yea" Votes: **R. Adrian, C. Brummund, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace**

"Nay" Votes: Nil

MOTION CARRIED.

3) Michigan Rehabilitation Services – Employment Support Services

All NMRE Counties $ 35,000.00

The recommendation by NMRE was to approve. County percentages will be based on actual use.

MOTION BY RICHARD SCHMIDT TO APPROVE THE REQUEST FROM MICHIGAN REHABILITATION SERVICES FOR LIQUOR TAX FUNDS IN THE AMOUNT OF THIRTY-FIVE THOUSAND DOLLARS ($35,000.00) FOR EMPLOYMENT SUPPORT SERVICES IN THE NORTHERN MICHIGAN REGIONAL ENTITY TWENTY-ONE (21) COUNTY REGION; SUPPORT BY GARY TAYLOR.

"Yea" Votes: R. Adrian, C. Brummund, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace

"Nay" Votes: Nil

MOTION CARRIED.

4) Community Recovery Alliance – Recovery Support Services

Antrim	$	10,131.84
Charlevoix	$	10,694.72
Cheboygan	$	10,694.72
Emmet	$	14,072.00
Otsego	$	10,694.72
Total	$	**$56,288.00**

The recommendation by NMRE was to approve. A potential 50% reduction may be warranted for Otsego County due to county fund balances; if funds are available, the full amount will be paid. SOR 3 funding will also be utilized as an additional resource.

MOTION BY RON QUACKENBUSH TO APPROVE THE REQUEST FROM COMMUNITY RECOVERY ALLIANCE FOR LIQUOR TAX FUNDS IN THE AMOUNT OF FIFTY-SIX THOUSAND TWO HUNDRED EIGHTY-EIGHT DOLLARS ($56,288.00) TO PROVIDE RECOVERY SUPPORT SERVICES IN ANTRIM, CHARLEVOIX, CHEBOYGAN, EMMET, AND OTSEGO COUNTIES; SUPPORT BY DOUG JOHNSON. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, C. Brummund, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace

"Nay" Votes: Nil

MOTION CARRIED.

5) Catholic Human Services – Jail Services

Missaukee	$	25,758.60
Wexford	$	57,201.40
Total	$	**82,996.00**

The recommendation by NMRE was to approve.

MOTION BY CHUCK VARNER TO APPROVE THE REQUEST FROM CATHOLIC HUMAN SERVICES FOR LIQUOR TAX FUNDS IN THE AMOUNT OF EIGHTY-TWO THOUSAND NINE HUNDRED NINETY-SIX DOLLARS ($82,996.00) TO SUPPORT JAIL SERVICES IN MISSAUKEE AND WEXFORD COUNTIES; SUPPORT BY GARY TAYLOR. ROLL CALL VOTE.

"Yea" Votes: **R. Adrian, C. Brummund, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace**

"Nay" Votes: **Nil**

MOTION CARRIED.

6) Child and Family Services of Northwestern Michigan – Youth Employment for Success (YES!) Program

Grand Traverse	$	10,212.00

The recommendation by NMRE was to approve. The original total amount requested was $20,424; a 50% reduction was made due to the county fund balance. Additional funding may be requested in the future at which point the fund balance will be reviewed.

MOTION BY ROBERT ADRIAN TO APPROVE THE REQUEST FROM CHILD AND FAMILY SERVICES OF NORTHWESTERN MICHIGAN FOR LIQUOR TAX FUNDS IN THE AMOUNT OF TEN THOUSAND TWO HUNDRED TWELVE DOLLARS ($10,212.00) TO SUPPORT THE YOUTH EMPLOYMENT FOR SUCCESS PROGRAM IN GRAND TRAVERSE COUNTY; SUPPORT BY DAVE FREEDMAN. ROLL CALL VOTE.

"Yea" Votes: **R. Adrian, C. Brummund, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace**

"Nay" Votes: **Nil**

MOTION CARRIED.

7) Catholic Human Services – Peer Recovery Program

Alcona	$	13,699.82
Alpena	$	37,670.20
Crawford	$	18,406.28
Grand Traverse	$	103,282.62
Montmorency	$	12,242.62
Ogemaw	$	27,768.90
Otsego	$	28,904.25
Presque Isle	$	16,929.22
Roscommon	$	31,625.66
Wexford	$	44,041.66
Total	$	**397,951.00**

It was noted that this request was brought back from the July meeting. The request originally included Benzie and Manistee counties; Benzie and Manistee counties were removed at the request of Mr. Schmidt.

The recommendation by NMRE was to approve. A potential 50% reduction may be warranted for Grand Traverse and Otsego Counties due to county fund balances; if funds are available, the full amount will be paid.

MOTION BY RICHARD SCHMIDT TO APPROVE THE REQUEST FROM CATHOLIC HUMAN SERVICES FOR LIQUOR TAX FUNDS IN THE AMOUNT OF THREE HUNDRED NINETY-SEVEN THOUSAND NINE HUNDRED FIFTY-ONE DOLLARS ($397,951.00) TO THE SUPPORT PEER RECOVERY PROGRAM IN ALCONA, ALPENA, CRAWFORD, GRAND TRAVERSE, MONTMORENCY, OGEMAW, OTSEGO, PRESQUE ISLE, ROSCOMMON, AND WEXFORD COUNTIES; SUPPORT BY DOUG JOHNSON. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, C. Brummund, D. Edwards, D. Freedman, D. Johnson, T. Larson, T. Muckenthaler, R. Quackenbush, R. Schmidt, G. Taylor, C. Varner, J. Wallace

"Nay" Votes: Nil

MOTION CARRIED.

Let the record show that the total amount of liquor tax funds recommended for approval on this date was **$592,998.44**.

PROPOSED FY23 MEETING SCHEDULE

The proposed meeting schedule for FY23 was included in the materials for the meeting on this date. Mr. Quackenbush requested that the July 3rd meeting be moved to July 10th.

MOTION BY JOHN WALLACE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING SCHEDULE FOR FISCAL YEAR 2023 AS AMENDED; SUPPORT BY DAVE FREEDMAN. MOTION CARRIED.

The FY23 meeting schedule will be posted to the Northern Michigan Regional Entity - Northern Michigan Regional Entity (nmre.org).

PUBLIC COMMENT
Let the record show that no comments from members of the public were expressed.

NEXT MEETING
The next meeting was scheduled for November 7, 2022 at 10:00AM.

ADJOURN
Let the record show that Ms. Brummund adjourned the meeting at 11:48AM.

PIHP Contract Change Order #6

Item 1:

NEW:

Schedule A, Statement of Work Section 1. General Requirements, S. Fiscal Audits and Compliance Examinations, 9. Financial Management System, letters a., b. and c. are hereby deleted and replaced in its entirety with the following:

a. The Contractor must maintain all pertinent financial and accounting records and evidence pertaining to this Contract based on financial and statistical records that can be verified by qualified auditors. The Contractor must comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. The Contractor and their subcontractors must use the principles and standards of 2 CFR 200 Subpart E for determining all costs related to the management and provision of MMSSSP services reported on the financial status report. The accounting and financial systems established by the Contractor must be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for individuals.

b. The accounting system must be capable of reporting the use of these specific fund sources by major population groups. In addition, cost accounting methodology used by the Contractor must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source. The Contractor must comply with the Standard Cost Allocation (SCA) methodology established by MDHHS when assigning the fund source and ensure subcontractor compliance with the SCA methodology.

c. The Contractor must maintain adequate internal control systems. An annual independent audit must evaluate and report on the adequacy of the accounting system and internal control systems

OLD:

Financial Management System

a. The Contractor must maintain all pertinent financial and accounting records and evidence pertaining to this Contract based on financial and statistical records that can be verified by qualified auditors. The Contractor must comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. The Contractor must use the principles and standards of 2 CFR 200 Subpart E for determining all costs related to the management and provision of MMSSSP services reported on the financial status report. The accounting and financial systems established by the Contractor must be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for individuals.

b. The accounting system must be capable of reporting the use of these specific fund sources by major population groups. In addition, cost accounting methodology used by the Contractor must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source.

c. The Contractor must maintain adequate internal control systems. An annual independent audit must evaluate and report on the adequacy of the accounting system and internal control systems.

Item 2:

NEW

Schedule A, Statement of Work Section 2.6. Use of Subcontractors is hereby deleted and replaced in its entirety with the following:

2.6. Use of Subcontractors

A. The Contractor must be able to demonstrate compliance with all contract activities set forth in this Contract either directly or through formal delegation of a specified contract activity to a subcontractor through a written subcontract agreement.

B. The term "subcontract(s)" includes contractual agreements between the Contractor and any other entity, including a provider, that performs any function or service for the Contractor related to securing or fulfilling the Contractor's required contract activities and obligations under the terms of the Contract. The term does not include network provider agreements that are limited in scope to the provision of covered services to enrollees (i.e., the actual delivery of clinical care). Examples of subcontractor classifications include but are not limited to:

1. Health Benefit Managers (HBMs) – entities that arrange for the provision of health services covered under this Contract

2. Administrative Subcontractors – entities that perform administrative functions required by this Contract such as claims payment, delegated credentialing, and utilization management.

C. All subcontracts must be in writing and incorporate the terms and conditions contained in this Contract. The Contractor must comply with all subcontract requirements specified in 42 CFR 438.230 and comply with federal and state laws, Medicaid regulations, and sub regulatory guidance.

D. All subcontracts, if using Medicaid funds, must fulfill the requirements of 42 CFR 434.6. All subcontracts are subject to review by the State at its discretion.

E. The Contractor shall be held fully liable and retain full responsibility for the performance and completion of all Contract requirements regardless of whether the Contractor performs the

work or subcontracts for services. The Contractor (and subcontractors, as applicable) must monitor the performance of all subcontractors on an ongoing basis. This includes conducting formal reviews consistent with industry standards. Both the Contractor and subcontractor must take corrective action on any identified deficiencies or areas of improvement.

F. The Contractor must obtain the approval of MDHHS before subcontracting any portion of the Contract requirements and must submit the subcontractor agreement and delegation grid to MDHHS annually, any time there is a material change, or upon request.

G. The Contractor must ensure there is a written agreement that specifies the activities and report responsibilities delegated to Subcontractors and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate, see the MDHHS Policies and Practice Guidelines https://www.michigan.gov/mdhhs/keep-mihealthy/mentalhealth/mentalhealth/practiceguidelines for a model agreement. All agreements are subject to review by the State at its discretion.

1. If Contractor determines revocation of a delegation to a subcontractor is appropriate, the Contractor must provide notice of such action to MDHHS ten (10) business days in advance of issuing such notice to the subcontractor.

2. If Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor must take corrective action, including when appropriate, revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. Contractor must provide:

a. Quarterly report to MDHHS of all subcontractor noncompliance and/or areas of subcontractor performance that were below standards or expectations of this Contract. This notice must include name of subcontractor and delegated functions; a brief description of specific non-compliance or performance deficiency; what action Contractor took to resolve the concerns; including specific monitoring is being completed by the Contractor; whether the concern has been resolved; and if not fully resolved what actions are occurring or planned to resolve the issue.

b. Any information or documentation related to subcontractor deficiency, inadequacy, or non-compliance to MDHHS upon request. Responsive information to such request by MDHHS must be produced to MDHHS within ten (10) business days

H. The Contractor must develop, maintain, and submit policies and procedures addressing auditing and monitoring subcontractors' performance, data, and data submission, including evaluation of prospective subcontractors' abilities prior to contracting with the subcontractor to perform services, collection of performance and financial data to monitor performance on an ongoing basis and conducting formal, periodic, and random reviews. The Contractor must

incorporate all subcontractors' data into the Contractor's performance and financial data for a comprehensive evaluation and identify subcontractor improvement areas.

I. Fiscal Viability of Subcontractors. Contractor must maintain a system to evaluate and monitor the financial viability of all subcontractors and risk bearing provider groups, including but not limited to CMHSPs. At least annually, the Contractor must make documentation of its review available to MDHHS upon request. MDHHS reserves the right to review these documents during Contactor site visits.

J. Delegation of Network Development. When the Contractor delegates network development responsibilities to a subcontractor, including a CMHSP or other network provider, the subcontracts must address the following:

1. Duty to treat and accept referrals

2. Prior authorization requirements

3. Access standards and treatment timelines

4. Relationship with other providers

5. Reporting requirements and time frames

6. Quality Assurance/Quality Improvement (QA/QI) Systems

7. Payment arrangements (including coordination of benefits) and solvency requirements

8. Financing conditions consistent with this Contract

9. Compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"

10. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements

11. Requirement to comply with the "Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans", which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mihealthy/mentalhealth/mentalhealth/practiceguidelines and require the subcontractor to cooperate with the Contractor's quality improvement and utilization review activities

12. Provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy

13. Subcontractors right to discuss treatment options with a recipient that may not reflect the Contractor's position or may not be covered by the Contractor

14. Subcontractors right to advocate on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services

15. Requirement to meet accessibility standards, both as established in Medicaid policy, and this Contract

K. In accordance with 42 CFR 422.216, the Contractor must establish payment rates for plan covered items and services that apply to deemed providers. The Contractor may vary payment rates for providers in accordance with § 422.4(a)(3).

1. Providers must be reimbursed on a fee-for-service basis.

2. The Contractor must make information on its payment rates available to providers that furnish services that may be covered under the contractor's private fee-forservice plan.

3. The Contractor must pay for services of noncontract providers in accordance with 42 CFR 422.100(b)(2)

L. In accordance with 42 CFR 422.208, any physician incentive plan operated by a Contractor, or its subcontractor, must meet the following requirements:

1. The Contractor makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

2. If the physician incentive plan places a physician or physician group at substantial financial risk (as determined in this section) for services that the physician or physician group does not furnish itself, the Contractor must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with this section.

a. For all physician incentive plans, the Contractor must provide to CMS, and to any Medicaid beneficiary, the information specified in 42 CFR 422.210.

b. The Contractor must provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to the State at least 30 days prior to the subcontract effective date. The State reserves the right to require an amendment of the subcontract if the provisions appear to jeopardize individuals' access to services. The State will provide notice of approval or disapproval of proposed contract language within 25 days of receipt.

M. In accordance with 42 CFR 447.325, the Contractor may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

N. The Contractor, and its subcontractors, as applicable, must retain, as applicable, beneficiary grievance and appeal records in accordance with 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

O. In accordance with 42 CFR 438.230(c), all subcontracts must allow the State, CMS, the HHS Inspector General, the Comptroller General, or their designees to have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract with the State. The subcontractor must make available, for purposes of an audit, evaluation, or inspection under this Contract, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries. The right to audit under this Contract will exist through 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later

P. Accreditation of Network Providers 1. The Contractor (and its subcontractors, as applicable) may enter into network provider agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The Contractor, or its subcontractor, must determine compliance through review of original correspondence from accreditation bodies to providers. Accreditation is not needed in order to provide access management system (AMS) services, whether these services are operated by a Contractor or through an agreement with the Contractor or for the provision of broker/generalist case management services. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

OLD:

2.6. Use of Subcontractors

A. Network Provider subcontracts must address the following:

1. Duty to treat and accept referrals

2. Prior authorization requirements

3. Access standards and treatment timelines

4. Relationship with other providers

5. Reporting requirements and time frames

6. QA/QI Systems

7. Payment arrangements (including coordination of benefits) and solvency requirements

8. Financing conditions consistent with this Contract

9. Compliance with Office of Civil Rights Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

10. EPSDT requirements

11. Requirement to comply with the “Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans”, which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html and require the subcontractor to cooperate with the Contractor's quality improvement and utilization review activities

12. Provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy

13. Subcontractors right to discuss treatment options with a recipient that may not reflect the Contractor's position or may not be covered by the Contractor

14. Subcontractors right to advocate on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services

15. Requirement to meet accessibility standards, both as established in Medicaid policy, and this Contract

B. All subcontracts entered into by the Contractor must be in writing and, if using Medicaid funds, fulfill the requirements of 42 CFR 434.6 and 42 CFR 438.6. All subcontracts are subject to review by the State at its discretion.

C. In accordance with 42 CFR 422.216, the Contractor must establish payment rates for plan covered items and services that apply to deemed providers. The Contractor may vary payment rates for providers in accordance with § 422.4(a)(3).

1. Providers must be reimbursed on a fee-for-service basis.

2. The Contractor must make information on its payment rates available to providers that furnish services that may be covered under the contractor's private fee-for-service plan.

3. The contractor must pay for services of noncontract providers in accordance with 42 CFR 422.100(b)(2)

D. In accordance with 42 CFR 422.208, any physician incentive plan operated by a Contractor must meet the following requirements:

1. The Contractor makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

2. If the physician incentive plan places a physician or physician group at substantial financial risk (as determined in this section) for services that the physician or physician group does not furnish itself, the Contractor must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with this section.

a. For all physician incentive plans, the Contractor must provide to CMS, and to any Medicaid beneficiary, the information specified in 42 CFR 422.210.

b. The Contractor must provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to the State at least 30 days prior to the subcontract effective date. The State reserves the right to require an amendment of the subcontract if the provisions appear to jeopardize individuals' access to services. The State will provide notice of approval or disapproval of proposed contract language within 25 days of receipt.

E. In accordance with 42 CFR 447.325, the Contractor may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

F. Accreditation of Subcontractors

The Contractor must enter into agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for

Ambulatory Health Care (AAAHC). The Contractor must determine compliance through review of original correspondence from accreditation bodies to providers. Accreditation is not needed in order to provide access management system (AMS) services, whether these services are operated by a Contractor or through an agreement with the Contractor or for the provision of broker/generalist case management services. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

Item 3

NEW:

Schedule A, Statement of Work Section 3. Project Management, 3.1 Reporting, D. Medical Loss Ratio (MLR) Reporting Requirements is hereby deleted and replaced in its entirety with the following:

D. Medical Loss Ratio (MLR) Reporting Requirements

The MLR is a measure of the percentage of premium dollars that each Contractor spends on clinical services and quality improvement activities. For each reporting year, MDHHS will require each Contractor to submit an MLR report that includes at least the total incurred claims, expenditures on quality improving activities, expenditures on fraud prevention activities, nonclaims costs, premium revenue, taxes and fees, and expenditure allocation methodologies. MDHHS will ensure Contractors are properly identifying and classifying costs across these categories.

1. The Contractor must submit a consolidated MLR report to the State for each reporting year as directed by MDHHS and in accordance with 42 CFR 438.8, medical loss ratio standards, and all other regulatory guidance as issued by CMS.

2. The Contractor must use the reporting tool provided by MDHHS for MLR reporting requirements and follow the state's reporting instructions for completing the requested information.

a. Technical specifications, including file formats, and explanatory materials are located on the MDHHS website at:

The MLR reporting replaces the Contractor obligation to complete an administrative cost report. The MLR report must provide sufficient administrative cost reporting to meet the actuarial needs. In addition to information required above this will include non benefit costs in the following categories:

a. administrative costs.

b. Taxes, licensing and regulatory fees, and other assessments and fees.

c. Contribution to reserves, risk margin, and cost of capital.

d. Other material non-benefit costs.

4. In accordance with 42 CFR § 438.8, each PIHP expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

5.The credibility adjustment is added to the reported MLR calculation before calculating any remittances. The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

6. The Contractor must aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

7. MLR must be equal to or higher than 85 percent and the MLR must be calculated and reported for each MLR reporting year by the Contractor.

8. If required by the State, the Contractor must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher.

9. The Contractor must require any subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

10. In any instance where the State makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the State, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change. In any instance where the State makes a retroactive change to the capitation payments for a MLR

reporting year where the MLR report has already been submitted to the State, the Contractor must submit a new MLR report meeting the applicable requirements.

11. The Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

OLD:

D. Medical Loss Ratio (MLR) Reporting Requirements

1. The Contractor must submit a report to the State that includes, at a minimum, at least the following information for each MLR reporting year:

a. Total incurred claims.

b. Expenditures on quality improving activities.

c. Expenditures related to activities compliant with §438.608(a)(1) through (5), (7), (8) and (b).

d. Non-claims costs.

e. Premium revenue.

f. Taxes, licensing and regulatory fees.

g. Methodology(ies) for allocation of expenditures.

h. Any credibility adjustment applied.

i. The calculated MLR.

j. Any remittance owed to the State, if applicable

k. A comparison of the information reported in this paragraph with the audited financial report required under §438.3(m).

l. A description of the aggregation method used in compliance with 42 CFR § 438.8.

m. The number of member months.

2. The formula for calculation of the MLR is defined below.

a. Incurred Claims +/- ISF created/used – HRA – Taxes + Healthcare Quality Improvement + Fraud Reduction Current Year Premium Revenue +/- Savings used/created – HRA expense – Tax expense (HICA/Use)

The MLR should be completed in accordance with 42 CFR § 438.8, the additional calculation components outlined below are intended to provide clarity regarding State specific items

b. Calculation Components

Include 1) direct claims paid to providers including all costs of CMHSP capitated contracts (excluding PIHP delegated Managed care administrative costs), 2) Unpaid claims for dates of service falling within the reporting year (accounts payable), 3) Estimate of claims incurred but not reported based on past experience, 4) payments to the ISF, and 5) incentives/bonuses paid to providers. Reduce claims by 6) Overpayment recoveries from providers, 7) prescription drug rebates, 8) claims recovered through fraud reduction efforts up to the amount of fraud reduction expense included in the numerator, 9) Hospital Rate Adjuster payments and 10) contribution to ISF fund. The following items must be excluded from incurred claims, consistent with the Medical loss ratio (MLR) standards outlined in 42 CFR § 438.8.

i. Non-claims costs, as defined in 42 CFR § 438.8, which include the following:

1. Amounts paid to third party vendors for secondary network savings.

2. Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

3. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

4. Fines and penalties assessed by regulatory authorities.

ii. Amounts paid to the State as remittance under 42 CFR § 438.8.

iii. Amounts paid to network providers under to § 438.6(d).

c. Healthcare Quality Improvement Include all Quality Improvement functions plus include Information Services costs if specifically related to the ability to accept, track, report, and analyze Quality Improvement data. Time and effort for individuals participating in External Quality Reviews (not already captured as Quality Improvement expenses) may be included.

d. Fraud Reduction Costs for activities designed to detect and/or prevent payment for fraudulent requests for reimbursement. (i.e. Medicaid Verification Process, Clinical Chart Reviews, etc.).

e. Premium Revenue Includes all capitation payments received from the State plus additional cost settlement revenue less any lapse.

f. Savings The use of Savings should increase premium revenue while the creation of Savings should reduce premium revenue.

g. The MLR reporting replaces the Contractor obligation to complete an administrative cost report. The MLR report will provide sufficient administrative cost reporting to meet the actuarial needs. In addition to information required above this will include non-benefit costs in the following categories:

i. Administrative costs.

ii. Taxes, licensing and regulatory fees, and other assessments and fees.

iii. Contribution to reserves, risk margin, and cost of capital.

iv. Other material non-benefit costs.

h. MLR must be equal to or higher than 85 percent and the MLR must be calculated and reported for each MLR reporting year by the Contractor. In accordance with 42 CFR § 438.8, each PIHP expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities. The credibility adjustment is added to the reported MLR calculation before calculating any remittances. The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. The Contractor must aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations. If required by the State, the Contractor must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher. The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes

sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. In any instance where the State makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the State, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change. In any instance where the State makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the State, the Contractor must submit a new MLR report meeting the applicable requirements. The Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

I. The Contractor must provide MLR reports to the State as specified in this Contract, and on forms and formats specified by the MDHHS. Forms and instructions are posted to the State website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html (See Financial Planning, Reporting and Settlement section of Schedule E).

E. Finance Planning, Reporting and Settlement

1. The final expenditure report must reflect incurred, but not paid claims. The Contractor must provide financial reports on forms and formats specified by the State. Forms and instructions are posted to the State website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html (See Financial Planning, Reporting and Settlement section of Schedule E).

2. Contractor must comply with:

a. Governmental Accounting Standards Board (GASB) standards for Generally Accepted Accounting Principles

b. Audit and Accounting Guide: State and Local Governments, current edition, by AICPA c. 2 CFR 200 Subpart E

F. Public Health Reporting PA 368 of 1978 requires that health professionals comply with specified reporting requirements for communicable disease and other health indicators. The Contractor must ensure compliance with all such reporting requirements through its provider contracts.

Item 4

NEW:

4. Schedule A, Statement of Work Section 3. Project Management, 3.1 Reporting, G. Annual Provider Survey Reporting is hereby added in its entirety with the following:

G. Annual Provider Survey Reporting In compliance with MDHHS policy bulletin MSA 21-39 (and any properly promulgated successor guidance issued) establishing annual cost reporting requirements for behavioral health service providers contracted with the Contractor and/or CMHSPs, the Contractor must support the data collection process by providing to MDHHS the contact information for all of their network providers (regardless of whether such network providers contract directly with the Contractor or directly with a subcontractor, including a CMSHP). This information is due to MDHHS annually upon request. The Contractor must ensure all network providers comply with the MDHHS cost reporting survey process and MDHHS cost reporting policy.

OLD:

None

Item 5

Schedule C Definitions

Schedule E Financial Reporting Requirement

Notice of Public Meeting

The Northern Michigan Regional Entity (NMRE) will hold meetings of its Board of Directors in accordance with the schedule supplied herein. Anyone who has special needs should contact the NMRE at 231.487.9144 or email adminsupport@nmre.org. Reasonable accommodations will be provided upon notification or request. Auxiliary aids and services are available upon request to individuals with disabilities.

This meeting is open to all members of the public under Michigan's Open Meeting Act.

NORTHERN MICHIGAN REGIONAL ENTITY
MEETINGS OF THE BOARD OF DIRECTORS

All Meeting Times Are 10:00am
Meetings Are Held on the 4th Wednesday of Every Month
at the NMRE Main Office located at
1999 Walden Drive in Gaylord

October 26, 2022

November 23, 2022

December 28, 2022

January 25, 2023

February 22, 2023

March 22, 2023

April 26, 2023

May 24, 2023

June 28, 2023

July 26, 2023

August 23, 2023

September 27, 2023

Directions: Collection Tool Cover page

Fill out the Collection Tool Cover page in its **entirety**. Make sure that the date is filled out, the MDHHS program contacts name is listed, the name of the managed care entity, the program and the provider ID number.

Please have the Managed Care Entity (MCE) contact fill out the name of the individuals submitting the Provider Screening Information Collection Tool (PSICT) as well as their title. Their tiles will either be CFO or Agent; CEO or Managing Employee; CIO (if applicable) ; and Board of Directors. (Each Board Members name and title must be listed in the table.)

This information is to be returned to the Program Contact of the MCE or MCO along with the PSICT.

Directions: : Provider Screening Information Collection Tool

Fill out the Provider Screening Information Collection tool in its **entirety**. (Follow directions on the form)

The CFO or Agent; CEO or Managing Employee; CIO (if applicable) and Board of Directors **must complete and sign the document.** (Each Board Member must fill out Section E and they must provide a signature. This can be accomplished by providing each member of the Board a copy of section E.)

The information is to be sent secured utilizing the following password: Mdhhs2022! (The passwords will be changed based on the year). It will always be MDHHS (year or submission)!

The MDHHS program contact will send the Cover page and PSICT to Latina McCausey who will then update CHAMPS and keep record of the data. (Latina's email will remain on the forms just in case a Program Contact leaves their position providing an alternate contact.)

PROVIDER SCREENING INFORMATION COLLECTION TOOL

Part I: INFORMATION REQUIRED BY LAW

Purpose and Authority: In accordance with 42 CFR 455, the Michigan Department of Health and Human Services (MDHHS) must collect specific information on owners, agents, board of directors and managing employees for the managed care entities with which MDHHS contracts. As a Managed Care Entity Provider (MCE), the MCE is acting as a Medicaid provider. ***The information collected here is the same information collected when the providers enroll as a CHAMPS fee-for-service provider.***

The purpose of collecting this information is to enable MDHHS to conduct the screenings required by 42 CFR 455 on these individuals/organizations. This information is housed within a secure environment in the CHAMPS Provider Enrollment subsystem and is only available to individuals within MDHHS who need this information to perform their work (for example, provider enrollment staff conducting the screenings and managed care division staff collecting, inputting, and maintaining the information).

Directions: Please complete the information as required and return via a secure e-mail to your Program Contact Latina McCausey (**McCauseyL@Michigan.gov**). The program contact is to forward this information to Latina McCausey (McCauseyL@michigan.gov).

Please keep copies of this information for referencing purposes

Definitions:

Agent – Any person who has been delegated the authority to obligate or act on behalf of the organization; for most MCEs, this will be the Chief Financial Officer

Managing Employee – The individual who controls or manages the organizations affairs; for most MCEs this will be the Chief Executive Officer or Executive Director

Board of Directors – A person who is a member of the Board of Directors for the organization

MCO – Managed Care Organization under 42 CFR 438

Managed Care Entity – An entity that operates as an MCO, PIHP or PAHP, PACE, ICO'S under 42 CFR 438

Managed Care Entity (MCE): _____

Section A: Identification of Owner of the Managed Care Entity

1. **Name of the Managed Care Entity** (MCO):

   _____

   Continue with question #2 through question #9 then move to Section B.

2. Type of Organization
   - ☐Corporate Charitable 501(3)(c)
   - ☐Corporate Non - Charitable
   - ☐Government
   - ☐Holding Company
   - ☐Sole Proprietor/Individual
   - ☐Partnership
   - ☐Other: _____

3. Percentage Owned of MCE listed above _____
4. Tax Identification Number/EIN or SSN if EIN is not available _____
5. Entity Legal Name: _____
6. Name under which organization does business in Michigan: _____
7. Phone number: _____
8. Start date of ownership of MCE listed above: _____
9. Street Address and zip code of the owner of the MCE listed above: May NOT be a P.O. Box

_____

Section B: Chief Financial Officer (CFO) Agent

1. **Name of the Managed Care Entity** (MCO):

_____

2. Percentage Owned of MCE listed above _____
3. Social Security Number _____
4. First Name: _____
5. Last Name: _____
6. Date of Birth: _____ (MM/DD/YYYY)
7. Phone number: _____ MUST supply home number
8. Start date with MCE listed in question #1: _____
9. Street Address and zip code: _____may **NOT** be a P.O. Box, must supply home address
10. Are you related to any other individual who has more than 5% interest in the MCE listed above?

☐**Yes** ☐**No**

If yes, please provide the following information for **EACH** individual who has more than 5% interest in the MCE to whom you are related:

a. First and Last Name of the individual to whom you are related (who has more than 5% interest in the MCE listed above): _____
b. Relationship to self (mother, sister, father, brother-in-law, etc.): _____

11. Do you have more than 5% ownership or control interest in any other disclosing entity (or fiscal agent or managed care entity).

☐**Yes** ☐**No**

If yes, please provide the following information for **EACH** disclosing entity in which you have more than 5% interest

a. Name of the disclosing entity in which you have more than 5% interest: _____
b. Tax ID of the disclosing entity in which you have more than 5% interest: _____

12. Please complete the attached form for this disclosure of convictions; exclusions, revocations or suspensions; final adverse legal actions; and agreement to Michigan Medicaid Managed Care Provider terms and conditions.

Part II: Terms and Conditions and Disclosure must be complete and signed and returned via email to your MDHHS Program Contact who is to submit the information to McCauseyL@michigan.gov (signature is needed at the bottom of the document)

Section C: Chief Executive Officer (CEO) OR Managing Employee

1. **Name of the Managed Care Entity** (MCO):

_____

2. Percentage Owned of MCE listed above _____
3. Social Security Number _____
4. First Name: _____
5. Last Name: _____
6. Date of Birth: _____ (MM/DD/YYYY)
7. Phone number: _____ MUST supply home number
8. Start date with MCE listed in question #1: _____
9. Street Address and zip code: _____may **NOT** be a P.O. Box, must supply home address
10. Are you related to any other individual who has more than 5% interest in the MCE listed above?

☐**Yes** ☐**No**

If yes, please provide the following information for **EACH** individual who has more than 5% interest in the MCE to whom you are related:

a. First and Last Name of the individual to whom you are related (who has more than 5% interest in the MCE listed above): _____
b. Relationship to self (mother, sister, father, brother-in-law, etc.): _____

11. Do you have more than 5% ownership or control interest in any other disclosing entity (or fiscal agent or managed care entity).

☐**Yes** ☐**No**

If yes, please provide the following information for **EACH** disclosing entity in which you have more than 5% interest

a. Name of the disclosing entity in which you have more than 5% interest:
b. Tax ID of the disclosing entity in which you have more than 5% interest:

12. Please complete the attached form for this disclosure of convictions; exclusions, revocations or suspensions; final adverse legal actions; and agreement to Michigan Medicaid Managed Care Provider terms and conditions.

Part II: Terms and Conditions and Disclosure must be complete and signed and returned via email to your MDHHS Program Contact who is to submit the information to McCauseyL@michigan.gov (signature is needed at the bottom of the document)

Section D: Chief Information Officers (CIO)

1. **Name of the Managed Care Entity** (MCO):

_____

2. Percentage Owned of MCE listed above _____
3. Social Security Number _____
4. First Name: _____
5. Last Name: _____
6. Date of Birth: _____ (MM/DD/YYYY)
7. Phone number: _____ MUST supply home number
8. Start date with MCE listed in question #1: _____
9. Street Address and zip code: _____may **NOT** be a P.O. Box, must supply home address
10. Are you related to any other individual who has more than 5% interest in the MCE listed above?

☐**Yes** ☐**No**

If yes, please provide the following information for **EACH** individual who has more than 5% interest in the MCE to whom you are related:

a. First and Last Name of the individual to whom you are related (who has more than 5% interest in the MCE listed above): _____
b. Relationship to self (mother, sister, father, brother-in-law, etc.): _____

11. Do you have more than 5% ownership or control interest in any other disclosing entity (or fiscal agent or managed care entity).

☐**Yes** ☐**No**

If yes, please provide the following information for **EACH** disclosing entity in which you have more than 5% interest

a. Name of the disclosing entity in which you have more than 5% interest: _____
b. Tax ID of the disclosing entity in which you have more than 5% interest: _____

12. Please complete the attached form for this disclosure of convictions; exclusions, revocations or suspensions; final adverse legal actions; and agreement to Michigan Medicaid Managed Care Provider terms and conditions.

Part II: Terms and Conditions and Disclosure must be complete and signed and returned via email to your MDHHS Program Contact who is to submit the information to McCauseyL@michigan.gov (signature is needed at the bottom of the document)

Section E: Board of Directors

13. **Name of the Managed Care Entity** (MCO):

_____

14. Percentage Owned of MCE listed above _____
15. Social Security Number _____
16. First Name: _____
17. Last Name: _____
18. Date of Birth: _____ (MM/DD/YYYY)
19. Phone number: _____ MUST supply home number
20. Start date with MCE listed in question #1: _____
21. Street Address and zip code: _____may **NOT** be a P.O. Box, must supply home address
22. Are you related to any other individual who has more than 5% interest in the MCE listed above?

    ☐**Yes** ☐**No**

    If yes, please provide the following information for **EACH** individual who has more than 5% interest in the MCE to whom you are related:
    c. First and Last Name of the individual to whom you are related (who has more than 5% interest in the MCE listed above): _____
    d. Relationship to self (mother, sister, father, brother-in-law, etc.): _____

23. Do you have more than 5% ownership or control interest in any other disclosing entity (or fiscal agent or managed care entity).

    ☐**Yes** ☐**No**

    If yes, please provide the following information for **EACH** disclosing entity in which you have more than 5% interest
    c. Name of the disclosing entity in which you have more than 5% interest: _____
    d. Tax ID of the disclosing entity in which you have more than 5% interest: _____

24. Please complete the attached form for this disclosure of convictions; exclusions, revocations or suspensions; final adverse legal actions; and agreement to Michigan Medicaid Managed Care Provider terms and conditions.

Part II: Terms and Conditions and Disclosure must be complete and signed and returned via email to your MDHHS Program Contact who is to submit the information to McCauseyL@michigan.gov (signature is needed at the bottom of the document)

A signature is needed at the bottom of the document by each individual person listed on the collection tool. Each person is to submit a signature based on their position title section.

CONTINUE TO NEXT PAGE TO COMPLETE
PART II: TERMS AND CONDITIONS AND DISCLOSURES

Part II: TERMS AND CONDITIONS AND DISCLOSURES

This form captures information on convictions; exclusions, revocations, or suspensions; final adverse legal actions; and terms and conditions. All applicable final adverse actions must be reported, regardless of whether any records were expunged, or any appeals are pending.

CRIMINAL CONVICTIONS

The managed care provider and fiscal agents of ownership and control information agree to provide proper disclosure of provider's owners and other covered persons criminal convictions related to Medicare, Medicaid, Title XX and other State Health Care Programs (Title V, Title XX, and Title XXI) [42 CFR 455.100, 42 CFR 455.106 and 42 U.S.C. § 1320a-7]. Specifically, the covered entity must disclose if the provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of:

- A Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

1. Do you have any convictions to report: ☐**Yes** ☐**No**

If yes, please attach separate sheet containing all disclosures of criminal convictions as required by law.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

The managed care provider and fiscal agents of ownership and control information agree to provide proper disclosure of provider's owners and other covered exclusions, revocations, or suspensions. Specifically, the covered entity must disclose if the provider, supplier, or any owner of the provider or supplier had, within the last 10 years preceding enrollment or revalidation of enrollment, any of the following:

- Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

- Any revocation or suspension of accreditation.

- Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

- Any current Medicaid payment suspension under any Medicaid enrollment.

- Any Medicaid revocation of any Medicaid provider billing number.

2. Do you have any exclusions, revocations, or suspensions to report: ☐Yes ☐No

If yes, please attach separate sheet containing all disclosures of exclusions, revocations, and suspensions as required by law.

FINAL ADVERSE LEGAL ACTION HISTORY

3. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you **☐Yes ☐No**

TERMS AND CONDITIONS

All individuals completing the provider screening form must read and attest to comply with the following terms and conditions

1. I agree to comply with the provisions of 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.

2. I agree to comply with all policies and procedures of the Medical Assistance Program

3. I agree to comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR Parts 160 and 164, Subparts A and E). I also agree to comply with the HIPAA security regulations, as applicable, for electronic protected health information by the compliance date, which is currently April 21, 2005 (45 CFR Parts 160 and 164, Subparts A and C)

4. I certify that I am not currently suspended, terminated, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.

5. I certify that all information furnished on the Provider Screening Form as Terms and Conditions and Disclosure Form is true and complete

6. Do you agree to the Terms and conditions listed above ☐Yes ☐No

Section B: Chief Financial Officer (CFO) OR Agent

Printed Name: _____

Signature: _____

Date: _____

Section C: Chief Executive Officer (CEO) OR Managing employee

Printed Name: _____

Signature: _____

Date: _____

Section D: Chief Information Officers (CIO)

Printed Name: _____

Signature: _____

Date: _____

Section E: Board of Directors

Printed Name: _____

Signature: _____

Date: _____