Northern Michigan Regional Entity

Board Meeting

August 28, 2024

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – July 24, 2024	Pages 2 – 8
7.	Correspondence	Pages 9 – 36
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – August 2024	Page 37
	c. Financial Report – June 2024	Pages 38 – 59
	d. Operations Committee Report – August 20, 2024	Pages – 64
	e. NMRE SUD Oversight Board Report – The Next Meeting is Sept. 9th at 10:00	
11.	New Business	
12.	Old Business	
	a. Northern Lakes Update	
	b. FY 25 PIHP Contract Update	Pages 65 – 66
13.	Presentation	
	Addiction Treatment Services – Mobile Care Unit	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – September 25, 2024 at 10:00AM	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – JULY 24, 2024
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Tom Bratton, Mary Marois, Michael Newman, Gary Nowak, Jay O'Farrell, Ruth Pilon, Richard Schmidt, Karla Sherman, Don Smeltzer, Don Tanner**
ABSENT:	**Ed Ginop, Gary Klacking, Eric Lawson, Chuck Varner**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Carol Balousek, Eugene Branigan, Lisa Hartley, Chip Johnston, Eric Kurtz, Brian Martinus, Diane Pelts, Brandon Rhue, Nena Sork, Denise Switzer, Deanna Yockey**
PUBLIC:	**Sam Borowiak, Chip Cieslinski, Dave Freedman, Joe Porterfield, Gary Taylor, Sharon Vreeland**

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

ROLL CALL
Let the record show that Ed Ginop, Gary Klacking, Eric Lawson, and Chuck Varner 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 an update on the FY25 PIHP Specialty Supports and Services Contract with the State was added under New Business.

MOTION BY DON SMELTZER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR JULY 24, 2024 AS AMENDED; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

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

MOTION BY MARY MAROIS TO APPROVE THE MINUTES OF THE JUNE 26, 2024 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY GARY NOWAK. MOTION CARRIED.

CORRESPONDENCE

1) The minutes of the June 28, 2024 Rural and Frontier Caucus meeting.
2) A letter dated June 28, 2024 from the Crawford County Board of Commissioners supporting the NMRE's Resolution Opposing MDHHS' Decision to Implement Conflict Free Access and Planning in Michigan.
3) A memorandum from Kristen Jordan dated June 28, 2024 to PIHP and CMHSP Executive Directors regarding Claims Submissions with the State sponsored Electronic Visit Verification (EVV) System at Initial Implementation for Behavioral Health.
4) Michigan Medicaid Policy Bulletin 24-24 dated July 1, 2024 announcing Behavioral Health Home (BHH) Expansion and Addition of Codes to Increase Eligibility for Youth with Serious Emotional Disturbance (SED).
5) Email correspondence from Jackie Sproat dated July 10, 2024 providing an update on Tiered Inpatient Psychiatric Rates.
6) Michigan Medicaid Provider L Letter 24-36 dated July 11, 2024 regarding Changes to the Non-Emergency Medical Transportation (NEMT) Benefit for Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP).
7) A legal response from the Community Mental Health Association of Michigan's (CMHAM) dated July 12, 2024 regarding the State's proposed Waskul Settlement Agreement.
8) The draft minutes of the July 10, 2024 regional Finance Committee meeting.

Mr. Kurtz drew attention to the June 28th minutes from the Rural Caucus meeting. The mission of the Rural Caucus was provided as: "The Rural and Frontier Caucus, a dedicated initiative within the Community Mental Health Association of Michigan (CMHA), advocates for a public mental health system that fully recognizes and addresses the distinctive characteristics inherent in Michigan's rural and frontier landscapes." Ms. Sherman asked whether others (MDHHS) recognize these differences. Mr. Kurtz responded that the committee is chaired by Matt Maskart, CEO of Pathways Community Mental Health in the Upper Peninsula and Kristan Jordan, Director of the Bureau of Specialty Behavioral Health Services at MDHHS, is a member but was not in attendance in June.

Mr. Kurtz acknowledged the letter from the Crawford Oscoda County Board of Commissioners supporting the NMRE's Resolution Opposing MDHHS' Decision to Implement Conflict Free Access and Planning in Michigan.

Mr. Kurtz next recognized the MMP L Letter regarding changes to the Non-Emergency Medical Transportation (NEMT) Benefit for Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP). Beginning October 1, 2024, MHPs will be required to cover NEMT for any Medicaid-covered service for SUD, Medical, and Behavioral Health. Prior to October, individuals will need to be transitioned from Meridian and United to one of the MHPs currently under contract in the region (Blue Cross Complete McLaren Molina, Priority Health). The lack of local transportation providers was emphasized.

The response from the CMHAM regarding the State's proposed Waskul Settlement Agreement will be discussed under the FY25 PIHP Specialty Supports and Services Contract with the State, which was added under New Business.

ANNOUNCEMENTS

Let the record show that there were no announcements during the meeting on this date.

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

Dave Freedman, a member of the Northern Lakes CMHA Board and the NMRE Substance Use Disorder (SUD) Oversight Committee, spoke about an upcoming request for liquor tax dollars from the Wexford County Sherrif for capital item. The liquor tax parameters approved by the NMRE Board in April state that "Applications that include any purchase of buildings or automobiles, renovations of any kind, or any other capital investments will not be considered." Mr. Freedman asked that Board that if the request brought for consideration on this date is approved, that similar consideration be given to future requests for capital expenses. The Recovery Community Organization in Grand Traverse County is in need of vehicles so that peers can transport individuals to treatment; however, this was not allowed due to the previously referenced criteria. Mr. Freedman clarified that he is not opposed to the request made but the Wexford County Sherrif but would like to see consistency regarding the use of liquor tax funds for capital expenses.

Joe Porterfield, Wexford County Administration, also spoke about the request from the Wexford County Sherrif for a TEK84full body scanner. There have been several incidents where substances have been smuggled into the jail in individuals' body cavities, jeopardizing the health and safety of inmates. The scanner is intended to save lives. Any consideration from the Board to approve the request would be appreciated.

Sam Borowiak, Executive Director of NMSAS Recovery Center, spoke about the changes to Non-Emergency Medical Transportation. Because NMSAS has clients who come for daily medication assisted treatment dosing, the change could cause a lapse in treatment and potential withdrawals. NMSAS is already working to get individuals enrolled so that their care will not be disrupted. Ms. Borowiak called the matter "very concerning."

REPORTS

Executive Committee Report

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

CEO Report

The NMRE CEO Monthly Report for July 2024 was included in the materials for the meeting on this date.

May 2024 Financial Report

- Net Position showed net deficit Medicaid and HMP of $1,941,623. Carry forward was reported as $11,624,171. The total Medicaid and HMP Current Year Surplus was reported as $9,682,548. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $30,258,704.
- Traditional Medicaid showed $139,203,717 in revenue, and $137,162,152 in expenses, resulting in a net surplus of $2,041,565. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $845,073.
- Healthy Michigan Plan showed $19,496,020 in revenue, and $23,479,208 in expenses, resulting in a net deficit of $3,983,188. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $10,779,098.

- Health Home showed $1,953,750 in revenue, and $1,711,720 in expenses, resulting in a net surplus of $242,030.
- SUD showed all funding source revenue of $19,860,373 and $18,184,070 in expenses, resulting in a net surplus of $1,676,303. Total PA2 funds were reported as $4,705,725.

The NMRE is closely monitoring FY24 revenue and comparing it to FY23. Year-end revenue is likely to be $3.2M over original projections, due to increased HSW payments.

The region currently has one open HSW slot with a packet pending in the MDHHS queue; if approved, the NMRE will receive a July payment for this individual. SED and CWP enrollments have increased substantially from the previous year.

Due to a glitch in the CHAMPS system, the NMRE has not been paid for individuals on HSW with spenddowns dating back to July 2023. The NMRE has recently learned that it will receive payments for unpaid HSW slots back to October 1, 2023. Some retroactive payments were received last week totaling $213K. There should be an additional payment coming to the region once the July 15th submissions have been reviewed. It is unclear whether any retroactive payments will be made for FY23.

Mr. Kurtz noted that only a small portion of the $116.3M appropriated in the April rate adjustment has been pushed out to PIHPs/CMHSPs. This is a "big concern" looking ahead to FY25 rates.

MOTION BY KARLA SHERMAN TO EMPOWER THE NORTHERN MICHIGNA REGIONAL ENTITY CHIEF EXECUTIVE OFFICER TO REQUEST THAT THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES DISTRIBUTE THE ENTIRETY OF THE FUNDING INCLUDED IN THE APRIL 2024 APPROPRIATION; SECOND BY GARY NOWAK. MOTION CARRIED.

MOTION BY MARY MAROIS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHY FINANCIAL REPORT FOR MAY 2024; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Operations Committee Report
The draft minutes from July 16, 2024 were included in the materials for the meeting on this date. It was noted that the region has supported Debra Welsch for CMHAM Board Treasurer.

NMRE SUD Oversight Committee Report
The draft minutes from the July 8, 2024 NMRE Substance Use Disorder Oversight Committee were included in the materials for the meeting on this date.

NEW BUSINESS
FY25 Liquor Tax Requests
The following liquor tax requests were presented to the NMRE Substance Use Disorder (SUD) Oversight Committee on July 8, 2024 and were recommended for approval by the NMRE Board of Directors. The total amount of funds requested on this date totals **$797,750.00**.

	Requesting Entity	Project	County	Amount
1.	Catholic Human Services	Alcona County Students Leading Students	Alcona	$12,100.00
2.	Centra Wellness Network	Benzie Area Youth (BAY) Initiative	Benzie	$7,790.00
3.	BASES	Charlevoix County Jail Groups	Charlevoix	$22,000.00
4.	Catholic Human Services	Generations Ahead	Grand Traverse	$79,827.00
5.	Munson Healthcare	Recovery Coaching Engagement	Grand Traverse	$68,497.00
6.	Catholic Human Services	Peers Project with Dr. Best	Grand Traverse	$49,627.00
7.	Catholic Human Services	SFCNM Opioid Prevention and Medication Safety	Grand Traverse	$155,000.00
8.	Catholic Human Services	Leelanau County SUD Youth Prevention	Leelanau	$36,740.00
9.	Catholic Human Services	Ogemaw Drug Free Coalition	Ogemaw	$8,213.00
10.	Wexford County Sherriff	Jail TEK84 Body Scanner	Wexford	$75,000.00
11.	Catholic Human Services	Jail-Based SUD Program	Wexford	$102,956.00
12.	Health Dept of Northwest MI	DFNM 21-County Alliance Media Campaign	All 21 Counties	$60,000.00
13.	Harm Reduction Michigan	Supplies to Combat the Opioid Epidemic	Emmet, Grand Traverse, Manistee, Wexford	$120,000.00

MOTION BY GARY NOWAK TO APPROVE THE LIQUOR TAX REQUESTS FOR FISCAL YEAR 2025 AS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE ON JULY 8, 2024, IN THE TOTAL AMOUNT OF SEVEN HUNDRED NINETY-SEVEN THOUSAND SEVEN HUNDRED FIFTY DOLLARS ($797,750.00); SUPPORT BY MARY MAROIS.

The determination was made that further discussion is needed regarding the request from the Wexford County Sheriff for the purchase of the TEK84 Body Scanner.

MOTION BY GARY NOWAK TO AMEND HIS PREVIOUS MOTION TO APPROVE LIQUOR TAX REQUESTS FOR FISCAL YEAR 2025 AS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE ON JULY 8, 2024WITH THE EXCEPTION OF THE REQUEST BY THE WEXFORD COUNTY SHERIFF FOR A TOTAL AMOUNT OF SEVEN HUNDRED TWENTY-TWO THOUSAND SEVEN HUNDRED FIFTY DOLLARS ($722.750); SUPPORT BY MARY MAROIS. ROLL CALL VOTE:

"Yea" Votes: B. Adrian, M. Marois, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

Discussion about whether the TEK84 body scanner is a capital expense followed. Mr. Porterfield noted that the total cost of the scanner (including installation) is slightly over $200K. Funding has been secured from additional sources, including Michigan Municipal Risk Management Authority (MMRMA), a Risk Avoidance Program (RAP) Grant, and Wexford County. Regarding whether the purchase constitutes a capital expense, the consensus was that it does; however, it is not building equity or generating revenue. The scanner would be used as a prevention instrument.

Mr. Newman questioned whether approval of the request will lead to other counties making the same request. Ms. Arsenov responded that it's possible and would be considered if the county balance supports the request.

MOTION BY MARY MAROIS TO APPROVE THE REQUEST FROM THE WEXFORD COUNTY SHERIFF FOR LIQUOR TAX DOLLARS IN THE AMOUNT OF SEVENTY-FIVE THOUSAND DOLLARS ($75,000.00) TO PURCHASE A TEK84 BODY SCANNER; SUPPORT BY GARY NOWAK. ROLL CALL VOTE.

"Yea" Votes: B. Adrian, M. Marois, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

FY25 PIHP Contract

Mr. Kurtz reported that after the FY25 PIHP Supports and Services Contract with the State had been sent to PIHP CEOs for comment, returned to MDHHS, resent to the PIHPs in a redline version, and then included in the materials for the July 26th Contract Negotiations meeting with five or six items added; the two most concerning were addressed as follows:

1) The contract would require the PIHP to agree to serve the Waskul settlement as "agreed to by the state of Michigan." The proposed settlement agreement would allow a subset of recipients (those on HSW in a Self-Determined arrangement) to receive an hourly rate of $31/hour for Community Living Supports (CLS). The agreement is currently being appealed by Washtenaw County. Because litigation is ongoing, Mr. Kurtz proposed that the NMRE not sign the Contract. Mr. Kurtz has discussed the matter with Neil Marchand, the attorney involved in the case. Ms. Pelts noted that, per the Medicaid Policy Manual, individuals who furnish CLS do not require a high school diploma or GED; the $31/hour wage is not sustainable. Mr. Johnston added that it also circumvents procurement processes.

2) PIHPs are currently under a risk corridor that is capped at 7.5%. PIHPs are required by contract to conduct an actuarial analysis of risk. An actuarily analysis would likely call for a risk corridor three or four times 7.5%. The PIHPs will need to retain as much savings as

possible until rates are properly adjusted. Mr. Johnston noted that the 7.5% figure was agreed to at the beginning of managed care as a placeholder pending actuarial analysis.

MOTION BY KARLA SHERMAN TO AUTHORIZE ATTORNEY CHRIS COOKE TO COMPOSE A LETTER TO ELIZABETH HERTEL, THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, REGARDING THE FINANCIAL RAMIFICATIONS OF THE PROPOSED WASKUL SETTLEMENT AGREEMENT AND THE FISCAL IMPLICATIONS OF THE SEVEN AND A HALF PERCENT (7.5%) INTERNAL SERVICE FUND CAP; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

OLD BUSINESS

Northern Lakes CMHA Update

Mr. Kurtz is considering opening the CEO search pending the forensic audit findings. Ms. Marois asked when these results may be expected. Mr. Kurtz responded that he received an update earlier in the month; the investigation for FY23 is in its final stages. The report will then need to be vetted by legal counsel and a determination will need to be made regarding additional fiscal years.

Ms. Marois reported that Northern Lakes Board Chair, Greg McMorrow, has asked for the findings of the Employment Engagement Survey. Mr. Kurtz agreed to ask Rehmann for the detailed report, but it may come at an additional cost.

PRESENTATION

Ideas from the Board

Ms. Sherman proposed that the NMRE hold a Board summit with policy makers and legislators sometime after the November election.

Additional presentation topic ideas may be sent to Mr. Kurtz or Ms. Balousek.

COMMENTS

Public

Mr. Freedman asked that, since the request for the body scanner was passed, future requests for capital purchases be similarly considered. Ms. Arsenov noted that the Recovery Care Organization in Traverse City is funded through the SOR Grant at a per diem rate. Transportation services are covered with COVID Block Grant Funding at the federal rate, and the NMRE is reimbursing for Peer Coaching with COVID Block Grant funds.

MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on August 28, 2024.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 12:02PM.

Regional Entity CEO Group

Jim Johnson, Vice Chair | Joseph Sedlock, Chair | Bradley Casemore, Spokesperson

REGIONAL ENTITY CEO MEETING

Date: Tuesday, June 4, 2024, Time: 12:30 pm – 3:30 pm

DRAFT – Minutes

1. Welcome / Introductions

The meeting was called to order by Joe Sedlock at 12:33 pm.

Present In Person: None

Present Via Zoom: Megan Rooney (Reg. 1), Eric Kurtz (Reg. 2), Mary Marlatt-Dumas (Reg. 3), Brad Casemore (Reg. 4), Joe Sedlock (Reg. 5), James Colaianne (Reg. 6), Eric Doeh (Reg. 7), Dana Lasenby (Reg. 8), Traci Smith (Reg. 9), Jim Johnson (Reg. 10)

Absent: None

Guests (selected/applicable portions): Bob Sheehan, Alan Bolter (CMHA)

CMHA Staff: Monique Francis

2. Agenda Changes / Previous Minutes Approval

Additions/changes to the agenda: Washtenaw Waskul Declarations added as Item 8 by James, HCBS added as Item 9 added by Megan, and FY25 Boilerplate added as bullet under Item 14 by Joe. **The group** agreed by consensus to accept the agenda for June 4, 2024, with additions, and approve the minutes from May 7, 2024.

Priority/Action Items

3. Conflict Free Access and Planning (Joe/All)

- Any updates

Joe reported that MSHN has been experiencing denials of authorizations for clients with effective waivers such as Hab Support Waiver slots. The Department is claiming that case management and service delivery cannot be provided by the same agency. This has not been implemented and is not yet a rule yet. MSHN is resisting this with the Department. Megan reported that NorthCare experienced a similar situation this past Winter and she fought it. The Department stated that the CMH had to have oversight of the plan, and that seemed to remedy the situation, but this was months ago. The Plan of Service was put into the EMR and staff signed off. Mary reported that they have 3 or 4 cases that have been reported as not being CFAP compliant and she has emailed the Department. She is awaiting feedback from them. Eric K. reported that the Department is proceeding with writing a plan and creating an IPOS. The group discussed the issues being created with enforcing the CFAP rules prior to the implementation date of 10/1/24. Joe recommended this be added to the Operation's Meeting Agenda and also be discussed with CMHAM. The group agreed by consensus to these actions.

4. Tiered Psychiatric Inpatient Rates (Megan)

Megan reported that MDHHS listened to the issues as she reported them last month regarding the outcomes from the recent EDIT meeting. She reported that they issued a statement that was identical to the information that came out of the EDIT meeting, and really did not address the issue. The group discussed details such as the fact that modifiers cannot be added to revenue codes. The group also discussed that negotiating these rates with Hospitals is going to be a hard process. Details such as medical necessity, minimum state rates, and Hospital Rates were also discussed. Mary suggested adding this to the Operation's Agenda to inform the Department that it is not operational. The group discussed and agreed that the State Minimum is already in the contract, so this issue would not see any resolution if brought forward at the Operation's Meeting.

5. HRA Rates (Megan)

These rates were inflated by $8 Million, and the psychiatric inpatient rates do not consider the HRA rates. Megan reported that she wondered how this was going to impact the tiered inpatient rates. Richard Carpenter expressed questions/concerns as follows – "At the same time MDHHS is increasing the SDP, we are seeing unprecedented rate increase requests from the Hospitals (along with threats to not contract with us or close units). What is the process to make sure we aren't both (MDHHS and the system) paying twice for the same cost increases? How does it get communicated to the hospitals that their all-inclusive rate is our contract

plus the SDP (so they will actually take our referrals)?" James reported that the CMHs in his Region are collaborating to try to work through this issue.

6. **Encounter Data Validation/OIG Requirements (Eric K.)**

Eric reported that a communication was sent to the Department with issues identified. Jackie sent a response which included a proposal to reduce the sample size by 25%. There has also been talk that this may be able to be removed from PIHP contracts, but as this is considered part of fraud reporting, Eric did not feel like this would be going away. He stated that the PIHP Directors need to continue to work with HSAG on this to find a solution. The group discussed and agreed that each of the CEOs in this group should be coordinating with their sub-groups on this topic. The group then discussed whether to add this to the Operation's Meeting Agenda, deciding to ask for a status update on Encounter Data Validation. Eric will be lead. Mary reported that several LRE staff in the QI realm reached out to the Department on this issue, and she would like to encourage them to continue to reach out to them. Joe stated that he understood that and stated that utilizing the current setup for liaisons that was created by the group of PIHP Directors can help to extend those efforts. The group continued to discuss that all efforts are good efforts when it comes to discussions, as long as the message to MDHHS remains the same.

7. **Establishment of Clinical Collaboration Group – Status (Brad)**

Joe asked if this should be kept on the agenda. Brad stated it could come off the standing agenda, with a reminder to be brought back for discussion in 3 months. Remove from agenda with tickler for 3 months.

8. **Washtenaw Waskul Declarations (added by James)**

James stated that he and Trish Cortes spoke on this issue at the May CEO Retreat. He reported that there are a couple of different tracks – minimum fee provision of $31/hour for service reimbursement is the first phase; CMS has to approve, PIHPs have to sign contracts, etc. All of this must happen by June 2025, or they will have a costing out provision – this will establish a CLS rate for everyone on Hab Waiver which takes a lot out of the CMH and PIHPs hands such as IPOS services. James stated that his agency does not agree with this settlement at all as it should be applied to all DCWs, not just the select few. James stated that all of the PIHPs – as an impacted party – have until July 15th to object to the settlement, or support the settlement (via a declaration), but the attorneys would like either of those by June 14th if possible. James stated that the provider network is going to be adversely affected by this, and other disciplines are likely to be adversely affected as well, not just CLS. Brad and Eric K. stated they were in full support of CMHPSM. The group discussed who was Counsel for whom. Neil Marchand for Washtenaw, Rozatti and Debler for CMHPSM. Bob Sheehan stated that Charlie Quigg was Counsel for the Association. Megan stated that CMS is going to ask how the Settlement numbers were reached, and it is not clear how this will get done. James stated if that happens, PIHPs will have to create separate rates for everyone (2nd provision discussed earlier).

9. **HCBS (added by Megan)**

Megan reported that they are experiencing multiple issues with the guidance being issued by MDHHS on behavioral treatment plans. She stated that there have been restrictions that need to be placed on the plans, and it is not known why there are more administrative hurdles being created. She stated there are contradictions with technical requirements and what the standard is. The gravity of what they are doing that will affect where people have to live is of great concern. She wondered if anyone else was having these issues with HCBS and the monitoring that is going to be required. Megan went on to state that these policies do not seem to meet the intent of CMS. Mary reported that she has discussed this issue at her PIHP, and they have determined that the technical requirement is a STATE requirement, so it should be addressed from that angle – to be in compliance with HCBS on a federal level. The group discussed what, if any, actions should take place. Mary suggested each PIHPs subject matter expert or Lead create a list of examples to bring to Kristen or another point person within the Department. Mary volunteered to begin a draft and reach out to the PIHP Leads identified and bring a final draft back to this group for approval. She will work to get this draft sent to everyone via email at least a week before next month's meeting, to be included in next month's packet for review and approval. Joe suggested adding this topic to the Operation's Meeting Agenda. The group agreed by consensus to add this to the agenda. Mary will be the lead.

10. **Michigan Opioid Advisory Commission Updates (Brad) – Remove from Agenda.**

11. **Michigan Opioid Task Force Updates (Brad)**

Four subcommittees brought forth short-term and long-term recommendations to the May 15th meeting. the four pillars those subcommittees are working on are Harm Reduction, Treatment, Prevention and Recovery Supports.

12. Michigan Autism Council Updates (Dana)

Dana forwarded updates to the group via email. The budget continues to grow and more services are being added to Autism.

13. Michigan Diversion Council Updates (Brad/Eric D.)

No report.

14. PIHP Contract Negotiations Update (Joe/Brad/Jim)

- Bulleted updated provided earlier this week.
- May 21st meeting was cancelled and has not been rescheduled yet.
- FY 25 Boilerplate

Joe reported to the group that the Contract Sanctions and Penalties section states that the Department can penalize PIHPs without written notice. Joe has sent some follow-up information to this group and can send more if needed. He would like the PIHP CEOs to join forces in negotiating for the right to notice of penalization. Mary agreed this was extremely concerning. Jim Johnson expressed concern with the Internal Service Fund as another section of the Boilerplate. Traci stated Region 9 was also concerned with the ISF boilerplate. No further discussion.

15. Provider Network Reciprocity (V. Suder/Dana)

- Update via email from Vicki Suder sent last week. No discussion.

SUD Provider Performance Monitoring Reciprocity (S. Sircely/Megan)

- Written update provided in packet.

16. Training Reciprocity (A. Dillon/Joe)

- No update.

17. Chief Finance Officers Group Report (R. Carpenter/Megan)

- No Notes provided. No discussion.

18. SUD Service Directors Group Report (D. Meier/Jim)

- No Notes provided.

19. CIO Forum Report (T. Cole/Brad)

- Update attached. No discussion.

20. Statewide Utilization Management Directors Group (Rotating Leader – Mary)

- Meeting notes were provided in the packet. No discussion.

21. PIHP Compliance Officers Report (K. Zimmerman/Eric K.)

- No meeting.
- No report.

22. MDHHS/PIHP Operations Meeting Planning (All)

- Next meeting is on June 6, 2024.
- Topics to Add to Agenda (if any)
  - Hab Waiver denials / CFAP implementation prior to 10/1/24 date (Joe will be lead)
  - HCBS compliance issues and policy conflicts (Mary will be lead)
  - Encounter Data Validation update from MDHHS (Eric K. will be lead)

23. CMHA Legislation & Policy Committee (Jim)

- No update or report.
- Next meeting is June 27, 2024.

24. CMHA Coordination (B. Sheehan, A. Bolter – 1:30pm)

Bob Sheehan and Alan Bolter joined the meeting at 1:30pm.

Topics for discussion provided by PIHP CEOs:

- CFAP based denials of authorizations for HSW slots

Joe informed Bob and Alan about the recent slew of denials received from The Department, prior to any policy being issued, implementation not being until October 1, 2024, and clients are going to be caught in

the middle and not receive services. He stated that the PIHPs will be taking this issue up with the Department this Thursday at their Operation's Meeting, and they wanted the Association to be aware of this occurring. Bob thanked the group for sharing this information.

Topics for discussion provided by Bob Sheehan:

- Legislative update
  Alan reported that the Governor signed SB 27 into law which codifies federal Parity law, on May 21, 2024. He stated that Dominic Polone and Marianne Huff were among those present at the bill signing. He reported that Rep. Brabec held a sub-committee meeting on SUD which was attended by Joel Smith and Nicole Adelman. Both testified to bring awareness to the group on the SUD topics being discussed. The May 17th Revenue Estimating Conference took place on May 17th, and the numbers are being solidified for both the House and Senate to finalize their versions of the budget over the next several weeks. The Budget should be finalized by their deadline of July 1, 2024. The group wondered if the House DHHS appropriations sub-committee had earmarked any of the Opioid funds yet. Alan stated that was unknown as of right now.
- FY 24 budget projections of PIHPs, given April rate changes
  Bob stated that there was $116 Million seen from these rate changes and many PIHPs saw a much smaller amount than they thought they would be getting. MSHN gained $3 Million in total, and with over 20% of the State's population served, they expected it to be much larger than that. Regions 2 and 6 reported they did not get a large chunk of the $116 Million either. Bob Sheehan asked if there was a key point person within the PIHPs to obtain details on declining Medicaid enrollees. He reported that what was in the appropriations was larger than the $116 Million, so we want to make sure that all of that is being captured. Joe suggested that we should ensure that the Department is indeed pushing out $116 Million – not a different amount such as $30-$40 Million. Bob Sheehan shared the Projected SFY amount as reported to him from the Department which showed the $116 Million.
- Conflict free access and planning: update on advocacy and MDHHS contract negotiations
  Bob reported that the Advocates have reached out to the Association to schedule a meeting. Bob thanked everyone who had submitted Resolutions and the continual pressure was appreciated.
- Response to advocates' letter to CMS regarding conflict of interest
  Bob reported that the Association would like to have a joint response on this, with the PIHP Directors. He asked what everyone's thoughts on this were. The group expressed the frustration with trying to set monthly "touch-base" meetings with the Advocates in the past – to no success – and there was no desire to try to recreate such meetings. The group encouraged the Association to continue in their efforts, but without the PIHP's involvement. Eric K. pointed out that CMS should DEFINITELY be responded to about how our system works, but without the involvement of the Advocates. Bob and Alan agreed, stating that they will draft a response and share it with this group before it is sent.

OTHER: No other discussions.

ADD to future Agenda in July:
None identified. See actionable items highlighted in blue.

The meeting adjourned at 2:42pm.

Respectfully Submitted,
Monique Francis, CMHA Committee Clerk

Medicaid Mental Health and Substance Use Disorder Payment Responsibility Grid

Introduction:

The grid below indicates Medicaid Health Plan (MHP) and Prepaid Inpatient Health Plan (PIHP) coverage responsibility for mental health and substance use disorder services. It should be used by MHPs, PIHPs, Community Mental Health Service Programs, providers and others, as applicable, to determine the responsible entity for payment of mental health and substance use disorder services delivered to Enrollees.

This grid generally delineates coverage responsibility by the setting in which a service is provided. MDHHS reserves the right to modify this grid in the future and will update it in accordance with any change in MDHHS policy. All entities should follow Medicaid policy, as described in the Medicaid Provider Manual and the entity's contract with the State and as directed by MDHHS.

Acronyms:

- CMHSP – Community Mental Health Services Program
- CCBHC – Certified Community Behavioral Health Clinic
- DRG – Diagnosis Related Group
- ED – Emergency Department
- FFS – Fee for Service
- I/DD – Intellectual/Developmental Disability
- MHA – Mental Health Assessment
- MHP – Medicaid Health Plan
- MAT – Medication Assisted Treatment
- NF – Nursing Facility
- OBSUT – Office-Based Substance Use Treatment
- OTP – Opioid Treatment Provider
- PAR – Pre-Admission Review
- PIHP – Prepaid Inpatient Health Plan
- SBIRT – Screening, Brief Intervention, and Referral to Treatment Services
- SED – Serious Emotional Disturbance
- SMI – Serious Mental Illness
- SUD – Substance Use Disorder

Notes:

- For enrollees who are not enrolled in an MHP and receive FFS Medicaid, FFS is the responsible payer wherever the grid indicates MHP coverage responsibility.
- Unless otherwise indicated by the most current ICD-10-CM coding guidelines, list first the ICD-10 code for the diagnosis, condition, problem, or other reason for the encounter/visit that is shown in the medical record to be chiefly responsible for the services provided, followed by additional ICD-10 codes that describe any coexisting conditions.
- Specialty supports and services provided to individuals with an I/DD outlined in the Medicaid Provider Manual are the responsibility of the PIHP; physical health, mental health and substance use disorder services for these individuals should be covered in accordance with this grid and Medicaid policy.
- Prior authorization may apply to services included in this grid; see relevant coverage rules for additional information.
- Refer to the Medicaid Provider Manual for additional coverage and reimbursement information, including information for individuals enrolled in an Integrated Care Organization.

Medicaid Mental Health and Substance Use Disorder Payment Responsibility Grid

Setting in Which Service is Provided					
Outpatient Office (e.g., Clinic, Physician Office)	**Emergency Intervention Services and Post-Crisis Stabilization Services**	**Medical Emergency Department (ED)**	**Inpatient Acute Care Hospital**	**Inpatient Psychiatric Hospital or Inpatient Psychiatric Bed/Unit Within Acute Care Hospital** *Excludes State Psychiatric Hospitals*	**Nursing Facility**
Mental Health Services for Individuals with Mild to Moderate Mental Illness or Whose Severity Has Not Yet Been Determined NOTE: Unless otherwise specified, the payment responsibilities delineated in this table hold true regardless of whether the individual has concurrent SUD or I/DD.					
Payer responsible: Mixed, depending on outpatient setting. The PIHP is responsible for outpatient mental health services provided at CCBHCs. The PIHP is also responsible for outpatient mental health services provided by SUD providers for individuals with co-occurring mental health and substance use disorders. (For outpatient emergency intervention and post-crisis stabilization services, see right.) The MHP is responsible for outpatient mental health services provided in other office- or clinic-based settings to individuals with mild to moderate mental illness or whose severity has not yet been determined. This includes necessary screening.	Payer responsible: PIHP. The PIHP is responsible for emergency intervention services and post-crisis stabilization services (in outpatient or residential settings) as outlined in the Intensive Crisis Stabilization Services section of the Medicaid Provider Manual. If the provider believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the provider should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP. The PIHP is responsible for stabilization services following psychiatric hospitalization. The PIHP and MHP should closely coordinate post-crisis stabilization services for shared enrollees.	Payer responsible: Mixed, depending on service provided. The MHP is responsible for medical screening and stabilization services and any medical treatment associated with the episode of care, including treatment of mild-to-moderate mental illness provided in the ED. If after medical screening and stabilization, a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the ED should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP.	Payer responsible: Mixed, depending on service provided. The MHP is responsible for all inpatient medical treatment associated with the episode of care, with the exception of inpatient psychiatric stays (see right). If a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the hospital should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP.	Payer responsible: PIHP. The PIHP is responsible for all inpatient psychiatric stays, either in inpatient psychiatric hospitals or psychiatric beds/units within a general acute care hospital. The PIHP provides the authorization for mental health inpatient admission and is responsible for mental health inpatient admission costs, including psychiatrists' fees.	Payer responsible: MHP or FFS, depending on beneficiary enrollment. Nursing facilities complete the Pre-Admission Screening and Annual Resident Review (PASARR). Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health, I/DD or related condition services that are of lesser intensity than specialized services to all residents who need such services.

Medicaid Mental Health and Substance Use Disorder Payment Responsibility Grid

Setting in Which Service is Provided					
Outpatient Office (e.g., Clinic, Physician Office)	**Emergency Intervention Services and Post-Crisis Stabilization Services**	**Medical Emergency Department (ED)**	**Inpatient Acute Care Hospital**	**Inpatient Psychiatric Hospital or Inpatient Psychiatric Bed/Unit Within Acute Care Hospital** *Excludes State Psychiatric Hospitals*	**Nursing Facility**
Mental Health Services for Individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) NOTE: Unless otherwise specified, the payment responsibilities delineated in this table hold true regardless of whether the individual has concurrent SUD or I/DD.					
Payer responsible: PIHP The PIHP is responsible for outpatient mental health services provided to individuals with SMI or SED.	Payer responsible: PIHP. The PIHP is responsible for emergency intervention services and post-crisis stabilization services (in outpatient or residential settings) as outlined in the Intensive Crisis Stabilization Services section of the Medicaid Provider Manual. If the provider believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the provider should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP. The PIHP is responsible for stabilization services following psychiatric hospitalization. The PIHP and MHP should closely coordinate post-crisis stabilization services for shared enrollees.	Payer responsible: Mixed, depending on service provided. The MHP is responsible for medical screening and stabilization services and any medical treatment associated with the episode of care. If after medical screening and stabilization, a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the ED should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP.	Payer responsible: Mixed, depending on service provided. The MHP is responsible for all inpatient medical treatment associated with the episode of care, with the exception of inpatient psychiatric stays (see right). If a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the hospital should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP.	Payer responsible: PIHP. The PIHP is responsible for all inpatient psychiatric stays, either in inpatient psychiatric hospitals or psychiatric beds/units within a general acute care hospital. The PIHP provides the authorization for mental health inpatient admission and is responsible for mental health inpatient admission costs, including psychiatrists' fees.	Payer responsible: PIHP for specialized services. Specialized services are those identified by the PASARR Level II and are provided or arranged by the PIHP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement, even though the PASARR process exempts individuals with a primary diagnosis of dementia. Specialized services are defined as those mental health services for residents who have a mental illness, I/DD or related condition which: 1) are of greater intensity than those normally required from a NF, 2) are provided in conjunction with usual NF services, 3) are determined through the PASARR process, 4) are provided or arranged for by the local CMHSP, *or* 5) result in the continuous and aggressive implementation of an individualized plan of care.

Medicaid Mental Health and Substance Use Disorder Payment Responsibility Grid

Setting in Which Service is Provided		
ASAM Level 1: Outpatient and ASAM Level 2: Intensive Outpatient (IOP) and High-Intensity Outpatient (HIOP)	**ASAM Level 3: Residential**	**ASAM Level 4: Inpatient**
Substance Use Disorder (SUD) Treatment Services		
Outpatient SUD Services Provided in Office-Based Setting Payer responsible: Mixed, depending on provider affiliation. • The PIHP is responsible for office-based substance use treatment (OBSUT) services delivered by providers with a specialty SUD services contract with the PIHP and eligible SUD services provided by CCBHCs. • The MHP is responsible for OBSUT services delivered by providers who do not have a specialty SUD services contract with the PIHP. **Outpatient SUD Services Provided in Medical ED** Payer responsible: MHP • The MHP is responsible for ambulatory withdrawal management and bridge MAT services provided in the ED. If the enrollee is admitted for acute medical detoxification, the ED costs are rolled into the inpatient DRG. **Outpatient SUD Services Provided in Other Settings and IOP, HIOP, and Partial Hospitalization Services** Payer responsible: PIHP **Ambulatory Withdrawal Management** Payer responsible: Mixed, depending on setting and provider affiliation. • The PIHP is responsible for ambulatory withdrawal management services provided at CCBHCs and CMHSPs. • Payment responsibility for ambulatory withdrawal management services delivered in office-based settings should follow guidance for outpatient SUD services provided in office-based settings, as described above.	**Clinically and Medically Managed Residential Treatment** Includes low intensity, population-specific high intensity, high intensity, and withdrawal management residential treatments. Payer responsible: PIHP **Nursing Facility** Payer responsible: MHP or FFS, depending on beneficiary enrollment. Services rendered for the treatment of alcohol and drug use are an ancillary service and are not included in the facility's per diem rate.	**Medically Managed Inpatient Treatment** Payer responsible: MHP, with one exception (see below). The MHP is responsible for medically managed intensive inpatient acute detox and associated potentially life-threatening substance-induced toxic conditions requiring acute medical monitoring or intervention and detoxification services in acute care settings. Medically managed inpatient or medically monitored intensive inpatient SUD services may be provided during inpatient psychiatric stays as part of treating co-occurring mental health and SUD conditions. These services are the responsibility of the PIHP and reimbursed as part of existing payment arrangements.

Medicaid Mental Health and Substance Use Disorder Payment Responsibility Grid

Setting in Which Service is Provided					
Outpatient Office (e.g., Clinic, Physician Office)	**Emergency Intervention Services and Post-Crisis Stabilization Services**	**Medical Emergency Department (ED)**	**Inpatient Acute Care Hospital**	**Inpatient Psychiatric Hospital or Inpatient Psychiatric Bed/Unit Within Acute Care Hospital** *Excludes State Psychiatric Hospitals*	**Nursing Facility**
Medical Services – Professional and Facility Services, Including Diagnostic Tests (e.g., Radiology and Laboratory Services, Including Toxicology Screening)					
Payer responsible: MHP.	Payer responsible: PIHP.	Payer responsible: MHP.	Payer responsible: MHP.	Payer responsible: Mixed, depending on service provided. The PIHP is responsible for costs related to providing a psychiatric admission, history and physical. The MHP is responsible for medical services.	Payer responsible: MHP or FFS depending on beneficiary enrollment. Ancillary services (defined in the Nursing Facility Chapter of the Medicaid Provider Manual) should be billed to the MHP or FFS based upon beneficiary enrollment.

email correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter
Subject:	Update on CFAP-related advocacy including recommendation, by CMHA, that October 1, 2024 planned CFAP implementation date be dropped
Date:	Thursday, July 25, 2024 9:45:26 AM
Attachments:	image001.png

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
Re: Update on CFAP-related advocacy including recommendation, by CMHA, that October 1, 2024 planned CFAP implementation date be dropped

As you know well, many of you, CMHA, and our allies have been working with MDHHS, over the past several years (and increasingly over the past several months) to build a Michigan-specific Conflict-Free Home and Community Based Services (HCBS) system in a way that meets CMS's Conflict-Free standards, ensures ease of access to mental health services for Michiganders, while minimizing the complexities and maximizing the efficiencies in our system.

CMHA wants to ensure that you are kept abreast of the advocacy work of CMHA, its members, and our allies. This email provides the latest status report on these efforts.

1. CMHA recommends dropping CFAP implementation date of October 1, 2024: Recognizing that a large number of CMHA member organizations have indicated that until the issues, raised below, are resolved they cannot take the steps necessary to implement CFAP-related changes by October 1, 2024. These changes include program redesign, staff layoffs, and a procurement process for outside contractors to take on PCP/Casemanagement or HCBS services by October 1, 2024.

Given this, CMHA recommended, to MDHHS, that the October 1, 2024 implementation date for the CFAP-related changes be dropped with a new date developed through the planning process outlined below and this change be announced to the field in advance of the upcoming MDHHS-CMHA meeting.

2. CMS comments: When reviewing the CMS comments relative to CMHA's CFAP proposals (you may remember seeing these comments) CMHA does not think that CMS and CMHA are very far apart relative to the requirements to retain the independence of three functions:

- HCBS eligibility determination (currently carried out by MDHHS)
- IPOS development, monitoring, and authorization (carried out by the CMHSP or its designated supports coordination/casemanagement provider organization)
- HCBS service delivery (carried out by a provider other than the organization carrying out IPOS development, monitoring, and authorization – whenever possible)

CMHA has shared this view with MDHHS and will continue to reiterate it.

3. CMHA obtains review by legal counsel: CMHA's and the National Council's DC-based legal

counsel on Medicaid managed care, Adam Falcone, has indicated that the CMS guidance document, cited above, does not refute the counter-proposal made by CMHA and its members but, instead, provides MDHHS with guidance relative the considerable discretion that Michigan has in meeting the CMS Conflict-Free standards.

4. CMHA to meet with MDHHS leadership: CMHA and the MDHHS staff leading the Department's Conflict Free Access and Planning (CFAP) development efforts are meeting next week to discuss several recommendations, made by CMHA, regarding this work. These recommendations and the context for these recommendations are captured in the excerpts, below, from CMHA's recent communication with the Department staff:

> **Preamble to CMHA recommendations:** CMHA wants to underscore, as we have in the past, that CMHA and its members are committed to the need to mitigate conflicts in the state's HCBS program. This commitment aims to ensure that organizations delivering services operate independently from those developing an Individual Plans of Service (IPOS). Such measures are essential to ensuring Michiganders have seamless access to high-quality HCBS services and supports and in ways that align closely with ongoing system innovations, including CCBHCs, Behavioral Health Homes, and Mi Kids Now.
>
> To ensure a well-designed CFAP implementation that incorporates diverse viewpoints and expertise from key stakeholders, CMHA proposes the following recommendations:
>
> A. That a **co-development group** be convened by MDHHS to work through the core CFAP design elements, with the expectation that the group complete its work within a **short time frame (several meetings within several weeks).**
>
> B. This co-development group would include the **MDHHS CFAP leadership team, the state's leading advocacy organizations, and CMHA.**
>
> C. The core CFAP design elements that this group would address include:
>
> 1. **Clarity around components required by CMS CFAP requirements**. There has been some confusion around the relevance of number of requirements outside of the separation of HCBS provider organization from IPOS development organization.
>
> 2. Mechanics as to how CFAP is to **be applied in context of other innovative models** existing in the Michigan system, such as the three below:
>
> - The requirements and mechanics as to how **CCBHCs** will integrate CCBHC requirements with CFAP requirements, given that some HCBS services are also CCBHC services and that many persons served by CCBHCs also receive HCBS services.
>
> - The requirements and mechanics as to how **Behavioral Health Home (BHH)** will integrate BHH requirements with CFAP requirements, given that many

persons served by BHHs also receive HCBS services.

- The requirements and mechanics as to how children's mental health services, within CMHSPs and provider organizations, will integrate the **Mi Kids Now/MichiCANS** requirements with CFAP requirements, given that some HCBS services are also core children's mental health services.

3. Processes for **ensuring continued HCBS service delivery during the transition to a fully CFAP compliant system** are crucial. Particularly for HCBS services exclusively provided by CMH or IPOS development organizations, identifying alternative community-based HCBS providers will require time. This transition also involves transferring individuals receiving HCBS services from CMH/IPOS organizations to new providers.

4. Mechanics as to **what constitutes a good-faith effort, by a CMH, to identify and contract with another organization to provide the HCBS services** for which the CMH or IPOS development organization is the only provider. Additionally, at what point does the failure of this good-faith effort to identify and contract with the provider organization for that HCBS service allow the CMH/IPOS development organization to be deemed compliant with or hold an exception from CFAP requirements for the relevant HCBS services.

5. CMHA measuring workforce impact of CFAP proposal of MDHHS: CMHA is polling its members to determine the number of persons who will be laid off, primarily direct care workers, if the current CFAP plan goes into effect. Those polling results are due to CMHA by Friday, July 26. The preliminary findings underscore the significant number of staff who will be laid off if the MDHHS CFAP plan goes into effect as planned.

CMHA will be using these data in our discussions with MDHHS and our allies across the state.

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

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Information on workforce impact of MDHHS CFAP approach
Date: Monday, July 29, 2024 11:40:10 AM
Attachments: image001.png
image002.png

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Information on workforce impact of MDHHS CFAP approach

As you may know, CMHA recently completed a survey of our members to determine the workforce impact of the Department's CFAP proposal. As the results of that survey, below, indicate, the impact is significant, resulting in a large number of layoffs of direct care workers and casemanagers/supports coordinators. (Thank you to the CMHA member organizations who participated in this survey.) The analysis below uses the responses from a sample of 19 CMHSPs and provider organizations and extrapolates it, conservatively to 60 organizations rather than to the larger number of CMHSPs and providers, totaling over 150.

These data have been shared, earlier today, with MDHHS leadership – the leadership with whom Alan and I are meeting to discuss the need to redesign the state's CFAP approach.

We share these data not to halt the work to ensure that Michigan is compliant with the CMS Conflict Free standards but to underscore the need for MDHHS, CMHA, and its members to work together to redesign and refine this approach, before launching a system change with an impact of this magnitude.

In summary, this study finds that if the MDHHS CFAP proposal is implemented as planned:

HCBS positions
1203 union direct care workers will lose their jobs when the HCBS work is moved out of those organizations
553 non-union direct care workers will lose their jobs when the HCBS work is moved out of those organizations

PCP development and casemanagement/supports coordination
856 union casemanagers/supports coordinators will lose their jobs when the PCP development/casemanagement/supports coordination work is moved out of those organizations
553 non-union casemanagers/supports coordinators will lose their jobs when the PCP development/casemanagement/supports coordination work is moved out of those organizations

Community Mental Health Association of Michigan

Workforce impact of MDHHS CFAP proposal

July 2024

	Community Living Supports (Group home and in-home		Respite services		Skill building		Supported/integrated employment		**Total HCBS positions**		**PCP development and casemanagement**	
	Number of persons in union positions	Number of persons in non-union positions	Number of persons in union positions	Number of persons in non-union positions	Number of persons in union positions	Number of persons in non-union positions	Number of persons in union positions	Number of persons in non-union positions	**Number of persons in union positions**	**Number of persons in non-union positions**	**Number of persons in union positions**	**Number of persons in non-union positions**
	244	105	1	47	69	11	67	12	381	175	271	80

Number of organizations responding:

19

If applied to entire CMHSP and provider system using as core number of organizations:									**Total HCBS positions**		**PCP development and casemanagement**	
60									**Number of persons**	**Number of persons**	**Number of persons**	**Number of persons**
	771	332	3	148	218	35	212	38	1203	553	856	253

Robert Sheehan
Chief Executive Officer

LOCAL NEWS

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Macomb County officials oppose state effort to reduce mental-health services reserve fund

It could cost Macomb CMH over $20 million, reduce future services

By **JAMESON COOK** | jcook@medianewsgroup.com | Macomb Daily

UPDATED: August 5, 2024 at 9:42 a.m.

Macomb County officials oppose an attempt by the state of Michigan to revise its contract with the county's Community Mental Health agency that could cost the agency millions of dollars by limiting the amount CMH can hold in reserves from its Medicaid income, including reaching back and seizing funds from prior years.

The county Board of Commissioners earlier this month passed a resolution to protest the state Department Health and Human Services seeking to change the language of its one-year contract renewal CMH, which provides an array of mental-health and substance abuse services.

CMH currently has a reserve fund of at least $43 million, but the state Department of Health and Human Services wants to alter their contract to cap CMH's Internal Services Fund for its Pre-Paid Inpatient Health Plan fund at 7.5% of its total of $269 million. That would reduce reserves to slightly over $20 million. That process, known as a "clawback," would produce a $23-million loss for Macomb CMH and make the agency more susceptible each year to swings in Medicaid income and possibly have to reduce services, CMH officials said.

Richard Carpenter, CMH's chief financial officer, said it would be irresponsible for CMH to agree to the new language and said the potential clawback may be illegal and "unenforceable" by the state.

"We are being asked to sign a contract that would give up our right to maintain this fund," Carpenter said. "Signing such a contract, I don't think would be

Instead of an "arbitary" cap, the amount that currently can be held in the reserve fund "is based on accounting principles and actuarial principles" to which CMHs across the state agree, Carpenter said.

County Commissioner Phil Kraft, who also is chair of the county CMH board, said CMH officials are alarmed by the proposed language change. Kraft a resolution on the matter at the county's board July, telling fellow commissioners it was "very important." The board approved it in a unanimous vote.

The county board's resolution says the state's proposal:

- "Erroneously implies profit driven or undue enrichment motives on the part of governmental entities instead of recognizing what is a formal transfer of governmental responsibility from the State to the Counties for the delivery of services;
- Limits the funding of the ISF to an amount that is less than what is actuarily sound" … and "is considered best practice for operating reserves of governmental entities as proposed by the Government Finance Officers Association;
- Overreaches and attempts to contractually limit its ability to operate as a PIHP and appropriately manage its risk; and
- Would (if enforceable) require MCCMH to return funding rightfully earned and retained from a prior contractual period."

DHHS said in a written response provided by spokesperson Lynn Sutfin the

Macomb County Commissione Phil Kraft speaks at a board committee last month in the county Administration Building in Mount Clemens.JAMESON COOK — THE MACOMB DAILY

"We share the goal of ensuring funding is available to provide quality services to our beneficiaries and responsible stewardship of Medicaid expenditures," DHHS officials said. "While that proposal will not be included in the initial FY25 contract, we are committed to discussing ISF rules and structure over the coming months for potential future contract changes.

"The Michigan Department of Health and Human Services appreciates feedback from the Pre-Paid Inpatient Health Plans on the FY2025 revisions to the Internal Service Fund section of the contract."

Upon learning about the proposal, Sheriff Anthony Wickersham expressed concern because his office works with the agency in responding to and treating county residents with mental-health and substance-abuse issues. He noted the societal trend is to increase services to people with those issues.

"Any reduction in mental-health services is ridiculous," Wickersham said. "Now is not a good time to be talking about reducing mental-health services."

He said any reduction will "increase problems in our community and in the jail

The centerpiece of the new $229-million jail replacement and expansion project is the new four-level Central Intake and Assessment Center to improve the delivery of treatment of those arrested and in need of services.

Macomb's concerns are supported by the Lansing-based Community Mental Health Association, said association CEO Robert Sheehan, who agreed a 7.5% cap would be too low.

"We're surprised and disappointed the state wants to cap it (the reserve fund)," Sheehan said in an interview. "The problem with capping it at 7.5% is that after one bad year … there would be no funds for the following year," thereby forcing agencies to cut services.

He said there should be an "actuarily sound rate" at around 15%.

The proposed new language could effect the 10 PIHPs/Community Mental Health agencies covering the state. Officials at two of the other agencies — Region 10 that is composed of Genesee, Lapeer, St. Clair, Sanilac counties, as well as the Upper Peninsula Health Plan — also have passed a resolution in opposition, Sheehan said.

The contract would apply for the state's fiscal year 2025, which starts Oct. 1.

CMH is one of the largest entities in the county, with a budget of over $270 million and employment roll of over 350.

Carpenter and CMH Interim CEO Traci Smith said while the $43 million in reserve may appear to be a large sum of money to provide services, that is not the case.

"Over the past three or four yeas have been relatively good years and we have put money into that reserve so that when the bad years come, we will have enough money," Carpenter said.

Macomb CMH is flush with funds due to Medicaid premiums increasing dramatically from 2020 to 2023 when the state did not remove anyone from Medicaid due to the COVID-19 pandemic. However, the state ended that policy in July 2023, forcing Medicaid recipients to reapply.

Already, in one year the number of Medicaid enrollees in Macomb County dropped by 23.4%, from 264,548 enrollees to 202,516 enrollees last June, thereby reducing Medicaid (PHIP) revenues, which originate from the federal government

Most of CMH's patrons are at 130% of the federal poverty level or below, but the agency also serves those above that level.

CMH served about 18,000 people last year, officials said.

U.S. Sen. Debbie Stabenow listens to staff at Macomb County Community Mental Health explain the workings of their Certified Community Behavioral Health Clinic in August 2023. MACOMB DAILY FILE PHOTO

Officials said there is no immediate concern for a reduction of services.

"We are ultimately going to ensure the provision of services for Macomb County residents in some shape or form. We want this come to a resolution as soon as possible," Smith said.

But there is concern for the future.

"We're in the process where everybody is falling off Medicaid, and we are still in the midst of that process," Carpenter said. "We do not know where the bottom is. Until eligibility stabilizes, the amount of revenue that we're receiving will likely continue to decline.

"We have this dichotomy of reducing revenue while service costs are going up, and we don't know when that's going to stop. This funding would be that safety net, backstop" to ensure continuing services.

The needs of our patients, the needs of consumers are not declining. If anything, with the opioid epidemic, with the levels of anxiety and other mental illnesses, some caused by the pandemic, some caused by other factors in the community, it's causing demand for services to go up."

Smith mentioned the continuing issue of a high number of opioid addictions in the county.

"The community is hurting, and the level of crisis is increasing," she said.

In addition to services to address mental-health and substance-abuse issue, CMH provides services to children with emotional disturbances, those who are developmentally disabled, those in a crisis situation, those with autism, veterans for navigation of services and those in need of general health care, among others.

Originally Published: August 5, 2024 at 9:40 a.m.

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

Subject: Neuro-psych testing
Date: Wednesday, August 14, 2024 9:31:23 AM

Dear Plan Partners,

MDHHS is providing this email as a clarification of payment responsibility to both PIHPs and MHPs specific to Behavioral and Psychological Services and Neuropsychological Screening or Testing (also referred to as Neuro-psych testing).

This clarification is needed as there are current access to care issues impacting beneficiaries. The goal is to provide guidance to plans and providers on payment responsibility and remove access to care barriers. As this is a clarification and not a retroactive change of any kind, there should not be recoupments as a result, but focus on responsibility moving forward. Expect that there will a Provider Alert following this communication and that the Medicaid Provider Manual will be updated in October with the following language as well.

In relation to Behavioral Health Services:

“Regarding neuropsychiatric testing, the Medicaid Health Plan is responsible for screening by the primary care provider (PCP). The PIHP is responsible for testing, assessment and/or evaluation. If results of the completed testing, assessment and/or evaluation do not determine the need for specialty behavioral health services for serious emotional disturbance (SED) or intellectual/developmental disabilities (I/DD)/Autism, the member should be referred back to the PCP for treatment or subsequent referral to the appropriate practitioner in the MHP network.”

Meghan E. Groen
Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health & Human Services

• Walk a Mile in My Shoes •

Mental Health Matters

RALLY

Tuesday, September 17, 2024

12:30 PM - 3:00 PM • State Capitol Building • Lansing

• MICHIGAN STATE CAPITOL • 110 N CAPITOL AVE, LANSING MI 48933 •

NMRE Day of Education

Season of Change:

Educational Summit on Substance Use Recovery and Prevention

Friday, September 20, 2024 from 9:30 am – 3:30 pm at Treetops Resort, Gaylord, MI

KEYNOTE SPEAKER:

Tobias Neal, MComm, ThM, Peer Recover Supports Coordinator

Northern Michigan Substance Abuse Services

EDUCATION AND ACTIVITIES:

PEER RECOVERY
KNOWING YOUR RIGHTS
NMRE PARTNERSHIP PRESENTATIONS
DOOR PRIZES
SWAG

Please register before September 13, 2024 at
https://www.eventbrite.com/e/982115422667?aff=oddtdtcreator or scan the QR Code.

Space is limited!

If you are in need of assistance to register, please call NMRE Customer Service at 1-833-285-0050.

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – AUGUST 14, 2024
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Connie Cadarette, Ann Friend, Kevin Hartley, Chip Johnston, Nancy Kearly, Eric Kurtz, Inna Mason, Allison Nicholson, Donna Nieman, Brandon Rhue, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

REVIEW AGENDA & ADDITIONS
No additions to the meeting agenda were requested.

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

MOTION BY KEVIN HARTLEY TO APPROVE THE MINUTES OF THE JULY 10, 2024 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

MONTHLY FINANCIALS
June 2024

- Net Position showed net deficit Medicaid and HMP of $3,486,255. Carry forward was reported as $11,624,171. The total Medicaid and HMP Current Year Surplus was reported as $8,137,916. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $28,714,072.
- Traditional Medicaid showed $156,096,777 in revenue, and $154,804,307 in expenses, resulting in a net surplus of $1,292,470. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $845,073.
- Healthy Michigan Plan showed $21,396,955 in revenue, and $26,130,730 in expenses, resulting in a net deficit of $4,778,725. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $10,779,098.
- Health Home showed $2,321,538 in revenue, and $2,031,456 in expenses, resulting in a net surplus of $290,082.
- SUD showed all funding source revenue of $22,355,333 and $20,522,585 in expenses, resulting in a net surplus of $1,832,748. Total PA2 funds were reported as $5,028,902.

PA2/Liquor Tax was summarized as follows:

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

Actual FY24 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,220,509	$1,218,276	$1,409,885	$5,028,902

Donna asked whether others have heard any discussions about pushing out the remainder of the $116M allocated in the April rate adjustment to the CMHSPs/PIHPs. Eric responded that Bob Sheehan was told that a rate adjustment is being worked on but is not certain. Deanna noted that eligibles continue to drop. Donna compared Centra Wellness' eligibles pre-pandemic (October 2019) to current and found them to be relatively close. Eric said that he suspects that the HSW payment glitch is a far broader issue than HSW. The issues of individuals on HSW being placed on spenddowns (and payments not sent to PIHPs when spenddowns are met) and the introduction of Plan First will factor into FY25 rates.

MOTION BY CONNIE CADARETTE TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JUNE 2024; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

<u>EDIT UPDATE</u>

The minutes from July 18th were included in the meeting materials.

- Pursuant to the Telemedicine chapter of the Medicaid Provider Manual (Section 2.2A), all telemedicine providers must have the capability to provide reasonably frequent in-person periodic evaluations.
- The 97151 (15minutes) code was developed for ABA by a behavioral analyst. For this reason, the U5 modifier is not needed. The 96127 (brief emotional/behavioral assessment), 96156 (health behavior assessment or reassessment), were suggested for use in other situations. Staff credentials for 97151 will need to be updated to show that the code is for use by BCBAs only.
- An update was made to the General Rules for Reporting tab to include language to define Indirect Costs to read: "Per the Same-Time Services Reporting tab, there are times when it is permissible that time could be reported as indirect. This means that an encounter is not submitted for this, and the cost is accounted as indirect service costs. The provider staff is still being paid **by the employer and the indirect cost should be built into the service rate** that is reimbursed by the CMHSP and/or PIHP."
- Individuals/beneficiaries are allowed to sleep while receiving respite services.
- Inpatient tiered rate reporting was delayed to October 1, 2024.
- Only Community Living Suports (H2015) and Respite (T1005) services that begin and end in the beneficiary's home (place of service/location code 12) require EVV. Currently SIP settings are not exempt from the EVV (although congregate settings are exempt).
- The Period 2 EQI template should fix the issue with H2023 (individual and group modifiers should not be allowed on the same encounter).
- Feedback was requested regarding the following Crisis Codes & Provider Qualifications:
  - Update to the definition of a Crisis Professional as it relates to H2011/HT (crisis intervention services/multi-disciplinary team).
  - BSWs working within their scope of practice related to T1023 (screening to determine if an individual is appropriate for participation in a program, project, or treatment protocol).
  - The addition of an ET modifier to code H0038 (Peer-Directed and Operated Support Services) to indicate Emergency Services.
  - The use of G0140 & G0146 (Principal Wellness Navigation – Peer Support).

Donna commented that she heard the 15-minute H2015 code for CLS may be going away in favor of the H0043 per diem code. Eric responded that he heard the same from Belinda Hawks during the PIHP CEO meeting on August 1st, although there has not been an official confirmation. If the change is made, timely communication is essential due to the calculations and contract updates that the CMHSPs will need to make. Brandon reached out to the statewide EVV Leads Workgroup to inquire about whether others have heard anything concrete about the code change; he will share any feedback he receives with the group.

EQI UPDATE

The Period 2 (October 1, 2023 through May 31, 2024) EQI report is due September 30th. The group agreed to a data pull date of September 3rd. Tricia requested reports from the Boards by September 20th. Required tabs were stated as: Attestations, Medicaid Service UNC, Non-Benefits Expenses, and Other Expenses; other tabs are optional. Tricia will notify the Boards following the next EQI meeting on September 12th if anything changes regarding the tabs or instructions.

ELECTRONIC VISIT VERIFICATION (EVV)

A subgroup of the regional Business Intelligence and Technology (BIT) has been assembled to collaborate on September 3rd EVV implementation. The workgroup consists of membership from the NMRE and the 5 member CMHSPs across several disciplines (Finance, IT, and Provider Network/Contracts).

LOCAL MATCH

The Quarter 4 local match payment is due to MDHHS August 16th. Kevin noted that Northern Lakes already made the Quarter 4 payment.

HSW UPDATE

The region was at 100% utilization of its 689 slots for the month of July. There are five open slots for August with 5 packets pending approval. Once approved, the region should receive full payment for August.

Missing spenddown payments/CHAMPS Issue

The NMRE continues to report missing payments to the department monthly. Payment data received earlier on this date showed $83K in backpay (Feb – July 2024). Deanna noted that changes to residential living codes used to be made once a year; they are now occurring more frequently. Tricia agreed to send the detailed August activity information to the CMHSPs.

PRELIMINARY FSR DUE TO MDHHS AUGUST 15TH

Preliminary Financial Status Reports were due to the NMRE August 9th. Four of the member CMHSPs are overspending PMPM. Deanna is reviewing Medicaid expenditures & revenue, HMP, Behavioral Health Home, local match and PBIP to populate NMRE report. The FSR shows FY24 revenue within $2M of FY23 revenue.

FY24 REVENUE

April 1st rates & PMPM Update

Deanna shared a summary of the impact of the April rate adjustment on PMPM through September 2024.

Total PMPM FY24 Projections

MA/SED/CWP	HMP	HSW	Total	
$68,813,531	$7,151,871	$27,560,089	$103,525,491	October – March Actual
$11,776,454	$1,135,596	$4,811,262	$17,723,313	April Actual
$11,533,697	$1,091,952	$4,618,333	$17,243,983	May Actual
$11,161,602	$1,027,000	$4,614,689	$16,803,291	June Actual
$10,956,285	$973,476	$4,730,110	$16,659,871	July Actual
$22,520,356	$2,145,583	$9,162,170	$33,828,108	August – Sept Projected
$136,761,926	13,525,478	$55,496,653	$205,784,057	Total Revised as of July 2024
			$204,895,685	Original FY24 PMPM Budget
			$888,372	Increase

Actual PMPM Paid to All Boards

	FY23 Last 10 Months	FY24 First 10 Months	Increase (Decrease)
Medicaid	$115,442,995	$114,241,570	($1,201,425)
HMP	$16,889,317	$11,379,896	($5,509,421)
HSW	$38,147,318	$46,334,483	$8,187,165
Total	$170,479,630	$171,955,949	**$1,476,319**

OTHER

General Funds

Connie reported that Northeast Michigan is out of General Funds; she asked what can be done if others in the region don't have any GF to give. Chip responded that local funds would have to be used. Erinn added that process can be implemented to limit the use of GF dollars. Chip agreed, stating that general funds use can be limited to inpatient first, and then broadened. Another solution could be a short-term loan. Eric said that, at the end of the day, it ends up coming out of the fund balance. Erinn noted that AuSable Valley saw a big swing in GF spending in the last quarter. Eric acknowledged that the NMRE is having the same issue with SUD block grant funds. Brian indicated that North Country may have a small surplus in GF that can be shared.

Eric reiterated that the glitch identified with HSW payments is likely indicative of a larger problem. Individuals on HMP have been shown to be on spenddowns.

Eric questioned whether the NMRE, because it has the powers and duties of a CMH, could be a repository for excess general funds for use in times such as this.

Personal Care in AFC

Erinn asked about changes to the regional boilerplates that remove personal care from AFC contracts. Chip explained that the increase in Social Security payment that an individual receives when they go into foster care is intended to cover the costs of personal care. Services over and above what has been agreed to with LARA, should be billed as CLS.

Under 1915(b) and 1915(b)(3) services, the state must show cost neutrality, meaning the cost of the service (CLS) in the residential placement must be commensurate with the cost of the same service that would have been furnished in an institutional setting. To meet this, the Department

created Personal Care (T1020) to lower the cost of CLS. The Medicaid Provider Manual, however, states that Personal Care cannot be paid with Medicaid when the individual's Social Security is intended to cover these services. The only time a CMHSP should pay for Personal Care is when the individual doesn't have Social Security; the CMHSP must then work to get the individual on Social Security. Eric noted that under very rare circumstances it can be allowed on a temporary basis. The State's original plan was to create a per diem paid to Specialized Residential providers.

The (privately owned) AFC home also receives a model payment "kicker" of $300 per month – now called an Adult Services Authorized Payment (ASAP), in addition to the Social Security payment. The ASAP is intended to augment Social Security rates because Social Security rates are far below those of private pay rates.

For individuals who need "extra care" placed in AFC homes, the CMHSP must notify MDHHS to stop the ASAP payment; the CMHSP must then negotiate with the homeowner for a rate above what the individual receives for Personal Care from Social Security. Contracts should address staffing that is above what is required by licensing. In that scenario, the CMHSP should only be paying for CLS.

Eric agreed to follow up with Belinda Hawks regarding a memorandum he sent in October 2023 on this topic.

NEXT MEETING

The next meeting was scheduled for September 11th at 10:00AM.

Chief Executive Officer Report

August 2024

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

July 24: Attended and participated in NMRE Internal Operations Committee Meeting.

Aug 1: Attended and participated in PIHP CEO/MDHHS Meeting.

Aug 6: Attended and participated in PIHP CEO Meeting.

Aug 9: Attended and participated in NMRE Internal Operations Committee Meeting.

Aug 14: Attended and participated in NMRE Regional Finance Committee Meeting.

Aug 20: Chaired NMRE regional Operations Committee Meeting.

Aug 21: Attended and participated in federal HSAG review.

Aug 27: Plan to attend PIHP CEO PIHP contract discussion.

Northern Michigan Regional Entity

June 2024 Finance Report

June 2024 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	1,292,470	845,073	13,510,136
Healthy Michigan	(4,778,725)	10,779,098	7,066,020
	$ (3,486,255)	$ 11,624,171	$ 20,576,156

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	487,540	1,619,617	(3,185,795)	(3,221,006)	(321,137)	1,767,155	(632,630)	$ (3,486,255)
Carry Forward		-	-	-	-	-	-	11,624,171
Total Med/HMP Current Year Surplus	487,540	1,619,617	(3,185,795)	(3,221,006)	(321,137)	1,767,155	(632,630)	$ 8,137,916
Medicaid & HMP Internal Service Fund								20,576,156
Total Medicaid & HMP Net Surplus								$ 28,714,072

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2023 through June 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 150,887,379	$ 5,209,398						$ 156,096,777
CMHSP Distributions	(144,889,658)		47,946,588	38,694,330	24,154,837	21,093,677	13,000,226	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	5,997,721	5,209,398	47,946,588	38,694,330	24,154,837	21,093,677	13,000,226	156,096,777
Expense								
PIHP Admin	2,059,214	46,243						2,105,456
PIHP SUD Admin		66,668						66,668
SUD Access Center		28,854						28,854
Insurance Provider Assessment	1,354,727	31,434						1,386,161
Hospital Rate Adjuster	2,091,164							2,091,164
Services		3,275,293	48,799,829	40,863,185	24,254,727	18,745,280	13,187,689	149,126,003
Total expense	5,505,105	3,448,492	48,799,829	40,863,185	24,254,727	18,745,280	13,187,689	154,804,307
Net Actual Surplus (Deficit)	$ 492,617	$ 1,760,906	$ (853,241)	$ (2,168,855)	$ (99,890)	$ 2,348,397	$ (187,463)	$ 1,292,470

Notes

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

Medicaid Savings - $845,073

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2023 through June 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 13,018,517	$ 8,378,438						$ 21,396,955
CMHSP Distributions	(10,406,420)		3,783,998	3,086,503	1,313,358	1,363,084	859,478	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	2,612,097	8,378,438	3,783,998	3,086,503	1,313,358	1,363,084	859,478	21,396,955
Expense								
PIHP Admin	212,327	114,247						326,574
PIHP SUD Admin		164,712						164,712
SUD Access Center		71,287						71,287
Insurance Provider Assessment	142,010	77,531						219,541
Hospital Rate Adjuster	2,262,836							2,262,836
Services		8,091,950	6,116,551	4,138,653	1,534,605	1,944,326	1,304,645	23,130,730
Total expense	2,617,173	8,519,727	6,116,551	4,138,653	1,534,605	1,944,326	1,304,645	26,175,680
Net Surplus (Deficit)	$ (5,076)	$ (141,289)	$ (2,332,553)	$ (1,052,150)	$ (221,247)	$ (581,242)	$ (445,167)	$ (4,778,725)

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

Net Surplus (Deficit) MA/HMP	**$ 487,540**	**$ 1,619,617**	**$ (3,185,795)**	**$ (3,221,006)**	**$ (321,137)**	**$ 1,767,155**	**$ (632,630)**	**$ (3,486,255)**
Medicaid/HMP Carry Forward								**11,624,171**
Total Med/HMP Current Year Surplus								$ 8,137,916
Medicaid & HMP ISF - based on current FSR								**20,576,156**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 28,714,072**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2023 through June 30, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 602,029		513,298	305,564	232,293	194,903	473,451	$ 2,321,538
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	602,029	-	513,298	305,564	232,293	194,903	473,451	2,321,538
Expense								
PIHP Admin	27,907							27,907
BHH Admin	26,957							26,957
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	257,083		513,298	305,564	232,293	194,903	473,451	1,976,592
Total expense	311,947	-	513,298	305,564	232,293	194,903	473,451	2,031,456
Net Surplus (Deficit)	$ 290,082	$ -	$ -	$ -	$ -	$ -	$ -	$ 290,082

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2023 through June 30, 2024

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 5,209,398	$ 8,378,438	$ 2,939,394	$ 4,418,217	$ 1,409,886	$ 22,355,333
Expense						
Administration	112,911	278,959	88,774	133,491		614,134
OHH Admin			62,357	-		62,357
Access Center	28,854	71,287	-	25,178		125,318
Insurance Provider Assessment	31,434	77,531	-			108,965
Services:						
Treatment	3,275,293	8,091,950	2,575,134	2,857,980	1,409,886	18,210,243
Prevention	-	-	-	873,247	-	873,247
ARPA Grant	-	-	-	528,321	-	528,321
Total expense	3,448,492	8,519,727	2,726,265	4,418,217	1,409,886	20,522,585
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 1,760,906	$ (141,289)	$ 213,129	$ -	$ -	$ 1,832,748

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

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

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 150,887,379	$ 5,209,398	$ -	$ 156,096,777
Medicaid Savings	845,073	-	-	845,073
Healthy Michigan	13,018,517	8,378,438	-	21,396,955
Healthy Michigan Savings	10,779,098	-	-	10,779,098
Health Home	2,321,538	-	-	2,321,538
Opioid Health Home	-	2,939,394	-	2,939,394
Substance Use Disorder Block Grant	-	4,418,217	-	4,418,217
Public Act 2 (Liquor tax)	-	1,409,885	-	1,409,885
Affiliate local drawdown	502,754	-	-	502,754
Performance Incentive Bonus	478,660	-	-	478,660
Miscellanous Grant Revenue	-	3,335	-	3,335
Veteran Navigator Grant	48,028	-	-	48,028
SOR Grant Revenue	-	1,465,479	-	1,465,479
Gambling Grant Revenue	-	101,306	-	101,306
Other Revenue	47	-	6,081	6,128
Total operating revenue	178,881,094	23,925,452	6,081	202,812,627
Operating expenses				
General Administration	2,569,236	469,664	-	3,038,900
Prevention Administration	-	88,426	-	88,426
OHH Administration	-	62,357	-	62,357
BHH Administration	26,957	-	-	26,957
Insurance Provider Assessment	1,496,737	108,965	-	1,605,702
Hospital Rate Adjuster	4,354,000	-	-	4,354,000
Payments to Affiliates:				
Medicaid Services	146,539,915	3,275,293	-	149,815,208
Healthy Michigan Services	15,038,780	8,091,950	-	23,130,730
Health Home Services	1,976,592	-	-	1,976,592
Opioid Health Home Services	-	2,575,134	-	2,575,134
Community Grant	-	2,857,980	-	2,857,980
Prevention	-	784,821	-	784,821
State Disability Assistance	-	-	-	-
ARPA Grant	-	528,321	-	528,321
Public Act 2 (Liquor tax)	-	1,409,886	-	1,409,886
Local PBIP	2,011,358	-	-	2,011,358
Local Match Drawdown	446,112	-	-	446,112
Miscellanous Grant	-	3,335	-	3,335
Veteran Navigator Grant	48,028	-	-	48,028
SOR Grant Expenses	-	1,465,479	-	1,465,479
Gambling Grant Expenses	-	101,306	-	101,306
Total operating expenses	174,507,715	21,822,917	-	196,330,632
CY Unspent funds	4,373,379	2,102,535	6,081	6,481,995
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	3,058,071	5,220,509	20,576,156	28,854,736
Unspent funds - ending	$ 7,431,450	$ 7,323,044	$ 20,582,237	$ 35,336,731

Northern Michigan Regional Entity

Statement of Net Position

June 30, 2024

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 50,145,316	$ 5,772,258	$ 20,582,237	$ 76,499,811
Accounts Receivable	4,172,110	2,887,385	-	7,059,495
Prepaids	106,007	-	-	106,007
Total current assets	54,423,433	8,659,643	20,582,237	83,665,313
Noncurrent Assets				
Capital assets	9,615	-	-	9,615
Total Assets	54,433,048	8,659,643	20,582,237	83,674,928
Liabilities				
Current liabilities				
Accounts payable	46,733,246	1,336,599	-	48,069,845
Accrued liabilities	268,318	-	-	268,318
Unearned revenue	34	-	-	34
Total current liabilities	47,001,598	1,336,599	-	48,338,197
Unspent funds	$ 7,431,450	$ 7,323,044	$ 20,582,237	$ 35,336,731

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 140,814,531	$ 150,887,379	$ 10,072,848	7.15%
Carryover	11,400,000	-	845,073	845,073	-
Healthy Michigan					
Capitation	19,683,372	14,762,529	13,018,517	(1,744,012)	(11.81%)
Carryover	5,100,000	-	10,779,098	10,779,098	0.00%
Health Home	1,451,268	1,088,451	2,321,538	1,233,087	113.29%
Affiliate local drawdown	594,816	446,112	502,754	56,642	12.70%
Performance Bonus Incentive	1,334,531	1,334,531	478,660	(855,871)	(64.13%)
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	82,503	48,028	(34,475)	(41.79%)
Other Revenue	-	-	47	47	0.00%
Total operating revenue	227,426,695	158,528,657	178,881,094	20,352,437	12.84%
Operating expenses					
General Administration	3,591,836	2,672,942	2,569,236	103,706	3.88%
BHH Administration	-	-	26,957	(26,957)	0.00%
Insurance Provider Assessment	1,897,524	1,423,143	1,496,737	(73,594)	(5.17%)
Hospital Rate Adjuster	4,571,328	3,428,496	4,354,000	(925,504)	(26.99%)
Local PBIP	1,737,753	-	2,011,358	(2,011,358)	0.00%
Local Match Drawdown	594,816	446,112	446,112	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	68,787	48,028	20,759	30.18%
Payments to Affiliates:					
Medicaid Services	176,618,616	132,463,962	146,539,915	(14,075,953)	(10.63%)
Healthy Michigan Services	17,639,940	13,229,955	15,038,780	(1,808,825)	(13.67%)
Health Home Services	1,415,196	1,061,397	1,976,592	(915,195)	(86.23%)
Total operating expenses	208,177,013	154,794,794	174,507,715	(19,712,921)	(12.73%)
CY Unspent funds	$ 19,249,682	$ 3,733,863	4,373,379	$ 639,516	
Transfers in			-		
Transfers out			-	174,507,715	
Unspent funds - beginning			3,058,071		
Unspent funds - ending			$ 7,431,450	4,373,379	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 3,508,974	$ 5,209,398	$ 1,700,424	48.46%
Healthy Michigan	11,196,408	8,397,306	8,378,438	(18,868)	(0.22%)
Substance Use Disorder Block Grant	6,467,905	4,850,928	4,418,217	(432,711)	(8.92%)
Opioid Health Home	3,419,928	2,564,946	2,939,394	374,448	14.60%
Public Act 2 (Liquor tax)	1,533,979	511,326	1,409,885	898,559	175.73%
Miscellanous Grants	4,000	3,000	3,335	335	11.17%
SOR Grant	2,043,984	1,532,988	1,465,479	(67,509)	(4.40%)
Gambling Prevention Grant	200,000	150,000	101,306	(48,694)	(32.46%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	21,519,468	23,925,452	2,405,984	11.18%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	766,935	469,664	297,271	38.76%
Prevention Administration	118,428	88,821	88,426	395	0.44%
Insurance Provider Assessment	113,604	85,203	108,965	(23,762)	(27.89%)
Medicaid Services	3,931,560	2,948,670	3,275,293	(326,623)	(11.08%)
Healthy Michigan Services	10,226,004	7,669,503	8,091,950	(422,447)	(5.51%)
Community Grant	2,074,248	1,555,686	2,857,980	(1,302,294)	(83.71%)
Prevention	634,056	475,542	784,821	(309,279)	(65.04%)
State Disability Assistance	95,215	71,413	-	71,413	100.00%
ARPA Grant	-	-	528,321	(528,321)	0.00%
Opioid Health Home Admin	-	-	62,357	(62,357)	0.00%
Opioid Health Home Services	3,165,000	2,373,750	2,575,134	(201,384)	(8.48%)
Miscellanous Grants	4,000	3,000	3,335	(335)	(11.17%)
SOR Grant	2,043,984	1,532,988	1,465,479	67,509	4.40%
Gambling Prevention	200,000	150,000	101,306	48,694	32.46%
PA2	1,533,978	511,326	1,409,886	(898,560)	(175.73%)
Total operating expenses	25,222,653	18,232,837	21,822,917	(3,590,080)	(19.69%)
CY Unspent funds	$ 4,322,183	$ 3,286,631	2,102,535	$ (1,184,096)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			5,220,509		
Unspent funds - ending			$ 7,323,044		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 1,441,359	$ 1,398,490	$ 42,869	2.97%
Fringes	666,212	475,218	447,372	27,846	5.86%
Contractual	683,308	512,487	444,472	68,015	13.27%
Board expenses	18,000	13,500	15,828	(2,328)	(17.24%)
Day of recovery	14,000	14,000	12,705	1,295	9.25%
Facilities	152,700	114,525	107,756	6,769	5.91%
Other	135,804	101,853	142,613	(40,760)	(40.02%)
Total General Admin	$ 3,591,836	$ 2,672,942	$ 2,569,236	$ 103,706	3.88%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 502,752	$ 377,064	$ 195,103	$ 181,961	48.26%
Fringes	145,464	109,098	43,018	66,080	60.57%
Access Salaries	220,620	165,465	93,788	71,677	43.32%
Access Fringes	67,140	50,355	31,530	18,825	37.38%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	56,250	82,527	(26,277)	(46.71%)
Board expenses	5,000	3,753	4,130	(377)	(10.05%)
Day of Recover	-	-	-	-	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	4,950	19,568	(14,618)	(295.31%)
Total operating expenses	$ 1,082,576	$ 766,935	$ 469,664	$ 297,271	38.76%

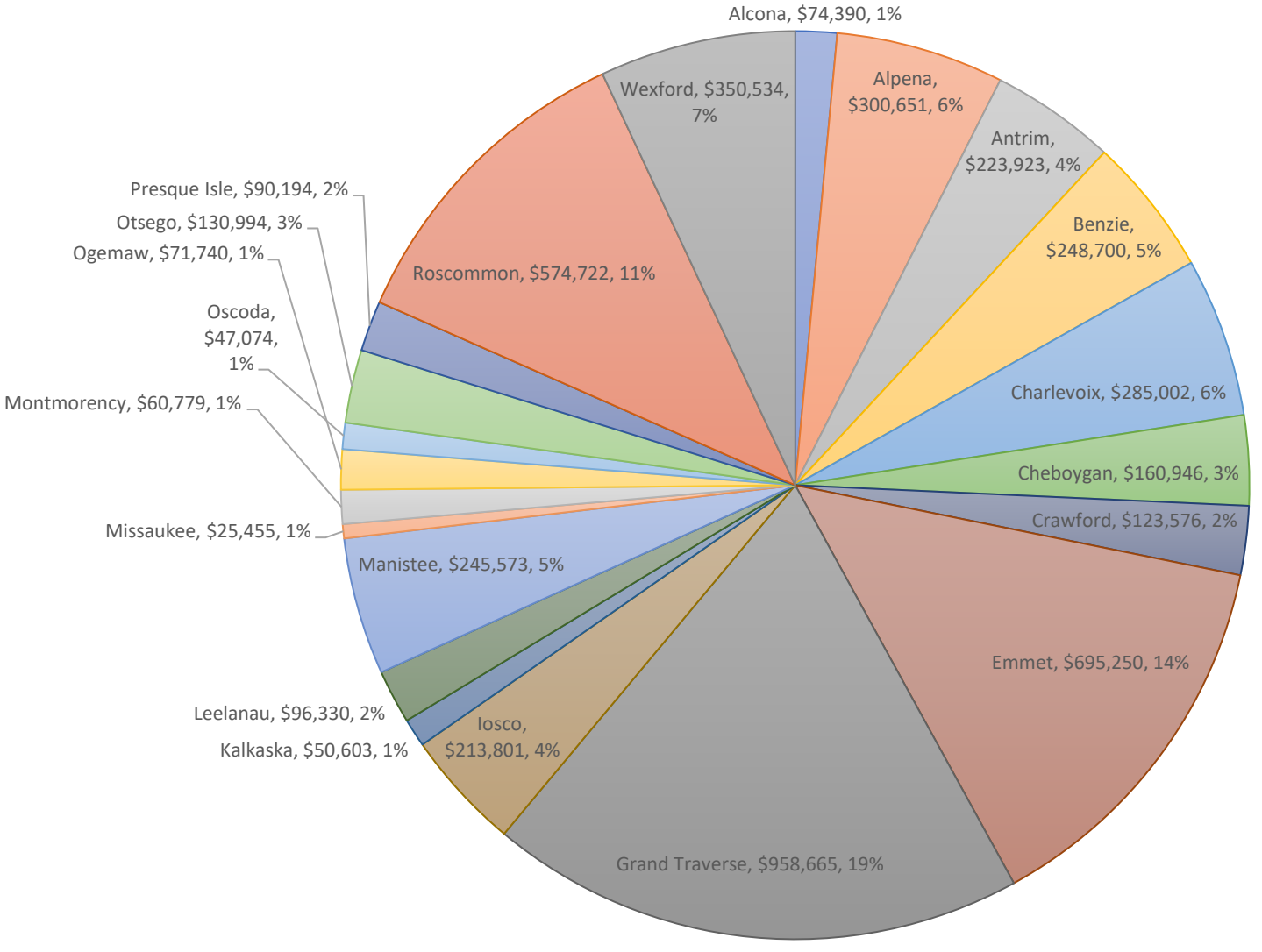
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2023 through June 30, 2024

	Projected FY24 Activity				Actual FY24 Activity			
	Beginning Balance	FY24 Projected Revenue	FY24 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 79,250	$ 23,184	$ 47,690	$ 54,744	$ 15,179	18,651	$ 1,388	$ 74,390
Alpena	302,452	80,118	115,089	267,482	53,588	51,571	3,818	300,651
Antrim	212,068	66,004	72,490	205,582	47,112	32,134	3,124	223,923
Benzie	224,046	59,078	21,930	261,194	42,226	15,215	2,357	248,700
Charlevoix	336,031	101,224	272,367	164,889	70,558	118,081	3,506	285,002
Cheboygan	163,153	84,123	141,260	106,016	56,397	55,202	3,403	160,946
Crawford	107,533	36,525	20,706	123,352	23,879	5,972	1,865	123,576
Emmet	771,608	181,672	478,053	475,227	120,667	192,574	4,452	695,250
Grand Traverse	1,035,890	440,668	524,017	952,541	306,142	371,053	12,314	958,665
Iosco	253,083	83,616	190,357	146,341	55,614	91,521	3,375	213,801
Kalkaska	42,471	41,470	34,179	49,762	27,568	17,071	2,365	50,603
Leelanau	86,055	62,190	51,029	97,215	42,087	28,907	2,905	96,330
Manistee	204,938	83,138	24,985	263,090	54,400	10,489	3,276	245,573
Missaukee	17,521	21,128	5,832	32,818	14,742	4,796	2,012	25,455
Montmorency	51,302	31,822	21,810	61,313	19,996	9,278	1,241	60,779
Ogemaw	96,797	74,251	96,041	75,006	45,369	67,612	2,814	71,740
Oscoda	55,406	20,578	38,064	37,920	14,291	21,511	1,112	47,074
Otsego	125,550	96,172	101,106	120,616	69,298	60,562	3,291	130,994
Presque Isle	96,731	25,177	85,120	36,788	16,474	21,295	1,716	90,194
Roscommon	559,806	82,157	87,287	554,676	57,591	39,470	3,205	574,722
Wexford	398,819	100,198	166,138	332,880	65,096	108,918	4,463	350,534
	5,220,509	1,794,492	2,595,550	4,419,450	1,218,276	1,341,881	68,004	5,028,902
PA2 Redirect								-
								5,028,902

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2023 through June 30, 2024

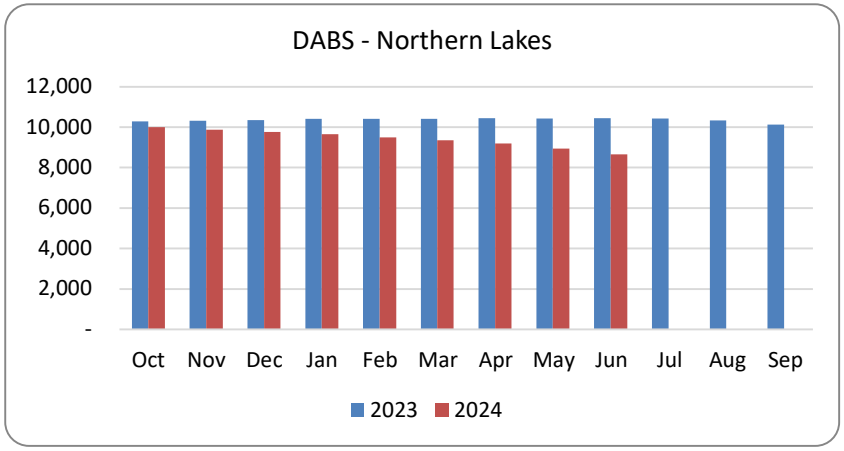
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	5,625	6,081	456	8.11%
Total operating revenue	7,500	5,625	6,081	456	8.11%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 5,625	6,081	$ 456	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,576,156		
Unspent funds - ending			$ 20,582,237		

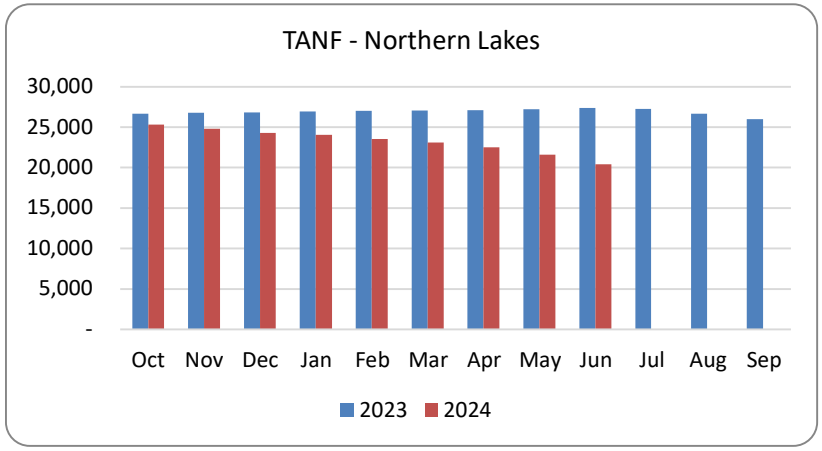
Northern Michigan Regional Entity

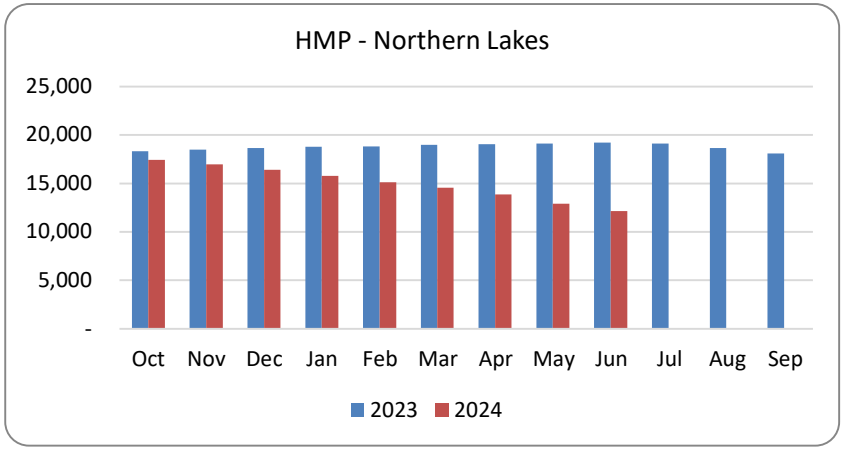
Narrative

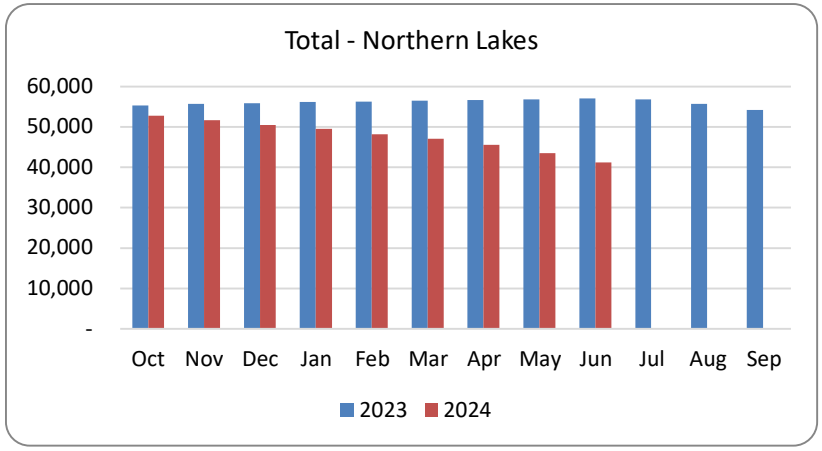
October 1, 2023 through June 30, 2024

Northern Lakes Eligible Members Trending - based on payment files







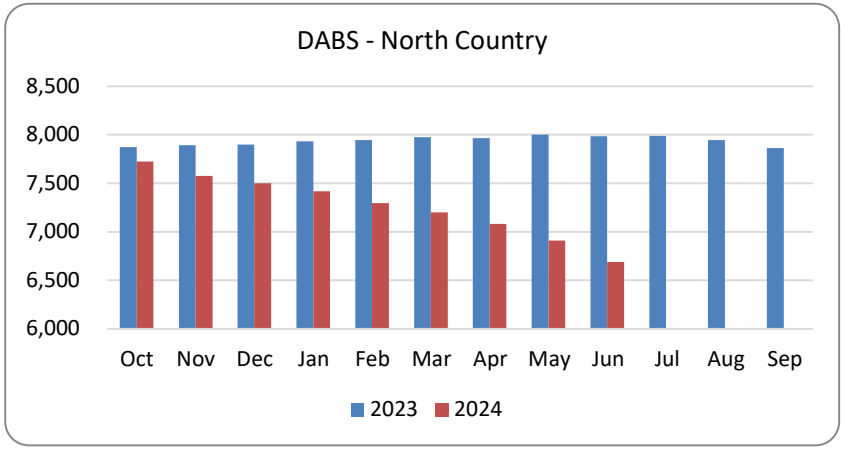


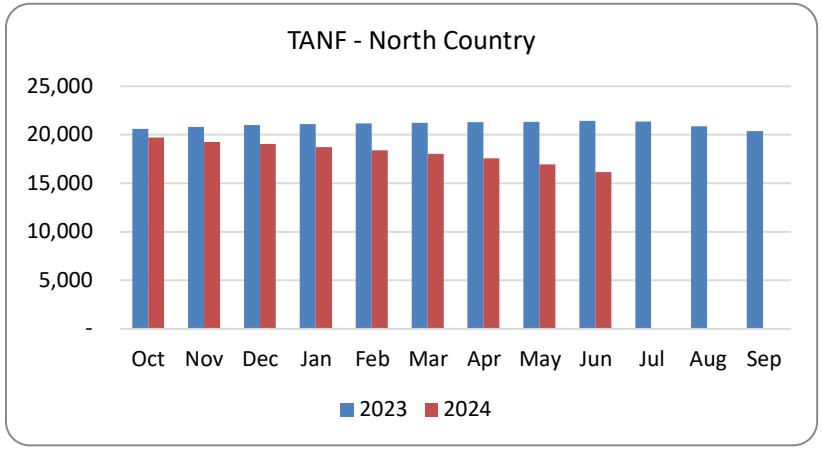
Northern Michigan Regional Entity

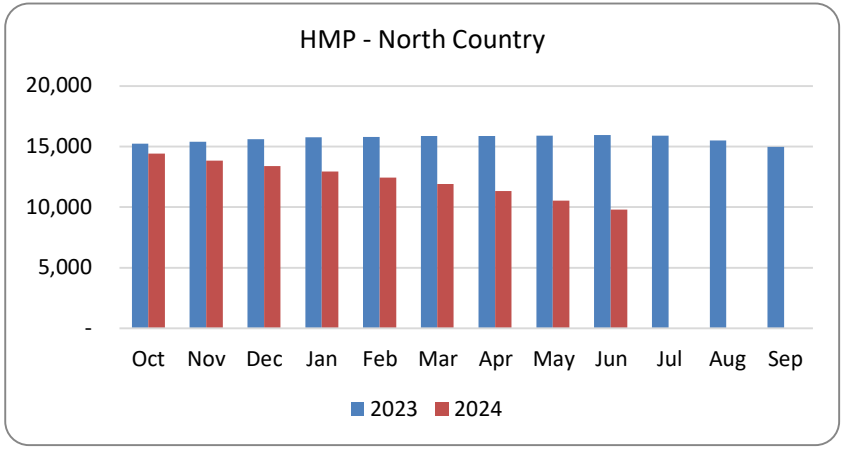
Narrative

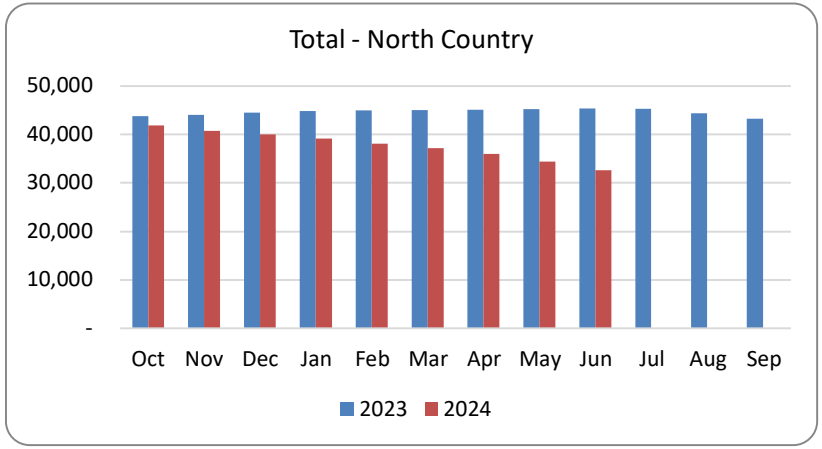
October 1, 2023 through June 30, 2024

North Country Eligible Members Trending - based on payment files







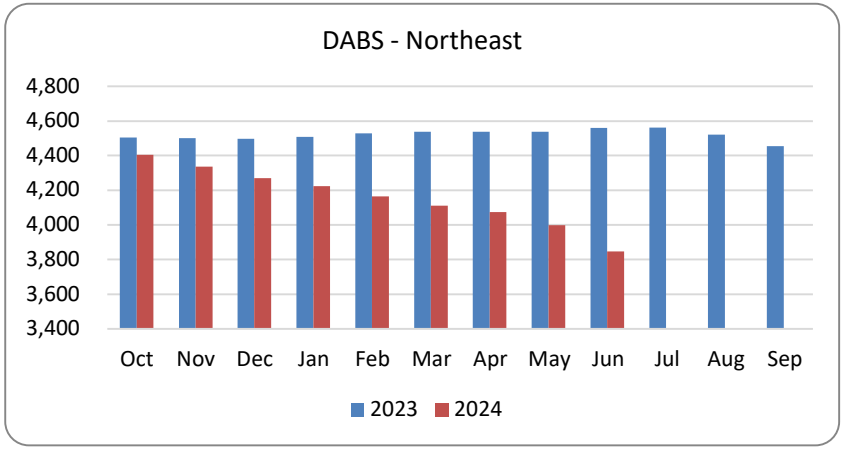


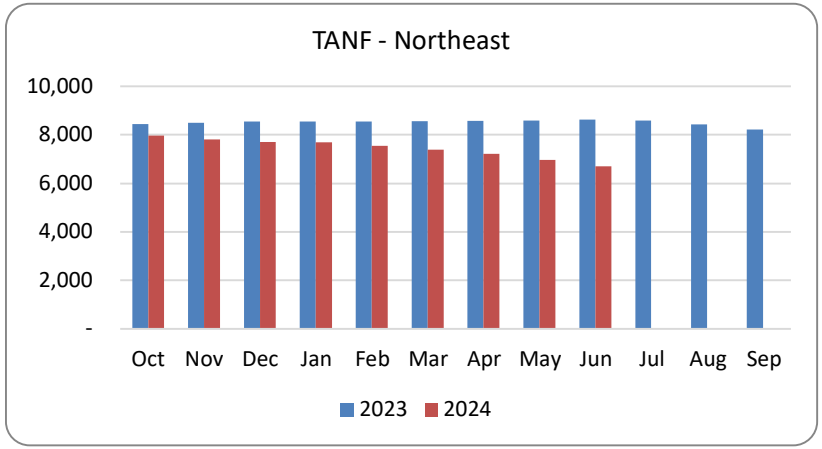
Northern Michigan Regional Entity

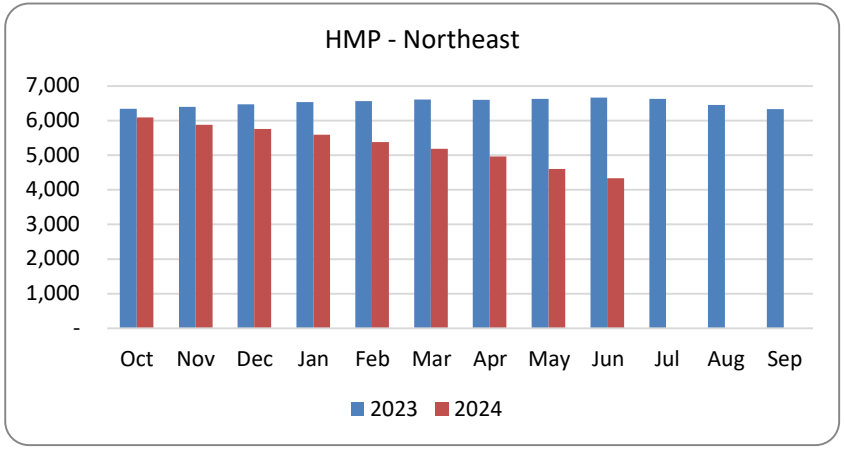
Narrative

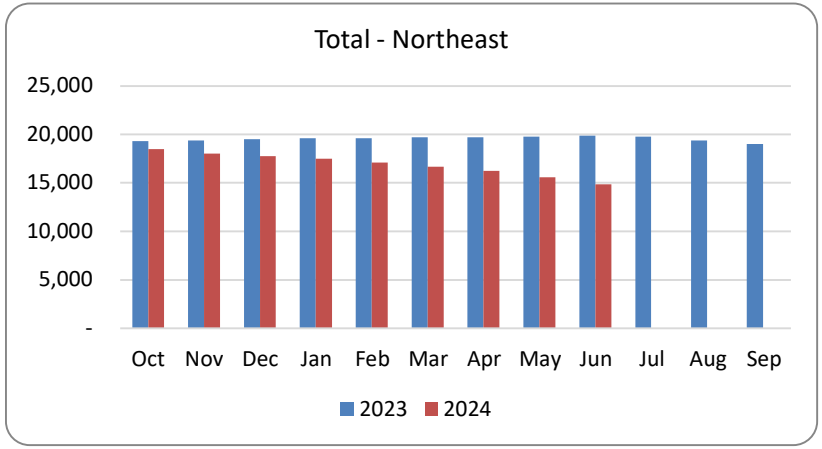
October 1, 2023 through June 30, 2024

Northeast Eligible Members Trending - based on payment files







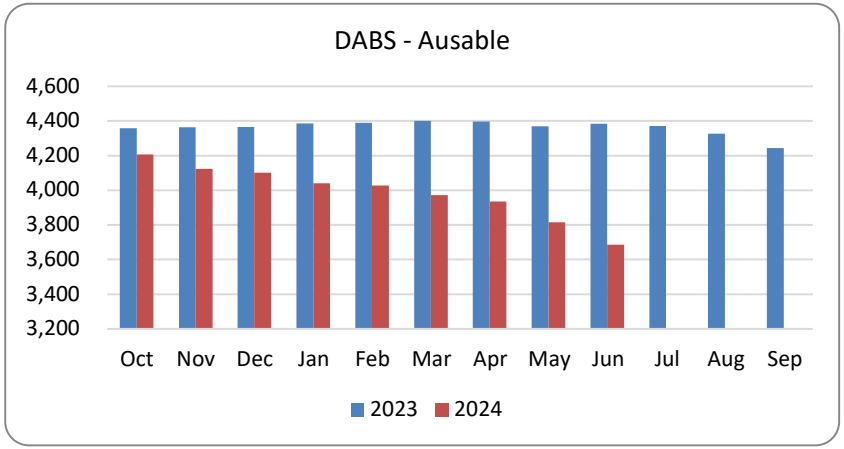


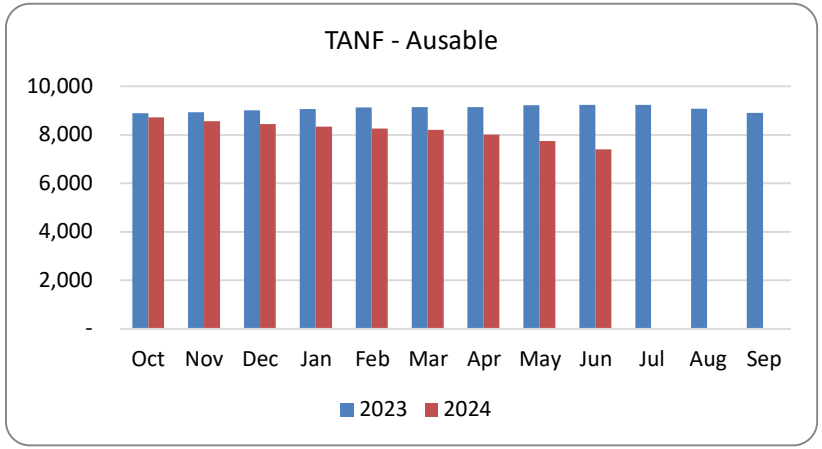
Northern Michigan Regional Entity

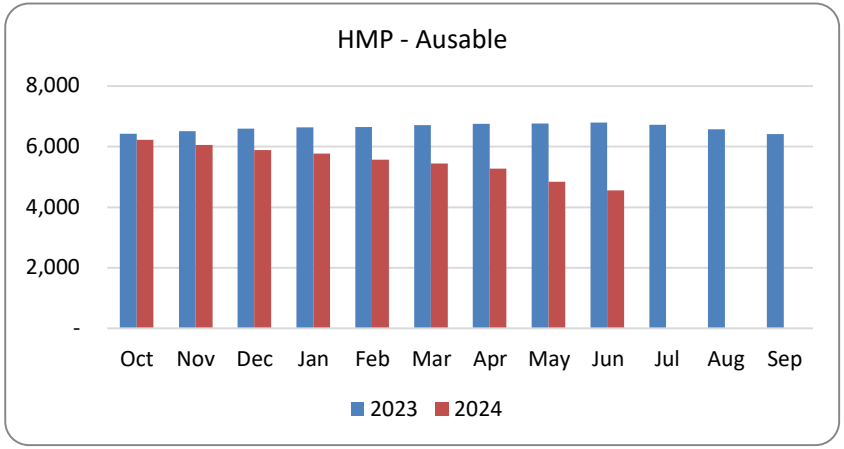
Narrative

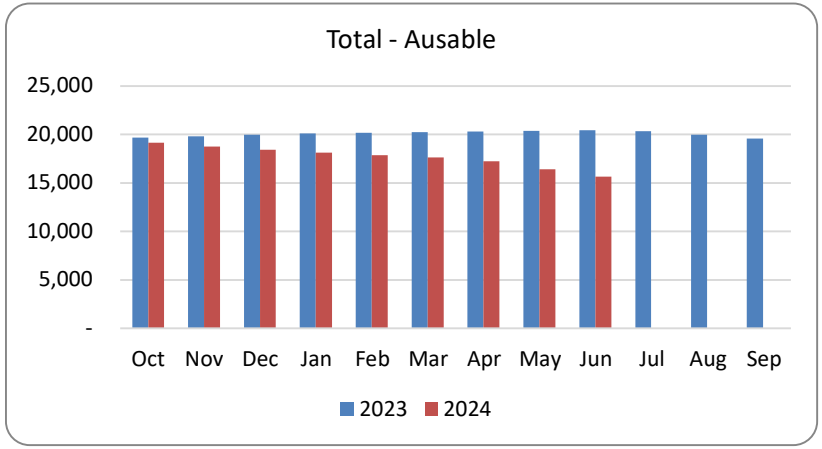
October 1, 2023 through June 30, 2024

Ausable Valley Eligible Members Trending - based on payment files







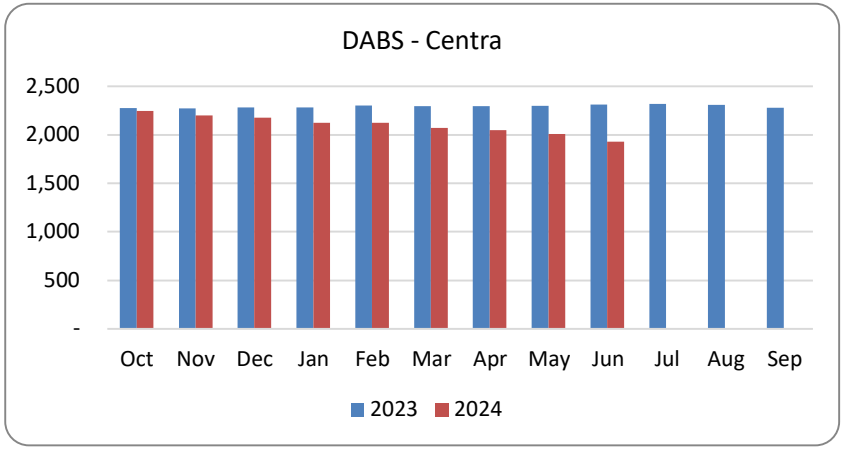


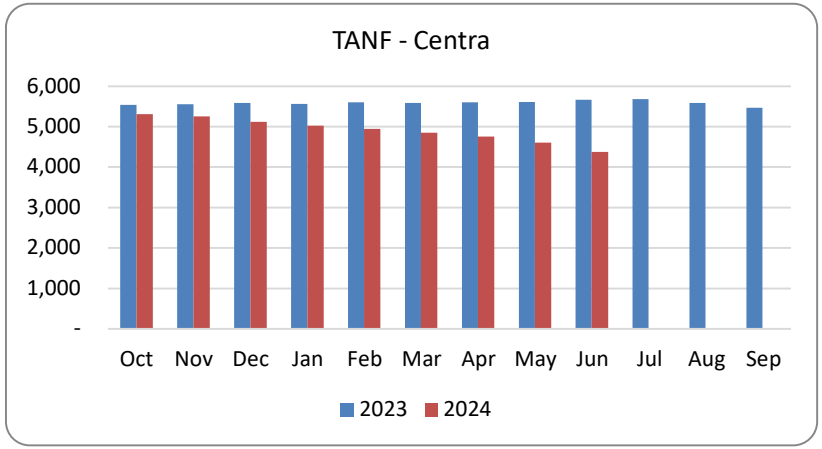
Northern Michigan Regional Entity

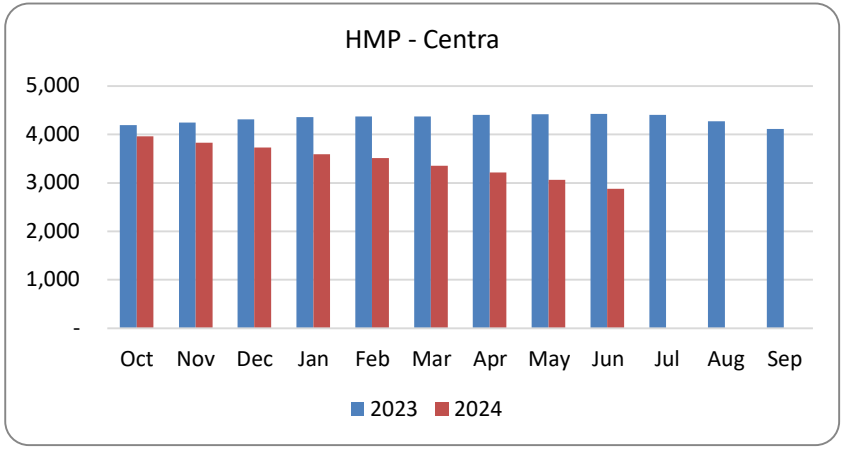
Narrative

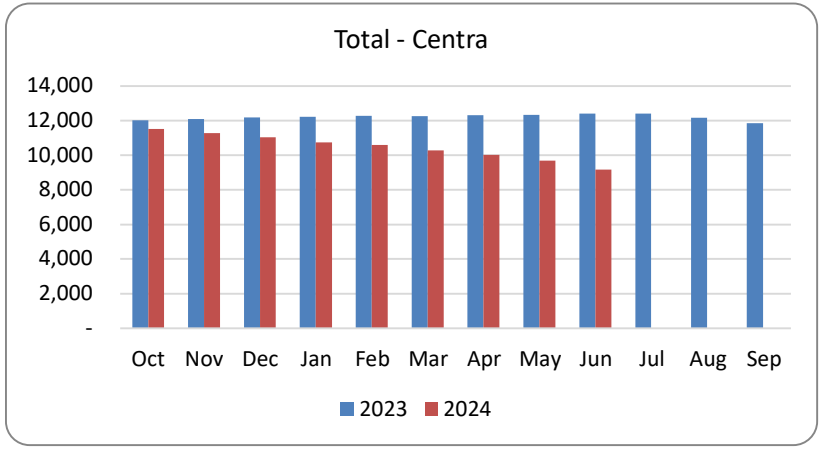
October 1, 2023 through June 30, 2024

Centra Wellness Eligible Members Trending - based on payment files







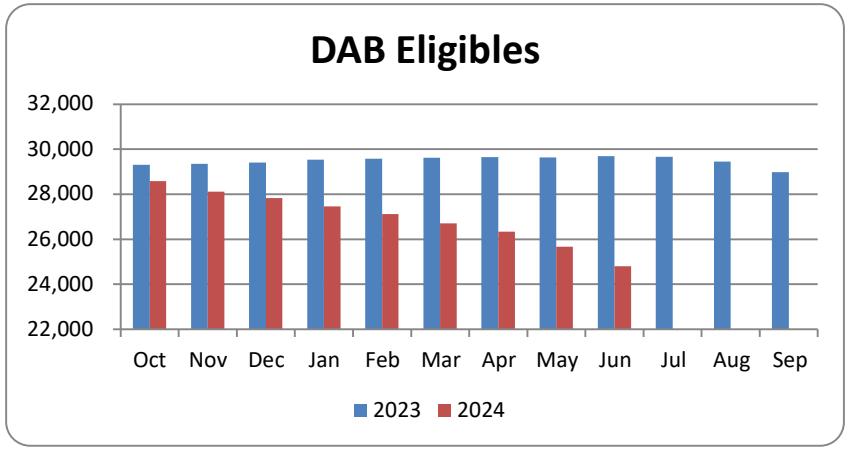


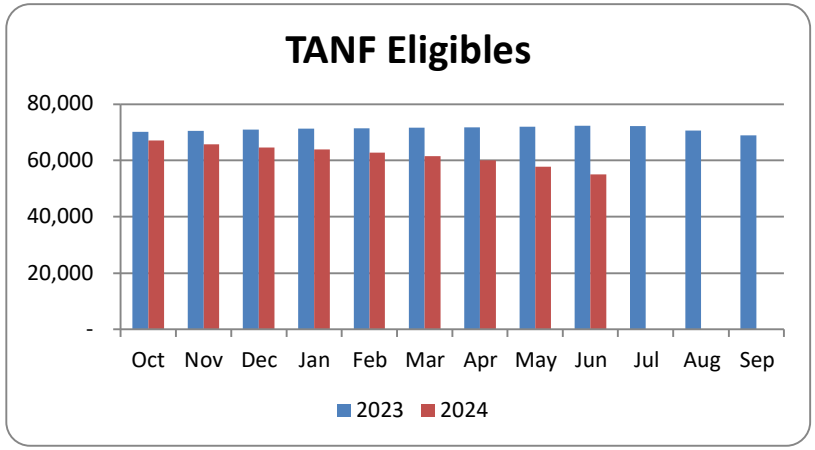
Northern Michigan Regional Entity

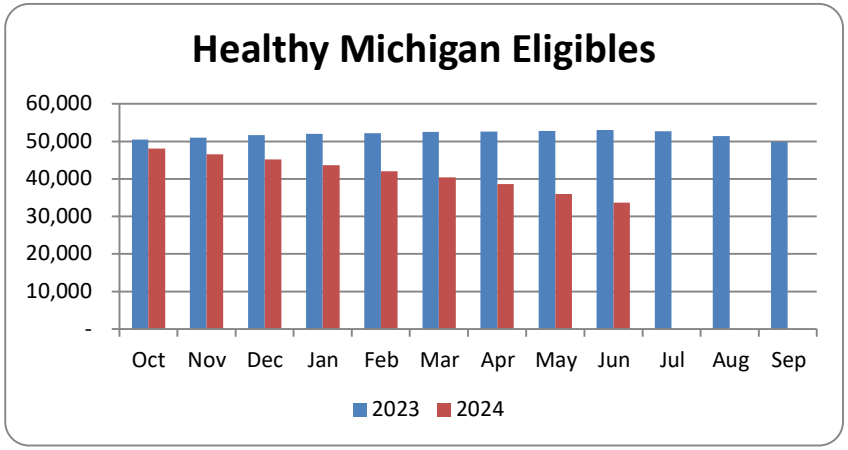
Narrative

October 1, 2023 through June 30, 2024

Regional Eligible Trending





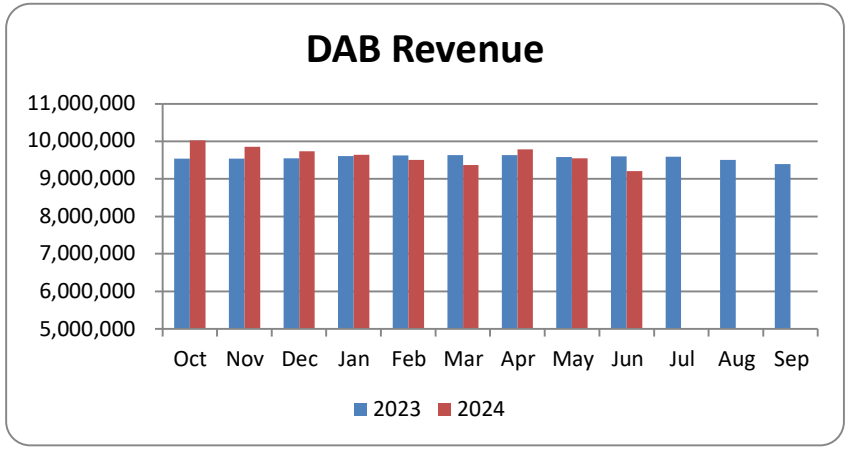


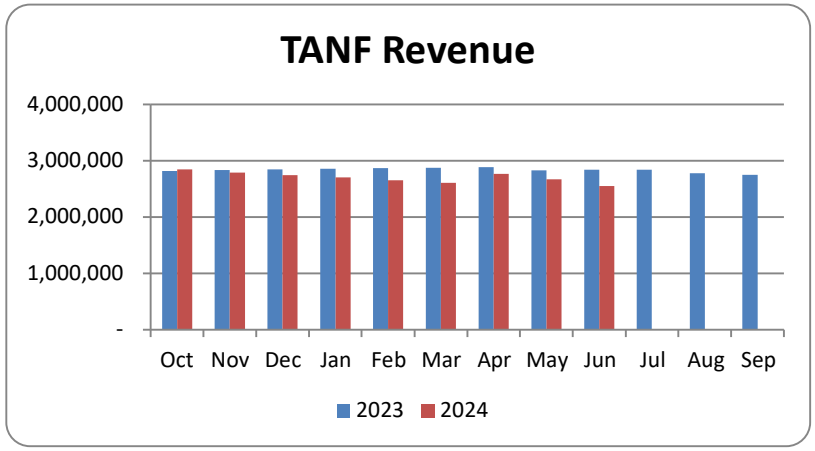
Northern Michigan Regional Entity

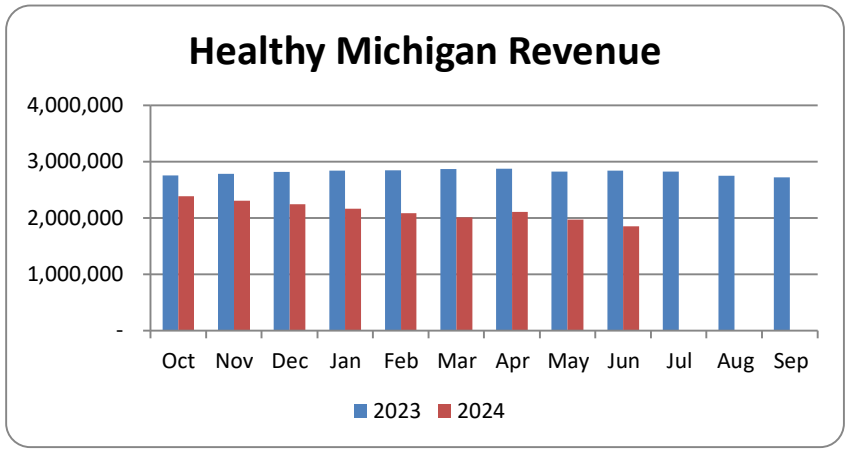
Narrative

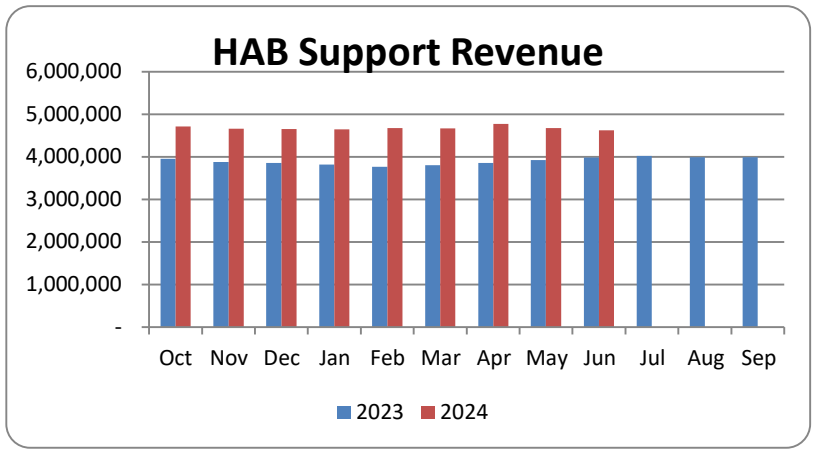
October 1, 2023 through June 30, 2024

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – AUGUST 20, 2024
GAYLORD CONFERENCE ROOM

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

REVIEW OF AGENDA AND ADDITIONS

Mr. Babbitt requested that a discussion about FY25 spending be added to the meeting agenda.

APPROVAL OF PREVIOUS MINUTES

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

MOTION BY DIANE PELTS TO APPROVE THE JULY 16, 2024 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY CHIP JOHNSTON. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

June 2024

- Net Position showed net deficit Medicaid and HMP of $3,486,255. Carry forward was reported as $11,624,171. The total Medicaid and HMP Current Year Surplus was reported as $8,137,916. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $28,714,072.
- Traditional Medicaid showed $156,096,777 in revenue, and $154,804,307 in expenses, resulting in a net surplus of $1,292,470. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $845,073.
- Healthy Michigan Plan showed $21,396,955 in revenue, and $26,130,730 in expenses, resulting in a net deficit of $4,778,725. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $10,779,098.
- Health Home showed $2,321,538 in revenue, and $2,031,456 in expenses, resulting in a net surplus of $290,082.
- SUD showed all funding source revenue of $22,355,333 and $20,522,585 in expenses, resulting in a net surplus of $1,832,748. Total PA2 funds were reported as $5,028,902.

It was noted that four of the Member CMHSPs (all but AuSable Valley) are overspending Medicaid. All five Member CMHSP are overspending HMP. The region will be tapping into carryforward dollars to cover the deficit.

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

FY24 Revenue Outlook
Mr. Kurtz has been told there will be no additional FY24 revenue adjustment. Even with the April rate adjustment, NMRE FY24 revenue has declined $3M compared to FY23.

General Funds and NMRE Block Grant
Four of the Member CMHSPs (all but North Country) are depleted of general funds. North Country is transferring $75K each to AuSable Valley, Northeast Michigan, and Northern Lakes.

A concept, first brought up in October 2021, was revisited due to the current state of general funds. Mr. Kurtz raised the notion of the CMHSPs transferring unspent general funds to the NMRE to hold in a special fund account. The NMRE would act as a repository and set the funds aside for CMHSP use. It was noted that permission from the state is needed to do a 236 transfer. The suggestion was made to amend the Operating Agreement to allow the NMRE to pool excess general funds.

Because a PIHP has all the powers and duties of a CMHSP, Mr. Kurtz asserted that 236 transfers should be allowed. Section 330.1236 of the Mental Health Code states in part:

> "At intervals during the year, the department shall review the expenditures of each community mental health services program, and if the department determines that funds that have been allocated to a program are not needed by that program, the department may, with the concurrence of the board, withdraw the funds. Funds so withdrawn may be reallocated by the department to other community mental health services programs."

Clarification was made that for a PIHP to use general funds to cover Medicaid, carry forward and internal service funds must both be exhausted.

Similar to the issue the CMHSPs are having with general funds, the NMRE has exhausted its SUD block grant allocation. Liquor tax funds will be needed to supplement block grant funding for SUD treatment services. The NMRE is working to reduce the need for block grant funds by potentially moving some Residential Room & Board costs to Medicaid. Mr. Kurtz will review waiver and IMD authorities more closely.

FY25 Spending
Mr. Kurtz reported that he is not anticipating any rate increase for FY25. Mr. Babbitt noted that the Medicaid and HMP overspend will likely be greater in FY25 than FY24. Until rates are appropriately adjusted, the region could end up spending well into the Internal Service Fund (ISF). Mr. Kurtz acknowledged that at some point, risk-based contracts (with the CMHSPs) may need to be considered.

<u>ALPINE CRU</u>
In October 2021, the decision was made to financially support the creation of an adult crisis residential unit in the NMRE 21-county region at a cost of up to $2,000,000 for two years. The Alpine CRU opened in Gaylord in March 2023. The NMRE agreed to pay 1/12th of the facilities operating costs beginning September 2023 for a period of one year. Current utilization and the

ongoing sustainability of the facility were discussed. Mr. Johnston voiced support for continuing the current funding arrangement for an additional year.

PIHP/CMHSP 24 CONTRACT

The NMRE/CMHSP Network Agreements were revised for FY24. The agreements contain language related to service obligations and delegated functions. Mr. Johnston explained that Megan Rooney, CEO of NorthCare Network, took NMRE's boilerplate and separated it into two separate agreements: 1) Service Contract and 2) Managed Care Contract. Mr. Johnston proposed the same for the NMRE and its CMHSPs. Mr. Kurtz said that he needs to do a thorough review of the documents but is in favor of the split. Amendments will likely be issued to extend the current contracts for 30-days prior to the new contracts taking effect.

FY25 PIHP CONTRACT

An updated version of the FY25 PIHP Contract was sent from MDHHS on August 15th. Among several changes pertaining to Certified Community Behavioral Health Clinics (CCBHC), language has been updated related to the Waskul Settlement Agreement to read: "Contractor must comply with all terms and conditions of the Waskul Settlement Agreement once it is approved, and all contingencies have been met." No changes to the ISF language occurred and there has been no memo pertaining to the willingness to negotiate further in FY 25.

Mr. Kurtz indicated that he is still hesitant to sign the Contract in its current form.

EVV AND H0043

Mr. Kurtz learned during the PIHP CEO meeting on August 1st that the 15-minute H2015 code for CLS may be going away in favor of the H0043 per diem code, although there has not been an official announcement. Follow-up from MDHHS confirmed that MDHHS is finalizing details of utilizing the H0043 CLS per diem code to be effective on October 1, 2024, with specific parameters on when it can be used.

PC/CLS TRAINING

Mr. Johnston has been educating staff in the region about the use of Community Living Supports (vs. Personal Care) in specialized residential settings. Mr. Johnston explained that the increase in Social Security payment that an individual receives when they go into foster care, in addition to the Adult Services Authorized Payment (ASAP) "kicker" that the provider receives, is intended to cover the costs of personal care. Additional staffing for services over and above what is required by licensing should be billed as CLS. The Medicaid Provider Manual states that Personal Care cannot be paid with Medicaid when the individual's Social Security is intended to cover these services. The only time a CMHSP should pay for Personal Care is when the individual doesn't have Social Security (in which case the CMHSP should work to get the individual enrolled), and on a temporary basis in very rare circumstances. The State's original plan was to create a per diem paid to Specialized Residential providers.

NEURO-PSYCH TESTING

When determining the necessity of Neuropsychiatric testing, the screening conducted by the Primary Care Physician (PCP) falls under the responsibility of the Medicaid Health Plan (MHP). The Prepaid Inpatient Health Plan (PIHP) is accountable for the testing, assessment, and evaluation

processes. If the results of the testing, assessment, or evaluation indicate that the beneficiary does not require specialty behavioral health services, the beneficiary may be referred to the PCP for treatment with the appropriate practitioner within the MHP network.

HSW SLOTS

The region was at 100% utilization of its 689 slots for the month of July. There are five open slots for August with 5 packets pending approval. Once approved, the region should receive full payment for August.

The NMRE continues to report missing HSW payments to the department monthly. Payment data received on August 17th showed $83K in backpay (Feb – July 2024).

INPATIENT RATES

NMRE Provider Network Manager, Chris VanWagoner, shared hospital rate requests for FY25.

BCA Stonecrest

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult Psychiatric Inpatient	$785.00	$808.55	3%
Enhanced 1:1 Staffing	$1,040.00	$1,071.20	3%

Cedar Creek

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult Psychiatric Inpatient	$1,075.00	$1,150.25	7%
Partial Hospitalization	$440.00	$470.80	7%
Enhanced 1:1 Staffing		$100 surcharge on per diem	NA

Forest View

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult and Child Psychiatric Inpatient	$1,078.35	$1,110.70	3%
Partial Hospitalization	$481.27	$495.71	3%

Havenwyck

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult Psychiatric Inpatient	$970.00	$999.01	3%
Adolescent Psychiatric Inpatient	$970.00	$999.01	3%
Partial Hospitalization	$427.00	$439.81	3%

Healthsource Saginaw

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult R&B All Inclusive	$1,050.00	$1,113.00	6.0%

McLaren Health System

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult Psychiatric Inpatient	$1,007.00	$1,037.21	3%
Partial Hospitalization	$504.00	$519.12	3%

MyMichigan Health

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult Psychiatric Inpatient	$1,073.00	$1,115,92	4%
Partial Hospitalization	$614.00	$638.56	4%

Trinity St. Mary's

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult Psychiatric Inpatient	$1,200.15	$1,296.16	8%
Partial Hospitalization	$511.35	$552.26	8%
ECT	$845.25	$878.80	4%

Trinity Muskegon

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult R&B All Inclusive	$1,050.00	$1,134.00	8%

UP Health System – Marquette

	FY24 Rate	Proposed FY25 Rate	% Increase
Adult Psychiatric Inpatient	$662.00	$695.00	5%
ECT	$675.00	$675.00	No Change

The decision was made not to include 1:1 rates in the contracts but to access this enhanced staffing level by Single Case Agreements. Single Case Agreements will also be used for admissions to Up Health System.

MOTION BY DIANE PELTS TO APPROVE FISCAL YEAR 2025 HOSPITALS RATE REQUESTS THAT DO NOT EXCEED A THREE PERCENT INCREASE FROM THE PREVIOUS YEAR'S RATE; SUPPORT BY NENA SORK. MOTION CARRIED.

The hospital rates approved during the meeting were for BCA Stonecrest, Forest View, Havenwyck, and McLaren Health Systems. Other hospital rates may be automatically approved if the amounts represent an increase of not more than 3% from the previous year's rate.

NLCMHA UPDATE

Mr. Kurtz and attorney Steve Burnham have communicated with the received forensic investigation team and some "draft" preliminary information has been received.

Mr. Kurtz indicated he plans to meet with the NLCMHA Board Chair over the next few weeks. This is unrelated to the forensic investigation.

OTHER

Mr. Johnston suggested that 1st and 3rd party revenues be omitted as "revenue" in the Medicaid and Healthy Michigan pages of the regional Financial Report. This recommendation will be shared with NMRE Chief Financial Officer, Deanna Yockey.

NEXT MEETING

The next meeting was scheduled for September 17th at 9:30AM in Gaylord.

email correspondence

From: Harrison, Julie (DHHS)
Subject: FY25 PIHP Contract Release
Date: Thursday, August 15, 2024 2:01:29 PM
Importance: High

SENDING ON BEHALF OF LAURA KILFOYLE

Greetings PIHPs,

Tomorrow you will receive the final version of the FY25 PIHP Contract from the Bureau of Grants and Purchasing for your signature. In preparation for that release, we wanted to provide additional context to the changes you'll see since you last reviewed the document on July 26.

In response to the feedback you provided at the July 26 contract negotiations meeting, and additional feedback provided to the CCBHC team, MDHHS has revised the CCBHC section of the FY25 PIHP contract template. Attached to this email you'll find a redlined version of the contract which specifically addresses the changes. Also, please find additional context for the entirety of FY25 CCBHC language here:

- States have flexibility to establish utilization management requirements for managed care plans to follow. Beyond State requirements, PIHPS have an obligation to conduct utilization management under Federal Medicaid Managed care rules.
- As a participant in the federal CCBHC demonstration, MDHHS is responsible for ensuring that the State and its CCBHCs meet the demonstration requirements.
- The intent of the CCBHC program is to promote access to comprehensive behavioral health services at the time of first contact. Per the SAMHSA CCBHC guidance, "All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs."
    - To ensure that the State is complying with these CCHBC requirements and promote accessibility of services consistent with Medicaid Managed Care rules, MDHHS is requiring that individuals who present at a CCBHC for services obtain screening and risk assessment to determine acuity of needs from that CCBHC, without being referred to a PIHP "access center" before obtaining CCBHC

services.
    - These requirements apply only to the nine core CCBHC services; PIHPs may continue to conduct screening and referral through their access centers for individual who request other non-CCBHC behavioral health services.
- MDHHS is committed to ensuring appropriate use of Medicaid and other funds, including funds that support the CCBHC program. These new requirements do not remove the need for CCBHCs and PIHPs to determine medical necessity for services. CCBHCs should only provide and refer members to medically necessary services based on mental health assessment results and person-centered planning process. PIHPs will have oversight over this process through retrospective review.
- PIHPs will confirm that the services rendered were medically necessary.

Another change from the version that you saw on July 26 is a revision to the Waskul Settlement Agreement. This language has been updated to: "Contractor must comply with all terms and conditions of the Waskul Settlement Agreement once it is approved, and all contingencies have been met."

Finally, MDHHS will be issuing a feedback document which outlines PIHP feedback and MDHHS responses to the Coordinating Agreement and the Medicaid Mental Health and Substance Use Disorder Payment Responsibility Grid. Thank you for your feedback regarding those two documents.

We appreciate your continued collaboration. Please respond with additional information as needed.

Best,
Laura

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