Northern Michigan Regional Entity

Board Meeting

November 24, 2021

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
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11.	New Business	
	a. PA2 Requests – Budgets are posted to nmre.org	
	b. CHS Coalition Updated Budget Amounts	Page 81
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12.	Old Business	
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13.	Presentation/Discussion	
	Lambert Public Relations Update	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – December 22, 2021	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – OCTOBER 27, 2021
GAYLORD BOARDROOM

ATTENDEES:	**Roger Frye, Ed Ginop, Randy Kamps, Terry Larson, Christian Marcus, Mary Marois, Gary Nowak, Jay O'Farrell, Richard Schmidt, Don Smeltzer, Joe Stone, Don Tanner**
ABSENT:	**Gary Klacking, Karla Sherman**
NMRE/CMHSP STAFF:	**Joanie Blamer, Eugene Branigan, Christine Gebhard, Chip Johnston, Eric Kurtz, Brian Martinus, Diane Pelts, Nena Sork, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Jim Harrington**

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

ROLL CALL
Let the record show that Gary Klacking and Karla Sherman were excused for the meeting on this date; all other Board Members were in attendance.

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

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

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

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR OCTOBER 27, 2021; SUPPORT BY JOE STONE. MOTION CARRIED.

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

MOTION BY ROGER FRYE TO APPROVE THE MINUTES OF THE SEPTEMBER 22, 2021 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY DON SMELTZER. MOTION CARRIED.

CORRESPONDENCE
1) The minutes from the October 7, 2021 PIHP CEO meeting.
2) NMRE Regional Quarter 3 FY21 Performance Indicator report.

3) An article from the October 11, 2021 edition of Crain's Detroit by Sherry Welch titled, "Group-home beds go unused as agencies struggle to pay enough to lure workers."
4) MDHHS document titled, "Behavioral Health 1915(i) State Plan Benefit Frequently Asked Questions."
5) Michigan Psychiatric Care Improvement Project (MPCIP) October 2021 update.
6) Michigan Integration Efforts October 2021 update.
7) A letter to Senator Shirkey and Members of the Senate Government Operations Committee opposing Senate Bills 597 and 598 from Michigan Association of Counties, Michigan Sheriffs Association, Michigan Judges Association, American Civil Liberties Union of Michigan, and Michigan Association for Family Court Administration.
8) Document titled, "The Impact of Community Mental Health (CMH) on Michigan's Jails" from Wayne State University School of Social Work Center for Behavioral Health and Justice.
9) Document titled, "SB 597 & 598 The Wrong Step at the Wrong Time Dangerous, Costly, and Bad for Michigan" from numerous advocacy organizations that oppose the bills.
10) Document titled, "Medicaid Reform: Myth vs. Fact" from the Michigan Association of Health Plans.
11) Document titled, Medicaid Reform: What Opponents of SB 597 & 598 Say and What they Really Mean are Two Different Things" from the Michigan Association of Health Plans.
12) The draft minutes from the October 13, 2021 NMRE Regional Finance Committee meeting.

Mr. Kurtz drew attention to the performance indicator report; the percent of discharges from a psychiatric inpatient unit who were seen for follow-up care within seven days was just missed for the child population at 94.74%. Mr. Kurtz highlighted the Crain's Detroit article by Sherri Welch. The effects of changes to 1915(i) waiver enrollment model (effective October 1, 2022) were discussed; former b(3) services beneficiaries will need to be enrolled in the Waiver Services Application (WSA). The letter to Sen. Shirkey from various advocacy groups opposing SB 597 & 598 was reviewed.

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

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

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

CEOs Report
The NMRE CEO Monthly Report for October 2021 was included in the materials for the meeting on this date. Mr. Marcus asked what can be done about funding issues and pay discrepancies. Mr. Kurtz responded that the FY22 budget included a (potentially permanent) $2.35 increase for direct care workers. The Operations Committee has discussed a variety of staff recruitment and retention efforts. Mr. Stone added that the worker shortage was discussed during the Chairpersons' meeting at the CMHAM Fall Conference. Mr. Kamps noted the need to enhance the working conditions and job satisfaction rates within the system.

August 2021 Financial Report

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

The estimated DCW lapse was reported as $6,347,000 (pending final numbers from Milliman). Ms. Yockey clarified that $10M of the surplus may be carried forward into FY22. Mr. Kamps asked whether any of the surplus can be used for infrastructure. Ms. Yockey responded that for FY21, no. Benefit stabilization efforts for FY22 continue to be discussed by the Operations Committee. An additional PA2 payment is anticipated for FY21. Mr. Marcus inquired about the Health Home surplus. Mr. Kurtz responded that it has to do with the funding model (more of a fee-for-services model that has to be reconciled). It was noted that approximately 700 individuals are enrolled in the Opioid Health Home to date; NMRE is on track to meet its goal of 1,000 enrolled. Mr. Kurtz added that $1M in ARP funds has been made available for each PIHIP for targeted substance use disorder treatment, prevention, and recovery projects.

MOTION BY JOE STONE TO RECEIVE AND FILE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR AUGUST 2021; SUPPORT BY GARY NOWAK. ROLL CALL VOTE. ROLL CALL VOTE.

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

MOTION CARRIED.

Operations Committee

The minutes from October 19, 2021 were included in the materials for the meeting on this date in draft form. The Operations Committee continues to discuss surplus funding and how it might be used to build crisis residential capacity in the region. Up to three facilities are being explored with a set number of beds allocated to NMRE clients of all populations. Mr. Marcus cautioned against building a facility/program and then not being able to keep it staffed. Mr. Kurtz responded that it's a "fine line." Mr. Kamps noted the possibility of shifting current staff. Ms. Gebhard spoke about the need for the center(s) to be sustainable. Ms. Pelts spoke about the framework of the Oscoda home.

NMRE SUD Oversight Board Report
Let the record show that the next meeting of the NMRE Substance Use Disorder Oversight Board is scheduled for 10:00AM on November 8, 2021.

NEW BUSINESS

Engagement Letter with Feldsman, Tucker, Liefer, Fidell, LLP
Per request of the Operations Committee, Mr. Kurtz contacted Adam Falcone to review the PIHP/CMHSP Contract (Network Provider vs. Subcontractor) in light of the Standard Cost Allocation (SCA) and the PIHP's Medical Loss Ratio (MLR) calculations.

MOTION BY JOE STONE TO APPROVE THAT THE NORTHERN MICHIGAN REGIONAL ENTITY ENGAGE WITH FELDSMAN, TUCKER, LEIFER, FIDELL, LLP FOR A LEGAL OPINION IN AN AMOUNT NOT TO EXCEED SEVEN THOUSAND FIVE HUNDRED DOLLARS ($7,500.00); SUPPORT BY GARY NOWAK. ROLL CALL VOTE.

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

MOTION CARRIED.

NMRE ICSS Plan of Correction
A letter dated October 14th from Kendra Binkley was included in the materials for the meeting on this date for informational purposes. MDHHS and BHDDA found Northeast Michigan CMHA had only one contact for the Intensive Crisis Stabilization Services (mobile crisis) in FY20 resulting in "contract noncompliance." A Plan of Correction is due to MDHHS by November 24, 2021. It was noted that Northeast Michigan has a schedule and a team in place; it is simply underutilized. Mr. Kurtz spoke with other PIHPs that had similar findings. Mr. Kurtz recognized that the issue is likely related to the KB lawsuit.

CMHAM Fall Conference Debrief
Mr. Stone commented that 400 individuals were in attendance with another 100 virtual. Ms. Pelts suggested that names not be required on evaluation forms to encourage honestly under the cloak of anonymity. Mr. Frye expressed disappointment that there were no handouts of the presentations. Mr. Kamps commented that he found Raymie Postema's session on mediation very informative. The 2022 Winter Conference is scheduled for February 8th–9th in Kalamazoo.

OLD BUSINESS

Senate Bills 597 & 598/House Bills 4925-4929 – The Latest
The NMRE's response to SB 597 & 597 drafted by Mr. Kurtz and the Lambert PR firm and Robert Sheehan's commentary in Crain's Detroit titled, "Build on Michigan's proven public mental health system" were distributed on this date. The NMRE's response will be sent to the NMRE's 21 county judges, prosecutors, Boards of Commissioners, sheriffs, administrators, and legislators. Mr. Stone voiced approval of the response.

PRESENTATION

Veteran Navigator Update
NMRE Veteran Navigator, Brian Martinus, was in attendance to provide an update on his activities during the coronavirus pandemic. As part of the Michigan National Guard's 46th Military

Police Command, Col. Martinus was deployed March 22, 2020 as part of the federal COVID-19 response. The 46th Military Police Command is one of three units in the US that respond to chemical, Biological, Radiological or Nuclear attacks or disasters within the United States. Under the COVID-19 pandemic, the 46th Military Police Command was deployed as a federal task force working in the central US. Hospital support was delivered by 4,500 military medical personnel to 14 states, 51 cities, and 71 hospitals. Vaccine support was delivered by 5,100+ military medical support personnel to 25 states, 42 cities, 48 vaccination sites with over 4.8 million vaccinations administered. Col. Martinus was in charge of behavioral health and religious support.

COMMENTS

Board

Mr. Kamps requested an update on the Public Relations Project and SUD Recovery Initiative during the November and/or December meetings.

Mr. Kamps expressed that a Northern Lakes Board Member has a child with I/DD; she asked why, as a natural support, she can't get paid (mileage reimbursement) for driving her son to a day program. Mr. Kamps did some investigating, and it was determined that it came down to one of the rules that distinguishes urban areas from rural. He asked how this (and other rules) can be changed for a rural environment. Mr. Kamps suggested compiling a list and working with the Northern Alliance and/or others. Mr. Tanner stressed the need for a rural exemption.

Ms. Gebhard announced that McLaren's Certificate of Need application was approved for the inpatient beds in Cheboygan.

MEETING DATES

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on November 24, 2021.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:42AM.

PIHP CEO Meeting
November 4, 2021
9:00AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

Pre-paid Inpatient Health Plans (PIHP)

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

Michigan Department of Health & Human Services (MDHHS)

Kim Bastche-McKenzie
Audrey Dick
Belinda Hawks
Larry Scott
Jackie Sproat
Krista Hausermann
Carrie Rheingans
Brenda Stoneburner
Matthew Seager
Price Pullins
Jody Lewis

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente
Krystalle Double

Status of Afghan Nationals Resettling in MI

1. Price Pullins reported that the point agencies have not encountered anything particularly concerning this week. The expectation is that if these point agencies do encounter a difficult mental health situation, they will contact the appropriate CMH.
2. Jody Lewis reported that she had shared an update on November 3, 2021 that was primarily for the medical directors. She said she would also pass on numbers of people settling in each area as the information arrives.
    a. She asked if there would be interest in a web page with links to webinars that serve as introductions to Afghan culture, ideas, and good or best practices for culturally competent behavioral health for the resettled population.
    b. She added that one suggestion that had been made was to call the new arrivals "New Americans" to reduce the stigma around them and add respect.

Quality Management Updates

1. Belinda Hawks reminded the PIHPs that the public health emergency was extended for 90 days on October 18, 2021, and that this extension would allow the PIHPs and providers to continue to leverage waiver flexibilities.
2. Belinda Hawks also alerted the PIHPs that a communication had been sent out stating that Michigan would be postponing the use of the SIS Child Michigan is waiting for more information from MI Kids Now before moving forward.
    a. The SIS Adult is already in use for those age 16 and over.

1915(i) Implementation Planning Questions/Concerns

1. The PIHPs requested that messaging for a system overhaul like the one for the 1915(i) be as widespread as the overhaul itself.
    a. They agreed that the messaging has widened recently, but this item was on the agenda prior to that widening. The PIHPs reported that their staff had been scrambling before the messaging broadened, and they wanted to ensure that this stayed on the radar for future endeavors.
2. A PIHP had asked what parts of the 1915(i) were live now and what was still waiting for implementation.
    a. Belinda Hawks reported that everything up to the state's work around Eligibility is live now. The eligibility piece will be live in 2022. The 1915(i) exists and the 1915(b) no longer exists.
    b. Michigan is operating under an 1115 authority now, with one contingency that is paused until Michigan can get the support application built. The PIHPs will be involved in user testing this application when MDHHS is ready to do so.
3. A PIHP raised some concern that the Medicaid Provider Manual still references the 1915(b)(3) criteria for inclusion and asked if that was staying under the 1915(i).
    a. Belinda Hawks responded that it was not, but that the manual had not yet been updated.

b. MDHHS will mostly be continuing with the benefit descriptions for the 1915(b), but the 1915(i) was effective as of October 2019. Policy has not caught up with the change yet.
c. MDHHS is looking to get public comment on policy changes in January 2022.

4. A PIHP requested that MDHHS circulate the 1915(i) leads list to the PIHP CEOs.

MPCIP & MI CAL Update

1. The MPCIP update has been distributed to the group via email.
    a. Krista Hausermann reported that work is being done on the universal credentialling process. The CMHs and PIHPs should know about it, as an invitation to participate has been sent out.
2. Krista Hausermann reported that the PIHPs would be receiving an email on November 4, 2021 about the MI CAL 988 rollout.
    a. An expectations document was delivered to the group via email.
    b. MDHHS will be sending further information documents out via email to both PIHP directors and CMHs at the same time.
    c. The 988 program is set to soft start in July 2022. The line will be active then. MI CAL is the primary or secondary call answerer for the 988 line across Michigan. MI CAL must be rolled out to answer those calls by July 2022, and MDHHS will prioritize areas of the state where there is currently no National Suicide Prevention Lifeline coverage.
    d. MDHHS will be hosting an executive-level overview on November 17, 2021 at 9:30 am and inviting leadership. The rollout schedule will be sent to the PIHPs prior to that.
    e. MDHHS has paused the rollout of the CMH crisis after-hours line under MI CAL. This is more intensive to roll out, and while it will stay active for Northcare, it will not extend into any new regions at this time.

Strategic Behavioral Health Integration and Coordination Initiatives

1. This update was distributed via email.

SUD Capacity 1003 Demonstration Update

1. Carrie Rheingans reported that the SUD Capacity 1003 Demonstration is in its third and final year.
    a. Her team is working through process improvement activities and plans to be done with those by the end of January or early February 2022. This will help her team make policy and practice recommendations from the 1003 project.
2. Carrie Rheingans' team received a recent survey the Office of Recovery Oriented Systems of Care (OROSC) conducted with Wayne State University about the current system.
    a. There were several training topics requested in the survey. One requested training topic from the SUD workforce was about trauma and skill-building.
        i. Michigan did do some training with the University of Michigan around trauma and resilience, but it was difficult for people to attend as it was multi-day and multi-week.

        ii. Her team is looking into request for training on how trauma might interplay with use of substances.
    b. With the 1003 dollars, MDHHS will be offering another round of training with the National Association of Social Workers (NASW) to train social workers on some special populations.
    c. MDHHS is working with a Michigan State researcher who has created online trainings for prescribers to become addiction certified. MDHHS is paying MSU a subcontract to adapt those trainings for other members of the workforce to use online for free.
        i. She hopes these trainings will be up and available this fiscal year and beyond as a free resource.
3. Carrie Rheingans also reported that Wayne State University is conducting a survey of providers who left either the SUD workforce or the public SUD workforce. They have identified around 500 providers that they could interview to discover why they left.
4. Her team is still waiting on some analysis of the data from the Inter-Tribal Council on the treatment and recovery program the Inter-Tribal Council has had for the past decade. Her team is also interviewing tribal members who have moved between tribal and PIHP settings for care.

Statewide Universal Credentialling

1. Jackie Sproat reported that the BHDDA has established a statewide workgroup to help meet the legislative requirement of a universal credentialling system.
    a. The legislative language for Statewide Universal Credentialling has been distributed to the group via email.
2. The workgroup had its first meeting November 3, 2021. The workgroup had a lot of good input and questions asked.
    a. One question was a request for clarification about whether the new statewide system or the current locally used systems would be the system of record.
    b. Several people suggested consideration for the CAQH ProView credentialling database.
    c. Another suggestion was to build from the work done over the last several years by the PIHP reciprocity workgroup.
3. A PIHP reported that they were working towards NCQA accreditation, and that credentialling was a large part of that. They had been planning to contract out to an accredited credentialling verification organization but wondered how that would affect what MDHHS is looking for in universal credentialling.
    a. A PIHP noted that if the state's system could be certified as a credentialling verification organization it would solve a lot of problems.
    b. A PIHP that is already NCQA accredited agreed and wanted to ensure they were on the correct direction and timeline as the state.
    c. A PIHP wondered about the impact for those PIHPs who already have a system in place for universal credentialling. Those PIHPs have already invested substantial dollars into their credentialling systems and already have providers inputting the information.

i. MDHHS responded that one of the next steps for a statewide workgroup would be an environmental scan to assess what systems are currently in place across the state.

4. A PIHP asked what the state's timeframe for achieving universal credentialling was.
    a. MDHHS responded that there were timelines in the legislative language. The state must begin reporting their progress on September 30, 2021, but at this time there is no hard completion date.
    b. MDHHS is aiming to have the CRM completed by September 30, 2022. However, the most important part of the timeline is that it works for the state overall.

DCW Reporting and Accounting in FY 22

1. The legislative language relating to the direct care worker reporting and accounting was distributed to the group via email.
2. Jackie Sproat reported that MDHHS is working on publishing an L-letter related to the FY 22 direct care wage increase. That letter is currently undergoing review by Michigan's Medicaid administration.
    a. There is also an internal MDHHS Direct Care Wage Premium Pay workgroup that is working to have as coordinated and unified an approach as possible across all Medicaid programs. For FY 22, the cost settlement process will be the same as it has been for FY 20 and FY 21.
        i. MDHHS is seeing monies lapsed back to the state, so it seems unlikely that MDHHS will be able to get away from the cost settlement process.
3. A PIHP stated that it made no sense to continue to cost settle when this premium wage is distributed as a regular part of the PIHPs' capitation rate.
    a. Jackie Sproat responded that the primary reason they are hearing is the internal need at MDHHS to track the premium wage separately because money has been lapsing back for the prior two fiscal years. It is also related to reporting and accountability.
4. Jackie Sproat highlighted Item 12 from the legislation, which requires that the report be submitted by February 1, 2022. MDHHS is still working out the formatting of this report.
5. A PIHP noted that they understood that Milliman had not separated out the direct care wage amounts in the rate certifications and stated that this would complicate matters. Without this separation in the rate certifications, the PIHPs do not know what they are reconciling to.
    a. Jackie Sproat reported that MDHHS has been working with Milliman to have Milliman provide estimates for the portion of the FY 21 payments attributable to Direct Care Wage increase dollars.
        i. This estimate was sent to the Financial Status Workgroup during the week of October 25, 2021.
        ii. The Chief Financial Officers for the PIHPs should now have the estimated amounts for FY 21.
    b. Another PIHP stated that it was problematic and probably inappropriate to cost settle on an estimate.

6. A PIHP asked if the Medicaid Health Plans would be cost settling as well.
    a. Jackie Sproat responded that all the managed care programs are going through this process.
7. Jackie Sproat reported that she had been asked about the ability to use the direct care wage increase for overtime. The clarification she had received was that the direct care wage increase can be applied to face-to-face hours that are above 40 hours in a week.
8. A PIHP raised the issue of applying the direct care wage increase to all hours paid as opposed to all hours worked. They noted that currently, when a direct care worker takes a day off they are reducing their income by losing that increase, even if they are using paid time off. The PIHP asked if that had been discussed.
    a. Jackie Sproat responded that her understanding was there had been no change on that front. Consistent with previous years, premium pay can only be applied to face-to-face time, not all hours paid.
    b. Belinda Hawks stated she believed that face-to-face included virtual platforms as well.

Medicaid Spenddown Assets and Redetermination

1. The PIHPs reported that they have been operating under a message that people with a Medicaid spend down are to be considered Medicaid eligible on the first day of the month. Individuals are not being disenrolled from Medicaid.
    a. The PIHPs are concerned that when the ban on disenrollment is lifted, those individuals might be disenrolled from Medicaid. Currently those individuals are creating assets and may have created considerable assets by the time the ban is lifted. Those assets may cause them to become Medicaid ineligible.
    b. The PIHPs are concerned that it would be difficult to get some of those individuals back on Medicaid to meet their health needs if they are disenrolled.
    c. The PIHP wants to know what directive or information they should share with those enrollees about those assets and how they can be or should not be used during this time.
2. Jackie Sproat said that MDHHS did ask to put a special focus on the Habilitation Supports Waiver population as a good number are on spend down. She said she can pass the concern on to the eligibility area at Medicaid.
3. The PIHPs said they would be happy to help distribute guidance; they would hate to see someone who used the money inappropriately have a negative impact down the road when the ban is lifted.

MDHHS Position on Mandatory Vaccines for Behavioral Health System

1. The PIHPs reported that they have been hearing different viewpoints from the regions about the federal mandate for vaccines in the behavioral health system. They asked if MDHHS would be making its viewpoint known.
    a. Belinda Hawks reported that the emergency order from President Biden was in effect and does apply to long term care facilities for people with IDD, to CMHs, and more.

    b. She has reached out to her counterparts in public health to ask where Medicaid behavioral health providers fall in this order.
    c. The order says it is applicable to Medicaid and Medicare services, so she believes it is a broad statement and the requirements apply to long-term care facilities. The CMHs are named specifically in the list, and the order speaks to a timeline for the vaccines to be started.
2. The PIHPs asked if MDHHS would publish its own view of this order or if the PIHPs should rely on public guidelines.
    a. Belinda Hawks said she would get more information to the group when she knows more.
3. A PIHP noted that it looks as though there is a January 4, 2022, start date for the mandate, like the OSHA rule that a worker must be fully vaccinated unless there is a documented exception.
4. A PIHP raised the concern about the effect this mandate will have on the workforce shortage they are already facing among direct care staff.
    a. Belinda Hawks noted there was a similar fear in nursing facilities when the mandate previously went into place for them, but staffing has actually gone up since the administrative announcement.
    b. The PIHP is concerned that the response may not be the same from the direct care workers.
5. The PIHPs requested clarification on if the PIHPs are covered under the order, as they are not CMHs.
6. A PIHP noted that the CMS rules are in the comment period right now, and the comment period is expected to end quickly.
7. Another PIHP stated that while the PIHPs might have the power to mandate that their own staff be vaccinated, they do not have the power to direct providers to mandate the vaccine. The PIHPs have control over their own employment, but not over the employment at providers.

Action Items

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

Board of Directors Meetings 9:30am unless otherwise indicated	
February 7 (conf.–4pm)	August 5
April 15	Oct. 23 (conf.–4pm)
June 6 (conf.–4pm)	December 2
Steering & Communications Mtgs 9:30am unless otherwise indicated	
January 14	July 15
March 11	September 16
May 13	November 10 (Th)
Regional & Member Assembly at annual conferences	
February 9: Regional Meetings Only (no Member Assembly), Kalamazoo	
June 6: Mem Assembly 5:30pm, Traverse City June 8: Regional Meetings, Traverse City	
October 25: Regional Meetings Only (no Member Assembly), Traverse City	
Children's Issues Committee 1:00pm	
January 18	June 21
March 15	September 20
April 19	November 15
Legislation & Policy Committee 9:30am	
January 19	June 22
March 16	September 21
April 20	November 16
Member Services Committee 9:30am	
January 20	June 23
March 17	September 22
April 21	November 17
Contract & Financial Issues Cmte 1:00pm	
January 20	June 23
March 17	September 22
April 21	November 17

Budget & Finance Committee 10:30am	
January 14	July 15
March 11	November 10 (Th)
By-Laws Committee 10:30am	
March 22	
Officers Meetings (after Steering) 11:30am	
January 14	July 15
PAC Committee	
Winter Conference	Fall Conference
Public Relations Workgroup 1st Wednesday of the month-10:00am	
March 2	September 15 WAM
April 6	October 5
May 25	November 2
August 3	December 7
The Provider Alliance 4th Monday of the month-10:00am	
January 24	July 25
February 28	August (no meeting)
March 28	September 26
April 25	October 25 (at conf.)
May 23	November 28
June 27	December – TBD
Persons Served Advisory Group 1:00pm – 2:00pm	
January 19	September 21
April 20	

***Supplemental Meetings of the CFI Committee were cancelled by group consensus at the November 2018 meeting. Only Full Committee meetings will be held in 2022.

Important Conference Dates
CMHA Winter Conference: Radisson Plaza & Suites, Kalamazoo, Pre-Conference Institutes: February 7, 2022 Full Conference: February 8 & 9, 2022
NACo Legislative Conf: TBD
NACBHDD Legislative Conf: TBD
MAC Legislative Conference: Lansing Center, Lansing March 21-23, 2022
National Council Conf: TBD
Capitol Hill Day: TBD
Walk-a-Mile in My Shoes Rally: Michigan State Capitol Grounds, Sept. 15, 2022
CMHA Spring Conference: Grand Traverse Resort, Traverse City Pre-Conference Institutes: June 6, 2022 Full Conference: June 7 & 8, 2022
MAC Annual Conf: Blue Water Center/Doubletree, Port Huron Sept. 18-21, 2022
CMHA Fall Conf: Grand Traverse Resort, Traverse City October 24 & 25, 2022

Directors' Forum
January 10, 2022 (Monday): 9am to Noon (DHHS join from 10:30am-Noon) Virtual (Zoom) only No Roundtable
March 30-31, 2022 **(Wednesday/Thursday)**: The James B. Henry Center – Rooms B106/107 Day 1 – 1pm to 4pm Networking Reception 4pm to 6pm Day 2 – 9am to 3pm In person with Zoom option available No Roundtable on Day 1 **subject to change if topics arise**
July 26-27, 2022 **(Tuesday/Wednesday)**: The James B. Henry Center – Rooms B106/107 Day 1 – 1pm to 4pm Networking Reception 4pm to 6pm Day 2 – 9am to 3pm In person with Zoom option available No Roundtable on Day 1 **subject to change if topics arise**
September 28-29, 2022 **(Wednesday/Thursday)**: The James B. Henry Center – Rooms B106/107 Day 1 – 1pm to 4pm Networking Reception 4pm to 6pm Day 2 – 9am to 3pm In person with Zoom option available No Roundtable on Day 1 **subject to change if topics arise**

Michigan Psychiatric Care Improvement Project (MPCIP)

November 2021 Update

Overview

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

Two Part Crisis System

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

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

Opportunities for improvement

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

MI-SMART (MEDICAL CLEARANCE PROTOCOL)

Overview

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

Current Activities:

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- As of 10/14/21: Adopted/Accepted by: 30 Emergency Departments, 14 Psychiatric Hospitals, 13 CMHSPs. 19 more facilities are in the process of implementing.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption
- Developing a commitment letter for Psych hospitals, CMHSPs, and EDs to sign
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MiSMART can help meet

Michigan Crisis and Access Line (MiCAL)

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

CALL SIDE

Overview

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

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

Current Activities

- Frontline Strong First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development. Crisis line is estimated to go live in Dec 2021/ January 2022.
- MiCAL and the Michigan Warmline staff have had almost 25,000 encounters since April 19th (MiCAL go live); mostly calls. Over half the encounters have been on the Warmline.
- Pilot is focused on streamlining and routinizing care coordination process with CMHSPs and ensuring that CRM technology supports these processes.
- MiCAL Rollout: MiCAL will rollout statewide in two phases.
    - Phase 1 FY 22: Starting in January 2022, MiCAL will rollout statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time.
    - Phase 2 FY 23: CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout will occur one PIHP at a time.
- On November 17th at 9;30 am, Executive Overview of 988 and MiCAL will be provided to PIHP, CMHSP, and CCBHC demonstration site leadership. MiCAL/988 Rollout schedule will also be provided.

BHDDA Customer Relationship Management (CRM) – Internal Business Processes

Overview

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

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

Current Activities

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

988 COALITION

Overview

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

Current Activities

- Official 988 Draft Plan was approved by the Workgroup and BHDDA Leadership and has been submitted to Vibrant and SAMHSA for their review. We expect feedback from them in November which we will incorporate into the final plan.
- We have developed an email list to keep Workgroup members up to date and to solicit their help as needed on topics such as marketing.
- Operations workgroup meetings with current NSPL centers have been scheduled to talk about Vibrant's expectations related to staff training, response times, follow up care, resources
- Resource workgroup meetings with 211, OpenBeds and NSPL centers are occurring to make sure that all Michigan NSPL centers have access to the most up to date resource information

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

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

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

Current Activities

- LARA is rolling out MiCARE regionally with a statewide completion date by early 2022.
- LARA is in the process of rolling out MiCARE statewide to all the psychiatric hospitals. There are 58 facilities. 70% attended the initial orientation.
- The Psychiatric Bed Advisory Workgroup met on Friday, October 22nd to support rollout and to focus on streamlining the referral process. Another meeting is being scheduled for November.

CRISIS STABILIZATION UNITS

Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
- MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders.
- Timing: Michigan Model developed by 12/1. Draft Certification rules developed by March 2022, finalized by Sept. 2022

Current Activities

- MDHHS is contracting with PSC/HMA to help develop a Michigan model and certification process.
- There will be a model for both children and adults. The adult model should be complete 12-1-2021.
- PSC is facilitating twice monthly stakeholder groups with the initial focus on setting high level standards, determining capacity needs, and a thorough assessment of existing CSU like facilities in Michigan.

- Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.
- PSC is also doing extensive research on best practices in other states as well as in Michigan. They have interviewed several other states.
- PSC is looking at available statewide data to help determine capacity needs.
- A draft model was presented to the Workgroup on November 3rd and was met with a positive response.
- PSC will schedule meetings specifically focused on rural populations and children to make sure that the model and the certification criteria will be effective for both specialty populations.

MOBILE CRISIS SERVICES

Overview

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

Target Date: Spring 2022

Current Activities – No new updates this month.

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

QUESTIONS OR COMMENTS?

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

Michigan Integration Efforts

November 2021 Update

Overview

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

Goals

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

Opportunities for Improvement

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

Behavioral Health Homes (BHH)

Overview

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

Current Activities:

- As of November 2, 2021, there are 938 people enrolled:
    - Age range: 7-84 years old
    - Race: 21% African American, 73% Caucasian, 1% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- The State of Michigan budget allocated funding to expand behavioral health homes into two new regions. MDHHS is working on policy documents to expand in 2022.
- Regions are continuing to enroll eligible beneficiaries and working to expand health home partners to increase capacity to serve more beneficiaries.

Questions or Comments

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

Certified Community Behavioral Health Clinics (CCBHC)

Overview

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

Current Activities

- The CCBHC Demonstration started on October 1, 2021!
- CCBHC's are working on their certification application in the BHDDA CRM and MDHHS staff are beginning to review the applications.
- The final CCBHC policy (MSA 21-34) and CCBHC Demonstration Handbook can be found on the CCBHC webpage MDHHS - Provider (michigan.gov)
- All technological systems met October 1st start date requirements. As of November 2, 2021, there are 428 people assigned to a CCBHC in the WSA.
- Final rates and implementation procedures have been submitted to CMS for approval. The Implementation Team has been engaging in ongoing technical assistance with CMS.
- An MDHHS marketing request has been submitted to begin a public marketing campaign. Marketing is intended to increase awareness of the CCBHC model, eligibility, and services among the public and other community providers. Marketing will target the eighteen counties with demonstration sites.

Questions or Comments

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

Opioid Health Homes (OHH)

Overview

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

Current Activities

- As of November 2, 2021, 1,703 beneficiaries are enrolled in OHH services.
- MDHHS has recently expanded OHH services to an additional nine counties within PIHP region 6, 7, and 10. Existing OHH's are expanding access with new providers and growing services for more beneficiaries.
- MDHHS is working on collaborating with many state agencies such as the Maternal and Infant Health division to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

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

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

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

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data between the CMH and FQHC. This effort should improve care coordination and integration efforts between the

physical health and behavioral health providers.

- Shiawassee County is starting to see shared patient data in Azara DRVS. Implementation of the care management module is underway and Saginaw County had their implementation kick off at the end of October.
- Providers are starting to deliver more in person appointments to enrollees, but telehealth is still offered and preferred by some patients.
- CMH's and FQHC's are partnering to provide COVID-19 vaccination clinics to CMH recipients.
- Analysis of the FY21 Integration Self-Assessment has been completed for all grantees. Results show that grantees are increasing levels of integration when compared to the FY20 Integration Self-Assessment.

Questions or Comments

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

Children's Services Discussion
October 28, 2021
11:00 – 12:00

Purpose: As part of the requirements of the MI Kids Now Initiative, MDHHS is seeking to increase the number of children/families receiving Intensive Crisis Stabilization Services (ICSS) for Children, Youth Peer Support (YPS) and Family Support and Training Services (with an emphasis on Parent Support Partner (PSP) during FY 22. MDHHS has funding available to support the increase in utilization as well as the needed trainings to go along with this expansion.

Included with this notice are the utilization and costs reported by the PIHPs for fiscal years 18, 19 and 20 for these services. This offers a perspective on what is currently taking place. During those three years the system averaged serving about 75,000 children/adolescents/young adults in the Early Periodic Screening, Detection and Treatment population (0 through 20 years) which is the focus of the MI Kids Now work.

Initial Focus (immediate changes needed):

- Part of the increase in utilization of the ICCS for children is that this service will be required to be available 24/7 and the needed policy change is in progress to reflect this requirement.
- For YPS, we are initially going to look at establishing a minimum number of Youth Peer Support Specialists at each CMHSP (potentially 2) to support the increased utilization.
- Family support and training services will need to be offered more broadly and we are also looking at establishing a minimum number of PSPs at each CMHSP (again potentially looking at 2 here as well).

We know there are workforce issues – within PIHPs and CMHSPS as well as with the direct care workforce and we know the FY has already started. The purpose of the discussion is to hear from you about what you will need to be able to increase the number of children/families that receive these services this FY and then be able to maintain those efforts moving forward. We are also aware that there are large rural areas of the state and being rural does not mean you do not have to provide a required service. Many states have successfully implemented these services within their rural and even frontier areas. We are looking for solutions to make this happen, we do not want to be told about all the barriers that exist. As indicated above, we have funding to support this effort so identifying how funding can help and potentially what needs to be invested in this effort will be beneficial to help us move forward.

Provide information during the meeting that is focused on:

- How to increase the number of children, youth and families served?
- For those ICSS programs that are not 24/7 now, what is needed to get there?
- What funding mechanisms can be improved, changed, implemented?

MDHHS will be monitoring these services closely going forward and we will be requesting additional information from you to monitor progress on your efforts and overall utilization. Our initial thoughts on what we intend to do:

1. Offer more training – we plan on having ICSS training and we will be working on increasing YPS and PSP trainings. There are quarterly trainings with ACMH already scheduled for FY22 with the ability to add more based on need for PSP and YPS.
2. We will be asking for the ICSS children's enrollments to be updated and resubmitted to reflect the new policy changes.
3. Extend the option of tele health for ICSS
4. Set a deadline for staff hiring – potentially January of 2022
5. Develop a monitoring plan – this should fit with the development of a dashboard and possible site reviewing process

ICSS FY 18-20

Region	Number Served	Average Number Served	Cost	Average Cost
CMH Partnership of SE MI	0	0	$0.00	$0.00
Detroit-Wayne MH Authority	3760	1253	$1,402,299.37	$467,433.12
Lakeshore Regional Entity	894	298	$378,688.85	$126,229.62
Macomb	355	118	$302,494.08	$100,831.36
Mid-State Health Network	699	233	$709,081.44	$236,360.48
NorthCare Network	42	14	$30,474.62	$10,158.21
Northern MI Regional Entity	589	196	$455,076.60	$151,692.20
Oakland	408	136	$171,695.00	$57,231.67
Region 10	41	14	$61,812.89	$20,604.30
Southwest MI Behavioral Health	407	136	$362,912.37	$120,970.79
Totals	**7195**	**2398**	**$3,874,535.22**	**$1,291,511.74**

YPS FY 18-20

Region	Number Served	Average Number Served	Total Cost	Average Cost
CMH Partnership of SE MI	172	57	$234,014.28	$78,004.76
Detroit-Wayne MH Authority	194	65	$28,248.78	$9,416.26
Lakeshore Regional Entity	21	7	$32,638.86	$10,879.62
Macomb	44	15	$74,348.31	$24,782.77
Mid-State Health Network	59	20	$60,186.52	$20,062.17
NorthCare Network	35	12	$8,750.70	$2,916.90
Northern MI Regional Entity	9	3	$328.16	$109.39
Oakland	108	36	$134,385.98	$44,795.33
Region 10	54	18	$90,549.40	$30,183.13
Southwest MI Behavioral Health	133	44	$193,719.00	$64,573.00
Totals	**829**	**276**	**$857,169.99**	**$285,723.33**

Family Support and Training FY 18-20				
Region	**Number Served**	**Average Number Served**	**Total Cost**	**Average Cost**
CMH Partnership of SE MI	1087	362	$1,061,703.83	$353,901.28
Detroit-Wayne MH Authority	4001	1,334	$4,387,792.79	$1,462,597.60
Lakeshore Regional Entity	3751	1,250	$3,094,292.01	$1,031,430.67
Macomb	1731	577	$3,306,622.03	$1,102,207.34
Mid-State Health Network	2082	694	$3,455,162.17	$1,151,720.72
NorthCare Network	368	123	$703,973.57	$234,657.86
Northern MI Regional Entity	694	231	$916,001.09	$305,333.70
Oakland	973	324	$1,473,007.09	$491,002.36
Region 10	1854	618	$2,646,299.76	$882,099.92
Southwest MI Behavioral Health	1010	337	$2,977,343.17	$992,447.72
Totals	**17551**	**5,850**	**$24,022,197.51**	**$8,007,399.17**

Crisis Stabilization Units in Michigan

Concept Paper

Background and Purpose

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

To develop certification criteria, MDHHS hired Public Sector Consultants (PSC) to convene and facilitate an advisory group of stakeholders for a series of statewide discussions and listening sessions on topics including rural areas, persons served, and children. The advisory group prepared for discussions in advance by reviewing selected readings from the National Council on Behavioral Health's *Roadmap to the Ideal Crisis System* and the Substance Abuse and Mental Health Services Authority's *National Guidelines for Behavioral Health Crisis Care*. PSC and the department have also consulted with other states and reviewed national guidance to identify best practices for the implementation of CSUs. The following outline of Michigan's CSU model is based on guidance that has been offered by stakeholders in the advisory group and listening sessions, PA 402, and best practice guidelines. It is important to note that, as certification standards are developed, flexibility for implementation in rural vs. urban areas will need to be considered.

A Vision for CSUs in Michigan

Vision

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

Improved access to care: There is no wrong door to access a CSU and insurance is not a barrier. All Michiganders know about CSUs, have easy access to a CSU when needed, and the capacity of CSUs meet the needs of the community.

Appropriate levels of care: Patients have the least restrictive care and are triaged to the appropriate level of care to stabilize them quickly. There is a decrease in inappropriate psychiatric hospitalizations and emergency department use.

Coordinated care: Stakeholders, including law enforcement, 911, 988, and emergency medical services (EMS), mobile crisis responders (of any type including multidisciplinary response teams [MDRT], Mobile Crisis Stabilization Services (MCSS), youth mobile crisis, juvenile urgent response teams (JURT), etc.) coordinate care for individuals in crisis. Individuals receive coordinated contact around their health from the initial CSU visit to community support follow-ups. Coordination occurs across systems and agencies including child welfare, aging and older adult services, and behavioral health systems and supports.

Positive individualized experience: CSUs provide high quality of care for those in crisis. People feel safe, respected, and supported in comfortable spaces that maximize privacy. Intake and release are seamless for the individual and the individual can expect that there will be linkage to further services beyond the period of crisis.

Family Driven/Youth Guided Care: Family and fictive kin are an important, if not the most crucial, part of a youth's support network. Because of the important role of family/fictive kin, treatment of youth optimally occurs as a part of a family unit. CSUs provide family-driven/youth-guided care which involves and supports the family as well as the youth.

Natural Supports: CSUs recognize the importance of family and friends in a person's recovery and seek to maximize positive impact through the involvement and support of a person's informal support network.

CSU Model Concept

The elements of a CSU model for Michigan below are based on and incorporate input received from stakeholders, best practices recommended by SAMHSA, and PA 402 of 2020.

Eligible Provider Entities

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

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

Populations Served

CSUs must provide crisis stabilization services to:

- All people in crisis, regardless of health care coverage
- Children and adults experiencing a crisis related to mental health, substance use, or both

Meeting the needs of diverse populations

Children and adults should be treated in physically separate facilities but in a parallel fashion. CSUs should ensure that all care and treatment is offered in a culturally competent manner. CSUs should be prepared to serve diverse populations, including tribal communities and other at-risk groups. CSUs must also have interpreters available on an as-needed basis to serve all populations. CSUs must be prepared to meet the needs of adults with serious mental illness (SMI), children with serious emotional disturbance (SED) and their families, people with intellectual and developmental disabilities (IDD), individuals with substance use disorders (SUD) in crisis, as well as people with co-occurring mental health and substance use issues.

Basic Requirements

CSUs must:

- Initiate assessment and treatment interventions upon arrival
- Conduct an initial psychosocial assessment and psychiatric evaluation within 24 hours
- Provide up to 72 hours of care
- Ensure timely access to appropriate medical services for physical health needs and provide ambulatory care level support for physical health
- Treat crises related to both mental health and substance use
- Provide treatment in the least restrictive manner possible, including providing care for individuals seeking voluntary treatment, and may treat individuals who need involuntary treatment for up to 72 hours (consistent with Sec. 409), after which the individual must be provided with the clinically appropriate level of care, resulting in one of the following:
    - The individual is no longer a person requiring treatment.
    - A referral to outpatient services for aftercare treatment.
    - A referral to a partial hospitalization program.
    - A referral to a residential treatment center, including crisis residential services.
    - A referral to an inpatient bed.
    - An order for involuntary treatment.

Geographic and Population Considerations

Different CSU models may be needed for different geographic locations and patient populations. While basic requirements will be the same for all CSUs, the way in which requirements are met will be based on the needs of the community. It is also critical that the needs of adults with SMI, children with SED, and adults or children with I/DD guide how CSUs are implemented within a community.

Staffing Requirements

CSUs must:

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

Importance of Peers

Peers should be present at each step of the patient process from intake and treatment to release and transportation. Peer support helps patients navigate a crisis and can help reduce staffing shortages.

Flexibility in Staffing

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

Physical Space Requirements

CSUs must:

- Provide a trauma-sensitive, comfortable, home-like environment
- Plan for special populations (e.g., I/DD, gender sensitive approaches)
- Provide separate waiting areas and treatment spaces for children and their families and adults
- Have spaces that ensure privacy
- Ensure physical spaces for sleeping and treatment are welcoming, conducive to recovery, and family- and individual-friendly
- Provide for individual physical needs (e.g., food, shower facilities)

Operational Standards

General

CSUs must:

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

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

CSUs must:

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

Complaint Resolution

CSUs must:

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

System Collaboration Requirements

CSUs must:

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

Data/Reporting Requirements

- CSUs must provide timely reports to MDHHS, as required. These could include:
    - Data on number served
    - Data on demographics capturing prevalence of populations served and examined related to diversity and equity
    - Data on insurance types billed
    - Disposition of all individuals served
    - Percentage of law enforcement, mobile crisis, and first responder referrals and percentage not referred to emergency department for medical care and not arrested (i.e., hospital and jail diversion)
    - Law enforcement and first responder drop-off time
    - Average length of stay per person served
    - Percentage completing outpatient follow up
    - Readmission rate within 30 days to CSU, crisis residential facility, or inpatient psychiatric hospital.
    - Total cost per crisis episode

Certification and Accreditation

CSU's must:

- Obtain JCAHO, CARF, or similar organization accreditation by soonest of 1/12/2023 or 3 years following MDHHS certification

MiCAL - PIHP/CMHSP/CCBHC Care Coordination Requirements:

Attachments: MDHHS Care Coordination Memo

Care Coordination between MiCAL and each CMHSP/PIHP/CCBHC is critical in the development of a comprehensive crisis system of care. Care Coordination will happen through three different transactions:

- Referrals to CMHSPs/PIHPs/CCBHCs with follow up by MiCAL
- MiCAL Activation of face-to-face crisis services
- Encounter Reports on MiCAL services provided to people who are open to services at CMHSPs, PIHPs, and CCBHCs

The follow requirements will help facilitate this coordination.

1. **Crisis and Access Service Information**
   MiCAL recognizes that crisis and access services vary from region to region in terms of population served, hours of service, and services provided. The BHDDA CRM through the Partner Portal will house details on crisis and access services provided by an individual CMHSP/PIHP/CCBHC.

2. **Referrals**
   CMHSPs and PIHPs will receive and acknowledge referrals from MiCAL through the Partner portal within 1 business day. (*Please note: an email is sent to a designated email address for notification of a referral in the portal*.)

Non-Crisis Request for Service Weekday Business Hours:

1. Person calls MiCAL
2. MiCAL provides support, triage and determination of risk level* and when necessary, performs a SAFE-T.
3. Risk Level is low
4. MiCAL determines payer type.
5. MiCAL does not do an official level of care assessment, but based on conversation, person appears to qualify for CMSHP/PIHP/CCBHC services based on severity of need and Medicaid. (note: when there is any doubt on severity, MiCAL will refer to the CMHSP).
6. MiCAL Staff make a warm handoff to CMHSP/PIHP/CCBHC Access during the day via three-way call.
7. MiCAL completes encounter note and referral form within the CRM.
8. Referral and MiCAL encounter will come to CMSHP/PIHP/CCBHC through the CRM portal in real time.
9. CMSHP/PIHP/CCBHC staff will receive, read, and acknowledge the referral. (*Note: CMSHP/PIHP/CCBHC will choose the people will receive referrals or they could go to a special email box. The email notification can be changed at any time by the CMHSP IT Administrator.)*

10. MiCAL staff will follow up with the person to make sure they are connected just like they do with any other referral.

Afterhours Request for Service Process:

1. Person calls MiCAL
2. MiCAL provides support, triage and determination of risk level.
3. Risk Level is low
4. MiCAL determines payer type.
5. MiCAL does not do an official level of care assessment, but based on conversation, person appears to qualify for CMSHP/PIHP/CCBHC services based on severity of need and Medicaid. (Note: when there is any doubt on severity, MiCAL will refer to the CMHSP).
6. MiCAL completes encounter note and referral form within the CRM.
7. Referral and MiCAL encounter will come to CMSHP/PIHP/CCBHC through the CRM portal in real time.
8. CMSHP/PIHP/CCBHC staff will receive, read, and acknowledge the referral. (*Note: CMSHP/PIHP/CCBHC will choose the people will receive referrals or they could go to a special email box. The email notification can be changed at any time by the CMHSP IT Administrator.)*
9. CMSHP/PIHP/CCBHC staff will contact the person in need based on the notes in the referral. (*When there is no warm handoff, MiCAL staff will document what the receiver of the referral is supposed to do upon receipt of the referral, i.e. call the person back at a specified number, call during specific times, wait for the person to show up for open access hours, wait for the person to call*.)
10. MiCAL staff will follow up with the person to make sure they are connected as they do with any other referral.

3. **MiCAL Activation of face-to-face crisis services**:
    - MiCAL's activation of face-to-face crisis services must be streamlined to optimize support for the caller with no re-screening or re-triage allowed.
    - All CMHSPs will provide a contact phone number(s) for 24/7 activation of face-to-face crisis services for MiCAL Call Specialists.
    - CMHSP direct or contract employee must be available 24/7 that can dispatch face-to-face crisis services: preadmission screening, mobile crisis, or CSU

Face to Face Crisis Service Request:

Draft Care Flow:

1. Person calls MiCAL
2. MiCAL does a risk assessment to determine level of risk*

3. Person is flagged as moderate to high risk, therefore some type of face-to-face crisis service is needed.
4. MiCAL contacts a local crisis service provider(s) that can dispatch face to face crisis services (i.e. mobile crisis, preadmission screening, CSU-like service).
   Requirement: Local crisis service provider(s) must be able to dispatch mobile crisis or accept a warm handoff for face-to-face crisis services without doing a duplicative risk assessment/ phone intervention. MiCAL will have a discussion with each CMHSP/PIHP/CCBHC to determine which local provider(s) should receive real-time crisis referrals.
5. MiCAL encounter and referral will come to "Local contact" through the CRM portal in real time.
6. Crisis Service Provider staff will receive, read, and acknowledge the referral. (*Note: Crisis Service Provider will choose the people will receive referrals or they could go to a special email box. The email notification can be changed at any time by the Crisis Service Provider IT Administrator.)*
7. MiCAL staff will follow up with the person to make sure they are connected just like they do with any other referral.

4. **Must receive encounter reports**.

   An important part of care coordination is ensuring that treatment providers are aware of services provided by MiCAL to the people they serve. MiCAL staff will ask callers if they are currently receiving services. They will also ask permission to share the encounter report with the treatment entity through the portal. Each entity must log into the CRM Partner Portal at least once daily to receive any encounter reports of activities by MiCAL.

MiCAL-9-8-8-Regional Rollout Timeline:

Rollout information and timeline shared with PIHP Directors via email on 10/29/21

Rollout information and timeline shared with CMHSP Directors via email on 11/4/21

MiCAL- 9-8-8 Presentation

- Presentation Date: Wednesday, Nov. 17th at 9:30 am
- Content: Overview of the MiCAL 9-8-8 Rollout and MiCAL's role with 9-8-8; Coordination Requirements

Region Specific Training:

- Will occur one month in advance of go live
- **MiCAL- 9-8-8 Director/Administrator Level Training** (Overview of the MiCAL 9-8-8 Rollout and MiCAL's role with 9-8-8; Coordination Requirements; training on CRM Functionality)
- **IT Email outlining staffing permissions via email** (Outline the correct profiles and process to add Crisis Service staff to the CRM)
- **PIHP/ CMHSP/ CCBHC Staff 9-8-8 MiCAL Rollout Training**: (Overview of the MiCAL 9-8-8 Rollout and MiCAL's role with 9-8-8; Coordination Requirements; In-Depth training on CRM Functionality)

MiCAL 9-8-8 Rollout:

January 2022: Region 3 counties

February 2022: Region 10 counties

March 2022: Region 2 counties

April & May 2022: Region 5 counties

June 2022: Region 6 counties

July and August 2022: Detroit Wayne Integrated Health Network – Wayne County

September 2022: Region 4 Counties

October 2022: Macomb

email correspondence

From: Robert Sheehan; Alan Bolter

Subject: Recommendation of CMHA and Provider Alliance Officers: response to MDHHS regarding the financial reporting requirements contained in Medicaid Bulletins MSA 21-39

Date: November 9, 2021

To: CEOs of CMHs and PIHPs
Cc: CEOs of Provider Alliance members
From: Robert Sheehan, CEO, CMHA of Michigan
Re: Recommendation of CMHA and Provider Alliance: response to MDHHS re: Medicaid Bulletins MSA 21-39
SUMMARY: As you know, CMHA (in partnership with the two contract negotiation teams – the CFI CMH Contract Negotiation Team and the PIHP Contract Negotiation Team) has been working, over the past year, to ensure that the revisions to the financial reporting processes, proposed by MDHHS and Milliman, are sound, comply with federal law and Michigan's Medicaid waivers, and value added. Below is the most recent update on that effort - with this update centered around the recently issued Michigan Medicaid bulletin MSA 21-39.
Note that, in this update, CMHA and the Officers of the Provider Alliance (the committee of CMHA representing the interests of the provider members of CMHA) are underscoring that the financial reporting outlined in Michigan Medicaid bulletin MSA 21-39:

- comes between the contractual relationship between the CMHs/PIHPs and the members of their provider network
- attempts to impose a requirement on provider organizations with which MDHHS has no direct contractual relation
- is based on a flawed interpretation of federal law and the state's Medicaid waivers.

Due to these concerns, CMHA, the two contract negotiation teams and the Provider Alliance leadership see this bulletin as not binding on the providers in the CMH and PIHP provider network, nor on the state's CMHs and PIHPs, until contract negotiations, between MDHHS and the state's CMHs and PIHPs are completed with agreement reached as to these financial reporting requirements.

Below is our recent communication to the Provider Alliance members on this topic.

BACKGROUND: Last week, MDHHS released Medicaid bulletin, MSA 21-39, a bulletin that would require providers to submit a great deal of detailed financial information to MDHHS. That bulletin is attached.
Following the issuance of this bulletin, MDHHS, the two contract negotiation teams (CMH and PIHP), and CMHA met to discuss MSA 21-39 (and other issues). The negotiation teams and CMHA underscored our deep concerns with this policy and the related flaws in the Standard Cost Allocation plan that MDHHS has been rolling out. We underscored that this policy is not valid in that it:

- comes between the contractual relationship between the CMHs/PIHPs and the members of

their provider network
- attempts to impose a requirement on provider organizations with which MDHHS has no direct contractual relation
- is based on a flawed interpretation of federal law and the state's Medicaid waivers.

During this discussion, some of the Milliman and MDHHS team asked for the legal and policy analysis upon which the two negotiation teams and CMHA are basing their interpretation of federal law and regulation. The three documents that contain this analysis are attached.

This negotiation session ended without movement toward an agreement around these financial reporting issues.

VIEWS OF PROVIDER ALLIANCE LEADERSHIP AND CMHA*:* As you may remember, there is a considerable level of disagreement between Milliman and MDHHS, on one side, and the state's CMHs, PIHPs, the Provider Alliance, and CMHA on the other side, regarding the soundness and value of this financial reporting effort.

As a result of that disagreement and the fact that changes to the financial reporting methods and constructs/concepts must be contained in the MDHHS contracts with the state's CMHs and PIHPs and reflect the negotiated agreement of both parties to these contracts – prior to being implemented – CMHs and PIHPs are not complying with the revised financial reporting proposed by MDHHS and Milliman until agreement is reached via contract negotiations. Such negotiations have only just begun**.**

Until these contract negotiations are completed with agreement as to these financial reporting requirements, they are not binding on CMHs, PIHPs, nor the contractual providers within the CMH and PIHP system, of which Provider Alliance members are core members and leaders.

CONCERNS OF PROVIDER ALLIANCE LEADERSHIP AROUND THIS PROPOSED POLICY: The leadership of the Provider Alliance has a number of initial concerns regarding this proposed policy:

1. These proposed reporting requirements are an unfunded and costly administrative burden with little value to the provider system and those served by the system
2. These requirements represent a heavy and complex burden for providers without a clear benefit to the provider system nor persons served
3. These proposed requirements are a slippery slope to more requirements outside of the MDHHS contracts with CMHs and PIHPs and provider contracts with CMHs and PIHPs.
4. These requirements are not in any of the contracts that providers have with CMHs nor PIHPs.
5. Training on the use of these complex tools and the concepts upon which they are based has not been offered to providers

RECOMMENDATION FROM LEADERSHIP OF PROVIDER ALLIANCE: The Provider Alliance leadership is recommending that Provider Alliance members and their stakeholders take the following actions:

1. Submit comments, during the weeks of November 8 and 15. to: Jackie Sproat, Jeffery Wieferich,

and the MDHHS Provider Policy Office:

- Reflect your concerns in that e-mail. (You can draw on the the concerns listed above, revised and expanded as you see fit.)

- indicate, in those comments, that until the MDHHS contracts with the state's CMHs and PIHPs are negotiated to reflect these requirements, as revised by these negotiations, that you, the provider organization, will not adhere to these reporting requirements.

To expedite this e-mail, these three e-mail addresses are provided below:

sproatj@michigan.gov
Wieferichj@michigan.gov
ProviderSupport@michigan.gov

2. Until agreement is reached between MDHHS and the CMH and PIHP Contract Negotiation Teams with guidance from the Provider Alliance, Provider Alliance members are strongly urged not to comply with any requirements reflecting a change to or additional financial reporting requirements.

Thank you,
CMHA Provider Alliance Officers

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
426 South Walnut Street
Lansing, MI 48933
517.374.6848 main
517.237.3142 direct
517.374.1053 fax
www.cmham.org

Bulletin Number: MSA 21-39

Distribution: Behavioral Health and Substance Use Disorder Service Providers, Community Mental Health Services Programs (CMHSPs), Prepaid Inpatient Health Plans (PIHPs)

Issued: November 1, 2021

Subject: Establishment of Cost Reporting Requirements for Behavioral Health Service Providers Contracted/Affiliated with CMHSPs/PIHPs

Effective: December 1, 2021

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to establish cost reporting requirements for behavioral health service providers contracted/affiliated with CMHSPs/PIHPs (hereafter referred to as network providers) to comply with state and federal requirements, including:

- Adherence to federal regulations under 42 CFR Part 438.66, and;
- The development and maintenance of a behavioral health fee schedule per Section 964 of the Michigan Department of Health and Human Services (MDHHS) budget boilerplate in Michigan Public Act 166 of 2020.

To comply with this requirement, and under the authority of U.S.C. §1396a(a)(30)(A) and 42 CFR. §438.66, the Behavioral Health & Developmental Disabilities Administration (BHDDA) is requiring the reporting of cost and other information from behavioral health service providers beginning December 1, 2021 to be completed annually.

Beginning December 1, 2021 and required annually thereafter, CMHSP/PIHP network behavioral health service providers (providers who contract with PIHPs and CMHSPs) must provide all relevant information for the provision of covered services delivered to Medicaid beneficiaries to MDHHS using standard reporting templates that are provided by MDHHS. (NOTE: MDHHS may change the elements within the templates at its discretion with proper advance notice to providers).

All CMHSP/PIHP network providers must report information that includes, but is not limited to: salary and wages, employee related expenses (e.g., fringe benefits), paid time off, training expenses, employee turnover, and other information determined necessary by MDHHS to

execute this policy. Moreover, all providers who meet a specific expenditure threshold established by MDHHS must submit more detailed information, such as the following:

a) Direct labor costs, including direct and indirect time spent providing for patients;
b) Direct service supervisory labor costs;
c) Employee related expenses associated with direct service staff and first line supervisors;
d) Travel related expenses associated with direct service staff and first line supervisors;
e) Clinical-related supplies and other expenses;
f) Provider administrative costs, and;
g) Costs defined as managed care administration.

CMHSPs are required to comply with the Standard Cost Allocation methodology, which will fulfill the detailed reporting requirement for providers above a certain expenditure threshold.

Specific reporting templates, instructions, and further guidance will be provided by MDHHS through additional communications in advance of the reporting due date.

More information regarding reporting requirements is available here on the MDHHS website.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be e-mailed to Provider Inquiry, Department of Health and Human Services, at ProviderSupport@michigan.gov. When you submit questions, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved

Kate Massey, Director
Medical Services Administration

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

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

November 16, 2021

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<City> <State> zipcode5-zipcode4

Dear Provider:

RE: Fiscal Year 2022 Direct Care Worker Wage Increase

Pursuant to Public Act 87 of 2021, the Michigan Department of Health and Human Services (MDHHS) will implement a wage increase for direct care workers. This applies to the MDHHS programs and service codes listed below:

Program Name	Services	Related HCPCS Codes
MI Choice Waiver	Community Living Supports, Respite, Adult Day Health	H2015, H2016, S5150, S5151, S5100, S5101, S5102
MI Health Link	Expanded Community Living Supports, Personal Care, Respite, Adult Day Program	H2015, H2016, S5150, S5151, T1019, S5100, S5101, S5102
Behavioral Health	Community Living Supports Overnight Health and Safety Supports Personal Care Prevocational Services Respite Skill Building ABA Adaptive Behavior Treatment ABA Group Adaptive Behavior Treatment ABA Exposure Adaptive Treatment Crisis Residential Services Residential Services -SUD Residential Services – Co-occurring SUD/MH Withdrawal Management – SUD Supported Employment	97153, 97154, 0373T, H0043, H0019, H0010, H0012, H0014, H0018, H2014, H2015, H2016, T2027, T1020, T2015, S5151, T1005, H2023

The wage increase for services provided October 1, 2021 through September 30, 2022 is intended to cover a $2.35 per hour increase in direct care worker wages, along with an additional $0.29 per hour for agencies to cover their additional costs associated with implementing this increase. **The $2.35 per hour should be paid in addition to the worker's regular wage, but cannot be less than the wage being received by, or the starting wage offered to, a qualifying direct care worker on March 1, 2020. This wage increase must be recorded separately from base pay on payroll documents and labelled as "FY 2022 Provider Pay Increase"**. The $2.35 per hour payment must be applied entirely to direct care worker wages. The $2.35 and $0.29 per hour amounts may be implemented by an equivalent as divided per billing unit. One example of "an equivalent as divided per billing unit" is, for programs billing in 15-minute increments, the payment would be $0.5875 per 15-minute unit for the direct care worker, and $0.0725 per 15-minute unit for the additional agency cost.

For program participants receiving services through a self-determination arrangement under the behavioral health, MI Health Link and MI Choice Waiver programs, direct care workers must receive this $2.35 wage increase for the hours or billing units worked between October 1, 2021, and September 30, 2022. The Fiscal Intermediary, or agency (for Agency with Choice), must receive $0.29 per hour for related taxes. The "equivalent as divided per billing unit" described above applies.

All wage increase payments are subject to audit and potential recoupment. Providers should retain documentation that supports the distribution to direct care workers and that payments were made in accordance with the requirements in this letter. Section 231 of Public Act 87 of 2021 requires additional wage reporting. MDHHS is currently working on the legislatively mandated reporting requirements and will provide additional guidance once they are finalized.

A direct care worker may choose to not receive the wage increase. This choice must be indicated in writing or electronically. This individual's employer must give back to the entity paying for services, as described in the table above, any funds allocated for this individual's wage increase.

Direct care workers should still follow the guidance issued in March 2020 titled "Actions for Caregivers of Older Adults During COVID-19" along with the document "Actions for Caregivers for Older Adults Addendum Frequently Asked Questions". These documents describe recommendations for in-home direct care workers and methods to assure a face-to-face visit is needed. These documents can be found at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448---,00.html.

Direct care workers who are providing behavioral health services should also follow the additional guidance found at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941-146590--,00.html.

Adult Foster Care homes and Homes For the Aged should follow guidance and reporting instructions provided on the MDHHS Coronavirus webpage at: https://www.michigan.gov/coronavirus/0,9753,7-406-98178_100722---,00.html under the Staffing tab and the “Direct Care Worker Resources” heading.

If you have questions, you can call Provider Support at 1-800-979-4662 or e-mail them at providersupport@michigan.gov.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Sincerely,

Kate Massey, Director
Medical Services Administration

Addicted Michigan: Narcan vending machine is just one step in emergent need

By: Marc Shollett
Wednesday, November 10, 2021

WEXFORD COUNTY, Mich., (WPBN/WGTU) – Chances are the vending machine where you work has a wide selection of snacks.

But if you worked at the Wexford County Sheriff's Office, that wouldn't be the case.

They have a vending machine that only offers one thing, and it could save a life.

"It's open 24 hours a day, seven days a week, and 365 days a year," said Wexford County jail Administrator Lt. Mike McDaniel.

McDaniel said the vending machine is the first of its kind around here.

Anyone can come in and walk out with a dose of Narcan, for themselves or for a loved one.

Narcan is used to reverse a drug overdose. It's credited with saving thousands of lives every year.

Managing Director of Substance Use Disorder Services at the Northern Michigan Regional Entity Sara Sircely has seen the impact steps like this can have.

"Well, we basically coordinate, manage, and fund the publicly funded substance use disorder services," said Sircely. "So, prevention, treatment, and recovery supports in the 21 counties in northern lower Michigan."

NMRE is a driving force for treatment in what can be a long road to recovery.

What's offered here, in this vending machine meets more of an emergent need, a lifesaver in a crisis moment.

But for many, it’s an important and valuable tool that can be used to keep someone alive long enough to get to recovery.

“Any way we can get this needed, helping drug into the hands of folks who might need that or might need to help somebody who is suffering an overdose. It’s fantastic.” Said Sircely.

And that’s why this is here. Those who might need it can get it. Not questions asked and free of charge.

It’s a very public display of a problem that too often is kept in the shadows. Having this here acknowledging the problem maybe the first step to addressing it.

“We need to be able to support them. And then we really need to be able to support folks in recovery,” Said Sircely. “So, recovery friendly communities making this normal, that this is a disease, and folks can recover from it and support folks then, yeah, it’s needed.”

According to the National Institute on Drug Abuse, states that increased access to medications like Naloxone through changes in law saw a 14% decrease in overdose deaths.

It’s that data that is promoting more and more locations like the sheriff’s office to offer it to anyone who may need it.

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

ATTENDEES:	**Connie Cadarette, Lauri Fischer, Kevin Hartley, Nancy Kearly, Eric Kurtz, Allison Nicholson, Larry Patterson, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**
ABSENT:	**Donna Nieman**

REVIEW AGENDA & ADDITIONS
No additions to the meeting Agenda were proposed.

REVIEW PRIOR MINUTES
The October minutes were included in the materials packet for the meeting.

MOTION BY LARRY PATTERSON TO APPROVE THE MINUTES OF THE OCTOBER 13, 2021 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY KEVIN HARTLEY. MOTION APPROVED.

MONTHLY FINANCIALS
September 2021

- Traditional Medicaid showed $204,540,431 in revenue, and $179,768,235 in expenses, resulting in a net surplus of $24,772,196. Medicaid ISF was reported as $7,738,320 based on the final FSR. Medicaid Savings was reported as $4,515,675.
- Healthy Michigan Plan showed $31,573,008 in revenue, and $25,685,577 in expenses, resulting in a net surplus of $5,887,431. HMP ISF was reported as $7,058,552 based on the Final FSR. HMP savings was reported as $0.
- Net Position* showed net surplus Medicaid and HMP of $30,659,626. Medicaid carry forward was reported as $4,515,675. The total Medicaid and HMP Current Year Surplus was reported as $28,251,301. Medicaid and HMP combined ISF was reported as $14,796,872; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $43,048,173.
- Health Home showed $508,884 in revenue, and $482,681 in expenses, resulting in a net surplus of $26,203.
- SUD showed all funding source revenue of $21,305,769, and $18,878,106 in expenses, resulting in a net surplus of $2,427,663. Total PA2 funds were reported as $6,146,019.

Milliman projection for DCW FY21 revenue was provided as $15,802,000. An additional FY21 PA2 payment is expected in December.

MOTION BY CONNIE CADARETTE TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR SEPTEMBER 2021; SUPPORT BY KEVIN HARTLEY. MOTION APPROVED.

DCW UPDATE
No L-letter has been produced to date regarding the $2.35/hour increase, but Eric learned from Jeff Wieferich that DCW will continue to be cost-settled separately and not included in CAP. A workgroup will be forming to discuss uses and tracking methods.

AFFILIATE PAYMENT WORKSHEET RECONCILIATION
Deanna noted that Tricia sent the worksheet reconciliations out the week of November 1st. Deanna asked that each Board send a response indicating agreement so she can produce it for the NMRE's financial audit.

OCTOBER MEDICAID HMP REVENUE
Deanna sent revenue calculating sheets for October revenue on November 5th. A drop in revenue was observed. Kevin noted that the member counts didn't show substantial change. Deanna's analysis showed:

- HMP unenrolled dropped by $9.08/member
- HMP enrolled dropped by $3.95/member
- Medicaid unenrolled dropped by $11.75/member
- Medicaid enrolled dropped by $7.27/member

HSW revenue decreased by $199K ($2.4M annualized). September to October Medicaid & HMP showed a $1.2M decrease ($14.4M annualized). An additional rate certification is forthcoming showing the DCW at $2.35 vs. $2.00, though the additional revenue for Q1 is not expected until January 2022.

EDIT UPDATE
The minutes from October 21st were included in the meeting materials. Discussion topics included:

- Michigan's CCBHC Demonstration Update – Discussion of T1040 code
- Coordination of Benefits (COB) Subgroup – Implementation planned for October 1, 2022
- Transportation Subgroup – Timeline pushed to January 2023
- Code Chart Changes Subgroup – Currently reviewing SUD Service lines
- Development of Tiered Rates for Inpatient Psychiatric Services – Planned implementation by October 1, 2022.
- Development of Tiered Rates for Licensed Residential Services – FY23 scheduled to be a "monitoring year"
- Code Chart and Provider Qualifications Chart Update – Mapping modifiers has been "extremely tedious"
- S5116 Code – Clarification provided for non-HSW population

The next EDIT meeting is scheduled for January 20, 2022.

EQI UPDATE – Review November Submission Process
Tricia reminded the Boards that she needs the reports prior to the submission date to allow time for her to do her portion. Some variances still showed for this report (contracted vs. direct-run services). Northeast Michigan reported that changes are being made to PCE to correct the issue.

LOCAL MATCH

The Local Match Obligation schedule was included in the meeting materials. It was noted that AuSable Valley has opted to not participate, which MDHHS is aware of.

SCA/MLR

Eric reported that contract negotiations and CFI, etc. met on November 4th. Disagreement remains regarding what is considered PIHP Managed Care Administration costs. The region is not moving forward pending a review of legal opinions, though some Boards are tracking time. Eric clarified there are two components:1) allocation of costs (follow GAAP), and 2) medical loss ratio calculations related to CMHSP administration. Eric added that a Medicaid Bulletin was released requiring subcontracted providers over $1M to report similar administrative costs to the Department. The Provider Alliance at the Association and the joint negotiation team have responded to the Department indicating it's an overreach and inappropriate given that the Department isn't a party to the contract between the CMH and the subcontracted provider. More information on this topic will be relayed to the Finance Committee as it becomes known.

OTHER

Lauri asked the Boards what they are doing to recruit staff. For example, she stated that a Northern Lakes direct-run home (Seneca Place) in Cadillac is currently understaffed and Northern Lakes employees are filling in, sometimes with overtime pay. Connie responded with Northeast Michigan's initiatives including cross training, pop-up job fairs, billboards, etc. Erinn replied that staffing was mainly an issue with AuSable Valley last winter. AuSable Valley also anticipates losing staff in January when the vaccine mandate takes effect; recruiting efforts are planned. A discussion about procuring COVID testing kits followed.

NEXT MEETING

The next meeting was scheduled for December 8th at 10:00AM.

Chief Executive Officer Report

November 2021

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

Nov 2: Chaired NMRE Internal Operations Committee.

Nov 3: Attended and participated in PIHP CEO Meeting.

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

Nov 5: Met with potential contractor about CRU regional options.

Nov 8: Attended and participated in NMRE SUD Oversight Board meeting.

Nov 8: Attended and participated in MDHHS Least Restrictive Policy discussion.

Nov 9: Chaired NMRE Internal Operations Committee.

Nov 10: Attended and participated in NMRE Regional Finance Committee.

Nov 18: Presented at North Country Board Retreat.

Nov 19: Attended and participated in PIHP Contract Negotiations Committee.

Nov 23: Plan to chair NMRE Operations Committee Meeting.

September 2021

Preliminary Finance Report

September 2021 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	24,772,196	4,515,675	7,738,320
Healthy Michigan	5,887,431		7,058,552
	$ 30,659,626	$ 4,515,675	$ 14,796,872

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Ausable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	2,151,507	2,410,803	7,383,121	8,600,893	1,807,648	5,704,498	2,601,158	$ 30,659,626
Direct Care Wage Estimated Surplus								(6,924,000)
Medicaid Carry Forward								4,515,675
Total Med/HMP Current Year Surplus								$ 28,251,301
Medicaid & HMP Internal Service Fund								14,796,872
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 43,048,173

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2020 through September 30, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Ausable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 198,855,326	$ 4,520,240						$ 203,375,566
CMHSP Distributions	(191,854,709)		63,662,834	53,104,505	31,986,283	26,459,511	16,641,575	(0)
1st/3rd Party receipts			504,381	-	660,484	-	-	1,164,865
Net revenue	7,000,617	4,520,240	64,167,215	53,104,505	32,646,767	26,459,511	16,641,575	204,540,431
Expense								
PIHP Admin	2,230,447	46,173						2,276,620
PIHP SUD Admin		75,189						75,189
SUD Access Center		50,970						50,970
Insurance Provider Assessment	1,113,075	23,525						1,136,600
Hospital Rate Adjuster	1,642,256							1,642,256
Services		3,540,879	57,389,741	46,798,719	31,574,138	21,147,818	14,135,305	174,586,600
Total expense	4,985,778	3,736,736	57,389,741	46,798,719	31,574,138	21,147,818	14,135,305	179,768,235
Net Actual Surplus (Deficit)	$ 2,014,839	$ 783,504	$ 6,777,474	$ 6,305,786	$ 1,072,629	$ 5,311,693	$ 2,506,270	$ 24,772,196

Notes

Medicaid ISF - $7,738,320 - based on Final FSR
Medicaid Savings - $4,515,675

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2020 through September 30, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Ausable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 21,272,495	$ 10,295,459						$ 31,567,954
CMHSP Distributions	(19,547,511)		7,132,690	5,904,370	2,423,399	2,444,048	1,643,004	-
1st/3rd Party receipts			-	-	5,054	-	-	5,054
Net revenue	1,724,984	10,295,459	7,132,690	5,904,370	2,428,452	2,444,048	1,643,004	31,573,008
Expense								
PIHP Admin	201,196	107,143						308,339
PIHP SUD Admin		174,472						174,472
SUD Access Center		118,274						118,274
Insurance Provider Assessment	102,452	51,838						154,290
Hospital Rate Adjuster	1,284,668							1,284,668
Services		8,216,433	6,527,044	3,609,263	1,693,434	2,051,243	1,548,117	23,645,534
Total expense	1,588,316	8,668,160	6,527,044	3,609,263	1,693,434	2,051,243	1,548,117	25,685,577
Net Surplus (Deficit)	$ 136,667	$ 1,627,299	$ 605,646	$ 2,295,107	$ 735,019	$ 392,805	$ 94,887	$ 5,887,431

Notes
HMP ISF - $7,058,552 - based on Final FSR
HMP Savings - $0

Net Surplus (Deficit) MA/HMP	**$ 2,151,507**	**$ 2,410,803**	**$ 7,383,121**	**$ 8,600,893**	**$ 1,807,648**	**$ 5,704,498**	**$2,601,158**	**$ 30,659,626**
Direct Care Wage Estimated Surplus								**$ (6,924,000)**
Medicaid Carry Forward								**4,515,675**
Total Med/HMP Current Year Surplus								**$ 28,251,301**
Medicaid & HMP ISF - based on Final FSR								**14,796,872**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 43,048,173**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2020 through September 30, 2021

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Ausable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 34,724		$ 182,153	26,323	30,534	6,668	$ 228,482	$ 508,884
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	34,724	-	182,153	26,323	30,534	6,668	228,482	508,884
Expense								
PIHP Admin	6,183							6,183
Insurance Provider Assessment	2,338							2,338
Hospital Rate Adjuster								
Services			182,153	26,323	30,534	6,668	228,482	474,160
Total expense	8,521	-	182,153	26,323	30,534	6,668	228,482	482,681
Net Surplus (Deficit)	$ 26,203	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,203

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2020 through September 30, 2021

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 4,520,240	$ 10,295,459	$ 2,278,001	$ 2,750,835	$ 1,461,234	$ 21,305,769
Expense						
Administration	121,362	281,615	72,180	180,156		655,313
OHH Admin	-	-	71,036	-		71,036
Access Center	50,970	118,274	-	25,933		195,177
Insurance Provider Assessment	23,525	51,838	11,990			87,353
Services:						
Treatment	3,540,879	8,216,433	2,105,935	1,801,561	1,461,234	17,126,042
Prevention	-	-	-	743,185	-	743,185
State targeted response	-	-	-	-	-	-
Total expense	3,736,736	8,668,160	2,261,141	2,750,835	1,461,234	18,878,106
PA2 Redirect			-			-
Net Surplus (Deficit)	$ 783,504	$ 1,627,299	$ 16,860	$ (0)	$ -	$ 2,427,663

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2020 through September 30, 2021

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 198,855,326	$ 4,520,240	$ -	$ 203,375,566
Medicaid Savings	4,515,675	-	-	4,515,675
Healthy Michigan	21,272,495	10,295,459	-	31,567,954
Healthy Michigan Savings	-	-	-	-
Health Home	508,884	-	-	508,884
Opioid Health Home	-	2,278,001	-	2,278,001
Substance Use Disorder Block Grant	-	2,750,835	-	2,750,835
Public Act 2 (Liquor tax)	-	1,461,234	-	1,461,234
Affiliate local drawdown	1,204,388	-	-	1,204,388
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	40,335	-	40,335
Veteran Navigator Grant	67,488	-	-	67,488
SOR Grant Revenue	-	1,364,873	-	1,364,873
Gambling Grant Revenue	-	186,094	-	186,094
Other Revenue	-	-	2,522	2,522
Total operating revenue	226,424,256	22,897,071	2,522	249,323,849
Operating expenses				
General Administration	2,671,337	616,980	-	3,288,317
Prevention Administration	-	85,835	-	85,835
OHH Administration	-	71,036	-	71,036
Insurance Provider Assessment	1,217,865	87,353	-	1,305,218
Hospital Rate Adjuster	2,926,924	-	-	2,926,924
Payments to Affiliates:				
Medicaid Services	169,880,856	3,540,879	-	173,421,735
Healthy Michigan Services	15,424,047	8,216,433	-	23,640,480
Health Home Services	474,160	-	-	474,160
Opioid Health Home Services	-	2,105,935	-	2,105,935
Community Grant	-	1,801,561	-	1,801,561
Prevention	-	657,350	-	657,350
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	1,461,234	-	1,461,234
Local PBIP	1,334,530	-	-	1,334,530
Local Match Drawdown	1,204,388	-	-	1,204,388
Miscellanous Grant	-	40,335	-	40,335
Veteran Navigator Grant	67,488	-	-	67,488
SOR Grant Expenses	-	1,364,873	-	1,364,873
Gambling Grant Expenses	-	186,094	-	186,094
Total operating expenses	195,201,595	20,235,898	-	215,437,493
CY Unspent funds	31,222,661	2,661,173	2,522	33,886,356
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	1,293,901	6,840,165	14,796,872	22,930,938
Unspent funds - ending	$ 32,516,562	$ 9,501,338	$ 14,799,394	$ 56,817,294

Northern Michigan Regional Entity

Statement of Net Position

September 30, 2021

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 14,507,055	$ 9,900,736	$ 5,212,811	$ 29,620,602
Accounts Receivable	28,804,370	1,216,407	9,586,583	39,607,360
Prepaids	57,980	-	-	57,980
Total current assets	43,369,405	11,117,143	14,799,394	69,285,942
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	43,369,405	11,117,143	14,799,394	69,285,942
Liabilities				
Current liabilities				
Accounts payable	10,629,749	1,615,805	-	12,245,554
Accrued liabilities	223,094	-	-	223,094
Unearned revenue	-	-	-	-
Total current liabilities	10,852,843	1,615,805	-	12,468,648
Unspent funds	$ 32,516,562	$ 9,501,338	$ 14,799,394	$ 56,817,294

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2020 through September 30, 2021

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 174,071,340	$ 174,071,340	$ 198,855,326	$ 24,783,986	14.24%
Carryover	6,600,000	6,600,000	4,515,675	(2,084,325)	(0)
Healthy Michigan					
Capitation	16,832,844	16,832,844	21,272,495	4,439,651	26.37%
Carryover	-	-	-	-	0.00%
Health Home	160,664	160,664	508,884	348,220	216.74%
Affiliate local drawdown	1,324,156	1,324,156	1,204,388	(119,768)	(9.04%)
Performance Bonus Incentive	1,229,649	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	100,000	100,000	67,488	(32,512)	(32.51%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	200,318,653	199,089,004	226,424,256	27,335,252	13.73%
Operating expenses					
General Administration	3,144,865	3,117,937	2,671,337	446,600	14.32%
Insurance Provider Assessment	1,600,452	1,600,452	1,217,865	382,587	23.90%
Hospital Rate Adjuster	3,834,600	3,834,600	2,926,924	907,676	23.67%
Local PBIP	1,229,649	-	1,334,530	(1,334,530)	0.00%
Local Match Drawdown	1,324,152	1,324,152	1,204,388	119,764	9.04%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	100,000	100,000	67,488	32,512	32.51%
Payments to Affiliates:					
Medicaid Services	167,358,096	167,358,096	169,880,856	(2,522,760)	(1.51%)
Healthy Michigan Services	15,049,128	15,049,128	15,424,047	(374,919)	(2.49%)
Health Home Services	157,008	157,008	474,160	(317,152)	(202.00%)
Total operating expenses	193,797,950	192,541,373	195,201,595	(2,660,222)	(1.38%)
CY Unspent funds	$ 6,520,703	$ 6,547,631	31,222,661	$ 24,675,030	
Transfers in			-		
Transfers out			-	195,201,595	
Unspent funds - beginning			1,293,901		
Unspent funds - ending			$ 32,516,562	31,222,661	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2020 through September 30, 2021

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,546,404	$ 4,546,404	$ 4,520,240	$ (26,164)	(0.58%)
Healthy Michigan	8,615,688	8,615,688	10,295,459	1,679,771	19.50%
Substance Use Disorder Block Grant	3,105,145	3,105,145	2,750,835	(354,310)	(11.41%)
Opioid Health Home	963,264	963,264	2,278,001	1,314,737	136.49%
Public Act 2 (Liquor tax)	1,533,979	1,533,979	1,461,234	(72,745)	(4.74%)
Miscellanous Grants	36,335	36,335	40,335	4,000	11.01%
SOR Grant	2,298,500	2,298,500	1,364,873	(933,627)	(40.62%)
Gambling Prevention Grant	200,000	200,000	186,094	(13,906)	(6.95%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	21,299,315	21,299,315	22,897,071	1,597,756	7.50%
Operating expenses					
Substance Use Disorder:					
SUD Administration	773,328	767,328	616,980	150,348	19.59%
Prevention Administration	87,516	87,516	85,835	1,681	1.92%
Insurance Provider Assessment	89,052	89,052	87,353	1,699	1.91%
Medicaid Services	3,187,188	3,187,188	3,540,879	(353,691)	(11.10%)
Healthy Michigan Services	6,894,144	6,894,144	8,216,433	(1,322,289)	(19.18%)
Community Grant	2,075,447	2,075,447	1,801,561	273,886	13.20%
Prevention	664,967	664,967	657,350	7,617	1.15%
State Disability Assistance	95,215	95,215	-	95,215	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	71,036	(71,036)	0.00%
Opioid Health Home Services	810,000	810,000	2,105,935	(1,295,935)	(159.99%)
Miscellanous Grants	36,335	36,335	40,335	(4,000)	(11.01%)
SOR Grant	2,298,500	2,298,500	1,364,873	933,627	40.62%
Gambling Prevention	200,000	200,000	186,094	13,906	6.95%
PA2	1,533,978	1,533,978	1,461,234	72,744	4.74%
Total operating expenses	18,745,670	18,739,670	20,235,898	(1,496,228)	(7.98%)
CY Unspent funds	$ 2,553,645	$ 2,559,645	2,661,173	$ 101,528	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,840,165		
Unspent funds - ending			$ 9,501,338		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2020 through September 30, 2021

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,721,088	$ 1,721,088	$ 1,458,449	$ 262,639	15.26%
Fringes	623,856	596,928	494,556	102,372	17.15%
Contractual	461,441	461,441	375,007	86,434	18.73%
Board expenses	21,600	21,600	16,868	4,732	21.91%
Day of recovery	14,000	14,000	243	13,757	98.26%
Facilities	166,884	166,884	134,030	32,854	19.69%
Other	135,996	135,996	192,184	(56,188)	(41.32%)
Total General Admin	$ 3,144,865	$ 3,117,937	$ 2,671,337	$ 446,600	14.32%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2020 through September 30, 2021

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 318,624	$ 318,624	$ 194,986	$ 123,638	38.80%
Fringes	115,560	115,560	85,977	29,583	25.60%
Access Salaries	133,320	133,320	151,883	(18,563)	(13.92%)
Access Fringes	28,188	28,188	43,294	(15,106)	(53.59%)
Access Contractual	-	-	-	-	0.00%
Contractual	159,996	159,996	128,093	31,903	19.94%
Board expenses	8,400	8,400	4,180	4,220	50.24%
Facilities	-	-	-	-	0.00%
Other	9,240	3,240	8,567	(5,327)	(164.41%)
Total operating expenses	$ 773,328	$ 767,328	$ 616,980	$ 150,348	19.59%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2020 through September 30, 2021

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	6,000	6,000	2,522	(3,478)	(57.97%)
Total operating revenue	6,000	6,000	2,522	(3,478)	(57.97%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 6,000	$ 6,000	2,522	$ (3,478)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			14,796,872		
Unspent funds - ending			$ 14,799,394		

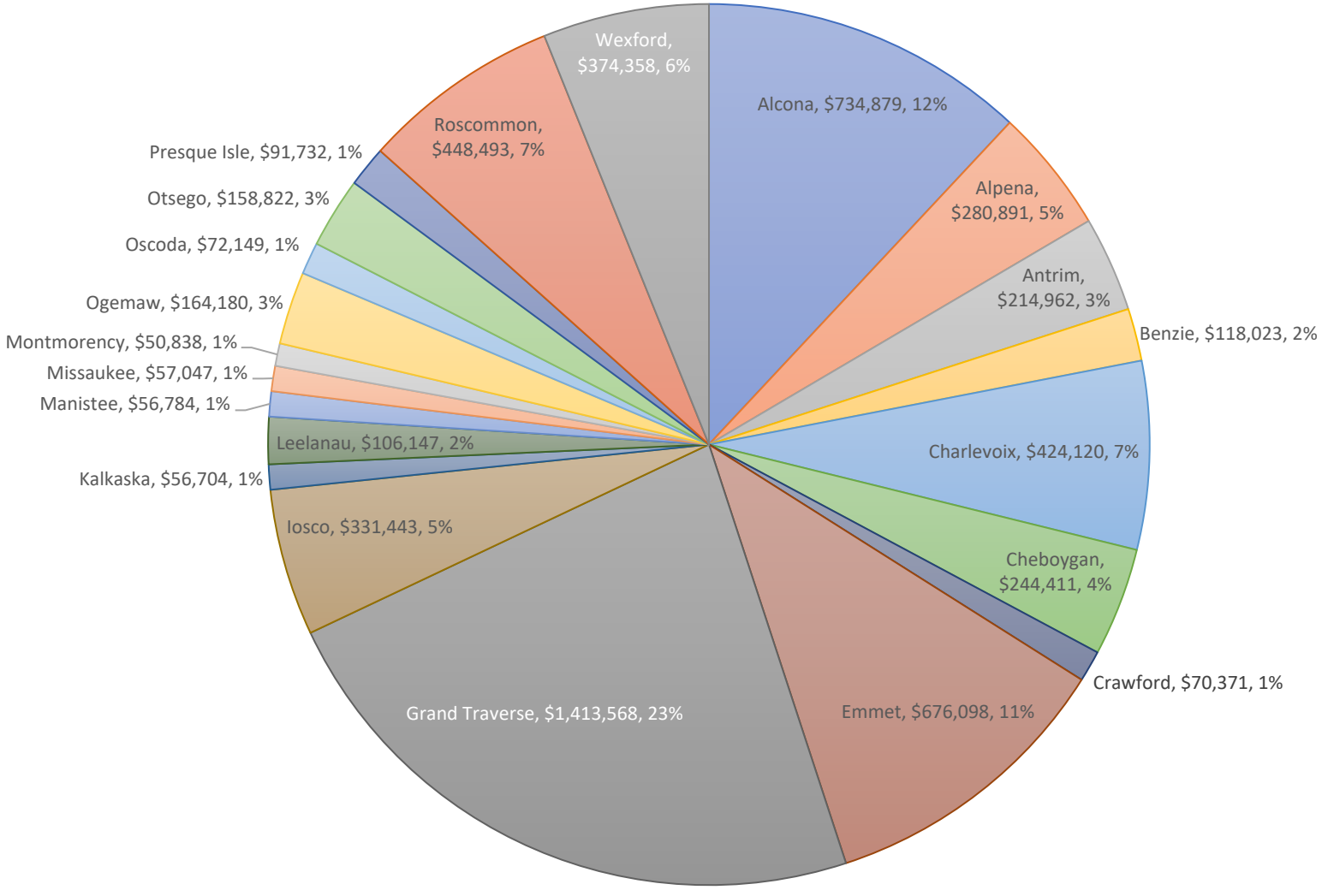
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2020 through September 30, 2021

	Beginning Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County					
Alcona	$ 88,107	$ 669,908	19,071	$ 4,065	$ 734,879
Alpena	326,729	29,632	64,292	11,177	280,891
Antrim	218,487	24,032	18,409	9,147	214,962
Benzie	118,479	22,333	15,887	6,901	118,023
Charlevoix	432,993	36,815	35,423	10,265	424,120
Cheboygan	303,118	30,842	79,586	9,962	244,411
Crawford	121,414	12,807	58,389	5,461	70,371
Emmet	648,645	65,134	24,645	13,035	676,098
Grand Traverse	1,612,893	168,619	331,891	36,052	1,413,568
Iosco	401,902	31,512	92,090	9,881	331,443
Kalkaska	109,739	14,808	60,918	6,925	56,704
Leelanau	162,144	21,938	69,430	8,505	106,147
Manistee	84,324	28,585	46,533	9,592	56,784
Missaukee	63,191	8,098	8,352	5,890	57,047
Montmorency	96,078	11,863	53,471	3,632	50,838
Ogemaw	228,036	24,510	80,127	8,239	164,180
Oscoda	78,291	7,662	10,549	3,254	72,149
Otsego	257,837	38,972	128,351	9,636	158,822
Presque Isle	111,192	9,245	23,683	5,023	91,732
Roscommon	442,922	33,852	18,898	9,383	448,493
Wexford	372,430	37,142	22,147	13,067	374,358
	6,278,950	1,328,303	1,262,142	199,093	6,146,019
PA2 Redirect					-
					6,146,019

PA2 Funds by County

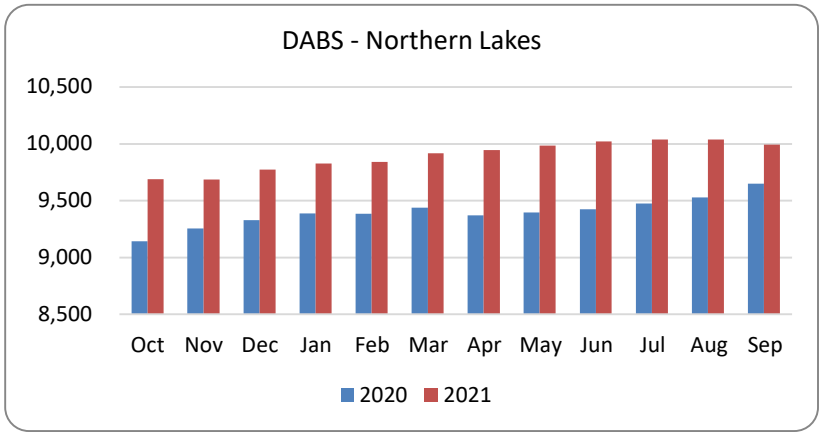


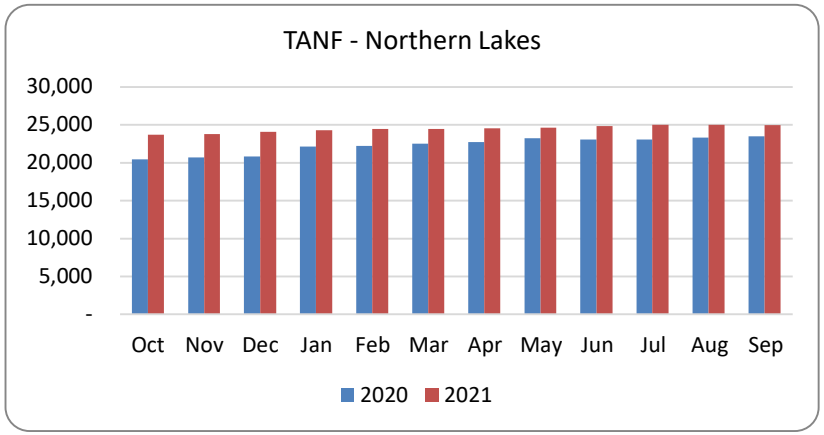
Northern Michigan Regional Entity

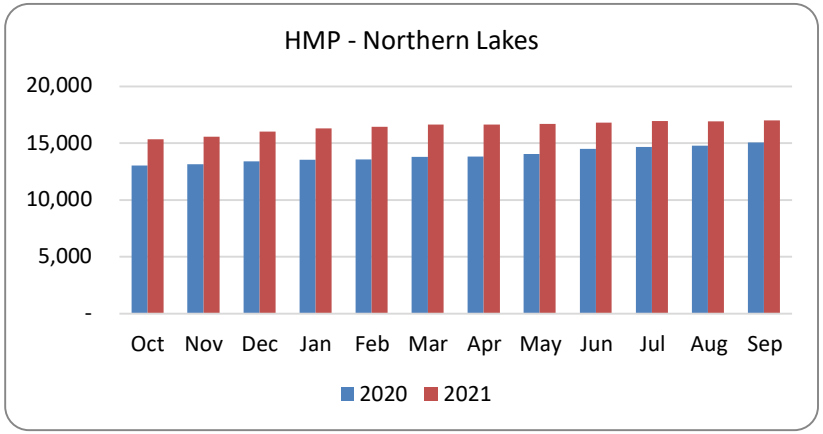
Narrative

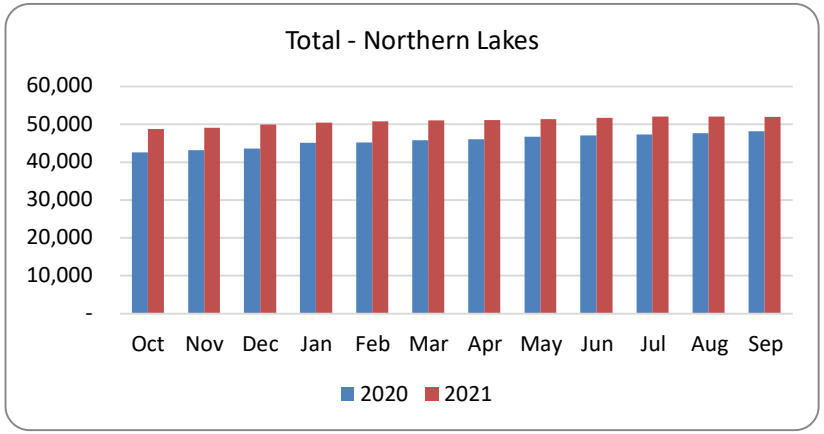
October 1, 2020 through September 30, 2021

Northern Lakes Eligible Trending







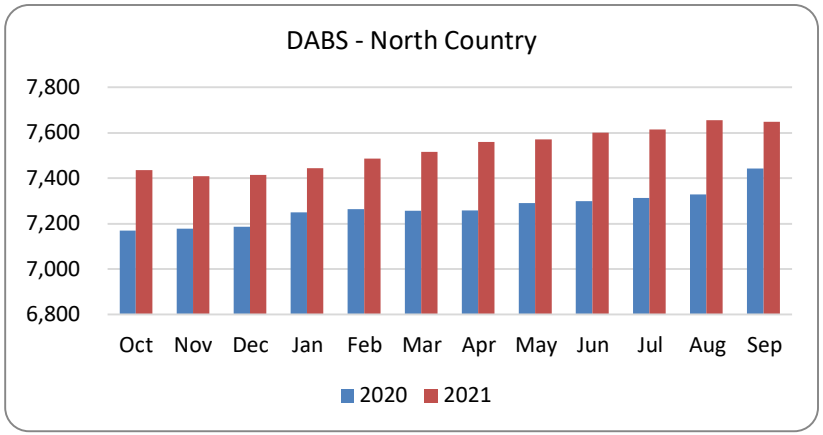


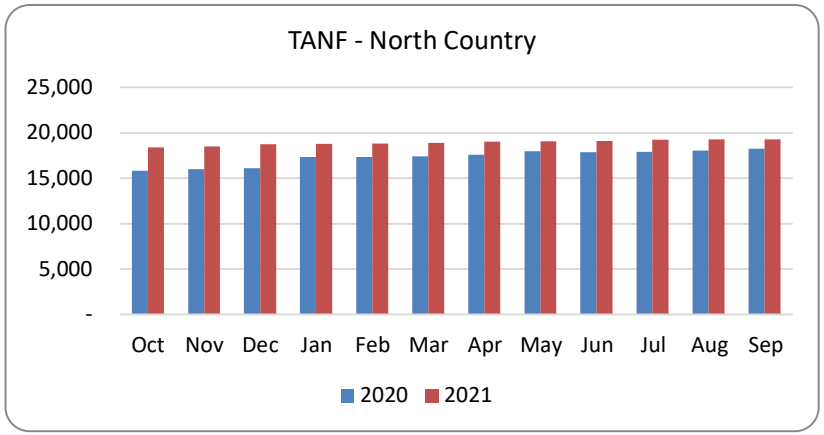
Northern Michigan Regional Entity

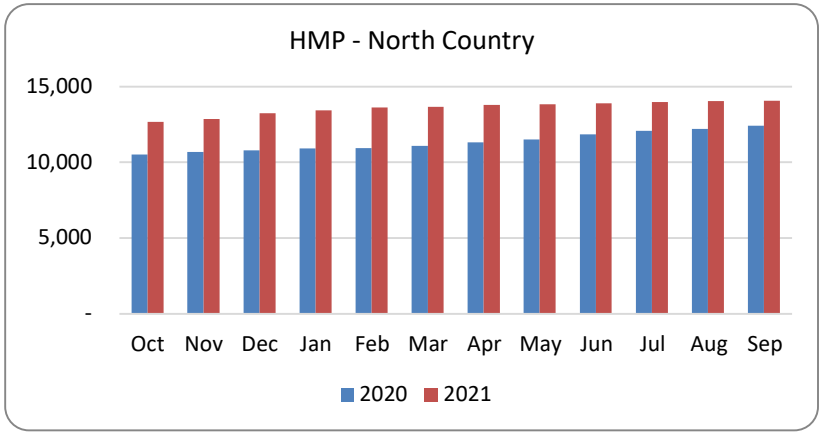
Narrative

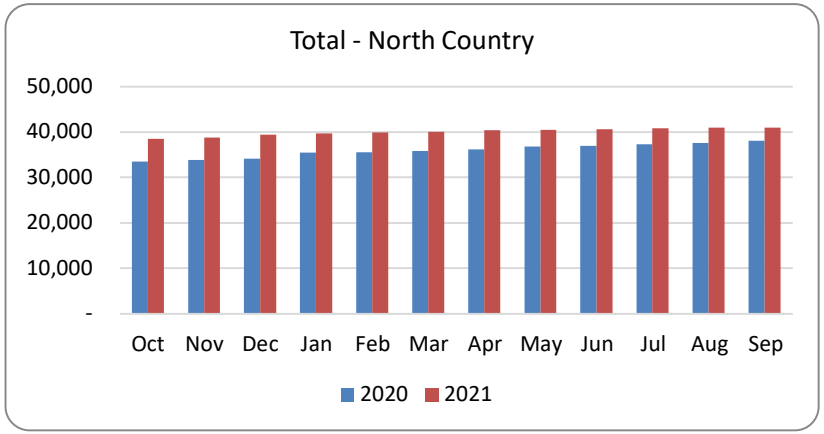
October 1, 2020 through September 30, 2021

North Country Eligible Trending







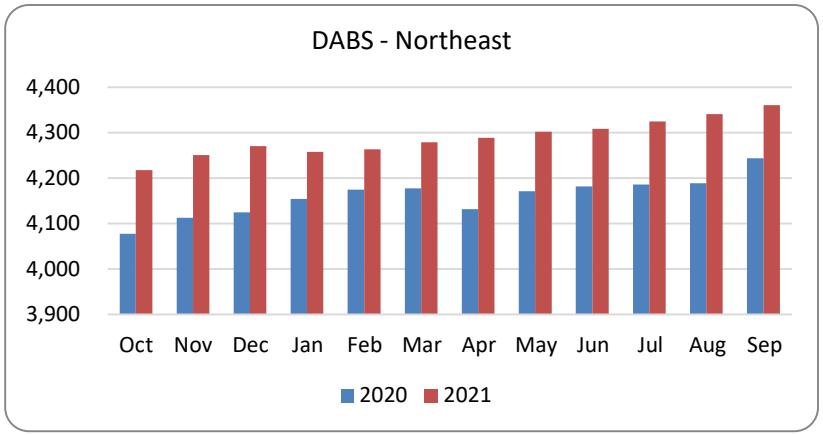


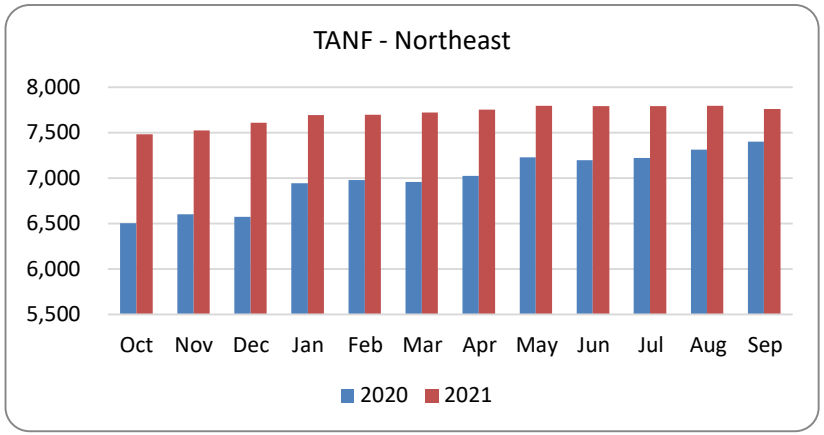
Northern Michigan Regional Entity

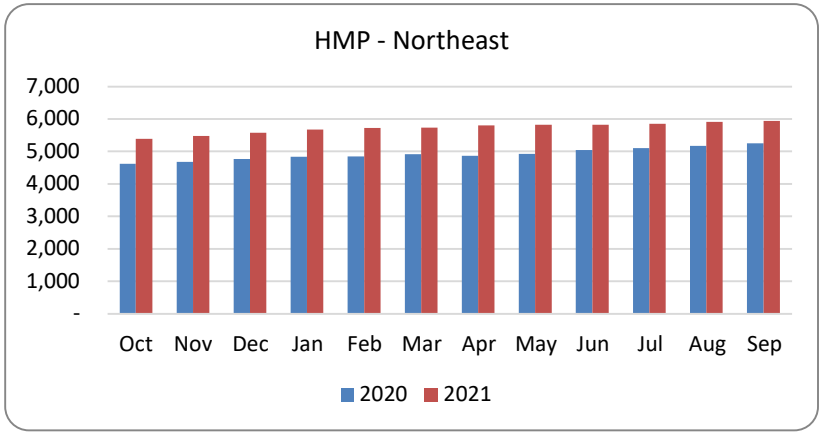
Narrative

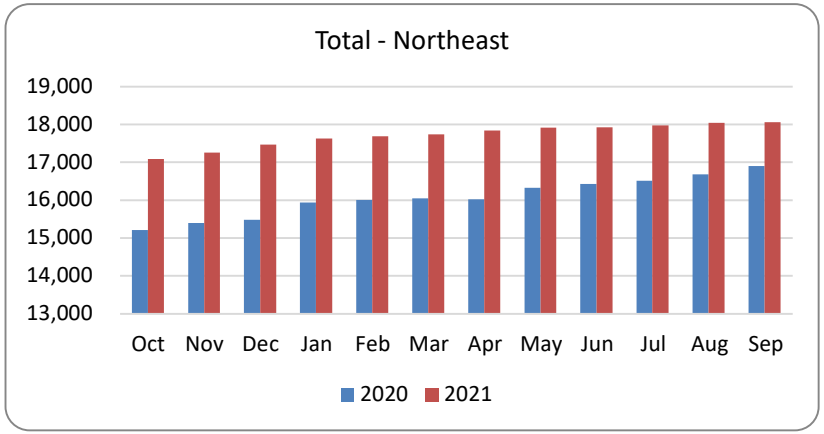
October 1, 2020 through September 30, 2021

Northeast Eligible Trending







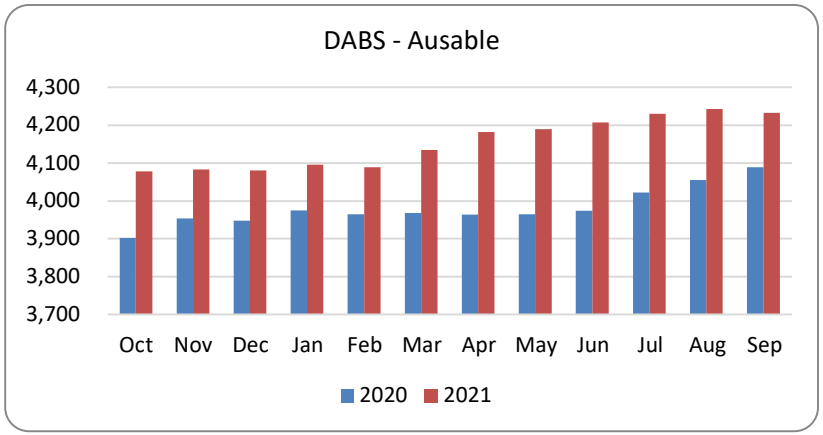


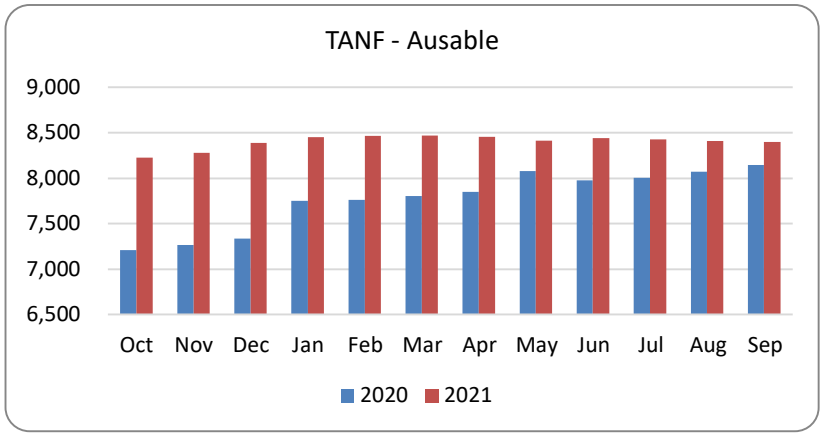
Northern Michigan Regional Entity

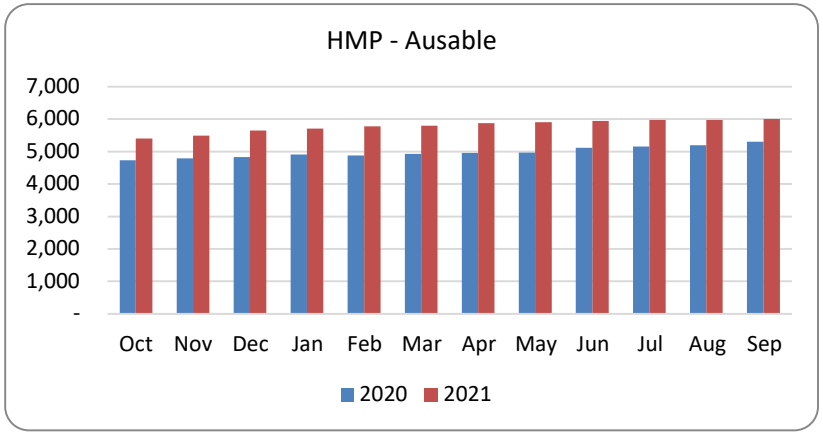
Narrative

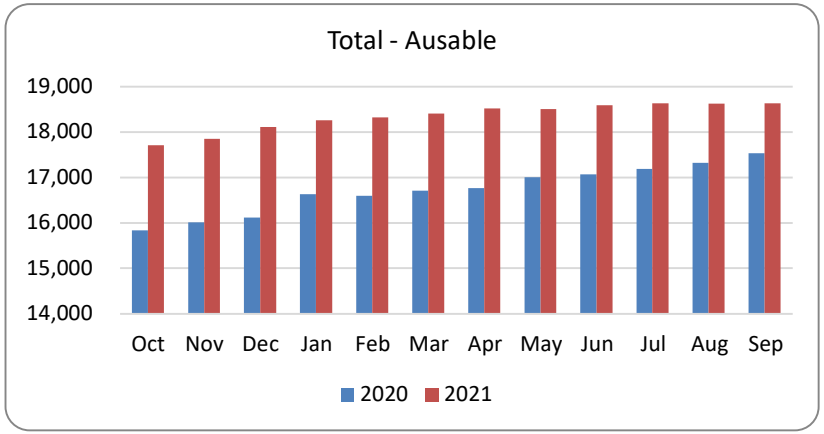
October 1, 2020 through September 30, 2021

Ausable Valley Eligible Trending







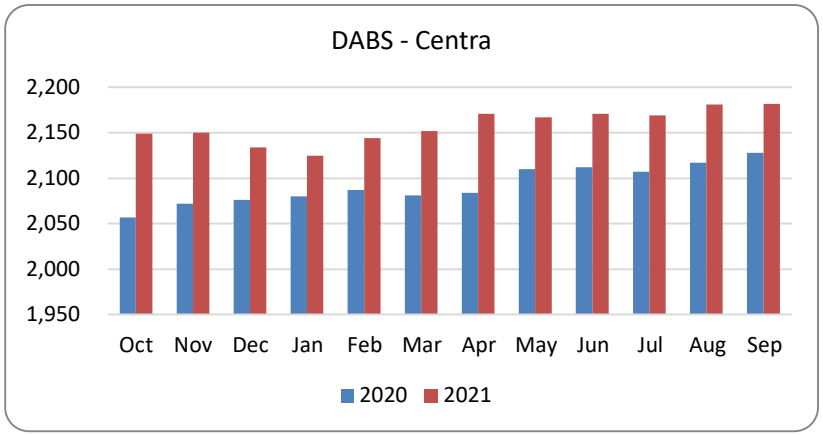


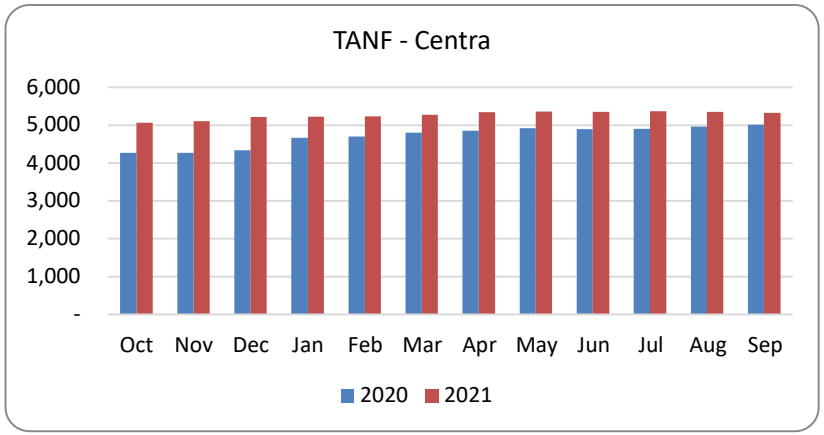
Northern Michigan Regional Entity

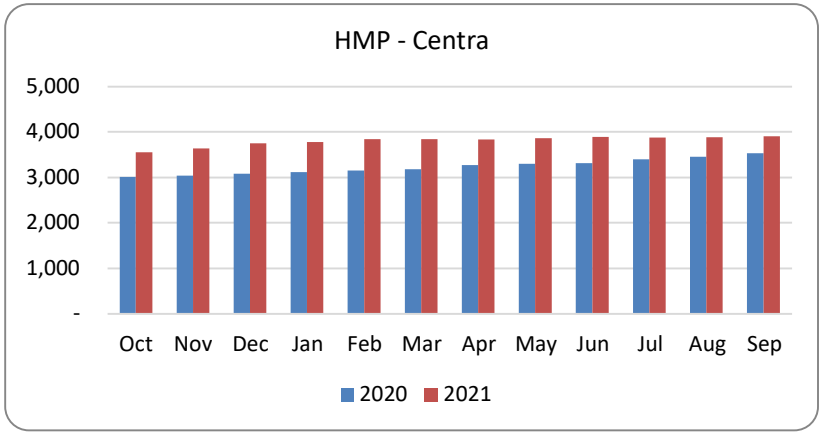
Narrative

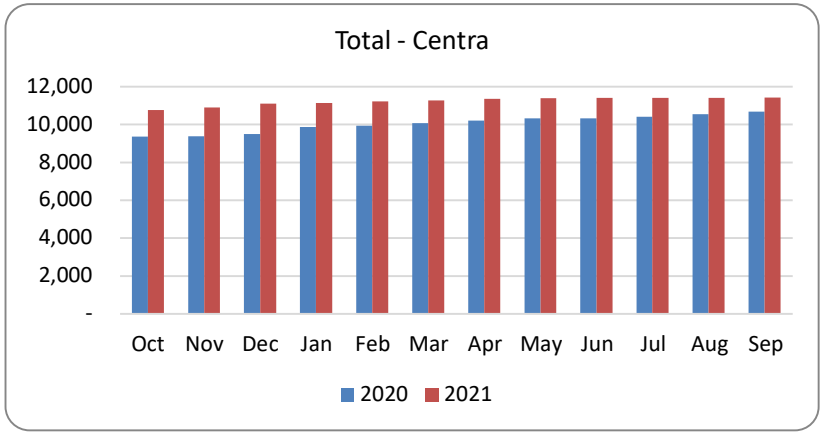
October 1, 2020 through September 30, 2021

Centra Wellness Eligible Trending







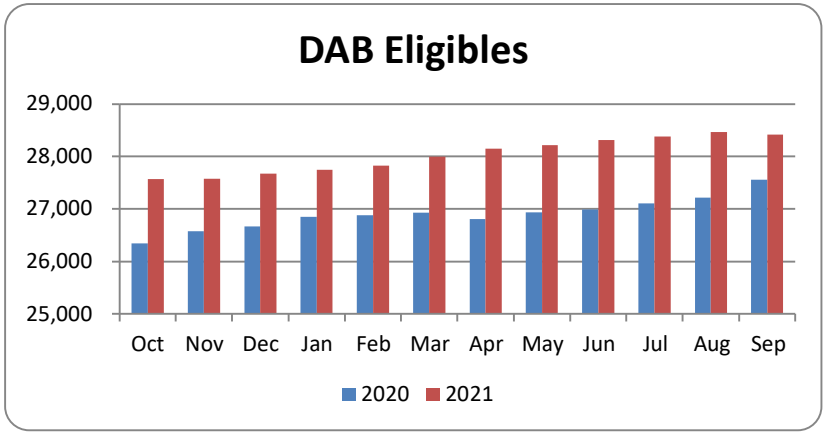


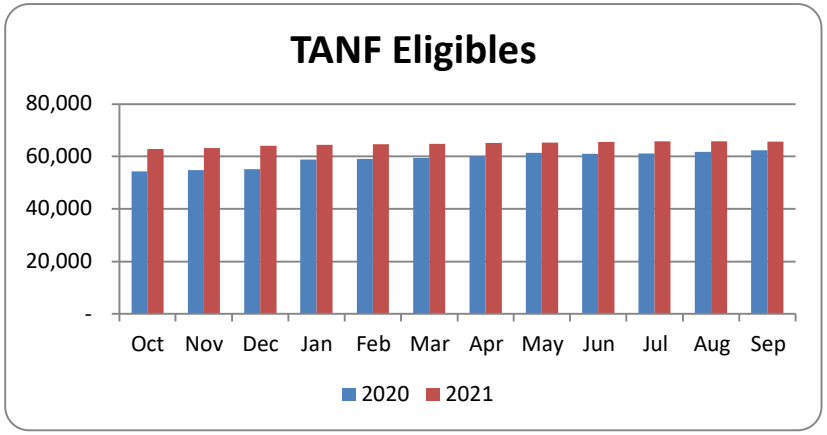
Northern Michigan Regional Entity

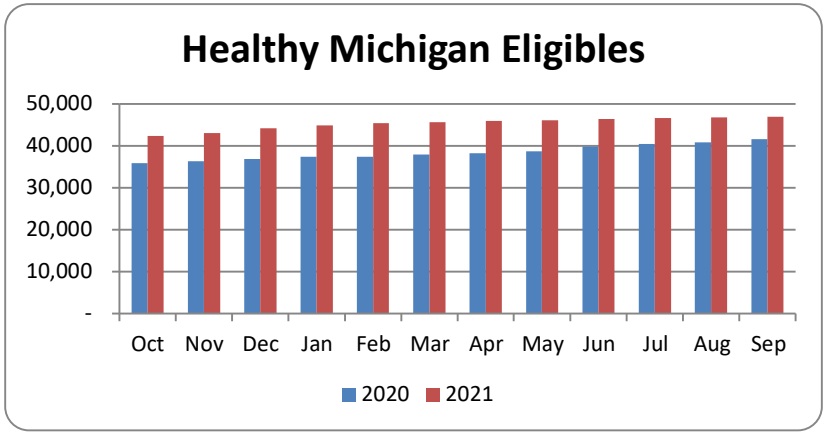
Narrative

October 1, 2020 through September 30, 2021

Regional Eligible Trending





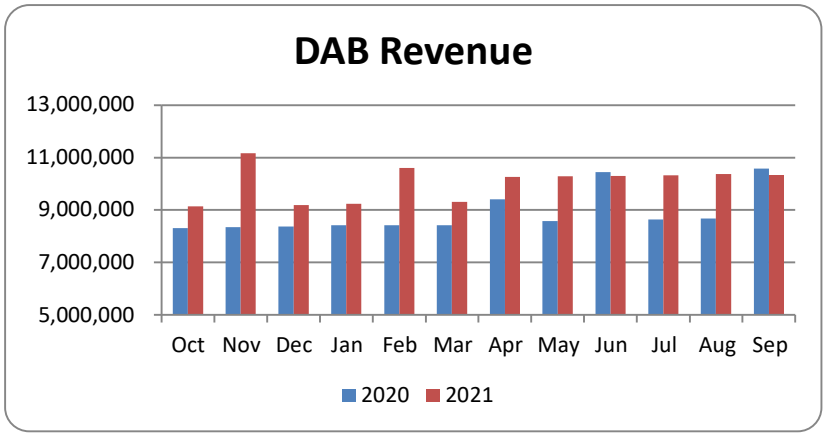


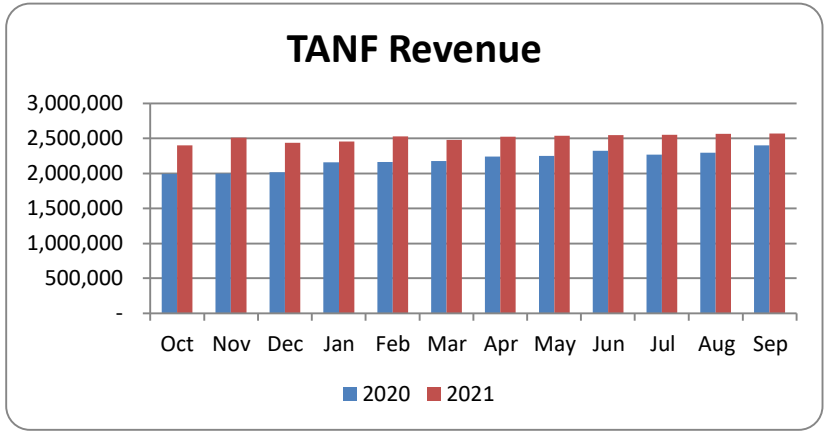
Northern Michigan Regional Entity

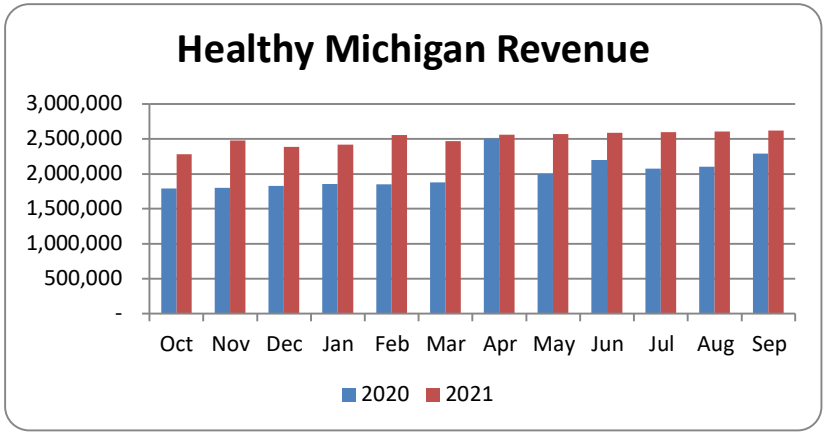
Narrative

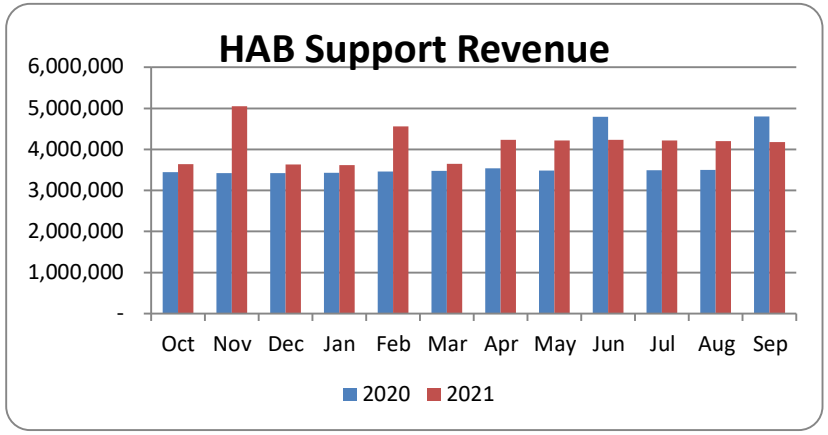
October 1, 2020 through September 30, 2021

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING
10:00AM – NOVEMBER 08, 2021
NMRE GAYLORD CONFERENCE ROOM

ATTENDEES:	**Tim Markey (Benzie), John Wallace (Cheboygan), Terry Newton (Emmet), Dave Freedman (Grand Traverse), Jay O'Farrell (Iosco), Richard Schmidt (Manistee), Ron Quackenbush (Ogemaw), Chuck Varner (Oscoda), Doug Johnson (Otsego), Terry Larson (Presque Isle), Tim Muckenthaler (Roscommon), Gary Taylor (Wexford)**
VIRTUAL:	**Carolyn Brummund (Alcona), Robert Adrian (Alpena), Robert Draves (Charlevoix), Sherry Powers (Crawford), Greg McMorrow (Leelanau),**
ABSENT:	**Melissa Zelenak (Antrim), David Comai (Kalkaska), Roger Frye (Montmorency), Chuck Varner (Oscoda)**
STAFF:	**Jodie Balhorn, Eugene Branigan, Eric Kurtz, Pamela Polom, Sara Sircely, Deanna Yockey, Carol Balousek, Lisa Hartley**

CALL TO ORDER
Let the record show that in the absence of Mr. Frye, Terry Larson was elected as Chair for the meeting on this date and the meeting was called to order at 10:00AM.

ROLL CALL
Let the record show that David Comai, Roger Frye, Chuck Varner, and Melissa Zelenak were absent from the meeting on this date; all other NMRE Substance Use Disorder Oversight Board Members were in attendance either in person or virtually.

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

APPROVAL OF PAST MINUTES
The September 13, 2021 minutes were included in the materials for the meeting on this date.

MOTION BY RON QUACKENBUSH TO APPROVE THE MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD FOR SEPTEMBER 13, 2021; SUPPORT BY TERRY NEWTON. MOTION CARRIED.

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

MOTION BY JAY O'FARRELL TO APPROVE THE AGENDA FOR THE NOVEMBER 8, 2021 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

CORRESPONDENCE
Let the record show that there was no correspondence to discuss during the meeting on this date.

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

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST
Let the record show that Mr. Tanner called for any conflicts of interest to any of the meeting agenda items; none were disclosed.

INFORMATIONAL REPORTS
Admissions
The admissions report through September 30, 2021 was included in the materials for the meeting on this date. Overall admissions were up 14.28% from FY20. The data showed that males made up most of the individuals served at 61.29%, outpatient was the highest level of treatment at 52.18%, and alcohol was the most prevalent primary substance at 49.08% (heroin was second at 17.06%). Sara Sircely noted that methamphetamine use is rising throughout the region reported as 12.73% vs. 9.23% in FY20.

Mr. Freedman commented about ATS shutting down detox due to staffing issues; he asked whether the NMRE has provisions in place to help with stability. Mr. Kurtz responded that he's met with Chris Hindbaugh; provider stability payments have been issued upon request. The issue with detox in Michigan is one of staffing; requires 24/7 nursing which is often unavailable. The NMRE is in the process of increasing rates to get it up and running. It was noted that the direct care worker shortage has reached critical levels.

Finance
August 2021 Monthly Report
SUD services through August 31, 2021 showed all funding source revenue of $19,357,458 and $17,454,194 in expenses, resulting in a net surplus of $1,903,264. Total PA2 funds were reported as $6,339,469. An additional liquor tax payment is due for FY21 in December.

MOTION BY TERRY NEWTON TO RECEIVE AND FILE THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER FINANCIAL REPORT FOR AUGUST 2021; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

Projects List
Ms. Sircely reviewed the approvals to date for FY22 by county. Ms. Sircely clarified that MAT services will be provided in Grand Traverse County utilizing SOR-2 funds.

RECOMMENDATION ITEMS
Recommendations List
The NMRE staff recommendations related to liquor tax use requests were included in the materials for the meeting on this date. Ms. Sircely noted that, in the future, PA2 requests will also be summarized by county.

PA2 Fund Use Requests

1) 53rd Circuit Recovery Court & Salvation Army – Transitional House

Cheboygan $ 6,000

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM THE FIFTY-THIRD (53RD) CIRCUIT COURT AND THE SALVATION ARMY FOR CHEBOYGAN COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF SIX THOUSAND DOLLARS ($6,000,00) TO HELP FUND TRANSITIONAL HOUSING; SUPPORT BY DAVE FREEDMAN.

Discussion: Mr. Freedman asked about blanks on the application. Ms. Sircely responded that, generally, blanks indicate "not applicable" or the response was stated previously on the application.

Roll call voting took place on Mr. Newton's motion.

"Yea" Votes	**R. Adrian, C. Brummund, B. Draves, D. Freedman, D. Johnson, T. Larson, T. Markey, G. McMorrow, T. Muckenthaler, T. Newton, J. O'Farrell, S. Powers, R. Quackenbush, R. Schmidt, G. Taylor, J. Wallace**
"Nay" Votes:	**Nil**

MOTION CARRIED.

2) 13th Circuit Court Community Corrections & Grand Traverse County Finance – Recovery Coaching

Grand Traverse $ 34,100

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM THE THIRTEENTH (13TH) CIRCUIT COURT COMMUNITY CORRECTIONS AND GRAND TRAVERSE COUNTY FINANCE FOR GRAND TRAVERSE COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF THIRTY-FOUR THOUSAND ONE HUNDRED DOLLARS ($34,100.00) TO PROVIDE PEER RECOVERY COACHING SERVICES TO INDIVIDUALS PARTICIPATING IN SOBRIETY COURT AND DRUG COURT; SUPPORT BY JAY O'FARRELL. ROLL CALL VOTE.

"Yea" Votes	**R. Adrian, C. Brummund, B. Draves, D. Freedman, D. Johnson, T. Larson, T. Markey, G. McMorrow, T. Muckenthaler, T. Newton, J. O'Farrell, S. Powers, R. Quackenbush, R. Schmidt, G. Taylor, J. Wallace**
"Nay" Votes:	**Nil**

MOTION CARRIED.

3) 13th Circuit Court Community Corrections & Grand Traverse County Finance – Supportive Recovery Housing

Grand Traverse $ 31,500

MOTION BY TERRY NEWTON TO APPROVE THE REQUEST FROM THE THIRTEENTH (13TH) CIRCUIT COURT COMMUNITY CORRECTIONS AND GRAND TRAVERSE

COUNTY FINANCE FOR GRAND TRAVERSE COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF THIRTY-ONE THOUSAND FIVE HUNDRED DOLLARS ($31,500.00) TO PROVIDE; SUPPORT BY RON QUACKENBUSH. ROLL CALL VOTE.

"Yea" Votes **R. Adrian, C. Brummund, B. Draves, D. Freedman, D. Johnson, T. Larson, T. Markey, G. McMorrow, T. Muckenthaler, T. Newton, J. O'Farrell, S. Powers, R. Quackenbush, R. Schmidt, G. Taylor, J. Wallace**

"Nay" Votes: **Nil**

MOTION CARRIED.

Let the record show that the total amount PA2 fund spending approved on this date was recorded as **$71,600**.

Catholic Human Services Coalition – Updated Amounts
Update budgets were included in the materials for the meeting on this date. The net difference was provided as ($4,639).

County	Project	Amount Requested	Amount Approved	Updated Request	Net Difference
Crawford	Coalition	$20,725	$20,725	$34,676	$13,951
Iosco	Coalition	$33,871	$33,871	$33,865	($6)
Oscoda	Coalition	$17,499	$17,499	$18,996	$1,497
Roscommon	Coalition	$42,447	$42,447	$22,366	($20,081)

MOTION BY TERRY NEWTON TO APPROVE THE REVISED REQUESTED AMOUNTS BY CATHOLIC HUMAN SERVICES FOR FISCAL YEAR 2022 PREVENTION COALITION FUNDING FOR CRAWFORD, IOSCO, OSCODA, AND ROSCOMMON COUNTIES; SUPPORT BY SHERRY POWERS. ROLL CALL VOTE.

"Yea" Votes **R. Adrian, C. Brummund, B. Draves, D. Freedman, D. Johnson, T. Larson, T. Markey, G. McMorrow, T. Muckenthaler, T. Newton, J. O'Farrell, S. Powers, R. Quackenbush, R. Schmidt, G. Taylor, J. Wallace**

"Nay" Votes: **Nil**

MOTION CARRIED.

Bear River Health – PA2 Request for Jail MAT Services approved in September
During the meeting on September 13, 2021, the NMRE Substance Use Disorder Oversight Board denied the PA2 request for jail mat services for Otsego County due to its effect on the fund balance. Since those services would cease effective October 1, 2021 without funding, the NMRE Governing Board opted to approve funding for three months during its meeting on October 27, 2021 for the amount of $22,623.

PUBLIC COMMENT
No comments from the public were voiced during the meeting on this date.

NEXT MEETING

Let the record show that the next meeting was scheduled for 10:00AM on January 10, 2022 at the NMRE office in Gaylord.

ADJOURN

MOTION BY JOHN WALLACE TO ADJOURN THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING FOR NOVEMBER 8, 2021; SECOND BY RON QUACKENBUSH. MOTION CARRIED.

Let the record show that Mr. Larson adjourned the meeting at 10:48AM.

Catholic Human Services

Updated Coalition Budget Amounts

County	Type	Project	Provider	FY	Requested	Approved Amount	UPDATED REQUEST	UPDATED TOTAL
Grand Traverse	Prevention	Coalition	CHS	2022	$ 90,180.00	$ 90,180.00		**$ 90,180.00**
Cheboygan	Prevention	Coalition	CHS	2022	$ 81,987.00	$ 81,987.00		**$ 81,987.00**
Crawford	Prevention	Coalition	CHS	2022	$ 20,725.00	$ 20,725.00	**$ 34,676.00**	**$ 34,676.00**
Iosco	Prevention	Coalition	CHS	2022	$ 33,871.00	$ 33,871.00	**$ 33,865.00**	**$ 33,865.00**
Kalkaska	Prevention	Coalition	CHS	2022	$ 52,452.00	$ -		
Montmorency	Prevention	Coalition	CHS	2022	$ 32,841.00	$ -		
Ogemaw	Prevention	Coalition	CHS	2022	$ 55,905.00	$ -		
Oscoda	Prevention	Coalition	CHS	2022	$ 17,499.00	$ 17,499.00	**$ 18,996.00**	**$ 18,996.00**
Roscommon	Prevention	Coalition	CHS	2022	$ 42,447.00	$ 42,447.00	**$ 22,366.00**	**$ 22,366.00**
					$ 427,907.00	$ 286,709.00		**$ 282,070.00**

Community Mental Health Association's Voluntary Special Assessment to support expanded advocacy work

November 2021

SUMMARY: This fact sheet proposes that our organization make a voluntary payment to CMHA, early in FY 2022, in response to a Voluntary Special Assessment by CMHA. The funds received by CMHA, through this special assessment will be used to strengthen what is already a sophisticated and multi-component advocacy capacity. This strengthened advocacy capacity is needed now to match the level of threats and opportunities faced by the state's CMHs and PIHPs and those whom we serve.

BACKGROUND: During its meeting on November 12, the CMHA Steering Committee, by a unanimous vote, supported the issuance, by CMHA, of a **Voluntary Special Assessment** of its CMH and PIHP members.

PURPOSE OF VOLUNTARY SPECIAL ASSESSMENT: The purpose of this special assessment (in which participation is voluntary on the part of each CMH and PIHP) is to provide a significantly increased level of funding for CMHA's advocacy work – **an increase designed to match the level of threats and opportunities faced by the state's CMHs and PIHPs and those whom we serve.**

These increased dollars would be used, as your dues and fees to CMHA are currently used, to fund the advocacy, government affairs, and media/public relations work of CMHA - but with greater intensity and reach.

The legal and accounting bases for your supporting this special assessment are no different than those for the dues and fees that you have traditionally paid to CMHA- **thus allowing the use of any funding source (Medicaid, GF, local, earned revenue, etc.) to be used to pay this special assessment**.

PAST ADVOCACY-FOCUSED SPECIAL ASSESSMENTS: You may remember that CMHA issued a special assessment, several years ago, when the initial privatization threat (via Section 298) was faced by our system. That special assessment was used to fund the advocacy capacity that currently exists within CMHA.

BUILDNG ON CURRENT CMHA ADVOCACY CAPACITY: CMHA's current advocacy capacity (used in the past and currently depending upon the issue) is made up of the following components:

- Social media campaigns
- Electronic Action Alerts
- Media relations including guest editorials
- Development of coalitions and partnerships with allies across the state
- Legislative relations (carried out by CMHA staff and CMHA's multi-client lobbyists) including dialogue with legislators and targeted contributions from the CMHA Advocacy Fund to the corporate accounts of legislators
- Dialogue with executive branch leaders
- Policy and fiscal analysis (sometimes captured in white papers)

Note that PAC contributions, by CMHA, do not use CMHA funds nor member dues and will not use the funds collected through this special assessment.

(A detailed summary of the application of these advocacy components to address the threat posed by SB 597 and 59 is attached)

EXAMPLES OF ADVOCACY WORK THAT WILL BE MADE POSSIBLE WITH SPECIAL ASSESSMENT: The funds collected through the Voluntary Special Assessment will be used to build upon the advocacy tools of CMHA by expanding their intensity and reach. Examples of this increased intensity and reach include:

- High profile social media advertisements
- Much stronger social media presence with "boosting" payments to social medial sites
- Development of professional videos, for use in a number of media formats and venues,
- Public opinion polls, with large sample of respondents
- Petition drives
- Full-page newspaper advertisements highlighting advocacy points and/or list of large and growing number of groups in support of CMHA stance
- Billboards
- Contributions (in addition to PAC fund) to elected officials who support CMHA stance
- Television and radio spots
- Targeted mailings and/or e-mails

APPROXIMATE SIZE OF SPECIAL ASSESSMENT: CMHA is working to draw together, through this special assessment, a public education and media relations fund of size – a size to compete in the public arena, with those who spend, at last count, 27 times what our association, members, and allies spend on such efforts.

To build this fund in a way that is roughly proportional to the size of the budgets of CMHA member organizations we are suggesting (only suggesting; you know your budget best) that any of the following be used (or any other method that your organization chooses) to get a sense of the size of the special assessment that each member consider contributing (**A reminder that this contribution is voluntary, with the amount given, if any, being determined by the CMHA member organization**):

- CMH members: Some ways to think through your organization's contribution:
  - A voluntary contribution equal to the CMH's dues to CMHA
  - A percentage (0.5%, 1%, 2%) of the CMH's budget
- PIHP members: Some ways to think through your organization's contribution:
  - A voluntary contribution equal to 4 times the PIHP's fees to CMHA
  - A percentage (0.5%, 1%, 2%) of the PIHPs budget

MECHANICS OF VOLUNTARY SPECIAL ASSESSMENT: Because of the voluntary nature of this special assessment, the mechanics differ from the traditional dues and fees invoicing process. The process that is being used for this special assessment is outlined below:

1. The request to participate in this special assessment is made by CMHA
2. Our organization reviews its ability to contribute to CMHA, through this special assessment, and indicates our willingness to contribute to the special assessment and the amount for which CMHA should invoice our organization. **CMHA has asked that this notification be provided to CMHA by our organization by December 31, 2021**. Of course, earlier notification is greatly appreciated by CMHA.
3. CMHA sends our organization an invoice in the amount that you have indicated in this survey.
4. Our organization pays the invoice.
5. CMHA implements the expansion of its public education and media relations work related to the most serious threats and opportunities facing CMHA members and those whom we serve.

RECOMMENDATION: That (name of your CMH or PIHP) authorize the payment of $xxxxx to CMHA in response to CMHA's Voluntary Special Assessment. These funds are intended to be used by CMHA to strengthen its marketing and advocacy work.

Community Mental Health Association of Michigan

Advocacy action plan and status report around system redesign proposals in Senate

November 16,2021

Advocacy component	Actions taken to date and in near future	Result of actions with electronic versions found at links within or below table
Analysis of bills and talking points		
CMHA analyzes bills and develops talking points that are distributed to CMHA members and allies	April 2021 with additions and revisions to present	Hard hitting bullet point and longer narrative documents developed and distributed widely
State Legislature focused advocacy		
Series of action alerts to thousands of constituents	April 2021 to present	Have generated over 9,000 e-mails to state elected officials to date
CMHA, members and allies testify at legislative hearings	Spring and summer 2021	Strong testimony by system leaders and persons served with clear statements in opposition to bills
Alternate visions and recommendations for advancing the system		
Alternate vision/approach developed and promoted	June 2021	Documents that outline concrete approaches to advancing Michigan's mental health systems as alternatives to system and person harming bills
CMHA and members involved in active dialogue with bill sponsors to underscore deep concerns with bills	April 2021 to present	Use of talking points and one-pagers,cited above
County Commission focused advocacy		
Distribute template for resolution, by county commissions, in opposition to bills; urging county commissions to pass resolutions opposing bills	May 2021 to present	Dozens of counties pass resolutions in opposition to bills (with more counties continually coming on board)
Counties pass resolutions in opposition		
Executive branch focused advocacy		
Regular discussions with leadership of MDHHS regarding opposition to the Senate bills	April 2021 to present	Executive branch understands danger in bills and political opposition to them
MDHHS Director interviewed at CMHA Fall conference regarding bills	Oct-21	
Partnering with allies		
Building growing coalition against bills with state's major advocacy organizations, education associations, labor, and others	May 2021 to present	Nearly 100 organizations have come out against the bills, with groups joining this effort every week
Partnering with the Michigan Association of Counties (MAC) in opposition to bills		
Media relations (traditional media and social media)		
Generate media stories related to concerns with bill packages	April 2021 to present	Regular media coverage - articles and editorials
Video testimonials from persons served developed and posted on social media	May 2021 to present	10 first person videos & 1 composite high production value video posted on Facebook as part of sequence of videos

Social media campaign underscoring strength and high performance of public system; CCBHC, Behavioral Health Homes, Opioid Health Homes	May 2021 to present	Dozen of Facebook and Twitter posts with short to-the-point phrases underscoring the strength of the public system and the dangers of the Senate bills

Electronic versions of documents noted above, and attached, can be found at the links below:

Analysis of bills talking points, and list of groups in opposition to bills

1. CMHA concerns related to Senator Shirkey bills:
   CMHA concerns related to Gearing Toward Integration-final https://cmham.org/wp-content/uploads/2021/07/CMHA-concerns-related-to-Gearing-Toward-Integration-final.pdf
2. CMHA talking points:
   Shirkey bill 2021 talking points 042121 https://cmham.org/wp-content/uploads/2021/07/Shirkey-bill-2021-talking-points-042121.pdf
3. CMHA two pager: Wrong Step Wrong Time; and list of organizations opposed to bills
   https://cmham.org/wp-content/uploads/2021/11/CMHA-Wrong-Step-Dock-v5.pdf

Alternate visions and recommendations for advancing the system

1. CMHA Within Our Reach Concrete Approaches Factsheet final https://cmham.org/wp-content/uploads/2021/07/CMHA-Within-Our-Reach-Concrete-Approaches-Factsheet-final-1.pdf
2. https://cmham.org/wp-content/uploads/2020/09/CMHA-Traditions-of-Excellence-Strengths-of-MI-mental-health-system-Infographic.pdf
3. CMHA CCBHC Infographic v4 https://cmham.org/wp-content/uploads/2021/07/CMHA-CCBHC-Infographic-v4.pdf
4. CMHA BHH OHH Infographic v2 https://cmham.org/wp-content/uploads/2021/07/CMHA-BHH-OHH-Infographic-v2.pdf

County resolution template

1. 2021 county resolution template - Senate and House bills 072121 https://cmham.org/wp-content/uploads/2021/07/2021-county-resolution-template-Senate-and-House-bills-072121.pdf

Media coverage (samples, not full listing)

1. Build on Michigan's proven public mental health system (Crain's)
   https://www.crainsdetroit.com/other-voices/commentary-build-michigans-proven-public-mental-health-system
2. Latest effort to reform Michigan's mental health system finds critics (Bridge)
   https://www.bridgemi.com/michigan-health-watch/latest-effort-reform-michigans-mental-health-system-finds-critics
3. Michigan Senate leader's plans to overhaul mental health system worries advocates (Detroit News)
   https://cmham.org/wp-content/uploads/2021/05/Detroit-News-Senate-leaders-plans-May-2021.pdf

Social media

1. Initial set of social media posts - highlighting public mental health system strengths
   https://www.dropbox.com/s/dp5fcaau2916i25/CMHA%20Copy.docx?dl=0

   Second waive of social media posts underscoring concerns with Senate bills
2. https://www.facebook.com/CMHAMich/photos/a.461461632456/10159732417267457/
3. https://www.facebook.com/CMHAMich/photos/a.461461632456/10159717433767457
4. https://www.facebook.com/CMHAMich/photos/a.461461632456/10159701975397457

First person videos

First person videos highlighting strengths of system and concerns over Senate bills

1. https://vimeo.com/lambertglobal/review/580450353/5093f21790?sort=lastUserActionEventDate&direction=desc
2. https://vimeo.com/lambertglobal/review/580454280/d0fd0b0661?sort=lastUserActionEventDate&direction=desc
3. https://vimeo.com/lambertglobal/review/580456052/02a6647889?sort=lastUserActionEventDate&direction=desc
4. https://vimeo.com/lambertglobal/review/580451749/49c3d4aaca?sort=lastUserActionEventDate&direction=desc
5. https://vimeo.com/lambertglobal/review/580451512/c1cc02de92?sort=lastUserActionEventDate&direction=desc
6. https://vimeo.com/lambertglobal/review/580456309/69b6aa946f?sort=lastUserActionEventDate&direction=desc
7. https://vimeo.com/lambertglobal/review/580453172/00852a24b6?sort=lastUserActionEventDate&direction=desc
8. https://vimeo.com/lambertglobal/review/580452989/a73884a628?sort=lastUserActionEventDate&direction=desc
9. https://vimeo.com/lambertglobal/review/580455027/a1ea4a6edb?sort=lastUserActionEventDate&direction=desc
10. https://vimeo.com/lambertglobal/review/580452458/0f1a1e49c9?sort=lastUserActionEventDate&direction=desc

    Video "They must think that we are not paying attention. Enough is enough"
11. https://www.youtube.com/watch?v=MtSuQHBue7k&ab_channel=94EProductions