Northern Michigan Regional Entity

Board Meeting

December 13, 2023

1999 Walden Drive, Gaylord

10:00AM

Agenda

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1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – October 25, 2023	Pages 2 – 7
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10.	Reports	
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	d. Financial Report – September 2023	Pages 79 – 100
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	e. NMRE SUD Oversight Board Report – November 6, 2023	Pages 106 – 109
11.	New Business	
	a. Liquor Tax Requests	Pages 110 – 113
	b. PA 152 Opt Out	Pages 114 – 115
	c. Waskul C. Washtenaw County	Pages 116 – 166
	d. Amendment No.1 to the PIHP Specialty Supports and Services Contract	
12.	Old Business	
	a. Northern Lakes Update	
13.	Presentation/Discussion	
	Naloxone Training – Donna Hardies and Lynda Rutkowski	Pages 167 – 202
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – January 24, 2024 at 10:00AM	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – OCTOBER 25, 2023
GAYLORD BOARDROOM

ATTENDEES:	**Tom Bratton, Ed Ginop, Gary Klacking, Eric Lawson, Michael Newman, Gary Nowak, Jay O'Farrell, Ruth Pilon, Karla Sherman, Don Smeltzer, Don Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Greg McMorrow**
ABSENT:	**Terry Larson, Richard Schmidt**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Carol Balousek, Lisa Hartley, Eric Kurtz, Diane Pelts, Brandon Rhue, Nena Sork, Deanna Yockey**
PUBLIC:	**Chip Cieslinski, Sue Winter**

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

ROLL CALL
Let the record show that Terry Larson and Richard Schmidt were excused from the meeting on this date; all other NMRE 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.

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

APPROVAL OF AGENDA
Let the record show that no changes to the meeting agenda were proposed. Mr. Bratton asked to discuss the CEO Search under the Northern Lakes Update.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR OCTOBER 25, 2023; SUPPORT BY DON SMELTZER. 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 JAY O'FARRELL TO APPROVE THE MINUTES OF THE SEPTEMBER 27, 2023 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

CORRESPONDENCE

1) The minutes of the September 28th – 29th Directors Forum.
2) Email correspondence from Bob Sheehan, Chief Executive Officer of the Community Mental Health Association of Michigan, to PIHP CEOs expressing Concerns regarding MDHHS' recently issued FY24 Delegation Agreement Reporting Request.
3) A memorandum from Jackie Sproat at MDHHS to PIHP and CMSHP CEOs dated October 2, 2023 introducing Direct Care Wage (DCW) Wage Increase L Letter 23-64.
4) MDHHS L-Letter 23-64 issuing a DCW increase of $0.85 (plus $0.11 admin) effective October 1, 2023.
5) The minutes of the September 18th MDHHS Conflict-Free Access and Planning Committee meeting.
6) Slide deck from the MDHHS Conflict-Free Access and Planning presentation dated September 18, 2023.
7) Email correspondence from CMHAM to Directors Forum members sharing data on Michigan's state psychiatric hospitals' capacity, patient type, and waiting lists.
8) A letter from Amy Grumbrecht of the Department of Licensing and Regulatory Affairs (LARA) dated October 10, 2023 announcing the end of the Michigan Care Access Referral Exchange (MiCARE) project, effective October 31, 2023.
9) Document from CMHAM titled, "Analysis: State of Michigan's Participation in Medicaid Shared Risk Arrangement with Michigan's Public Mental Health System," dated October 2023.
10) Email correspondence from CMHAM announcing that the Guardianship Reimbursement program was halted effective October 18, 2023.
11) Slide deck from CMHAM 2024 – 2029 Strategic Plan Development presentation.
12) The draft minutes of the October 11, 2023 regional Finance Committee meeting.

Mr. Kurtz drew the Board's attention to the number of state hospital beds statewide. Currently there are only 30 state hospital beds available for children. Mr. Kurtz next recognized the Stop Work Order for guardianship payments effective October 18, 2023.

Mr. Lawson inquired about the email correspondence from Bob Sheehan detailing Concerns regarding MDHHS' recently issued FY24 Delegation Agreement Reporting Request. MDHHS notified PIHPs on September 28, 2023 that they are required to submit the entirety of their subcontractor delegation agreements in effect for FY2024 using a PIHP Delegated Subcontractor Review Tool supplied by the Department. Mr. Kurtz will be issuing a response opposing the request. Mr. Kurtz reported that the NMRE will respond by the October 30th due date but will not be changing any current practices.

ANNOUNCEMENTS

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

PUBLIC COMMENT

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

Executive Committee Report

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

CEO Report
The NMRE CEO Monthly Report for October 2023 was included in the materials for the meeting on this date. Mr. Kurtz highlighted September 25th and October 4th meetings with Kristen Jordan. The October 4th meeting with the UP touched on concerns unique to Regions 1 and 2 in terms of reporting requirements, fidelity standards, etc. Ms. Jordan seemed very receptive and agreed to meet with the CMHAM Rural and Frontier caucus moving forward.

August 2023 Financial Report
- Net Position showed net surplus Medicaid and HMP of $2,576,220. Budget stabilization was reported as $16,369,542. The total Medicaid and HMP Current Year Surplus was reported as $18,945,762. Medicaid and HMP combined ISF was reported as $16,369,542; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $35,315,304.
- Traditional Medicaid showed $181,960,455 in revenue, and $182,379,829 in expenses, resulting in a net deficit of $419,374. Medicaid ISF was reported as $9,306,578 based on the current FSR. Medicaid Savings was reported as $7,742,649.
- Healthy Michigan Plan showed $32,647,645 in revenue, and $29,652,051 in expenses, resulting in a net surplus of $2,995,594. HMP ISF was reported as $7,062,964 based on the current FSR. HMP savings was reported as $8,626,893.
- Health Home showed $2,235,330 in revenue, and $1,970,612 in expenses, resulting in a net surplus of $264,718.
- SUD showed all funding source revenue of $27,767,834 and $24,670,908 in expenses, resulting in a net surplus of $3,096,926. Total PA2 funds were reported as $5,075,597.

A lapse of $1M – $2.5M is anticipated for FY23. Liquor tax funds in the amount of $2,720,209 were approved for projects for FY23. At the end of August, only $1,827,582 had been billed. Ms. Yockey noted that any unspent PA2 will remain in the county balances.

MOTION BY DON SMELTZER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR AUGUST 2023; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Operations Committee Report
The minutes from October 17, 2023 were included in the materials for the meeting on this date.

NMRE SUD Oversight Committee Report
Let the record show that the next meeting of the NMRE Substance Use Disorder Oversight Committee is scheduled for November 6, 2023 at 10:00AM in the NMRE conference room.

NEW BUSINESS
CMHAM Conference Update
Mr. Kurtz asked about impressions from the CMHAM Winter Conference that was held October 22nd – October 24th.

Ms. Pelts mentioned that she attended the CMHAM Strategic Planning Session. Opportunities and threats to the system were discussed. Bob Sheehan is expected to distribute a summary in the coming weeks.

The core group of Rural and Frontier Caucus members met to discuss current issues. The group agreed that their main objective is to have a voice prior to policy promulgation. Code changes that have created an administrative burden on direct care staff and onerous grant processes were also

discussed. Mr. Kurtz noted that the Michigan Center for Rural Health at MSU is underneath Tom Renwick (former Director of the Bureau of Community Based Services, Behavioral Health and Developmental Disabilities Administration, MDHHS). Mr. Kurtz intends to invite Mr. Renwick to a meeting on rural access. The next meeting of the Rural and Frontier Caucus is scheduled for December 12th at 2:00PM.

Mr. Johnston expressed that he felt that the session led by Meghan Groen, Senior Deputy Director Behavioral and Physical Health and Aging Services Administration, MDHHS, appeared scripted and not a "healthy dialogue." Ms. Groen reported that the Certified Community Behavioral Health Clinics (CCBHC) served 6,500 individuals (75% of whom were eligible for CMHSP services anyway) at a cost of $100M. Health Homes have far better outcomes. Mr. Kurtz noted that US Senate Bill 2993 (Ensuring Excellence in Mental Health Act) would amend the Social Security Act and the Public Health Service Act to permanently authorize CCBHCs.

Mr. Johnston commented that the session titled, "Creating a Value-Added Role through Board Governance" facilitated by Susan Radwan of Learning Edge Mentoring was very well done. Mr. Bratton noted that Ms. Radwan was one of the speakers that Northern Lakes brough in to discuss Policy Governance during the Board Retreat held on October 2nd.

Mobile Care Unit/Van

Mr. Kurtz informed the Board that in 2019, State Opioid Response (SOR) grant funds were available to allow SUD providers to purchase Mobile Care Units. One of the NMRE's SUD providers purchased two vans for this purpose. Recently, the provider expressed an interest in relinquishing one of the vans. Because it was purchased with grant funding, it cannot be sold but it can be repurposed. The NMRE will likely take possession of the van and purchase insurance. An RFP will be issued to ascertain a purpose for the vehicle.

OLD BUSINESS

Northern Lakes CMHA Update

The contractual oversight review of Northern Lakes by Rehmann is currently underway. Over 100 Northern Lakes staff have been interviewed. A report will be presented to the NMRE Board at the conclusion of the audit.

Mr. Bratton explained that the Northern Lakes Board has had a standing CEO Search Committee for several months (Mr. Bratton is the Chair). During its meeting on October 19th, the Northern Lakes Board discussed the topic of the CEO search. A motion was approved to request that the NMRE Board Chair assign a CEO search committee for Northern Lakes comprised of one individual from each of Northern Lakes' six counties (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford).

The NMRE has agreed to conduct an RFP for a CEO search firm. Until the Northern Lakes Board completes the bylaws and all the of the obligations of the enabling agreement, the CEO search process is premature. Mr. Kurtz would also like to have the findings from the Human Resources audit by Rehmann prior to beginning the CEO search so that they may inform the Search Committee. Mr. McMorrow expressed that previous help received from NMRE regarding the CEO search was extremely valuable.

MOTION BY ERIC LAWSON TO AUTHORIZE THE NORTHERN MICHIGAN REGIONAL ENTITY TO FACILITATE AND HOST THE NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY'S CHIEF EXECUTIVE OFFICER SEARCH COMMITTEE WITH THE

AGREEMENT THAT THE HUMAN RESOURCES AUDIT BY REHMAN IS FINALIZED AND ALL THE OBLIGATIONS OF THE ENABLING AGREEMENT ARE FULFILLED PRIOR TO ISSUING A REQUEST FOR PROPOSALS TO SECURE A SEARCH FIRM; SECOND BY KARLA SHERMAN. ROLL CALL VOTE.

"Yea" Votes: T. Bratton, E. Ginop, G. Klacking, E. Lawson, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, K. Sherman, D. Smeltzer, D. Tanner, C. Varner

"Nay" Votes: Nil

PRESENTATION

OHH and BHH HEDIS Outcomes

NMRE Clinical Services Director, Branislava Arsenov, was in attendance to present Region 2 Health Home outcomes to the Board.

Timeline:

- The NMRE's Health Home program began in 2018 with the implementation of the Opioid Health Home (OHH) which included eight Health Home Partners (HHP).
- In 2020, the NMRE expanded its Health Home program to include Behavioral Health Homes (BHH) which consisted of the five member CMHSPs.
- In 2021, the NMRE added an Alcohol Health Home which included four Health Home Partners.
- In 2022, The NMRE added eight additional Health Home Partners.
- In 2023, the NMRE had over 1,600 individuals enrolled in Health Home Programs regionwide.

Health Homes Provide:

- Care Coordination for Eligible Clients
- Sustainable Reimbursement for Care Coordination (which would otherwise not be covered)
- Excellent Health Outcomes for Enrollees/Changes in Social Determinants of Health
- Access to Care (for children and the mild/moderate population)
- Overall Cost Efficiency

Ms. Arsenov reviewed Health Home outcomes for Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS measures are used by more than 90 percent of US health plans to measure performance on important dimensions of care and services. Information was pulled from the State's Care Connect 360 (CC360) system.

OHH Measures

	Michigan Total	NMRE Total	All OHH Programs	NMRE OHH Program
FUA 7 Rates Follow-up after ED visit for alcohol or other drug use within 7 days.	27.04%	27.25%	63.16%	**78.38%**
FUH 30 Rates Follow-up after ED visit for alcohol or other drug use within 30 days.	42.26%	44.49%	80.97%	**91.89%**
IET14 AD Initiation of treatment in 14 days	37.20%	30.64%	79.45%	**91.40%**
PQI Prevention Quality Indicator (number of admits for ambulatory care/chronic conditions)	74.91	41.29	144.32	**25.65** (lower = better)

Mr. Johnston emphasized that the PQI result represents a huge dollar amount in savings which can be reinvested into services.

BHH Measures

	Michigan Total	NMRE Total	All OHH Programs	NMRE OHH Program
AAP AD Adult Access to Preventative/Ambulatory Services	74.20	75.95	98.26	**99.58**
FUM 7 Rates Follow-up after ED visit for mental Illness within 7 days.	45.59%	55.52%	74.29%	**94.12%**
CBP Controlling Blood Pressure	29.86	18.74	28.48	**33.33**
FUH 30 Follow-up after hospitalization for Mental Illness within 30 days.	66.17%	74.84%	90.32%	**88.89%**

It was noted that the Follow-Up After Emergency Department Visit for Substance Use (FUA) and Follow-Up After Hospitalization for Mental Illness (FUH) measures are tied to the PIHPs' Performance-Based Incentive Payment. The NMRE earned an additional $2,352,351 in PBIB funds in FY23.

NMRE BHH revenue was reported as $2.5M; of that, $70K is spent on administration (2.8%). NMRE OHH revenue was reported as $4.5M; of that, $216K is spent on administration (4.8%). Ms. Yockey reported that all Health Home Programs are operating at a surplus; surplus funds can be used as local dollars after one year.

In FY25, the NMRE intends to expand the Opioid Health Home into an SUD Health Home to address all substances.

COMMENTS

Board

Mr. Smeltzer encouraged the NMRE to share BHH success stores and outcomes with CMHAM.

Mr. Bratton noted that there was a table set up at the Fall Conference addressing the MDHHS Gambling Prevention Initiative; he was impressed with the work that the NMRE has done.

Staff/CMHSP CEOs

Ms. Arsenov reported that the number of open HAB Waiver slots in the region has been reduced to 19; additional packets are in the queue for approval by MDHHS. Because over 97% of the region's slots are currently filled, the risk of losing slots to other PIHP regions has lessened.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on December 13, 2023.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 12:05PM.

Regional Entity CEO Group

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

REGIONAL ENTITY CEO MEETING

Date: Tuesday, October 3, 2023, Time: 1:30 pm – 3:30 pm

DRAFT – Minutes

1. Welcome / Introductions

The meeting was called to order by Joe Sedlock at 1:32pm.

Present In Person: None

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

Absent:

Guests (selected/applicable portions): Alan Bolter and Bob Sheehan (CMHA), Kristen Jordan (MDHHS), Mila Todd (Reg. 4)

CMHA Staff: Monique Francis

2. Agenda Changes / Previous Minutes Approval

Additions/changes to the agenda: None. **The group** agreed by consensus to accept the agenda with additions for October 3, 2023, and approve the minutes from September 5, 2023.

Priority/Action Items

3. PIHP Contract – Inspector General Related Provisions (Mila Todd/Brad)

Mila spoke about the contract language received from the OIG as invasive and increasing administrative burden for PIHPs. She reported that this language speaks to policies, reports, projections for future years, etc. Feedback was provided to the OIG asking for source citations. The OIG replied that the language will stay as written. She reported there have been preliminary discussions on certain reports, and next steps are to prepare a red-line report to the OIG to begin further good-faith negotiations. Mila reported that contract negotiations have seen a shift, and these negotiations are taking place directly with the OIG office. General counsel is involved, and they feel there is a general disconnect as to what the OIG office can and cannot do. The group discussed some of the particulars of the requirements listed in the language. The group discussed possible next steps, including submitting the red-line proposal. The group also discussed the likelihood of the OIG holding their position. Mila felt that they likely would, which would place all of the PIHPs in the position of having to choose whether they will sign this amendment or not. Legal opinions are being considered. Eric Kurtz wondered what the AG's opinion may be of the OIG's stance on this issue – suggesting that getting their opinion may be useful in this instance. Eric Doeh pointed out that you cannot transfer authority from one executive agency to another agency that is not a part of that branch. The group discussed taking this issue to the Department (Director Hertel), getting an AG opinion, and refusing to sign the amendment as multiple options for future action. Eric Doeh suggested taking the stance with the OIG that this is an unenforceable set of requirements – as opposed to focusing on this being too much burden placed on the agency. Pointing out an example of "What would we do to enforce in XXX situation?" could possibly help to push this thought across.

4. FY24 Rates/PIHP Budget Projections (Brad)

Brad asked if each CFO of all regions should gather and share FY year end data, budget projections, ISF estimates, financial status, etc. He is wondering if others are seeing estimates that are not favorable as his region is. Megan felt that it is systemic – not isolated – for the PIHPs. Cutting Healthy Michigan rates, MLRs are under 85%, and many other actions have contributed to this. Dave agreed he would share data as well as James. James stated that DAB and TANF rates were not correct as the wrong month's data was used. This messed up CHAMPS, and they are going to be correcting this. Jim Johnson and Joe Sedlock also agreed to share data for projected ISF and projected savings. Jim will ask the CFO group to gather and coordinate this data, with the request being created by Brad and sent to Jim for this purpose. James and Mary are being asked to pay the risk

corridor before they receive their deficits, so in the end, the court order needs to be put in place and followed or it could adversely affect others who may fall into this situation.

5. **Electronic Verification Visit (James)**
James stated that CLS and Respite has moved from the PIHPs to the CMHs. He stated that this process is going to be a mess. Brad shared emails with the group on this topic. Dave agreed with James. He stated that with all of the details, there will be a need to follow up on abnormalities or just for clarity. Joe stated that this discussion mirrored the OIG discussion in that the managed care roll continues to come into play. This seems to be another example of the skewed view of the PIHPs by the Department. James stated that this issue could cost CLS and respite providers to be lost to the system.

6. **Date of Death Audit, CMS, MDHHS (All) – *Kristen Jordan, MDHHS, 3:00pm***
Kristen stated they received a letter from CMS indicating the final penalties and interest amounts. She stated that the Department is going to file an appeal to CMS which may not be successful but will buy some more time. The plan is to operationalize how to do the recoup. The Department will only recoup the Federal share, not the State part. The total was $27 Million. $9.8 Million looks to be the PIHP share, less $1.3 Million that has already been recouped which leaves approx. $8.5 Million. This is the BH portion. Recoups will likely start in April. Joe asked Kristen if she could confirm if these were for capitation payments made for those who had active CHAMPS files after the date of death for an additional month or two. Kristen confirmed. Kristen also stated that the $8.5 Million is an estimate and everyone should wait for final numbers as the F Map may still need to be applied. Megan asked if any lapsed funds were being considered during this time frame. Kristen stated that the Department would have to look at the fiscal numbers for that time period. Kristen will look into this. Megan then asked if there would be another rate-setting adjustment since this would affect actuarial sound numbers. Kristen stated it depends on the split evens out for the recoupment among the PIHPs. Eric Doeh asked if this is for multiple years or a particular Fiscal Year. Kristen stated that the audit period was for 2014-2016. Joe asked if the Department has handled this issue so that there would not be another need for future recoupment. Kristen stated that the Department has identified the problem and corrected it.

7. **Delegated Functions (added by Mary)**
No minutes taken for this item.

8. **MichiCANS (added by Brad)**
Brad stated when it comes to clinical tools and clinical activity, he is optimistic and would like to see everyone try what the Department is asking and worry about the financing later. Joe stated that the need to screen all foster children for the soft launch sites is what is operationally challenging. Mary clarified that the Department sent out clarification that the soft launch sites do NOT have to screen ALL foster children, but the goal is to have all screened by all CMHs upon full implementation.

9. **1915(i)SPA (added by Mary)**
Mary asked if everyone got an email on this topic. Not all had. No discussion.

10. **Michigan Opioid Advisory Commission Updates (Brad)**
No meeting since the last PIHP CEO meeting. No update. The Advisory Commission is beginning to do technical assistance planning.

11. **Michigan Opioid Task Force Updates (Brad)**
The first meeting of this group took place last month for the 10 representatives of each region. He urged all to stay in touch with whoever that representative is.

12. **Michigan Autism Council Updates (Dana)**
Dana sent packet of information to the group. Nothing significant to report.

13. **Michigan Diversion Council Updates (Brad/Eric D.)**
No update provided.

14. **PIHP Contract Negotiations Update (Joe/Brad/Jim)**
- Written update provided in packet. Amendment imminent from the Department.

15. **Provider Network Reciprocity (V. Suder/Dana; S. Sircely/Eric K.)**
- Inpatient – Brief update included in packet.
- SUD Provider Performance Monitoring Reciprocity – No update received.

16. **Training Reciprocity (A. Dillon/Joe)**

- No update received.

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

- No update received. Dana announced that Cheryl Johnson is the new CFO for OCHN.

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

- August 25, 2023 notes provided in packet.

19. CIO Forum Report (B. Rhue/Brad)

- No update received. Concern over SMEs who had been attending regularly from the Department.

20. Statewide Utilization Management Directors Group

- Dave Pankotai stated that auditors are tending to ding for having ranges in the IPOS. This has not been found anywhere in writing, and we should seek clarification from the Department. Joe stated that MSHN is in discussions to try to obtain an answer on this issue. They have been cited multiple times and expect contract action next. He will keep the group informed of the results as they occur.

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

- No update received.

22. MDHHS/PIHP Operations Meeting Planning (All)

- Next meeting was October 5, 2023 – Cancelled.
- Topics to Add to Agenda (if any)
  - None

23. CMHA Legislation & Policy Committee (Jim)

- Meeting took place last week. Items from Alan should be reviewed.

24. CMHA Coordination (B. Sheehan – 3:00pm)

Discussion topics from Bob Sheehan:

- OMA Movement? (Joe)
  No discussion. No movement on Open Meeting Act.
- Legislative Updates (Alan)
  Alan reported that the House Health Policy Committee is reviewing several bills on telehealth reimbursement rates. 4579-4580. HB 4213 is also in committee with some language referring to audio only being reimbursed the same as video service. SB27 is also up for review, which only codifies federal parity law. The Legislature looks to end session on November 8 or 9 this year. Alan then reported on HB 4841 which adds regulations and requirements to AFC homes which include nursing hours and social work hours. The bill's sponsor plan on removing some of the more stringent requirements so as not to detrimentally affect these AFC homes. Alan spoke about the House and Senate package of bills related to the extension of FMLA which would apply to entities who employ 50 or more people and would require up to 15 weeks of paid time off for those who are eligible for this leave – in addition to the 40 hours already in place. This legislation is not likely to move this Fall. Senator Stabenow has issued the Ensuring Excellence in Mental Health Act which will further CCBHCs by providing operating grants, utilize 340B and other items to make sure this program is permanent moving forward.
- FY24 Rates (Bob)
  Bob asked if the Directors had concerns on this issue. Joe informed Bob that the PIHPs are beginning to gather data to review the rates. There are some whose rates appear to have improved the revenue position, but this may not be the case across the board. Alan spoke about the reporting requirements for Direct Care Wages and overtime, as covered in a recent L letter put out by the Department. The group expressed frustration with the lateness of the issuance of this letter. Hopefully the rates can be adjusted to include the overtime.
- Opioid Settlement Dollars
  Bob wondered if the counties had been staying in contact with the SUD Directors on how these settlement dollars should be spent. Eric Doeh expressed frustration over not always needing to be involved in how the funds sent to the County get spent. Dave Pankotai stated that as a unique entity who is still part of County government, he has had some helpful collaborations in his area. Bob stated that the Association is encouraging the counties to collaborate with the PIHP SUD Directors. MSHN has offered help to the municipalities and is hopeful that there will be some response soon, but none has been received yet.

- DSNIP
  Bob stated that the Association has been approached by several health plans on this and he wondered if they had been reaching out to PIHPs as well. Mary stated that one reached out to her, but they were not from her area, and nothing came of the meeting. Bob stated they have been approached by Humana, CVS, and CareSource.

OTHER:

ADD to November Agenda:

1. No items identified.

The meeting adjourned at 3:35pm.
Respectfully Submitted,
Monique Francis, CMHA Committee Clerk

Regional Entity CEO Group

Jim Johnson	Joseph Sedlock	Bradley Casemore
Vice Chair	Chair	Spokesperson

REGIONAL ENTITY CEO MEETING

Date: Tuesday, November 7, 2023, Time: 12:30 pm – 3:30 pm

DRAFT – Minutes

1. Welcome / Introductions

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

Present In Person: Joe Sedlock (Reg. 5), Jim Johnson (Reg. 10)

Present Via Zoom: Sandra Lambert in for Megan Rooney (Reg. 1), Mary Marlatt-Dumas (Reg. 3), Brad Casemore (Reg. 4), James Colaianne (Reg. 6), Eric Doeh (Reg. 7), Dana Lasenby (Reg. 8), Dave Pankotai (Reg. 9)

Absent: Eric Kurtz (Reg. 2)

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

CMHA Staff: Monique Francis

2. Agenda Changes / Previous Minutes Approval

Additions/changes to the agenda: CY2024 Meeting Schedule added as Item 6 (added by Joe), ICTS/PRTF added as Item 7 (added by Jim), Pace and Volume of MDHHS Initiatives as Item 8 (added by Joe), and MOIG and PBIP discussion to be included in Item 14 (added by Brad). **The group** agreed by consensus to accept the agenda for November 7, 2023, with the additions, and approve the minutes from October 3, 2023.

Priority/Action Items

3. Health Plan Rebid [MI Healthy Life] (All)

Joe opened the floor for discussion on this topic. Brad encouraged everyone to pay close attention to integrated care and population health as they are still being discussed. Some felt that many of the MHPs are too small to be included or involved, but others may warrant working with. The group discussed potential for new MHPs as new bidders. Some felt there may be new bidders regarding the DSNIPs. The group discussed the need for clarification regarding what the "relationship with the PIHP" would indicate moving forward. Concern was expressed for access to care for certain populations being moved from one to another depending on the severity of their diagnosis (mild to moderate vs. severe). The group discussed whether or not MHPs would be required to cover crisis services and supports, for those being served by PIHPs, and whether this would create the need for a contract. Is there a formal relationship to be established? Brad suggested the PIHPs could meet to discuss strategy moving forward, but with time constraints of this RFP process it may be a situation where everyone will need to share what is happening within their respective regions. The group discussed whether or not they have been contacted by MHPs regarding the RFP process. The group also discussed the need to be careful before signing on or agreeing to anything with MHPs before discussing with other PIHPs.

4. Status: PIHP CFO FY24 Year End Projections (Joe)

The group discussed what the status of this project was. Brad will send a paragraph to Jim Johnson to send to the CFO group to obtain this information.

5. Psychiatric Bed Registry Discussion (Joe)

Joe recently spoke with Krista Hausermann after LARA removed the platform for discussion on this issue. He reported that MSHN is advocating for the easiest solution to have a bed registry on a website that simply tells Hospital Staff and Eds where to call and who has the beds – no passwords or other unnecessary information. Joe urged any who had input on this to call Krista to discuss. The group had no further discussion on this topic.

6. CY2024 Meeting Schedule (added by Joe)

Joe explained the conflicts with current meeting dates as scheduled for 2024.

January is scheduled on the 2nd. The group agreed by consensus to move the meeting date to the 9th.

February is scheduled on the 6th. The group agreed by consensus to move the meeting date to the 13th.

July meeting is scheduled on the 2nd. The group agreed by consensus to move the meeting date to the 9th.

7. ICTS/PRTF (added by Jim)

Jim received an email from Darlita Paulding (sp?) at MDHHS, requesting the name of a key contact staff from PIHPs to attend transition meetings. She has requested this from some PIHPs regarding ICTS/PRTF services. Region 4 received this request and provided a name. Region 9 did the same. Region 5 anticipates that this staff person they will provide to MDHHS will be there in a supervisory capacity. Region 10 will be following up with MDHHS on this.

8. **Pace and Volume of Initiatives (added by Joe)**

Joe stated that the number of initiatives from MDHHS is beginning to drain the staff in his region. He would like to strengthen advocacy around how many initiatives are being handed down to the PIHPs. Mary agreed. She suggested setting a meeting with Kristen Jordan every month to work to reduce the number of initiatives. Joe asked the group what the strategy should be to bring this into focus for the Department. Brad suggested inviting Kristen to the December meeting to discuss this issue. James agreed. Eric D. wondered why we aren't inviting Elizabeth Hertel as opposed to Kristen. He also wondered why we aren't utilizing Bob Sheehan as a "go-between" in this issue. Brad agreed that this group should reach out directly to the Director. Joe stated that he felt starting with Kristen was out of respect for her position to see if some sort of action were to come from the discussions and if NOT, then reach out to Director Hertel. Eric understood, stating that he would want to make sure Kristen was aware that the group wanted the concerns to be shared with Director Hertel. Mary stated the offering to Kristen that the group would be willing to meet with both her and Director Hertel may be a good approach. Dana agreed this was a good idea, stating that there are some things Kristen is not educated on, and some things Elizabeth is not educated on. Working with both Kristen and Elizabeth may help to educate and prioritize many items. Eric D. stated that whatever works best to move things forward and not waste anyone's time is the direction he would agree to. Eric and Dana both gave examples of what information and concerns should be shared with the Department, while offering solutions at the same time. Joe reinforced that he was not trying to have any of the initiatives removed, just a way to prioritize them. He asked for a volunteer to create a list of concerns that could be circulated among the 10 CEOs for review and add to. Dana Lasenby will create a document and send it along to the other CEOs one at a time. Joe will add this document to the December agenda. The group agreed by consensus to the approach outlined.

9. **OPEN –** No agenda items added here.

10. **Michigan Opioid Advisory Commission Updates (Brad)**

Brad reported that OAC listening sessions have begun. They have posted a community survey on their website.

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

Opioid Task Force met recently. The group agreed to meet 4 times in 2024. Location will be rotated around the State. Brad encouraged everyone to know who their representatives on this task force are.

12. **Michigan Autism Council Updates (Dana)**

This group met late in October. They had a presentation from Michigan Rehabilitation. Dana was reappointed to this Council. There was a Behavioral Analysts conference on November 3 & 4. The Michigan Autism Council goes over a lot of legislative items – Dana will share that info with this group. The Autism Navigator program has been funded within the Autism Alliance. She gave details on other legislation they have discussed and what their recommendations are. She reported that the Department has asked for recommendations for people to form a workgroup on school services.

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

No discussion.

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

- Next meeting is 11/17/23. MIOG language was discussed. The OIG has stated this is non-negotiable.

Brad stated that PBIP 2024 is finalized. Brad also reported that Mila Todd has been the point person on MIOG language along with Amanda Ittner. He thanked them for their work on this. Joe reported that he will be contacting Jackie Sproat regarding PBIP to make sure finalization is firm.

15. **Provider Network Reciprocity (V. Suder/Dana; S. Sircely/Eric K.)**

- Inpatient – No update received.
- SUD Provider Performance Monitoring Reciprocity – No update received.

16. **Training Reciprocity (A. Dillon/Joe)**

- No update received.

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

- Megan Rooney will be taking the liaison role over from Jim Johnson. Monique will update the liaison list.

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

- 9/22/23 and 10/27/23 notes provided in packet. No discussion.

19. CIO Forum Report (B. Rhue/Brad)

- No update received. EVV and API are in the forefront of everyone's minds in this group.

20. Statewide Utilization Management Directors Group

- 10/10/23 Notes provided in packet.

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

- No notes received.

22. MDHHS/PIHP Operations Meeting Planning (All)

- Next meeting is 12/07/23.
- Topics to Add to Agenda (if any)
  - None

23. CMHA Legislation & Policy Committee (Jim)

- No update – no report.

24. CMHA Coordination (B. Sheehan – 3:00pm)

Discussion topics from Bob Sheehan:

- Legislative Updates (Alan)

  Alan reported that this was the last week for the Legislature to be in session for this year. He gave details on Proposal 1 regarding campaign financing, and energy items. He also gave details on parity bills (SB 27 which codifies federal statute into state law, and HB 4707 which is much more detailed). The Association is hopeful that a vote will be held on HB 4707 before the end of this week. Alan stated that the Health Plans are putting all of their resources into killing this bill which would expand parity, address medical necessity according to ASAM levels, and covers in and out-of-network coverage. He stated that only the House will be on the ballot for Elections, so a lot of legislative issues may be pushed off until Lame Duck. Alan then spoke about the 4 telehealth bills that are also being opposed by the Health Plans. He stated that these bills will be on the agenda and hopefully move out of the House this week, with action next year. Alan spoke about several SUD bills that were introduced in the last couple of weeks. These bills are regarding naloxone distribution, harm reduction, needle exchange programs, and fentanyl test strips. The group requested Association support to keep naloxone vending machines protected. Alan made note of this. He went on to give details of a bill that would allow PAs to administer/use seclusion and restraint in certain situations. He gave details of the legislation and testimony on the removal of the Social Work Licensure exam, as well as legislation regarding generic equivalents of naloxone. Alan reported that there is a group working on the Open Meetings Act. HB 4693 would allow for remote participation for non-elected Boards. Alan reminded the group that when the Legislature adjourns this year, all bills being discussed will still be able to be voted on next year, as this is NOT lame duck. Alan will continue to work with MAC on HB 4693 to clarify how the requirements will be listed. Alan then gave details on an update recently given by Megan Groen on the Medicaid redetermination process. Bob Sheehan thanked Joe for letting him know that they were going to use SNAP and Food Stamp benefit data, but that they would not be going retro on this. Eric Doeh stated that the Department needs to be aware that the status of Medicaid redetermination is not good. Alan stated that he believes the Department is trying to show the Legislature what a large job this is. Bob went on to explain that Megan is likely trying to play up the current status of the State of Michigan as compared to other states across the nation.

- Opportunity for PIHPs to share Wakely and PIHP views of FY24 rates with State Budget Office staff (Bob)

  Bob reported that the State Budget Office reached out to the Association for a meeting to discuss concerns on FY24 rates. He asked if the PIHPs would like to be involved in this meeting. Alan stated

that since the Department makes budget recommendations, being involved in these discussions could be politically beneficial. Bob reported that Matt Ellsworth from the SBO attended the CMHA Fall Conference and heard concerns regarding FY24 rates. Joe would bring up total allocation for the State of Michigan. Bob stated that Kristen Jordan has stated that they are going to require Health Plans to pay better rates, and they would like Health Plans to pay crisis services when they are a PIHP client. Joe asked if that would imply an intended partnership. Bob stated the Association is keeping their eyes on this.

- Concerns shared by other associations regarding $.85/hour DCW wage pass through (Bob)
  Bob reported that several associations are having issues with the wage pass through. Some employers/providers were under the impression that they would get another $.85/hour at the new fiscal year (Oct. 1, 2023), which is not correct. They have informed Bob that they are going to be reaching out to the Department, but Bob has asked them to discuss this issue with their PIHPs first. The group discussed different interpretations of the wording on funding versus actual pay which has created a lot of ambiguity. With the State coming out and saying $.85 will be paid directly to the staff, the problem becomes sustainability. The group continued to discuss details of overtime and other issues related to the DCW wage pass through. Bob reported that the language does not mandate that you pay overtime with this funding, but it does say that you can. If you use this, then other sources may be smaller. All agreed that this wage pass through has to be worked into the rate structure or it will not work.
- Any PIHPs being approached by MHPs as part of their rebid package? (Bob)
  Bob wondered if the PIHPs had been approached by any of the Health Plans. Region 6 has had one reach out to them. Region 5 has not seen any new contact. Region 3 has been contacted by one. Region 4 has been contacted by a couple. CareSource has reached out to the Association, so Bob let the group know that they may be contacted by them.
- Section 1513 inpatient rate discussion – summary of 11/6/23 discussion (Bob)
  Bob stated that Section 1513 was originally a move to have a tiered rate system, which was thought to have died, but it has resurfaced. Bob stated that there was $8 Million to build inpatient rates. Bob stated that we have suggested using HRA payments, but that the conversations needed to include PIHPs who were not represented at this meeting. Joe stated that the tiered levels are according to staffing ratios, which can escalate due to acuity levels. Bob stated that the Association wants to make sure the right people are authorizing this. Anyone interested in joining this workgroup should reach out to him. Dana Lasenby would like to join this group and Mary Dumas would like to have someone from Region 3 appointed to this group.
- Brad Casemore passed along the following question:
  At RE CEO this afternoon, do you mind asking if other Regions are experiencing challenges when MDHHS discharges someone from the State Hospital to one of the Spec Res providers under the State's contract (I think this is ICTS) for 90 days, if at the 90 day mark when the individual becomes the CMH's responsibility the individual does not yet have Social Security and the State is telling the CMH they have to pay for the expenses out of their GF?ISK experienced this recently.
  Bob will follow up with Dr. Mellos on this issue and reach out to Brad with answers.

OTHER:

Dave Pankotai reported that he will not be renewing his contract with Macomb County. This contract ends on December 31, 2023. He will be accepting a position in Kentucky.

ADD to December Agenda:

1. MDHHS Prioritized List of Initiatives document created by Dana Lasenby.

The meeting adjourned at 2:53pm.

Respectfully Submitted, Monique Francis, CMHA Committee Clerk

As you may know, the Michigan House may soon take a vote on HB 4707 (sponsored by Rep. Brabec), which is a very comprehensive mental health and substance use disorder parity legislation that would provide REAL parity for those with commercial insurance for the first time in Michigan. We have been told the House may take a vote on HB 4707 as soon as this week and try to push it through the legislative process before the Legislature adjourns for the fall.

HB 4707 would go a long way in closing the gap that people with commercial insurance have in trying to access meaningful mental health and substance use disorder services. Access to care for individuals not served in the public mental health system has been one of the greatest areas of need for people with commercial based insurance. Below are some key details included in HB 4707:

Medically necessary treatment of a mental health or substance abuse disorder

- It is in accordance with the generally accepted standards of mental health and substance use disorder care.
- t is clinically appropriate in terms of type, frequency, extent, site, and duration.
- It is not primarily for the economic benefit of the insurer or purchaser or for the convenience of the patient, treating physician, or other health care provider.

An insurer would be required to provide coverage for the full continuum of service intensities and levels of care described in the most recent versions of the following:

- The ASAM Criteria by the American Society of Addiction Medicine.

Out-of-network services

If services for the medically necessary treatment of a mental health or substance use disorder are not available in-network within the geographic or timeliness access standards under law, the insurer would have to arrange coverage to ensure the delivery of medically necessary out- of-network services and any medically necessary follow-up that meet those geographic and timeliness standards to the maximum extent possible. **In these cases, the insured would not have to pay more in total for benefits rendered than the cost-sharing they would pay for the same covered services received from an in-network provider.**

REQUEST FOR ACTION: **We are asking you to reach out to your legislators (House & Senate) and the Governor and URGE them to support HB 4707 and encourage their leadership to bring the bill up for a vote in the fall legislative session. HB 4707 will go a long way in improving people's lives across the state.**

Please feel free to customize your response as you see fit*

We also need you **to ask that the members of your Board of Directors, your staff, and your community partners make those same contacts – SIMPLY FORWARD THIS EMAIL TO THEM**.

Thank you in advance for your support and advocacy on this important topic.

Click the link below to log in and send your message:
https://www.votervoice.net/BroadcastLinks/Etpvt7gQ1f8AxhXi-83zAg

HOUSE BILL NO. 5371

November 14, 2023, Introduced by Reps. Brabec, Phil Green, Paiz, Rheingans, MacDonell, Edwards, Dievendorf, Arbit, Pohutsky, Coffia, Morse, Tsernoglou, Neeley, O'Neal, Hood, Snyder, Hope, Price, Grant, Fitzgerald, Brixie, McKinney, Morgan, Roth, Wozniak, Mueller and VanderWall and referred to the Committee on Health Policy.

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding section 109o.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 109o. (1) The department must develop a prospective payment system under the medical assistance program for funding certified community behavioral health clinics. The payment system must fully comply with all federal payment methodologies. The department must submit to the federal Centers for Medicare and

Medicaid Services any approval request necessary for a Medicaid 1115 waiver.

(2) The department must certify as a certified community behavioral health clinic a community mental health center licensed by the department that adheres to all federal certified community behavioral health clinic requirements.

(3) Subject to approval, the prospective payment system must be implemented before January 1, 2028.

(4) The department shall promulgate rules to implement this section.

(5) As used in this section and section 109p:

(a) "Certified community behavioral health clinic" means an entity that has been certified by the department in accordance with federal criteria and the protecting access to Medicare act of 2014, Public Law 113-93, or an appropriate change or waiver to the Medicaid state plan.

(b) "Prospective payment system" means a payment methodology that funds, in advance, a certified community behavioral health clinic for the anticipated costs of carrying out the direct and indirect clinical and administrative activities required of certified community behavioral health clinics.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No.____ or House Bill No. 5372 (request no. 04673'23) of the 102nd Legislature is enacted into law.

HOUSE BILL NO. 5372

November 14, 2023, Introduced by Reps. Phil Green, Brabec, Paiz, Rheingans, MacDonell, Edwards, Dievendorf, Arbit, Pohutsky, Coffia, Morse, Tsernoglou, Neeley, O'Neal, Hood, Snyder, Hope, Price, Grant, Fitzgerald, McKinney, Brixie, Morgan, Roth, Wozniak, Mueller and VanderWall and referred to the Committee on Health Policy.

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding section 109p.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 109p. (1) The state shall not implement policy that is contradictory or interferes with the implementation of federal definitions or requirements for a certified community behavioral health clinic.

(2) The state shall develop a process of determination for

additional certified community behavioral health clinic sites within specific geographic regions that must comply with federal community behavioral health clinic requirements.

(3) The state must continue to participate with the federal government to implement community behavioral health clinics. To opt out of participation, there must be a vote of the legislature.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No.____ or House Bill No. 5371 (request no. 02603'23 **) of the 102nd Legislature is enacted into law.

Subject: Prevention Policy 01 - Synar

Re-Issued: July 21, 2015; October 20, 2023

Effective: November 1, 2023

PURPOSE:

The purpose of this policy is to specify Prepaid Inpatient Health Plans (PIHP) requirements with regard to federal Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG) Synar compliance.

The policy was revised in October 2023 to update the minimum required age to purchase tobacco to 21 years, to align with federal requirement language, and to amend requirements for PIHP regions that do not achieve a Retailer Violation Rate (RVR) of 20% or less.

SCOPE:

This policy applies to PIHPs and their Synar-related provider network, including Designated Youth Tobacco Use Representatives (DYTUR), which are part of substance use disorder (SUD) services administered through the Michigan Department of Health and Human Services, Substance Use, Gambling and Epidemiology Section (MDHHS/SUGE).

BACKGROUND:

The Center for Substance Abuse Prevention (CSAP) within the Substance Abuse and Mental Health Services Administration (SAMHSA) assists states in complying with the Synar Amendment's goals by issuing programmatic requirements and guidance.

CSAP is charged with overseeing the states' implementation of the Synar requirements and provides technical assistance on the requirements and youth tobacco access issues in general. CSAP also provides guidance to states regarding the conduct of random, unannounced inspections. Specifically, in conducting their annual Synar surveys, states must:

- Develop a sampling frame that includes both over-the-counter and vending machine locations accessible to youth and young adults under the age of 21.
- Ensure that the sampling frame includes, at a minimum, 80% of the tobacco outlets in the state. CSAP requires states that use a list frame to conduct and report the results of a coverage study designed to assess the completeness of the sampling frame every 3 years.
- Design a sampling methodology and implementation plan that are based on sound survey sampling methodology.
- Sample a large enough number of outlets to meet SAMHSA's precision requirement (one-sided 95% confidence interval).
- Obtain a completion rate of 90% or better.
- Record the actual steps of the survey process in the field and keep records of all sources of sample attrition in the field.
- Weight the results of the Synar survey to account for unequal probabilities of selection, differences in percentages of eligible outlets between strata or clusters, and other deviations from the intended design.

States are also required to submit an annual report and an implementation plan with regard to Synar related activities. These requirements are incorporated in the annual SUPTRS Block Grant application. The state may be penalized up to 10% of the State's federal SUPTRS Block Grant award for non-compliance.

A state can avoid the 10% reduction in its SUPTRS Block Grant funds if the state stipulates that it will spend its own funds to improve compliance with the law. Specifically, under the alternative penalty, a state that fails to meet Synar requirements can take the following steps to avoid being penalized:

- Submit a corrective action plan to the Assistant Secretary for Mental Health and Substance Use within 90 days of receipt of notice that they are not in compliance with the Synar regulations, which outlines strategies they will take to reduce the Retail Violation Rate to 20% or less. States may not use SUPTRS Block Grant funds to pay for these activities and must find alternate sources of funds to cover these costs.

The Synar Requirements are summarized as follows:

1) States must enact a youth access to tobacco law restricting the sale and distribution of tobacco products to individuals under 21. The Michigan Youth Tobacco Act (YTA) satisfies this requirement by restricting the sale and distribution of tobacco products, including vapor products and alternative nicotine products, to youth and young adults under the age of 21.

2) States must actively enforce their youth access to tobacco laws.

3) The State must conduct a formal Synar survey annually to determine retailer compliance with the tobacco youth access law and to measure the success of state compliance with the Synar program.

4) The State must achieve and maintain a youth tobacco non-sales rate of 80% or better during the formal Synar survey.

In addition, SAMHSA/CSAP requires that an accurate listing of tobacco retail outlets be maintained, including periodic tobacco retail outlet coverage studies intended to confirm the accuracy of the list and establishes Synar sampling requirements.

REQUIREMENTS:

It is the responsibility of the PIHP to implement tobacco retail access prevention measures to achieve and maintain a youth and young adult under the age of 21 tobacco non-sales rate of 80% or better within their region. Activities associated with Synar best practices and other evidenced based prevention such as conducting inspections, and providing merchant or vendor education are defined as prevention services and must be carried out by a licensed (Community Change, Alternatives, Information, Training (CAIT) license) substance use disorder prevention provider.

In doing so, it is required that the PIHP will:

1) Use best practices relative to reducing access to tobacco products by youth and young adults under the age of 21.

2) Develop and implement a regional plan of Synar/tobacco prevention activity that will restrict youth and young adults under the age of 21 access to tobacco and surpass the 80% non-sales rate.

3) Incorporate data including youth and young adults under the age of 21 sales data and analysis of the effectiveness of Synar related activities when developing PIHP region plan.

4) Identify a DYTUR agency to implement Synar-related activities. The agency or individual identified as the DYTUR, must have knowledge in youth tobacco access reduction and related Synar prevention initiatives.

5) Conduct activities necessary to ensure the Tobacco Retailer Master List is correct and participate in the clarification and improvement process, as well as the CSAP Coverage Study. Submit to SUGE all information as required by the MDHHS/PIHP contract agreement.

6) Annually conduct and complete the Formal Synar Survey to all outlets in the random sample drawn by MDHHS/SUGE during the designated time period and utilize the official MDHHS protocol. Additionally, complete the compliance check report (CCR) forms and CCR spreadsheet and submit all required information to MDHHS per the MDHHS/PIHP contract agreement.

7) Collaborate with local partners (e.g., law enforcement, community coalitions, or local health departments) on Synar and related activities.

8) Ensure providers within the PIHP region are aware of Synar requirements and procedures prior to the formal Synar inspection period.

9) Monitor progress, address challenges (e.g., lack of youth inspectors) and any other issues during the formal Synar inspection period to ensure inspection timeframe requirements are met.

10) Contribute to enforcement of the Michigan YTA at tobacco outlets within the PIHP region by conducting non-Synar enforcement checks with law enforcement participation, non-Synar enforcement activity through civilian checks, and/or vendor education with tobacco retailers.

11) Seek to change community norms and conditions by forming relationships with stakeholders for the purposes of developing joint initiatives and/or for collaboration to impact sales trends to youth.

12) Report on YTA enforcement activities carried out by law enforcement agencies, including the number of violations, to satisfy federal reporting requirements. Correspondingly, it is the responsibility of the PIHP to comply with Synar protocol and demonstrate a good faith effort to obtain and report required information. Documentation of good faith effort may be required if the PIHP cannot provide the required information.

Note: SUPTRS Block Grant funds cannot be used to fund law enforcement to enforce the Michigan Youth Tobacco Act; this includes Formal Synar and non-Synar activities.

It is recommended that non-Synar checks be carried out in no less than 25% of the outlets in the PIHP region with priority to vendor categories that have historically had a higher sell rate to youth and young adult under the age of 21, e.g., gas stations, tobacco specialty stores, grocery stores and drug stores.

For PIHPs with a 20% "sell rate" or Retailer Violation Rate (RVR) higher than 20% for two consecutive Synar surveys, the requirement is:

1) Conduct Vendor Education activities, utilizing the MDHHS approved vendor education protocol, with no less than 50% of the total outlets within the PIHP region during the MDHHS designated Vendor Education period.

2) Conduct non-Synar compliance checks with no less than 50% of the outlets within the region during the subsequent third year.

3) Provide a corrective action plan regarding which activities or services the PIHP will fund to achieve compliance with the required RVR rate.

Or provide an alternative corrective action plan that the PIHP will undertake to achieve compliance with the required RVR rate. The plan must be approved by the Department.

REPORTING REQUIREMENTS:

See the MDHHS/PIHP agreement for PIHP reporting requirements.

PROCEDURE:

The PIHP must adhere to MDHHS-provided protocols, including the Formal Synar Survey Protocol, the Vendor Education Protocol, the Synar Tobacco Retailer Master List Update Guidance, and Coverage Study Procedures. Identification and implementation of activities, and local data collection and evaluation procedures, are left to the discretion of the PIHP. Technical assistance to PIHPs in development of local procedures is available through MDHHS. All associated protocols are placed on the MDHHS website and updated as needed.

REFERENCES:

Substance Abuse and Mental Health Services Administration (SAMHSA*). Programmatic Requirements for the Synar Program.* Programmatic Requirements for the Synar Program | SAMHSA

Youth Tobacco Act 31 of 1915, MCL1915 PA31, Michigan Legislature, 1915-1916 Legislative Session, Lansing, MI. (Amended July 22, 2022. http://www.legislature.mi.gov/documents/mcl/pdf/mcl-Act-31-of-1915.pdf

APPROVED BY:

Kristen Jordan

Kristen Jordan, Director
Bureau of Specialty Behavioral Health Services

MICHIGAN
OPIOID
ADVISORY
COMMISSION

Community Voices

Partner. Listen. Learn.

community impact survey

on the use of state
opioid settlement funds

These dollars are different.

Funds from the national opioid settlements are being received by state and local governments throughout the country.

Given the nature of the opioid settlements, the OAC believes that there is a responsibility to include community voices—especially individuals and families who have been directly impacted—in conversations around planning and use of state opioid settlement funds.

The community impact survey is one way to do that.

Take the Michigan Opioid Settlement Funds:
Community Impact Survey

For more information visit the OAC's website or contact oac@legislature.mi.gov

COVID-19 Public Health Emergency Unwind

Resumption of Standard Medicaid Operations

Meghan Groen
Senior Deputy Director
Behavioral & Physical Health & Aging Services Administration

November 1, 2023

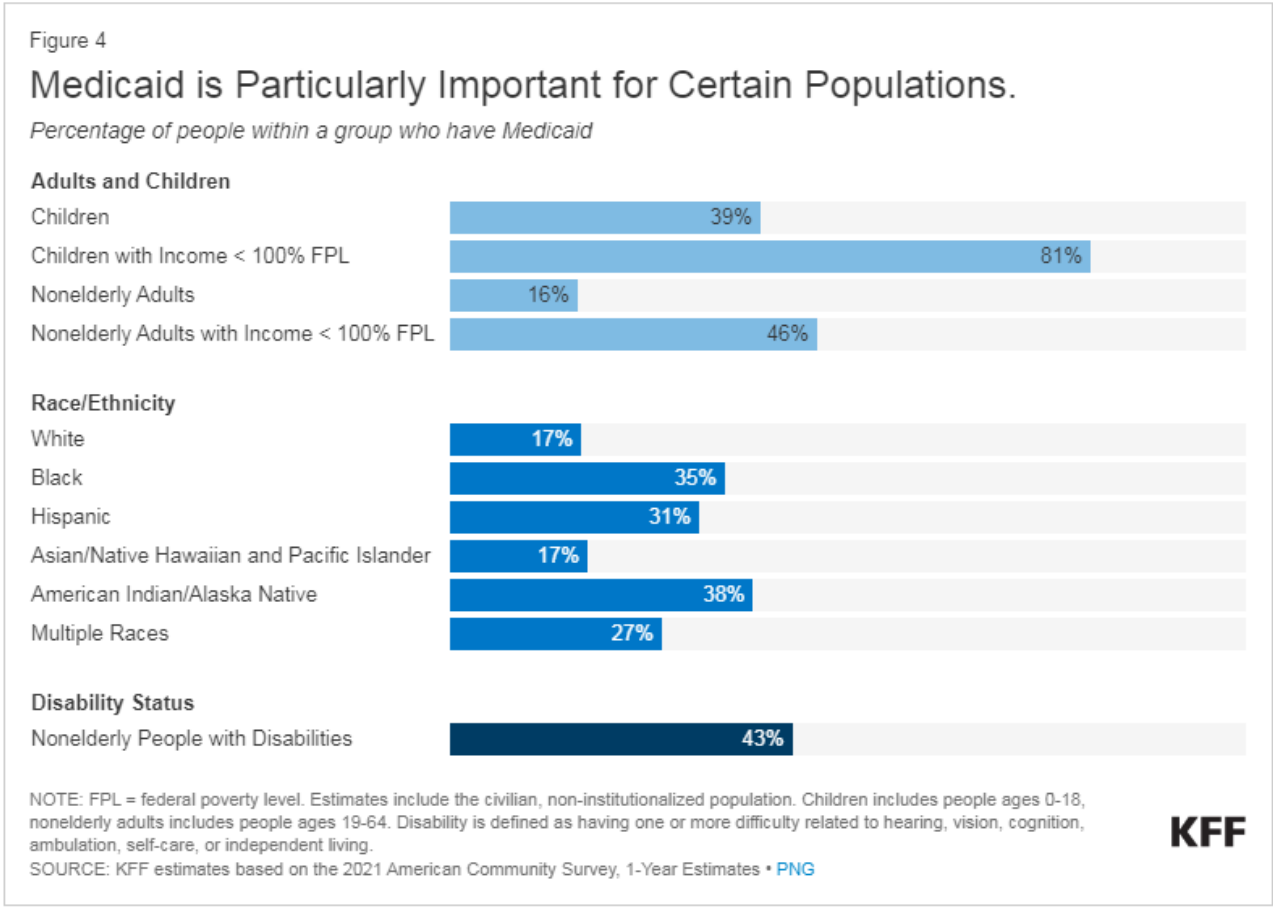
MDHHS
Michigan Department of Health & Human Services

Medicaid Background

MDHHS
Michigan Department of Health & Human Services

Medicaid Program Background

- Medicaid is a health care program jointly financed by States and the Federal government.
  - States have flexibility to design and administer their Medicaid programs within federal guidelines.
- Medicaid is the nation's largest public health insurance program for people with low income.

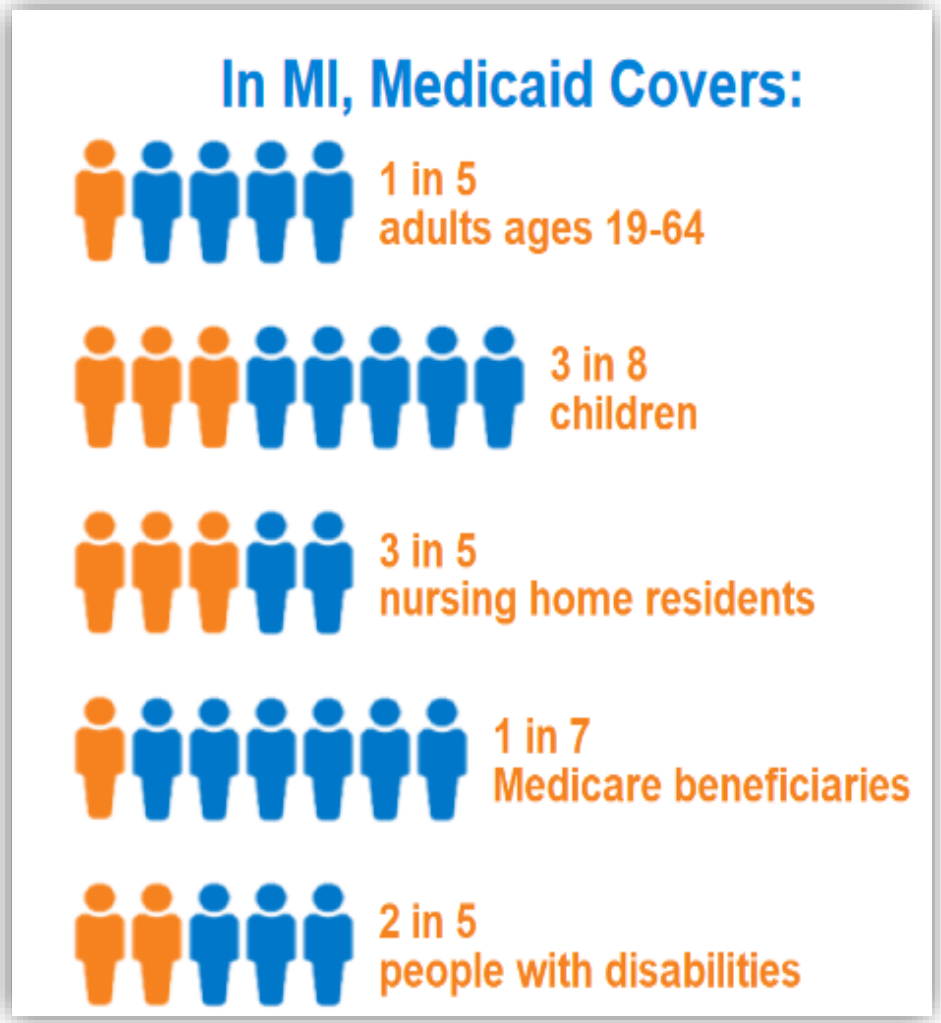


Source: Kaiser Family Foundation, 10 Things to Know About Medicaid, June 30, 2023, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/

Michigan's Medicaid Program

In FY22, Michigan's Medicaid program afforded health coverage to over **3 million Michiganders** each month, including:

- **1.02 million children**;
- **326,000 people** living with **disabilities**;
- **157,000 seniors**; and
- More than **1 million adults** in the **Healthy Michigan Plan**.



Graphic from: Kaiser Family Foundation 2022 Michigan Fact Sheet

PHE Unwind Overview

MDHHS
Michigan Department of Health & Human Services

Federal Renewal Requirements

- For individuals whose Medicaid eligibility is based on modified adjusted gross income methods (MAGI),42 CFR § 435.916 states:
  - The eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months.
  - Renewal on basis of information available to agency.
  - The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
    - This is “ex parte” renewal or passive renewal.

PHE Unwind Overview

2020

- January: Public Health Emergency begins
- March: Families First Coronavirus Relief Act (FFCRA)
  - Continuous coverage requirement effective January 1, 2020, through the end of the PHE

2022

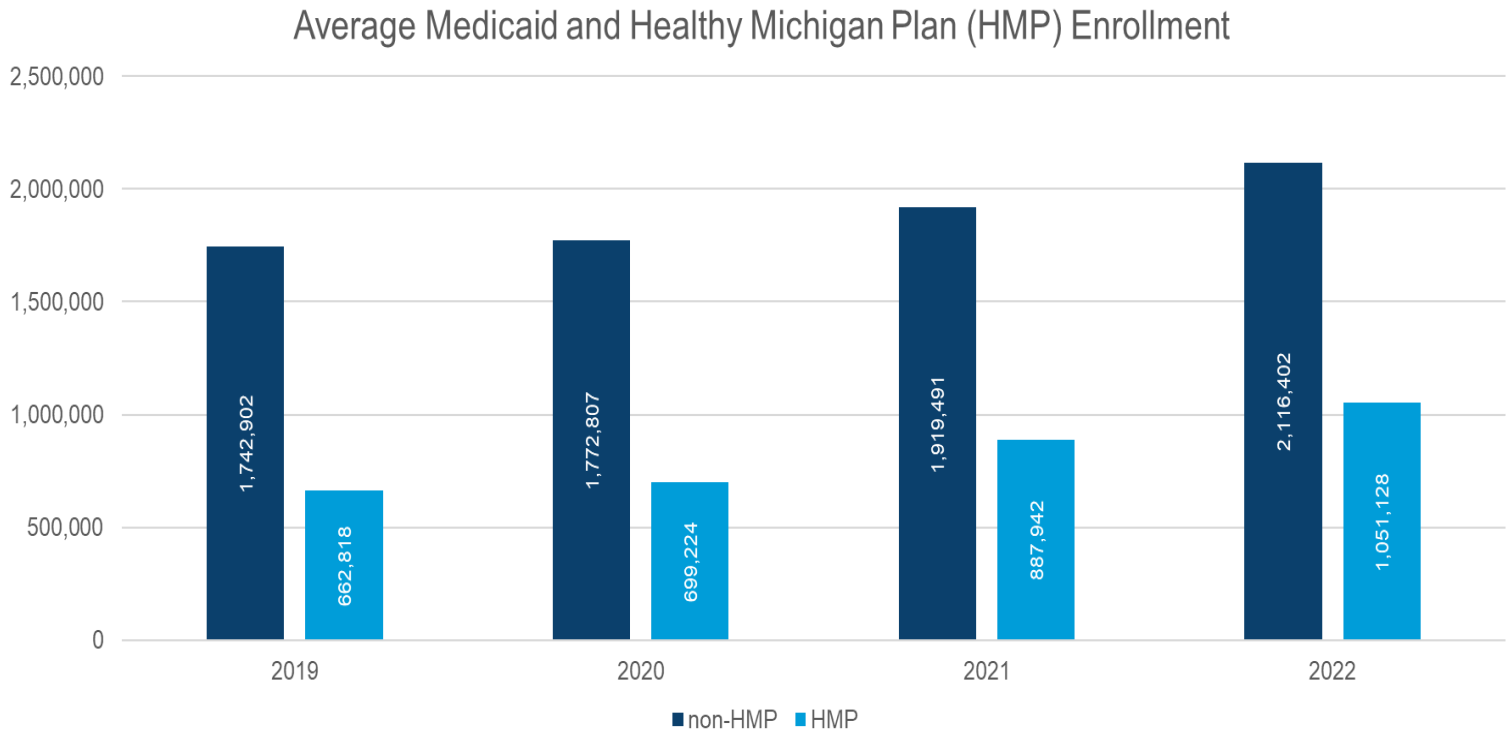
- December: Congress passes Consolidated Appropriations Act
  - Decouples Medicaid continuous enrollment from the end of the PHE

2023

- March 31: Last day of Medicaid continuous enrollment provisions
- April: MDHHS begins to restart renewals
- July: first month beneficiaries have coverage terminations in Michigan

Medicaid Enrollment Growth

- March 2020 enrollment: 2,395,319
- May 2023 Enrollment: 3,214,910
- **819,591 additional individuals covered (34.2% increase)**



Michigan’s Approach to Unwinding

MDHHS
Michigan Department of Health & Human Services

Keeping Residents Covered

- Goal: MDHHS's highest priority is to keep as many Medicaid beneficiaries enrolled and provide a smooth transition to the Marketplace to those no longer eligible.
- MDHHS is working to reach this goal through:
  - Enhancing ex parte renewal process.
  - Adopting special CMS waivers and flexibilities during the unwind.
  - Conducting robust outreach through mail, phone, text messages, and email.
  - Conducting statewide media campaign.
  - Partnering with Managed Care Organizations (Medicaid Health Plans, PHIPs, Integrated Care Organizations).

PHE 1902(e)(14)(A) Waivers

- MDHHS has submitted 1902(e)(14)(A) waivers for the following strategies:
  - Renew Medicaid eligibility based on financial findings from the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or other means-tested benefit programs.
  - Renew Medicaid eligibility for individuals with no income and no data returned on an ex parte basis ($0 income strategy).
  - Renew Medicaid eligibility for individuals with only Title II or other stable sources of income (e.g., pension income) without checking required data sources.
  - Permit managed care plans to provide assistance to enrollees to complete and submit Medicaid renewal forms.
  - Designate pharmacies, community-based organizations, and/or other providers as qualified entities to make determinations of PE on a MAGI basis for individuals disenrolled from Medicaid or CHIP for a procedural reason in the prior 90 days (or longer period elected by the state).
  - Reinstate eligibility effective on the individual's prior termination date for individuals who were disenrolled based on a procedural reason and are subsequently redetermined eligible for Medicaid During a 90-day Reconsideration Period.
  - Extend automatic reenrollment into a Medicaid managed care plan to up to 120 days after a loss of Medicaid coverage ("Managed Care Plan Auto-Reenrollment Strategy").

PHE Special Flexibilities

- MDHHS is also electing the following flexibilities that do not require waiver approval from CMS:
  - Renew Medicaid eligibility for individuals with stable sources of income or assets (e.g., many life insurance policies) when no useful data source is available.
  - Delay procedural terminations for beneficiaries for one month while the state conducts targeted renewal outreach.
  - Send lists to managed care plans and providers for individuals who are due for renewal and those who have not responded.
  - Inform all beneficiaries of their scheduled renewal date during unwinding.
  - Use managed care plans and all available outreach modalities (phone call, email, text) to contact enrollees when renewal forms are mailed and when they should have received them by mail.
  - Extend the 90-day reconsideration period for MAGI and/or add or extend a reconsideration period for non-MAGI populations during the unwinding period.
  - Extend the amount of time managed care plans have to conduct outreach to individuals recently terminated for procedural reasons.

Robust Communication

- Media campaign: Radio, social media, minority media outlets.
- Toolkit for community and provider partners:
  - Social media and web resources
  - Beneficiary letters and flyers
  - Additional print materials such as wallet card, posters, and brochure
- Earned media: Press release and media interviews.
- Many of the materials have been translated into Spanish and Arabic.
- Toolkit and other materials routinely shared with the Legislature

Communication Strategies

Established a dedicated website at michigan.gov/2023benefitchanges for all beneficiary and stakeholder information

Convening regular meetings with key partners and statewide associations

Biweekly email updates, timely and frequent briefings to inform, educate, and support our legislative partners

Hosting educational webinars to support broad awareness and engagement

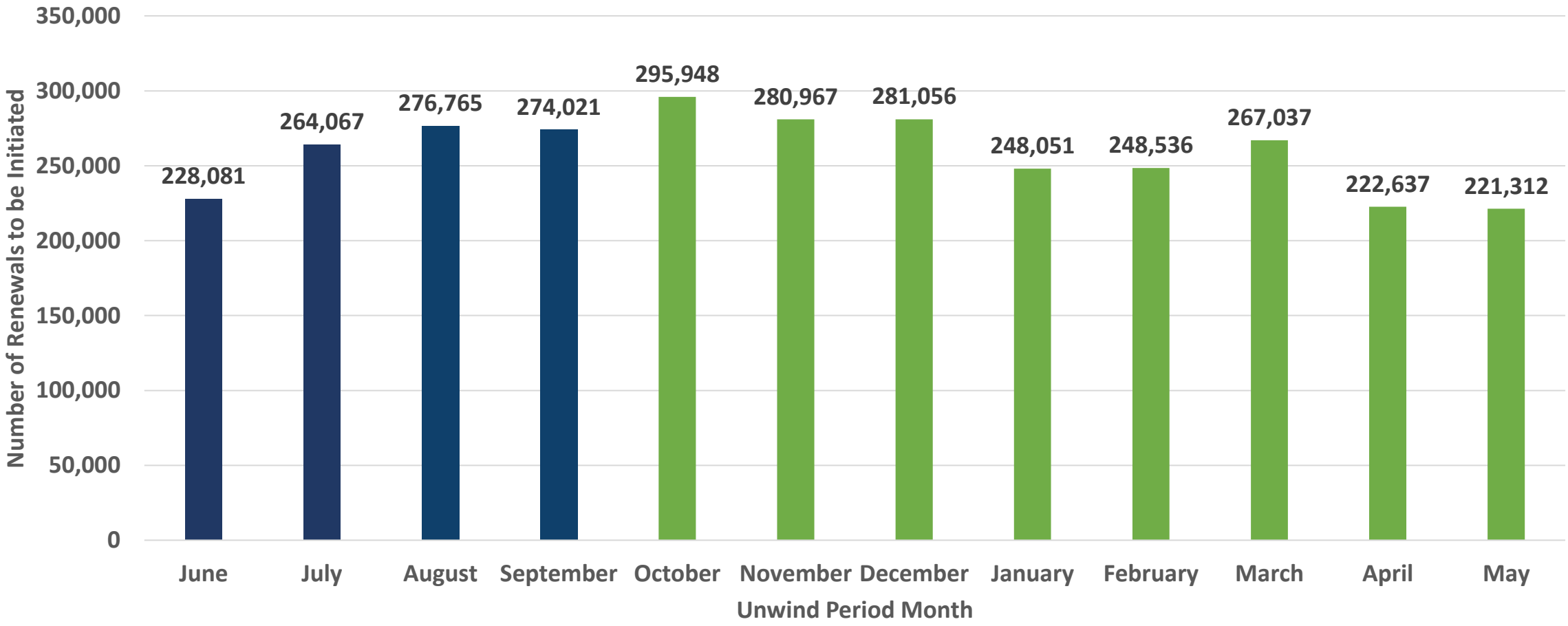
Proactive phone and email outreach to beneficiaries who have not returned paperwork and could be subject to closure

DHHS Local Office Collaboration

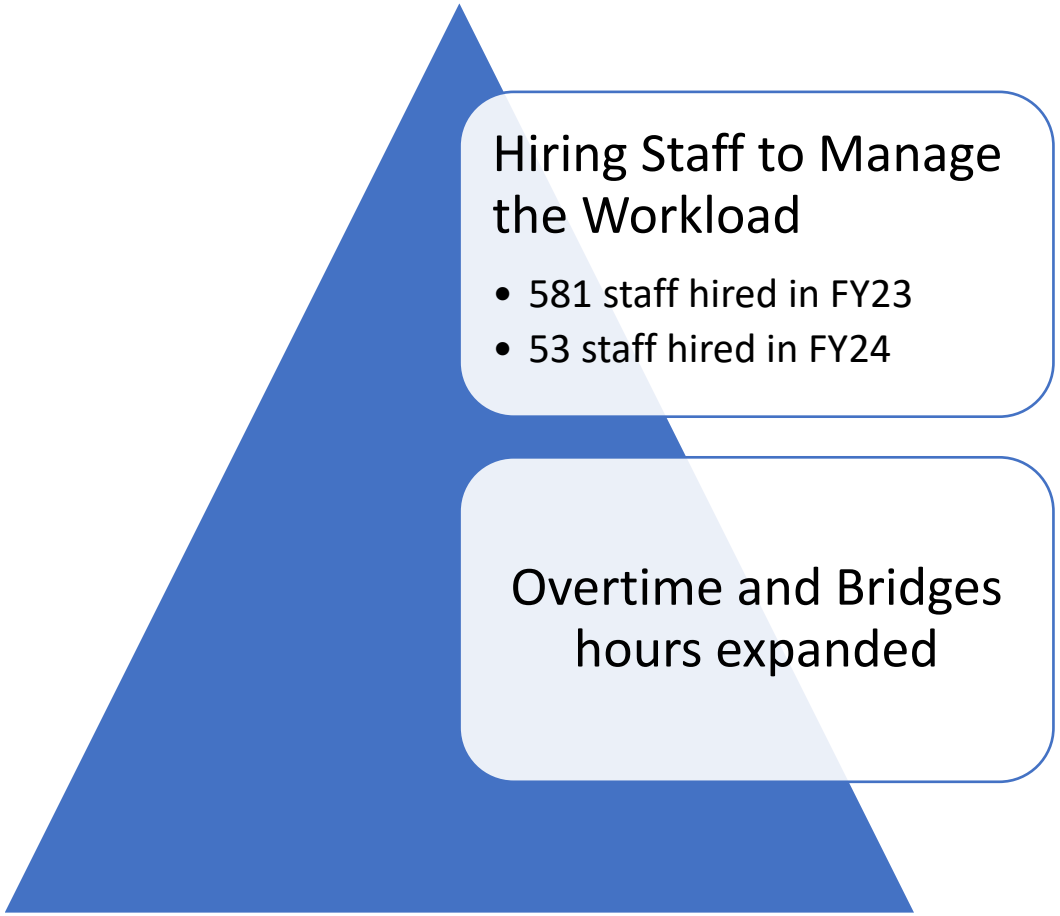
MDHHS
Michigan Department of Health & Human Services

Monthly Renewals

Starting the unwind MDHHS had 3,108,477 Medicaid renewals to review



Ensuring Local Office Success



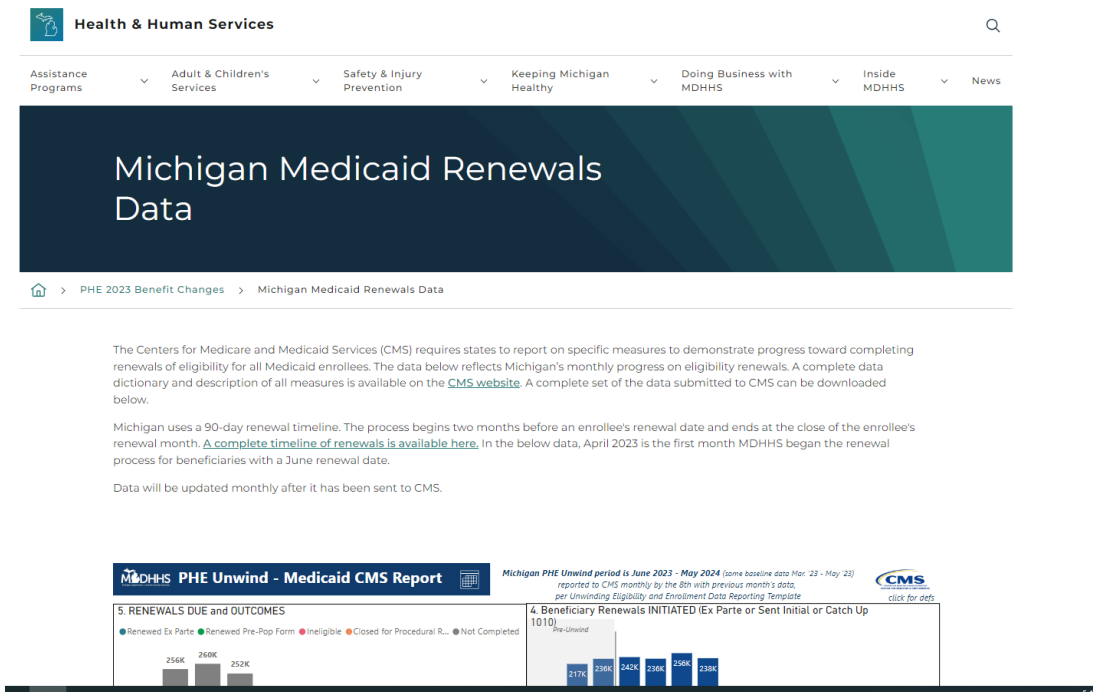
- Local Office Enhancements:
  - ESA, technical, BPHASA, and Local Office collaboration
  - Policy and Business Process clarifications and communications
  - Conducting statewide and individual trainings
  - One-on-one support provided to local office as requested
  - Local office input to continually improve reports
  - Increase passive renewals
  - Automated processes
  - Aligning review dates for families

Medicaid Renewal & Closure Data

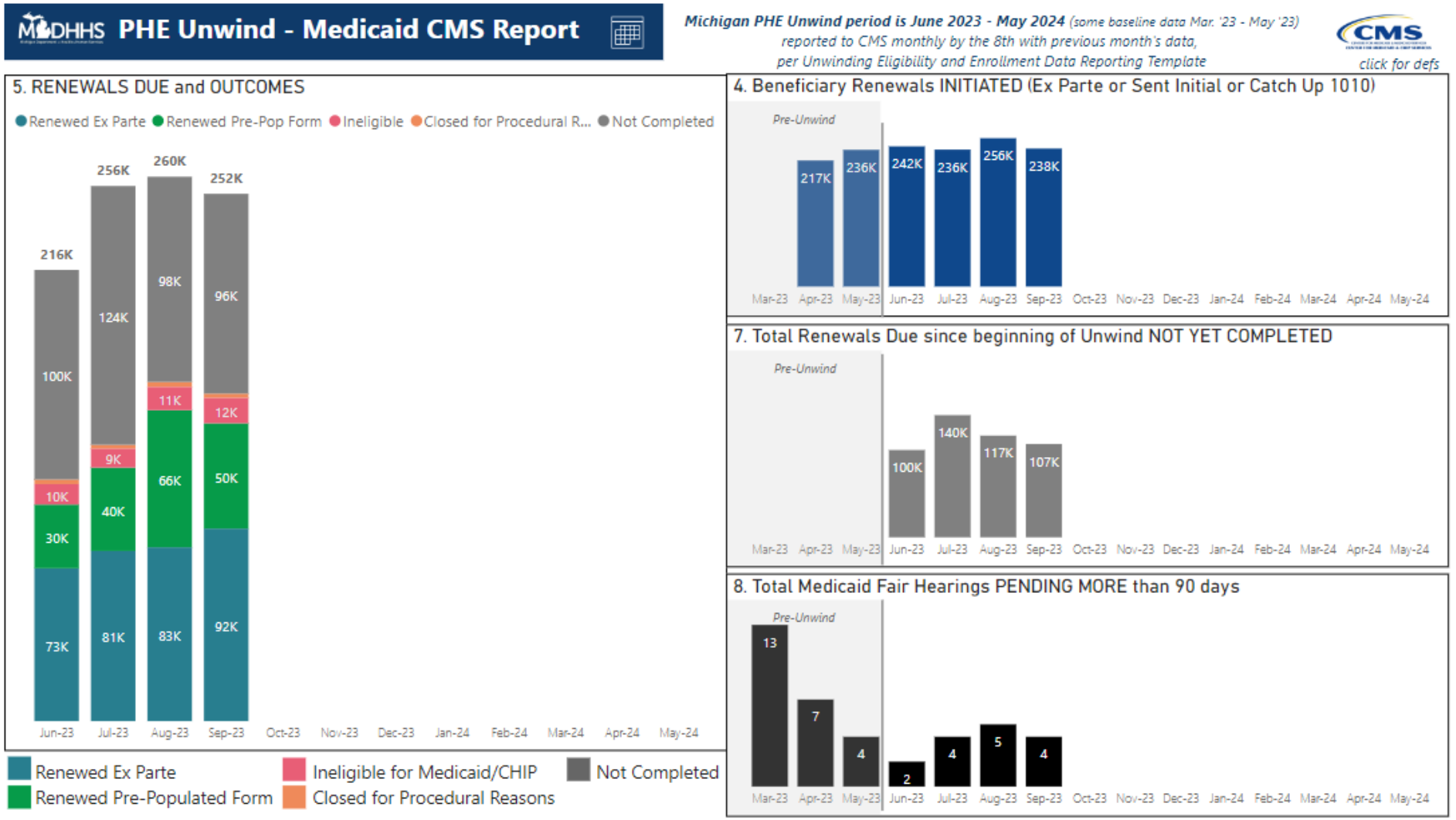
MDHHS
Michigan Department of Health & Human Services

Medicaid Renewals & Closures

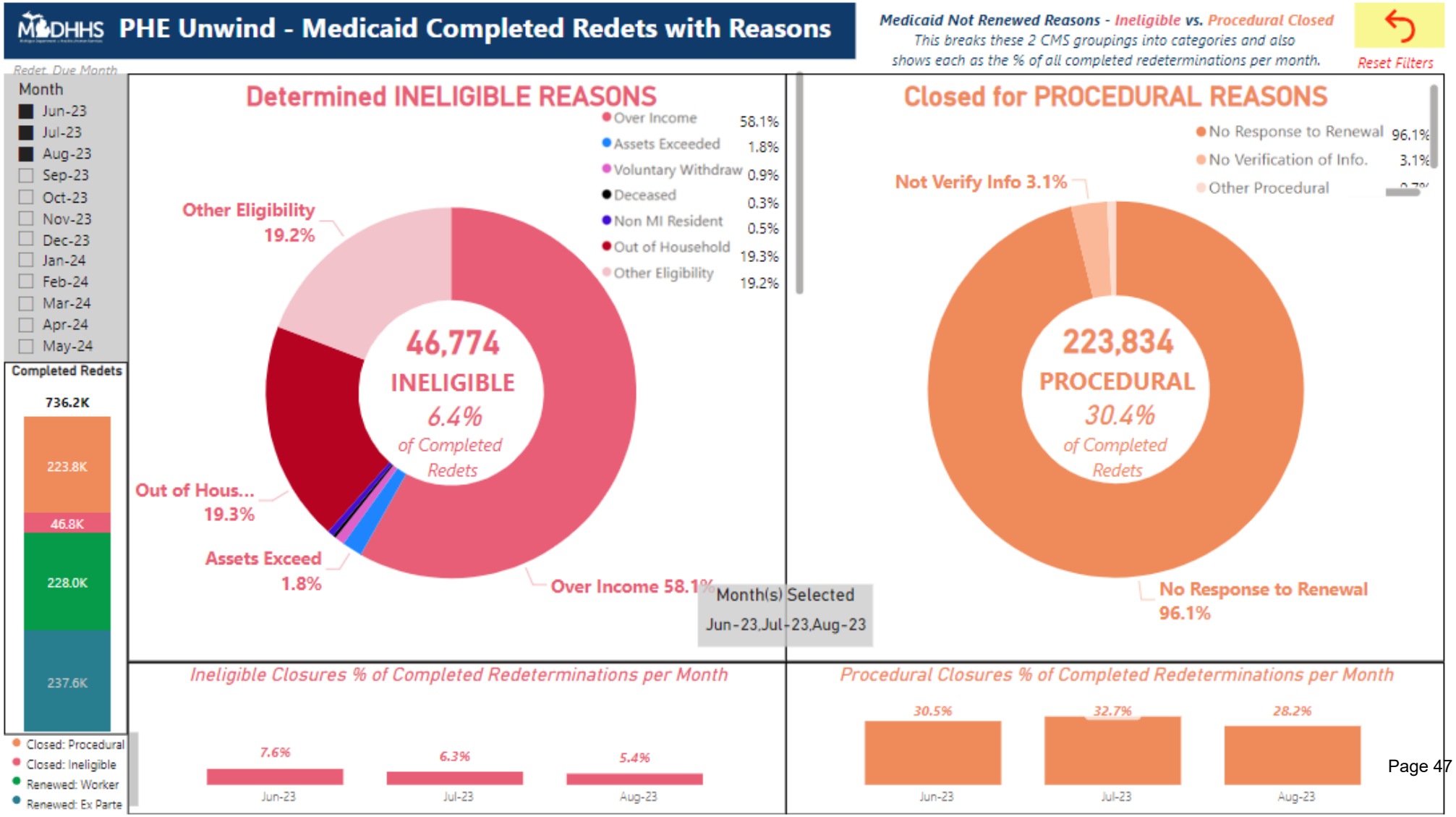
- MDHHS is committed to transparency and supplying unprecedented amounts of data during the unwind
- MDHHS updates data monthly, including data submitted to CMS
- Data is available at: https://www.michigan.gov/mdhhs/end-phe/michigan-medicaid-renewals-data



CMS Reported Data



Additional Monthly Data



Marketplace Transitions

MDHHS
Michigan Department of Health & Human Services

MDHHS & DIFS Partnership to Ensure Smooth Marketplace Transitions

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

MDHHS Michigan Department of Health & Human Services

- Implemented a joint Marketplace Coordination Workgroup to support robust interagency communication and coordination.
- Released joint guidance to MDHHS's contracted Medicaid Health Plans (MHPs) regarding permissible beneficiary outreach, including establishing an outreach strategy for MHPs that offer a Marketplace plan.
- Developed an outreach strategy to assure that individuals who are transitioning from Medicaid coverage due to excess income are aware of their options for staying covered.
  - Includes providing education about the Federal Marketplace and how to find additional resources, including navigators and assisters in their community.
- Built website for specific Marketplace information and education related to PHE.
  - https://michigan.gov/staycovered

Important Resources & Phone Numbers

MDHHS
Michigan Department of Health & Human Services

Resources and Phone Numbers

- MDHHS Website: michigan.gov/2023benefitchanges
  - Information for providers and beneficiaries
- DIFS Website: michigan.gov/staycovered
  - Information on Marketplace coverage
- MI Bridges Help Desk: 1-844-799-9876
  - Available 8am - 5pm Monday - Friday
  - Assistance with accessing MI Bridges Account
- Local Office/UCL Phone Number: (844) 464-3447
  - 9am - 3pm Monday - Friday
  - To reach a specialist

Questions

MDHHS
Michigan Department of Health & Human Services

Indicator 1a: Percentage of Children Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours -- 95% Standard

	Percentage	Number of Emergency Referrals for Children	Number Completed in Three Hours for Children
Detroit Wayne Mental Health Authority	98.68	833	822
Lakeshore Regional Entity	98.36	489	481
Macomb Co CMH Services	99.19	246	244
Mid-State Health Network	97.69	909	888
NorthCare Network	100.00	56	56
Northern MI Regional Entity	99.41	169	168
Oakland Co CMH Authority	99.73	364	363
Region 10	99.67	300	299
CMH Partnership of Southeast MI	98.81	168	166
Southwest MI Behavioral Health	100.00	228	228
Statewide Total	**99.15**	**3,762**	**3,715**

Indicator 1b: Percentage of Adults Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours -- 95% Standard

	Percentage	Number of Emergency Referrals for Adults	Number Completed in Three Hours for Adults
Detroit Wayne Mental Health Authority	96.88	2,852	2,763
Lakeshore Regional Entity	97.79	1,809	1,769
Macomb Co CMH Services	99.64	1,117	1,113
Mid-State Health Network	99.70	2,627	2,619
NorthCare Network	99.63	273	272
Northern MI Regional Entity	98.83	771	762
Oakland Co CMH Authority	97.05	1,388	1,347
Region 10	99.78	908	906
CMH Partnership of Southeast MI	99.54	649	646
Southwest MI Behavioral Health	99.11	899	891
Statewide Total	**98.79**	**13,293**	**13,088**

Indicator 2: The Percentage of New Persons During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	48.04	3,137	1,507
Lakeshore Regional Entity	55.52	1,405	780
Macomb Co CMH Services	16.28	1,216	198
Mid-State Health Network	61.94	4,396	2,723
NorthCare Network	63.34	581	368
Northern MI Regional Entity	54.54	1,432	781
Oakland Co CMH Authority	34.79	1,282	446
Region 10	54.23	2,327	1,262
CMH Partnership of Southeast MI	52.28	1,142	597
Southwest MI Behavioral Health	68.26	2,202	1,503
Statewide Total	**50.92**	**19,120**	**10,165**

Indicator 2a: The Percentage of New Children with Emotional Disturbance During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# MI Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	26.57	527	140
Lakeshore Regional Entity	60.74	517	314
Macomb Co CMH Services	12.86	350	45
Mid-State Health Network	61.13	1,410	862
NorthCare Network	65.95	185	122
Northern MI Regional Entity	55.25	476	263
Oakland Co CMH Authority	18.50	427	79
Region 10	50.69	649	329
CMH Partnership of Southeast MI	53.52	327	175
Southwest MI Behavioral Health	56.84	614	349
Statewide Total	**46.20**	**5,482**	**2,678**

Indicator 2b: The Percentage of New Adults with Mental Illness During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# MI Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.22	2,090	1,175
Lakeshore Regional Entity	51.85	702	364
Macomb Co CMH Services	17.51	731	128
Mid-State Health Network	63.84	2,649	1,691
NorthCare Network	61.89	349	216
Northern MI Regional Entity	52.48	825	433
Oakland Co CMH Authority	46.87	766	359
Region 10	55.19	1,321	729
CMH Partnership of Southeast MI	50.67	673	341
Southwest MI Behavioral Health	73.11	1,417	1,036
Statewide Total	**52.96**	**11,523**	**6,472**

Indicator 2c: The Percentage of New Children with Developmental Disabilities During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# DD Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	32.60	408	133
Lakeshore Regional Entity	50.60	83	42
Macomb Co CMH Services	19.61	102	20
Mid-State Health Network	42.74	248	106
NorthCare Network	64.00	25	16
Northern MI Regional Entity	69.14	81	56
Oakland Co CMH Authority	10.00	30	3
Region 10	55.32	282	156
CMH Partnership of Southeast MI	58.00	100	58
Southwest MI Behavioral Health	64.84	128	83
Statewide Total	**46.68**	**1,487**	**673**

Indicator 2d: The Percentage of New Adults with Developmental Disabilities During the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service

	Percentage	# DD Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	52.68	112	59
Lakeshore Regional Entity	58.25	103	60
Macomb Co CMH Services	15.15	33	5
Mid-State Health Network	71.91	89	64
NorthCare Network	63.64	22	14
Northern MI Regional Entity	58.00	50	29
Oakland Co CMH Authority	8.47	59	5
Region 10	64.00	75	48
CMH Partnership of Southeast MI	54.76	42	23
Southwest MI Behavioral Health	81.40	43	35
Statewide Total	**52.83**	**628**	**342**

Indicator 2e: The Percentage of New Persons During the Quarter Receiving a Face-to-Face Service for Treatment or Supports Within 14 calendar days of a Non-emergency Request for Service for Persons with Substance Use Disorders

		Admissions			
	Percentage	# of Non-Urgent Admissions to a Licensed SUD Treatment Facility as reported in BH TEDS	# of Expired Requests Reported by the PIHP	Total	# of Persons Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request
Detroit Wayne Mental Health Authority	62.46	2,748	1,048	3,796	2,371
Lakeshore Regional Entity	67.63	1,233	222	1,455	984
Macomb Co CMH Services	80.55	1,107	173	1,280	1,031
Mid-State Health Network	73.41	2,548	476	3,024	2,220
NorthCare Network	56.89	501	123	624	355
Northern MI Regional Entity	69.22	1,060	152	1,212	839
Oakland Co CMH Authority	87.68	1,181	110	1,291	1,132
Region 10	74.00	1,469	339	1,808	1,338
CMH Partnership of Southeast MI	59.84	803	310	1,113	666
Southwest MI Behavioral Health	69.90	1,311	367	1,678	1,173
Statewide Total	**70.16**	**13,961**	**3,320**	**17,281**	**12,109**

Indicator 3: Percentage of New Persons During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# of Persons Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	90.33	2,440	2,204
Lakeshore Regional Entity	63.98	1,166	746
Macomb Co CMH Services	69.50	718	499
Mid-State Health Network	63.09	3,555	2,243
NorthCare Network	66.37	455	302
Northern MI Regional Entity	66.28	943	625
Oakland Co CMH Authority	98.92	1,020	1,009
Region 10	81.62	1,621	1,323
CMH Partnership of Southeast MI	67.96	724	492
Southwest MI Behavioral Health	54.26	1,865	1,012
Statewide Total	**72.23**	**14,507**	**10,455**

Indicator 3a: The Percentage of New Children with Emotional Disturbance During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	81.71	421	344
Lakeshore Regional Entity	61.87	459	284
Macomb Co CMH Services	50.83	181	92
Mid-State Health Network	56.82	1,165	662
NorthCare Network	71.43	161	115
Northern MI Regional Entity	68.87	318	219
Oakland Co CMH Authority	98.86	352	348
Region 10	80.38	474	381
CMH Partnership of Southeast MI	67.53	231	156
Southwest MI Behavioral Health	54.84	558	306
Statewide Total	**69.31**	**4,320**	**2,907**

Indicator 3b: The Percentage of New Adults with Mental Illness During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	92.94	1,630	1,515
Lakeshore Regional Entity	66.12	546	361
Macomb Co CMH Services	77.00	413	318
Mid-State Health Network	63.68	1,988	1,266
NorthCare Network	64.84	256	166
Northern MI Regional Entity	66.07	507	335
Oakland Co CMH Authority	98.77	568	561
Region 10	79.37	858	681
CMH Partnership of Southeast MI	64.01	389	249
Southwest MI Behavioral Health	54.95	1,121	616
Statewide Total	**72.78**	**8,276**	**6,068**

Indicator 3c: The Percentage of New Children with Developmental Disabilities During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# DD Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	89.38	292	261
Lakeshore Regional Entity	60.27	73	44
Macomb Co CMH Services	74.51	102	76
Mid-State Health Network	81.85	314	257
NorthCare Network	52.38	21	11
Northern MI Regional Entity	60.00	75	45
Oakland Co CMH Authority	100.00	32	32
Region 10	92.86	224	208
CMH Partnership of Southeast MI	83.12	77	64
Southwest MI Behavioral Health	41.89	148	62
Statewide Total	**73.63**	**1,358**	**1,060**

Indicator 3d: The Percentage of New Adults with Developmental Disabilities During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# DD Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	86.60	97	84
Lakeshore Regional Entity	64.77	88	57
Macomb Co CMH Services	59.09	22	13
Mid-State Health Network	65.91	88	58
NorthCare Network	58.82	17	10
Northern MI Regional Entity	60.47	43	26
Oakland Co CMH Authority	100.00	68	68
Region 10	81.54	65	53
CMH Partnership of Southeast MI	85.19	27	23
Southwest MI Behavioral Health	73.68	38	28
Statewide Total	**73.61**	**553**	**420**

Indicator 4a(1): The Percentage of Children Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days -- 95% Standard

	Percentage	# Children Discharged from Psychiatric Inpatient Unit	# Children Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	96.15	52	50
Lakeshore Regional Entity	92.86	84	78
Macomb Co CMH Services	54.67	75	41
Mid-State Health Network	98.74	159	157
NorthCare Network	96.30	27	26
Northern MI Regional Entity	95.45	44	42
Oakland Co CMH Authority	97.30	37	36
Region 10	94.57	92	87
CMH Partnership of Southeast MI	100.00	52	52
Southwest MI Behavioral Health	100.00	66	66
Statewide Total	**92.60**	**688**	**635**

Indicator 4a(2): The Percentage of Adults Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days -- 95% Standard

	Percentage	# Adults Discharged from Psychiatric Inpatient Unit	# Adults Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	97.78	540	528
Lakeshore Regional Entity	98.02	303	297
Macomb Co CMH Services	47.24	434	205
Mid-State Health Network	97.35	603	587
NorthCare Network	91.57	83	76
Northern MI Regional Entity	96.39	166	160
Oakland Co CMH Authority	96.79	249	241
Region 10	97.21	287	279
CMH Partnership of Southeast MI	95.11	184	175
Southwest MI Behavioral Health	98.34	302	297
Statewide Total	**91.58**	**3,151**	**2,845**

Indicator 4b: The Percent of Discharges from a Substance Abuse Detox Unit Who are Seen for Follow-up Care Within 7 Days -- 95% Standard

	Percentage	# SA Discharged from Substance Abuse Detox Unit	# SA Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	98.86	527	521
Lakeshore Regional Entity	98.02	101	99
Macomb Co CMH Services	100.00	304	304
Mid-State Health Network	98.01	201	197
NorthCare Network	93.75	48	45
Northern MI Regional Entity	94.97	159	151
Oakland Co CMH Authority	100.00	182	182
Region 10	95.60	91	87
CMH Partnership of Southeast MI	99.16	119	118
Southwest MI Behavioral Health	98.36	244	240
Statewide Total	**97.67**	**1,976**	**1,944**

Indicator 5: Percentage of Area Medicaid Recipients Having Received PIHP Managed Services

	Percentage	Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients
Detroit Wayne Mental Health Authority	5.93	49,928	841,876
Lakeshore Regional Entity	5.29	18,867	356,886
Macomb Co CMH Services	4.67	12,682	271,511
Mid-State Health Network	7.08	35,625	503,038
NorthCare Network	6.77	5,696	84,160
Northern MI Regional Entity	7.67	12,046	156,994
Oakland Co CMH Authority	7.62	18,963	248,930
Region 10	7.07	17,948	253,895
CMH Partnership of Southeast MI	6.34	10,358	163,495
Southwest MI Behavioral Health	6.91	18,785	271,860
Statewide Total	**6.53**	**200,898**	**3,152,645**

Indicator 6 (old #8): The Percent of Habilitation Supports Waiver (HSW) Enrollees in the Quarter Who Received at Least One HSW Service Each Month Other Than Supports Coordination

	Percentage	# of HSW Enrollees Receiving at Least One HSW Service Other Than	Total Number of HSW Enrollees
Detroit Wayne Mental Health Authority	93.74	928	990
Lakeshore Regional Entity	94.53	588	622
Macomb Co CMH Services	94.23	408	433
Mid-State Health Network	62.19	931	1,497
NorthCare Network	99.18	363	366
Northern MI Regional Entity	97.33	620	637
Oakland Co CMH Authority	94.90	781	823
Region 10	97.71	555	568
CMH Partnership of Southeast MI	91.10	635	697
Southwest MI Behavioral Health	93.40	651	697
Statewide Total	**91.83**	**6,460**	**7,330**

Indicator 10a (old #12a): The Percentage of Children Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit -- 15% or Less Standard

	Percentage	Number of Children Discharged from Inpatient Care	# Children Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	7.27	165	12
Lakeshore Regional Entity	7.96	113	9
Macomb Co CMH Services	2.47	81	2
Mid-State Health Network	9.52	231	22
NorthCare Network	3.45	29	1
Northern MI Regional Entity	3.64	55	2
Oakland Co CMH Authority	8.51	47	4
Region 10	7.25	138	10
CMH Partnership of Southeast MI	5.26	57	3
Southwest MI Behavioral Health	0.00	104	0
Statewide Total	**5.53**	**1,020**	**65**

Indicator 10b (old #12b): The Percentage of Adults Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit -- 15% or Less Standard

	Percentage	Number of Adults Discharged from Inpatient Care	# Adults Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	17.71	1,875	332
Lakeshore Regional Entity	11.93	419	50
Macomb Co CMH Services	17.46	504	88
Mid-State Health Network	12.33	1,022	126
NorthCare Network	13.73	102	14
Northern MI Regional Entity	8.58	268	23
Oakland Co CMH Authority	10.82	416	45
Region 10	12.01	533	64
CMH Partnership of Southeast MI	10.61	245	26
Southwest MI Behavioral Health	9.57	575	55
Statewide Total	**12.47**	**5,959**	**823**

November 6, 2023

Northern Michigan Regional Entity
Attn: Eric Kurtz
1999 Walden Drive
Gaylord, MI 49735

Re: Terry A. Larson – Resignation from Governing Board

Mr. Kurtz,

Thank you for the opportunity to serve the residents of Northern Michigan as a representative of Presque Isle County on the Governing Board of the Northern Michigan Regional Entity.

Due to recent health challenges, I must resign from the Governing Board.

Respectfully,

Terry A. Larson

Cc: Presque Isle County Board of Commissioners

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – NOVEMBER 8, 2023
VIA TEAMS

ATTENDEES:	**Laura Argyle, Brian Babbitt, Connie Cadarette, Ann Friend, Chip Johnston, Nancy Kearly, Eric Kurtz, Brian Martinus, Allison Nicholson, Donna Nieman, Larry Patterson, Brandon Rhue, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

REVIEW AGENDA & ADDITIONS
Brandon asked to add a discussion of psychiatric inpatient modifiers under the EDIT update.

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE OCTOBER 11, 2023 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY ERINN TRASK. MOTION APPROVED.

MONTHLY FINANCIALS
During the meeting, the September Financial report was reviewed using trend data for Northern Lakes. Following the meeting, actual numbers were received from Northern Lakes and the report was revised to indicate the following:

September 2023

- Net Position showed net deficit Medicaid and HMP of $215,344. Budget stabilization was reported as $16,369,542. The total Medicaid and HMP Current Year Surplus was reported as $16,154,198. Medicaid and HMP combined ISF was reported as $16,369,542; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $32,523,740.
- Traditional Medicaid showed $198,687,690 in revenue, and $201,137,511 in expenses, resulting in a net deficit of $2,449,821. Medicaid ISF was reported as $9,306,578 based on the current FSR. Medicaid Savings was reported as $7,742,649.
- Healthy Michigan Plan showed $35,861,654 in revenue, and $33,627,176 in expenses, resulting in a net surplus of $2,234,478. HMP ISF was reported as $7,062,964 based on the current FSR. HMP savings was reported as $8,626,893.
- Health Home showed $2,418,616 in revenue, and $2,166,835 in expenses, resulting in a net surplus of $251,781.
- SUD showed all funding source revenue of $30,471,105 and $27,809,959 in expenses, resulting in a net surplus of $2,661,146. Total PA2 funds were reported as $5,097,296.

A fully funded ISF is expected going into FY24.

Liquor tax funds in the amount of $2,720,209 were approved for projects for FY23. At the end of September only $2,030,095 had been billed. Ms. Yockey noted that any unspent PA2 will remain in the county balances. Actual revenue came in at $1.8M vs. the projected $1.5M. Over $5M in PA2 fund balances will be carried over into FY24.

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR SEPTEMBER 2023; SUPPORT BY ANN FRIEND. MOTION APPROVED.

EDIT UPDATE

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

- Clarification was made that DBT Code H2019 is used for adults only; the code chart was updated to omit any reference to children, effective October 1, 2023.
- The EQI workgroup discussed adding a MH line to the EQI process for service codes H0004 and H0005 when reported with the HH modifier.
- The COB subgroup met to work on updating COB instructions for FY24 driect-run services.
- A CCBHC update was provided but it does not pertain to Region 2.
- The Appendix subgroup completed its task in September and all changes were reflected in the October update to the FY24 Behavioral Health Code Chart and Qualifications workbook.
- September and October updates to the Code Chart and Provider Qualifications may be found at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/Mental-Health/Reporting-Requirements/SFY_2024_Behavioral_Health_Code_Charts_and_Provider_Qualifications.xlsx?rev=6dc5a025017b410890b3895387a448ce.
- The question of billing SUD MAT services bundles when Medicaid is secondary to commercial insurance was raised. Commercial insurers are using H0020, which is a CMS code.
- The question of whether two entities can bill for the same code was raised (e.g., a crisis provider and hospital liaison both using code H2011 on the same day). Guidance will be provided during the January 19th meeting.

Erinn referred to the September 25, 2023 update to the Behavioral Health Code Sets, Charts, and Qualifications. Under "General Rules for Reporting," a section was added to read: "Sleeping Providers: There should not be sleeping staff at any time for any service on any waiver, state plan or 1915(i). No matter the code/modifier, you cannot report it when the staff are asleep. They need to be awake to bill for this service." Erinn questioned whether per diem codes are exempt from the rule. Donna responded that it was not discussed but she can raise the topic during the January 19th meeting.

Psychiatric Inpatient Modifiers

The Department is planning to implement a psychiatric inpatient tiered rate system in Q3 FY24 and would like the EDIT group to review and provide feedback on tiered rate modifiers. The Department and Milliman are currently working to establish rates for each tier.

- Z1/Tier 1 = regular staffing ratio
- Z2/Tier 2 = 2:1 staffing ratio
- Z3/Tier 3 = 1:1 staffing ratio
- Z4/Tier 4 = 1:2 staffing ratio

It was noted that series billings will make it difficult to change modifiers in the system throughout the day. Eric has reached out to Kristen Jordan and the Association for input. Brandon noted that the topic has not been discussed in the CIO Forum. Ann clarified that the UB4 form includes a field for modifiers.

Eric was unable to attend a meeting on October 30th to resurrect the 1513 Inpatient Workgroup. Bob Sheehan and 5 – 6 staff from Milliman were on the call. Milliman has developed a provider survey template to send to hospitals to gather FY22 financials to develop tiered model. CMHAM is planning to consult with the hospital association. Further discussions are expected. Brandon agreed to keep committee members informed.

INTERIM FSR

The Interim FSR will be submitted by the November 10th due date.

EQI

Tricia received communication from Crystal Williams on November 7th regarding viewing the EQI in terms of capitated dollars and moving away from the individual MH and SUD funding lines. These changes would go into effect for the Period 1 FY24 due in June. Tricia asked for any feedback from the CMHSPs. The consensus from the group was that they were in favor of simplifying if all the necessary detail is maintained.

A data pull date for the next EQI will be selected in December.

DCW FY24 RATE

Each of the Boards confirmed that they are passing the DCW increase to providers but internal wages have been raised above the enhanced rate.

Laura asked whether there has been any discussion of a regional direct care policy. Connie responded that each CMHSP has its own processes. Erinn responded that Region 10 adopted a regional policy. Eric remarked that any policy would reiterate the information contained in L-Letter 23-64.

Richard Carpenter has compiled a list of issues related to the DCW L-Letter, but he has had no response to date.

This topic will remain a standing agenda item until fully implemented.

HSW SLOTS

The NMRE currently has 18 of its 689 HSW slots open; additional packets are pending. Because 97% of the region's slots are currently filled, the risk of losing slots to other PIHP regions has lessened.

FY24 BUDGET

The NMRE Board approved the FY24 Preliminary budget on September 27, 2023. October revenue was greater than September despite the decrease in eligibles.

OTHER

Deanna stated that the three-year cycle to select an audit firm is up FY23. Rather than issuing an RFP, the suggestion was made to extend the contract with Roslund, Prestage & Company. If an RFP is issued, it should go out in April. The Boards were agreeable to an extension of the RPC agreement.

All reports will be due to the NMRE on Feb. 14th for Feb. 28th reporting (PIHP FSR bundle, EQI including an attestation to accuracy, completeness, and truthfulness of claims and payment data, PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k), Medical Loss Ratio).

All FY23 encounters should be entered into the system by November 21st.

NEXT MEETING

The next meeting was scheduled for December 14th at 9:00AM.

Chief Executive Officer Report

November/December 2023

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

Nov 1: Attended and participated in NMRE Internal Operations Committee meeting.

Nov 2: Attended and participated in MDHHS PIHP CEO meeting.

Nov 6: Attended and participated in NMRE SUD Oversight Committee meeting.

Nov 7: Attended and participated in PIHP CEO meeting.

Nov 8: Attended and participated in Regional Finance Committee meeting.

Nov 21: Attended and participated in Rural Core Group meeting.

Nov 28: Attended and participated in Rehman Management Review Update.

Nov 29: Attended and participated in NMRE Internal Operations Committee meeting.

Dec 4: Chaired NMRE Operations Committee meeting.

Dec 5: Attended and participated in PIHP CEO meeting.

Dec 7: Attended and participated in MDHHS PIHP CEO meeting.

Dec 7: Attended and participated in Rural Core Group meeting.

September 2023

Preliminary Finance Report revised 11/16/23

Preliminary September 2023 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	(2,449,821)	7,742,649	9,306,578
Healthy Michigan	2,234,478	8,626,893	7,062,964
	$ (215,344)	$ 16,369,542	$ 16,369,542

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	1,599,688	2,310,760	(2,263,278)	(349,560)	(2,982,150)	2,317,495	(848,299)	$ (215,344)
Budget Stabilization Full Year		1,878,908	4,919,342	4,095,691	2,272,462	1,955,236	1,247,903	16,369,542
Total Med/HMP Current Year Surplus	1,599,688	4,189,668	2,656,064	3,746,131	(709,688)	4,272,731	399,604	$ 16,154,198
Medicaid & HMP Internal Service Fund								16,369,542
Total Medicaid & HMP Net Surplus								$ 32,523,740

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2022 through September 30, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 192,391,198	$ 6,296,492						$ 198,687,690
CMHSP Distributions	(184,470,592)		60,468,539	50,710,051	31,149,235	26,093,925	16,048,841	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	7,920,606	6,296,492	60,468,539	50,710,051	31,149,235	26,093,925	16,048,841	198,687,690
Expense								
PIHP Admin	2,480,251	66,963						2,547,214
PIHP SUD Admin		99,626						99,626
SUD Access Center		39,547						39,547
Insurance Provider Assessment	1,755,039	44,568						1,799,607
Hospital Rate Adjuster	2,263,800							2,263,800
Services		5,110,168	61,210,069	52,337,343	34,751,168	24,100,819	16,878,150	194,387,717
Total expense	6,499,090	5,360,872	61,210,069	52,337,343	34,751,168	24,100,819	16,878,150	201,137,511
Net Actual Surplus (Deficit)	$ 1,421,516	$ 935,620	$ (741,530)	$ (1,627,292)	$ (3,601,933)	$ 1,993,106	$ (829,309)	$ (2,449,821)

Notes

Medicaid ISF - $9,306,578 - based on current FSR

Medicaid Savings - $7,742,649

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2022 through September 30, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 22,803,823	$ 13,057,831						$ 35,861,654
CMHSP Distributions	(20,209,441)		7,358,746	6,116,007	2,509,854	2,542,829	1,682,005	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	2,594,383	13,057,831	7,358,746	6,116,007	2,509,854	2,542,829	1,682,005	35,861,654
Expense								
PIHP Admin	255,894	145,890						401,785
PIHP SUD Admin		217,055						217,055
SUD Access Center		86,160						86,160
Insurance Provider Assessment	171,868	100,120						271,988
Hospital Rate Adjuster	1,988,448							1,988,448
Services		11,133,466	8,880,495	4,838,275	1,890,070	2,218,440	1,700,995	30,661,741
Total expense	2,416,210	11,682,691	8,880,495	4,838,275	1,890,070	2,218,440	1,700,995	33,627,176
Net Surplus (Deficit)	$ 178,172	$ 1,375,140	$ (1,521,749)	$ 1,277,732	$ 619,784	$ 324,389	$ (18,990)	$ 2,234,478

Notes
HMP ISF - $7,062,964 - based on current FSR
HMP Savings - $8,626,893

Net Surplus (Deficit) MA/HMP	**$ 1,599,688**	**$ 2,310,760**	**$ (2,263,278)**	**$ (349,560)**	**$ (2,982,150)**	**$ 2,317,495**	**$ (848,299)**	**$ (215,344)**
Medicaid Carry Forward								**16,369,542**
Total Med/HMP Current Year Surplus								$ 16,154,198
Medicaid & HMP ISF - based on current FSR								**16,369,542**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 32,523,740**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2022 through September 30, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 473,479		680,406	342,032	166,312	194,226	562,161	$ 2,418,616
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	473,479	-	680,406	342,032	166,312	194,226	562,161	2,418,616
Expense								
PIHP Admin	27,439							27,439
BHH Admin	45,447							45,447
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	148,812		680,406	342,032	166,312	194,226	562,161	2,093,949
Total expense	221,698	-	680,406	342,032	166,312	194,226	562,161	2,166,835
Net Surplus (Deficit)	$ 251,781	$ -	$ -	$ -	$ -	$ -	$ -	$ 251,781

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2022 through September 30, 2023

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 6,296,492	$ 13,057,831	$ 4,314,899	$ 4,645,208	$ 2,156,675	$ 30,471,105
Expense						
Administration	166,589	362,945	121,279	232,000		882,814
OHH Admin			122,946	-		122,946
Access Center	39,547	86,160	-	23,196		148,903
Insurance Provider Assessment	44,568	100,120	-			144,688
Services:						
Treatment	5,110,168	11,133,466	3,720,287	2,997,395	2,156,675	25,117,991
Prevention	-	-	-	1,245,299	-	1,245,299
ARPA Grant	-	-	-	147,318	-	147,318
Total expense	5,360,872	11,682,691	3,964,512	4,645,208	2,156,675	27,809,959
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 935,620	$ 1,375,140	$ 350,387	$ -	$ -	$ 2,661,146

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2022 through September 30, 2023

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 192,391,198	$ 6,296,492	$ -	$ 198,687,690
Medicaid Savings	7,742,649	-	-	7,742,649
Healthy Michigan	22,803,823	13,057,831	-	35,861,654
Healthy Michigan Savings	8,626,893	-	-	8,626,893
Health Home	2,418,616	-	-	2,418,616
Opioid Health Home	-	4,314,899	-	4,314,899
Substance Use Disorder Block Grant	-	4,645,208	-	4,645,208
Public Act 2 (Liquor tax)	-	2,156,674	-	2,156,674
Affiliate local drawdown	594,816	-	-	594,816
Performance Incentive Bonus	626,931	-	-	626,931
Miscellanous Grant Revenue	-	4,000	-	4,000
Veteran Navigator Grant	89,589	-	-	89,589
SOR Grant Revenue	-	1,752,115	-	1,752,115
Gambling Grant Revenue	-	141,316	-	141,316
Other Revenue	995	-	7,083	8,078
Total operating revenue	235,295,510	32,368,535	7,083	267,671,128
Operating expenses				
General Administration	3,109,347	685,954	-	3,795,301
Prevention Administration	-	117,811	-	117,811
OHH Administration	-	122,946	-	122,946
BHH Administration	45,447	-	-	45,447
Insurance Provider Assessment	1,926,907	144,688	-	2,071,595
Hospital Rate Adjuster	4,252,248	-	-	4,252,248
Payments to Affiliates:				
Medicaid Services	189,277,549	5,110,168	-	194,387,717
Healthy Michigan Services	19,528,275	11,133,466	-	30,661,741
Health Home Services	2,093,949	-	-	2,093,949
Opioid Health Home Services	-	3,720,287	-	3,720,287
Community Grant	-	2,997,395	-	2,997,395
Prevention	-	1,127,488	-	1,127,488
State Disability Assistance	-	-	-	-
ARPA Grant	-	147,318	-	147,318
Public Act 2 (Liquor tax)	-	2,156,675	-	2,156,675
Local PBIP	2,185,313	-	-	2,185,313
Local Match Drawdown	594,816	-	-	594,816
Miscellanous Grant	-	4,000	-	4,000
Veteran Navigator Grant	89,589	-	-	89,589
SOR Grant Expenses	-	1,752,115	-	1,752,115
Gambling Grant Expenses	-	141,316	-	141,316
Total operating expenses	223,103,440	29,361,627	-	252,465,067
CY Unspent funds	12,192,070	3,006,908	7,083	15,206,061
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,636,590	5,408,166	16,369,542	24,414,298
Unspent funds - ending	$ 14,828,660	$ 8,415,074	$ 16,376,625	$ 39,620,359

Northern Michigan Regional Entity

Statement of Net Position

September 30, 2023

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 53,230,935	$ 7,372,015	$ 16,376,625	$ 76,979,575
Accounts Receivable	2,770,715	3,094,157	-	5,864,872
Prepaids	115,928	-	-	115,928
Total current assets	56,117,578	10,466,172	16,376,625	82,960,375
Noncurrent Assets				
Capital assets	125,002	-	-	125,002
Total Assets	56,242,580	10,466,172	16,376,625	83,085,377
Liabilities				
Current liabilities				
Accounts payable	41,215,076	2,051,113	-	43,266,189
Accrued liabilities	198,844	-	-	198,844
Unearned revenue	-	-	-	-
Total current liabilities	41,413,920	2,051,113	-	43,465,033
Unspent funds	$ 14,828,660	$ 8,415,059	$ 16,376,625	$ 39,620,344

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2022 through September 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 187,752,708	$ 192,391,198	$ 4,638,490	2.47%
Carryover	11,400,000	11,400,000	7,742,649	(3,657,351)	(0)
Healthy Michigan					
Capitation	19,683,372	19,683,372	22,803,823	3,120,451	15.85%
Carryover	5,100,000	5,100,000	8,626,893	3,526,893	69.15%
Health Home	1,451,268	1,451,268	2,418,616	967,348	66.66%
Affiliate local drawdown	594,816	594,816	594,816	-	0.00%
Performance Bonus Incentive	1,334,531	1,334,531	626,931	(707,600)	(53.02%)
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	110,000	89,589	(20,411)	(18.56%)
Other Revenue	-	-	995	995	0.00%
Total operating revenue	227,426,695	227,426,695	235,295,510	7,868,815	3.46%
Operating expenses					
General Administration	3,591,836	3,559,248	3,109,347	449,901	12.64%
BHH Administration	-	-	45,447	(45,447)	0.00%
Insurance Provider Assessment	1,897,524	1,897,524	1,926,907	(29,383)	(1.55%)
Hospital Rate Adjuster	4,571,328	4,571,328	4,252,248	319,080	6.98%
Local PBIP	1,737,753	-	2,185,313	(2,185,313)	0.00%
Local Match Drawdown	594,816	594,816	594,816	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	91,716	89,589	2,127	2.32%
Payments to Affiliates:					
Medicaid Services	176,618,616	176,618,616	189,277,549	(12,658,933)	(7.17%)
Healthy Michigan Services	17,639,940	17,639,940	19,528,275	(1,888,335)	(10.70%)
Health Home Services	1,415,196	1,415,196	2,093,949	(678,753)	(47.96%)
Total operating expenses	208,177,013	206,388,384	223,103,440	(16,715,056)	(8.10%)
CY Unspent funds	$ 19,249,682	$ 21,038,311	12,192,070	$ (8,846,241)	
Transfers in			-		
Transfers out			-	223,103,440	
Unspent funds - beginning			2,636,590		
Unspent funds - ending			$ 14,828,660	12,192,070	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2022 through September 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 4,678,632	$ 6,296,492	$ 1,617,860	34.58%
Healthy Michigan	11,196,408	11,196,408	13,057,831	1,861,423	16.63%
Substance Use Disorder Block Grant	6,467,905	6,467,905	4,645,208	(1,822,697)	(28.18%)
Opioid Health Home	3,419,928	3,419,928	4,314,899	894,971	26.17%
Public Act 2 (Liquor tax)	1,533,979	1,533,979	2,156,674	622,695	40.59%
Miscellanous Grants	4,000	4,000	4,000	-	0.00%
SOR Grant	2,043,984	2,043,984	1,752,115	(291,869)	(14.28%)
Gambling Prevention Grant	200,000	200,000	141,316	(58,684)	(29.34%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	29,544,836	32,368,535	2,823,699	9.56%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	1,022,576	685,954	336,622	32.92%
Prevention Administration	118,428	118,428	117,811	617	0.52%
Insurance Provider Assessment	113,604	113,604	144,688	(31,084)	(27.36%)
Medicaid Services	3,931,560	3,931,560	5,110,168	(1,178,608)	(29.98%)
Healthy Michigan Services	10,226,004	10,226,004	11,133,466	(907,462)	(8.87%)
Community Grant	2,074,248	2,074,248	2,997,395	(923,147)	(44.51%)
Prevention	634,056	634,056	1,127,488	(493,432)	(77.82%)
State Disability Assistance	95,215	95,215	-	95,215	100.00%
ARPA Grant	-	-	147,318	(147,318)	0.00%
Opioid Health Home Admin	-	-	122,946	(122,946)	0.00%
Opioid Health Home Services	3,165,000	3,165,000	3,720,287	(555,287)	(17.54%)
Miscellanous Grants	4,000	4,000	4,000	-	0.00%
SOR Grant	2,043,984	2,043,984	1,752,115	291,869	14.28%
Gambling Prevention	200,000	200,000	141,316	58,684	29.34%
PA2	1,533,978	1,533,978	2,156,675	(622,697)	(40.59%)
Total operating expenses	25,222,653	25,162,653	29,361,627	(4,198,974)	(16.69%)
CY Unspent funds	$ 4,322,183	$ 4,382,183	3,006,908	$ (1,375,275)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			5,408,166		
Unspent funds - ending			$ 8,415,074		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2022 through September 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 1,921,812	$ 1,745,616	$ 176,196	9.17%
Fringes	666,212	633,624	580,547	53,077	8.38%
Contractual	683,308	683,308	458,109	225,199	32.96%
Board expenses	18,000	18,000	17,676	324	1.80%
Day of recovery	14,000	14,000	12,674	1,326	9.47%
Facilities	152,700	152,700	138,965	13,735	8.99%
Other	135,804	135,804	155,760	(19,956)	(14.69%)
Total General Admin	$ 3,591,836	$ 3,559,248	$ 3,109,347	$ 449,901	12.64%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2022 through September 30, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 502,752	$ 502,752	$ 280,525	$ 222,227	44.20%
Fringes	145,464	145,464	67,142	78,322	53.84%
Access Salaries	220,620	220,620	106,933	113,687	51.53%
Access Fringes	67,140	67,140	41,970	25,170	37.49%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	75,000	154,605	(79,605)	(106.14%)
Board expenses	5,000	5,000	5,295	(295)	(5.90%)
Day of Recover	-	-	11,040	(11,040)	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	6,600	18,444	(11,844)	(179.45%)
Total operating expenses	$ 1,082,576	$ 1,022,576	$ 685,954	$ 336,622	32.92%

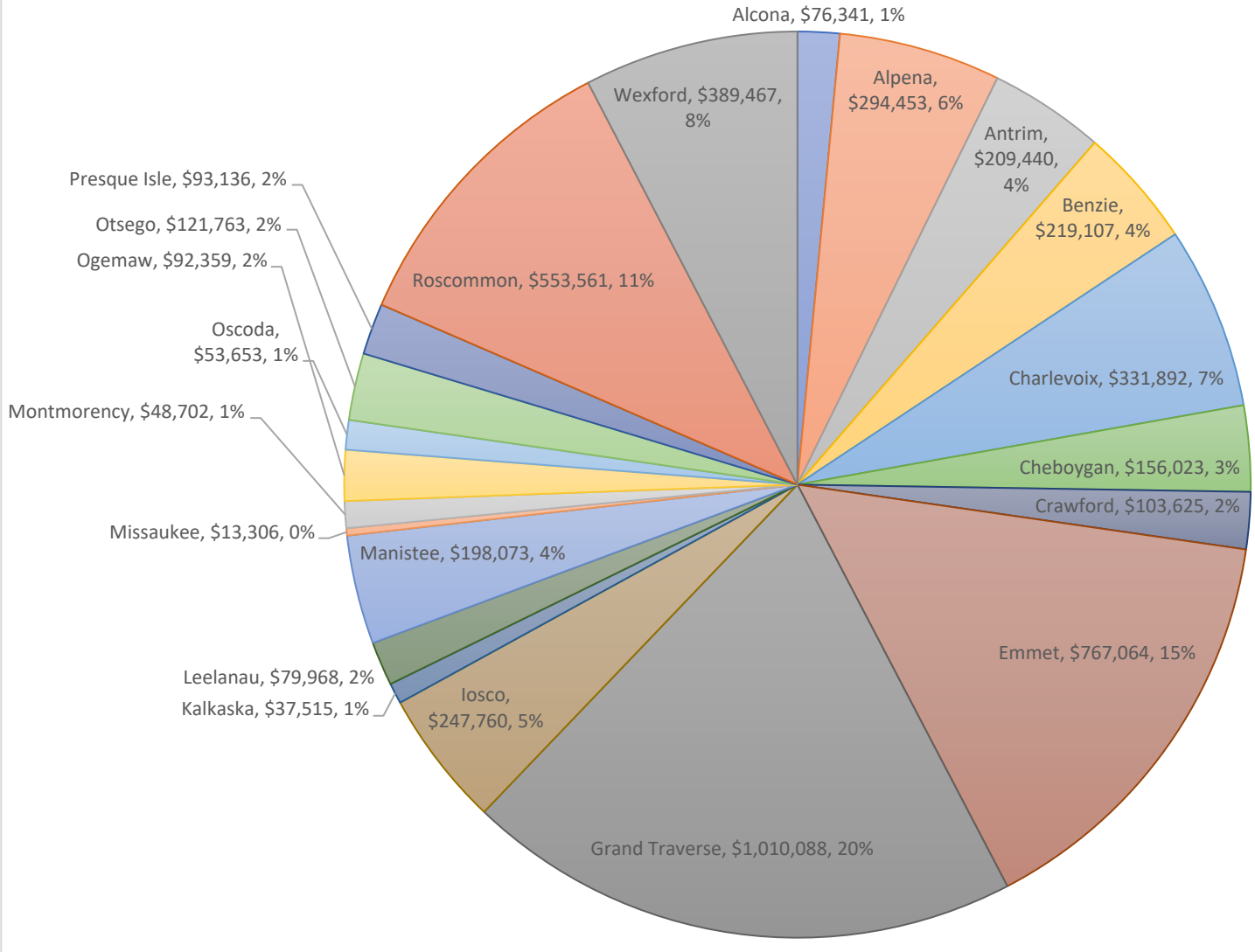
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2022 through September 30, 2023

	Projected FY23 Activity				Actual FY23 Activity			
	Beginning Balance	FY23 Projected Revenue	FY23 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 59,376	$ 20,389	$ 4,410	$ 75,355	$ 23,294	6,329	$ -	$ 76,341
Alpena	263,254	69,040	45,317	286,976	81,792	50,593	-	294,453
Antrim	219,249	59,729	80,820	198,158	69,368	79,177	-	209,440
Benzie	173,705	52,923	14,857	211,771	62,810	17,408	-	219,107
Charlevoix	359,548	89,334	110,699	338,183	104,607	132,263	-	331,892
Cheboygan	191,247	74,954	138,728	127,472	87,305	122,528	-	156,023
Crawford	92,406	31,228	17,903	105,731	37,472	26,254	-	103,625
Emmet	716,610	155,245	115,175	756,679	191,088	140,634	-	767,064
Grand Traverse	1,282,987	406,430	1,248,209	441,208	466,326	739,225	-	1,010,088
Iosco	329,202	70,865	180,735	219,332	83,918	165,360	-	247,760
Kalkaska	74,226	31,700	83,823	22,103	40,660	77,372	-	37,515
Leelanau	102,658	56,613	117,817	41,454	65,033	87,723	-	79,968
Manistee	131,924	68,873	10,407	190,390	81,084	14,936	-	198,073
Missaukee	37,771	18,044	48,883	6,931	21,382	45,847	-	13,306
Montmorency	54,974	27,338	42,322	39,990	29,966	36,238	-	48,702
Ogemaw	154,130	50,286	142,919	61,497	65,407	127,178	-	92,359
Oscoda	65,061	20,039	36,568	48,532	20,646	32,053	-	53,653
Otsego	108,477	88,483	94,620	102,340	102,689	89,402	-	121,763
Presque Isle	75,221	22,256	5,450	92,027	25,736	7,821	-	93,136
Roscommon	524,550	74,697	72,090	527,157	85,627	56,616	-	553,561
Wexford	396,468	79,925	108,457	367,936	94,719	101,720	-	389,467
	5,413,044	1,568,386	2,720,209	4,261,221	1,840,928	2,156,677	-	5,097,296
PA2 Redirect								-
								5,097,296

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2022 through September 30, 2023

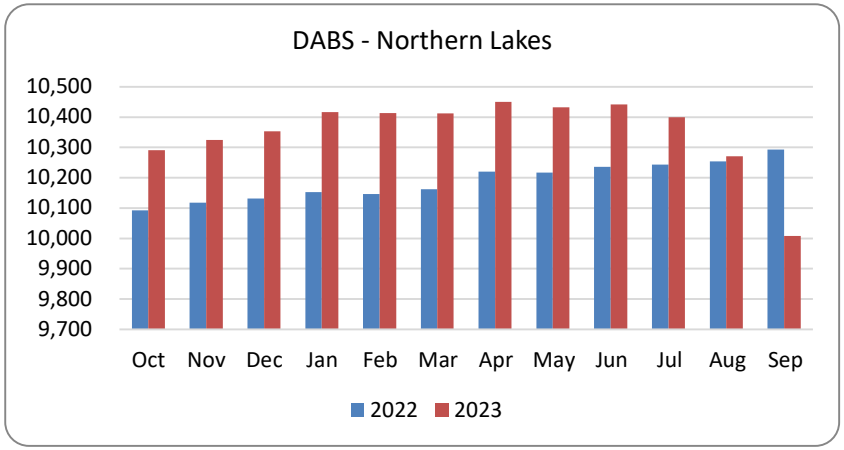
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	7,500	7,083	(417)	(5.56%)
Total operating revenue	7,500	7,500	7,083	(417)	(5.56%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 7,500	7,083	$ (417)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,369,542		
Unspent funds - ending			$ 16,376,625		

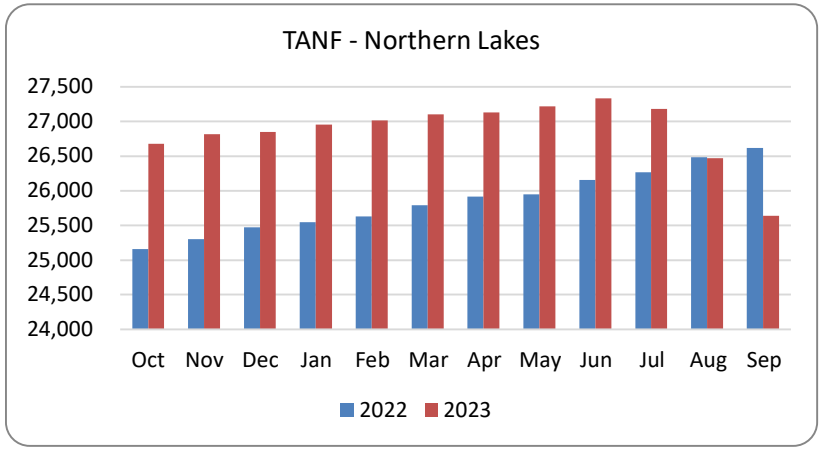
Northern Michigan Regional Entity

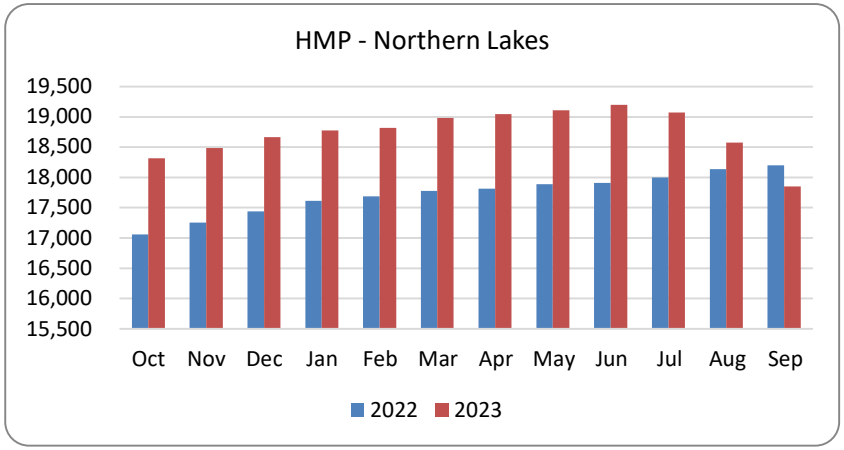
Narrative

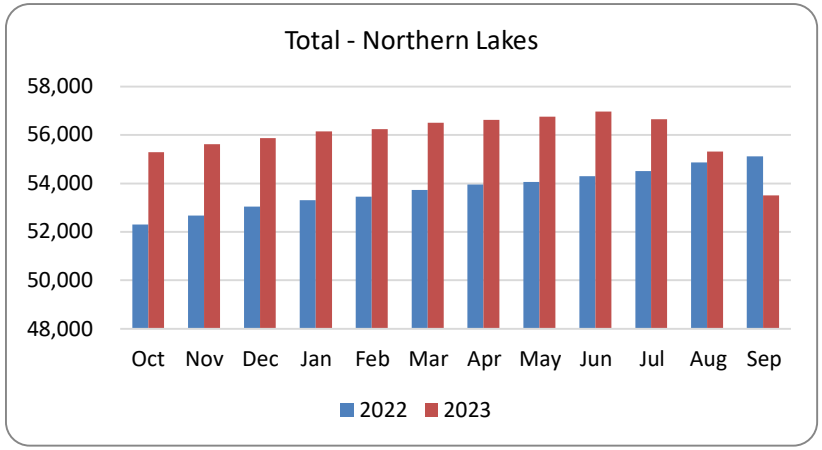
October 1, 2022 through September 30, 2023

Northern Lakes Eligible Members Trending - based on payment files







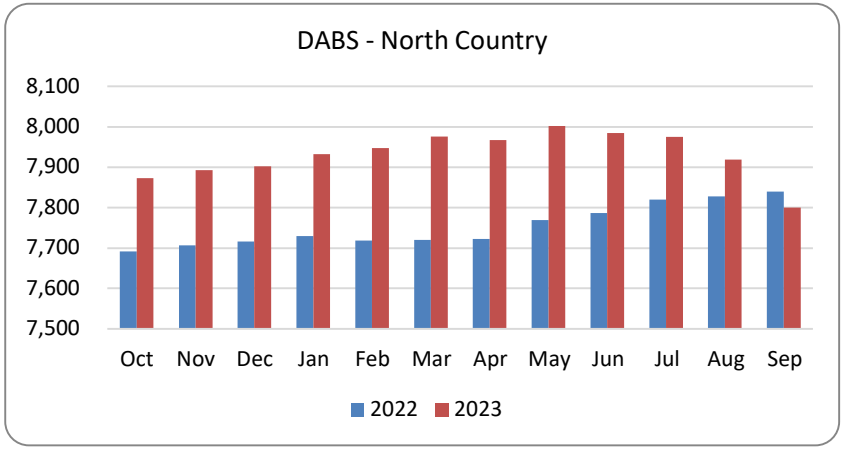


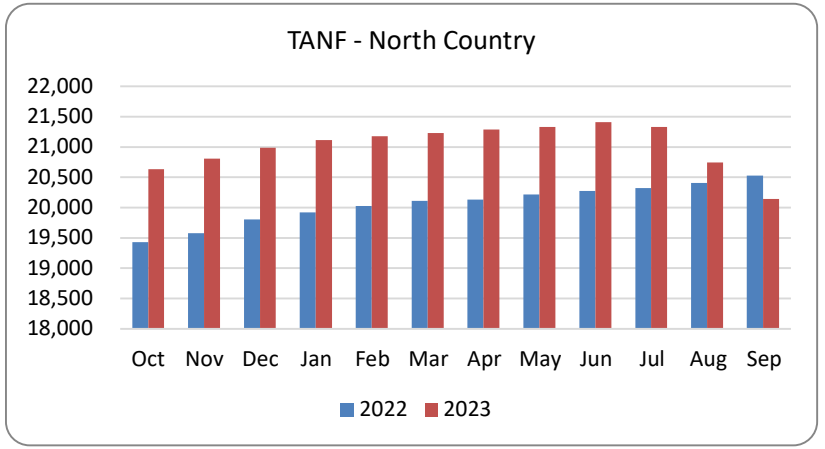
Northern Michigan Regional Entity

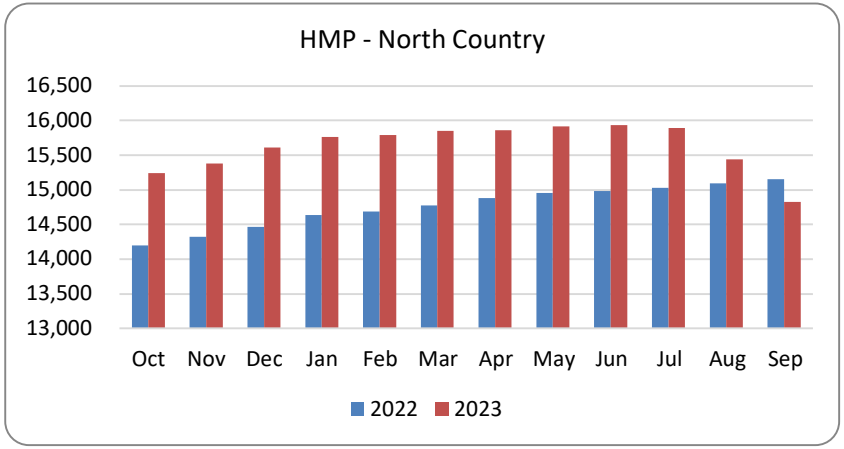
Narrative

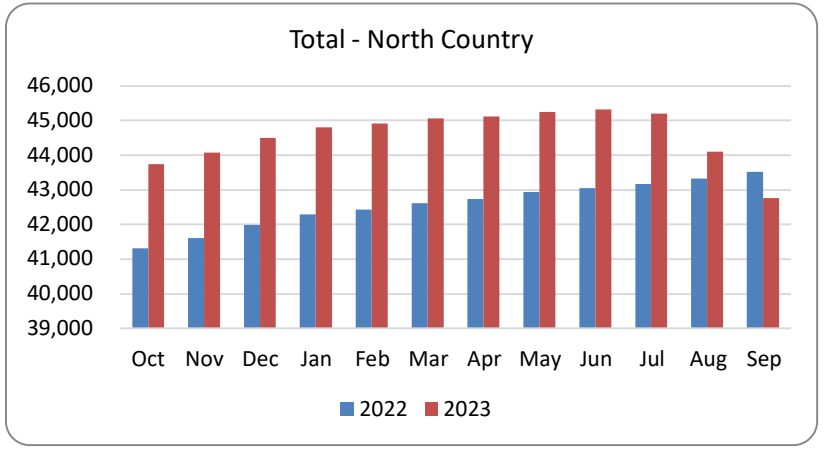
October 1, 2022 through September 30, 2023

North Country Eligible Members Trending - based on payment files







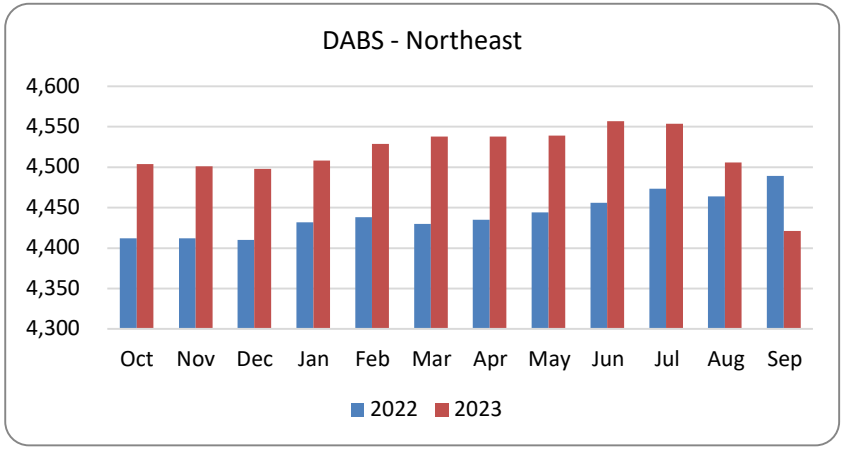


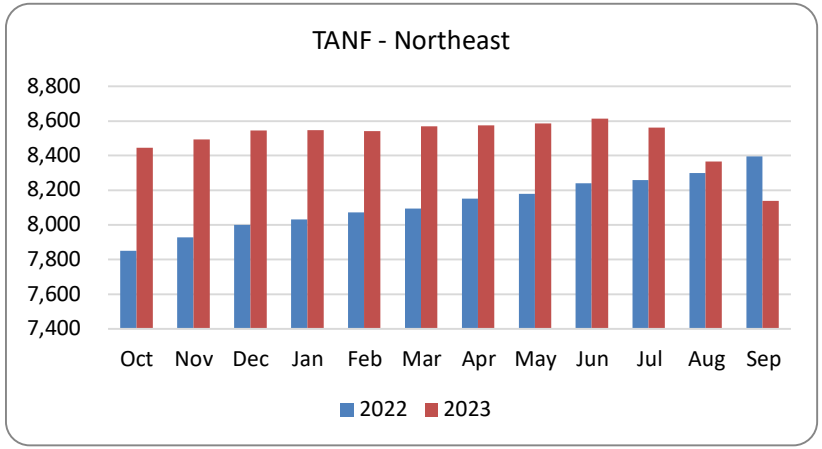
Northern Michigan Regional Entity

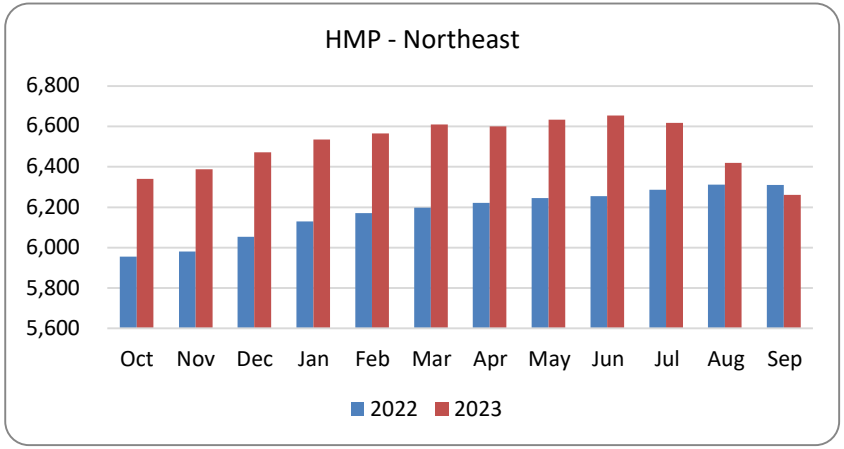
Narrative

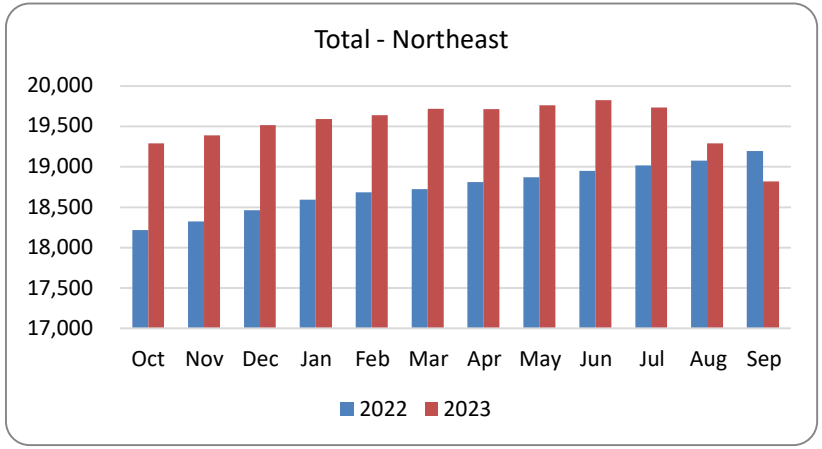
October 1, 2022 through September 30, 2023

Northeast Eligible Members Trending - based on payment files







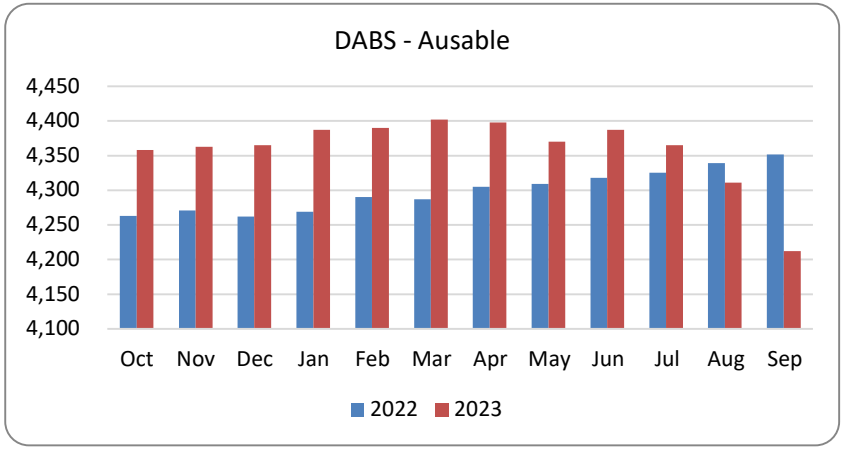


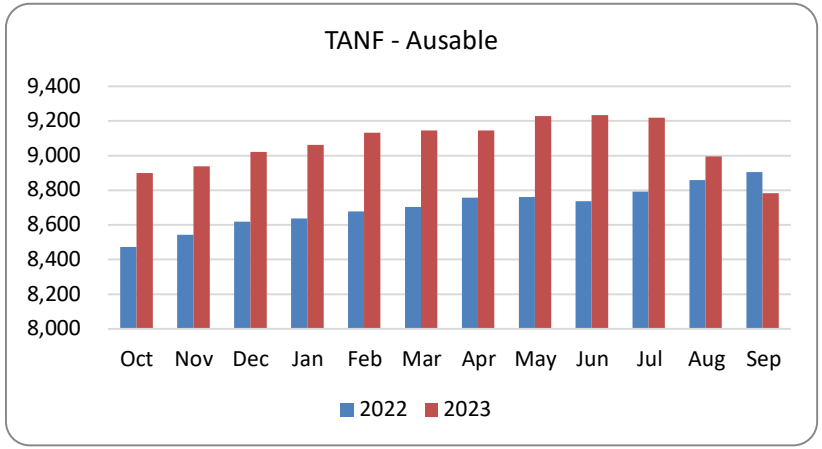
Northern Michigan Regional Entity

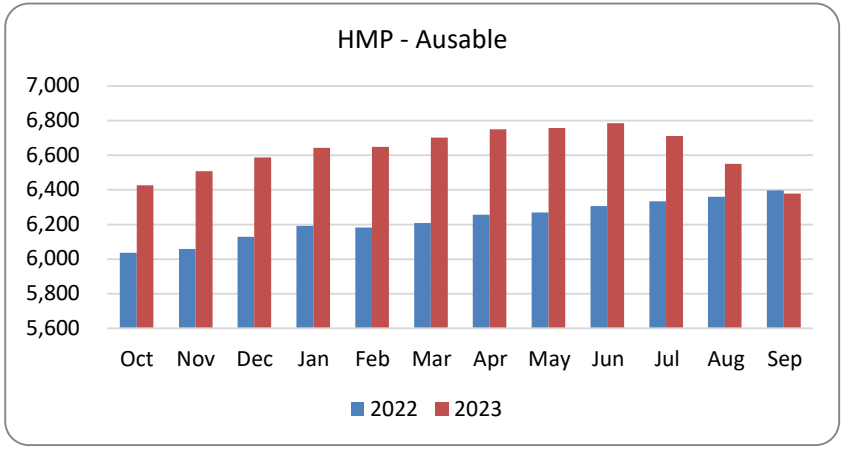
Narrative

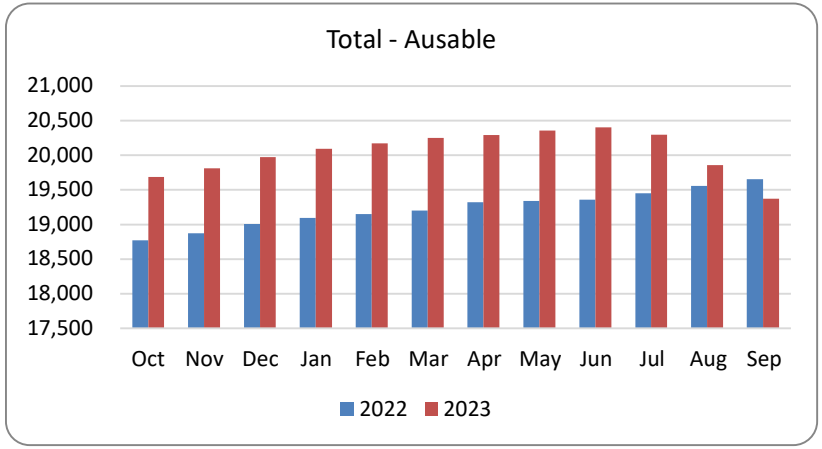
October 1, 2022 through September 30, 2023

Ausable Valley Eligible Members Trending - based on payment files







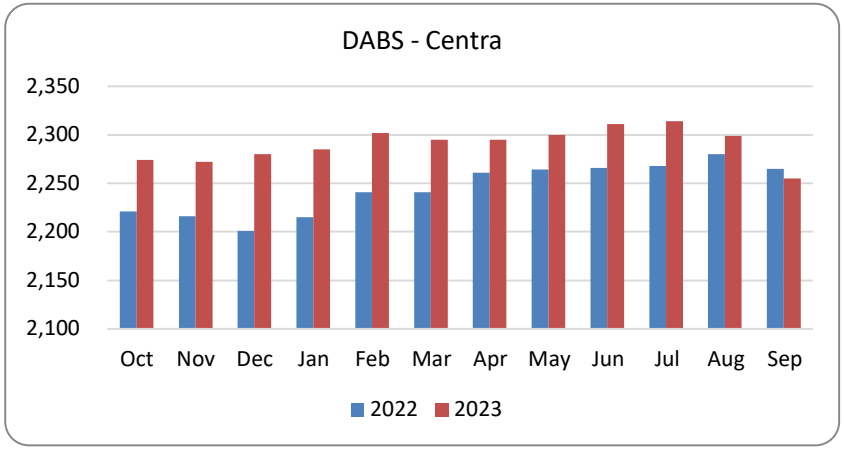


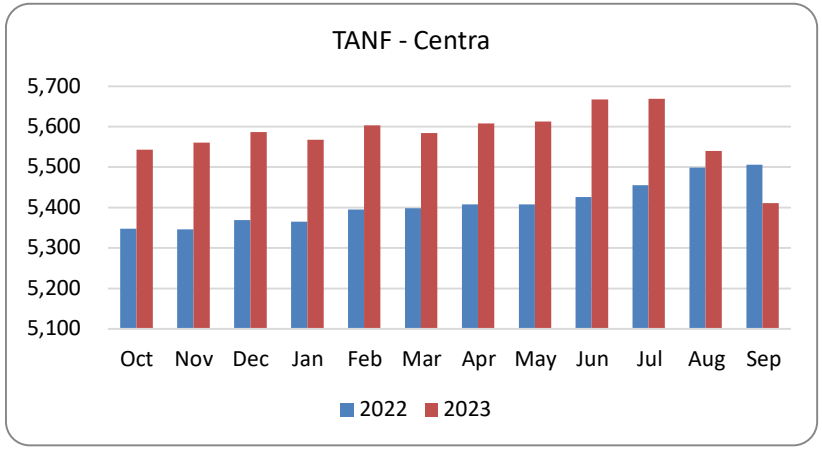
Northern Michigan Regional Entity

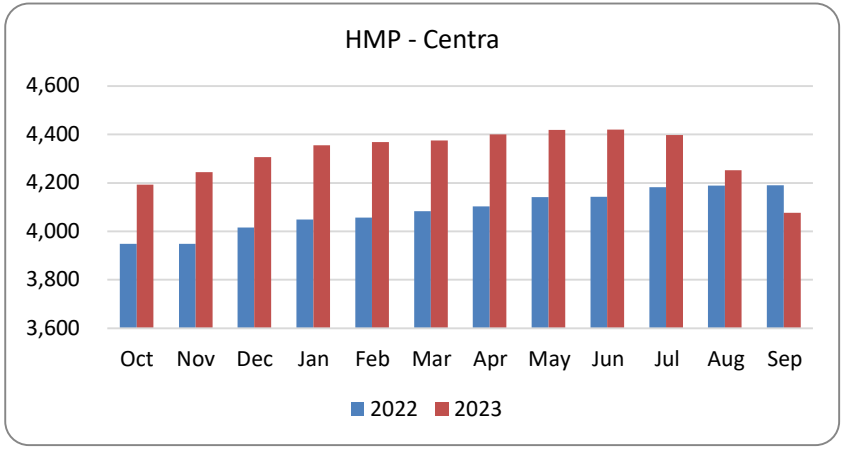
Narrative

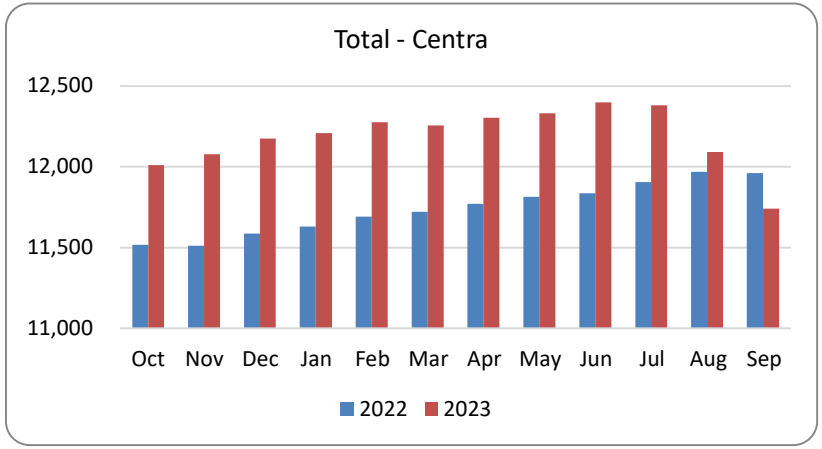
October 1, 2022 through September 30, 2023

Centra Wellness Eligible Members Trending - based on payment files







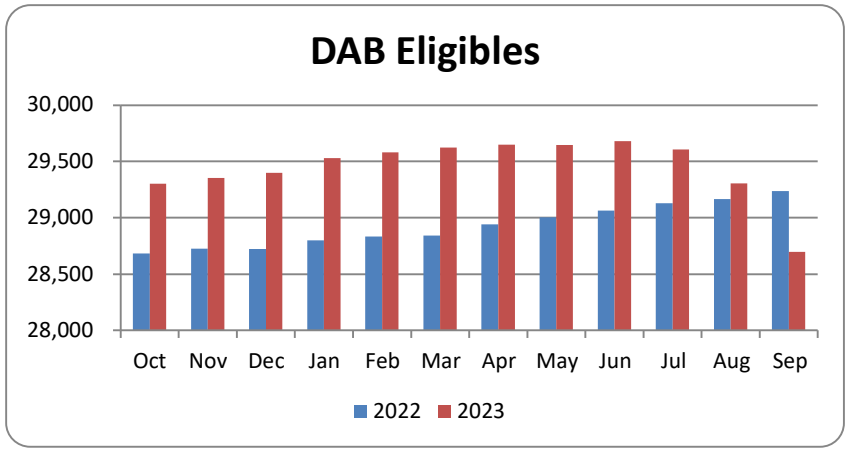


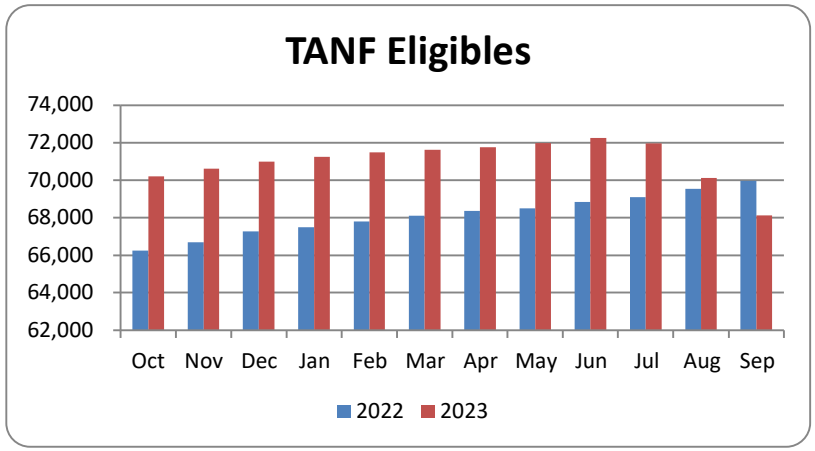
Northern Michigan Regional Entity

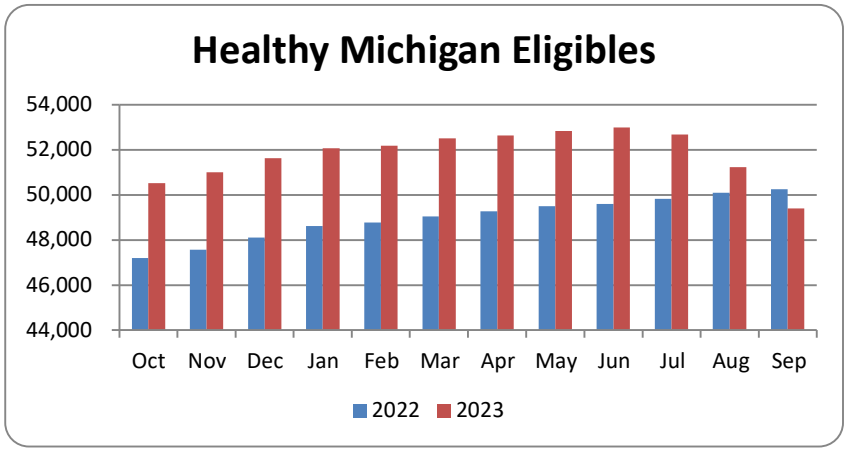
Narrative

October 1, 2022 through September 30, 2023

Regional Eligible Trending





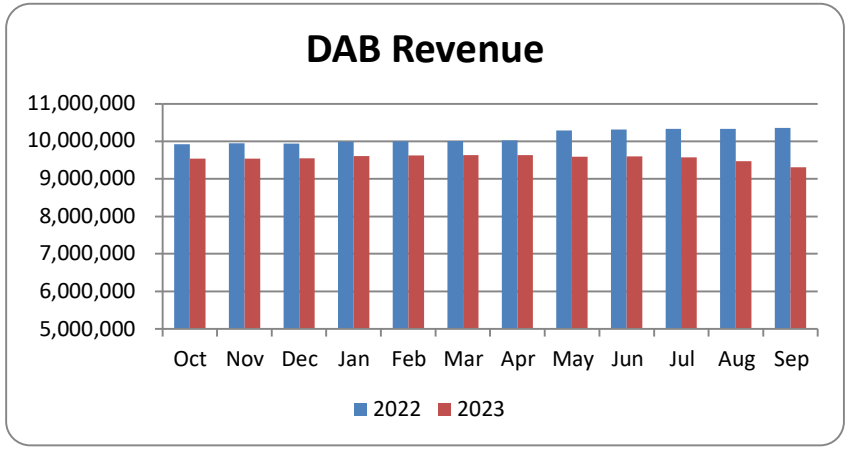


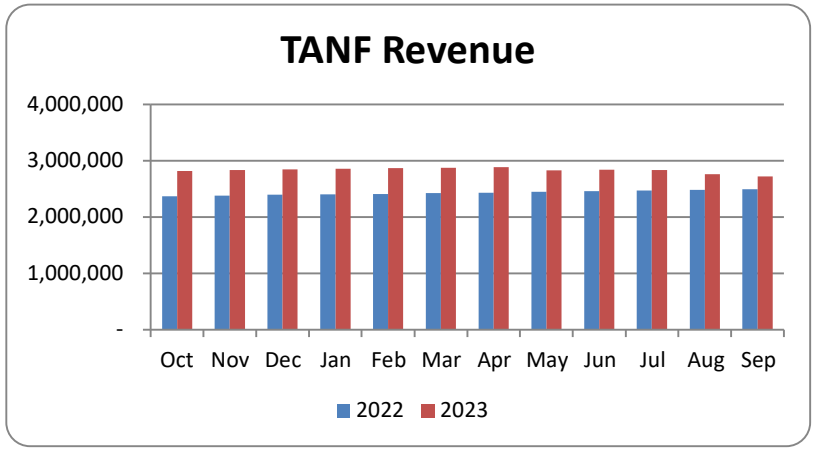
Northern Michigan Regional Entity

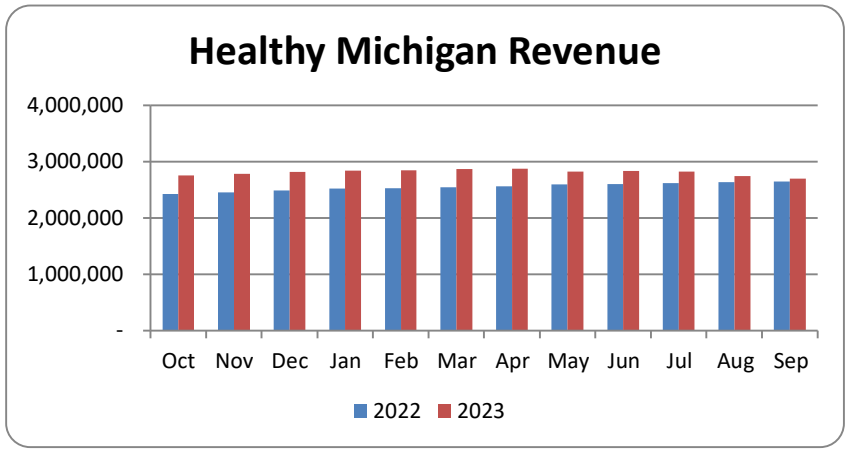
Narrative

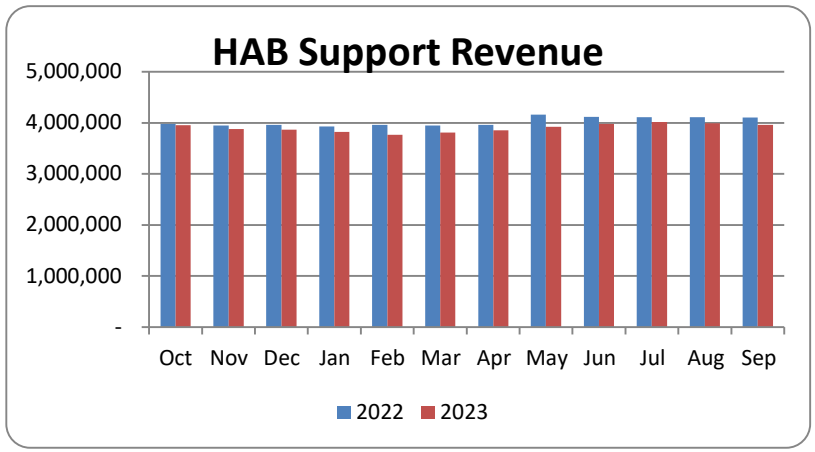
October 1, 2022 through September 30, 2023

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – DECEMBER 4, 2023
GAYLORD CONFERENCE ROOM

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

REVIEW OF AGENDA AND ADDITIONS

Ms. Sork requested an update on communications with MDHHS regarding CLS and Personal Care in specialized residential settings. Mr. Kurtz added a discussion about opting out of PA 152. Mr. Johnston added discussions about PA 423 and his conversation with Congressman Jack Bergman.

APPROVAL OF PREVIOUS MINUTES

The minutes from November 21st were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE OCTOBER 17, 2023 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY BRIAN BABBITT. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

September 2023

- Net Position showed net deficit Medicaid and HMP of $215,344. Budget stabilization was reported as $16,369,542. The total Medicaid and HMP Current Year Surplus was reported as $16,154,198. Medicaid and HMP combined ISF was reported as $16,369,542; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $32,523,740.
- Traditional Medicaid showed $198,687,690 in revenue, and $201,137,511 in expenses, resulting in a net deficit of $2,449,821. Medicaid ISF was reported as $9,306,578 based on the current FSR. Medicaid Savings was reported as $7,742,649.
- Healthy Michigan Plan showed $35,861,654 in revenue, and $33,627,176 in expenses, resulting in a net surplus of $2,234,478. HMP ISF was reported as $7,062,964 based on the current FSR. HMP savings was reported as $8,626,893.
- Health Home showed $2,418,616 in revenue, and $2,166,835 in expenses, resulting in a net surplus of $251,781.
- SUD showed all funding source revenue of $30,471,105 and $27,809,959 in expenses, resulting in a net surplus of $2,661,146. Total PA2 funds were reported as $5,097,296.

A small lapse, if any, is anticipated for FY23.

MOTION BY DIANE PELTS TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR SEPTEMBER 2023; SUPPORT BY BRIAN MARTINUS. MOTION APPROVED.

FY24 Revenue
A summary of payment and enrollment activity from September through November of 2023 was included in the meeting materials. NMRE Chief Financial Officer, Deanna Yockey, joined the meeting to discuss the analysis.

Since September revenue has increased for DAB by $299,578 (3.2%), decreased for HMP by $476,970 (-17.6%), and decreased for TANF by $18,138 (-0.7%), resulting in a net decrease of $195,530 (-1.32%). Annualized, this results in a revenue decrease of $2,346,355.

Ms. Yockey explained that living codes rates were updated for individuals on the Habilitation Supports Waiver (HSW). The effect of those changes, annualized, results in a revenue increase of $7,393,669, which could offset the projected losses.

Currently 13 empty HSW slots in the region. Each slot averages $7,135 in revenue. November HSW numbers were provided as:

	Medicaid & HMP	Spenddown	Total
AuSable Valley	89	2	91
Centra Wellness	74	5	79
North Country	161	5	166
Northeast Michigan	140	1	141
Northern Lakes	176	8	184
Total	**640**	**21**	**661**

Since September enrollment activity has shown a decrease in DAB of 1,334 (-4.6%), a decrease in HMP of 4,888 (-9.8%), and a decrease in TANF of 5,182 (-7.6%) for a total decrease in eligibles of 11,404 (-7.76).

Ms. Yockey will continue to monitor payment and enrollment activity for the coming months.

SELF-DETERMINATION
This topic was placed on the agenda at the request of Ms. Pelts. Ms. Pelts noted that the Self-Directed Services Technical Services (January 31, 2022) from MDHHS doesn't align with compliance rules; this has been reflected in recent Medicaid Encounter Verification (MEV) audits. Mr. Kurtz responded that either more compliance training is needed, or the State needs to take on the risk for self-directed individuals. Mr. Kurtz requested that the CMHSPs send him their self-determination client arrangement templates for his review.

The use of a qualified provider agency to serve as employer of record for staff selected by the individual (Agency Supported Self-Direction) was discussed. Agency Supported Self-Direction (Also Known as Agency with Choice) allows the individual to direct as much, or as little employer and administrative responsibilities as agreed upon in the IPOS and Agency Agreement while a provider agency serves as employer of record.

Mr. Kurtz reported that Jefferson Wells is no longer under contract with the NMRE. Beginning with quarter 3 of FY23, the NMRE will be performing the MEV audits.

REGIONAL DATA PERSON

This topic was placed on the agenda at the request of Mr. Babbitt. During the December 2nd regional Business Intelligence & Technology (BIT) meeting, staff from Centra Wellness shared that they do not have an SQL writer on staff. Centra Wellness had been contracting with an individual to develop data tables pulled from PCE, but he is not renewing his contact. Centra Wellness inquired about whether a portion of an FTE could be purchased from a member CMHSP. It was noted that the NMRE lost a Power BI programmer in August. The position was recently posted but will likely take some time to fill. In the meantime, NMRE's current Business Intelligence Analyst, Tom Melnik, will be transitioning to a more regional position and assisting Centra Wellness with its immediate needs. This type of arrangement may be expanded on in the future.

ALPINE CRU

The Alpine Crisis Residential Unity in Gaylord is expected to receive certification by the end of the week. A net-cost contract with North Shores Center is in place. The NMRE has agreed to pay 12 months of the facility's estimated costs.

A subcommittee of the Business Intelligence & Technology (BIT) Committee is being formed to determine regional billing and reporting processes. The region's PCE Project Manager, Katie Wagner, will be a member of the subcommittee.

The five member CMHSPs should be able to place individuals in the facility on or about December 15th.

MCLAREN PSYCHIATRIC UNIT

CMS approval has been granted to McLaren Northern Michigan's inpatient psychiatric facility in Cheboygan. The CMHSPs may now bill Medicaid for inpatient stays at the 18-bed facility.

INTENSIVE COMMUNITY TRANSITION SERVICES (ICTS)

Email correspondence dated November 30th from Darlita Paulding, ICTS Specialist at MDHHS was included in the meeting materials. ICTS/Psychiatric Residential Treatment Facilities (PRTF) is stepping-down individuals discharged from the state psychiatric hospitals to ultimately return to community settings. PIHPs are required to be actively involved in treatment and discharge planning meetings for these individuals. To coordinate this effort, each PIHP was asked to supply the name of a key contact person. Mr. Kurtz will respond assigning NMRE Clinical Services Director, Bea Arsenov as the contact person.

It was noted that the Home-and-Community Based Services Rule does not apply to PRTFs as they are CMS certified.

NLCMHA UPDATE

Rehmann is continuing its audit of Northern Lakes' financial and human resources programs as part of the NMRE's enhanced contractual oversight obligation. A management summary report is expected in January. Mr. Martinus provided an update on the Grand Traverse Center for Mental Wellness, expected to open in Traverse City in late 2024.

OTHER

Follow-Up on CLS and PC

This topic was placed on the agenda as a follow-up to the discussion in October regarding billing for Personal Care and CLS in specialized residential settings. The current code chart shows that billing for personal care in specialized residential settings is permitted. Mr. Johnston asserted that personal care in specialized residential settings is not allowed as the individual's social security payment is intended to cover the service; additional services should be billed to Community Living Supports (CLS), as "personal assistance" is a CLS-covered service.

Following the October meeting, Mr. Kurtz sent correspondence to MDHHS to offer input and clarification. A meeting is being scheduled with MDHHS on possible remedies.

Opt Out of PA 152

Public Act 152, the Publicly Funded Health Insurance Contribution Act, created a law that limits the amount that public employers pay toward employee medical benefit plans, effective January 1, 2024. Mr. Kurtz informed the CEOs that he plans to ask the NMRE Board for permission to opt out of the Act. It was noted that a ⅔ vote of the governing body is needed to opt out. Diane reported that AuSable Valley has opted out since 2020. Mr. Johnston reported that Centra Wellness has opted out since the law went into effect. Mr. Johnston shared a legal opinion from Steve Burnham from 2011.

Update on PA 423 of 1980 or MCL 330.1226a

This topic was placed on the agenda as a follow-up to the discussion in August regarding 1st and 3rd party interactions. Mr. Johnston emphasized that General Funds cannot be used to supplement Medicaid. Mr. Johnston referenced section 330.1226a of the Mental Health code, which details the requirements for special fund accounts for third party reimbursements. The GF line item in the fiscal appropriations is for "NON-MEDICAID" individuals only.

Mr. Johnston reported that a meeting was held on this date which included representatives from Milliman and MDHHS. After much discussion, it was concluded that third party payments do not need to be offset with general funds. GF is base funding for CMHSPs, not an insurance and, as such, cannot be considered in Coordination of Benefits.

Mr. Johnston noted that CCBHC funding is cost settled and not part of PA 423.

Conversation with Congressman Jack Bergman

Mr. Johnston shared the highlights of a conversation he had recently with Congressman Jack Bergman. Rep. Bergman's office is concerned about rural communities being "swept up into the vortex of urban and suburban regulations." There is also concern about Senator Stabenow's SB-

2993 which would amend the Social Security Act and the Public Health Service Act to permanently authorize Certified Community Behavioral Health Clinics (CCBHCs). The reasoning of putting a program in a state plan to include individuals not on Medicaid was questioned. It was noted that the Behavioral and Opioid Health Homes are state plan amendment services available to Medicaid beneficiaries.

NEXT MEETING

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

NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING
10:00AM – NOVEMBER 6, 2023
GAYLORD CONFERENCE ROOM & MICROSOFT TEAMS

Alcona	☒ Carolyn Brummund	**Kalkaska**	☐ David Comai
Alpena	☒ Burt Francisco	**Leelanau**	☐ Greg McMorrow
Antrim	☒ Pam Singer	**Manistee**	☐ Richard Schmidt
Benzie	☐ Tim Markey	**Missaukee**	☐ Vacant
Charlevoix	☒ Anne Marie Conway	**Montmorency**	☒ Don Edwards
Cheboygan	☐ John Wallace	**Ogemaw**	☒ Ron Quackenbush
Crawford	☒ Sherry Powers	**Oscoda**	☒ Chuck Varner
Emmet	☒ Terry Newton	**Otsego**	☒ Doug Johnson
Grand Traverse	☒ Dave Freedman	**Presque Isle**	☐ Terry Larson
Iosco	☒ Jay O'Farrell	**Roscommon**	☐ Darlene Sensor
		Wexford	☒ Gary Taylor

Staff	☒ Bea Arsenov	Clinical Services Director
	☒ Jodie Balhorn	Prevention Coordinator
	☒ Carol Balousek	Executive Administrator
	☒ Lisa Hartley	Claims Assistant
	☒ Eric Kurtz	Chief Executive Officer
	☒ Pamela Polom	Finance Specialist
	☐ Brandon Rhue	Chief Information Officer/Operations Director
	☒ Denise Switzer	Grant and Treatment Manager
	☒ Deanna Yockey	Chief Financial Officer
Public	Rebecca Ferns, Kaelie Fessler, Nichole Flickema, Jesse Hartman, Chip Johnston, Stephanie Lichota, Trish Otremba, Catie Push, Linda Solem, Kara Steinke, Hailey Stewart	

CALL TO ORDER
Let the record show that in the absence of Mr. Schmidt, Vice-Chair, Jay O'Farrell called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that David Comai, Terry Larson, Tim Markey, Greg McMorrow, Darlene Sensor, Richard Schmidt, and John Wallace were absent for the meeting on this date; all other SUD Oversight Committee members were in attendance either in Gaylord 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 minutes were included in the materials for the meeting on this date.

MOTION BY TERRY LARSON TO APPROVE THE MINUTES OF THE SEPTEMBER 11, 2023 NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING; SUPPORT BY PAM SINGER. MOTION CARRIED.

APPROVAL OF AGENDA

Let the record show that a presentation by the Iosco County Youth Coalition was added under Presentations.

MOTION BY DAVE FREEDMAN TO APPROVE THE AGENDA FOR THE NOVEMBER 6, 2023 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE AS AMENDED; SUPPORT BY ANN MARIE CONWAY. MOTION CARRIED.

ANNOUNCEMENTS

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

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST

Let the record show that Mr. O'Farrell called for any conflicts of interest to any of the meeting agenda items; none were declared.

INFORMATIONAL REPORTS

Admissions

The admissions report through September, 2023 was included in the materials for the meeting on this date. Admissions for FY23 were up 3.75% from FY22. The data showed that outpatient was the highest level of treatment admissions at 45.27%, and alcohol was the most prevalent primary substance at 55.13%, methamphetamine was second at 17.16%, and heroin was the third most prevalent primary substance at 11.69%. It was noted that stimulant use is rising sharply throughout the 21-county region. Ms. Arsenov clarified that the report only captures primary substance use; methamphetamine is also frequently a secondary substance.

It was noted that Fentanyl is captured under synthetic opiates. Other substances may also have fentanyl added. Test strips are available to determine whether a substance contains fentanyl.

August Financial Report

SUD services through August 31, 2023 showed all funding source revenue of $27,767,834 and $24,670,908 in expenses, resulting in a net surplus of $3,096,926. Total PA2 funds were reported as $5,075,597. FY23 claims continue to roll in which will reduce the deficit.

FY24 LIQUOR TAX REQUESTS

Single County

1) Bay Area Substance Education Services (BASES) – Charlevoix County Jail Groups (4th Year)

Charlevoix	$	20,000.00

The recommendation by NMRE was to approve.

MOTION BY RON QUACKENBUSH TO APPROVE THE REQUEST FROM BAY AREA SUBSTANCE EDUCATION SERVICES (BASES) FOR CHARLEVOIX COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF TWENTY THOUSAND DOLLARS ($20,000.00) TO

FUND GROUP SERVICES TO INDIVIDUALS IN THE CHARLEVOIX COUNTY JAIL; SUPPORT BY DOUG JOHNSON. MOTION CARRIED.

2) Catholic Human Services – Hands That Heal Trainings (New)

Grand Traverse $ 13,475.00

The recommendation by NMRE was to approve. Mr. Freedman asked whether a "Train the Trainer" model is used to which Linda Solem replied, "yes." The trainings will occur in Grant Traverse County.

MOTION BY DAVE FREEDMAN TO APPROVE THE REQUEST FROM CATHOLIC HUMAN SERVICES FOR GRAND TRAVERSE COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF THIRTEEN THOUSAND FOUR HUNDRED SEVENTY-FIVE DOLLARS ($13,475.00) TO FUND HANDS THAT HEAL TRAININGS; SUPPORT BY TERRY NEWTON. MOTION CARRIED.

The total of the liquor tax requests approved during the meeting on this date was provided as **$33,475**.

County Overviews
The impact of the liquor tax requests approved on this date on county fund balances was shown as:

	Projected FY24 Available Balance	Amount Approved 11/6/23	Projected Remaining Balance
Charlevoix County	$207,472.47	$20,000.00	$187,472.47
Grand Traverse County	$44,649.10	$13,475.00	$31,174.10

Clarification was made that the "Projected Remaining Balance" reflects funding available for projects while retaining a fund balance equivalent of one year's receivables.

PRESENTATIONS
Iosco County Students Leading Students (SLS) Presentation
Stephanie Lichota, a Prevention Specialist with Up North Prevention, a Catholic Human Services Initiative was in attendance along with youth from the Iosco County Students Leading Students (SLS) prevention coalition. Rebecca Ferns, Jesse Hartman, Catie Push, and Hailey Stewart reported that the SLS prevention coalition, active since July 2023, has a total of 51 members. The SLS Coalition works with Rotary Interact, Rotary International's youth service club.

It was noted that prevention block grant funding was cut $94,546 for FY24.

Naloxone Training
by Nichole Flickema from the Health Department of Northwest Michigan and the SAFE in Northern Michigan Prevention Coalition provided training on the use of naloxone/Narcan to reverse an opioid drug overdose.

Signs and Symptoms of an Opioid Overdose
- Unresponsive
- Blue lips

- Blue/gray skin
- Foaming at the mouth
- Loud snoring/gurgling sounds
- Slow or no breathing
- Eyes rolled back

The Three Things to Do When Someone is Overdosing from Opioids:

1) Access – Call 911.
2) Administer – Insert naloxone/Narcan into the nostril and push the plunger.
3) Aftercare – Provide rescue breathing.
4) Administer a second dose of Narcan if the individual is till unresponsive after 2 -2 3 minutes.

BE AWARE: Administering naloxone to an opioid-dependent individual can cause withdrawal symptoms.

PUBLIC COMMENT

Let the record show that there were no public comments expressed.

NEXT MEETING

The next meeting was scheduled for January 8, 2024 at 10:00AM.

ADJOURN

Let the record show that Mr. O'Farrell adjourned the meeting at 11:26AM.

CHARLEVOIX COUNTY JAIL GROUPS (4TH YEAR)

Organization/Fiduciary:	**BASES**
County:	**Charlevoix**
Project Total:	**$ 20,000**

DESCRIPTION:

BASES will provide 80 groups at the Charlevoix County Jail for men and women separately that will focus on DBT skills education to address mental health and substance abuse concerns, planning and coordinating resources upon release and relapse prevention services. This will be done for $200 per group totaling $16,000 and purchase materials for use within the program of $4,000 for a grand total of $20,000. We will be educating participants on healthy coping skills to address substance abuse and co-occurring mental health issues as well as coordinate their aftercare services upon release from the jail with hopes that we can see 20% or more engage in services upon release.

Recommendation: Approve

County	Project	Requested Budget
Charlevoix	Charlevoix County Jail Groups	$20,000

CHARLEVOIX COUNTY OVERVIEW

Projected Available FY24 Balance	$207,472.47

Project	Requested Budget	Remaining County Running Balance
Charlevoix County Jail Groups - BASES	$20,000	$187,472.47

County	One Year Fund Balance (withheld)	Projected FY24 Beginning Balance	Projected Remaining FY24 Available Balance	Sum of Current Requested Project Amounts	Projected Remaining Balance
Charlevoix	**$89,333.50**	**$285,051.70**	**$207,472.47**	**$20,000**	**$187,472.47**

HANDS THAT HEAL TRAININGS (NEW)

Organization/Fiduciary:	**Catholic Human Services**
County:	**Grand Traverse**
Project Total:	**$ 13,475**

DESCRIPTION:

Hands That Heal is an international curriculum to train caregivers of trafficking victims that exhibit re-occurring and co-occurring substance misuse disorders that have been overlooked and underdiagnosed. The HTH training educates and puts in place community strategic plans for preventative initiatives and recovery care. In planning and assessing community needs regarding this demographic, education in developing a strategic plan to address the pressing needs of local survivors, how this is functioning in the local context, and how best to work with local culture, economic, social and religious contexts. This curriculum is a collaboration of over 40 professionals from diverse backgrounds. It is cross-cultural in its perspective. The objective is to inform and train community stakeholders, caregivers, and prevention specialists to connect this issue with co-occurring and substance use disorders addressing life skills training, behavioral health, medical and education. The goals are to provide a community-based training in an informal educational format that can be used effectively in local communities: a. making people aware of this lost demographic in our communities, b. informing them of multi-faceted ways to address the problems associated with trafficking survivors and SUD, c. training potential prevention and caregivers in transformational care.

Recommendation:	Approve

County	Project	Requested Budget
Grand Traverse	Hands that Heal Trainings	$13,475

GRAND TRAVERSE COUNTY OVERVIEW

Projected FY24 Available Balance	$44,649.10

Project	Requested Budget	Remaining County Running Balance
Hands that Heal Trainings	$13,475	$31,174.10

County	One Year Fund Balance (withheld)	Projected FY24 Beginning Balance	Projected Remaining FY24 Available Balance	Sum of Current Requested Project Amounts	Projected Remaining Balance
Grand Traverse	**$406,429.50**	**$559,989.07**	**$44,649.10**	**$13,475**	**$31,174.10**

STEVEN E BURNHAM
ATTORNEY AT LAW
10286 N RIVERVIEW
PLAINWELL, MICHIGAN 49080-9688

October 12, 2011

Chip Johnston
Chief Executive Officer
Centra Wellness Network
310 N Gloucheski Drive
Manistee, Michigan 49660-0335

RE: Publicly Funded Health Insurance Contribution Act, SB7 of 2011

Dear Mr. Johnston:

You have requested that I provide a brief legal opinion regarding the recently enacted Publicly Funded Health Insurance Contribution Act, otherwise known as Senate Bill 7 or Public Act 152 of 2011.

You have specifically requested comment on two particular questions. The first is whether the act applies to Centra Wellness Network. The second is a brief explanation on the ability to opt out of the Act's application.

I will answer your questions sequentially. I will start with a brief overview of the Act itself. This is not intended to be an exhausted discussion of the Act or it's implications or ramifications- simply a brief wave of the hand description. Beginning January 1, 2012, public employers who offer medical benefit plans to their employees or elected official may not pay more than 80% of the total annual costs of all the medical benefit plans they offer to said employees or elected officials. Additionally, any collective bargaining agreement or contract settled on or after the effective date would have to comply with the requirements of the act as well. The Act defines what are 'costs', 'total costs', 'medical benefit plan' and what is a local unit of government and a public employer. The Act makes allowances for having either an 80/20 cap or a 'hard cap' of an overall dollar amount- ($5,500 for individual coverage, $11,000 for individual and spousal coverage and $15,000 for employees with family coverage).

The first question posed is whether or not your agency is subject to the Act. The simple answer to that question is **YES**. A local unit of government is defined as a city, county,

village, township or authority (SEE Sec 2 (d) of Act). Further a 'public employer' is defined as the "...state, a local unit of government or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision; a school district, a public school academy, or an intermediate school district..... (SEE Sec 2(f) of Act). As you are aware you agency is formed under the auspices of the Urban Cooperation Act and the Mental Health Code. Your agency is clearly a public employer and therefore subject to the Act.

The second question you have requested a brief response to is whether or not your board may opt out of the Act. Interestingly enough the Act does permit a public employer to opt out the Act. Section 8 of the Act indicates that "**by a 2/3 vote of its governing body each year, a local unit of government may exempt itself from the requirements of this act for the next succeeding year.**" Each succeeding year requires a new vote. There are penalty provisions if a public employer does not comply with the Act- Section 9. The penalty provision imposes a financial reduction of certain state funding- specifically funding coming from the economic vitality incentive program and certain funding under the state school aid act of 1979. However a quick review of these sections would seem to indicate that your agency does not receive funding from either of those sources. I do not see the penalty provision as being a reason to not opt out if that is the boards' direction. I would recommend that in the event the board pursues this option that a roll call vote be taken on the motion.

I hope this brief correspondence covers the two questions you have posed. The statute is new- just signed into law on September 27, 2011 and therefore a bit untested as to the direction is will ultimately take. For purposes of Centra Wellness Network two statements are true- you are a public employer subject to the Act and you are eligible to opt out of the provisions of the Act through a 2/3's vote of your board.

If you have additional questions please do not hesitate to contact me. Thank you for the opportunity to be of service to you and your board.

Steven E. Burnham
Attorney At Law
269.744.1489
seburn@kalcounty.com

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

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

SETTLEMENT AGREEMENT

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

W I T N E S S E T H :

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

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

WHEREAS, DHHS denies these claims, and,

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

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

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

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

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

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

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

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

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

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

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

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

Settlement Agreement until the Sunset Date described in Section E.

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

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

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

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

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

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

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

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

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

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

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

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

B. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c) Specifically,

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

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

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

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

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

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

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

determination is not the subject of a Medicaid Fair Hearing.

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

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

9) DHHS shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Contingencies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Attorneys' Fees and Costs

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

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

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

G. Merger of Claims into Settlement Agreement

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

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

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

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

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

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

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

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

H. Miscellaneous

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

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

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

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

[**Signatures follow**]

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ATTACHMENT A:
COMMUNITY LIVING SUPPORTS CODE H2015

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

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

See Habilitation Supports Waiver.

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

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

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

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

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

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

ATTACHMENT B
MEDICAL NECESSITY CRITERIA

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

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

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

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

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

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

ATTACHMENT C

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

Costing Out Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

Groups Secure Over $100M in Additional State Expenditures for Michiganders With Developmental Disabilities

FOR IMMEDIATE RELEASE: December 4, 2023

CONTACT:

- Patrick Fowler, Communications, National Center for Law and Economic Justice | fowler@nclej.org
- Rachel Huddleston, Director of Communications, Disability Rights Michigan | RHuddleston@drmich.org
- Kathleen Homan, President and CEO, Washtenaw Association for Community Advocacy | khoman@Washtenawaca.org

Lansing, MI – The National Center for Law and Economic Justice and Disability Rights Michigan are pleased to announce a **settlement** of a federal civil rights action that will, if approved by the Court, secure more than $110 million in additional State expenditures for Michiganders with intellectual and developmental disabilities (I/DD) who rely on Medicaid Community Living Support (CLS) services to live at home and participate in their communities.

Subject to legislative appropriations and various other approvals, the settlement will provide self-determination CLS recipients in Michigan's Habilitation Supports Waiver a rate of $31/hour, a 35% increase over the current $20.50. Under self-determination (SD), I/DD individuals or their families need not depend on care agencies but can hire their own staff and control their own lives. The SD rate for Overnight Health & Safety Support services (OHSS) will also increase, to 70% of the new CLS rate. Both rates will be adjusted for inflation.

The CLS rate increases represent an additional expenditure of at least ***$22 million annually***, amounting to ***more than $110 million*** over the five-year term of the deal. The OHSS increases will add to this total.

If the funding or other contingencies are not met by May 2025, an **alternative costing-out procedure** will ensure that each SD CLS recipient has a budget that, line by line, is sufficient to support their individual needs. The costing-out procedure will be implemented in any event when the settlement expires in 2029.

"Our lawsuit was about preventing institutionalization and empowering folks living with I/DD to thrive in their communities," **said Edward Krugman, Senior Attorney at the National Center for Law and Economic Justice.** "The huge uptick in funding means that Michiganders who need assistance to get out of the house and into the community will be able to hire and retain their support staff by paying these hardworking caregivers something close to what they deserve."

The case was filed in 2016 and was eventually dismissed by the district court. In November 2020, however, in a **major ruling** that covered almost every aspect of Medicaid funding for the I/DD

community, the U.S. Court of Appeals for the Sixth Circuit reversed the dismissal. The Court extended important legal precedent by ruling that isolation at home and risk of institutionalization constitute violations of the "integration mandate" under the Americans with Disabilities Act, which requires that people with disabilities be provided services in the most integrated setting appropriate to their needs. Both unjustified isolation at home and risk of institutionalization, the Court held, constitute discrimination based on disability.

Said Cindy Waskul, the mother and guardian of Plaintiff Derek Waskul, "This has been a long eight years with lots of ups and downs. The wait is finally over, and now I can look to the future with peace of mind, knowing that finding appropriate staff for Derek will not be difficult because the wage will now fit this challenging job. The increased CLS rate will also allow Derek to participate fully and meaningfully in activities in his community. I'm thrilled that so many in Michigan will benefit from this settlement."

"We brought this suit to challenge budget cuts that threatened our plaintiffs with institutionalization," said **Nick Gable, Senior Attorney at Disability Rights Michigan.** "This settlement will ensure that people with developmental disabilities will be able to afford the services they need to thrive in their communities. This system hopefully will now work as it should."

Helping to fix the system "is a monumental win for the people ACA serves," said Kathleen Homan, President and CEO of WACA. "The settlement reinforces that people with I/DD have the right to be fully included in their community and proves that their voices can be heard. I want to thank NCLEJ and DRM for their eight years of hard work and their commitment to people with I/DD. A special thanks to the individual plaintiffs for their strength and courage to stand up for their rights and the rights of the people in Michigan with I/DD."

The National Center for Law and Economic Justice (NCLEJ) advances racial and economic justice for low-income families, individuals, and communities across the country through groundbreaking impact litigation, policy advocacy, and support for grassroots organizing. Founded in 1965, NCLEJ protects access to critical benefits such as food stamps, Medicaid, and childcare; empowers low-wage workers, advocates for people with disabilities; and fights unlawful debt collection.

Disability Rights Michigan (DRM) is the independent, private, nonprofit, nonpartisan protection and advocacy organization authorized by Federal and State law to advocate for and protect the legal rights of people with disabilities in Michigan.

The Washtenaw Association for Community Advocacy (WACA) was organized by a group of parents in 1949 as one of the first organizations in Michigan to advocate for people with developmental disabilities and their families. The parents sought equal education rights for their children with developmental disabilities living in a state institution. They believed, as WACA does today, that each person, regardless of their disability, has the right to authentic power and control over their life. The parents' early and ongoing dynamic contributions to the field of disability rights advocacy built the strong foundation for the work WACA has done for 74 years.

Creating Environments Free of Substance Use

SAFE IN NORTHERN MICHIGAN

SAFEinNM.com

Drug Free Northern Michigan Coalition Alliance

OVERDOSE PREVENTION AND RESPONSE TRAINING

WHAT TO EXPECT

- The Science of Addiction
- Introduction to Overdose Prevention & Response
- Identifying Opioids
- Defining an Overdose
- Identifying Risk Factors & Overdose Prevention
- Recognizing an Overdose
- 3 A’s of Overdose Response
- Resources

THE SCIENCE OF ADDICTION

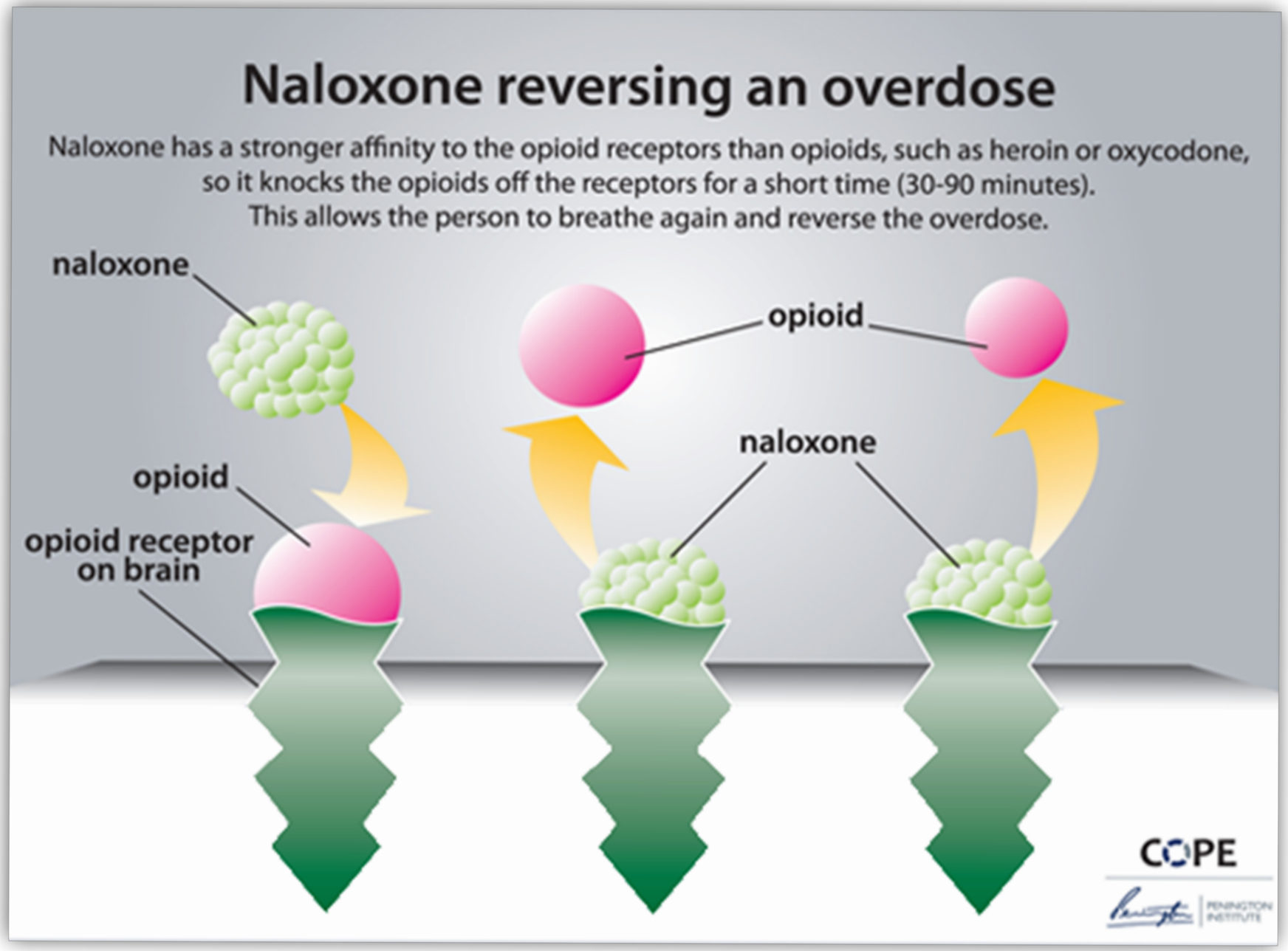
WHAT IS NALOXONE HYDROCHORIDE (HCL)/NARCAN®?

INTRODUCTION TO OVERDOSE PREVENTION & RESPONSE

i. Naloxone hydrochloride (Narcan®) is a medication that reverses an opioid overdose

ii. Works on all **opioids,** including fentanyl

iii. Naloxone allows bystanders to prevent fatal overdoses


Naloxone reversing an overdose
Naloxone has a stronger affinity to the opioid receptors than opioids, such as heroin or oxycodone, so it knocks the opioids off the receptors for a short time (30-90 minutes). This allows the person to breathe again and reverse the overdose.
naloxone
opioid
opioid receptor on brain
opioid
naloxone
COPE
PENNINGTON INSTITUTE

GOOD SAMARITAN LAW

The Good Samaritan Law protects the individual seeking emergency medical services and the person receiving medical attention from drug possession charges in certain circumstances.

Act No. 307
Public Acts of 2016
Approved by the Governor
October 6, 2016
Filed with the Secretary of State
October 6, 2016
EFFECTIVE DATE: January 4, 2017

STATE OF MICHIGAN
98TH LEGISLATURE
REGULAR SESSION OF 2016

Introduced by Reps. Pscholka, Singh, Schor, Forlini, Hughes, Lyons, Afendoulis, Glenn, Sheppard, Tedder, Crawford, Aaron Miller, Pagel, Inman, Muxlow, Irwin, Webber, Leutheuser, Wittenberg, Yonker, Kivela, Garcia, Iden, Heise, Maturen, Vaupel, Jenkins, Kelly, LaVoy, Durhal, Hoadley, Plawecki, LaGrand, Garrett, Moss, Lucido, Poleski, Yanez, Greig, Cochran, Gay-Dagnogo, Banks, Byrd, Geiss, Hovey-Wright, Zemke, Driskell, Townsend, Faris and Lane

ENROLLED HOUSE BILL No. 5649

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," by amending section 7403 (MCL 333.7403), as amended by 2015 PA 220.

The People of the State of Michigan enact:

Sec. 7403. (1) A person shall not knowingly or intentionally possess a controlled substance, a controlled substance analogue, or a prescription form unless the controlled substance, controlled substance analogue, or prescription form was obtained directly from, or pursuant to, a valid prescription or order of a practitioner while acting in the course of the practitioner's professional practice, or except as otherwise authorized by this article.

(2) A person who violates this section as to:

(a) A controlled substance classified in schedule 1 or 2 that is a narcotic drug or a drug described in section 7214(a)(*iv*), and:

(*i*) That is in an amount of 1,000 grams or more of any mixture containing that substance is guilty of a felony punishable by imprisonment for life or any term of years or a fine of not more than $1,000,000.00, or both.

SUMMARY OF MICHIGAN LEGAL AMENDMENTS REGARDING NALOXONE

- Naloxone can be prescribed to an individual or an organization to distribute or administer it to another person. (2014 PA 311)
- Individuals who prescribe, dispense and administer naloxone are protected from civil and criminal liability for injuries or death related to those actions. (2014 PA 313,314)
- Public schools are allowed to possess and administer naloxone if adequate policy and procedure are in place (2016 PA 384,385)
- Public schools are protected from civil and criminal liability related to the administration of naloxone (2019 PA 38)
- Michigan's Chief Medical Officer can issue a standing order for naloxone. Under this order, anyone in the state can obtain naloxone through a participating pharmacy. (2016 PA 383) List of participating pharmacies: www.michigan.gov/opioids
- Government agencies and employees (including law enforcement) are allowed to possess, purchase, and dispense naloxone (2019 PA 39)
- Government agencies and employees are protected from criminal and civil liabilities for injury or death resulting from naloxone administration or from failure to administer naloxone. (2019 PA 39, 2020 PA 321)

WHAT MEDICATIONS OR SUBSTANCES PEOPLE MIGHT OVERDOSE ON?

OPIOIDS

Oxycodone
Oxymorphone
Hydrocodone
Hydromorphone
Fentanyl
Morphine
Codeine
Methadone
Tramadol
Buprenorphine
Heroin

NON-OPIOIDS

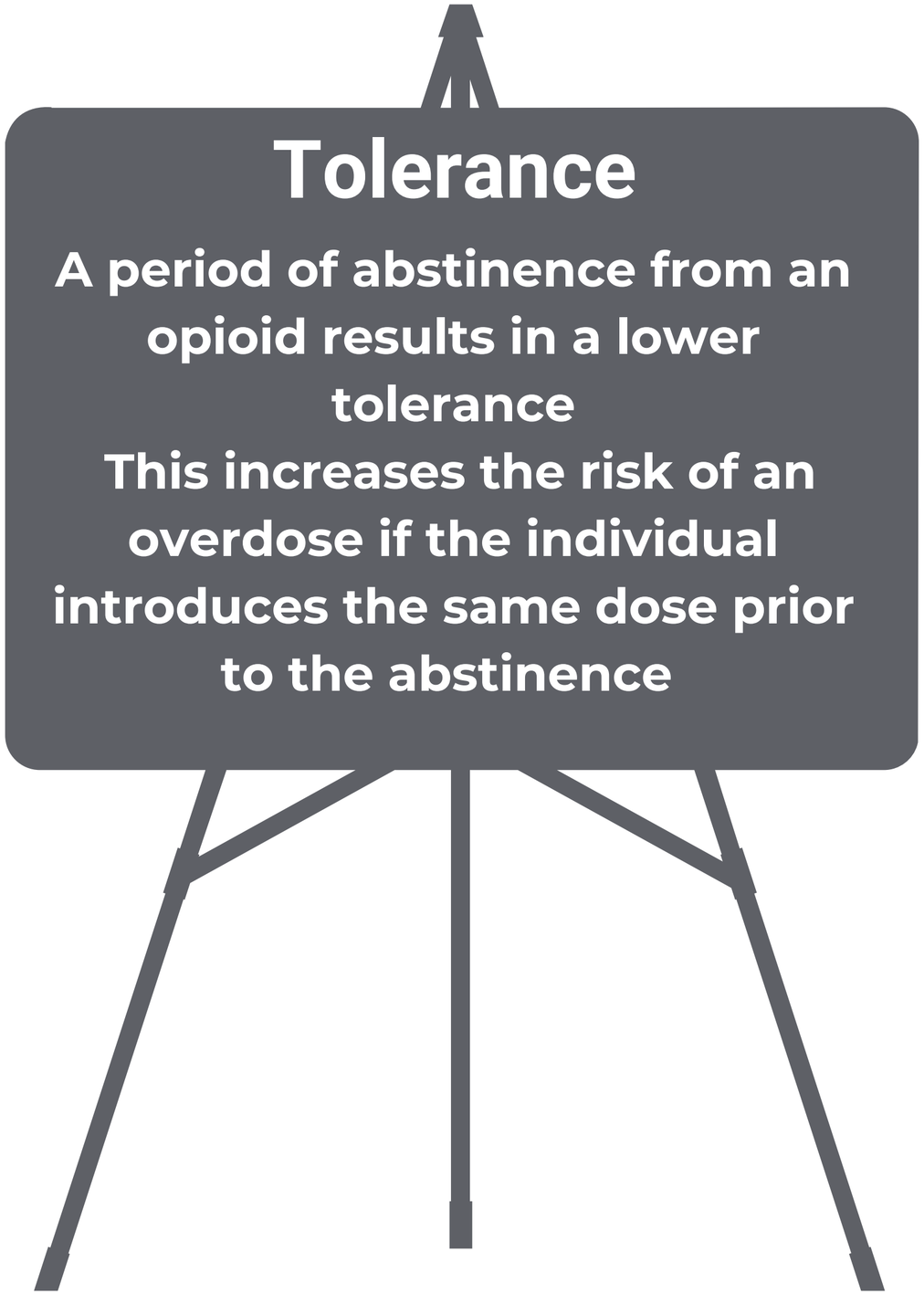
Cocaine
Methamphetamine
Psychostimulants (Adderall®, Ritalin®, Vyvanse®, Concerta®)
Alcohol
Marijuana
Benzodiazepines (Xanax®, Klonopin®, Ativan®)
Xylazine
Ketamine

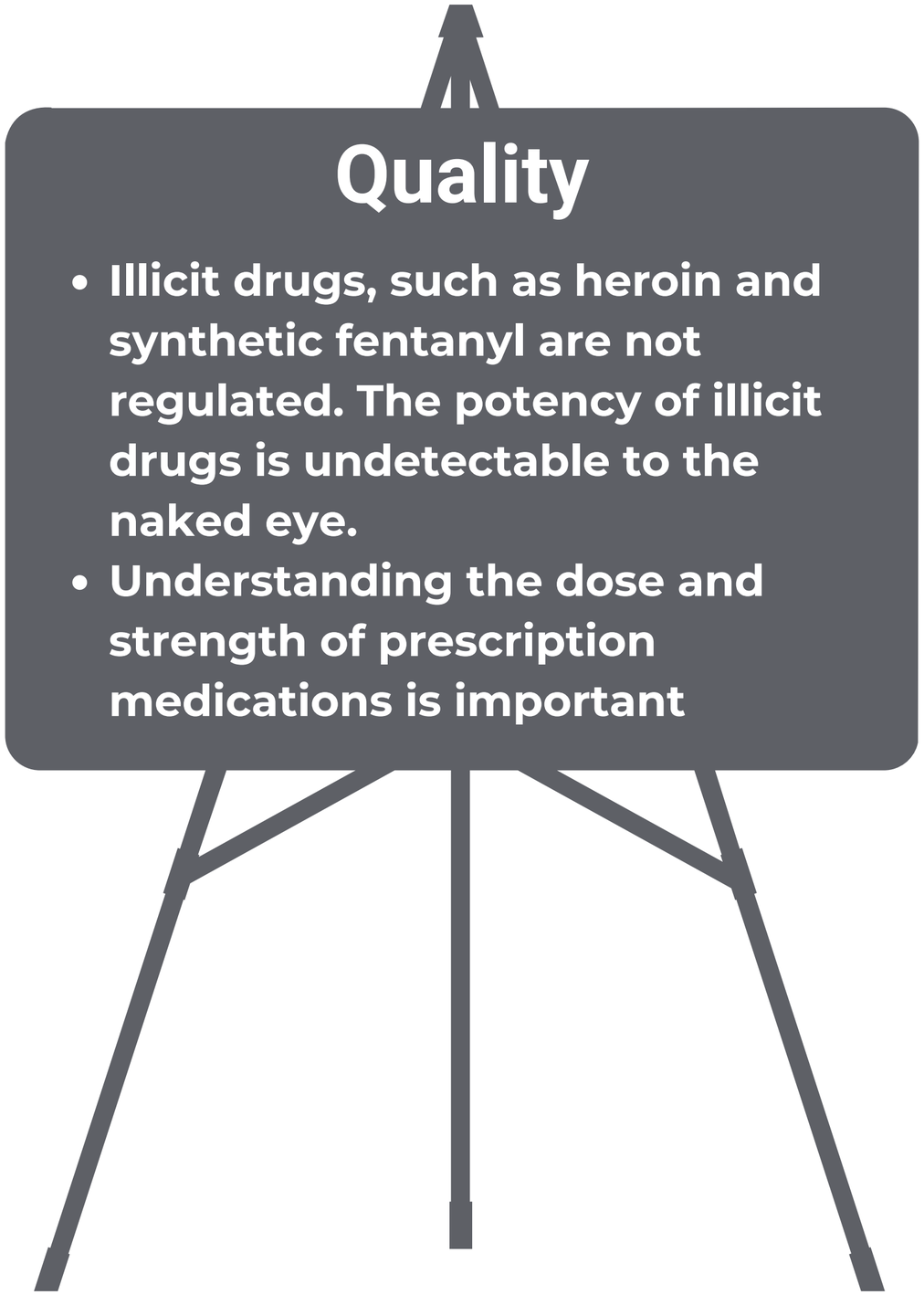
DEFINING AN OVERDOSE

An overdose is when someone takes too much of a medication or substance that it starts to overwhelm the body causing it to shut down.

IDENTIFYING RISK FACTORS & OVERDOSE PREVENTION


Mixing
One medication or substance can amplify the effect(s) of the other


Tolerance
A period of abstinence from an opioid results in a lower tolerance
This increases the risk of an overdose if the individual introduces the same dose prior to the abstinence


Quality
Illicit drugs, such as heroin and synthetic fentanyl are not regulated. The potency of illicit drugs is undetectable to the naked eye.
Understanding the dose and strength of prescription medications is important


Using Alone
Using alone does not put an individual at risk of an overdose, but it increases the risk of a fatal overdose, as no one is there to respond.

RECOGNIZING AN OPIOID OVERDOSE

3 A'S OF OVERDOSE RESPONSE

ASSESS (CALL 911)

1. Check for signs of opioid overdose
    a. Non-responsive to voice or touch
    b. Non-responsive to sternum rub
    c. Breathing is prolonged, irregular, or has stopped
    d. Lips are blue or grayish color
    e. Are there evident signs?
    f. Suspected opioid use + Unresponsive or slow/no breathing = Opioid Overdose
2. **Call 911**

ADMINISTER - INTRANASAL NARCAN® RESCUE KIT

1. Lay individual on their back and clear their nostrils
2. Remove the nasal spray from the box and peel back the tab to open
3. Hold the device with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle **(do not prime)**
4. Tilt the individual's head back slightly
5. Gently insert the nozzle entirely into one nostril
6. Press the plunger firmly to give the dose of intranasal naloxone hydrochloride
7. If another dose is needed, administer to the other nostril for better absorption

ADMINISTER - INTRANASAL NARCAN® RESCUE KIT

Click to Play Video

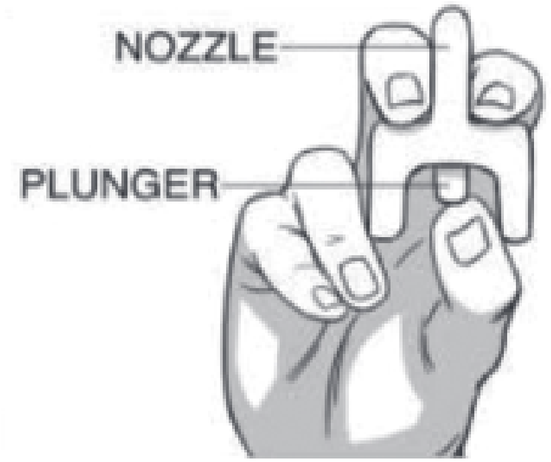
ADMINISTER - INTRANASAL NARCAN® RESCUE KIT

How to give Narcan® Nasal Spray

- Take Narcan® Nasal Spray out of box.
- Peel back tab with the circle to open the Narcan® Nasal Spray.

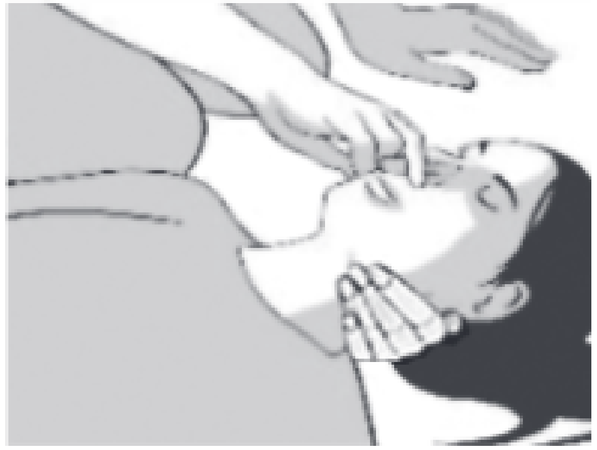
IMPORTANT: Do not remove Narcan® until ready to use and do NOT test the device.

1



- Hold the Narcan® Nasal Spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

2

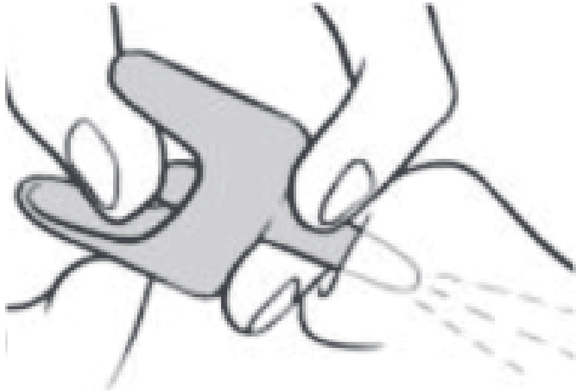


- Tilt the person's head back and provide support under the neck with your hand.

3

ADMINISTER - INTRANASAL NARCAN® RESCUE KIT

How to give Narcan® Nasal Spray

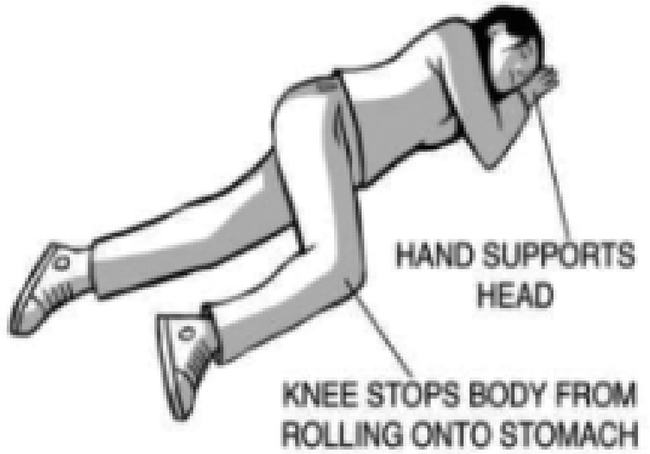


- Gently insert the tip of the nozzle into one nostril, until your fingers on either side of the nozzle are against the bottom of the person's nose.
- Press the plunger firmly to give the dose of Narcan® Nasal Spray. Remove the Narcan® Nasal Spray from the nostril after giving the dose.

4

- Wait and watch the person closely.
- If the person does not respond in 2-mins, repeat the steps and give the second dose of Narcan® Nasal Spray in box.

5



- Call 911 right away, if you have not done so already.
- Roll the person on their side and place them in the 'recovery position'.

6

AFTERCARE

1. An individual is likely to go into respiratory failure during an opioid overdose. **It is vital to provide rescue breathing to supply enough oxygen to preserve life**
2. Naloxone hydrochloride will not have an immediate effect. The medication takes 2-3 minutes to work
    a. Brain damage can occur after only 3 minutes without oxygen
    b. Rescue breathing may be effective in reviving a person if naloxone hydrochloride is not available

AFTERCARE CONT.

3. Rescue Breathing

a. **Lay individual on their back**

b. **Tilt individuals head back** to open the airway

c. **Check mouth for anything** that might be blocking the airway. Wearing gloves, remove any foreign substance using a fish-hook sweep

d. **Pinch nose tightly and create a seal** around the individuals mouth with your mouth (use a face shield if available)

e. **Give the individual two breaths** first to make sure the **air is getting into the lungs.** Then, **continue rescue breathing** by giving **one breath every five seconds** for **2-3 minutes** while watching for their chest to rise

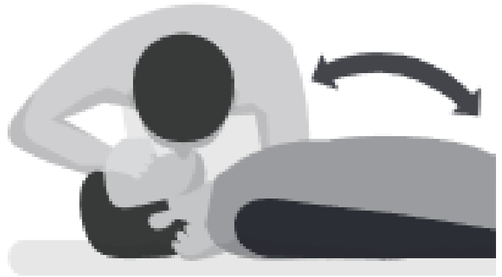
AFTERCARE - RESCUE BREATHING

Rescue breathing steps

Tilt the head back, lift the chin, and pinch the nose.

Start with two breaths into the mouth. Continue with one breath every 5 seconds.

The person's chest should rise and fall with each breath; if not, check to make sure the head is tilted back and the mouth is clear.



Keep doing rescue breathing until the person breathes on their own or until medical help arrives.

AFTERCARE CONT.

4. **Return to Administer step** of the rescue response process if the individual **does not respond or improve after 2-3 minutes**

    a. An additional dose of naloxone hydrochloride may be administered as needed. **The individual can NOT overdose on naloxone hydrochloride**

    b. Continue to the **Aftercare** step for the rescue response process

5. Repeat the process of **Administering** medication and preforming **Aftercare** until either:

    a. The individual has be come responsive; or

    b. Emergency Medical Services have arrived

6. **BE AWARE:**

a. **Administering naloxone hydrochloride to an opioid-dependent individual can cause withdraw symptoms.** The individual may attempt to use additional opioids to relieve these withdraw symptoms. Prevent the individual from taking any further opioids.

b. Naloxone wears off in 30-90 minutes. The individual is at risk of experiencing another overdose, even if they do not use additional opioids.

Example - Heroin is a short lasting opioid (3-6 hours), methadone is a long-lasting opioid (24-48 hours), both outlast naloxone hydrochloride

RESOURCES

Northern Michigan Regional Entity Access Center: 800-834-3393

Prevention, Early Intervention Services. Outpatient Services, Residential Services, Medication Assisted Treatment, Subacute Withdrawal Management, Women's Specialty Services & Peer Recovery Support Services

NMSAS Peer Recovery Coaches: 989-732-1791,

http://www.nmsasrecoverycenter.org/

Multiple Pathways: http://youpickrecovery.org/

Families Against Narcotics: https://www.familiesagainstnarcotics.org/

RESOURCES

Disposal of Medication: Proper disposal of unwanted household medications can help prevent substance misuse.

Visit the Michigan Department of Environmental, Great Lakes, and Energy for **Map of Household Drug Take Back Locations in Michigan:**

Michigan.gov/EGLEdrugdisposal |

RESOURCES

MSP Angel Program: The MSP Angel Program allows an individual struggling with drug addiction to walk into a MSP post during regular business hours and ask for assistance.

MSP Locations:
Alpena
Cadillac
Gaylord
Houghton Lake
West Branch

Michigan State Police
Angel
Program

QUESTIONS?

THANK YOU!

Overdose Prevention and Response Training Evaluation

https://forms.office.com/r/jYpXwu1EDs

HARM REDUCTION MICHIGAN
Naloxone Distribution Boxes
only within the NMRE region

0	County	Encounter Location Name in SUP	Address	City	Zipcode	Funded by	Date Placed
1	Alcona	Harrisville - Alcona County Building Narcan Box	106 N. 5th St.	Harrisville	48740	NMRE	
2	Alcona	Harrisville - Harrisville UMChurch Narcan Box	217 N. State St.	Harrisville	48740	HRMI	2/2/2023
3	Alcona	Oscoda - Gilberts Drug Store Narcan Box	212 S. State St.	Oscoda	48750	NMRE	
5	Alpena	Alpena - CHS Community Narcan Box	154 S. Ripley Blvd.	Alpena	49707	NMRE	5/15/2023
6	Alpena	Alpena - Meds Cafe	427 W Campbell St.	Alpena	49707	HRMI	1/19/2023
7	Alpena	Alpena - The Drug Store Narcan Box	2236 US-23 South	Alpena	49707	NMRE	3/25/2023
8	Antrim	Alba - Star Twp. Fire Station Narcan Box	6775 Alba Hwy.	Alba	49611	NMRE	3/23/2023
9	Antrim	Alden - Higgins Store Narcan Box	9105 Helena Rd.	Alden	49612	NMRE	12/29/2022
10	Antrim	Alden - UMChurch Narcan Box	9015 Helena Rd.	Alden	49612	HRMI	8/23/2022
11	Antrim	Bellaire - Bellaire Family & Cosmetic Dentistry	4631 M-88	Bellaire	49615	NMRE	4/19/2023
12	Antrim	Bellaire - Butch's Tackle and Marine	6235 Crystal Springs Rd.	Bellaire	49615	NMRE	12/29/2022
13	Antrim	Bellaire - Terrrain Narcan Box	213 N. Bridge St.	Bellaire	49615	HRMI	9/28/2022
14	Antrim	Bellaire - UMChurch Narcan Box	401 N. Bridge St.	Bellaire	49615	HRMI	9/15/2022
15	Antrim	Central Lake - Torch Cannabis Co. Narcan Box	7957 State St.	Central Lake	49622	HRMI	6/4/2022
16	Antrim	Elk Rapids - ER Primary Care Narcan Box	115 Bridge St.	Elk Rapids	49629	HRMI	12/16/2022
17	Antrim	Elk Rapids - Short's Pull Barn Narcan Box	211 Industrial Park Dr.	Elk Rapids	49629	HRMI	11/8/2022
18	Antrim	Elk Rapids - St. Paul's Church Narcan Box	403 Traverse St.	Elk Rapids	49629	HRMI	10/8/2022
19	Antrim	Ellsworth - Gold Nugget Narcan Box	6513 Center St.	Ellsworth	49729	HRMI	11/16/2022
20	Antrim	Kewadin - Waters Edge Market Narcan Box	7262 Cairn Hwy.	Kewadin	49648	NMRE	12/29/2022
21	Antrim	Mancelona - BoJack's Bakery Narcan Box	102 W State St.	Mancelona	49659	NMRE	4/3/2023

HARM REDUCTION MICHIGAN
Naloxone Distribution Boxes
only within the NMRE region

0	County	Encounter Location Name in SUP	Address	City	Zipcode	Funded by	Date Placed
22	Antrim	Mancelona - Resource Center Narcan Box	205 Grove St.	Mancelona	49659	NMRE	1/5/2023
23	Benzie	Benzonia - Benzie County HD Narcan Box	6051 Frankfort Hwy., Ste. 100	Benzonia	49616	HRMI	8/28/2022
24	Benzie	Frankfort - Jacobson Marine Resort Narcan Box	15 4th St.	Frankfort	49635	HRMI	5/31/2023
25	Charlevoix	Charlevoix - Alano Club Narcan Box	106 Mason St.	Charlevoix	49720	NMRE	3/16/2023
26	Charlevoix	Charlevoix - BASES Recovery Center Narcan Box	101 M-66 N.	Charlevoix	49720	NMRE	3/16/2023
28	Crawford	Grayling - Crawford County Sheriff/Jail Narcan Box	200 W. Michigan Ave.	Grayling	49738	HRMI	8/27/2022
29	Crawford	Grayling - DHD10 Narcan Box	501 Norway St., Suite 1	Grayling	49738	NMRE	3/24/2023
30	Crawford	Grayling - NLCMHA Narcan Box	204 Meadows Dr.	Grayling	49738	DHD10	3/24/2023
31	Emmet	Harbor Springs - Community Health Center Narcan Box	3434 M-119, Ste. C	Harbor Springs	49740	NMRE	3/16/2023
35	Grand Traverse	TC - 488 Northside Narcan Box	488 Munson Ave.	Traverse City	49686	HRMI	6/8/2023
36	Grand Traverse	TC - 488 Southside Narcan Box	488 Munson Ave.	Traverse City	49686	HRMI	5/26/2023
37	Grand Traverse	TC - Catholic Human Services Narcan Box	1000 Hastings St.	Traverse City	49686	NMRE	3/23/2023
38	Grand Traverse	TC - Higher Grounds Narcan Box	806 Red Dr.	Traverse City	49684	HRMI	3/16/2023
39	Grand Traverse	TC - Jubilee House Narcan Box	325 Washington St.	Traverse City	49684	HRMI	10/8/2022
40	Grand Traverse	TC - Mack's Dentistry Narcan Box	3347 S. Airport Rd., Ste. D	Traverse City	49684	HRMI	6/16/2023
41	Grand Traverse	TC - Pines Narcan Box	11th St.	Traverse City	49684	HRMI	7/14/2023
42	Grand Traverse	TC - Plato's Closet Narcan Box	1780 S. Garfield Ave.	Traverse City	49686	HRMI	4/22/2023
43	Grand Traverse	TC - Safe Harbor Narcan Box	517 Wellington St.	Traverse City	49686	HRMI	12/12/2022
44	Grand Traverse	TC - Spanglish Narcan Box	1333 Yellow Dr.	Traverse City	49684	HRMI	5/26/2023

HARM REDUCTION MICHIGAN
Naloxone Distribution Boxes
only within the NMRE region

0	County	Encounter Location Name in SUP	Address	City	Zipcode	Funded by	Date Placed
45	Grand Traverse	TC - St. Vincent DePaul Narcan Box	1207 Woodmere Ave.	Traverse City	49686	HRMI	3/24/2023
46	Grand Traverse	TC - Traverse Area District Library Narcan Box	610 Woodmere Ave.	Traverse City	49686	HRMI	1/6/2023
47	Grand Traverse	TC - Well-Spring Psychiatry Narcan Box	1305 E. Eighth St.	Traverse City	49686	HRMI	10/6/2022
54	Kalkaska	Kalkaska - Bear Lake Christian Church Narcan Box	221 E. Bear Lake Rd.	Kalkaska	49646	NMRE	3/7/2023
55	Kalkaska	Kalkaska - Fire Dept. Narcan Box	209 Laurel St.	Kalkaska	49646	NMRE	4/10/2023
56	Kalkaska	Kalkaska - Kalkushka Lounge Narcan Box	302 S. Cedar Street	Kalkaska	49646	HRMI	5/27/2022
57	Kalkaska	Kalkaska - M&S Party Store Narcan Box	6133 US-131	Kalkaska	49646	NMRE	3/7/2023
58	Kalkaska	Rapid City - RC Market Place Narcan Box	8174 Rapid City Rd. NW	Rapid City	49676	HRMI	5/10/2022
59	Kalkaska	Rapid City - Village Market Narcan Box	9556 Rapid City Rd. NW	Rapid City	49676	NMRE	4/13/2023
60	Kalkaska	South Boardman - Country Store Narcan Box	4969 US-131 SW	South Boardman	49680	NMRE	3/7/2023
64	Leelanau	Maple City - Foothills Cafe Narcan Box	7097 S. Dunns Farm Rd.	Maple City	49664	HRMI	6/4/2022
66	Manistee	Manistee - Clean Lines Tattoo Narcan Box	366 River St.	Manistee	49660	HRMI	6/6/2022
67	Manistee	Manistee - HRMI Narcan Box	115 Washington Street	Manistee	49660	HRMI	5/12/2022
68	Manistee	Manistee - Meds Cafe Narcan Box	70 Arthur St.	Manistee	49660	HRMI	5/26/2023
74	Montmorency	Atlanta - Thunder Bay CHS Narcan Box	11899 M-32	Atlanta	49709	NMORC	5/8/2023
75	Montmorency	Hillman - Thunder Bay CHS Narcan Box	15774 S. State St.	Hillman	49746	NMORC	5/8/2023
79	Ogemaw	West Branch - DHD2 Narcan Box	630 Progress St.	West Branch	49661	NMRE	1/12/2023
80	Oscoda	Fairview - Thunder Bay CHS Narcan Box	1910 E. Miller Rd.	Fairview	48621	NMORC	5/8/2023
81	Otsego	Gaylord - NMSAS Recovery Center Narcan Box	2136 West M-32	Gaylord	49735	NMRE	4/24/2023

HARM REDUCTION MICHIGAN
Naloxone Distribution Boxes
only within the NMRE region

0	County	Encounter Location Name in SUP	Address	City	Zipcode	Funded by	Date Placed
82	Presque Isle	Onaway - Thunder Bay CHS Narcan Box	21258 W. M-68 Hwy.	Onaway	49765	NMORC	5/8/2023
83	Presque Isle	Rogers City - Meds Cafe Narcan Box	2352 US-23	Rogers City	49779	HRMI	1/28/2023
84	Presque Isle	Rogers City - Thunder Bay CHS Narcan Box	205 S. Bradley Hwy.	Rogers City	49779	NMORC	5/8/2023
90	Wexford	Cadillac - Mancino's Pizza Narcan Box	707 N. Mitchell St.	Cadillac	49601	DHD10	7/10/2023
91	Wexford	Cadillac - NLCMHA Narcan Box	527 Cobb St.	Cadillac	49601	DHD10	3/27/2023
92	Wexford	Cadillac - Owl Eye Coffee Narcan Box	317 N. Mitchell St.	Cadillac	49601	HRMI	8/15/2022
93	Wexford	Cadillac - Salvation Army Narcan Box	607 S. Mitchell St.	Cadillac	49601	DHD10	3/23/2023
94	Wexford	Cadillac - Wexford Habitat for Humanity Restore Narcan Box	7545 E. 34 Rd.	Cadillac	49601	DHD10	3/23/2023
95	Wexford	Cadillac - YMCA Narcan Box	9845 Campus Dr.	Cadillac	49601	DHD10	7/10/2023