Northern Michigan Regional Entity

Board Meeting

June 22, 2022

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 – May 25, 2021	Pages 2 – 7
7.	Correspondence	Pages 8 – 92
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – No Report	
	c. CEO's Report – June 2022	Page 93
	d. Financial Report – April 2022	Pages 94 – 115
	c. Operations Committee Report – June 21, 2022	
	e. NMRE SUD Oversight Board Report – The next meeting is July 11th	
11.	New Business	
12.	Old Business	
	a.. Senate Bills 597 & 598/House Bills 4925-4929 – The Latest	
	b. Grand Traverse County and Northern Lakes CMHA	
13.	Presentation/Discussion	
	NMRE Member Satisfaction Survey Report	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – May 25, 2022 at 10:00 am	
16.	Adjourn	

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – MAY 25, 2022
GAYLORD BOARDROOM

ATTENDEES:	**Ed Ginop, Gary Klacking, Terry Larson, Mary Marois, Gary Nowak, Jay O'Farrell, Justin Reed, Richard Schmidt, Karla Sherman, Don Smeltzer, Joe Stone, Don Tanner**
ABSENT:	**Roger Frye, Christian Marcus**
NMRE/CMHSP STAFF:	**Brian Babbitt, Jodie Balhorn, Christine Gebhard, Lauri Fischer, Eric Kurtz, Diane Pelts, Pamela Polom, Sara Sircely, Nena Sork, Tricia Wurn, Deanna Yockey, Carol Balousek**
PUBLIC:	**Chip Cieslinski, Jackie Guzman, Derek Miller, 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 Roger Frye and Christian Marcus were excused from the meeting on this date; all other NMRE Board Members were in attendance.

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

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

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

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR MAY 25, 2022; SUPPORT BY JOE STONE. MOTION CARRIED.

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

MOTION BY MARY MAROIS TO APPROVE THE MINUTES OF THE APRIL 27, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY ED GINOP. MOTION CARRIED.

PRESENTATION
FY21 Financial Audit
Derek Miller, CPA with Roslund Prestage & Company was in attendance to report on the NMRE's FY21 Financial Audit.

The NMRE saw a 34.78% increase in total assets over FY20, a 60% increase in liabilities (due to $8.8M lapse of funding due to State), and an 8.34% increase in net position. Operatng revenue increased by 5.97%, operating expenses increased by 10.44%.

Mr. Miller reported that the NMRE had a clean audit and stated that he was “very happy” with the outcome.

MOTION BY RICHARD SCHMIDT TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY FISCAL YEAR 2021 FINANCIAL AUDIT BY ROSLUND, PRESTAGE AND COMPANY, PC; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

CORRESPONDENCE

1) The minutes from the May 5, 2022 PIHP CEO meeting.
2) Slides from the Community Mental Health Association of Michigan (CMHAM) April Public Relations Report by Lambert.
3) Email correspondence from CMHAM dated May 9, 2022 regarding its planned office move.
4) Email correspondence from CMHAM regarding the Election of Board Officers.
5) A summary of the FY23 Senate and House Budget Proposals prepared by CMHAM.
6) Exhibit E, List of Opioid Remediation Uses, from the Opioid Settlement Agreement.
7) Email from MDHHS regarding the FY21 Perfomance Based Bonus Incentive Pool Award for NMRE.
8) Memorandum from Eric Kurtz dated May 3, 2022 to Amanda Zabor and Darrell Harden in response to MDHHS’s request for a Plan of Correction for Intensive Crisis Stabilizaion Services provided by Northeast Michigan CMHA.
9) Local news clips from TV 7&4 (upnorthlive) and 9&10 News covering the distribution of Carter Kits on April 27, 2022.
10) Draft minutes of the May 11, 2022 NMRE Regional Finance Committee meeting.

Mr. Kurtz reported that NMRE received the full $1.7M Performance Bonus Incentive Payment for FY21. NMRE was one of, or possibly the only, PIHP that met all the standards at 100%. According to the MDHHS-PIHP Contract, the remaining amount in the pool will be redistributed to regions that met the standards; therefore, NMRE was awarded an additional $1.3M (which the CMHSPs can use as local funds).

Mr. Kurtz drew attention to his Memorandum to MDHHS regarding a request for a Plan of Correction for Northeast Michgan CMHA. Mr. Kurtz explained that he does not feel that a POC is warranted as the alleged contract non-compliance was related to the (under) utilization of Intensive Crisis Stabilization Services (ICSS) rather than their availability. It was noted that, in the future, financial penalties will be tied to timely responses POC requests.

ANNOUNCEMENTS

Let the record show that Mary Marois announced the appointment of Angie Griffis to the NMRE Board of Directors by the Northern Lakes Community Mental Health Authority Board.

PUBLIC COMMENTS

Let the record show that Christine Gebhard introduced North Country Community Mental Health Aughority’s Chief Operating Officer, Brian Babbitt to the Board; Mr. Babbitt will assume the role of Chief Executive Officer upon Ms. Gebhard’s retirement on July 1, 2022.

Mr. Reed stated that he attended the meeting of the Grand Traverse County Board of Commissioners on May 18th. He spoke publicly about the county’s intention to break away from Northern Lakes CMHA as a recipient of services. Mr. Russell made it clear that he wasn’t

speaking on behalf of the NMRE Board. He stressed the need for the county to have a clear plan. This topic will be discussed further as a separate Agenda item under “New Business.”

REPORTS

Executive Committee Report

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

CEOs Report

The NMRE CEO Monthly Report for May 2022 was included in the materials for the meeting on this date. Mr. Kurtz thanked Northeast Michigan CMHA for the invitation to participate in its Annual Board Planning Session.

Financial Report

March 2022

- Net Position showed net surplus Medicaid and HMP of $8,248,294. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $24,606,411. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $40,964,528.
- Traditional Medicaid showed $99,621,062 in revenue, and $90,082,236 in expenses, resulting in a net surplus of $9,538,825. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $15,432,891 in revenue, and $13,157,185 in expenses, resulting in a net surplus of $2,275,707. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $734,211 in revenue, and $520,044 in expenses, resulting in a net surplus of $214,167.
- SUD showed all funding source revenue of $12,092,064, and $10,063,392 in expenses, resulting in a net surplus of $2,028,672. Total PA2 funds were reported as $5,814,770.

The direct care wage surplus was estimated as $3.5M.

Mr. Stone stressed the need for spending plans to reduce the potential lapse. The pause in redeterminations continues to affect revenue (the NMRE is currently being paid for 1 million individuals on HMP; prior to the pandemic, the number was approximately 500,000). It is anticipated that the Public Health Emergency will extend through the end of the fiscal year.

MOTION BY ED GINOP TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2022; SUPPORT BY JAY O’FARRELL. MOTION CARRIED.

Operations Committee Report

The draft minutes from May 17, 2022 were included in the materials for the meeting on this date.

NMRE SUD Oversight Board Report

The draft minutes from the May 9, 2022 were included in the materials for the meeting on this date. One liquor tax request was recommended for approval and will be discussed under “New Business.”

NEW BUSINESS

Liquor Tax Request

Catholic Human Services – Cheboygan Substance Free Coalition/Cheboygan Youth Coalition - $23,366

MOTION BY GARY NOWAK TO APPROVE THE REQUEST FROM CATHOLIC HUMAN SERVICES FOR CHEBOYGAN COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF TWENTY-THREE THOUSAND THREE HUNDERD SIXTY-SIX DOLLARS ($23,366.00) TO EXPAND THE CHEBOYGAN SUBSTANCE FREE COALITION TO INCLUDE THE CHEBOYGAN YOUTH COALITION; SUPPORT BY KARLA SHERMAN. ROLL CALL VOTE.

"YEA" VOTES: E. Ginop, G. Klacking, T. Larson, M. Marois, G. Nowak, J. O'Farrell, J. Reed, R. Schmidt, K. Sherman, D. Smeltzer, J. Stone, D. Tanner

"NAY" VOTES: Nil

American Rescue Plan Act (ARPA) Grant Recommendations

Ms. Sircely summarized the recommendations of NMRE staff for APRA grant awards based in the recent Request for Proposals. Clarification was made that the funding is for four years.

Project	Amount	Recommended for Contract
Prevention Evidence-Based Practice	$119,060	Health Department of Northwest MI*
Same Day Appointments for Detox, Residential, or Methadone	$50,000	
SUD Health Home Maintenance	$10,000	
Telehealth Technology	$75,000	Catholic Human Services - $50,000 Bear River Health - $25,000**
Recovery Community Organization	$150,000	Bear River Health - $81,970
Recovery Support Services	$75,000	***
Recovery Housing	$100,000	****

* Catholic Human Services also submitted a request for a media campaign but these funds may not be utilized for a media campaign.

** Sacred Heart also applied for these funds; however, there are no NMRE funded clients in treatment services at the location.

*** Catholic Human Serices applied for these funds; however, Women's Specialty Services (WSS) will be utilized due to the request.

**** Billy Jane's Recovery House also applied; however, SOR 2 funding will be utilized due to the request. Project Unity also applied for these funds but the requested activities are not allowable under the grant. Sacred Heart applied for these funds as well. The agency would like to establish a recovery home in Emmet or Cheboygan County; however, there is no house currently.

MOTION BY ED GINOP TO APPROVE AMERICAN RESCUE PLAN ACT GRANT FUNDS TO THE HEALTH DEPARTMENT OF NORTHWEST MICHIGAN IN THE AMOUNT OF ONE HUNDRED NINETEEN THOUSAND SIXTY DOLLARS ($119, 060.00), CATHOLIC HUMAN SERVICES IN THE AMOUNT OF FIFTY THOUSAND DOLLARS ($50,000.00), AND BEAR RIVER HEALTH IN THE AMOUNT OF ONE HUNDRED SIX THOUSAND NINE HUNDRED SEVENTY DOLLARS ($106,970.00); SUPPORT BY MARY MAROIS. MOTION CARRIED.

Grand Traverse County and Northern Lakes
Mr. Kurtz has met with Grand Traverse County Administrator, Nate Alger, and Northern Lakes CMHA staff about the county's intent to separate from Northern Lakes CMHA. An evaluation is currently underway. No Letter of Intent (to dissolve the enabling agreement) has been sent to the State to date. It was noted that Grand Traverse County Sheriff, Tom Bensley, is pusing hard for the separation. Mr. Kurtz clarified that what is being suggested is not what occurred in Washtenaw County; Washtenaw went from having an urban cooperative agreement (UCA) with the U of M to a county department (but was already a CMH).

Ms Marois acknowledged that it is a complex problem. She stated that the Northern Lakes Governing Board operatates unce a Policy Governance (Carver) Model, which is ineffective. The Board is often restricted from making key decisions. Ms. Marois emphasized that there are many, many unanswered questions currently. It was noted that separation isn't the only answer (the enabling agreement could be redone). Mr. Kurtz is well versed in different arrangements and will continue to share his expertise with the parties involved. Mr. Reed indicated that transparency needed between the county and the public is essential.

OLD BUSINESS
Senate Bills 597 & 598/House Bills 4925 – 4929 – The Latest
The Senate Bills were close to passing the Michigan Senate in early March. New versions of the bill will most likely change again on the Senate floor and may be headed for a vote by the end of June.

COMMENTS
Board
Mr. Smeltzer compared the situation with Grand Traverse County and Northern Lakes CMHA to a similar to a split in Benzie County in 2010 with townships breaking apart from the county planning and zoning department.

Mr. Tanner reported that Centra Wellness Network is speaking with the Sheriff's office about adding qualified mental health professionals to work in the police department (funded with local from third party billing).

Mr. Russell announced that parking for the Cherry Festival (July 2nd – July 9th) will be available at Northern Lakes CMHA parking lot; proceeds will benefit the Light of Hope Clubhouse.

Staff/CMHSP CEOs
The Day of Recovery Education took place May 20th at Treetops Resort; this was the first gathering of individuals served since before the pandemic.

Ms. Gebhard announced that North Country CMHA signed an agreement with Pine Rest to train four child psychiatrist fellows. North Country CMHA is also looking to implement an onsite pharmacy and has engaged a recruiting firm to find adult psychiatrist. An adult adult crisis residential unit is scheduled to open later this year in Gaylord.

Ms. Gebhad spoke about response following the tornado in Gaylord on May 20th. North Country CMHA's Director of Crisis Services, Carole Doherty, coordinated with law enforcement, first responders, hospitals, AFC homes, etc. Ms. Gebhard acknowledged that ther is more to be done in the aftermath; resources are posted on the North Country Community Mental Health (norcocmh.org) website. Mr. Kurtz added that individuals throughout the State reached out to inquire about staff and building safety and to offer support.

Ms. Pelts added that AuSable Valley CMHA is also looking to establish an onsite pharmacy.

Public
Sue Winter thanked NMRE staff for offering support after the tornado in Gaylord on May 20th.

MEETING DATES
The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on June 22, 2022.

ADJOURN
Let the record show that Mr. Tanner adjourned the meeting at 11:39AM.

PIHP CEO Meeting
June 2, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

Pre-paid Inpatient Health Plans (PIHP)

Dr. Timothy Kangas (Northcare Network)	Region 1
Sara Sircely (Northern MI Regional Entity)	Region 2
Mary Marlatt-Dumas (Lakeshore Regional Entity)	Region 3
Stacia Chick (Lakeshore Regional Entity)	Region 3
Amanda Tarantowski (Lakeshore Regional Entity)	Region 3
Stephanie VanDerKooi (Lakeshore Regional Entity)	Region 3
Amy Embury (Lakeshore Regional Entity)	Region 3
Brad Casemore (Southwest Michigan Behavioral Health)	Region 4
Joe Sedlock (Mid-State Health Network)	Region 5
Dani Meier (Mid-State Health Network)	Region 5
James Colaianne (CMH Partnership of Southeast Michigan)	Region 6
Yolanda Turner (Detroit Wayne Mental Health Authority)	Region 7
Dave Pankotai (Macomb County CMH Services)	Region 9
Jim Johnson	Region 10

Michigan Department of Health & Human Services (MDHHS)

Kim Batsche-McKenzie
Audrey Dick
Erin Emerson
Darrell Harden
Krista Hausermann
Belinda Hawks
Kristen Jordan
Leah Julian
Amy Kanouse
Brian Keisling
Phil Kurdunowicz
Lindsay McLaughlin
Lindsey Naeyaert
Carrie Rheingans
Kelsey Schell
Jackie Sproat
Brenda Stoneburner
Jared Welehodsky
Keith White
Jeff Wieferich
Amanda Zabor

Community Mental Health Services Programs (CMHSPs)

Nicole Adelman
Joel Ebbers
Kari Kempema
Helen Klingert
Diane Salters
Lauren Todaro
Michele VanderSchel

Attorney General's Office
Scott Mertens
Matt Walker

Michigan Department of Technology, Management & Budget (MDTMB)
Herve Mukuna
Matthew Ellsworth

Michigan Public Health Institute (MPHI)
Kristi Bente
Krystalle Double
Stacy Smith

Children's Bureau Update

1. Lindsay McLaughlin shared that the Children's Bureau continues to hire staff. She named three new members of the team. Interviews and hiring processes are ongoing for other roles.
    a. The division director for the office of the Advocate for Children, Youth, and Families has been hired. The new Division Director is Patty Neitman, a current employee of MDHHS with experience in both child welfare and behavioral health.
    b. The Bureau has also hired Erin Mobley to work in the Quality Monitoring and Improvement Section.
    c. Lindsay McLaughlin also notified the group that she has a new executive secretary, Sara Salamey, who the group may see emails from soon.
2. Lindsay McLaughlin thanked the PIHPs and their Autism Leads for their participation in the Autism Evaluation Workgroup.
    a. Phil Kurdunowicz shared that the Children's Bureau will be working towards a policy bulletin within the next month to address some of the confusion over evaluation referral policies. Once it is posted, it will be circulated.

HCBS Update

1. A PIHP asked if there had been any movement on appointing a designee to participate with the PIHPs' Chief Compliance Officers.
    a. Belinda Hawks stated that she had met with the site review team and the federal compliance manager and provided them the schedule. She believes they should be reaching out.

Public Health Emergency Unwind

1. Jeff Wieferich shared that MDHHS had not received notice about the end of the Public Health Emergency from the federal government. The government has promised a 60-day notice when they will not be renewing the public health emergency, and MDHHS has not received that notice. This should mean that the Public Health Emergency will continue into July.
    a. MDHHS expects that at that time it will be renewed again, and thus MDHHS and the PIHPs will have longer to work on the unwind process.
2. MDHHS continues to work on efforts to provide information to the PIHPs so they can be of assistance and plan how to do so. MDHHS recommends continuing to watch the website that MDHHS built for the unwind efforts for updated information.
    a. MDHHS also has started a campaign to remind people to update their information.

Follow Up CFO Involvement

1. The PIHPs requested that they be able to have their CFOs sit down with individuals in the department who have accounting/budgeting expertise.
    a. The PIHPs feel their end of things tends to be more focused on accounting and using their accounting systems to reconcile what MDHHS wants policy-wise, whereas MDHHS has a

stronger focus on policy. They are having difficulty bridging the gap to ensure they are providing MDHHS with what it needs while remaining in compliance with the things they are audited on.

   b. The comparison the PIHPs gave was to the autism referral workgroup, and how it brought in experts to get everything aligned correctly.
   c. A PIHP reported that there were a lot of initiatives that touch on financial reporting and structure, but that those initiatives do not appear to be coordinated. Some of the things being discussed go in two different directions instead of a unified single direction. There may be ways to unify these processes and streamline things across initiatives.

2. The PIHPs' preference for the workgroup with CFOs and someone with accounting/budgeting expertise is that it be a small group of around seven people to make it possible to work through issues quickly.
3. A PIHP shared that they have recently been receiving forms, instructions, interpretations, and directions directly from Milliman. The PIHPs do not have a contractual relationship with Milliman and need clarity that these communications are sanctioned by MDHHS. This is especially true in cases where the message could be interpreted as in contradiction to current contract language, or where it is not supported by any contract language.
   a. MDHHS thanked the PIHP for sharing and assured them that Milliman would not be sending anything to the field that was not approved by the state.

MPCIP & MI CAL Update

1. Krista Hausermann reported that crisis services projects continue to move ahead, and that there are no significant updates.
   a. The PIHPs stated that they find written updates extremely helpful even if they are status quo. They asked if she anticipated releasing something in that fashion soon.
   b. Krista Hausermann responded that she did. A written update was distributed to the group alongside these meeting notes.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Erin Emerson shared that the position posting for the manager over the service delivery transformation area that houses the health home projects, PIPBHC, and the CCBHC project would be up through Sunday, June 5, 2022.
2. The team leads shared updates on their sections.
   a. Kelsey Schell reported that the Opioid Health Home initiative currently had over 2000 beneficiaries enrolled and 38 health home partners within the program. The program looks forward to expanding into more regions and gaining more partners.
   b. Lindsey Naeyaert shared that behavioral health homes had expanded services to two PIHP regions: the CMH Partnership of Southeast Michigan and Detroit, and Wayne Integrated Health Network. Both regions have enrolled beneficiaries.

c. Lindsey Naeyaert also stated that for PIPBHC, Saginaw and Shiawassee counties were still finalizing data validation for the Azara implementation. They would begin training and adoption later in June 2022. Barry County, partnering with Cherry Health, has started validating its measures, and its data will be going live the week of June 5, 2022.
d. Amy Kanouse reported that CCBHC continues to move along. There are now around 35,000 Medicaid beneficiaries assigned, and nearly 5,000 non-Medicaid individuals.
    i. She notified the PIHPs that they would receive communication soon from Denise Richards to set up the mid-year check-ins with the CCBHCs.
    ii. She hopes these meetings would be individual, at about an hour and a half, and would be scheduled for July and August.

3. A written update has been provided to the PIHPs via email.

Opioid Settlement Roles and Responsibilities

1. The PIHPs explained that they had requested this meeting because they wanted to document roles and responsibilities for the next six months. They did not want to overstep or underperform.
2. Matthew Walker introduced himself as an Assistant Attorney General working on opioid litigation for the Attorney General's office. He is the point of contact for all opioid litigation against drug distributors, pharmacies, and drug manufacturers.
    a. Scott Mertens introduced himself as the section head in the Corporate Oversight Division. He oversees securities, antitrust, and business. Matthew Walker is his direct employee. He requested that the PIHPs follow up with them through communications such as email if questions or concerns got very deep or specific.
3. Matthew Walker presented on the opioid settlements, their history, and the legislation surrounding them. The slides from this presentation have been distributed to the group via email.
4. The PIHPs asked about the roles of the PIHPs/CMHSPs, MDHHS, the Attorney General's office, and the local entities.
    a. Matthew Walker responded that the role of the Attorney General's office is to pursue settlements to the best of their ability. Their role is to finalize and get those settlements. For public health questions, he would refer the PIHPs to Jared Welehodsky at MDHHS. MDHHS is public-health focused, the Attorney General's office is focused on legality and getting the settlements.
    b. Jared Welehodsky introduced himself. He works in policy for MDHHS to coordinate the opioid response and to support the opioid task force. He is working to educate on best practices for the funding the local governments will be receiving.
    c. Jeff Wieferich explained that his team was following Jared Welehodsky's lead on policy for this funding, so he does not have any specific next steps yet.
5. A PIHP asked about the ability of local jurisdictions to assign their share to another jurisdiction, such as a township to a county. The PIHP asked if jurisdictions could assign their share not only to their county but to a PIHP or CMH entity to administer on their behalf.
    a. Matthew Walker clarified that he could not interpret or provide legal advice as to what the settlement says or does not say from a department perspective.

b. Personally, he reads it that voluntary assignment can occur to other participating local subdivisions, which he does not believe the PIHPs classify as. He is unsure if that specific mechanism within the settlement would work, but it is something the PIHPs could explore with their counsel.
    i. A PIHP asked if it would stop a jurisdiction from *contracting* with a PIHP to provide a comprehensive opioid settlement program.
        1. Matthew Walker replied that to his knowledge the settlement would not prevent that.

6. A PIHP explained that one of their statutory obligations is to provide funding and oversight for all publicly-funded substance abuse services and supports in their given geographic areas, including the submission of a strategic plan to the department. They expressed concern about trying to bring the use of funds from this grant in line with the public responsibilities they have.
    a. Matthew Walker shared that this settlement is different in that it directly involves local subdivisions, some who have sued and some who have not.
        i. The structure of the settlement provides eligibility to receive direct payments to specific local governments including counties, anyone who would be considered a litigating government due to filing suit against those defendants as of a certain date, and any local subdivision whose population was 10,000 or more in the 2019 census estimate. All those parties are eligible for direct payments.
        ii. He suggested that within their region it may be best for the PIHP to approach individual local subdivisions and ask how they can help.
            1. The PIHP agreed that that was what they were doing.
7. A PIHP stated that they could see from the literature that the use of settlement dollars is broader than a PIHP's traditional focus, which they believe is good. They asked, however, if the expectation or requirement was that SUD prevention or treatment services using those dollars was to be provided in the same structure as current SUD services. If so, they asked who was charged with overseeing and monitoring that.
    a. Matthew Walker responded that he couldn't answer from a statutory perspective, only the perspective of the settlement. He does not believe the settlement has the expectation that services be provided within the existing framework. However, there may be another legal perspective or statute to consider that he is unaware of.
    b. The PIHPs asked MDHHS for its perspective.
        i. MDHHS responded that as they have been talking with local governments about the settlement, they have shared contact information for all SUD Directors. They have been trying to make sure the local governments are aware of the services that the PIHPs administer and that they have the contact information to coordinate with ongoing efforts at the PIHP level.
    c. Matthew Walker noted that the money that is received by local subdivisions is belongs to the local subdivision, whatever that means in terms of how they spend it. He would hope they would check the different regulations, but from MDHHS's perspective it is not MDHHS money that is coming to the subdivisions, so MDHHS cannot condition how they spend it based on MDHHS rules.

    d. He stated that if there is mishandling of the funds, the Attorney General's office would have a role in doing that enforcement.
8. Carrie Rheingans shared a survey that MDHHS did of 1000+ people across Michigan to ask what they might prioritize in their community for settlement dollars. The long report about those survey findings can be found at this link: https://chrt.org/wp-content/uploads/2022/05/MDHHS_FinalOpioidsReport_May2022.pdf

Electronic Visit Verification

1. Jackie Sproat reported that the individuals leading the effort to put an MDHHS statewide Electronic Visit Verification system in place asked all the managed care areas and Medicaid to share the same information with MDHHS's managed care contracted entities.
    a. The RFP was not out yet, but it should be released soon.

1513 Inpatient Rate Workgroup Update

1. Jackie Sproat reported that with the reorganization, MDHHS has taken a step back from the work on implementing a tiered rate for psychiatric services. MDHHS wants to ensure that what it puts in place will address access to care issues.
    a. The plan is no longer to have tiered rates with dollar amounts within 2023, but MDHHS is working to add z-modifiers to the code chart so that the PIHPs and CMHs who are payers could implement the structure.
2. The PIHPs asked if it was voluntary or expected to be implemented.
    a. Jackie Sproat responded that it was voluntary, but it would be helpful if a few regions did so to provide better data for modelling rate development.
    b. A PIHP noted that in a voluntary implementation arrangement, some of the hospitals may want to structure their contracts with *all* PIHPs to incorporate the tiered rates. A hospital may take the position that they would not have a single per diem rate anymore.
    c. Another PIHP expressed concern that hospitals might use the lack of dollar amounts tied to those rates to begin their billing base point at already-expensive prices and then build cost higher for certain higher-need individuals, rather than allowing the hospital to lower its rate for those with lower staffing needs.
3. The PIHPs stated that they were not making recommendations or requests, but were merely expressing the potential consequences to the delay.

email correspondence

From: Alan Bolter
To: Alan Bolter
Cc: Robert Sheehan
Subject: Passage of SB 714
Date: Wednesday, June 15, 2022 7:29:46 PM
Attachments: SB 714.pdf
2021_2022_session_cabinet_senate_bills_00701_00800_SB0714_substitutes_S04075"21 (S-2).pdf

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As you know, this afternoon the Senate passed SB 714, which is the mental health supplemental budget bills sponsored by Sen. Shirkey as a sweetener for SBs 597 & 598. The bills were not on the formal agenda today for consideration, but did pass on the 36-1 vote. The measure would provide $565.5 million Gross ($17.5 million General Fund/General Purpose (GF/GP)) for the current fiscal year directed largely at various aspects of the behavioral health system. $548.7 million would be sourced from funding Michigan has received through the federal American Rescue Plan Act.

As introduced, funding in SB 714 was tie-barred to Senate Bills 597 and 598. Under the S-2 that passed today only the following items are tied to the passage of SBs 597 & 598:

- Sec. 302. Health and Human Services. Directs that the adjustments in part 1 for Medicaid Mental Health Services be used to replace local match with GF/GP. Bars spending or distributing the funding in the line unless Senate Bills 597 and 598 are enacted into law.

- Sec. 306. Health and Human Services. Directs that the part 1 appropriation for Clinical Integration Fund be used to provide grants to facilities and providers that integrate their setting with physical and behavioral health services and providers. Designates the part 1 funding as a work project. Bars spending or distributing the funding in the line unless Senate Bills 597 and 598 are enacted into law.

- Sec. 308. Health and Human Services. Directs that the part 1 funding for Community Mental Health Services Program (CMHSP) Integration Readiness be used to support CMHSP efforts to make information technology, staff, and administrative improvements for integration. Designates the part 1 funding as a work project. Bars spending or distributing the funding in the line unless both Senate Bills 597 and 598 are enacted into law.

- Sec. 311. Health and Human Services. Directs that the part 1 funding for DHHS integration readiness be used to make one-time investments to support implementation of Senate Bills 597 and 598. Designates the part 1 funding as a work project. Bars spending or distributing the funding in the line unless Senate Bills 597 and 598 are enacted into law.

- Sec. 315. Health and Human Services. Directs the Department to appropriate $15.0 million of part 1 funding for Integrated Care Center to the Detroit Wayne Integrated Health Network to implement a centrally located integrated service center to provide physical and mental health services. Designates the part 1 funding as a work project. Bars spending or distributing the funding in the line unless Senate Bills 597 and 598 are enacted into law.

- Sec. 316. Health and Human Services. Directs that the part 1 funding for Jail Diversion Fund be allocated to the Jail Diversion Fund, which would be administered by the Mental Health

Diversion Council. Directs the Council to distribute grants to local entities to establish or expand jail diversion programs, with 50.0% going to community-based mobile crisis intervention services that include full integration with 911 dispatch centers, include both coresponder clinicians and peers, have access to residential treatment facilities, include telehealth response and follow-up services, and employ mental health professionals independent of law enforcement. Directs that the other 50.0% go to pre-arrest or post-arrest diversion programs for individuals with behavioral health needs, with priority given to nonurbanized areas. Allows grant applications to be made by any applicable local entity and must be distributed using a prospective payment model. Directs the DHHS to seek Federal authority under the American Rescue Plan to use enhanced Medicaid matching funds. Requires local entities receiving grants to submit a report containing metrics and requires the Council to compile and provide an annual report to the Legislature. Allows local entities to use a portion of funding to contract with independent entities to create the report. Outlines metrics to be used. Designates the part 1 funding as a work project. Bars spending or distributing the funding in the line unless Senate Bills 597 and 598 are enacted into law.

I understand the passage of SB 714 has raised a number of concerns about the final passage of SBs 597 & 598. I do believe Sen. Shirkey will make a BIG push to move the bills out of the senate in the next two weeks before the legislature breaks for the summer. Passage of SB 714 does not ensure defeat for us on 597 & 598, I believe we still have a solid group of senators opposed to the passage of those bills regardless of today's vote (they have told us as much).

Please reach out to your House and Senate members and tell them you oppose any effort to privatize the public mental health system. We do have an active action alert out there on our website.

Below is Sen Shirkey's statement from the Senate Floor on the passage of SB 714:

I have stood at this podium and said these words before and they bear repeating, Everyone in our state should have access to quality mental health services regardless of their means and regardless of what their ZIP code happens to be. But far too many don't, and that's got to change. Today I hope we will take a critical step forward toward the goal of providing every Michigan resident with access to quality mental health services by passing this bill—Senate Bill No. 714. If we do, we will be providing our local communities with resources for jail diversion, new treatment units to reduce emergency room overcrowding, and substance abuse programs. We'll also be investing significantly in our community hospitals, giving them additional resources to increase bed capacity and make needed structural improvements. And, we'll help attract and retain mental health professionals. We'll also be investing in programs specifically designed to more proactively address mental health risks amongst our children.

Mr. President, I've said this before and I'm not proud to say it again, Michigan's mental health system is failing patients, their families, providers, and taxpayers. This bill is a piece—an important piece—of what I hope is a comprehensive plan to address this broken system. I see this plan having at least four steps. First, targeted strategic investments, and this bill is a good start. **Secondly, challenging ourselves to honestly evaluate policy constraints holding us back from solving the**

chronic issues that have plagued our system to date. Third, committing to a new governance model that is based on honestly informing, sincerely inspiring, enthusiastically encouraging and most importantly, trusting citizens to do the right thing. Fourth, and this is really important, enlisting every citizen of our state to play their role in this effort. This cannot be just another government program. We need to make everyone aware of the importance of mental health and how and where they and their loved one, their neighbor, their co-worker can receive quality care when needed.

Mr. President, I don't pretend in any way to have all the answers, but I am confident in one thing. If we're going to change the trajectory of our mental health in Michigan, it cannot be a government program and it has to include the broadest definition of the word 'We' for every citizen in this state. I ask for your support of this important next step

Alan Bolter
Associate Director
Community Mental Health Association of Michigan
426 South Walnut Street, Lansing MI 48933
(517) 374-6848 Main
(616) 340-7711 Cell

email correspondence

From: Info CMHAM <info@cmham.org>
Sent: Tuesday, June 7, 2022 9:18 AM
To: Carol Balousek (NMRE)
Subject: ACTION ALERT - SBs 597 & 598 may come up for a vote soon
Attachments: 2022 CMHA CCGP Factsheet v5.pdf

Call to Action

As you may know, Senate Bills 597 & 598 were close to passing the Michigan Senate back in early March, new versions of the bills continue to get worse and will most likely change again on the Senate floor. **Rumors are swirling that Sen. Shirkey may try to push SBs 597 & 598 out of the Senate sometime in the next two weeks.**

Senate Bills 597 & 598 attempt to reboot the failed section 298 effort from a few years ago. This legislation would privatize all Medicaid mental health services by giving full financial control and oversight or decision making to for-profit insurance companies. Supporters of Senate Bills 597 & 598 make a lot of false promises, do not be fooled these bills are a shell game, just shifting who pays the bills for a small fraction of people in the Medicaid program.

REQUEST FOR ACTION: **We are asking you to reach out to your legislators (House & Senate) and the Governor and URGE them to reject these bills when they come before them for a vote. We need to get as many Senators to oppose SBs 597 & 598 as possible. This approach is nothing more than a health plan money grab, these bills will not improve care for Michigan's most vulnerable citizens, and it will give control to entities who have not proven they can do the job – this is BAD public policy.**

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**. This will not be the last action alert we send out on this topic, but it is critical that lawmakers hear from us – there has been tremendous turnover in the Michigan Legislature since 2016 (when 298 first appeared) this will be the first time many lawmakers are hearing about this issue.

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

Click the link below to log in and send your message:
https://www.votervoice.net/BroadcastLinks/4IN7l5IH-Cz8N5obBBMXCA

SB 597 & 598:
The Wrong Step At The Wrong Time

Dangerous, Costly & Bad for Michigan

Community Mental Health Association of Michigan

Recent legislation sponsored by Senate Majority Leader Mike Shirkey attempts to reboot the failed section 298 effort from a few years ago. This legislation would privatize all Medicaid mental health services by giving full financial control, oversight, and decision making to for-profit insurance companies. Supporters of Senate BIlls 597 & 598 make several false promises. Do not be fooled--these bills are a shell game--simply shifting who pays the bills for a small fraction of people in the Medicaid program.

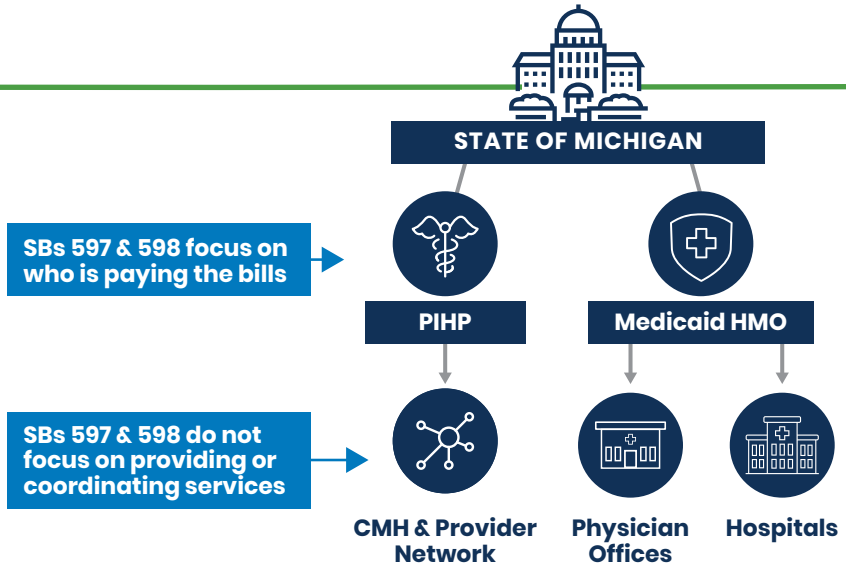
CCGP

- Care
- Governance
- Cost
- Performance

Care

Senate Bills 597 & 598 only focus on CONTRACTS and MONEY, they are NOT focused on people.

The only thing these bills integrate is funding. They do not integrate care and will not improve access to care or provide better outcomes for Michiganders.



Cost

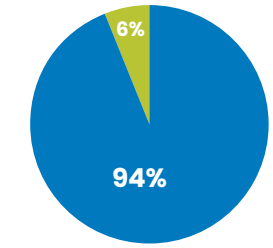
This proposal will dramatically increase the costs of services WITHOUT an increase in the services delivered. This will ultimately lead to an overall reduction in services.

Michigan Medicaid Health Plans showed record profits in 2020 with over $550 million.

Health plans double the overhead of the current public system

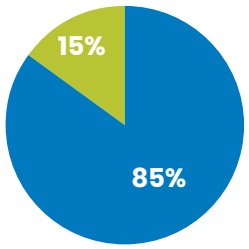
Current administrative overhead – Health Plans 12-15% vs Public Mental Health Systems (PIHPs) 6% = $200,000,000 - $400,000,000 MORE in costs without providing additional services or guaranteeing better quality or outcomes. Overall there will be less money available for needed services.

Resources for Care



- Dollars for services
- Public system admin

Resources for Care



- Dollars for services
- Health plan admin

Governance

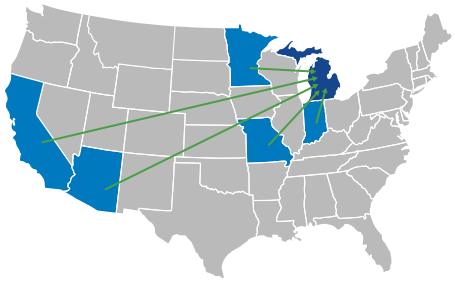
Senate Bills 597 & 598 eliminate local control and local decision making from our communities and give our money and mental health care decisions to out-of state based insurance companies **These changes will cause care decisions to be made in corporate board rooms hundreds or thousands of miles away.**

Local County Board of Commissioners, sheriffs & judges will have zero input on decisions made for their communities by insurance companies. Who will they call during a crisis? A 1-800-NUMBER?

Many of Michigan's large Medicaid Health Plans are based in other states:

- Missouri
- Minnesota
- California
- Indiana
- Arizona

Decisions made elsewhere are impacting lives in Michigan.



Performance

Health plans do not have a good track record on behavioral health. Currently they are responsible for the Medicaid mild to moderate benefit for mental health services.

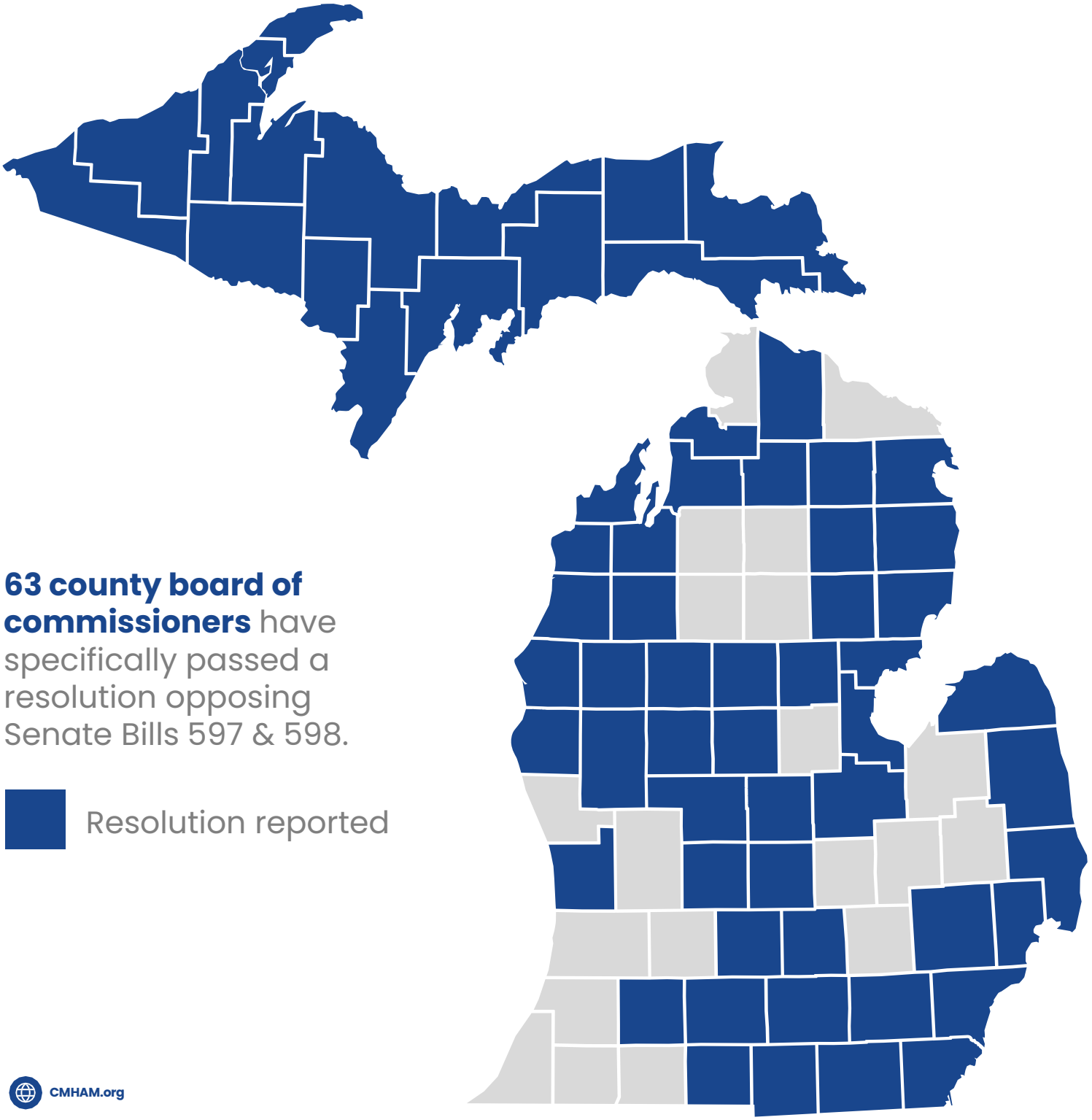
The 2021 National Committee for Quality Assurance (NCQA) annual report card rating for Michigan's private Medicaid health plans show that for the 8 key areas for treatment Michigan's health plans average less than 2.4 out of 5 stars in the "Mental and Behavioral Health" category. **This is a FAILING GRADE.**

In July 2019, the Health Endowment Fund Commissioned a report - Access to Mental Health Care in Michigan. **This report showed the area of greatest unmet need for Adults with Mental Illness (AMI) in Michigan is mild-to-moderate conditions, which was almost double the rate of more serious conditions such as bipolar or recurrent depression.**

Empty Promises

Support Local Control & Local Decision-Making

Community Mental Health Association of Michigan



63 county board of commissioners have specifically passed a resolution opposing Senate Bills 597 & 598.

Resolution reported

Michigan Psychiatric Care Improvement Project (MPCIP)

June 2022 Update

Overview

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

Two Part Crisis System

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

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

Opportunities for improvement

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

In March 2022, Michigan Department of Health and Human Services had a significant reorganization for behavioral health services. Crisis services that were previously under the Behavioral Health and Developmental Disability Administration for the most part fall under the new Crisis Services Section in the Community Based Services Bureau in the Behavioral and Physical Health and Aging Services Administration (BPHASA).

988/MICAL IMPLEMENTATION

988 is the new 3 digit dialing code for the National Suicide Prevention Lifeline. The MiCAL and 988 sections of this report are being combined because MiCAL staff will answer 988 calls, texts, and chats statewide.

Michigan Crisis and Access Line Overview

- For questions or comments specifically related to MiCAL, please contact MDHHS-BHDDA-MCAL@michigan.gov.
- Legislated through PA 12 of 2020 and PA 166 of 2020.
- Overall Model: One statewide line which links to local services tailored to meet regional and cultural needs and is responsible for answering Michigan 988 calls based on SAMHSA's model. It will provide a clear access point to the varied and sometimes confusing array of behavioral health services in Michigan.
- Supports all Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. Warm hand-offs and follow-ups, crisis resolution and/or referral, safety assessments,24/7 warm line, and information and referral offered.
- MiCAL will not replace CMHSP crisis lines. It will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, Mobile Crisis Teams and Crisis Stabilization Units.
- Common Ground is the MiCAL staffing vendor.
- Pilot start date: Upper Peninsula and Oakland April 2021; Operational Statewide October 2022.
- MiCAL Rollout: MiCAL will rollout statewide in two phases.
- Phase 1 FY 22: Starting in January 2022, MiCAL will rollout statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time.
- Phase 2 FY 23: CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout will occur one PIHP at a time. Afterhours coverage services are currently provided as a pilot in the Upper Peninsula.

- Michigan Peer Warmline is operated under MiCAL by Common Ground. It is statewide. It operates 10 am to 2 am 7 days per week.

988 Overview

- For questions/ comments please contact MPCIP-support@mphi.org.
- **988** is the new three digit dialing code for the National Suicide Prevention Lifeline. It is not a new crisis line. It is managed by Vibrant at the Federal Level.
- **988 Expanded Purpose**: With the addition of 988, the Lifeline is expanding crisis coverage for all behavioral health/ emotional crises in addition to people feeling suicidal.
- Per the FCC, by July 16, 2022 all telecom carriers must activate the 988 dialing code.
- **988 Implementation Plan**: Michigan completed an extensive 988 Implementation planning process with stakeholder involvement which was funded by Vibrant. Michigan's Official 988 Plan was submitted to Vibrant and SAMHSA on January 21, 2022.
- **Michigan Coverage**:
    - Over the next several months to a year, Michigan will transition from a regional call coverage system to statewide call coverage through MiCAL except for Network 180 covering Kent County and Macomb CMH covering Macomb County.
    - MiCAL will also be responsible for answering 988 chats and text as well. MDHHS is working our MiCAL contractor Common Ground on developing a roll out plan for chat and text.
- Vibrant is contracting with federally funded **back up centers** to answer call, chat, and text overflow.
- **Public Relations**: Michigan is choosing to do a soft rollout per Vibrant's guidance. This means we will wait to send out public marketing materials until we are confident that the Michigan infrastructure is fully operational and adequately staffed. We anticipate starting marketing in early 2023.

Current Activities for 988/MiCAL

- MDHHS received a 2 year SAMHSA 988 Implementation grant mid April. Key focus areas are: adequate statewide coverage, common practices for centers, stakeholder engagement/marketing, stable diversified funding, and 911/ 988 collaboration.
- **As of June 1st, Michigan has active instate coverage for all 988 calls originating from Michigan counties**.
- MiCAL is rolling out care coordination protocols with publicly funded crisis and access services (CMHSPs, PIHPs, state demo CCBHCs, and CMHSP contract providers). Coordination is in place with services in Prepaid Inpatient Health Plan geographic regions 1, 2, 3, 5, 8, and 10. It will be coordinated with Region 6 by the end of June. It will be coordinated with all regions by the end of October. Map of the Prepaid Inpatient Health Plans (michigan.gov).
- MDHHS is developing a stakeholder engagement plan with an emphasis on marketing to high-risk groups through trusted community partners. MDHHS will re-activate it's 988 Stakeholder Group in late July to help with develop this marketing plan. Stakeholders receive this newsletter to help keep them informed.
- MDHHS is setting up a 988 website.
- MDHHS staff are presenting on 988 and the crisis services system at stakeholder conferences and meetings.
- 988 Center Practices: Operations workgroup meetings with current 988 centers are focused on developing common practices around Imminent Risk, Active Rescues and Follow Up.
- 911/988 Collaboration: State level 911/988 workgroup is meeting at least monthly to develop collaborative practices, with the initial focus on coordinated active rescues.
- Common Ground is onboarding new staff for 988 go live.

- MiCAL integration with OpenBeds/MiCARE is in progress.

Current Activities for Michigan Peer Warmline and Frontline Strong Crisis Line

- There have been 36,482 Warmline encounters since go-live at the end of April 2021.
- There have been 35,689 MiCAL encounters since go-live on April 19, 2022 (this includes MiCAL number, NSPL, and CMHSP afterhours calls).
- Frontline Strong First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development. Staff recruitment is underway. Common Ground has hired a Project Manager who brings a wealth of first responder, training, and crisis line experience. Crisis line is estimated to go live in late Summer 2022.
- Michigan Peer Warmline is refining data gathered during the call, i.e. reason for the call and services provided.

CRISIS STABILIZATION UNITS

Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
- MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders. Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.
- Timing: Michigan Model developed by 12/1. Draft Certification rules will be developed by summer 2022, draft administrative rules and draft Medicaid policy will be completed by September 30, 2022.

Current Activities

- Draft Certification Standards deadline is being extended to summer 2022. A small subset of the stakeholder group is developing draft certification criteria for adults. There is special attention being paid to congruency with funding requirements, licensing requirements of related services, and accreditation. PSC extensive research on best practices in other states is being incorporated in the model.
- MDHHS is exploring internal staffing needs for CSU certification.
- PSC is looking at available statewide data to help determine capacity needs. They are also using the new Crisis Talk Crisis Services Calculator.
- PSC is also researching funding models for this service.
- The Michigan Model is being tailored to the needs of Children and Families. Stakeholder meetings will be held in in late summer.

ADULT MOBILE CRISIS INTERVENTION SERVICES

Overview

- Mobile crisis services are one of the three major components that SAMHSA recommends as part of a public crisis services system.
- MDHHS goal is to eventually expand mobile crisis across the state for all populations, taking advantage of the enhanced Medicaid match.
- MDHHS has contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan, with special attention on strategies for rural areas.
- Per Diversion Fund legislation MDHHS will pursue the advanced Medicaid match and ensure that the model meets requirements.
- There is coordination with the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS)

Target Date: September 2022

Current Activities –

- Multiple parts of MDHHS are working on expanding mobile crisis services: Diversion Council, BCCHPS, and Bureau of Community Based Services. Internal meetings are occurring to ensure that models for children/families and adults stay aligned whenever possible.
- PA 162 and 163 of 2021 set up a Diversion Fund and pilot program for mobile crisis. MDHHS is coordinating internally around implementation plans, prior to stakeholder involvement.
- PSC is coordinating work with the Diversion Council and Wayne State Center for Behavioral Health Justice (CBHJ) who are also focused on looking at adult mobile crisis models.
- Public Sector Consultants is pulling together legislative and funding requirements and best practices to develop a draft model for adults.

MI-SMART (MEDICAL CLEARANCE PROTOCOL)

Overview

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

Current Activities:

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- As of 6/15/22: Adopted/Accepted by: 49 Emergency Departments, 24 Psychiatric Hospitals, 13 CMHSPs.
    - 34 more facilities are pursuing the implementing at their facility, including Sparrow Health and LifeWays.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption
- Partnering with MHA to distribute a survey targeted to provider groups with the goal of outreach and recruitment.

- Developing a commitment letter for Psych hospitals, CMHSPs, and EDs to sign.
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MiSMART can help meet.
- Partnering with MHA Keystone to develop a Quality Improvement project for statewide medical clearance.
- Transitioning Medical Clearance Workgroup to an Advisory Group.
- Record high COVID numbers in Emergency Departments are impeding progress

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

- **For questions/ comments on the psychiatric bed registry implementation please contact MPCIP-support@mphi.org.**
- For questions on the MiCARE/Openbeds platform, please contact Haley Winans, Specialist, LARA, WinansH@michigan.gov.
- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.
- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- The Psychiatric Bed Registry is housed in the MiCARE/ OpenBeds platform which is Michigan's behavioral health registry/ referral platform which is operated and funded by LARA.
- MiSMART will eventually house all private and public Behavioral Health Services and will have a public facing portal.
- The Psychiatric Bed Registry Advisory Group's purpose will transition from choosing a platform to supporting successful rollout and maximization of the OpenBeds platform to meet Michigan's needs.
- LARA is rolling out MiCARE regionally with a statewide completion date by mid-2022.
- Target audience: Psychiatric Hospitals, Emergency Departments, CMHSP staff, PIHP staff.
  - Public and broader stakeholder access through MiCAL.
  - Broad cross-sector Advisory Workgroup.
- Target Implementation Date: Implemented statewide by June / July 2022.

Current Activities

- LARA is in the process of rolling out MiCARE statewide a PIHP region at a time. The focus is on substance use disorders treatment services. They have met with provider entities in 5 of 10 PIHP regions. They recently held a meeting to start the rollout process for providers in the remaining PIHP regions. They will reach out shortly to CMHSPs to bring them on as searchers. Please watch for emails.
- Targeted rollout to psychiatric hospitals was paused due to this last wave of COVID. The Onboarding date was pushed back from February 2022 to June 30,2022.
- Psychiatric hospitals are being encouraged to onboard as they are able. There are 58 facilities. 70% attended the initial orientation.
- MDHHS PBR Implementation Team is developing a survey of psychiatric facilities for a status on MiCARE implementation which will be distributed before the end of June.
- LARA reached out to all psychiatric hospitals earlier this month to offer help with onboarding.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e. bed categorization, acuity, the rollout, and referral process.
- MDHHS PBR Implementation Team held a listening session with psychiatric hospitals to have an indepth discussion on how we can successfully implement MiCARE in Michigan. They will hold similar sessions with staff from CMHSPs and from Emergency Departments.

MDHHS Customer Relationship Management (CRM) – Internal Business Processes

Overview

- **For questions or comments specifically related to the CRM, please contact** MDHHS-BHDDA-MCAL@michigan.gov.
- Behavioral and Physical Health and Aging Services Administration (BPHASA) will transition its internal business processes to a customer relationship management (CRM) system. The Behavioral Health CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between BPHASA and its customers: PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.
- The development process includes written documentation of the business process, describing the process and highlighting requirements, and the translation of the business process into technology. All this information is included in the user training.
- Stakeholders for each process are actively engaged throughout the design process and user testing.
- Training materials on the CRM and each of the business processes are housed within the CRM. Training materials include videos and written job aids.
- Virtual, synchronous training and "Learning Lab hours" are held when a business process goes live.
- Completed Processes: Customer Service Inquiry, CCBHC Certification, ASAM Level of Care

Current Activities

- Universal Credentialing (PA 282 of 2020): Stakeholder workgroup composed of representatives from CMHSPs, PIHPs, and BPHASA is meeting regularly to develop the business process for Universal Credentialing. After this step is complete then the Stakeholder group will participate in automating the business process in the CRM.
- Specialty Program Certifications: Business Process development has been completed. Requirements for CRM development is in progress. Programs included are: homebased, ACT, intensive crisis stabilization, clubhouse, therapeutic foster care, crisis residentials, and wraparound.
- The Critical Incident Database project has been developed in the CRM. The manual entry is in the testing training phase. There is work still being done offering an integration opportunity with electronic health records. A training and rollout plan is being developed. Everyone will be trained and onboarded by mid September, 2022.
- CMHSP Certification: The CRM work is complete. Rollout plans and training have been developed. This process will rollout to CMHSPs about 4 months prior to their certifications coming due. The first group of CMHSPs received notification earlier this week.

QUESTIONS OR COMMENTS:

- Please contact MPCIP-support@mphi.org to be added to the distribution list for this update. Community Mental Health Association of Michigan distributes this document to its' members.
- Krista Hausermann, LMSW, CAADC, Strategic Initiative Specialist, MDHHS
  HausermannK@Michigan.gov

COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN

BOARD OF DIRECTORS

CEO Report:
Selected Items

June 2022

1. ADVOCACY AROUND SYSTEM REDESIGN PROPOSALS IN STATE LEGISLATURE

Talking points and infographics in opposition to proposals

- SB 597 & 598: The Wrong Step at the Wrong Time: Dangerous, Costly & Bad for Michigan:
- Wrong Step at the Wrong Time: Care Cost, Governance, Performance
- These stars do not align with quality behavioral health

Large and diverse coalition opposing bills

- Over 100 organizations have joined CMHA in opposing these bills

"Within Our Reach" concrete approaches to advancing the system

- CMHA and its members proposed a number of concrete actions to advance the system: Within Our Reach: Concrete approaches to building a world class public mental health system in Michigan.

Action Alerts & Petition

- A series of Action Alerts resulted in over 14,000 e-mails to Michigan legislators (each from a constituent in the legislator's own district), with nearly 4,500 e-mails sent to Michigan's Governor.
- Petition found on CMHA's Advocacy webpage has garnered thousands of signatures

Strong alliance with Michigan counties and the Michigan Association of Counties (MAC)

- MAC's Podcast 83 interviews Alan Bolter about threat to local control in Senate Bills 597-98
- MAC's advocacy platform allows for voices of counties to express opposition to bills
- MAC talking points sheet on SB 597& 598mental health legislation for members' use
- Sixty-two Michigan counties have passed resolutions in support of local control and against SBs 597-98.

Illustrated video highlighting the dangers of the bills

- Illustrated video outlining, in accessible terms, the dangers of SB 597 & 598

Series of social media posts

- A set of to-the-point social media posts and their increased visibility through "buying up" CMHA's social media ad visibility

First-person hard-hitting video

- Hard-hitting video with high production values posted on social media and websites of partners: "They must think that we are not paying attention; enough is enough".

Public opinion polling

- Public opinion polling by renowned polling firm, EPIC-MRA showed strong opposition to the aims of SB 597 & 598. Press release announcing the poll results.

Multi-state analysis of impact of privatized system management

- Study of the impact of the movement of the management of 6 state's Medicaid behavioral health benefit to private health plans. This study was released by the Center for Healthcare Integration and Innovation (CHI2), the research and analysis arm of CMHA. This is the 3rd such study conducted by CMHA.

Frequent and accurate press coverage generated by continual media relations

- A sample of these media stories are found on CMHA's Advocacy Resources page

Regular periodic advocacy briefings

- CMHA staff holding live virtual updates on this advocacy effort and the status of the bills

Active dialogue with State Legislators, Governor's office, and MDHHS leadership

- Regular dialogue around these bills with key Senators and Representatives, the Governor's Office, and the leadership of MDHHS

Electronic media messages

- Daily messages in MIRS and Gongwer – the two most respected sources of Capitol news – underscoring opposition to these bills. These messages are found on CMHA's Advocacy Resources webpage.

2. ADDRESSING WORKFORCE GAP AND ADMINISTRATIVE BURDEN

Workforce gap (recruitment and retention)

- Longstanding partnership with range of DCW/DSP coalitions
- Partnership with MDHHS, MDE, LEO, WSU, NASW on budget proposals – loan repayment, stipend
- Recent development of comprehensive set of proposed actions – resulting in active dialogue with MDHHS leadership

Administrative burden

- Longstanding work with MDHHS and legislature regarding unnecessary administrative burdens and paperwork
- H2015, Financial reporting complexity
- Recent development of comprehensive set of proposed actions – resulting in active dialogue with MDHHS leadership

3. BEHAVIORAL HEALTH AND JUSTICE EFFORTS:

Efforts to provide incompetent to stand trial (IST)-related services in community settings

- Working to develop legislation and practices to support these efforts

Diversion efforts using the sequential intercept model

- From mobile teams to treatment courts, in-jail services to post-release supports

Efforts to support the use of sound Assisted Outpatient Treatment (AOT) across Michigan

- Partnership with the WSU Center for Behavioral Health and Justice: https://behaviorhealthjustice.wayne.edu/

4. EDUCATION AND TRAINING – CONTINUAL GROWTH

Continually growing set of offerings on evidence-based and promising practices via MDHHS-CMHA partnership

https://www.cmham.org/education-events/conferences-training/

Recently developed partnership with Georgetown University

CMHA recently hosted Georgetown University's national conference "Infant & Early Childhood Mental Health Consultation: Equity from the Start". https://www.ecmhc.org/

CMHA-designed offerings & in partnership with SAMHSA's MHTTC

CMHA continues to develop a range of association-designed and sponsored offerings, often in partnership with groups, including the SAMHSA-funded Great Lakes Mental Health Technology Transfer Center. https://www.ecmhc.org/

5. MENTAL HEALTH AND SCHOOL-AGED CHILDREN

Partnership with MDE and other stakeholders around: 31n initiative and mental health workforce

Multi-year partnership with K-12 community on a range of mental health issues

Formation of K-12 based Behavioral Health Learning Community (BHLC)

Founding organization of BHLC around a comprehensive statewide resource to address mental health needs of school-age children and adolescents. https://www.bhlcofmi.org/

Sound Science-Based Behavioral Threat Assessment

Working with mental health, education, and public safety leaders from across Michigan to ensure the use of sound behavioral threat assessment and prevention efforts in schools and communities. 1,300 participants in CMHA-sponsored session on BTA management

6. MICHIGAN'S BEHAVIORAL TELEHEALTH RESOURCE CENTER

Diverse Advisory Group & link to national resources

- Clinicians and administrators from CMHA members & state's major advocacy groups
- Link to Center for Connected Health Policy, Upper Midwest Telehealth Resource Center
- Guiding Center's policy recommendations to MDHHS and surveying of stakeholders

Policy guidance & dialogue with MDHHS

- On-going dialogue with MDHHS around recommendations around temporary and permanent behavioral telehealth policy
- Regular updates on telehealth use patterns

Obtaining voice of stakeholders

- Conducted statewide surveys of clinicians, clinical supervisors, and persons served on use of behavioral telehealth
- https://www.cmham.org/resources/telehealth/

7. WORK WITH NATIONAL ASSOCIATIONS

National Council for Mental Wellbeing

- All CMHA members are National Council members
- CMHA serve as liaison to National Council on statewide issues
- CMHA draws upon CCBHC, national legislative and policy, legal counsel, and other resources from National Council
- CMHA is co-leading effort on efforts to protect and strengthen the nation's mental health safety net

National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)

- All CMHA members are NACBHDD members
- CMHA links to national legislative and policy work directly related to county-based systems
- CMHA link to NACo via NACBHDD

COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN

CEO REPORT

JUNE 2022

Community Mental Health Association of Michigan

CMHA OVERVIEW

June 2022

Robert Sheehan, CEO,

Community Mental Health Association of Michigan

Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan (CMH Association or CMHA) is a non- profit trade association with membership made up of:

- 46 public Community Mental Health Service Programs (CMHSP)
- 10 public specialty health plans [Prepaid Inpatient Health Plans (PIHP)] – created and governed by the CMHs
- Over 100 affiliate members (provider organizations and other stakeholders)

Purpose of CMHA

- Promote, maintain and improve a comprehensive range of community-based mental health services, which enhance the quality of life, promote the emotional well-being, and contribute to healthy individuals, families, and communities

Strategic platforms for CMHA's work

- Strategic Platform 1: government relations/advocacy
- Strategic Platform 2: education and training
- Strategic Platform 3: policy and data analysis
- Strategic Platform 4: linking with information, resources, partnerships; representation of members interests in a range of policy making settings
- Strategic Platform 5: media and public relations

1. Strategic platform: government relations and advocacy

Advocacy agenda	Develop, with approval by Legislative and Policy Committee, and Association Executive Board, biennial Legislative Advocacy Agenda – which guides advocacy work
Advocacy via partnerships	Provide legislative and public policy advocacy, often in partnership with multi-client lobby firms on contract with CMHA, and a range of stakeholders and allies, on behalf of CMHA and its membership
Grassroots advocacy	Develop and implement a wide range of advocacy tools- many of which are designed to support grass roots advocacy by CMHA members and allies

Strategic platform: government relations and advocacy

Analysis of legislation and MDHHS budget	Analyze MDHHS budget, from Governor's recommended budget, through both houses, to passage signing – keeping members aware of changes
Financial support for state elected officials	Support, via PAC and Advocacy Fund, those in the State Legislature and Governor's Office who are allied with the advocacy agenda of CMHA and its members
Federal Hill Day	Organize Michigan delegation to National Council Hill Day event in Washington DC

2. Strategic platform: education and training

Provide over 250 conferences and trainings to over 20,000 participants per year

Focusing on evidence-based and promising practices covering over 30 topic areas

Face-to-face; virtual/webinar; one-time and learning community formats

Education and training partnerships with:

- MDHHS
- National Council for Mental Wellbeing
- National Association of County Behavioral Health & Developmental Disabilities Directors (NACBHDD)
- Michigan Health Endowment Fund
- Robert Wood Johnson Foundation
- SAMHSA Great Lakes Mental Health Technology Transfer Center (MHTTC)
- Georgetown University

3. Strategic platform: policy and data analysis

- **CMHA's Center for Healthcare Integration and Innovation (CHI2)** regularly issues white papers on a range of policy areas (posted on CMHA website)
- CHI2 researchers, analysts, and authors drawn from national and state-level policy consultants, fiscal analysts on contract with CMHA, graduate social work students, and CMHA staff

Strategic platform: policy and data analysis

- **In-depth quantitative analyses** that make sense out of the large volume of data generated within and outside of Michigan's public mental health system, for both technical and lay audiences and policy makers, key trends
- These analyses have been key in the government relations and advocacy work of CMHA and its allies

4. Strategic platform: linking and representation

Link CMHA and its members with information, resources, media, partners:

- Modern, comprehensive, and easy-to-navigate **website**
- **Weekly Update:** providing up-to-date information on a range of topics of interest and value to CMHA members
- **Connections:** journal, electronically published periodically and frequently throughout the year

Strategic platform: linking and representation

Represent CMHA and involve members in a range of policy making venues – state and national

Negotiate, on behalf of all 46 CMHSP members, the CMHSP contract with MDHHS

Speak at member- and ally-sponsored events across the state

Maintain an active media-relations initiative with a national associations

5. Strategic platform: media and public relations

- **Obtain media – traditional and social media- coverage** for themes within the Advocacy agenda of CMHA and the work of CMHA and its members.
- **Celebrating the strength and performance** of the state's public mental health system.
- **Pre-empting and responding to threats** to the system and mis-statements by opponents to the system

Strategic platform: media and public relations

Advanced social media presence, first person videos, infographics

Joint media efforts with CMHA PR Committee, members, and allies

Media interviews, guest editorials, press releases, press events

Longstanding partnership with experienced PR firm, Lambert, and media outlets across the state

CMHA Governance Structure

- Board of Directors
- (42 Board members)
  - Board and CEO Appointees – elected by each Association region
  - Standing Committee Co-chairs
  - PIHP Representatives
  - Provider Alliance Representatives

Officers (also serve, as a group, as Executive Committee)

- President
- 1st Vice President
- 2nd Vice President
- Treasurer
- Secretary
- Immediate Past President

A limit 2 officers from any one region

Officers are elected at Spring/Summer Member Assembly

Steering Committee

- Standing Committee Co Chairs
- Officers
- PIHP Representatives

The Steering Committee meets during the months that the Executive Board does not. Acts on behalf of the Executive Board – often on time-sensitive issues.

CMHA Regional Structure

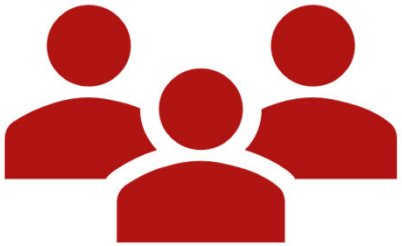
- 6 Regions:
  - Central (9 CMHSPs and PIHPs serving the region)
  - Metro (3 CMHSPs/PIHPs)
  - Northern (5 CMHSPs and PIHPs serving the region)
  - Southeast (8 CMHSPs and PIHPs serving the region)
  - Upper Peninsula (5 CMHSPs and PIHPs serving the region)
  - Western (16 CMHSPs and PIHPs serving the region)

CMHA Structure

- **Children's Issues** - focuses on mental health issues related to children, adolescents, and their families
- **Contract and Financial Issues** - focuses on CMHSP and PIHP contracts with MDHHS and related financial issues; source of membership of CMHSP contract negotiation team
- **Member Services** - develops and guides the delivery of services to Association members, including 3 annual conferences and Boardworks

- **Legislation and Policy Committee** - reviews proposed and passed legislation and the policies, and practices of the executive branch (most often MDHHS) related to mental health, developmental disabilities, and substance abuse issues reviews policies; establishes CMHA's bi-annual Advocacy Agenda
- **Budget and Finance Committee** – reviews and makes recommendations to Board on issues related to financial operations of the Association: budget and budget modifications, dues, audit

- Committees are co-chaired by a CMH or PIHP board member and CMH or PIHP CEO; chairs appointed by President
- Committee vice chairs appointed by committees
- Co chairs are members of Steering Committee and Board of Directors



Attendance at all committees is open to Board and staff of any CMHA member

All are hybrid/teleconferenced to allow for members from across the state to participate

CMHA Staff

Alan Bolter	Associate Director
Christina Ward	Director of Education & Training
Inder Abrol	Chief Financial Officer
Monique Francis	Executive Secretary
Anne Wilson	Training & Meeting Planner
Bethany Rademacher	Training & Meeting Planner
Jodi Hammond	Training & Meeting Planner
Amber Miller	Training & Meeting Planner
Cynthia Wellman	Training & Meeting Planner
Cheryl Bywater	Training & Meeting Planner
Dana Ferguson	Senior Accounting Specialist
Regina MacDonald	Accounting Assistant
Audrey Daul	Administrative Assistant
Robert Sheehan	Chief Executive Officer

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Michigan Integration Efforts

Service Delivery Transformation

June 2022 Update

Overview

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

Goals

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

Opportunities for Improvement

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

Behavioral Health Homes (BHH)

Overview

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

Current Activities:

- As of June 1, 2022, there are 1,225 people enrolled:
    - Age range: 7-85 years old
    - Race: 31% African American, 72% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- On May 1, 2022, The Behavioral Health Home expanded services to 3 counties including Livingston, Washtenaw, and Wayne. Lenawee and Monroe will join the expansion in July 2022.
- Updated resources, including the policy, directory, and handbook, will be available on the Michigan Behavioral Health Home website soon. Behavioral Health Home (michigan.gov)
- The new regions to join the BHH are PIHP Region 6 and Region 7. This expansion added 5 new counties and 21 BHH provider sites.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Certified Community Behavioral Health Clinics (CCBHC)

Overview

- MI has been approved as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state by CMS. The demonstration launched in October 2021 with a planned implementation period of two years. 13 sites, including 10 CMHSPs and 3 non-profit behavioral health providers, are participating in the demonstration. The CCBHC model increases access to a comprehensive array of behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay.
- CCBHCs are required to provide nine core services: crisis mental health services, including 24/7 mobile crisis response; screening, assessment, and diagnosis, including risk assessment; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans.
- CCBHCs must adhere to a rigorous set of certification standards and meet requirements for staffing, governance, care coordination practice, integration of physical and behavioral health care, health technology, and quality metric reporting.
- The CCBHC funding structure, which utilizes a prospective payment system, reflects the actual anticipated costs of expanding service lines and serving a broader population. Individual PPS rates are set for each CCBHC clinic and will address historical financial barriers, supporting sustainability of the model. MDHHS will operationalize the payment via the current PIHP network.

Current Activities

- The CCBHC Demonstration has been operational since October 1, 2021. As of June 1, 2022, 34,291 Medicaid beneficiaries and 5,294 individuals without Medicaid were assigned to the 13 demonstration CCBHC sites. Assignment has increased steadily since the start of the demonstration.
- All 13 demonstration sites have received full certification! Certifications are valid for two years, and demonstration sites will participate in a site visit during demonstration year 2.
- The MDHHS CCBHC Implementation Team has been addressing operational issues that arise as the demonstration moves forward, including assignment and transfer among CCBHCs, encounter reporting, and alignment with existing financial reporting requirements. Updates to technological systems, including the WSA and CHAMPS, are ongoing. A manual detailing metric technical specifications, requirements, and submission procedures is under development and data scoping is underway to evaluate these requirements.
- A dashboard has been finalized to assist in the monitoring of service delivery and payment distribution.
- Funding has been approved to support the costs of CCBHC services to non-Medicaid beneficiaries. CCBHCs are expected to exhaust all other revenue sources, including existing grants, sliding fees, and third-party payments, prior to utilizing MDHHS funds.
- The final CCBHC policy (MSA 21-34) and CCBHC Demonstration Handbook can be found on the CCBHC webpage MDHHS - Provider (michigan.gov). Revisions to the handbook are ongoing.
- A MDHHS marketing campaign remains under development. Marketing is intended to increase awareness of the CCBHC model, eligibility, and services among the public and other community providers. Marketing will target the sixteen counties with demonstration sites. Counties will be prioritized based on CCBHC's level of readiness to accommodate an increased volume of recipients while meeting sufficient access requirements.

Questions or Comments

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

Opioid Health Homes (OHH)

Overview

- Medicaid Health Homes are an optional State Plan Amendment under Section 1945 of the Social Security Act.
- Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration.
- Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.
- As of October 1, 2022, OHH services are available to eligible beneficiaries in 48 Michigan counties. Service areas include PIHP region 1, 2, 6,7, 9, 10 and Calhoun and Kalamazoo counties in PIHP region 4.

Current Activities

- As of June 1, 2022, 2,205 beneficiaries are enrolled in OHH services.
- MDHHS has expanded OHH services to an additional nine counties within PIHP region 6, 7, and 10 in. Existing OHH's are expanding access with new providers and growing services for more beneficiaries. There are currently 38 Health Home Partners providing services to OHH beneficiaries.
- MDHHS is potentially looking to expand OHH services statewide in FY23.
- MDHHS is working on collaborating with many state agencies such as the Maternal and Infant Health division to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

- Kelsey Schell (schellk1@michigan.gov)

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

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

- Saginaw County: Saginaw County Community Mental Health and Great Lakes Bay Health Centers
- Shiawassee County: Shiawassee County Community Mental Health and Great Lakes Bay Health Centers to increase primary care

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.
- Shiawassee and Saginaw counties are starting to see shared patient data in Azara DRVS. Both counties are finalizing data validation and will move toward training and adoption of the system.
- Barry County attended their kickoff and are currently mapping and validating data.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Michigan Department of Attorney General

Opioid Settlements

WHOLESALE DRUG DISTRIBUTORS AND JANSSEN

Background

By 2017, over 2,000 federal lawsuits had been filed by government entities against opioid-related defendants. Among those defendants were opioid distributors and manufacturers.

In 2017, a federal judicial panel consolidated these cases into multidistrict litigation (MDL).

- The MDL was consolidated under one judge in the Northern District of Ohio.

In 2019, after receiving pressure from the MDL judge, three of the nation's largest drug distributors—McKesson, Cardinal Health, and AmerisouceBergen—agreed to settlements. Janssen, an opioid manufacturer, also agreed to settlement.

In 2021, the details of the settlement were released.

Who is settling?

Three of the Nation's largest wholesale drug distributors: McKesson, Cardinal Health, and AmerisourceBergen

- This includes several thousand subsidiaries of these companies.

Opioid manufacturer Janssen, a subsidiary of Johnson and Johnson.

What is being settled?

Many governments have agreed to release certain legal claims against these defendants, related to opioids.

In exchange for government's releasing those claims, the defendants have agreed to do certain things and pay money.

- Doing certain things is known as injunctive relief.
- Paying money is known as monetary payments.

What do the defendants have to do?

Janssen (Opioid Manufacturer), for 10 years, has agreed to:

- Stop selling and manufacturing opioids
- Stop promoting opioids
- Stop providing financial incentives to sales teams for opioid sales
- Stop lobbying for federal, state, local, and regulatory provisions that encourage or require health care providers to prescribe opioids
- Stop lobbying against federal, state, local, and regulatory provisions that
  - Support non-opioid pain relief
  - Prescribing the lowest effective dose
  - Prescribing naloxone and using urine testing for those with opioid prescriptions
  - Support evidence-based treatments (like MAT)

What do the defendants have to do?

The Distributors have agreed, for a period of 10 years, to:

- Create and implement a Controlled Substance Monitoring Program (CSMP)
  - CSMP is responsible for onboarding and approval of new controlled substance pharmacies, setting and adjusting pharmacy thresholds, setting and adjusting pharmacy thresholds, terminating or suspending pharmacies, and identifying red flags.
  - CSMP must conduct ongoing due diligence and conduct site visits, among other things
- Create and implement a National Clearinghouse to receive and analyze data received from this injunctive relief.
  - The Clearinghouse will allow Distributors to obtain comprehensive data from other Distributors , pharmacies, and other relevant sources.
  - States will have access to the data to query without limitation.

What do the defendants have to pay?

The Distributors and Janssen will pay up to $26 billion nationwide.

Michigan will receive up to 3.4%, or approximately $776 million over the course of 18 or less payments.

Payments are unlikely to be the same from year to year because of certain options in the settlement agreement.

Participation of States and eligible local governments is key

Michigan is a participating state and 269 of 278 eligible local subdivisions participated in the settlements

Tribes have a separate settlement.

DISTRIBUTORS: Base and Incentives

Base 55%
Incentives 45%
Net Abatement Amount

Incentives are earned by obtaining releases from subdivisions and limiting additional subdivisions from filing suit.

During the first two years, States that settle are treated as if receiving full base and incentive.

Illustrative only- Executed Agreements Control.

Incentive A

Incentive A provides for payment of all but Incentive D payments in exchange for near full peace.

Incentive A is earned by:

- Passing a Statute or court ruling that terminates existing and bars future claims by subdivisions (including special districts);
- Receiving releases on behalf of (i) all general purpose subdivisions above 10,000 population, (ii) larger school and hospital/health districts, and (iii) all currently litigating subdivisions; or
- A combination of these approaches that results in a complete bar of existing and future claims (e.g., legislation barring future claims combined with 100% participation by litigating subdivisions).

Incentive B

- Incentive B is not relevant if a State earns Incentive A.
- Incentive B is up to 25%.
- Incentive B is earned by obtaining releases from litigating subdivisions.

Incentive B Sliding Scale:

Participation or Case-Specific Resolution Levels	Incentive B Award
85%	30%
86-90%	40%
91-94%	50%
95-99%	60%
99-99.9%	95%
100%	100%

Not structured in time periods, as with Incentive B under the J&J Agreement.

Incentive C

- Incentive C is not relevant if a State earns Incentive A.
- Incentive C is up to 15%.
- Incentive C is earned by getting larger (population of 30,000) non-litigating and any-sized litigating counties and cities to join the deal.

Incentive C Sliding Scale:

Participation, Release, or Resolution Levels	Incentive C Award
60-69%	25%
70-74%	35%
75-79%	40%
80-84%	45%
85-89%	55%
90-92%	60%
93%	65%
94%	75%
95-97%	90%
98-99%	95%
100%	100%

There is no timing element.

Incentive D

5% share of the State's total Abatement Fund allocation (see page 20). Payable starting in year 6 through year 18.

Qualifying Criteria

- State must have had no later Litigating Subdivisions bring suit and proceed past preliminary motions.

Why Participation is Important

JOHNSON & JOHNSON: Base and Incentives

Base 45%

Incentives 55%

Global Settlement Abatement Amount

Incentives are earned by obtaining releases from subdivisions and limiting additional subdivisions from filing suit.

Illustrative only- Executed Agreements Control.

Incentive A

Incentive A provides for payment of all but Incentive D payments in exchange for near full peace.

Earning Incentive A also causes substantial payments, the first three years of payments, accelerated and paid within 90 days.

Incentive A is earned by:

- Passing a Statute or court ruling that terminates existing and bars future claims by subdivisions (including special districts);
- Receiving releases on behalf of (i) all general purpose subdivisions above 10,000 population, (ii) larger school and hospital/health districts, and (iii) all currently litigating subdivisions; or
- A combination of these approaches that results in a complete bar of existing and future claims (e.g., legislation barring future claims combined with 100% participation by litigating subdivisions).

Incentive B

- Incentive B is not relevant if a State earns Incentive A.
- Incentive B is up to 30%.
- Incentive B is earned from obtaining releases from litigating subdivisions.

Incentive B Sliding Scale:

Participation or Case-Specific Resolution Levels	Incentive B Award
75%	50%
76%	52%
77%	54%
78%	56%
79%	58%
80%	60%
85%	70%
90%	80%
95%	90%
100%	100%

Timing element
Incentive B is structured in time periods and states will receive a percentage of sliding scale payments depending on when they reach 75% of litigating subdivisions signed on: (a) 0-210 days = 100% of sliding scale; (b) 211-365 = 75% of sliding scale; and (c) 366-2 years from effective date = 50% of sliding scale.

Incentive C

- Incentive C is not relevant if a State earns Incentive A.
- Incentive C is up to 20%. It breaks Incentive C in two parts.
- Incentive C is earned by getting larger (population of 30,000) litigating and non-litigating counties and cities to join the deal. 5% is awarded for obtaining a State's ten largest general purpose subdivisions (cities and counties).

Incentive C Sliding Scale:

Participation, Release, or Resolution Levels	Incentive C(1) Award
60%	40%
70%	45%
80%	50%
85%	55%
90%	60%
91%	65%
92%	70%
93%	80%
94%	90%
95%	100%

There is no timing element.

Incentive D

5% share of the State's total Abatement Fund allocation (see page 20). Payable starting in year 6 through year 18.

Qualifying Criteria

- State must have had no later Litigating Subdivisions bring suit and proceed past preliminary motions in the 5 years following the Effective Date.

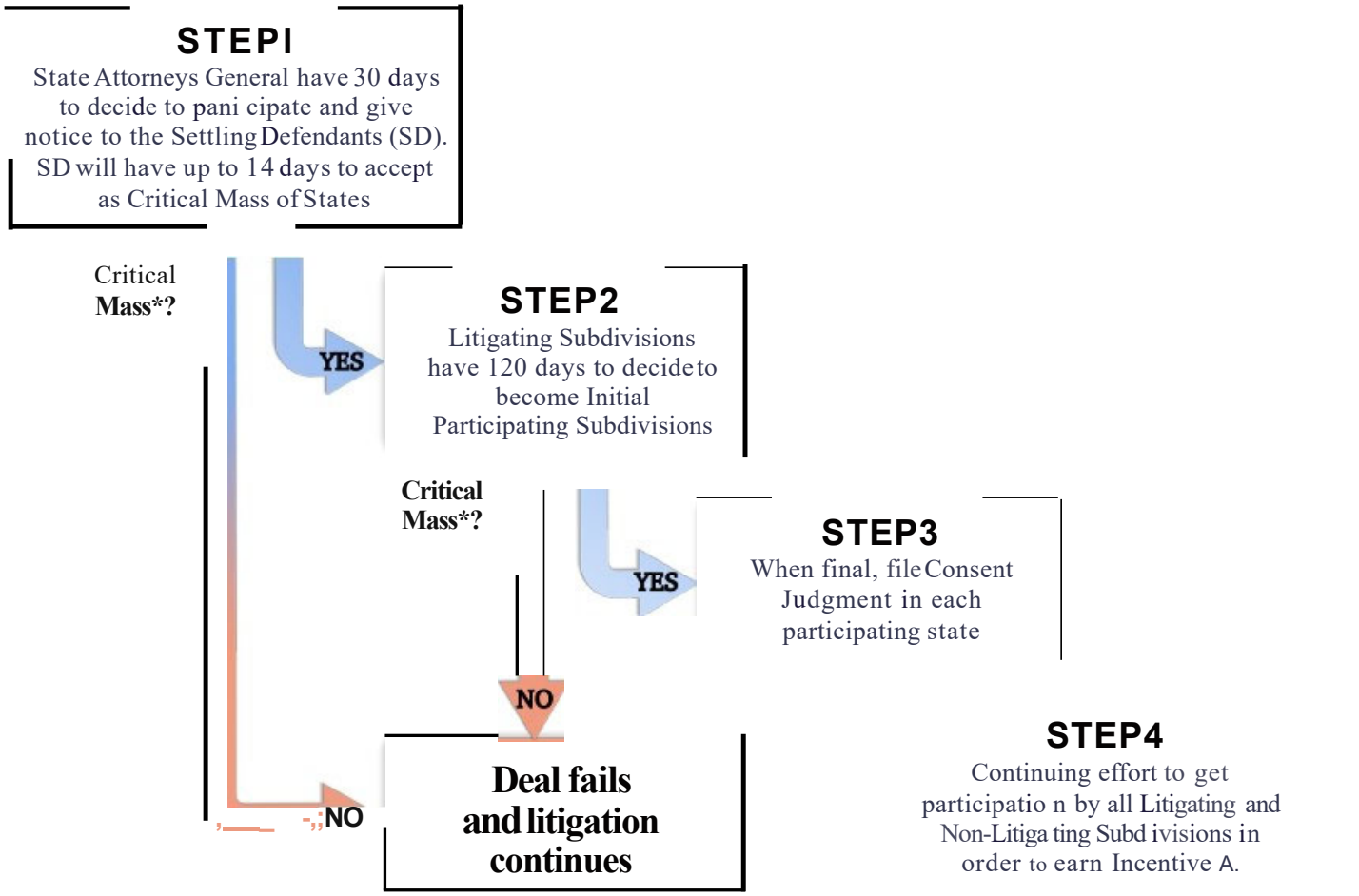
Why Participation is Important

Legislative Effort for Incentive A

Bills were passed to ensure Michigan receives Incentive A:

- SB 993 – Michigan Opioid Healing and Recovery Fund
- SB 994 – Opioid Advisory Commission
- SB 995 – Bar to new civil lawsuits against settling defendants

Implementation



*Solediscretion of Distn"butors & J&J

2021.07.22 Subject to Update & Correction/ Executed Agreements Control

Michigan State-Subdivision Agreement

Available at Michigan.gov/agopioids

- Controls the allocation of funds to the State and Local Subdivisions, instead of what is listed in Master Settlement Agreement.
  - Allocates 50% to Local Subdivisions and 50% to the State. This is instead of 15% to Local Subdivisions, 15% to the State, and 70% to a fund.
  - Deductions for an Administrative Fund, Litigating Local Government Attorney Fee Fund, and Special Circumstance Fund.
- Allocations to individual local subdivisions are determined by a nationally used formula, modified by a litigation adjustment.
- Individual local subdivisions with an allocation percentage of less than .0023% (approx. $7,500 or less in total) will receive their complete recovery in the first payment.
- Local subdivisions may voluntarily assign all or part of their allocation to another participating subdivision.

Michigan State-Subdivision Agreement

Available at Michigan.gov/agopioids

- Attorney fees are limited to 15% of an individual Litigating Local Government's recovery and offset by a National Fee Fund.
  - For example, Subdivision A contracted with Attorney X for a 30% contingency fee. Attorney X's fee is limited to 15% of Subdivision A's recovery by the Michigan State-Subdivision Agreement and by order of the Court. The National Fee Fund pays 7% and the remainder is paid by the Litigating Local Government Attorney Fee Fund. Fees are paid over the course of 7 years.
- Special Circumstance Fund: Local subdivisions may apply for additional funding for any local impact that is not captured by a Local Government's allocation percentage.
  - The application deadline is March 30, 2022, but there is active effort to move this date back because everything is taking longer than expected.

How may settlement funds be used?

Governed by "**opioid remediation**" as defined in the Distributor and Janssen Settlements; Guided by "Exhibit E" of the **Distributor and Janssen Settlements**

- **Opioid Use Disorder** (OUD) Treatment
- Treatment and **Recovery Support**
- **Connecting People** to Help
- Address Needs of **Criminal Justice-Involved Persons**

How may settlement funds be used?

Continued

- Address Needs of **Pregnant Women**, **Infants**, and **Parents**
- **Prevention**
- First Responder **Support**
- **Leadership** Planning
- **Training**
- **Research**

When will payments begin?

Payment #1

Second or Third Quarter of 2022

Payment #2

Second or Third Quarter of 2022

Subsequent payments will be received annually in July.

Contact Information

Matt Walker

- AG-OpioidLitigation@michigan.gov
- 517-335-7042

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00 – JUNE 8, 2022
VIA TEAMS

ATTENDEES:	**Connie Cadarette, Lauri Fischer, Ann Friend, Donna Nieman, Larry Patterson, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey**

REVIEW AGENDA & ADDITIONS
Connie asked to add a discussion about the permanency of the Direct Care Wage (DCW) increase to the meeting Agenda.

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

MOTION BY LAURI FISCHER TO APPROVE THE MINUTES OF THE MAY 11, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

MONTHLY FINANCIALS
April 2022

- Net Position showed net surplus Medicaid and HMP of $11,237,846. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $27,595,963. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $43,954,080.
- Traditional Medicaid showed $116,688,180 in revenue, and $104,588,806 in expenses, resulting in a net surplus of $12,099,374. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $18,544,308 in revenue, and $15,245,225 in expenses, resulting in a net surplus of $3,299,083. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $856,272 in revenue, and $654,027 in expenses, resulting in a net surplus of $202,245.
- SUD showed all funding source revenue of $14,223,951, and $11,886,588 in expenses, resulting in a net surplus of $2,337,363. Total PA2 funds were reported as $5,241,696.

The direct care wage surplus was estimated at $4,160,611.

Connie noted that updated numbers were sent for Northeast Michigan CMHA which are not reflected in this report; she acknowledged that the difference was immaterial for the day's discussion.

Clarification was made that the surplus amounts listed in the Financial Summary page reflect the net after the direct care wage estimates were subtracted.

Deanna mentioned that the May payment included the $2.35/hour DCW in the rates.

MOTION BY CONNIE CADARETTE TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR APRIL 2022; SUPPORT BY ERINN TRASK. MOTION APPROVED.

EDIT UPDATE
Donna reported that the next EDIT meeting is scheduled for July 21st.

EQI UPDATE
Tricia reported that the EQI was submitted by the May 31st due date. A variance report is expected. The next EQI is due on September 30th for October – May. The Mid-Year Status Report is due on June 21st If the Board want to report their estimates , Deanna would like information by June 17th; otherwise, Deanna will trend expenditures from prior periods. The FSR Projection is due August 15th.

PERMANENCY OF THE DIRECT CARE WAGE
As contracts are being prepared for FY23, Connie questioned whether the DCW can be added to the rates. Donna and Lauri each responded that they included the increase in the rates for Centra Wellness and Northern Lakes.

Lauri reported that for "mom & pop" specialized residential providers the $2.35 was rolled in at 90% (11.56% increase); the ending hourly all-inclusive rate for specialized residential providers was calculated at $22.98 (a 4%-5% COLA is also likely).

Erinn reported that AuSable Valley included an increase of approximately 20% to account for staffing shortages, inflation, etc. (closer to 25% for DCW).

Donna reported that Centra Wellness conducted and RFP and landed at an increase of approximately 13% (not inclusive of DCW), although increases were implemented via Contract Addenda throughout FY22.

Deanna reported that NMRE did a 15% increase for FY22 and a 25% increase for FY23.

MDHHS's survey on unit rates for Agency and Self-Directed care was discussed. Jeffery Wieferich indicated that the premium pay should be included for both SD and organizational providers.

Deanna explained that the (gradual) resumption of Medicaid redeterminations at the end of the public health emergency makes FY23 budgeting problematic. Deanna questioned whether the Boards would like to create their budgets based on what they feel they are going to need (as was done for FY22). Erinn stated that Rehmann plans to develop a "projection template" once the rates have been announced by Milliman (July); an assumption regarding the drop in eligibles will have to be built in (as revenue and cash flow will decrease through the year). Deanna noted that the region should enter FY23 with a fully funded ISF and fully funded carry forward. A rate increase is anticipated with a drop in eligibles resulting in an overall decrease in revenue.

During the July meeting, time will be devoted to discussing the FY23 rate setting and budgeting processes.

NEXT MEETING
The next meeting was scheduled for July 13th at 10:00AM via Teams.

Chief Executive Officer Report

June 2022

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

May 27: Attended and participated in PIHP Contract Negotiations Meeting.

June 1: Attended and participated in PIHP CEO Meeting.

June 2: Met with Grand Traverse County and Northern Lakes Administrators.

June 7 & 8: Attended CMHAM Summer Conference.

June 13: Met with MDHHS staff regarding PIHP responsibilities regarding Northern Lakes and Grand Traverse County.

June 15: Chaired NMRE Internal Operations Oversight Committee Meeting.

June 16: Presented on Contract Compliance to Northern Lakes Board Committee of the Whole.

June 17: Attended CMHAM Advocacy Briefing.

June 21: Chaired NMRE Operations Committee Meeting.

Northern Michigan Regional Entity

April 2022 Finance Report

April 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	12,099,374	11,296,867	9,298,368
Healthy Michigan	3,299,083	5,061,250	7,059,749
	$ 15,398,457	$ 16,358,117	$ 16,358,117

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	728,315	1,736,531	3,050,667	3,336,414	611,840	1,276,315	497,764	$ 11,237,846
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 27,595,963
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 43,954,080

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through April 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 113,253,910	$ 2,728,805						$ 115,982,715
CMHSP Distributions	(109,078,112)		36,249,534	29,992,084	18,344,102	14,975,548	9,516,845	-
1st/3rd Party receipts			402,159	-	303,306	-	-	705,465
Net revenue	4,175,798	2,728,805	36,651,693	29,992,084	18,647,407	14,975,548	9,516,845	116,688,180
Expense								
PIHP Admin	1,478,397	29,589						1,507,986
PIHP SUD Admin		34,727						34,727
SUD Access Center		31,851						31,851
Insurance Provider Assessment	778,635	16,119						794,754
Hospital Rate Adjuster	1,262,492							1,262,492
Services		1,980,924	32,349,422	26,788,846	17,838,020	13,072,948	8,926,836	100,956,996
Total expense	3,519,524	2,093,210	32,349,422	26,788,846	17,838,020	13,072,948	8,926,836	104,588,806
Net Actual Surplus (Deficit)	$ 656,274	$ 635,595	$ 4,302,271	$ 3,203,238	$ 809,388	$ 1,902,600	$ 590,009	$ 12,099,374

Notes

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

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through April 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 12,010,770	$ 6,529,565						$ 18,540,335
CMHSP Distributions	(10,711,281)		3,906,129	3,245,145	1,330,757	1,330,437	898,814	-
1st/3rd Party receipts			-	-	3,973	-	-	3,973
Net revenue	1,299,489	6,529,565	3,906,129	3,245,145	1,334,730	1,330,437	898,814	18,544,308
Expense								
PIHP Admin	134,036	71,325						205,361
PIHP SUD Admin		83,711						83,711
SUD Access Center		76,778						76,778
Insurance Provider Assessment	70,236	37,403						107,639
Hospital Rate Adjuster	1,023,176							1,023,176
Services		4,775,110	3,762,901	2,541,939	857,018	1,192,809	618,783	13,748,561
Total expense	1,227,448	5,044,327	3,762,901	2,541,939	857,018	1,192,809	618,783	15,245,225
Net Surplus (Deficit)	$ 72,041	$ 1,485,238	$ 143,228	$ 703,206	$ 477,712	$ 137,627	$ 280,031	$ 3,299,083

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

Direct Care Wage Estimated Surplus	**(384,302)**	**(1,394,833)**	**(570,029)**	**(675,259)**	**(763,912)**	**(372,275)**	**$ (4,160,611)**
Net Surplus (Deficit) MA/HMP/DCW	**$ 728,315**	**$ 1,736,531**	**$ 3,050,667**	**$ 3,336,414**	**$ 611,840**	**$ 1,276,315**	**$ 497,764**	**$ 11,237,846**
Medicaid & HMP Carry Forward								**16,358,117**
Total Med/HMP Current Year Surplus								$ 27,595,963
Medicaid & HMP ISF - based on unaudited FSR								**16,358,117**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 43,954,080**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through April 30, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 213,997		252,698	73,353	49,838	34,395	231,991	$ 856,272
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	213,997	-	252,698	73,353	49,838	34,395	231,991	856,272
Expense								
PIHP Admin	9,594							9,594
BHH Admin	-							-
Insurance Provider Assessment	2,158							2,158
Hospital Rate Adjuster								
Services	-		252,698	73,353	49,838	34,395	231,991	642,275
Total expense	11,752	-	252,698	73,353	49,838	34,395	231,991	654,027
Net Surplus (Deficit)	$ 202,245	$ -	$ -	$ -	$ -	$ -	$ -	$ 202,245

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through April 30, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 2,728,805	$ 6,529,565	$ 2,092,844	$ 1,601,118	$ 1,271,619	$ 14,223,951
Expense						
Administration	64,316	155,036	56,500	92,559		368,411
OHH Admin			70,028	-		70,028
Access Center	31,851	76,778	-	14,882		123,511
Insurance Provider Assessment	16,119	37,403	9,587			63,109
Services:						
Treatment	1,980,924	4,775,110	1,740,199	925,594	1,271,619	10,693,446
Prevention	-	-	-	568,083	-	568,083
State targeted response	-	-	-	-	-	-
Total expense	2,093,210	5,044,327	1,876,314	1,601,118	1,271,619	11,886,588
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 635,595	$ 1,485,238	$ 216,530	$ (0)	$ -	$ 2,337,363

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2021 through April 30, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 113,253,910	$ 2,728,805	$ -	$ 115,982,715
Medicaid Savings	11,296,867	-	-	11,296,867
Healthy Michigan	12,010,770	6,529,565	-	18,540,335
Healthy Michigan Savings	5,061,250	-	-	5,061,250
Health Home	856,272	-	-	856,272
Opioid Health Home	-	2,092,844	-	2,092,844
Substance Use Disorder Block Grant	-	1,601,118	-	1,601,118
Public Act 2 (Liquor tax)	-	1,271,619	-	1,271,619
Affiliate local drawdown	449,800	-	-	449,800
Performance Incentive Bonus	1,363,500	-	-	1,363,500
Miscellanous Grant Revenue	-	21,087	-	21,087
Veteran Navigator Grant	65,794	-	-	65,794
SOR Grant Revenue	-	546,269	-	546,269
Gambling Grant Revenue	-	70,125	-	70,125
Other Revenue	-	-	4,267	4,267
Total operating revenue	144,358,163	14,861,432	4,267	159,223,862
Operating expenses				
General Administration	1,790,604	323,344	-	2,113,948
Prevention Administration	-	48,677	-	48,677
OHH Administration	-	70,028	-	70,028
BHH Administration	-	-	-	-
Insurance Provider Assessment	851,029	63,109	-	914,138
Hospital Rate Adjuster	2,285,668	-	-	2,285,668
Payments to Affiliates:				
Medicaid Services	98,270,607	1,980,924	-	100,251,531
Healthy Michigan Services	8,969,477	4,775,110	-	13,744,587
Health Home Services	642,275	-	-	642,275
Opioid Health Home Services	-	1,740,199	-	1,740,199
Community Grant	-	925,594	-	925,594
Prevention	-	519,406	-	519,406
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	1,271,619	-	1,271,619
Local PBIP	-	-	-	-
Local Match Drawdown	449,800	-	-	449,800
Miscellanous Grant	-	21,087	-	21,087
Veteran Navigator Grant	65,794	-	-	65,794
SOR Grant Expenses	-	546,269	-	546,269
Gambling Grant Expenses	-	70,125	-	70,125
Total operating expenses	113,325,254	12,355,491	-	125,680,745
CY Unspent funds	31,032,909	2,505,941	4,267	33,543,117
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,254,458	6,231,624	16,358,117	24,844,199
Unspent funds - ending	$ 33,287,367	$ 8,737,565	$ 16,362,384	$ 58,387,316

Northern Michigan Regional Entity

Statement of Net Position

April 30, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 25,511,269	$ 7,408,046	$ 16,362,384	$ 49,281,699
Accounts Receivable	39,093,904	2,558,884	-	41,652,788
Prepaids	65,491	-	-	65,491
Total current assets	64,670,664	9,966,930	16,362,384	90,999,978
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	64,670,664	9,966,930	16,362,384	90,999,978
Liabilities				
Current liabilities				
Accounts payable	31,208,002	1,166,920	-	32,374,922
Accrued liabilities	175,295	-	-	175,295
Unearned revenue	-	62,445	-	62,445
Total current liabilities	31,383,297	1,229,365	-	32,612,662
Unspent funds	$ 33,287,367	$ 8,737,565	$ 16,362,384	$ 58,387,316

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2021 through April 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 112,543,137	$ 113,253,910	$ 710,773	0.63%
Carryover	11,296,664	11,296,664	11,296,867	203	0
Healthy Michigan					
Capitation	20,566,272	11,996,992	12,010,770	13,778	0.11%
Carryover	5,061,832	5,061,832	5,061,250	(582)	(0.01%)
Health Home	506,772	295,617	856,272	560,655	189.66%
Affiliate local drawdown	1,204,388	602,194	449,800	(152,394)	(25.31%)
Performance Bonus Incentive	1,334,531	1,334,531	1,363,500	28,969	2.17%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	64,169	65,794	1,625	2.53%
Other Revenue	-	-	-	-	0.00%
Total operating revenue	233,011,551	143,195,136	144,358,163	1,163,027	0.81%
Operating expenses					
General Administration	3,021,688	1,746,603	1,790,604	(44,001)	(2.52%)
BHH Administration	-	-	-	-	0.00%
Insurance Provider Assessment	1,645,387	959,809	851,029	108,780	11.33%
Hospital Rate Adjuster	4,001,228	2,334,047	2,285,668	48,379	2.07%
Local PBIP	1,334,531	-	-	-	0.00%
Local Match Drawdown	1,204,388	602,194	449,800	152,394	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	113,687	65,794	47,893	42.13%
Payments to Affiliates:					
Medicaid Services	173,402,120	101,151,237	98,270,607	2,880,630	2.85%
Healthy Michigan Services	15,233,944	8,886,467	8,969,477	(83,010)	(0.93%)
Health Home Services	456,768	266,448	642,275	(375,827)	(141.05%)
Total operating expenses	200,508,190	116,060,492	113,325,254	2,735,238	2.36%
CY Unspent funds	$ 32,503,361	$ 27,134,644	31,032,909	$ 3,898,265	
Transfers in			-		
Transfers out			-	113,325,254	
Unspent funds - beginning			2,254,458		
Unspent funds - ending			$ 33,287,367	31,032,909	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2021 through April 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 2,565,934	$ 2,728,805	$ 162,871	6.35%
Healthy Michigan	9,763,272	5,695,242	6,529,565	834,323	14.65%
Substance Use Disorder Block Grant	5,709,003	3,330,249	1,601,118	(1,729,131)	(51.92%)
Opioid Health Home	2,320,384	1,353,555	2,092,844	739,289	54.62%
Public Act 2 (Liquor tax)	1,533,979	511,326	1,271,619	760,293	148.69%
Miscellanous Grants	36,335	21,195	21,087	(108)	(0.51%)
SOR Grant	1,215,000	708,750	546,269	(162,481)	(22.93%)
Gambling Prevention Grant	200,000	116,667	70,125	(46,542)	(39.89%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	14,302,918	14,861,432	558,514	3.90%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	589,449	323,344	266,105	45.14%
Prevention Administration	90,144	52,584	48,677	3,907	7.43%
Insurance Provider Assessment	116,901	68,192	63,109	5,083	7.45%
Medicaid Services	3,387,649	1,976,129	1,980,924	(4,795)	(0.24%)
Healthy Michigan Services	7,453,459	4,347,851	4,775,110	(427,259)	(9.83%)
Community Grant	2,077,452	1,211,847	925,594	286,253	23.62%
Prevention	664,967	387,897	519,406	(131,509)	(33.90%)
State Disability Assistance	95,215	55,545	-	55,545	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	70,028	(70,028)	0.00%
Opioid Health Home Services	2,117,226	1,235,052	1,740,199	(505,147)	(40.90%)
Miscellanous Grants	36,335	21,195	21,087	108	0.51%
SOR Grant	1,215,000	708,750	546,269	162,481	22.93%
Gambling Prevention	200,000	116,667	70,125	46,542	39.89%
PA2	1,533,978	511,326	1,271,619	(760,293)	(148.69%)
Total operating expenses	20,058,810	11,282,484	12,355,491	(1,073,007)	(9.51%)
CY Unspent funds	$ 5,117,907	$ 3,020,434	2,505,941	$ (514,493)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,231,624		
Unspent funds - ending			$ 8,737,565		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2021 through April 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 1,008,623	$ 903,938	$ 104,685	10.38%
Fringes	549,516	303,667	298,772	4,895	1.61%
Contractual	433,304	252,763	456,476	(203,713)	(80.59%)
Board expenses	16,100	9,394	11,201	(1,807)	(19.24%)
Day of recovery	14,000	9,000	250	8,750	97.22%
Facilities	152,700	89,075	69,970	19,105	21.45%
Other	127,000	74,081	49,997	24,084	32.51%
Total General Admin	$ 3,021,688	$ 1,746,603	$ 1,790,604	$ (44,001)	(2.52%)

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2021 through April 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 281,288	$ 113,124	$ 168,164	59.78%
Fringes	166,800	97,300	29,192	68,108	70.00%
Access Salaries	194,484	113,449	94,456	18,993	16.74%
Access Fringes	57,588	33,593	29,055	4,538	13.51%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	58,331	50,830	7,501	12.86%
Board expenses	5,000	2,919	1,640	1,279	43.82%
Facilities	-	-	-	-	0.00%
Other	10,404	2,569	5,047	(2,478)	(96.46%)
Total operating expenses	$ 1,070,484	$ 589,449	$ 323,344	$ 266,105	45.14%

Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through April 30, 2022

County	Beginning Balance	FY22 Projected Revenue	Current Receipts	FY22 Approved Projects	County Specific Projects	Region Wide Projects by Population	Ending Balance
					Actual Expenditures by County		
Alcona	$ 83,635	$ 19,313	$ 9,981	$ 38,301	22,991	$ 888	$ 78,545
Alpena	315,554	66,080	33,805	160,005	68,504	2,440	258,768
Antrim	243,061	53,592	28,497	95,690	45,795	1,997	220,259
Benzie	144,391	49,804	26,429	27,891	11,425	1,507	152,808
Charlevoix	467,765	82,100	44,047	262,209	76,959	2,241	322,809
Cheboygan	280,756	68,778	37,263	176,925	96,560	2,175	234,081
Crawford	85,250	28,559	16,166	32,978	11,620	1,192	77,479
Emmet	754,134	145,253	81,450	278,987	99,676	2,846	641,473
Grand Traverse	1,615,220	376,032	198,647	909,582	329,709	7,872	1,220,605
Iosco	359,368	70,274	36,147	160,492	54,593	2,157	289,754
Kalkaska	73,813	33,023	17,415	42,665	20,766	1,512	69,035
Leelanau	131,774	48,924	27,463	97,254	52,798	1,857	110,635
Manistee	90,411	63,745	34,923	36,315	16,233	2,094	101,246
Missaukee	66,066	18,058	9,211	50,287	25,156	1,286	51,068
Montmorency	64,849	26,456	13,449	36,920	20,452	793	62,182
Ogemaw	164,571	54,659	26,394	80,483	40,106	1,799	154,259
Oscoda	76,895	17,086	8,905	43,817	17,476	711	59,446
Otsego	205,220	86,909	45,046	210,283	111,311	2,104	150,216
Presque Isle	102,301	20,617	10,441	47,065	25,906	1,097	92,415
Roscommon	488,633	75,491	38,046	63,178	22,800	2,049	487,748
Wexford	417,956	82,829	42,500	111,588	57,314	2,853	406,865
	6,231,626	1,487,584	786,220	2,962,916	1,228,151	43,471	5,241,696
PA2 Redirect							-
							5,241,696

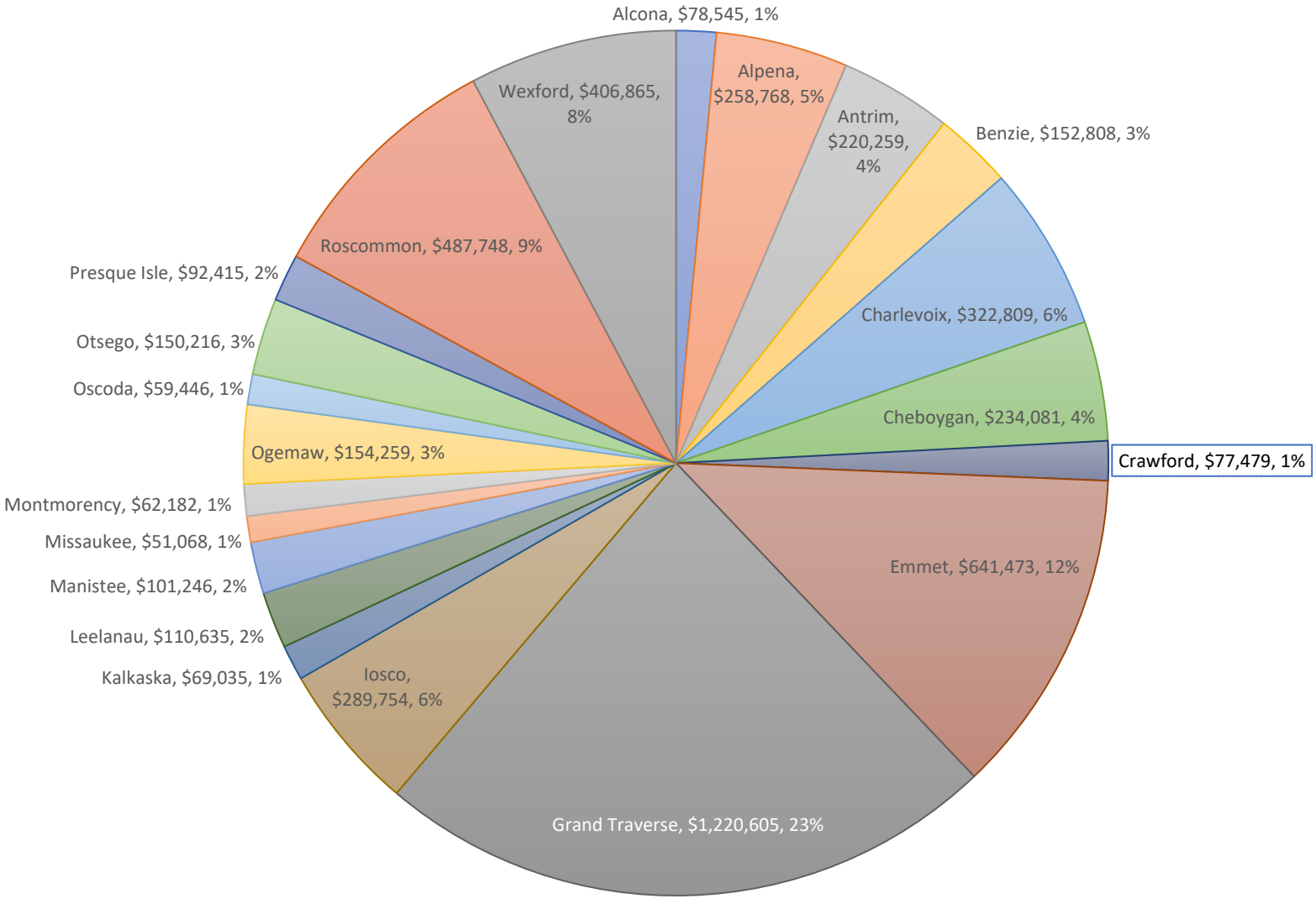
Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2021 through April 30, 2022

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	1,456	4,267	2,811	193.06%
Total operating revenue	2,501	1,456	4,267	2,811	193.06%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 1,456	4,267	$ 2,811	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,358,117		
Unspent funds - ending			$ 16,362,384		

PA2 Funds by County



Northern Michigan Regional Entity

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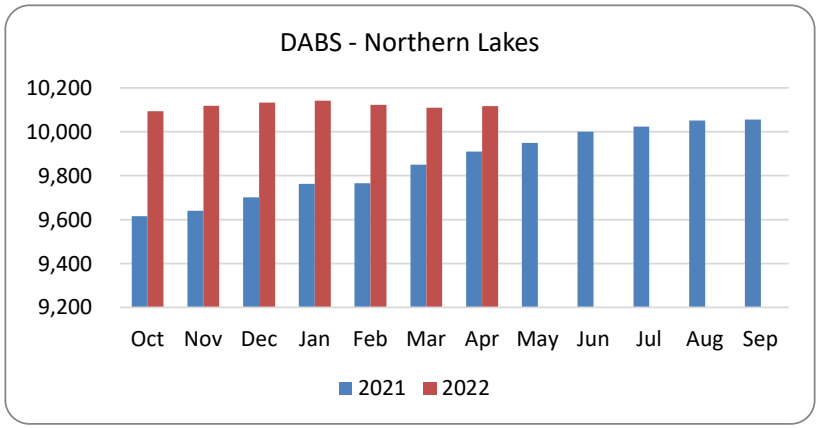
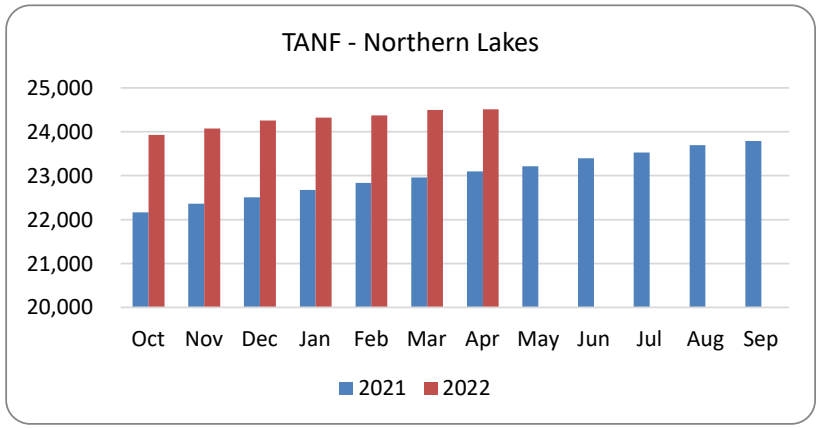
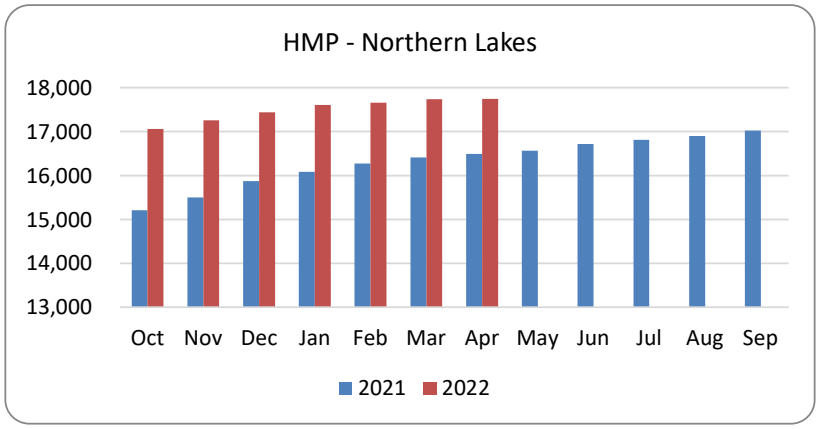
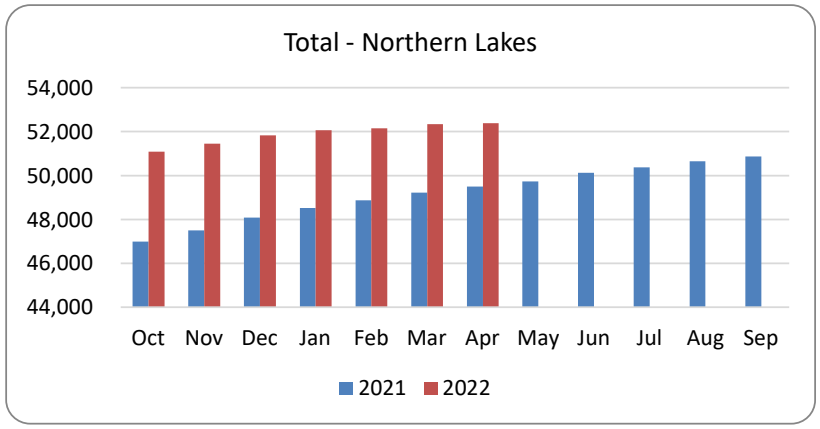
October 1, 2021 through April 30, 2022

Northern Lakes Eligible Trending - based on payment files









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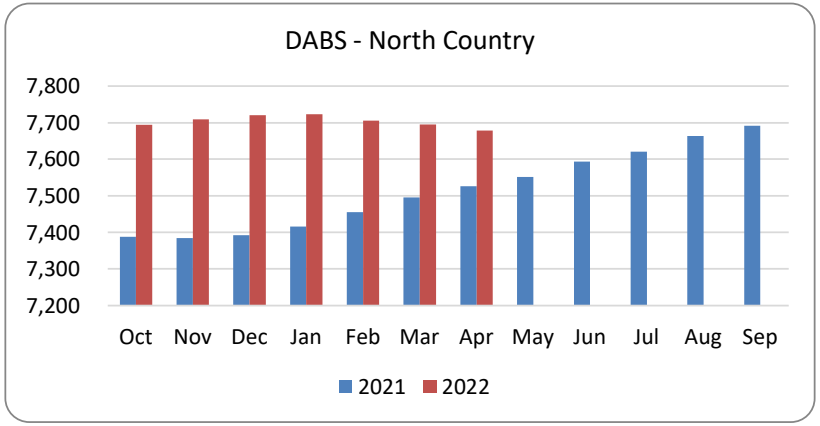
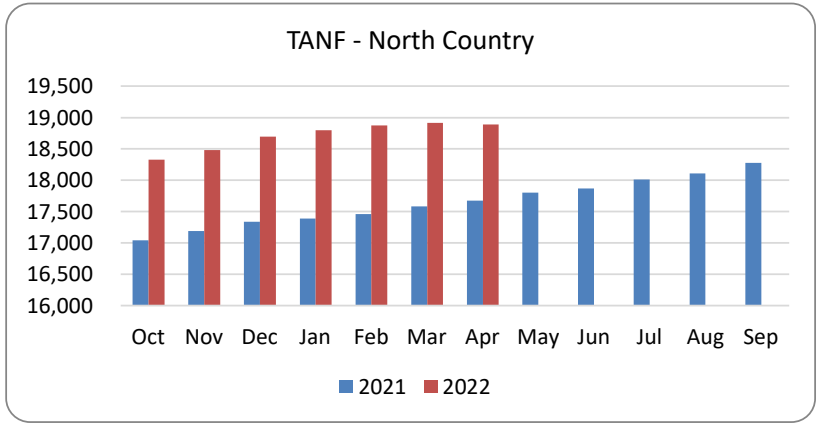
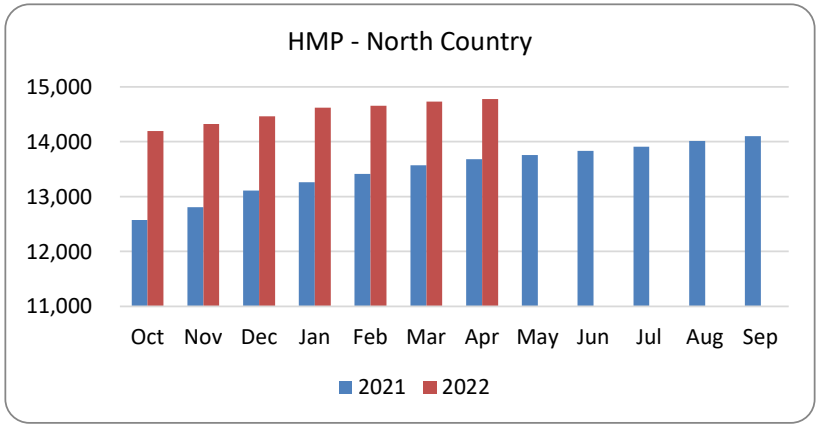
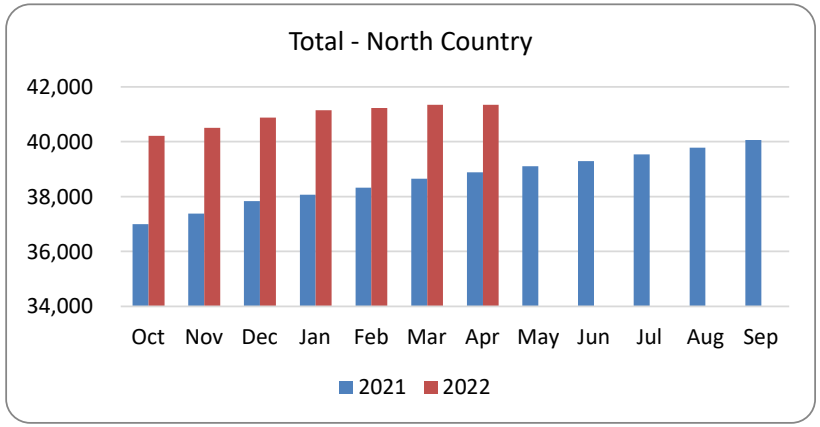
October 1, 2021 through April 30, 2022

North Country Eligible Trending - based on payment files









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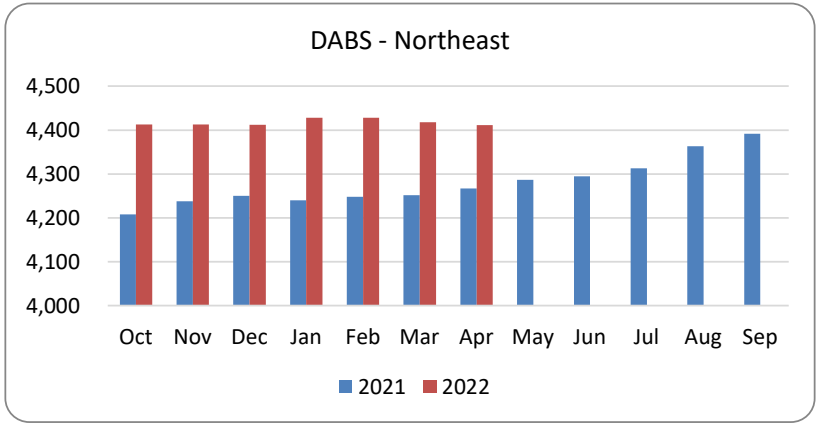
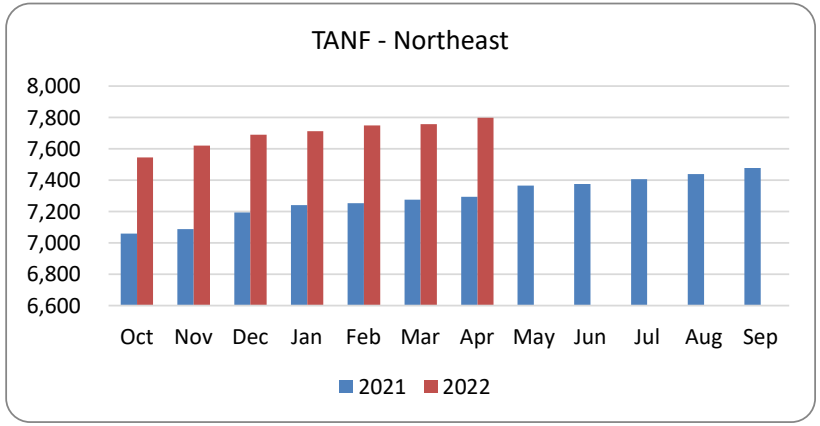
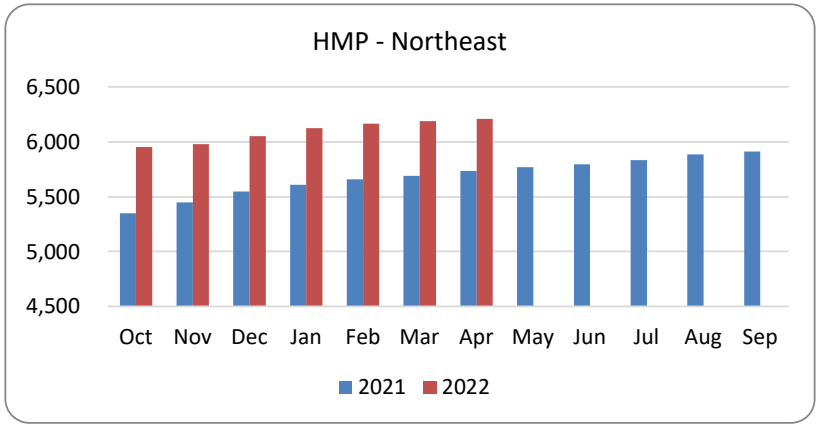
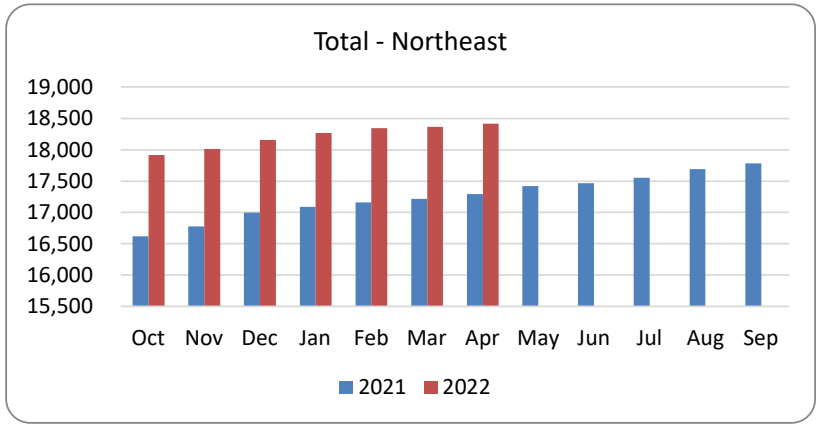
October 1, 2021 through April 30, 2022

Northeast Eligible Trending - based on payment files









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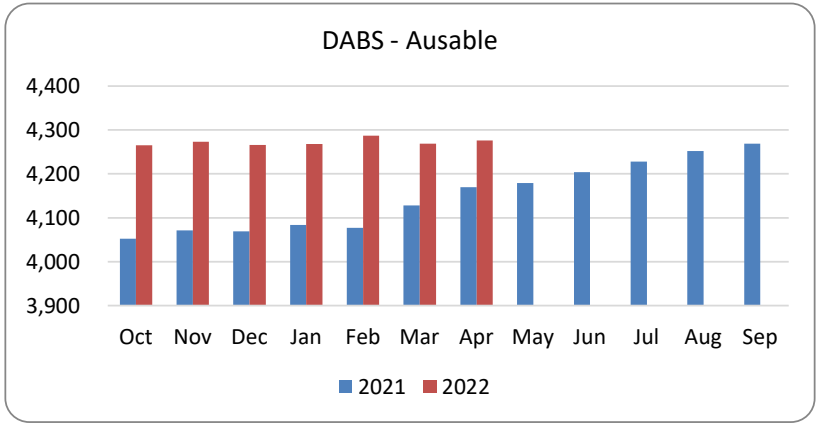
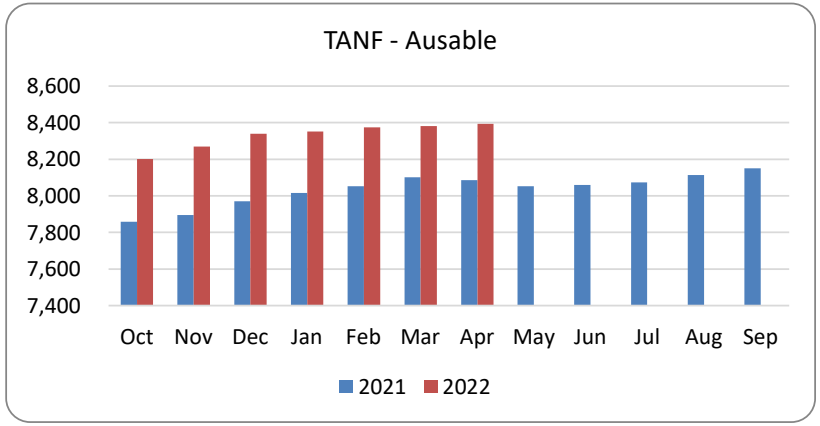
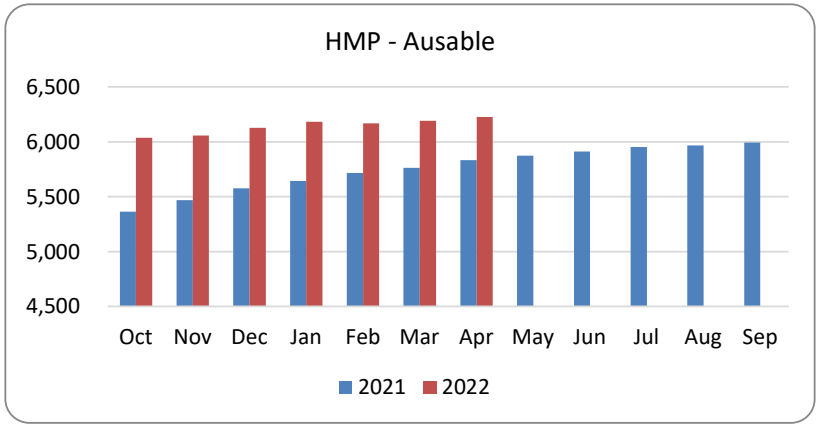
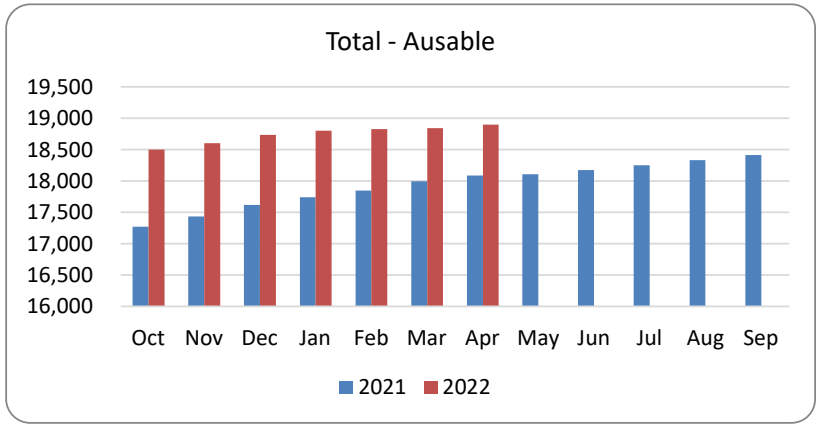
Ausable Valley Eligibles Trending - based on payment files









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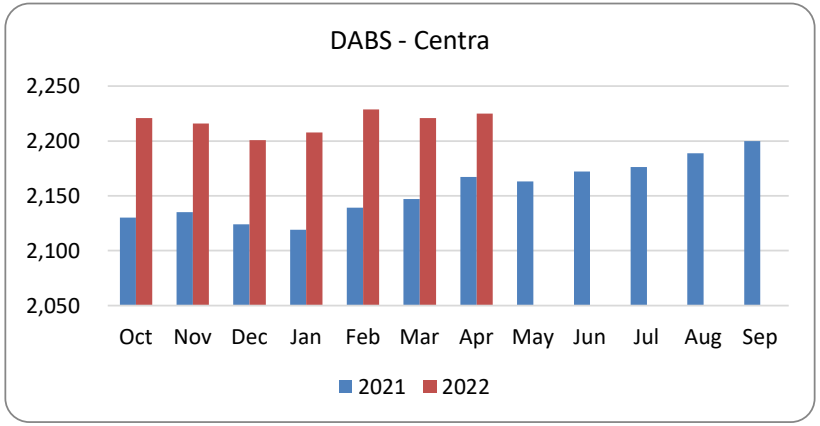
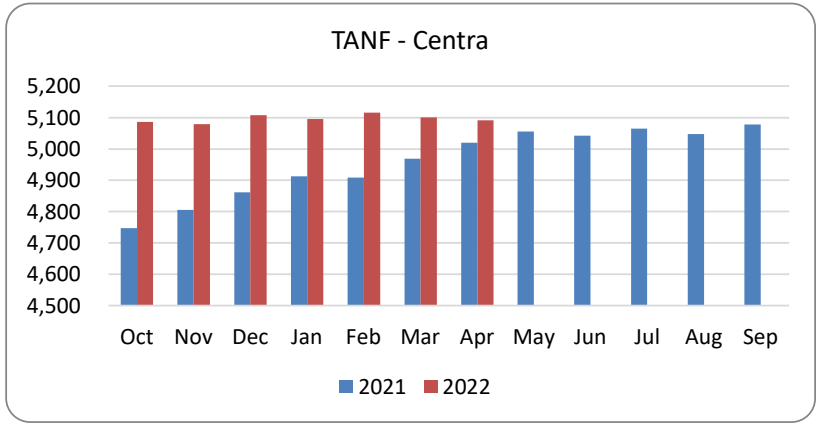
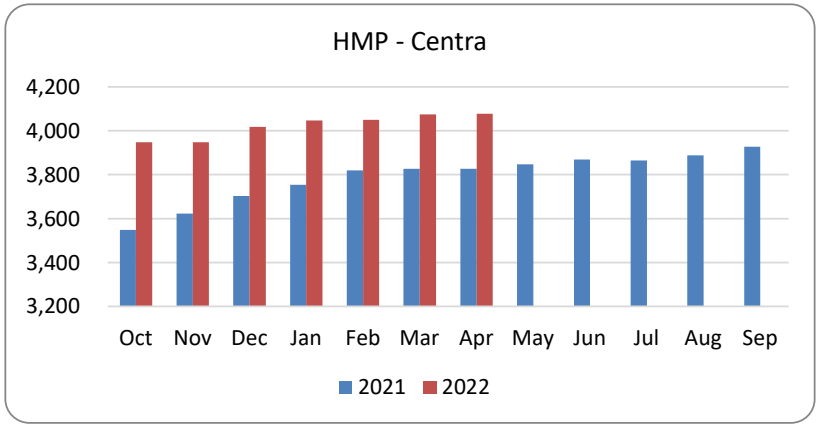
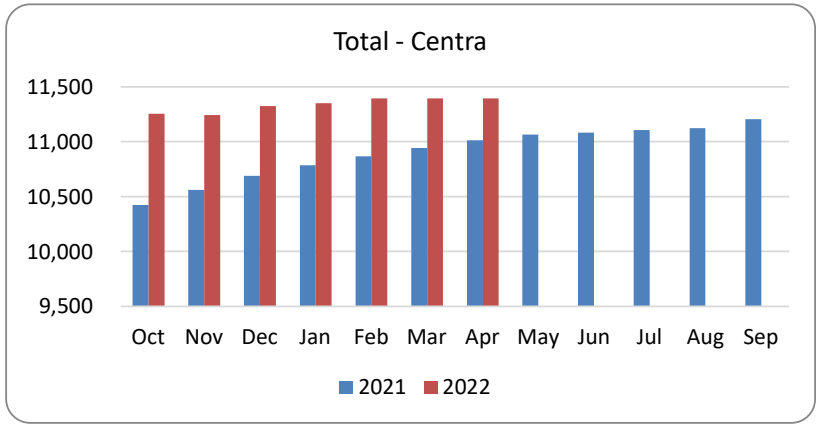
Centra Wellness Eligibles Trending - based on payment files









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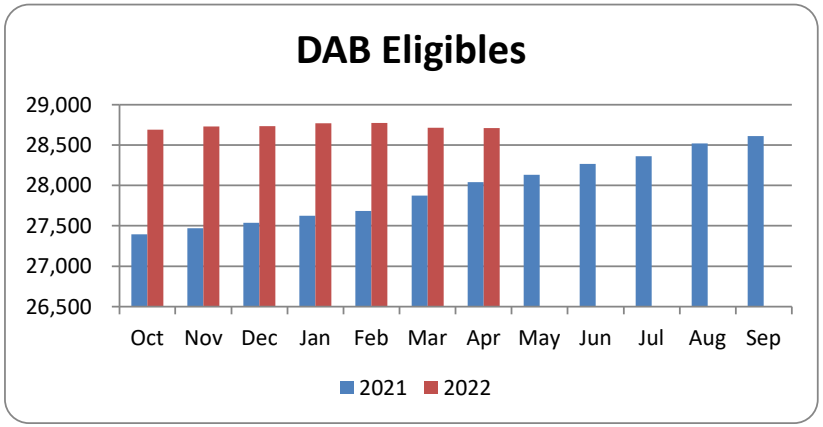
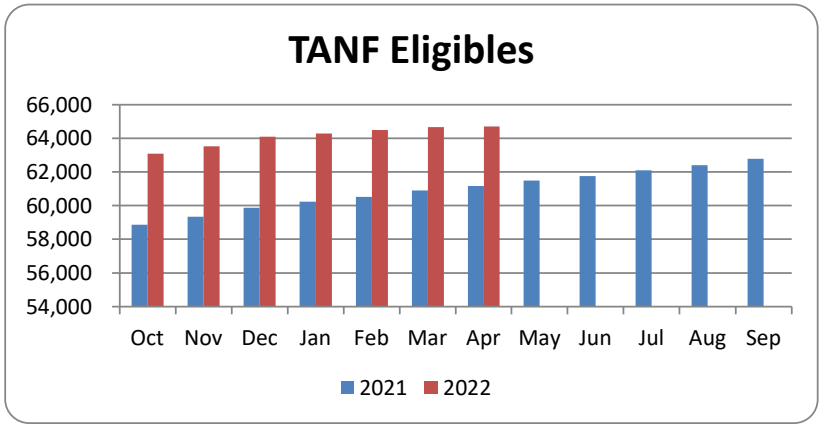
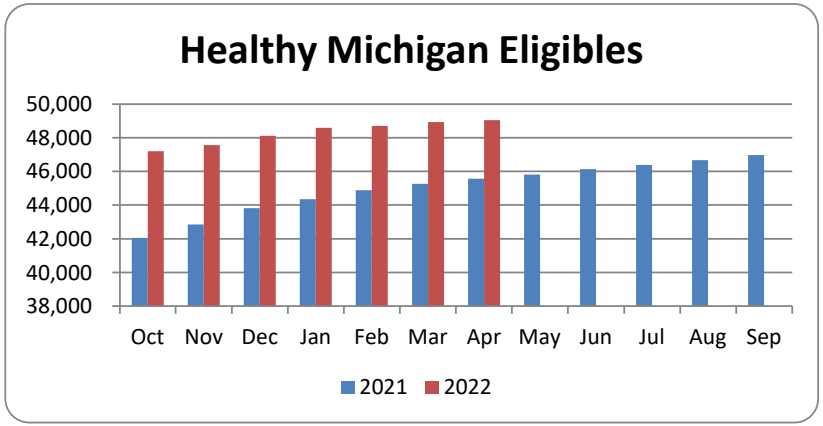
Regional Eligible Trending







Northern Michigan Regional Entity

Narrative

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Regional Revenue Trending