Northern Michigan Regional Entity

Board Meeting

October 26, 2022

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – September 28, 2022	Pages 2 – 8
7.	Correspondence	Pages 9 – 85
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report	
	c. CEO's Report – October 2022	Page 86
	d. Financial Report – August 2022	Pages 87 – 108
	c. Operations Committee Report – October 18, 2022	Pages 109 – 112
	e. NMRE SUD Oversight Board Report – Next meeting is November 7, 2022	
11.	New Business	
	a. Christine Gebhard Contract (Northern MI CHIR, general advocacy, Traverse City Crisis Services Unit, other as needed)	
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	
	Quality Assurance and Performance Improvement Program Update	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – December 7, 2022	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – SEPTEMBER 28, 2022
GAYLORD BOARDROOM

ATTENDEES:	**Kate Dahlstrom, Ed Ginop, Gary Klacking, Christian Marcus, Mary Marois, Gary Nowak, Jay O'Farrell, Richard Schmidt, Karla Sherman, Don Smeltzer, Don Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Angie Griffis (Roscommon), Terry Larson (Rogers City)**
NMRE/CMHSP STAFF:	**Bea Arsenov, Joe Balberde, Lauri Fischer, Chip Johnston, Eric Kurtz, Pamela Polom, Brandon Rhue, Heidi Serven, Sara Sircely, Teresa Tokarczyk, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Chip Cieslinski, Dave Freedman, Donna Hardies, Melissa Fruge, Rob Palmer**

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 all NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

APPROVAL OF AGENDA
Let the record show that Liquor Tax Requests and Board Per Diem Rates were added under "New Business;" Provider Screening Information Collection Tool was removed from the agenda.

MOTION BY MARY MAROIS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR SEPTEMBER 28, 2022 AS AMENDED; SUPPORT BY GARY NOWAK. MOTION CARRIED.

APPROVAL OF PAST MINUTES
Let the record show that the August minutes of the NMRE Governing Board were included in the materials for the meeting on this date. Mr. Smeltzer indicated that he did not attend virtually; he will be marked as absent.

MOTION BY DON SMELTZER TO APPROVE THE MINUTES OF THE AUGUST 24, 2022 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS AS AMENDED; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

CORRESPONDENCE

1) The minutes from the September 1st PIHP CEO meeting.
2) CMHAM "Advocacy Around Addressing MDHHS Action and Inaction on Key Policy and Practice Issues" document dated August 2022.
3) Email correspondence from Bob Sheehan at CMHAM discussing items related to the development of CMHA's CCBHC recommendations.
4) CMHAM "Michigan's State Demonstration, Demonstration Growth, and Initiatives to Make CCBHC a Permanent Part of Michigan's Healthcare Landscape" document revised September 7, 2022.
5) Medicaid Provider L Letter 22-44 regarding Michigan's Revised Statewide Transition Plan for Home and Community-Based Services Waiver Programs dated September 20, 2022.
6) CMHAM "Written Comments for the House Health Policy Committee" regarding HB 6355 dated September 22, 2022.
7) Michigan House and Senate Candidates for the November 8, 2022 election.
8) Letter from Eric Kurtz and Don Tanner to the Northern Lakes CMHA Board of Directors outlining next steps in the NMRE's enhanced contractual oversight of NLCMHA.
9) The draft minutes from the September 14th NMRE Regional Finance Committee meeting.

Mr. Kurtz stated that the latest version of the Associations' CCBHC Recommendations is better (good enough) and confirms that concerns were heard.

Ms. Dahlstrom referred the "MPCIP and MI CAL Update" in the September PIHP CEO meeting minutes. Mr. Kurtz noted that although a bed registry that was up to date and accurate would be beneficial, the design of the psychiatric bed registry is cumbersome and overwhelming and will not solve the fact that there are normally no psychiatric beds available statewide for timely placements. The psychiatric bed registry is scheduled for implementation in December 2022.

Mr. Kurtz drew attention to the correspondence from CMHAM regarding HB 6355. Michigan HB 6355 calls for CMHSPs to establish preadmission screening units in order to conduct preadmission screenings for hospital admissions within 3 hours. Mr. Kurtz stressed that the problem is not timely screenings; the problem is finding hospital beds. Individuals often have to wait in the ED, though it was noted that hospitals are required to provide treatment. Ms. Dahlstrom asked whether hospitals could convert some ED rooms for this purpose. Mr. Kurtz responded that they could but whether they would is unclear.

ANNOUNCEMENTS

Let the record show new Board Members Chuck Varner and Eric Lawson, representing AuSable Valley and Northeast Michigan respectively were introduced and welcomed. Staff sitting in for CEOs (who were attending Directors Forum) were introduced.

PUBLIC COMMENTS

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

REPORTS

Executive Committee Report

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

CEOs Report
The NMRE CEO Monthly Report for September 2022 was included in the materials for the meeting on this date. Mr. Kurtz Eric highlighted the Grand Traverse County Behavioral Health Services Community Input Summit on August 30th and the Northern Lakes Six County (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford) Administrators meeting on September 12th; the next Northern Lakes Six County Administrators meeting is scheduled for October 3rd.

July 2022 Financial Report
- Net Position showed net surplus Medicaid and HMP of $12,117,012. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $28,475,129. Medicaid and HMP combined ISF was reported as $16,358,117; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $44,833,246.
- Traditional Medicaid showed $168,681,306 in revenue, and $154,712,217 in expenses, resulting in a net surplus of $13,969,089. Medicaid ISF was reported as $9,298,368 based on the unaudited FSR. Medicaid Savings was reported as $11,296,867.
- Healthy Michigan Plan showed $26,812,584 in revenue, and $22,720,930 in expenses, resulting in a net surplus of $4,091,653. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,216,598 in revenue, and $1,016,957 in expenses, resulting in a net surplus of $199,641.
- SUD showed all funding source revenue of $20,997,804, and $17,899,716 in expenses, resulting in a net surplus of $3,098,088. Total PA2 funds were reported as $5,149,752.

The direct care wage surplus was estimated at $5,943,730. A Potential lapse of $11M for FY22 was reported. Ms. Yockey noted that county PA2 balances can be monitored by comparing the "FY22 Projected Revenue" column with the "Ending Balance" column.

Mr. Lawson asked whether NMRE has a calculation of its administrative expenses. Ms. Yockey responded that she estimates that it is under 5%; she can produce an exact percentage for the October meeting.

Mr. Schmidt expressed that the Michigan House and Senate is looking to pass a bill for secondary road control using liquor tax funds (county portion). Ms. Dahlstrom questioned whether a portion of the marijuana tax be allocated to mental health. Mr. Tanner responded that townships are receiving a tremendous amount of money.

MOTION BY RICHARD SCHMIDT TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JULY 2022; SUPPORT BY ERIC LAWSON. MOTION CARRIED.

Operations Committee Report
The draft minutes from August 20, 2022 were included in the materials for the meeting on this date. Mr. Johnston reported that he was involved in discussions about the CCBHC with leadership from the UP. Rural Boards have voiced their objections with making the CCBHC a State Plan service; this message has been received loud and clear. Huge support for the Behavioral Health Home (BHH) has been expressed. A regional BHH Summit took place on September 23rd which highlighted many successes of the program; Lindsay Naeyaert was in attendance.

NMRE SUD Oversight Board Report
The draft minutes from September 12, 2022 were included in the materials for the meeting on this date. During the meeting, Carolyn Brummund was elected as Chair and Richard Schmidt was elected as Vice-Chair.

Ms. Sircely reviewed the proposed FY23 SUD grant awards.

MOTION BY JAY O'FARRELL TO APPROVE FISCAL YEAR 2023 GRANT FUNDING RECOMMENDATIONS MADE BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD ON SEPTEMBER 12, 2022; SUPPORT BY GARY NOWAK. ROLL CALL VOTE.

"Yea" Votes:	**K. Dahlstrom, E. Ginop, G. Klacking, C. Marcus, M. Marois, G. Nowak, J. O'Farrell, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner, C. Varner**
"Nay" Votes:	**Nil**

NEW BUSINESS

Liquor Tax Requests
Seven liquor tax reqests for FY23 were presented to the NMRE Substance Use Disorder Oversight Board on September 13, 2022; a summary of the requests and the SUD Board's recommendations were included in the materials for the meeting on this date.

Mr. Marcus asked what Recovery Alliance is. Ms. Sircely responded that Recovery Alliance is "a Recovery Community Organization focused on mobilizing resources of the recovery community to increase the sustainability of long-term recovery from SUD." Clarification was made that the contract with Michigan Rehabilitation Services in an annual renewal for employment services via a match agreement (similar to local drawdown).

MOTION BY KARLA SHERMAN TO APPROVE THE SEPTEMBER 13, 2022 LIQUOR TAX USE RECOMMENDATIONS BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD TOTALING FIVE HUNDRED NINETY-TWO THOUSAND NINE HUNDRED NINETY-EIGHT DOLLARS AND FORTY-FOUR CENTS ($592,998.44); SUPPORT BY MARY MAROIS. ROLL CALL VOTE.

"Yea" Votes:	**K. Dahlstrom, E. Ginop, G. Klacking, C. Marcus, M. Marois, G. Nowak, J. O'Farrell, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner, C. Varner**
"Nay" Votes:	**Nil**

MDHHS-PIHP Contract Change Order No.6
A summary of the adjustments made to the MDHHS-PIHP Contract in Change Order #6 was included in the meeting materials. Added language includes, "The Contractor must comply with the Standard Cost Allocation (SCA) methodology established by MDHHS when assigning the fund source and ensure subcontractor compliance with the SCA methodology." The model delegation agreement was removed and referenced only as a guide. Use of the SCA template is optional.

Additional language was also added related to the use of Subcontractors, though it was noted that the term "subcontractor" does not include network provider agreements that are limited in scope to the provision of covered services to enrollees (i.e, the actual delivery of clinical care).

MOTION BY GARY NOWAK TO AUTHORIZE THE CHIEF EXECUTIVE OFFICE TO SIGN CHANGE ORDER NUMBER SIX (NO. 6) TO THE CONTRACT BETWEEN THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE NORTHERN MICHIGAN REGIONAL ENTITY; SUPPORT BY ED GINOP. ROLL CALL VOTE.

"Yea" Votes:	**K. Dahlstrom, E. Ginop, G. Klacking, C. Marcus, M. Marois, G. Nowak, J. O'Farrell, R. Schmidt, K. Sherman, D. Smeltzer, D. Tanner, C. Varner**
"Nay" Votes:	**Nil**

Proposed FY23 Board Meeting Schedule
The proposed FY23 Board Meeting Schedule was included in the meeting materials. It was noted that the November meeting would fall on the day before Thanksgiving and the December meeting would fall between Christmas and New Year's.

MOTION BY KARLA SHERMAN TO HOLD A COMBINED NOVEMBER AND DECEMBER NORTHERN MICHIGAN REGIONAL ENTITY BOARD MEETING ON DECEMBER 7, 2022, SUPPORT BY MARY MAROIS. MOTION CARRIED.

The approved meeting schedule will be posted on the NMRE.org website.

Board Per Diem Rates
Per request of the Board in August, Ms. Yockey collected and reviewed the per diem rates from the five member CMHSPs.

	AuSable Valley	Centra Wellness	North Country	Northeast Michigan	Northern Lakes	NMRE
< 4 Hours	$40	$40	$50	$50	$50	$40
> 4 Hours	$75			$75	$75	$75
Mileage	IRS rate	IRS rate	IRS rate	IRS rate	95% of IRS rate	IRS rate

MOTION BY RICHARD SCHMIDT TO KEEP THE NORTHERN MICHIGAN REGIONAL ENTITY'S BOARD PER DIEM AND MILEAGE REIMBURSEMENT RATES THE SAME; SUPPORT BY GARY NOWAK. MOTION CARRIED.

~~**Provider Screening Information Collection Tool**~~

OLD BUSINESS
Senate Bills 597 & 598/House Bills 4925 – 4929 – The Latest
Rumors continue that Sen. Shirkey & Rep. Whiteford are drafting a compromise bill that would combine SBs 597 & 598 along with HBs 4925 – 4928 in an attempt to get "something" done before the end of the year. Any compromise bill between Sen. Shirkey and Rep. Whiteford would likely be as bad as the current version of SBs 597 & 598, which would still privatize Medicaid

mental health services by giving financial control and oversight or decision making to for-profit insurance companies.

Grand Traverse County and Northern Lakes CMHA
Mr. Kurtz attended the Northern Lakes CMHA Board Committee of the Whole meeting on September 15th. Mr. Kurtz was asked to move forward with the contractual oversight and CEO Search assistance offered. A lease agreement for Brian Martinus has been signed and he will assume the position of Interim CEO on October 3, 2022. The search process for a permanent CEO will begin as soon as possible. Ms. Marois will be chairing the Search Committee and will work with NMRE staff. The goal is to have a permanent CEO hired for NLCMHA by the end of the year.

All but one of NLCMHA's counties (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford) have signed the Memorandum of Understanding (MOU) to revisit the enabling agreement; Wexford is expected to sign soon. Separating from NLCMHA is currently off the table.

PRESENTATION
Health Home Update
NMRE Clinical Services Director, Bea Arsenov, and Lead Care Coordinator, Heidi Serven were in attendance to provide an update on the region's health homes.

The purpose of the health home program was stated as "to provide comprehensive care management and coordination of services to address all of an individual's health care needs."

NMRE Health Homes		
Alcohol Health Home	**Behavioral Health Home**	**Opioid Health Home**
• Began in FY22 with block grant funds	• Began in FY14 with Centra Wellness and Northern Lakes • Expanded to all five member CMHSPs in October 2020	• Began in FY19 when MDHHHS selected the NMRE as the first pilot region
• First enrollment began in December 2021 • 48 clients are currently enrolled at 4 providers	• 400 individuals enrolled in the NMRE region and over 1,700 enrolled statewide	• 1,024 enrolled in the NMRE region and 2,279 enrolled statewide. • OHH services have expanded to 7 PIHP regions with plans to expand to all regions in the state in FY23

Goals for the program were stated as:
- Improve care management of beneficiaries with Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED), Opioid Use Disorder, Alcohol Use Disorder including those receiving MAT, along with other chronic conditions.
- Improve care coordination between physical and behavioral health services
- Improve care transitions between primary, specialty, and inpatient settings of care
- Identify and improve Social Determinants of Health

Outcomes for the health home programs include:
- Lower than state average for inpatient hospital admissions for ambulatory care

- Higher than state average for follow-up after emergency visits
- Higher than state average for initiation and engagement in alcohol and other drug abuse or dependance treatment

Ms. Sherman asked how the NMRE can make the general public aware of the health home programs. Ms. Arsenov responded that the NMRE and the five member CMHSPs are working to spread the word among primary care providers. Mr. Kurtz added the importance of CMHSPs having a "no wrong door" approach to services.

COMMENTS

Board

Ms. Dahlstrom asked whether the NMRE has an avenue to meet with Munson and McLaren hospitals. Mr. Kurtz responded that there is nothing formal but he is always willing to meet. This topic will be placed on the meeting agenda for October.

Mr. Schmidt noted that Munson has opened new emergency rooms in northern Michigan.

MEETING DATES

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on October 26, 2022.

ADJOURN

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

PIHP CEO Meeting
October 6, 2022
9:30AM – 12:00PM
Michigan Public Health Institute – Microsoft Teams Meeting

Contents

Attendees

Pre-paid Inpatient Health Plans (PIHP)

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

Wayne State University

Asmara Ruth Afewak

Michigan Department of Health & Human Services (MDHHS)

Lisa Collins	Dana Moore
Vendella Collins	Lindsey Naeyaert
Alicia Cosgrove	Kelsey Schell
Audrey Dick	Ashley Seeley
Erin Emerson	Mary Shehan-Boogaard
Krista Hausermann	Angie Smith-Butterwick
Belinda Hawks	Jackie Sproat
Leah Julian	Brenda Stoneburner
Amy Kanouse	Rita Subhedar
Brian Keisling	Scott Wamsley
Phil Kurdunowicz	Keith White
Arden Malfait	Jeff Wieferich
Lindsay McLaughlin	Amanda Zabor

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

Michigan Public Health Institute (MPHI)

Kristi Bente

Krystalle Double

Guardianship Data Request

1. Vendella Collins and Asmara Ruth Afewak presented on the request they had for guardianship data. The intent of the request is to determine the extent of guardianships throughout the state.
    a. A copy of this presentation has been distributed to the group via email.
2. A PIHP asked if the Michigan Developmental Disabilities Council could get the information they needed from the State Court Administration Office.
    a. The presenters responded that from what they understood, the best source would be via the PIHPs.
3. Mid-State Health Network noted that they do not have the requested information in their care management system. This is something they would have to retrieve from their partners in the field.
    a. Other PIHPs agreed that it was most likely that the CMHs would have the necessary information, not the PIHPs themselves.
4. MDHHS noted that the Michigan Developmental Disabilities Council may then have to expand the audience for the request to the CMHs instead.
    a. The presenters thanked the PIHPs and MDHHS for the clarification. The best contact people and organizations were something they had hoped to discover via the presentation.
5. The presenters asked about the best way to reach out to the CMHs to proceed.
    a. The PIHPs and MDHHS supported the idea that MDHHS and the Michigan Developmental Disabilities Council go directly to the CMHs with their request.

Children's Bureau Update

1. Lindsay McLaughlin introduced Ali Cosgrove as the new Chief of Staff for the Bureau of Children's Coordinated Health Policy and Support.
    a. She also announced Mary Luchies as the manager for the new Intellectual/Developmental Disabilities (IDD) and Autism Spectrum Disorder (ASD) section within the Bureau.
2. Phil Kurdunowicz shared the scope and goals of the new IDD and ASD section of the Bureau.
    a. The new section is intended to help provide clinical leadership when it comes to serving the IDD and ASD populations. MDHHS wants to continue the tradition of training and expand to trainings related to treatment as well.
    b. The second focus of the new section is on the Medicaid program, helping to inform policy development and provide oversight for service delivery to children and families with IDD and ASD.
    c. The third piece of the new section is supporting the work of the Autism Council and providing subject matter expertise.
3. Lindsay McLaughlin reported that the Clinical Support and Service Navigation team lead by Patty Neitman continues with its work to increase coordination and access to the public behavioral health system.

4. Ali Cosgrove shared that MDHHS had received a new grant for $3.1 million to expand the Infant-Toddler Court.
    a. The Infant-Toddler Court focuses on targeted service for children who are at risk of coming into foster or institutionalized care or who are already in such care and can be quickly and safely reunited with their families with that support in place.
    b. Currently Michigan has an Infant-Toddler Court in Wayne County and Midland County.
    c. The hope is to expand those existing sites and to add additional sites. MDHHS will be hiring a coordinator for the program through MPHI.
5. Phil Kurdunowicz provided an update about Applied Behavioral Analysis (ABA) services.
    a. He reported that MDHHS has received some questions and concerns from ABA providers about current service utilization guidelines for ABA services within the public mental health system.
    b. Some ABA providers are working on a letter to MDHHS highlighting their concerns; MDHHS will share the letter with the PIHPs when it is received.
    c. He suspects that this will lead to a workgroup or a discussion between the PIHPs and providers about service utilization guidelines for ABA.
        i. MDHHS wants to be supportive of this conversation as part of the PIHP contract, as MDHHS does delegate utilization management.
    d. A PIHP thanked MDHHS for the transparency.
    e. A PIHP requested that, in cases of more individualized feedback for specific entities, MDHHS encourage direct work between PIHPs and those offering the feedback.
6. Phil Kurdunowicz reported that MDHHS was accepting RFP proposals for the first cohort of MI Kids Now until October 10, 2022.
    a. The application date for the second cohort has not yet been set.
    b. MDHHS encourages all CMHs who are interested in participating to take up the grant opportunity.
    c. The grant is an RFP process. There is, however, enough funding for all the CMHs to participate, and so there is room for collaboration between the CMHs.
7. Phil Kurdunowicz reported that during the Public Health Emergency, MDHHS had waived the requirement for children's mental health practitioners to have one year of experience in the examination, evaluation and treatment of minors and their families for individuals with a Master's degree. MDHHS asked if that was a flexibility that should be maintained, or one that can be allowed to expire, based on workforce.
    a. The PIHPs responded that the end of the Public Health Emergency does not mean the end of staffing issues. They recommend continuing all flexibilities that can be continued until the workforce stabilizes and the hiring process smooths.
8. A PIHP requested that MDHHS review the status of the Waiver Supports Application (WSA) as it pertains to ABA and autism services.
    a. Phil Kurdunowicz stated that MDHHS had originally used the WSA to support the 1915(i) activities for the ABA benefit. MDHHS has since transitioned the ABA benefit from the 1915(i) to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). MDHHS kept the enrollment processes going.

b. MDHHS is interested in transitioning away from using the WSA. MDHHS believes use of the WSA is contributing to confusion in the field; some providers believe children are only eligible for ABA instead of the full spectrum of ASD services.
c. MDHHS also hopes this will reduce the reporting requirements for providers as well.
    i. MDHHS is working on a new report through Attachment E in the PIHP contract for treatment codes for treatment and evaluation. MDHHS hopes to keep the report brief, focusing on utilization and authorization of services. MDHHS wants to work with the CIO forum on the fine details.
    ii. The intent is to start that reporting this fiscal year, which would require contract amendment.
d. The sunset date for use of the WSA for ABA and ASD is April 1, 2023.
e. The intent is that the database will still be available for a period after the WSA is no longer the reporting method.
    i. It might also be possible to arrange a download for the PIHPs to allow the PIHPs to retain the data for their operational purposes.

9. A PIHP asked if the decision to retire the WSA system for ABA reporting was firm.
    a. Phil Kurdunowicz responded that MDHHS was moving forward with the April 1, 2023, date. This date was chosen to give the PIHPs enough time to make corresponding adjustments to their operations.
    b. The PIHP noted that transitioning away from the WSA will also come with a loss of management tools that the PIHPs will now have to replicate to monitor performance of their system. The PIHPs will have to build replacement structures for management and oversight that WSA tools had previously been used for.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Lindsey Naeyaert provided the update.
    a. As of October 1, 2022, there are 76 counties eligible to provide Opioid Health Home services.
        i. Regions 5, 8, and the remaining counties in Region 4 were added on October 1, 2022.
        ii. There are currently over 2,500 people enrolled in Opioid Health Home services, and MDHHS has provided ten spots for Community Health Worker (CHW) training. MDHHS will continue to support CHW training and the health home model by providing more CHW certification training in the upcoming fiscal year.
    b. Behavioral Health Homes currently have about 1,700 beneficiaries enrolled.
        i. Behavioral Health Homes are currently available in 5 out of 10 regions.
        ii. MDHHS plans to expand into Region 5 in April 2023.
    c. PIPBHC just started Year 5 of its grant, which is the final year.
        i. MDHHS continues to focus on sustainability and how to continue those services as it approaches the end of the grant.
    d. MDHHS is still waiting for guidance from the federal level on expansion for the CCBHCs.

i. CMS is currently seeking feedback around the demonstration, so if the PIHPs have any feedback that they would like MDHHS to share, MDHHS would be happy to relay that.

e. MDHHS has just finished the first year of the CCBHC demonstration. As of October 4, 2022, MDHHS had 44,000 Medicaid beneficiaries and around 7,400 non-Medicaid individuals assigned in the WSA to those 13 CCBHC demonstration sites.
    i. MDHHS completed the Year 1 virtual demonstration check-in calls and will use those calls to develop technical assistance for Year 2.
    ii. MDHHS is currently working on finalizing financial reporting requirements for the initial demonstration year.

HCBS Update

1. Belinda Hawks provided the HCBS update.
    a. MDHHS has sent out invitations for listening sessions happening October 25 and 26, 2022. The listening sessions are intended for individuals served in the behavioral health system.
        i. She requested they forward those to their network so the individuals served could participate.
        ii. MDHHS is collecting feedback from all stakeholders related to the conflict-free access and planning work that continues through workgroup efforts.
    b. MDHHS is considering including a State of the Workforce survey alongside the National Core Indicators survey for the adult IDD population.
        i. MDHHS would leverage the current HCBS provider contact information for this survey.
        ii. The timeline is yet to be determined, but MDHHS is targeting February or March 2023 for implementation of the survey. This would become an annual survey.
        iii. A PIHP asked what kind of information was sought through the survey.
            1. The survey would be 92 questions, but most are yes/no questions to ensure the survey is reaching the correct providers. The remaining questions seek a little more detail about benefits offered to the workforce.
            2. Once MDHHS has more details of the survey, they will share it in this forum.

Public Health Emergency Unwind

1. Jeff Wieferich reported that MDHHS anticipates the Public Health Emergency will be extended into January, but also expects to receive notice that it will be the last extension. MDHHS expects to receive the 60-day advance notice of the end of the Public Health Emergency in November.
    a. He requested the PIHPs stay alert for any communications that may come from MDHHS to keep them updated. The website will continue to be updated as well.
    b. MDHHS will continue doing what it can to make the transition go as smoothly as possible.

2. Belinda Hawks added that she had heard there was a planned set of webinars to stakeholders related to the Public Health Emergency impact.
    a. The meetings were not calendared yet, but they are planned.

MPCIP & MI CAL Update

1. Krista Hausermann provided the MPCIP and MI CAL update. A written copy was distributed via email.
    a. Crisis Stabilization Units (CSUs) are moving ahead with certification rules. A survey was sent out to CMHs, Psychiatric Hospitals, and Acute Care Hospitals to assess people's interest in CSUs and similar services out there.
        i. One of the challenges around CSUs is identifying and providing a sustainable financing mechanism for all populations.
        ii. The populations include services for mental health crisis and co-occurring crises. Some services related to Substance Use Disorder (SUD) services will also need to be provided, such as withdrawal management.
        iii. MDHHS will require CSUs to have a contract with regional PIHPs to help provide the public funding for services like withdrawal management.
        iv. The internal review of these rules has been completed, and MDHHS is ensuring they stay in alignment with the requirements in the PIHPs' contracts.

Opioid Advisory Commission Update

1. Brad Casemore reported that the Opioid Advisory Committee has met three times.
    a. Opioid Advisory Committee has provided for a full-time staff position to work with the committee and the council.
    b. The first report is due March 30, 2023.
    c. All commission meetings are streamed live, and the public can join from the Opioid Advisory Committee website at: http://council.legislature.mi.gov/Council/OAC.

Opioid Settlement & Housing Support

1. Rita Subhedar provided the update on supportive housing services.
    a. The need for recovery support services to address a spectrum of social factors including housing was identified as a priority in the opioid settlement prioritization survey issued in 2021.
    b. MDHHS is looking into covering supportive housing services for individuals with SUD diagnoses.
        i. Services would include housing preference assessments, assistance in applying for housing, developing individualized community integration plans, and assisting in securing accommodations for disabilities.

ii. Right now, MDHHS only covers these services for Severe Emotional Disturbance (SED), Serious Mental Illness (SMI), and IDD diagnoses. SUD would be added as a qualifying diagnosis to the 1915(i) Behavioral Health State Plan Amendment.
iii. MDHHS hopes to cover these services under Medicaid by FY 2024.

Injectable Medication in Residential Treatment Facilities Policy

1. Rita Subhedar reported that MDHHS is allowing residential treatment centers to submit professional claims for injectable medication-assisted treatment to fee-for-service.
    a. These changes will be effective retroactively to October 1, 2022. The purpose of the change is to ensure access to these treatments as required under the 1115 waiver.
    b. The Plans are not to include injectable medication-assisted treatment in the per-diem rate to the residential treatment centers.
2. A PIHP asked if there would be any billing technical assistance available to the residential treatment centers.
    a. Rita Subhedar said she could take that back to the provider support section; they have some materials on submitting professional claims to fee-for-service.
    b. She provided her email address to the group. The address is SubhedarR1@michigan.gov.

Community Mental Health Association of Michigan
DIRECTORS FORUM
September 28-29, 2022

Summary of key discussion topics and decisions

(Note: This summary is supplemented by the handouts distributed, electronically and in hard copy, in advance of, during, and subsequent to the Directors Forum.)

Legislative and policy status report: Alan Bolter provided a view of the political scenarios that are most likely to emerge in the coming months, surrounding the system redesign bills (Senator Shirkey & Representative Whiteford bills). Alan Bolter provided an update on HB 6355, which would amend the prescreening authorization process – Alan shared the CMHA testimony provided in the House Health Policy committee on 9/22/22. Alan Bolter updated members on a budget issue regarding public guardians - $5 million was added in the FY23 budget for guardianship, boilerplate section 950 outline the payment method. The directors had a lengthy discussion around the use of guardians in the system, Alan Bolter agreed to send out a survey monkey asking for the system's input on the use of guardians (survey was sent out on 10/18/22). Alan Bolter also shared a letter that CMHA co-signed with other stakeholder groups regarding a statewide DSNP as a replacement to the MI Health Link.

Update on **MDHHS/Milliman-proposed financial reporting overhaul** and related work of CMH and PIHP contract negotiations teams: Joe Sedlock outlined MLR issues statewide expectations and package of requirements. Requires PIHP submit to the state their delegated functions – what is delegated to CMHs. DHHS will create a model delegation agreement and post it publicly. Purpose is to use this model, not a mandate, but a preferred model (can look at promoting or removing certain functions) . DHHS will review comment on and maybe approve at some point.

Group wanted to know the SCA impact on the CMH contract – the CMH negotiations team reported that there has not been any updates on this issue with the CMH contract.

Workforce roundtable discussion: Rich Thiemkey, Barry County CMHA, mentioned that BCCMHA had discovered some inconsistencies within the Behavioral Health Code Chart and Provider Qualifications document. It seemed that making a few minor changes to the aforementioned code chart (bringing consistency) could add flexibility for current CMH staff and thus help a little with the workforce issue. Attached the simple document we created which gives further explanation.

CCBHC issue / workforce, growing demand for mild moderate & duals, very few LMSW, cannot bill licensed professional counselors with Medicare. BCBS added limited licensed people to provide services / commercial insurance is flexible, is there a way for public system to get more flexibility?

The group discussed the Mi Kids Now loan forgiveness program, but it was a very limited amount of time. The group was notified that CMHA had communicated with department staff about the short turnaround time with the following message:

- A longer lead time in advance of the application period. MDHHS indicated that the notice of the next application period will be provided farther in advance of the next application period to give applicants more time to prepare materials for submission during the application period.

- A second application period for the Mi Kids Now Loan Repayment Program will take place in the spring of 2023, with new dollars for this program included in the FY 2023 budget.

- A similar loan repayment program – but for clinicians serving adults - is expected to be funded with the FY 2023 appropriations line designated for strengthening the behavioral health recruitment and retention efforts.

State facility billing update: Several CMHs indicated that they have halted the payment of state facility bills and have filed billing dispute notifications with MDHHS. The group discussed a possible strategy to move the issue forward. Suggestions included seeking at Attorney General's opinion, legislative involvement through boilerplate or statute, or seeking another 3rd party to get involved. Alan Bolter agreed to reach out to Rep. Felicia Brabec and ask for her help on this topic, CMHA members want timely and accurate bills and to be responsible for the BH services, should not be paying for physical health costs. CMHA staff will report back to the group after they meet with Rep. Brabec.

Changes in county commission make-up – Alan Bolter shared with the group the Kent County contract language used by county commission candidates in Kent County (the platform they were running on). CMHA staff wanted members to be aware this was happening in parts of the state – Ottawa County had almost all of it board loose to such candidates, Lapeer county saw 5 of the 7 commissioners loose to Contract type candidates, Muskegon and North Country also have new commissioners that are similar.

Behavioral Health and Opioid Health Homes – Someone asked the question about expansion of BHH & OHH, below is the boilerplate that outline the expansion:

BHH and OHH Boilerplate language from DHHS FY '23 budget: BHH and OHH (pp. 208-209)
Sec. 1005. (1) From the funds appropriated in part 1 for health homes, the department shall maintain the number of behavioral health homes in PIHP regions 1, 2, 6, 7, and 8 and maintain the number of substance use disorder health homes in PIHP regions 1, 2, 4, 6, 7, 9, and 10. The department may expand the number of behavioral health homes in PIHP region 5 and the number of substance use disorder health homes in PIHP regions 3, 4, 5, and 8.

(2) On a quarterly basis, the department shall provide a report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on the number of individuals being served and expenditures incurred by each PIHP region by site.

State Demonstration and Expansion CCBHC sites – Concerns remain for some on becoming a CCBHC site, no contract providers available, geographic size (6 counties 3200 sq miles), financial concerns – required to take all comers. Concern around FQHC becoming CCBHC, unfunded mandates for various services.

Sarah Lurie from CEI raised a concern that the PPS payment will not cover all of their CCBHC related expenses. Can they use Medicaid lapse dollars to cover those costs? They also want to look at the mechanics of CCBHC shortfall, how is that resolved?

Discussion, with MDHHS leadership, of a range of policy, practice, and statutory issues

Workforce Shortage: **Kristin Jordan** – kicked off a workforce steering committee to collect information across the department, over 100 priorities on the list. DHHS ranked items high – medium – low, Director Hertel blessed the list and they can now work on the items. Wages, admin requirements, duplication of efforts, reporting requirements – goal is to stabilize the workforce. TIMEFRAME – Less than a year for quick wins (6 months – year for timing) direct link between Belinda's efficiencies group and the workforce steering committee.

What are the quick wins? Reviewing contracts looking for duplication, admin requirements, communication and marketing for DCW workers – benefits of working in the field. HMA will do market research with DCW on how we can do a better job on recruiting and retaining staff

Funding MSU/Wayne state to increase psych students. Behavioral Health tuition reimbursement first tier of awards will go out to CMH staff, getting announcements out in the next 6 months.

Conflict Free Work **– Belinda Hawks/TBD Solutions (Josh Hagedorn & Remi Romanowski)**

Inform – frame – feedback stage in workgroup right now , how requirements are interrupted, waiver questions. Frame – define problem, criteria, develop options and evaluate options. Options need to be developed – state has not selected an option. DHHS plans to adopt 1 statewide option / regulation

Survey and listening session will capture how workgroup prioritize criteria (timing mid/late October for listening session, 1 evening 1 daytime session – virtual). Is this just an I/DD – Belinda DHHS expanded to kids and SMI group

Administrative Burden **– Belinda Hawks** – A workforce flexibility document from DHHS (included in the packet) 2 meetings in the summer to revise and update the info and document. Items they could act on they did and act on it was updated in spreadsheet.

DHHS will focus on training requirements and admin burdens, they will use the document as a framework to move forward

Belinda said DHHS going to put together a HSRI workforce availability survey for I/DD services, look at individuals served but also look at the stability of workforce – start time of February or March of 2023. Survey would compare MI to other states

MI Kids Now Initiative **– Lindsay McLaughlin** – Ali Cosgrove is the new Chief of Staff for the Children's Bureau

Lindsay McLaughlin and Phil Kurdunowicz provided an overview of this initiative with a focus on the movement to the use of CANS, from CAFAS, for all children served in the state's mental health and child welfare systems. Lindsay also talked about the loan repayment program and allowing for more time up front.

Crisis Stabilization and Psych Bed Registry **– Krista Hausermann –** No significant news for bed registry – LARA still rolling out, holding listening session for ED staff, LARA will send out info in November, LARA is going to create a webpage. Trying to integrate with psych hospital EHR platform to get the real time info.

CSU – still working through the rules (in lieu of licensing) working through the rules process, working on certification rules for adults first then kids (end of 2023 for completion). Want to focus on kids CSUs in 24. Working to create a CSU pilot for 23 (up to 10 sites) up and running by mid 2024, create best practices etc. DHHS wants cites to get certified once that process is finalized (come into compliance once the rules are finalized)

MCTP/PRTF/Community Residential and state hospital capacity, discharges **– Dr. Mellos –** Dr. Mellos walked through a slide deck on careflow which reviewed the evaluations for competency at the Forensic Center is way up, Probate waitlist is 70 (chapter 4) IST in jail is 90 (chapter 10), IST bonded is 50 (chapter 10 process)

Dr. Mellos was optimistic on workforce, he said in the last 3 weeks DHHS has had an significant uptick in applications for DCW. DHHS only took 70 beds offline, 7 of them being kids beds.

Tiered Rate Process **– Jackie Sproat –** Work on the tiered rate is on pause, DHHS priority continues to be how any future tiered rate process will help increase access to inpatient care., available funding – proposal must align with objectives and available money.

MDHHS plans for use of opioid settlement dollars **– Jared Welehodsky** – DHHS discussing investment plans and projects with settlement dollars – expanding recovery housing (DHHS looking seeking recommendations for models), highest at-risk someone recently released from jail or prison, improving the care and coordination coming a priority (housing is an issue for parolees, not connected to transportation, too many parolees in one place is not a good idea, are the dollars flexible – can we fill in other gaps (bricks and motar), more flexible than other grant dollars.

Update on CCBHC State Demonstration initiative and efforts related to potential permanency of the CCBHC system in Michigan **– Lindsey Naeyaert –** Overview on permanency – demo extended to 2027 and add additional sites through HHS, waiting on feedback from HHS on guidance to expand the demo (no short term plans to add CCBHC to ISPA or waiver) 44,000 Medicaid in CCBHC & 7200 non Medicaid people. DHHS will finalize mid-year check in with CCBHC sites and determine how best to support sites in year 2 of demo. Update handbook and adding additional codes and develop cost report as year end close out and review quality data.

Monique will send follow-up email out to the group referencing CCBHC numbers.

Debriefing from the morning's MDHHS discussions or any other issues:

Concerns over specific actions, decisions, or lack of action by MDHHS: Directors Forum members noted a number of concerns with MDHHS initiatives, and the lack of urgency by MDHHS on a number of fronts:

Conversation regarding eGRAMS as a tool, the group was concerned that DHHS staff was unaware of the administrative problems with the tool. – it is very complicated causing members to redo 5-6 times.

Groups feels that communication with MDHHS has gotten worse in the past 6 months, no coordination withing department staff and no sense of urgency.

DHHS staff does not understand the admin issues / burdens of what it actually means – site visits, eGRAMS. The groups thinks we should give MDHHS specific examples, make a list of urgent items to tackle first.

CMHA should prioritize the list of recommendations based on urgency, convey the importance of the issues. MDHHS should not be allowed to add something new without taking something away. There must be improved communication and coordination across the department in order to avoid conflict – they continue to send out messages and requests for information then it changes and is requested by someone else.

The group would like to meet at the Fall conference to review the meeting with Farah Hanley and CMHA staff and discuss next action steps on a number of issues. CMHA staff is setting up the meeting for Monday morning of the conference.

In addition the group discussed the possibility of the January meeting being with ONLY Farah and/or Director Hertel in order to have a more in depth conversation. What is the value to the department updates at these meetings?

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITY ADMINISTRATION

FINANCIAL LIABILITY FOR MENTAL HEALTH SERVICES

Filed with the secretary of state on September 20, 2022

These rules become effective 7 days after filing with the secretary of state.

(By authority conferred on the department of health and human services by sections 114, 818, and 842 of the mental health code, 1974 PA 258, MCL 330.1114, 330.1818, and 330.1842)

R 330.8005, R 330.8239, R 330.8240, R 330.8242, and R 330.8279 of the Michigan Administrative Code are amended, as follows:

PART 8. FINANCIAL LIABILITY FOR BEHAVIORIAL HEALTH SERVICES

SUBPART 1. DEPARTMENT OF HEALTH AND HUMAN SERVICES

R 330.8005 Definitions.

Rule 8005. As used in this part:

(a) "Assets" means real and personal property that is owned, in whole or in part, by the responsible party and that has cash value or equity value.

(b) "Department" means the department of health and human services.

(c) "Dependent" means an individual who is allowed as an exemption under section 30 of the income tax act of 1967, 1967 PA 281, MCL206.30.

(d) “Excess medical expenses” means medical and dental expenses that exceed the threshold dictated by section 16 of the internal revenue code of 1986, 26 USC 213, that would be allowed to be deducted on itemized tax returns, less expenses for medical health services for the individual paid to the department or community mental health services programs.

(e) “Family of 1” means the individual who has no dependent.

(f) “Family of 2” means the individual and their spouse.

(g) “Family size” means a family unit consisting of the individual, spouse, and dependents.

(h) “Individual” means the individual, minor or adult, that receives services from the department or a community mental health services program or from a provider under contract with the department or a community mental health services program.

(i) “Liquid asset” means an asset that can be easily converted to cash. Examples of liquid assets include, but are not limited to, the following:

(i) Checking and savings accounts.
(ii) Cash.
(iii) Certificates of deposit.
(iv) Treasury bills.
(v) Money market investments.
(vi) Bonds.
(vii) Marketable securities, including stocks and bonds.
(viii) Pensions.
(ix) Deferred compensation.
(x) Annuities.
(xi) Other funds that can be withdrawn or used as collateral for a loan.

(j) “Poverty guidelines” means the version of the poverty threshold as issued annually by the United States Department of Human Services.

(k) "Protected assets" means the portion of assets, as specified in these rules, that must not be considered when the total financial circumstance is used to determine financial liability.

(l) "Protected income" means the portion of income, as specified in these rules, that must not be considered when the total financial circumstance is used to determine financial liability.

(m) “Qualifying income” means income from whatever source derived, regardless of whether the source is reported on federal or state returns. Qualifying income includes, but is not limited to, the following:
(i) Earned and unearned income.
(ii) Government benefits.
(iii) Other entitlements.

(n) “Responsible party” means a person who is financially liable for services furnished to an individual, including the individual, and, as applicable, the individual’s spouse and parent or parents of a minor.

(o) "Spouse" means the legal marriage partner of the individual.

(p) "Undue financial burden" means a determination of ability-to-pay that would unduly impact the health and well-being of the individual or dependents to access the basic necessities of life, including, but not limited to, food, housing, clothing, and healthcare.

R 330.8239 Determination of ability-to-pay for non-residential services; parents of an individual; member or non-member of the household.

Rule 8239. (1) A responsible party’s ability-to-pay for nonresidential services must be the amount established by this rule’s non-residential ability-to-pay table based upon the responsible party’s qualifying income and the most current poverty guidelines. The responsible party’s ability-to-pay must be established on a per-session, monthly, or annual basis, and the basis selected, and methodology used must be identified and described in the department’s and community mental health services program’s written policies.

(2) The ability-to-pay for a parent of an individual must be determined, as follows:

(a) If the parents of an individual, or the individual and spouse, are members of the same household, the department or community mental health services program shall use

the combined qualifying income to determine the ability-to-pay.

(b) If the parents of an individual, or the individual and spouse, are not members of the same household, the ability-to-pay of each parent or of the individual and their spouse is determined separately.

(c) A parent shall not be determined to have an ability-to-pay for more than 1 individual at any 1 time, and a parent's total liability for 2 or more individuals shall not exceed 18 years.

(d) If either parent or either spouse has been made solely responsible for an individual's medical and hospital expenses by a court order, the other parent or spouse is determined to have no ability-to-pay.

(e) The ability-to-pay of the parent or spouse made solely responsible by court order must be determined in accordance with this section. The ability-to-pay of a parent made solely responsible by court order must be reduced by the amount of child support the parent pays for the individual.

(f) If an individual receives services for more than 1 year, the department or community mental health services program must annually redetermine the adult responsible parties' ability-to-pay.

(3) An ability-to-pay may be determined on a per-session basis for nonresidential services other than respite care services. During a calendar month, the per-session ability-to-pay must not be more than the monthly ability-to-pay amount determined from the non-residential ability-to-pay process and table specified as follows:

(a) Determine the percent of poverty specified as the current federal minimum mandatory income level to qualify for medical assistance program or its successor, as specified in the patient protection and affordable care act of 2010, Public Law 111-148, or its successor.

(b) Multiply 100% of poverty guideline income for family size by the percentage determined in subdivision (a) of this subrule. The result is the income level at which the responsible party will have zero ability-to-pay from this table.

(c) Determine qualifying income.

(d) Divide qualifying income by income calculated in subdivision (b) of this subrule and convert to a percentage.

(e) Match the percentage determined in subdivision (d) of this subrule to the table in subrule (4) of this rule to determine the percent of income to charge as the ability-to-pay.

(f) Deduct from qualifying income the poverty guideline income for family size determined in subrule (b) of this rule, at which the responsible party will have zero ability-to-pay. The result is income available for cost of care.

(g) Multiply the percentage determined in subrule (e) of this rule by income available for cost of care determined in subrule (f) of this rule. The result is the annual ability-to-pay.

(4) The following income and ability-to-pay crosswalk table must be used in the determination of the percent income for subrule (3)(e) of this rule.

Qualifying income as percent of applicable poverty guidelines charged as ability-to-pay	Percentage of Income
100%	0%
101 - 125%	3%

126 - 150%	4%
151 - 175%	5%
176 - 200%	6%
201 - 225%	7%
226 - 250%	8%
251 - 275%	9%
276 - 300%	10%
301 - 325%	11%
326 - 350%	12%
351 - 375%	13%
376 - 400%	14%
401 +	15%

(5) The per-session ability-to-pay is applicable to each session of service provided to all individuals for whom the responsible party has an obligation to pay under section 804 of the mental health code, 1974 PA 258, MCL 330.1804, but may not be, in aggregate, more than the monthly ability-to-pay amount.

(6) A responsible party who has been determined under the medical assistance program or its successor to be Medicaid eligible is determined to have a $0.00 ability-to-pay for all mental health services other than inpatient. The ability-to-pay for inpatient services must be the amount determined as the patient pay amount by the medical assistance program or its successor.

(7) If the ability-to-pay for parents is assessed separately and their combined ability-to-pay is more than the cost of services, then the charges must be prorated based on the ratio of each parent's income.

(8) A responsible party may request a new determination, based on the party's total financial circumstances, within 30 days after notification of the initial determination made from the ability-to-pay process and table specified in subrule (4) of this rule.

(9) Parents of children receiving public mental health services under the home and community-based waivers are determined to have a $0.00 ability-to-pay for the services provided as part of the community-based waivers for children. Parents shall independently arrange and pay for services that exceed or are not included in the services provided under the home and community-based waivers for children if the parent desires expanded services or those services are not included.

R 330.8240 Determination of fee for respite services.

Rule 8240. (1) The fee for respite services for a full day or any portion of the day must be determined by dividing the monthly ability-to-pay amount determined from the non-residential table specified in R 330.8239 by 30 and rounding up to the nearest dollar but must not be more than the cost of services. A responsible party may request a new determination under R 330.8239(8).

(2) Respite fees charged during a calendar month may not be, in aggregate, more than the monthly ability-to-pay amount determined from the non-residential table.

R 330.8242 Ability-to-pay determinations based on total financial circumstances.

Rule 8242. (1) If a responsible party's ability-to-pay is determined pursuant to section 819 of the mental health code, 1974 PA 258, MCL 330.1819, all the following provisions apply:

(a) The financial determination based on the responsible party's total financial circumstances must consider all the following as specified in these process and table in subrule (2)(i) of this rule:

(i) Qualifying income and protected income.

(ii) Net liquid assets and protected assets.

(iii) Applicable poverty guidelines for family size.

(iv) Excess medical expenses.

(v) Court-ordered payments, including those payments from a divorce decree.

(vi) Student loan payments.

(vii) Additional tax obligations assessed by municipal, county, state, or federal taxing authorities.

(b) If the responsible party is the individual and is a family of 1 who has no expenses other than room and board expenses in an inpatient, specialized residential, or supported independent housing, an alternate full financial determination under subrule (2) of this rule must be completed that does not take into consideration all the provisions specified in R 330.8242. This alternate full financial determination must only include the following:

(i) Qualifying income and protected income.

(ii) Net liquid assets and protected assets.

(iii) The personal needs allowance under the medical assistance program or its successor.

(iv) Expense deduction equal to the provider payment rate for appropriate living arrangements allowed under the medical assistance program or its successor.

(c) When determining ability-to-pay for an individual receiving inpatient services, one half of any compensation paid to the individual for performing labor under section 736 of the mental health code, 1974 PA 258, MCL 330.1736, must be protected.

(d) Protected assets must be the same asset limit amounts allowed for the Medicaid group 2 category under the medical assistance program or its successor.

(e) The department shall develop policies, procedures, and other tools for use in calculating a responsible party's ability-to-pay under these rules.

(2) The public mental health system full financial consideration ability-to-pay process and table is described as follows:

(a) Determine the percent of poverty specified as the current federal minimum mandatory income level to qualify for medical assistance programs or its successor as specified in the patient protection and affordable care act of 2010, Public Law 111-148, or its successor.

(b) Determine net assets by subtracting all costs incurred to liquidate liquid assets, including protected assets, from liquid assets.

(c) Determine qualifying income.

(d) Deduct from qualifying income to determine total income available for cost of care for all the following:

(i) Protected income.

(ii) Poverty guideline for family size at percent or poverty determined in subdivision (a) of this subrule.

(iii) Excess medical expenses.

(iv) Court ordered payments, including a divorce decree.

(v) Student loan payments.

(vi) Additional tax obligations assessed by municipal, county, state, or federal taxing authority. The result is income available for cost of care.

(e) Divide qualifying income from subdivision (c) of this subrule by the poverty guidelines for family size at 100% of poverty and convert to a percentage.

(f) Match percentage determined in subdivision (e) of this subrule to the table in subrule (3) of this rule to determine the percent of income available for cost of care to charge as ability-to-pay.

(g) Multiply the percentage determined in subdivision (f) of this subrule by the income available for cost of care determined in subdivision (a) of this subrule. The result is the annual ability-to-pay from income.

(h) Add net assets from subdivision (b) of this subrule to the annual ability-to-pay from income determined from subdivision (g) of this subrule. The result is the annual ability-to-pay.

(3) The following income and ability-to-pay crosswalk table must be used in the determination of the percent income for subrule (2)(f) of this rule.

Qualifying Income as a Percent of applicable poverty guidelines.	% Of Income charged as Ability- to-Pay
100%	0%
101 - 200%	10%
201 - 250%	15%
251 - 300%	20%
301 - 400%	25%
401+	30%

(4) The alternate calculation process for full financial consideration for ability-to-pay is as follows:

(a) Determine net assets by subtracting all costs incurred to liquidate liquid assets and protected assets from liquid assets.

(b) Determine qualifying income.

(c) Deduct from qualifying income, as applicable, all the following:

(i) Protected income.

(ii) Personal needs allocation.

(iii) Expense deduction equal to the provider payment rate for appropriate living arrangements as allowed under the medical assistance program or its successor. The result is the income available for the cost of care.

(d) Add net assets from subdivision (a) of this subrule to income available for cost of care from subdivision (c) of this subrule. The result is the annual ability-to-pay.

R 330.8279 Undue financial burden.

Rule 8279. A responsible party's ability-to-pay must not create an undue financial burden that does either of the following:

(a) Unduly impacts the health and well-being of the individual or their dependents as determined by the ability to access the basic necessities of life, including, but not limited to, food, housing, clothing, and healthcare.

(b) Deprives the party and his or her dependents of the financial means to maintain or reestablish the individual in a reasonable and appropriate community-based setting.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

September 30, 2022

Mr. Timothy Engelhardt, Director
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW Mail Stop 315H
Washington, DC 20201

Dear Mr. Engelhardt,

On April 15, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a one-year extension to Michigan's MI Health Link demonstration. To clarify our future goal for this program, the Michigan Department of Health and Human Services (MDHHS) expressed its intent to pursue a multi-year extension of the end date for its Financial Alignment Initiative (FAI) program through December 31, 2026.

In accordance the recent final rule, CMS-4192-F, MDHHS is pleased to present to CMS its transition plan to move its Medicare-Medicaid Plans into an Integrated Special Needs Plan (SNP) model by January 1, 2026.

Michigan intends to build on the lessons learned through its FAI in the development of a Highly Integrated Dual Eligible or Fully Integrated Dual Eligible SNP model. MDHHS is committed to obtaining stakeholder input leading up to the implementation of its integrated model and will make incremental changes to existing programs to assure a seamless transition for currently enrolled MI Health Link members beginning in 2026.

We look forward to your feedback and our continued partnership with the Medicare-Medicaid Coordination Office through this transition.

Sincerely,

Farah Hanley
Chief Deputy for Health

ar/sw/FAH

Attachment

cc: Scott Wamsley, Director, Bureau of Aging, Community Living, and Supports
Erin Emerson, Director, Strategic Partnerships and Medicaid Administrative Services
Nicole Hudson, State Assistant Administrator, MDHHS
Pam Gourwitz, Director, Integrated Care Division

Transition Plan for MI Health Link

Michigan Department of Health and Human Services

September 2022

Disclaimer: The decisions in this transition plan are under MDHHS' consideration and subject to change.

Acronyms

BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMHSP	Community Mental Health Services Program
CMS	The Centers for Medicare and Medicaid Services
CY	Calendar Year
D-SNP	Dual Eligible Special Needs Plan
FAI	Financial Alignment Initiative
FIDE SNP	Fully Integrated Dual Eligible Special Needs Plan
HCBS	Home- and Community-Based Services
HIDE SNP	Highly Integrated Dual Eligible Special Needs Plan
ICO	Integrated Care Organizations
ICT	Integrated Care Team
I/DD	Intellectual and Developmental Disabilities
IT	Information Technology
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MCO	Managed Care Organization
MDHHS	Michigan Department of Health and Human Services
MHLO	The MI Health Link Ombudsman
MHP	Medicaid Health Plan
MLTSS	Managed Long-Term Services and Supports
MMP	Medicare-Medicaid Plan
PIHP	Prepaid Inpatient Health Plan

RFP	Request for Proposal
SMAC	State Medicaid Agency Contract
SPA	State Plan Amendment

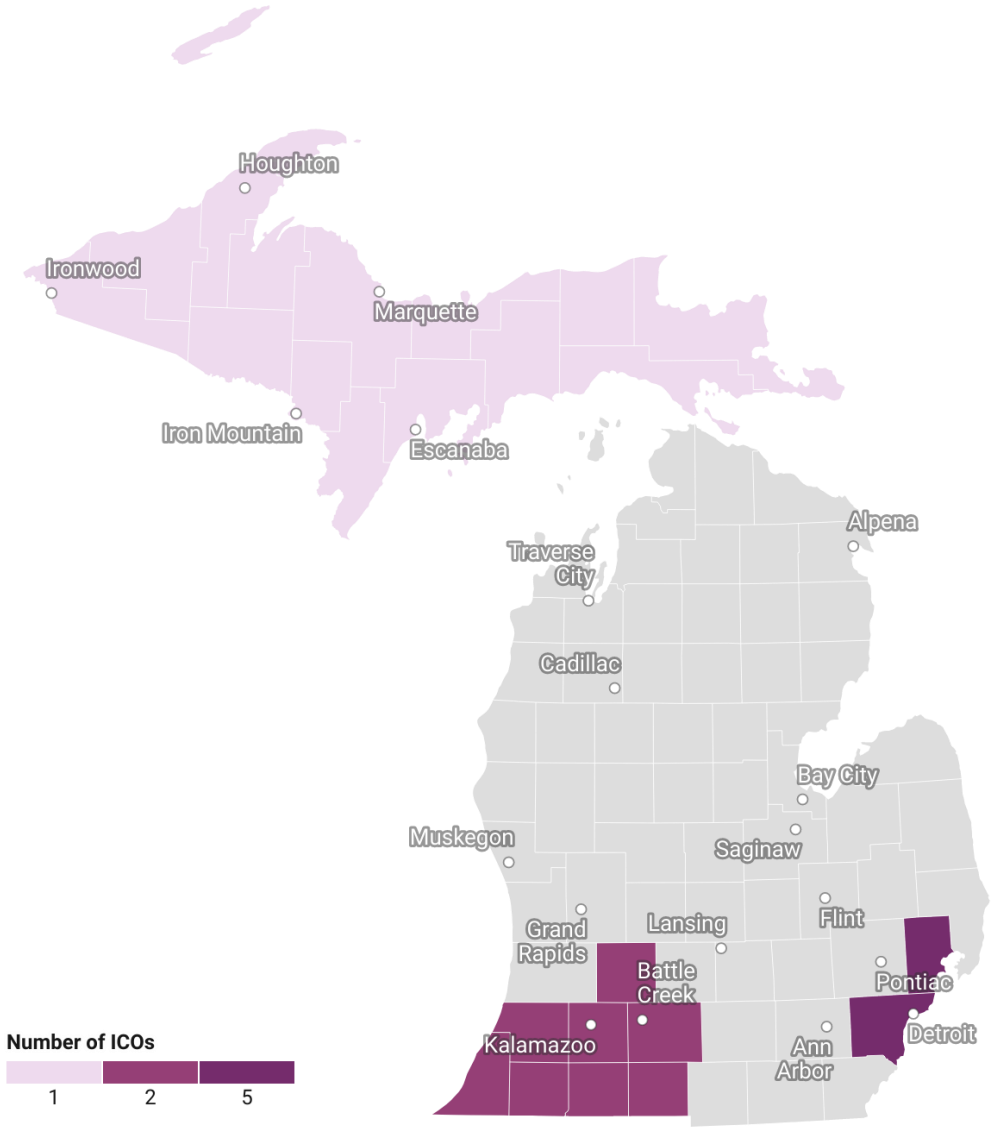
Background

The Centers for Medicare and Medicaid Services (CMS) released its Medicare Advantage (MA) and Part D Final Rule on April 29, 2022. Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (hereafter referred to as the final rule) includes considerable modifications to CMS regulations governing Dual Eligible Special Needs Plans (D-SNPs), with implications for Michigan's Medicaid programs serving dually eligible individuals and the state's overall duals strategy. One of the final rule's provisions is that the Financial Alignment Initiative (FAI) demonstration (MI Health Link in Michigan) will end on December 31, 2023. However, states have the opportunity to transition their Medicare-Medicaid Plans (MMPs) to integrated D-SNP models by December 31, 2025, if they submit a transition plan to CMS by October 1, 2022. The MI Health Link demonstration intends to transition to an Integrated Dual Eligible Special Needs Plan by January 1, 2026, and is exploring the best option for Michigan, either a highly integrated or fully integrated D-SNP. Building off the successes of MI Health Link, MDHHS's will work to provide as much continuity and coordination into the D-SNP as possible. This transition plan details successes and lessons learned during the demonstration, key features of Michigan's planned integrated D-SNP model, considerations for the transition, Michigan's process for engaging stakeholders, and the State's timeline for policy and operational steps.

The MI Health Link demonstration was launched by Michigan and CMS on March 1, 2015, to coordinate care for dually eligible individuals ages 21 and above. Through a three-way contract between CMS, Michigan, and the Integrated Care Organizations (ICOs - Michigan's term for MMPs), CMS and Michigan give the ICOs risk-adjusted capitation payments to finance all Medicare and most Medicaid services. The ICOs also "provide care coordination, supplemental benefits required under the demonstration, and flexible benefits that vary from plan to plan".[1] Medicaid long-term services and supports (LTSS) are covered through the ICOs while Medicaid behavioral health (BH) services are carved out. MI Health Link continued the existing structure for Medicaid BH services, substance use disorder services, and home- and community-based services (HCBS) waiver services for people with intellectual or developmental disabilities (I/DD) wherein these are financed through specialty managed care plans called Prepaid Inpatient Health Plans (PIHPs). The Michigan Department of Health and Human Services (MDHHS) contracts directly with the PIHPs for the Medicaid BH benefit and the ICOs contract with the PIHPs for the Medicare BH benefit. MI Health Link operates in four regions, spanning the following counties: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne, and all counties in the Upper Peninsula. Figure 1 (below) depicts the number of ICOs that serve each county within MI Health Link's service areas.

[1] Holladay, Scott, Jennifer Howard, Matt Toth, Guadalupe Suarez, Brittany D'Cruz, Ben Huber, Paul Moore, et al. "Financial Alignment Initiative Michigan MI Health Link Second Evaluation Report." RTI International, March 2022. https://innovation.cms.gov/data-and-reports/2022/fai-mi-secondevalrpt.

Figure 1. Number of ICOs in MI Health Link service areas



MI Health Link's key successes

The Michigan MI Health Link Second Evaluation Report found that the program is broadly supported by stakeholders. Michigan's MMPs have achieved high Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores on beneficiary satisfaction surveys over the years, with several top scores among MMP plans nationwide every year. Beneficiaries consistently report that the most important aspects of MI Health Link are the following:

1. $0 copayments and deductibles for all covered services
2. Access to a care coordinator to help them navigate their care and to assist with care planning

3. A single card for all Medicare and Medicaid services

Enrollees also valued the additional benefits and improved access to some services provided by MI Health Link. MI Health Link joined Medicaid LTSS and HCBS into a single managed care model, which had never been done before in Michigan. The demonstration expanded beneficiaries' access to State Plan Personal Care services through its 1915(b) waiver, and through a corresponding 1915(c) waiver program, expanded access to HCBS. Finally, MI Health Link built a strong, data-driven quality of care program that included traditional health plan quality metric oversight and an intelligent assignment algorithm to passively enroll eligible individuals into ICOs based on ICOs' performance and capacity. This strengthened MI Health Link's health plan oversight, compliance, and program outcomes.

Lessons learned from MI Health Link

MI Health Link created pathways for ICOs to support beneficiaries who could be safely transitioned from a nursing home to community living. The demonstration required ICOs to cover State Plan Personal Care services and nursing facility transition services. It also created a complementary 1915(c) waiver that allows beneficiaries who qualify for nursing facility level of care (NFLOC) with expanded Medicaid eligibility (i.e., the 217 group) to access HCBS through their ICO. The program has seen an incremental increase in transitions per year since 2019 despite care coordination challenges and other barriers that were exacerbated by the COVID-19 pandemic. However, early evaluation data comparing MI Health Link beneficiaries to other Medicaid beneficiaries with long-stay nursing facility admissions, showed that MI Health Link beneficiaries had a higher functional status and needed a lower level of care. This suggests that there is an opportunity for ICOs and nursing facilities to identify additional higher functioning individuals who are interested and able to transition, and to provide the appropriate care coordination and discharge planning to assure appropriate supports are in place for them to safely reside in the community.

Another lesson learned involves the need for improved behavioral health coordination to support whole person needs. Effective communications and data sharing between the ICOs and PIHPs have been a persistent challenge. The State addressed this in part, by building an information technology system for the entities to exchange information and convening a workgroup for operational and technical assistance. However, challenges have continued, "particularly in Southeast Michigan where each PIHP works with five ICOs".[2] This could be addressed through further coordination and plan accountability, which would improve the timeliness of information sharing and help plans adapt to beneficiaries' needs in real time.

Having multiple sources of enrollment data, as well as ongoing transaction processing challenges, also presented lessons and opportunities. Uncertainty about beneficiaries'

[2] Holladay, Scott, Jennifer Howard, Matt Toth, Guadalupe Suarez, Brittany D'Cruz, Ben Huber, Paul Moore, et al. "Financial Alignment Initiative Michigan MI Health Link Second Evaluation Report." RTI International, March 2022. https://innovation.cms.gov/data-and-reports/2022/fai-mi-secondevalrpt.

enrollment status negatively impacted ICOs', providers', and enrollees' experiences in the program. ICOs have consistently highlighted the lack of a single source of truth for enrollment status as an issue. This has generated financial challenges for the State and ICOs, as the ICOs are "expected to provide services to enrollees whose status was in doubt [and this] appears to have resulted in subsequent enrollment reconciliations by the State".[3] The Second Evaluation Report suggests alleviating challenges and costs by using a single source of truth for enrollment.

Michigan's 2022 D-SNPs

Michigan currently has a coordination-only D-SNP model. The state has 17 D-SNPs. Figure 2 shows the number of counties that each D-SNP serves, which ranges from 75 to 3, with an average of 35.

Figure 2. Number of counties served by D-SNPs

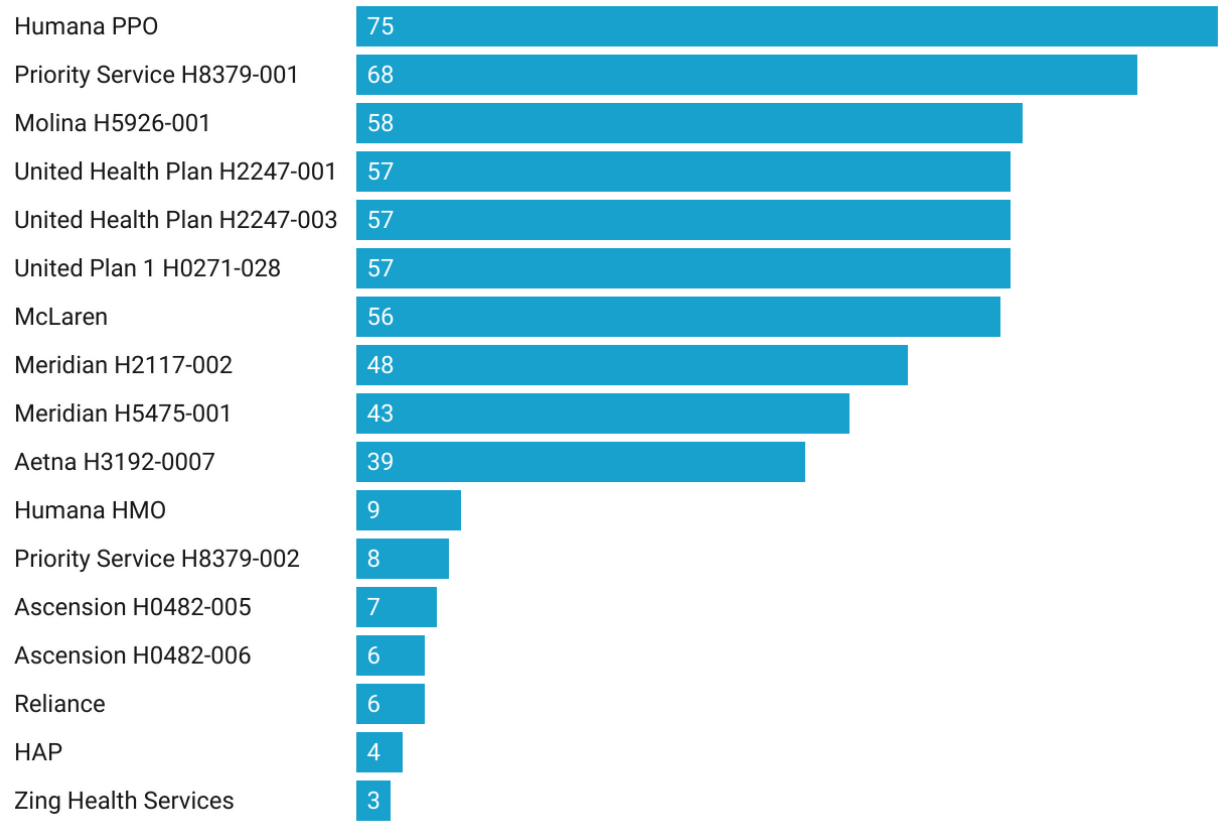
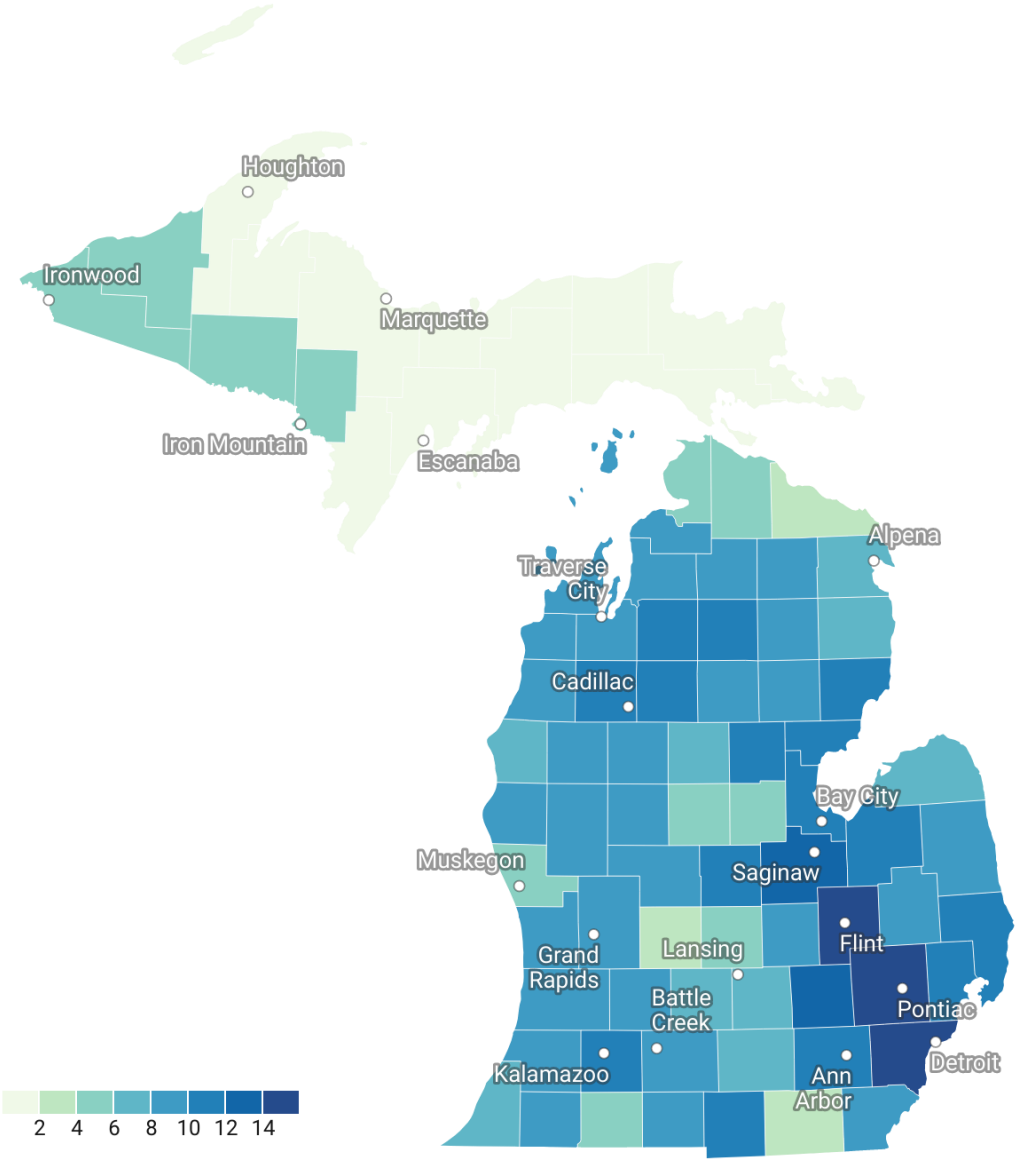


Figure 3 (below) shows that in every county across the state there is at least one D-SNP. The number of D-SNPs per county ranges from 1 (in many Upper Peninsula counties) to 15 (in Genesee, Oakland, and Wayne counties). The average number of D-SNPs per county is 7.

[3] Holladay, Scott, Jennifer Howard, Matt Toth, Guadalupe Suarez, Brittany D'Cruz, Ben Huber, Paul Moore, et al. "Financial Alignment Initiative Michigan MI Health Link Second Evaluation Report." RTI International, March 2022. https://innovation.cms.gov/data-and-reports/2022/fai-mi-secondevalrpt.

Figure 3. Number of D-SNPs per county



As of 2021, between 11 to 25 percent of full benefit duals are served by D-SNPs in Michigan[4].

[4] Talamas, Ana, Kelsey Cowen, Giselle Torralba, and Danielle Perra. “Working with Medicare Webinar - State Contracting with D-SNPs: Introduction to D-SNPs and D-SNP Contracting Basics.” Integrated Care Resource Center, December 2020. https://www.integratedcareresourcecenter.com/webinar/working-medicare-webinarstate-contracting-d-snps-introduction-d-snps-and-d-snp-contracting

Michigan’s Plan for an Integrated D-SNP model

MDHHS welcomes the opportunity to continue the successes of the MI Health Link program by exploring the conversion to an Integrated Dual Eligibles Special Needs Plan by January 1, 2026. MDHHS is exploring a transition to a highly or fully Integrated D-SNP, with the expectation of providing the greatest degree of continuity in the infrastructure and expectations for beneficiaries, providers, and health plans. Over the coming two years, MDHHS will work closely with beneficiaries, stakeholders, and health plans to ensure a successful and sustainable program. To maintain the successful elements of MI Health Link and build off its high level of coordination, MDHHS is exploring the best option to transitions to an integrated D-SNP. The transition to an integrated D-SNP will require strong stakeholder engagement, changes to State Medicaid Agency Contracts along with other policies regarding D-SNP contracting. These changes will be ready for implementation and launch of the new Duals Special Needs Plan on January 1, 2026.

MDHHS will submit a 1915(b/c) waiver renewal application for MI Health Link to gain an extension through at least 2025, as the current authority ends in December 2024. It is not yet determined whether the State will allow the waiver to sunset or use another waiver after the transition. Additionally, existing authority for the MDHHS Comprehensive Medicaid Managed Care Program carves LTSS and BH out of the health plan contract. MDHHS is still reviewing how to best coordinate LTSS and BH services. Stakeholder involvement and new authorities may be required for this transition.

MDHHS is aware that the upcoming Comprehensive Medicaid Managed Care Health Plan contract re-procurement will be occurring during the MMP transition period, and the results of this re-procurement have the potential to significantly impact the State’s current landscape for serving dually eligible individuals through a coordinated model. MDHHS is also aware that while MMP and D-SNP contracts operate on a Calendar Year timeline, the Comprehensive Medicaid Managed Care Plans use a Fiscal Year calendar. The State is exploring potential re-procurement impacts, as well as the impacts of this operational difference as it considers contracting and authority options.

Table 1. Key features of Michigan's Integrated D-SNP model

Feature	MDHHS' plan
Eligibility	Based on the current eligibility for MI Health Link, individuals who are enrolled in both Medicare and Medicaid and who are aged 21 or older will be eligible for the new integrated D-SNP model. MDHHS is exploring whether to include duals under age 21 in its model as the current D-SNP footprint is statewide and covers duals of all ages, including those that are not considered Full-benefit duals. Additionally, MDHHS may consider some population exclusions, to be determined.
Medicaid benefits	**Covered benefits:** The integrated D-SNPs will be required to cover all Medicaid benefits that are covered by MI Health Link. This includes, but is not limited to, physical healthcare, possibly behavioral healthcare, medications, LTSS, and care coordination. MDHHS is still determining how all of these services will be coordinated. MDHHS intends to require that Medicaid LTSS, including HCBS benefits for individuals who qualify for a nursing facility level of care, nursing facility services, and personal care, be covered. A complete list of current MI Health Link services can be found here. **LTSS:** MI Health Link united Medicaid LTSS and HCBS into a single managed care model. MDHHS intends to maintain this robust and successful LTSS system by keeping LTSS carved in. The State is continuing to explore arrangements established in other states that create pathways for community partnerships in the LTSS space. **HCBS:** MDHHS plans to retain its HCBS coverage upon transitioning to an integrated D-SNP. Michigan will work with CMS to determine the preferred approach to transition this element within a D-SNP model. This may include requiring D-SNPs to include HCBS as a supplemental benefit or establishing a new 1915(c) waiver to operate concurrently with the D-SNP. **BH:** Michigan is pursuing behavioral health coordination and collaboration. MDHHS will continue soliciting input from stakeholders to inform its approach. **Carve-outs:** Michigan is still reviewing which carve outs may be necessary, in accordance with the final rule.
No deductibles or co-payments	Michigan intends to institute a policy of zero cost sharing for beneficiaries under its new

	integrated D-SNP. In MI Health Link, the ICOs are required to cover all services without deductibles or co-payments except the resident share of Medicaid long-term nursing facility services. Beneficiaries consistently report that this is a main contributor to their high satisfaction with the demonstration. To ensure that beneficiaries are not billed for co-payments, the current MI Health Link communication practices that explicitly document zero co-payments will be maintained. This includes zero co-pays on member cards, explanations of payments for providers, and an information sheet that members can show providers. MDHHS will work with the D-SNPs to make the new program's zero cost sharing policy clear, using these practices.
Single member ID card	Another element of MI Health Link that enhances beneficiaries' experience is the demonstration's single ID card for all services covered by each ICO. Single member ID cards advance coordination and are used by D-SNPs in other states. Michigan's new model will likewise use a single enrollee ID card for all Medicaid and Medicare covered services.
Care coordination	Michigan's integrated D-SNP model aims to continue the use of Care Coordinators, Integrated Care Teams (ICTs), and person-centered care plans to facilitate collaboration and coordination among enrollees' healthcare providers. Care coordination helps enrollees access Medicare, Medicaid, and other services. It is "characterized by advocacy, communication, and resource management to promote quality, cost effectiveness and positive outcomes" (MI Health Link Contract). As is the case in MI Health Link, care coordination services will be provided by plans' care coordinators – qualified individuals who are trained in person-centered planning. Care coordination will be supported by a beneficiary's ICT – a team that includes the enrollee, their chosen allies or legal representative, care coordinator, primary care physician, and others who are needed or requested by the enrollee. Supported by the ICT, the enrollee will develop and use their person-centered care plan, which will include key information about their health, services, and providers as well as their preferences for care, concerns, and goals. The D-SNPs will employ an electronic platform to support care coordination.
Quality program	MDHHS will apply lessons learned from the MI Health Link demonstration to build a robust quality program for the integrated D-SNP model. Under MI Health Link, an External Quality Review Organization performed compliance reviews of all contracted managed care plans in 2018 and 2019. While D-SNPs are not necessarily subject to this, Michigan is interested in making some of the External Quality Review

	requirements mandatory in its integrated D-SNP model. MI Health Link collects standardized quality metrics from the ICOs. Some of these are quality withhold measures, and "the State and CMS use performance on those measures to determine what portion of the withheld payments will be returned to each plan".[5] MDHHS is exploring these and other ways to financially incentivize performance in the new model. Additional quality activities that Michigan plans to implement include administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to enrollees to assess beneficiary satisfaction. MDHHS recognizes the current quality-based passive algorithm process used in MI Health Link may not translate to an integrated D-SNP environment. The State will work with CMS to explore other ways to incorporate quality-based mechanisms to drive outcomes and performance. MI Health Link recently created a quality and performance data dashboard; MDHHS will consider constructing a similar tool for the new program.
Exclusively aligned enrollment	Michigan aims to pursue exclusively aligned enrollment. The State will seek additional stakeholder feedback as this policy is defined. It will also consult with health plans that have both a D-SNP and either an ICO or Medicaid Health Plan (MHP) regarding their corporate structure to identify any changes plans need to make to come into compliance.
Other enrollment policy options	MDHHS is exploring other policies to promote enrollment into the D-SNP such as default enrollment and Medicaid auto-assignment. With a policy of default enrollment, when Medicaid beneficiaries enrolled in Medicaid Managed Care Organizations (MCOs) become eligible for Medicare, they would be automatically enrolled in their MCO's aligned D-SNP. Default enrollment would thus facilitate beneficiaries' smooth transitions to the D-SNP. The State would provide Medicaid beneficiaries advance notice, including an opt out option. Michigan may also consider using Medicaid auto-assignment. Under this policy, duals who enroll in an integrated D-SNP (with an aligned Medicaid MCO) would be automatically assigned to that D-SNP's aligned Medicaid MCO.

[5] Holladay, Scott, Jennifer Howard, Matt Toth, Guadalupe Suarez, Brittany D'Cruz, Ben Huber, Paul Moore, et al. "Financial Alignment Initiative Michigan MI Health Link Second Evaluation Report." RTI International, March 2022. https://innovation.cms.gov/data-and-reports/2022/fai-mi-secondevalrpt.

	MDHHS recognizes that the on-going passive enrollment process for MI Health Link beneficiaries will need to be dissolved in the integrated D-SNP due to regulatory authority differences. Additionally, MI Health Link does not currently allow ICOs to utilize agents and brokers to enroll beneficiaries directly into their plans. MDHHS plans to adapt to the integrated D-SNP's different enrollment processes during its transition. Stakeholders have expressed interest in changing the current quarterly special election period to be monthly, which aligns with the current enrollment flexibility offered in MI Health Link. MDHHS will solicit additional stakeholder input on these policies and recommendations.
Enrollee advisory committee	In accordance with the final rule, MDHHS will require MA organizations that offer a D-SNP to have at least one enrollee advisory committee in Michigan. The committee's role will be to gather and to respond to input from enrollees. It will be representative of each D-SNP's enrollee population. Per the final rule, this body will ask for enrollees' perspectives about access to and coordination of services, health equity, and how to improve these, as well as other topics. In transitioning to the new enrollee advisory committee requirements, Michigan will draw from its experience with the MI Health Link Advisory Committees and the ICO Advisory Councils. MI Health Link initially developed three state level advisory committees organized by region. Currently, MI Health Link has a single statewide committee for all program regions. The group consists of enrollees, their family members and allies, as well as advocates, peer or trade organization representatives, and service provider representatives. The committee meetings are facilitated by state staff and advocates. The current MI Health Link committee will be dissolved effective 12/31/2025 because it is unknown whether beneficiaries and providers will remain engaged with the program through the transition to an integrated D-SNP model. MDHHS is committed to assuring the majority of membership on the committee consists of program enrollees, their families, or allies and thus will solicit new membership for the integrated D-SNP committee in 2026. Each ICO has at least one consumer advisory council that gives input to the governing board of the parent organization. One-third of ICO council members are enrollees; other members include caregivers and community stakeholders. The ICOs currently support council members' participation by organizing needed transportation, communications, and other activities.

Standardized housing, food insecurity, and transportation questions on Health Risk Assessments	Michigan intends to mandate a standardized health risk assessment for the integrated D-SNPs that includes questions about enrollees' housing stability, food security, and access to transportation, in accordance with the final rule. This tool is being developed and tested in MI Health Link. The standardized assessment for D-SNPs will include questions from the domains outlined in the Final Rule, and may include questions found in CMS's list of screening instruments. The standardized health risk assessment is intended to assure plans are evaluating and assigning risk consistently, as well as help them to gain an understanding of Social Determinants of Health (SDoH) that enrollees may be facing to better address members' needs. To assure compliance with SDoH and other risk related requirements, MDHHS is exploring opportunities to electronically obtain the data from the standardized tool for quality oversight purposes.
Other integration standards	Michigan is exploring other integration standards to use for its D-SNP. These will include requiring contracted plans to provide consolidated communications and materials to enrollees. The State will leverage its experience with MI Health Link to develop additional policies and procedures in accordance with the final rule.

Michigan's plan to sustain the MI Health Link Ombudsman

The MI Health Link Ombudsman (MHLO) is an advocate and problem-solver for MI Health Link beneficiaries. The MHLO's duties include providing information about MI Health Link and other resources, helping to address problems with services and benefits, and supporting beneficiaries with filing grievances, appeals and complaints. Two free legal services programs for low-income Michiganders, Michigan Elder Justice Initiative and the Counsel and Advocacy Law Line, operate the program. MHLO works with beneficiaries primarily through a toll-free hotline and email correspondence. Program staff meet with the CMS-State Contract Management Team monthly. With free and confidential services, the MHLO is an invaluable resource for MI Health Link beneficiaries. MHLO generally "resolve[s] complaints quickly through three-way calls between the enrollee, the ICO, and the MHLO program".[6]

Currently, MHLO is funded by a grant from the Michigan Department of Health and Human Services that is available due to Federal funding. Michigan has received a total of about $2.9 million in Federal funds from CMS in collaboration with the Federal Administration for Community Living for the MHLO since MI Health Link began. When MI Health Link transitions to an integrated D-SNP, Michigan will need to sustain the MHLO through state funds, without Federal grant funding. Michigan is committed to assuring the MHLO program continues in accordance with the Final Rule, and is exploring future funding opportunities, learning from the experiences of other states such as Virginia. As noted in the final rule, Virginia maintained its ombudsman services when its FAI demonstration ended by funding them through Medicaid. MDHHS will continue to engage the MHLO as a key stakeholder throughout the planning and implementation phases of the transition.

[6] Holladay, Scott, Ellen J Bayer, Ira Dave, Cleo Kordomenos, Paul Moore, Joyce Wang, Emily Gillen, et al. "Financial Alignment Initiative Michigan MI Health Link First Evaluation Report." Evaluation to CMS. RTI International, 2019. https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder73/Folder1/Folder173/MI_FAI_EvalReport1.pdf?rev=acc359111473488d8055a8efdc0bd0fc.

Table 2. Key considerations for the MI Health Link transition

Key consideration	MDHHS' plan
Beneficiary transitions	MDHHS will work closely with CMS to ensure a seamless transition and continuity of care for beneficiaries. To realize this, MDHHS will work with CMS to assure current MI Health Link enrollees are notified of programmatic changes and their enrollment options prior to January 1, 2026. For ICOs that have an integrated D-SNP product effective January 1, 2026, MDHHS will work with CMS to seamlessly transition their members to the new program. In the event an ICO does not have a D-SNP product effective January 1, 2026, members will be provided with their enrollment options before being transitioned to an available D-SNP.
Beneficiary communications	MDHHS is aware of the need to provide advance notice of the transition to beneficiaries and plans. The State will send out a sequence of notices that inform beneficiaries of their plan ending and the alternative plan options available to them. Michigan plans to send an initial notice detailing when coverage will end along with a summary of the options available to beneficiaries well in advance of MI Health Link ending on December 31, 2025. Notices will be in alignment with CMS requirements and will incorporate best practices used by other states. They will include all applicable beneficiary appeal rights, including rights that pertain to changes in covered services that result from the transition. MDHHS will use Maximus, a contracted unbiased enrollment broker, to serve as a support system for MI Health Link members impacted by this transition who are seeking education and assistance with regard to their enrollment options. Other enrollment options may be available for D-SNPs and will also be considered for communications. Michigan plans to develop customer scripts, FAQs, and additional materials to be distributed to the enrollment broker to assist enrollees in transferring from MI Health Link to an integrated D-SNP.
Training	MDHHS is committed to engaging in education and training meetings over the next few years to ensure that all participants in the transition understand the requirements and processes. MDHHS will ensure that communication and information about the transition is provided to all entities involved in the transition process. Michigan will develop outreach to educate D-SNPs, Medicaid MCOs, and other organizations that may require training such as the enrollment broker, the Ombudsmen, the Area Agencies on Aging, and other stakeholders. The state will evaluate whether additional staff and resources are needed to implement training

	and other activities to facilitate a smooth transition.

Stakeholder Engagement Process

MDHHS is committed to stakeholder engagement to inform the state's decision-making during MI Health Link's transition to an integrated D-SNP model. Michigan's stakeholder engagement process includes both initial engagement in the summer of 2022 and ongoing engagement throughout the planning and implementation phases for the new D-SNP model.

Initial Engagement

MDHHS' initial engagement with stakeholders consists of two components. Prior to October 1, 2022, when the transition plan is due to CMS, MDHHS accepted written and verbal feedback from ICOs that participate in MI Health Link and other health plans that operate in Michigan. MDHHS also conducted several virtual stakeholder interviews to obtain feedback on important considerations they should take into account for the transition process. Stakeholders participating in the virtual interviews are some of the organizations that will be impacted by the transition.

The health plans that provided feedback as of September 1, 2022, voiced their support for the most integrated type of D-SNP, a FIDE SNP. Health plans were interested in building on the successes of the MI Health Link program, including high beneficiary satisfaction. Plans expressed their support for a BH carve-in, however, they acknowledged that carving in BH would present unique challenges and should be approached carefully. Additionally, plans supported aligned or exclusively aligned enrollment and expanding the program statewide.

In the discussions held to date (MDHHS is holding additional conversations in the coming weeks), stakeholders provided valuable insights concerning the integrated D-SNP model MDHHS should pursue and priorities for the transition. One stakeholder shared that it is important to consider what is unique to Michigan and what has worked in Michigan. Stakeholders advised preserving the current MI Health Link system to the extent possible. One stakeholder suggested implementing a joint contract that includes the health plans, the BH system, the aging network, the State, and CMS. Another stakeholder conveyed that they lean towards exclusively aligned enrollment because it maintains the coordination benefits of MI Health Link, even though it removes some beneficiary choice. Additionally, stakeholders highlighted the importance of leaning into the expertise in the community, improving care coordination at the local level, implementing consumer and vendor protections, and enhancing information sharing. They suggested providing the State with more power to hold providers and plans accountable for ensuring access to care. MDHHS is taking this feedback into consideration.

Ongoing Engagement

MDHHS values stakeholder perspectives and will continue working with partners after the submission of the transition plan on October 1, 2022. The State anticipates hosting regular

stakeholder presentations to share progress and solicit input on the transition plan and design details of the integrated D-SNP. A post-presentation survey will be used to collect feedback. The State expects to reach out to stakeholders including health plans, providers, and advocacy organizations that were not contacted during the initial engagement to obtain input. In particular, MDHHS looks forward to discussions with community-based organizations to inform decisions about design details. MDHHS also plans to have ongoing technical assistance discussions with its colleagues at CMS and the Medicare-Medicaid Coordination Office.

Timeline

July 2022	MDHHS received written and verbal feedback from several health plans and other stakeholders
August–September 2022	MDHHS conducted interviews with stakeholders including advocacy organizations, service providers, and D-SNPs
October 2022 – December 2026	MDHHS will hold continued stakeholder engagements as needed and appropriate; to be determined

Timeline for Policy and Operational Steps

High Level Timeline

Year	Policy and Operational Tasks
2022	● Stakeholder engagement: ○ Initial stakeholder engagement; define and implement ongoing stakeholder engagement process ● Policy considerations: ○ Determine if any State legislative authorizations are needed, and timing ○ Determine if any Medicaid authorities are needed, and timing ● Program development: ○ Identify preliminary capabilities of ICOs to meet CMS requirements for transition an integrated D-SNP in MI Health Link service areas ● General planning activities: ○ Define project management team and MDHHS resources; engage all relevant state departments and subject matter experts in project planning ○ Draft comprehensive project plan with timeline **10/1/22: Submit transition plan to CMS**
2023	● Stakeholder engagement: ○ Ongoing stakeholder engagement ○ Advisory council engagement; identify future requirements ● Policy considerations: ○ State legislative authority, if needed ○ Medicaid authorities, if needed ○ Examine options for continued ombudsman program funding ○ D-SNP SMAC updates for CY 2024 ○ Medicaid rebid considerations ● Program development: ○ Determine D-SNP components for transition, including mandatory and optional features ○ Beneficiary communications: identify notice requirements; marketing and member materials, transition FAQs ○ D-SNP communications: reporting, quality measures, contract management ● IT system changes: ○ Define requirements that impact IT systems, including Medicare/ Medicaid alignment, enrollment, payment enhancements, data sharing, reporting, quality measurement and others to be defined ○ Identify IT system changes and processes needed to implement exclusively aligned enrollment ○ Begin IT system planning and designing processes based on requirements ○ Identify IT system changes needed to support D-SNP reporting, encounter data, quality measurement and other data sharing requirements

2024	● Stakeholder engagement: ○ Ongoing stakeholder engagement ○ Advisory council engagement; plan for future requirements ● Policy considerations: ○ Prepare needed waiver/SPA/etc. authority application(s) ○ Phase-in additional contract updates in the D-SNP SMAC for CY 2025 ○ Select option for continued ombudsman program funding ○ Medicaid rebid considerations ○ Plan for Medicaid procurement and/or D-SNP contracting processes for 2025 ● Program development: ○ Beneficiary communications: continue development of marketing and member materials, and transition FAQs; notification schedule ○ D-SNP communications: continue development of reporting, quality measures, and contract management ● IT system changes: ○ Begin implementation of IT system changes and processes needed to implement exclusively aligned enrollment ○ Begin implementation of IT system changes needed to support D-SNP reporting, encounter data, quality measurement and other data sharing requirements
2025	● Stakeholder engagement: ○ Ongoing stakeholder engagement ○ Advisory council engagement; implement new requirements ● Policy considerations: ○ Submit needed waiver/SPA/etc. authority application(s) ○ Phase-in final contract updates in the D-SNP SMAC for CY 2026 ○ Implement option for continued ombudsman program funding ○ Implement Medicaid procurement process? ○ Implement D-SNP contracting process ● Program development: ○ Beneficiary communications: finalize marketing and member materials, and transition FAQs; notify beneficiaries ○ D-SNP communications: finalize reporting, quality measures, and contract management requirements; coordinate with contracting ● IT system changes: ○ Final testing and implementation of IT system changes and processes needed to implement exclusively aligned enrollment ○ Final testing and implementation of IT system changes needed to support D-SNP reporting, encounter data, quality measurement and other data sharing requirements ○ Begin migration of MMP beneficiaries to integrated D-SNPs **12/31/25: MI Health Link FAI end date**
2026	**1/1/26: Start date for D-SNP contracts and oversight**

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Harm Reduction: A Consensus Statement of Support
by Michigan's 10 Community Mental Health Entities (Pre-Paid Inpatient Health Plans)

Michigan has a comprehensive infrastructure of prevention, treatment and recovery services for people living with a substance use disorder (SUD). Individuals living with a SUD, however, often follow a bumpy road to recovery and sobriety. Social stigma, judgment from others and shame are barriers to individuals seeking treatment. Even after people have engaged in treatment, they can stumble on that road and relapse. Most people living with addictions, however, do recover. A 2017 Harvard study found that while 10% of the U.S. adult population has had a SUD, 9.1% of American adults are in recovery. Despite that, per the CDC, the U.S. exceeded 107,000 drug overdose deaths in 2021 largely related to heroin, methamphetamine and cocaine being laced with synthetic opioids like fentanyl.

Harm reduction is an evidence-based strategy to keep people alive by supporting those struggling with active substance use *wherever they are* in their journey to recovery. If they are still using substances, a harm reduction approach works to lower the chance of overdose or of contracting Human Immunodeficiency Virus (HIV), Hepatitis C (HCV) or other diseases. Harm reduction strategies include distribution of naloxone, the overdose reversal medication that's saved many lives, and Syringe Service Programs (SSPs) which offer education about and connections to treatment pathways as they concurrently safely dispose of used syringes and distribute sterile syringes.

The myth that distributing sterile syringes increases drug use by enabling people to keep using drugs has been thoroughly discredited. In fact, individuals who use syringe service programs are 5 times more likely to engage in treatment and 3 times more likely to quit using drugs than individuals with a SUD that do not use an SSP (per CDC). Syringe Service Programs are not associated with any increase in crime (per NIH) and studies show that for every one dollar spent on harm reduction efforts, $3 is saved in public health costs. Programs have also been shown to result, for example, in a 50% reduction in incidence of HIV and HCV (per NIH). By any measure, Syringe Service Programs are an effective means to save lives and keep people healthy along their journeys to recovery in our communities.

As the Mental Health Code – designated Community Mental Health Entities, Michigan's Prepaid Inpatient Health Plans (PIHPs), the regional entities that oversee the state's public behavioral health system, strongly endorse evidence-based practices like harm reduction. We are working to create a coordinated seamless continuum of care including prevention, harm reduction, treatment, and recovery. Along those lines, 86 SSP sites have been established around the state. We strongly support the work of Michigan's Syringe Service Programs in helping save lives of people who may be struggling with substance misuse or are in the early stages of recovery. We encourage our community partners to do the same.

ENDORSED AND ADOPTED BY ALL TEN OF MICHIGAN'S PRE-PAID INPATIENT HEALTH PLANS/
DESIGNED COMMUNITY MENTAL HEALTH ENTITIES, OCTOBER 4, 2022

Michigan Psychiatric Care Improvement Project (MPCIP)

October 2022 Update

CONTENTS

MPCIP 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, and Crisis Receiving and Stabilization Facilities.
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 through Community Mental Health Service Programs.

Opportunities for Improvement

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

988/MiCAL Implementation

The MiCAL, 988, Peer Warmline, and Frontline Strong sections of this report are combined because MiCAL (staffed by Common Ground) answers the calls, texts, and chats to these lines statewide.

Michigan Crisis and Access Line (MiCAL) Overview

- Legislated through PA 12 of 2020 and PA 166 of 2020.
- Based on SAMHSA's Model: One statewide line which links to local services tailored to meet regional and cultural needs and is responsible for answering Michigan 988 calls. MiCAL 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 and locates 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 or 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.
- Piloted in Upper Peninsula and Oakland April 2021; Operational Statewide October 2022.

988 Overview

- **988 went live on July 16, 2022,** as 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.

- **988 Implementation Plan**: Michigan's Official 988 Implementation Plan was submitted to Vibrant and SAMHSA on January 21, 2022. It was developed by a cross sector stakeholder group through a Vibrant funded planning process.
- **Michigan Coverage**: As of June 1, 2022, Michigan has active statewide coverage for all 988 calls originating from Michigan counties through MiCAL. Seven counties have primary coverage through Network 180, Gryphon Place, or Macomb CMH.
- **988 Chat and Text**: MiCAL will also be responsible for answering 988 chats and texts.
- Vibrant is contracting with federally funded back up centers to answer call, chat, and text overflow.

Current Activities for 988/MiCAL

- MDHHS received a 2 year SAMHSA 988 Implementation grant mid-April 2022. Key focus areas are (1) adequate statewide coverage, (2) common practices for centers, (3) stakeholder engagement/marketing, (4) stable diversified funding, and (5) 911/988 collaboration.
- **MiCAL Rollout**: MiCAL will rollout statewide in two phases.
    - **Phase 1 FY 22**: 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. 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 PIHP geographic regions 1, 2, 3, 4, 5, 6, 7, 8, and 10. It will be coordinated with region 9, all regions, by the end of October. Map of the Prepaid Inpatient Health Plans (michigan.gov).
    - **Phase 2 FY 23**: CMHSP After Hours Crisis Coverage. Afterhours coverage services are currently provided as a pilot in the Upper Peninsula. MiCAL is beginning to plan for 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 with occur one CMHSP at a time and will start with regions that volunteer participation beginning in January 2023. Afterhours Process Improvement meetings have been occurring throughout September to gather CMHSP and PIHP feedback, and the final meeting will occur on October 4.
- MiCAL integration with OpenBeds/MiCARE is in progress.
- MDHHS created a 988 chat/text implementation plan and submitted it to SAMHSA mid-September 2022.
- **There have been 61,241 MiCAL encounters since go-live on April 19, 2021 (this includes MiCAL number, NSPL, and CMHSP afterhours calls).**
- **988 Center Practices:** Operations workgroup meetings with current 988 centers are focused on developing common practices around Imminent Risk, Active Rescues and Follow Up.
    - Michigan's 988 workgroup is finalizing Michigan's Center Protocol document, which has incorporated Vibrant's requirements and standards and will be utilized and adopted by all of Michigan's 988 call centers as the framework for expected operations.
- **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.
    - Michigan's 988/911 workgroup finalized the Involuntary Emergency Intervention Workflow. The workflow was created to standardize the way in which staff at all centers are expected to be trained

and handle 988 involuntary emergency intervention processes. It will also be shared with 911 centers as an informational tool.

- **Public Relations**: 988 Implementation is currently focused on ensuring that there is adequate staffing and coordination with 911 and other crisis service providers before openly marketing the 988 number. This was a rollout approach that was recommended by SAMHSA and Vibrant. Targeted marketing will begin early 2023.
    - MDHHS developed a website to share with its stakeholders: 988 Suicide & Crisis Lifeline and Michigan Crisis & Access Line, as well as a MiCAL/988 Quick Facts document for reference.
    - MDHHS has been providing presentations to key stakeholder groups. During the month of October 2022, we will present to TYSP- Emergency Department Community of Practice, Tribal Nations Behavioral Health Meeting, and attending the Blue Cross Blue Shield of MI Healthy Safety Net Symposium.
    - During the planning process, Michigan's 988 Stakeholder group agreed to be active participants in the public awareness/marketing process. As stated earlier, we are reaching back out to this Stakeholder group in early November and December 2022 for their help in developing the comprehensive publicity campaign.
    - Starting in January 2023, MDHHS' public awareness activities will target people most at risk for behavioral health crises and suicide through communication channels via trusted community partners such as community groups, advocacy organizations, and allied professionals. A public awareness/ marketing plan which will identify existing channels such as newsletters, websites, and conferences through which to promote 988. The plan will also provide 988 marketing materials to key stakeholders who can give them to people who might benefit from calling 988.

Stakeholder Participation:

- At this time, we are asking partners to refrain from actively advertising the 988 number, but we have no problem with them sharing the 988 number, general information about 988, and 988 resources.
- We are asking stakeholders to begin replacing the former NSPL number (the 800 number) with 988 and to partner with us in identifying and notifying us of places where the 800 number needs to be replaced.
- Starting in January 2023 partners can openly advertise 988 and utilize SAMHSA's promotional materials.

Current Activities for Michigan Peer Warmline and Frontline Strong Together

- Michigan Peer Warmline is operated under MiCAL by Common Ground. It is statewide. It operates 10 am to 2 am 7 days per week.
- Michigan Peer Warmline is refining data gathered during the call, i.e. reason for the call and services provided.
- **There have been 50,738 Warmline encounters since go-live at the end of April 2021.**
- Frontline Strong First Responder Crisis support project called Frontline Strong Together in partnership with Wayne State is operated under MiCAL by Common Ground and is available statewide 24/7. Common Ground has hired a Project Manager who brings a wealth of first responder, training, and crisis line experience. Frontline Strong Together went live in August 2022.
- **There have been 40 Frontline Strong Together encounters since go-live mid-August 2022.**

Crisis Stabilization Units

Overview

Michigan Public Act (PA) 402 of 2020 added Chapter 9A (Crisis Stabilization Units) to the Mental Health Code, which requires the Michigan Department of Health and Human Services (MDHHS) to develop, implement, and oversee a certification process for CSUs (certification is in lieu of licensure). CSUs are meant to provide a short-term alternative to emergency department and psychiatric inpatient admission for people who can be stabilized through treatment and recovery coaching within 72 hours.

To encourage participation and creation of CSUs, MI Legislature has designated funding in the FY 2023 budget to account for at least 9 CSUs. To develop a model and certification criteria for CSUs in Michigan, MDHHS engaged Public Sector Consultants (PSC) to convene and facilitate an advisory group of stakeholders. The stakeholder workgroup reviewed models from other states and Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders.

Michigan Model developed by 12/1. MDHHS is developing draft certification rules for adult CSUs and will solicit feedback in fall of 2022, with goals of finalizing the criteria during Q1 of 2023. The certification criteria for children CSUs will be developed during FY 2023, with an implementation date in FY 2024.

Current Activities

- Draft CSU Certification standards are being finalized to share with stakeholders for their feedback.
- CSU Certification rules will start the Administrative rules process January 2023.
- A survey was issued to acute and psychiatric hospitals and CMHSPs to assess the existence of any walk-in urgent care or crisis care behavioral health services similar to a CSU such as an EMPATH unit and a psychiatric emergency room. This survey also assesses entities' interest in providing CSU services.
- MDHHS will operate a CSU Community of Practice Pilot which will result in a Best Practice Implementation Handbook and pilot entities receiving CSU certification. Participants are recruited through the CSU survey.
- The Michigan Model has been tailored to include Children and Families. It has been shared for public feedback. Listening sessions with people with lived experience will occur in November and December.

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.
- 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) and their intensive mobile crisis stabilization services.

Current Activities

- Multiple areas of MDHHS are working on the expansion of mobile crisis services: Diversion Council, BCCHPS, and Bureau of Specialty Behavioral Health 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 around implementation plans internally, prior to stakeholder involvement.
- Public Sector Consultants has pulled together legislative and funding requirements, recommendations from Wayne State Center for Behavioral Health Justice (CBHJ), and other best practices to develop a draft model for adults. This model will be altered over the next couple of years based on stakeholder feedback from Diversion Fund pilots, CCBHC discussions, and feedback from people with lived experience.

MI-SMART (Medical Clearance Protocol)

Overview

- Standardized communication tool between EDs, CMHSPs, and Psychiatric Hospitals to rule out physical conditions when someone in the Emergency Department (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 9/26/22: Adopted/accepted by 54 Emergency Departments, 26 Psychiatric Hospitals, and 14 CMHSPs.
    - 30 more facilities are pursuing the implementing at their facility, including Munson Medical Center, Sparrow Health, and McLaren Bay Region.
    - We are excited to welcome UPHS Marquette and LifeWays as new MI-SMART users!
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption.
- MHA sent communication to members from their small and rural hospitals informing them about the MI-SMART Form. They were sent a link which they can fill out if they are interested in learning more about how to implement the MI-SMART Medical Clearance Process at their facility.
- MHA and MDHHS co-signed a letter encouraging the use of the MI-SMART Medical Clearance Process. This letter was signed by MDHHS Chief Medical Executive Dr. Natasha Bagdasarian and MHA Executive Vice President Laura Appel. MHA distributed the letter to their members in August.
- Provided a presentation on the MI-SMART Medical Clearance Process at the MHA Small and Rural Hospital Council meeting in September.

- Drafting a letter to send to PIHPs/CMSHPs aiming to work regionally to increase adoption of the MI-SMART Form.
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MI-SMART can help meet.
- Transitioning Medical Clearance Workgroup to an Advisory Group.
- Record high COVID numbers in Emergency Departments are impeding progress.

Psychiatric Bed Treatment Registry

Overview

- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.
- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- The Psychiatric Bed Registry is housed in the MiCARE/OpenBeds platform, which is Michigan's behavioral health registry/referral platform, operated and funded by LARA.
- MiCARE 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 the end of 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 December 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 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.
- All inpatient psychiatric facilities received communication from LARA and MDHHS notifying them that the goal deadline to complete the onboarding into MiCARE (OpenBeds®) was extended to the end of June 2022. MDHHS has been, and will continue, contacting and working with psychiatric facilities. With the support from LARA, all facilities will be onboarded into MiCARE/OpenBeds within the coming months. MDHHS will begin ensuring psychiatric facilities' bed availability is regularly updated.
- Psychiatric hospitals are being encouraged to onboard as they are able. There are 58 facilities. Nearly all psychiatric hospital has attended the initial orientation.
- LARA reached out to all psychiatric hospitals to offer help with onboarding.
- MDHHS sent a survey to all inpatient psychiatric facilities in June. The purpose of the survey was (1) to comply with legislative requirements and (2) to collect information from all psychiatric hospitals for protocol development around the use of the OpenBeds platform. MDHHS received a lot of great responses from the survey and has been meeting one on one with several psychiatric facilities to gain additional feedback.

- MDHHS and LARA, in partnership with Bamboo Health, hosted a demonstration of the OpenBeds platform for all bed searchers in September. This allowed those who have not had a chance to attend a demonstration the opportunity to learn more about the OpenBeds platform.
- MDHHS is in the process of conducting small group listening sessions with representatives from Psychiatric Hospitals, Community Mental Health Services Programs, and Emergency Departments. The goal is to understand partner requirements so that MDHHS could provide technical assistance and support to facilities utilizing OpenBeds and to develop usage protocols for MiCARE. In doing so, MDHHS would like to gain an understanding of how to implement the platform in the most optimal and cost neutral way. Our next listening session will be with representatives from Emergency Departments. If you are interested in attending, please contact us at mpcip-support@mphi.org.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e., bed categorization, acuity, the rollout, and referral process.

MDHHS Staff Update - Crisis Services & Stabilization Section

Due to a significate reorganization within Michigan Department of Health and Human Services (MDHHS), crisis services that were previously under the Behavioral Health and Developmental Disability Administration (BHDDA) are now part of the new Crisis Services and Stabilization Section in the Bureau of Specialty Behavioral Health Services within the Behavioral and Physical Health and Aging Services Administration (BPHASA).

Questions or Comments

Community Mental Health Association of Michigan distributes this document to its' members.
To be added to the distribution list for this update - please contact MPCIP-support@mphi.org

MiCAL questions or comments - contact MDHHS-BHDDA-MiCAL@michigan.gov
MiCARE/Openbeds platform questions - contact Haley Winans, Specialist, LARA, WinansH@michigan.gov

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Michigan Integration Efforts

Service Delivery Transformation

October 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.

Service Delivery Transformation Section

- Erin Emerson, Senior Policy Executive
- Lindsey Naeyaert, Section Manager
- Amy Kanouse, Behavioral Health Program Specialist
- Kelsey Schell, Health Home Analyst

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.
- Behavioral Health Home services are available to beneficiaries in 42 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), 6 (Southeast Michigan), 7 (Wayne County), and 8 (Oakland County).

Current Activities:

- As of October 4, 2022, there are 1,750 people enrolled:
    - Age range: 7-85 years old
    - Race: 24% African American, 71% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- Resources, including the BHH policy, directory, and handbook, are available on the Michigan Behavioral Health Home website. Behavioral Health Home (michigan.gov)
- MDHHS staff will be working to expand the BHH into PIHP Region 5, Mid-State Health Network. Anticipated start date is April 1, 2023.
- MDHHS staff met with each region in July to discuss successes, barriers, and focus for FY23.

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. The Safer Communities Act was signed with provisions for CCBHC Demonstration expansion, extending MI's demonstration until October 2027. 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 wrapped up its first year. As of October 4, 2022, 44,019 Medicaid beneficiaries and 7,407 individuals without Medicaid are assigned in the WSA to the 13 demonstration CCBHC sites. Assignment has increased steadily since the start of the demonstration.
- Virtual DY1 Check-In calls have been completed for all CCBHCs. Together, MDHHS, PIHPs, and CCBHCs reviewed clinical workflows, discussed support needs for DY2, reviewed trending utilization, troubleshooted challenges, and celebrated successes. A training and technical assistance series will take place during DY2 with topics identified as areas of interest during these meetings.
- The MDHHS CCBHC Implementation Team is working to finalize financial reporting requirements for the initial demonstration year and continuing to address additional operational issues that arise as the demonstration moves forward.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Amy Kanouse (kanousea@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 76 Michigan counties. Service areas include PIHP region 1, 2, 4, 5, 6, 7, 8, 9, and 10.

Current Activities

- As of October 1, 2022, 2,555 beneficiaries are enrolled in OHH services.
- With the OHH expansion, LE's have continued to expand OHH services with new Health Home Partners (HHPs). There are currently 38 HHPs contracted to provide services to OHH beneficiaries. Some HHPs are contracting with multiple LEs.
- MDHHS continues to collaborate with many state agencies 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 moving to training and adoption. Barry County is working through data validation.
- PIPBHC sites are focused on sustainability and the ways in which integrated care can continue after the end of the grant. The sites are also currently working on completing the annual PIPBHC Integration Self-Assessment Survey to determine how each agency views the current level of integration.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

MEMORANDUM

October 3, 2022

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs)

FROM: Jeffery L. Wieferich MA, LLP *JW*
Director
Bureau of Specialty Behavioral Health Services

SUBJECT: Veteran Affairs (VA)/ Medicaid Service Requests

This memo is to provide clarification and guidance on coordination of Medicaid and Veteran Affairs (VA) benefits, either known or assumed.

In some regions, Veterans are being required to produce a denial letter from the VA before being able to access services in the publicly funded behavioral healthcare network. There are also occasional instances where an outpatient service is being requested from the PIHP provider network even if the service is covered by the VA, due to distance to the VA facility.

If a person is a Medicaid beneficiary and they meet medical necessity for behavioral health services, it is the obligation of the PIHP to provide the service(s). In these and other instances, the Access Center and / or provider should assess the individual as they would any other person requesting services from the standpoint of presumptive eligibility. Whether a service may or may not be covered by another payor can be determined during an authorization process, however the individual is receiving immediate care.

In instances where there is another payor, documentation to show travel or other hardship that makes the PIHP provider network the most beneficial for the individual to receive care can be noted in their chart and services should continue.

Please share this information and clarification with your Access Center and provider network. If there are any questions or further clarification is needed, please contact Brian Webb via phone at 517-335-2299 or via email at WebbB3@michigan.gov.

c: Executive Directors of Community Mental Health Service Programs (CMHSP)
Belinda Hawks
Brenda Stoneburner
Brian Webb
Kendra Binkley

email correspondence

From: Info CMHAM
To: Carol Balousek (NMRE)
Subject: [EXTERNAL]ACTION ALERT - Tell Legislators NO Lame Duck Deals on SBs 597 & 598
Date: Monday, October 17, 2022 10:32:17 AM

Community Mental Health Assocation of Michigan

Call to Action

Rumors have been swirling around Lansing for the past several weeks that Sen. Shirkey & Rep. Whiteford have been drafting a compromise bill that would combine SBs 597 & 598 along with HBs 4925 – 4928 in an attempt to get "something" done before the end of the year. Most of the talk around a compromise bill has been to move all of the Medicaid kids services including autism and foster care over to private insurance companies and then the state would create 1 statewide entity to manage the other populations (essentially going from 10 PIHPs to 1 PHIP or ASO). CMHA and our allies have not been part of the discussions with Sen. Shirkey and Rep. Whiteford, those discussions have been behind closed doors so can only speculate on the content of such a proposal, but we do know that both sides have had multiple conversations and meetings.

With the November 8 General Election and the lame duck legislative session fast approaching we want to make sure that policy makers still know we are out here, and we are watching. After the election on November 8, there are only 11 more scheduled session days left in the calendar year. We certainly do not want termed out legislators passing a half-baked idea as they are walking out the door just for the sake of doing "something".

We believe any compromise bill between Sen. Shirkey and Rep. Whiteford will be equally as bad as the current version of SBs 597 & 598, which would still privatize Medicaid mental health services by giving them financial control and oversight or decision making to for-profit insurance companies.

REQUEST FOR ACTION: **We are asking you to reach out to your legislators (House & Senate) and the Governor and URGE them to not support a LAME DUCK deal on SBs 597 & 598. Stakeholders have not been part of the recent or meaningful discussions and the Legislature should not be making changes of this magnitude with so few legislative days left. 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 before the end of the year. It is critical that lawmakers hear from us before the critical November 8 election and know this is an issue that is important to the voters in their districts.

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/zoM83LiQmJlephO3FbS5wA

email correspondence

From: Monique Francis <MFrancis@cmham.org>
Sent: Friday, September 23, 2022 9:38 AM
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Clarifying voluntary nature of the After Hours Process Improvement – MiCAL Rollout Phase 2

To: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons; CEOs of CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Clarifying voluntary nature of the After Hours Process Improvement – MiCAL Rollout Phase 2

During this week's CFI Committee meeting, the concern was raised around the rumor that the state's CMHs would be required to use MiCAL for their after-hours on-call/crisis system even if they like their current after hours system/provider. CMHA reached out to the MiCAL leadership and received a prompt and clarifying response. Below are the relevant excerpts from that MDHHS response:

> "We are not requiring anyone to use MiCAL right now for their afterhours and I am not sure we will ever require it. We are going to ask for volunteers. We are rolling it out very slowly over the next several years, maybe an additional 2 to 3 CMHSPs in FY 23. We just wanted to be inclusive of the broad spectrum of CMHs as we streamlined the afterhours process. Please let people know because the last thing we want is CMHSPs to stop their contracts with their current afterhours providers. I will also make sure to mention this next week at the Directors' meeting. Thanks for reaching out."
>
> **Krista Hausermann, LMSW, CAADC**
> Crisis Services Section Manager
> Bureau of Community Based Services
> Behavioral and Physical Health and Aging Services Administration, MDHHS

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

Exploring partnership with Wakely for actuarial consultation

Revised September 9, 2022

Background

In June of 2022, CMHA and a number of other Michigan-based healthcare associations met with the representatives of Wakely, one of the nation's more prominent actuarial firms working in the field of Medicaid finance and rate development. More on Wakely at: https://www.wakely.com/

This meeting provided the participants with a picture of the work that Wakely does, across the country and within Michigan, to support at-risk Medicaid payers and providers in promoting sound Medicaid rates.

Subsequent to that initial meeting, CMHA hosted a meeting, in July of 2022, of the Wakely representatives with the CEOs of CMHA member organizations to discuss the work that Wakely does, across the country and within Michigan, to support at-risk Medicaid payers and providers in promoting sound Medicaid rates.

A debriefing of this July meeting, involving a large number of the CEOs of the state's CMHSPs and PIHPs, was held in late August.

This proposal emerged from the August debriefing.

Proposal

In summary: To initiate discussions, with Wakely (nationally recognized actuarial consulting firm), centered around the development of a contract between Wakely and CMHA for the scope of work outlined in this proposal, applying the steps and conditions outlined in this proposal.

Aim or this initiative: Ensure that Medicaid capitation rates, provided to the state's public mental health system via payments to the state's PIHPs, provide sufficient and equitable funding to the system.

Rationale behind proposal

Why an actuarial consultant is needed:

The Medicaid capitation rates paid to Michigan's community-based public mental health system dictate much of what the system can do – from impacting service access, intensity, scope and duration to the wages paid to contractors and staff. These rates determine the level of funding provided to the state's PIHPs, who, in turn, finance the state's CMHSPs, who provide and purchase Medicaid services with those dollars.

The leaders of the state's community-based public mental health system have long been concerned that these rates do not provide sufficient funding for the system to meet the mental health services needs of Michigan's Medicaid population.

Examples of the concerns expressed by the leaders of Michigan's CMHSPs, PIHPs, and providers include:

- Lack of the adequate reflection of increased wages and provider costs – related to efforts to address staff recruitment and retention – in the FY 2023 rates
- Over-estimation of Medicaid enrollment and enrollment growth - for years – resulting in deflated per enrollee per month rates
- Lack of sound measurement of the complexity and cost of care as a key variable impacting statewide and regional rates
- Use of utilization trends – two years old – unadjusted to reflect current the subsequent year's expected utilization trends (an especially acute issue when the significant utilization increases experienced in 2022 are not included in the trended utilization used to project FY 2023 utilization and related capitation rates)
- The imposition of artificial and unrealistic administrative cost estimates, of 6% to 8% (1% for CCBHC), when standard managed care administration rates, excluding profit, are two to three times that rate.
- The lack, for decades, of an Internal Services Fund (ISF) payment as part of the capitation payment, as required by CMS.
- The use of variables and algorithms to establish the rates, state-wide and regionally, that are inadequate, inappropriately interpreted and used, and unclear in their rate impact.

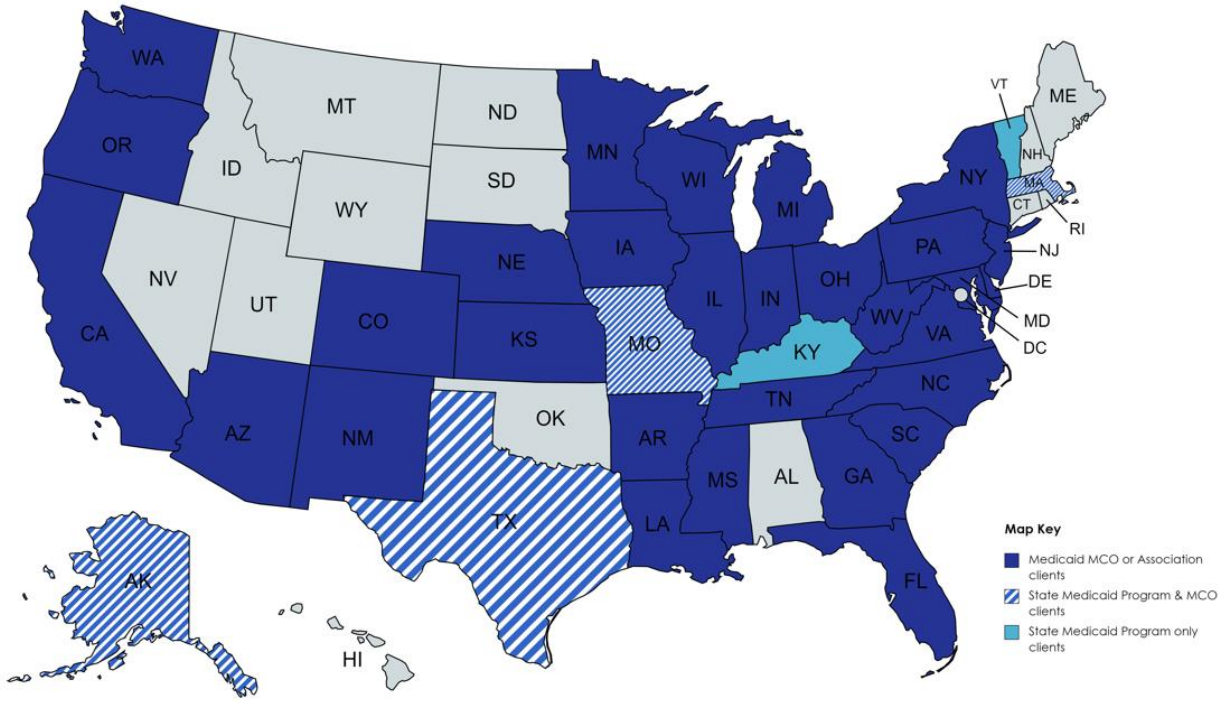
Needed is a seasoned and experienced actuarial firm to work alongside the community-based public system to examine the Milliman rates and the variables and methods used to determine them and provide analyses and guidance to the system's leaders as they work to ensure that these rates are sufficient and equitable. Such analyses and guidance is needed relative to the core Medicaid capitation rates paid the system and in relation to the CCBHC, Behavioral Health Home, Opioid Health Home, and Direct Care Worker payments.

Why Wakely is proposed as partner:

While there are three prominent actuarial firms in the country working with Medicaid rates – Milliman, Mercer, and Wakely), only Wakely has developed a track record in providing actuarial consultation to at-risk Medicaid payer and provider groups, across the country.

The map, below, highlights the states in which Wakely provides consultation to at-risk Medicaid plans and provider groups.

Additionally, Wakely has been working in Michigan providing consultation to the state's Medicaid Health Plans, for the past several years, and has recently kicked-off a partnership with the Area Agencies on Agency Association of Michigan – giving Wakely a sound understanding of the Michigan Medicaid landscape and the state's ratesetting process.



Steps, in sequence, of exploration of partnership and contract with Wakely

1. Proposal is reviewed with CMHA Executive Committee to refine the proposal and obtain support to move ahead with preliminary steps in this effort.
2. Review proposal with CMHA Steering Committee to ensure an understanding of the proposal.
3. Form a small and diverse group - the Actuarial Consultation Group - made up of representatives of the PIHPs, CMHSPs, and Provider Alliance members of CMHA. These members could be recommended by the leaders of these organizations as well as being drawn from the membership of CMHA's Contract and Financial Issues (CFI) Committee, the Ratesetting Group, Standard Cost Allocation workgroup, and the Medical Loss Ratio Workgroup.

   This Actuarial Consultation Group meets with Wakely representatives to explore a contract for Wakely to carry out a range of actuarial initiatives related to the analysis of Milliman's FY 2023 PIHP capitation rate certification letter, to determine the soundness of these rates.

   Wakely has provided a preliminary analysis structure for the firm's analysis of Milliman's FY 2023 Medicaid capitation rates:

   a. Reviewing actuarial rate setting documents with an eye toward:
      i. Pressure testing key assumptions
      ii. Determination of appropriate base period for rate determination
      iii. Determination of trends that should be reflected in rates
      iv. Determination of the policy and program change adjustments
      v. Determination of COVID impacts on the rates
      vi. Determination of appropriate administrative costs to be assumed in the rates

vii. Determine determination of risk and area/geographic factors

b. Providing independent support in assessing actuarial soundness
c. Participating in discussions with rate setting actuaries (if requested by the Actuarial Consultation Group)

4. Wakely provides CMHA with the cost of providing the services outlined by the small group.
5. CMHA examines the cost of the contract with Wakely, in consultation with the members of the Actuarial Consultation Group. If the cost is not reasonable, discussions with Wakely will continue until a scope of work with a reasonable cost is identified. If not able to be identified, this process stops.
6. If the scope of work and cost appear reasonable, CMHA, also in consultation with the members of the Actuarial Consultation Group, determines a range of options for assessment CMHA members for this cost.
7. CMHA presents, to the CMHA Executive Committee, the proposal to contract with Wakely and the options for assessing CMHA members to cover this cost.
8. The CMHA Executive Committee presents the recommendation, to the CMHA Board of Directors, to contract with Wakely along with the recommended method for assessing CMHA members for the cost of the contract.
9. If approved by the CMHA Board of Directors, CMHA executes a contract with Wakely and the work begins

Mechanics for work with Wakely (if the contract with Wakely is approved by the CMHA Board of Directors)

1. The work by Wakely would center around an analysis of Milliman's FY 2023 PIHP capitation rate certification letter, to determine the soundness of these rates.
    - Of immediate focus of this analysis:
        - A critique of variables used and not used by Milliman in determining the FY 2023 rates
        - The determination of costs that should be but are not reflected in the rates (eg., administrative burdens (cost of implementing iSPA, etc.), wage and salary demands, provider cost demands
        - A determination of the variables or factors leading to wide year-to-year swings in the rates established statewide and for each region
2. The Actuarial Consultation Group would guide Wakely, on behalf of CMHA and its membership, and serve as the liaisons to those members.
3. Questions related to this analysis by Wakely will be sought and reviewed by the Actuarial Consultation Group, with the Group working with Wakely to integrate these questions into the Wakely analysis.
4. The initial scope of work, with Wakely, will be limited to the tasks outlined above.
5. If, subsequent to the completion of this initial scope of work, the Actuarial Consultation Group, CMHA, or CMHA members seek additional work by Wakely, CMHA will work with the Actuarial Consultation Group, the CMHA Executive Committee, and the CMHA Board of Directors to determine the cost to be assessed of CMHA members for these additional costs.

Community Mental Health Association of Michigan

Advancing Michigan's mental health system by strengthening the partnership between MDHHS and Michigan's community based mental health system [1]

September 2022

This document, developed by the Community Mental Health Association of Michigan (CMHA) and its members, outlines a number of recommendations designed to advance the state's public mental health system by strengthening the partnership between the Michigan Department of Health and Human Services (MDHHS) and the state's community based mental health system – the state's Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHP), and the private providers in the networks of the state's CMHSPs and PIHPs. These parties - MDHHS and the community-based mental health system - make up the state's public mental health system.

The nationally recognized development, design, and work of Michigan's public mental health system have been the result of a number of factors, **chief among them the longstanding partnership between the State of Michigan and the state's community based mental health system**. Given this, steps to strengthen that relationship are outlined below.

Partnership strengthening and system advancement recommendations

Below is a set of **concrete recommendations**, designed to address the observations cited above.

Given the urgency of the issues faced by the system and the growing needs of Michiganders for ready access to high quality mental health care, these recommendations are **not intended as long term goals, but, instead, as actions to be taken immediately and in the near future.**

1. Vision of public system – co-developed and widely circulated: The changing healthcare landscape in Michigan and across the country (with the emergence of a number of innovative clinical, financing, and partnering developments), the impact of the COVID pandemic, the reorganization of the behavioral health operations within MDHHS, and growing recognition, among Michiganders, of the central importance of mental health and mental health care call for a clear vision for the state's public mental health system.

Such a vision, containing concrete actions to fulfill that vision, and widely circulated:

- Is key to the advancement of the state's public mental health system
- Will close the currently existing vision vacuum that invites a range of system change and redesign proposals that are, at times, well-intended but not linked to sound practice, financing, nor structure nor to the desires articulated by the persons served by that system.
- Unifies the work of the system by preventing system fragmentation, and project conflict, and a sense of continual system threat or erosion

[1] For ease in reading, the terms "mental health system" and "behavioral health system", when used in this document, refer to the system that serves persons with mental illness, emotional disturbance, intellectual/developmental disabilities, and persons with substance use disorders.

This vision, to be sound and supported by the large and diverse set of system stakeholders, should be co-developed, under the leadership of MDHHS, by MDHHS, representatives of the community based system, and representatives of other stakeholder groups, develop a written vision for the state's public mental health system.

2. Designate behavioral health lead within MDHHS: Clearly identify the lead, within MDHHS, for the department's behavioral health (BH and IDD) work. This person would: hold the responsibility and authority for the Department's mental health work; serve as the point person, within the Department, for the system; have the responsibility for ensuring that the efforts led by MDHHS, on the behavioral health front are driven by the co-developed vision for the state's public mental health system; ensure that the Department's behavioral efforts are in sync with each other and not in conflict.

3. Focus on a small number of high leverage efforts: MDHHS to prioritize its major initiatives, relative to the community system, to focus on a smaller number of issues and initiatives – driven by the vision described above. This effort would prioritize those of central importance to the work of that system and those with the greatest potential positive impact on the system and those served by the system. This prioritization would be driven by a focus on the persons served – their access to quality care, health, safety, and their experience of care/services/supports.

Such prioritization is key in recognition of the system's scarce staff and time resources must be focused on core issues and not fragmented and depleted with the pursuit of more minor, less central issues.

With such prioritization, MDHHS and the community based system will be able to allocate staff and other resources to those prioritized issues, leaving other initiatives, with lower priority, in abeyance until significant progress has been made on the high priority issues and projects.

4. Use of a co-development approach to policy and practice development and decision making: Based on the view that MDHHS and the community-based mental health system are partners, pursue a co-development approach to policy and practice development and implementation.

The co-development approach is based on several assumptions:

- MDHHS holds the final responsibility, authority, and expertise for a range of issues
- The community system holds a parallel set of responsibilities, authorities, and expertise on many if not all of these issues. This expertise is grounded in years of experience in the field and the current real-time knowledge of the behavioral health needs of their communities and the dynamics within their organizations and their communities.
- Integrating these responsibilities, authority, and expertise into the decision making process will ensure a sound and actionable set of policies and practices

This approach consists of two components:

A. MDHHS drawing in subject matter experts, from the community system, through the appointment to MDHHS workgroups of staff identified by CMHA and its members, with those representatives of the system being seen as active participants (not merely advisors) in a process that is open to revision and refinement of the aim, content, and core premises and constructs of proposed policies or practices.

B. A parallel se of regular discussions with CMHA and the leaders of the state's CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks, of the progress of these co-development efforts. This discussion would be an active dialogue with the aim of integrating the views, revisions of the draft policy and/or practices, and alternate approaches, raised by these system leaders, on the content and core premises and constructs of the emerging policies and practices – views that only leaders can provide, given their organization-wide and system-wide perspective.

This co-development approach leads to the timely development of sound, inclusive, dialogue-rich, transparent and actionable/realistic policies, practices, and decisions.

5. Identify, for each MDHHS initiative, a clear lead and decision maker: A single lead for each MDHHS initiative – and, where appropriate, the lead for the community based system on these initiatives - would improve the clarity of the decision making process, the timeliness of that process. This lead, while holding the final responsibility and authority for a given initiative, could, of course, work with a team within MDHHS to guide that decision making.

The designation of a single lead for a given initiative would:

- Foster real-time dialogue and the prompt resolution of issues, as part of – and not outside of – the dialogue or workgroup process
- Provide a reliable source for the provision of answers to questions, from the field, on policy or initiative development and implementation.
- Clarify from whom the written confirmation of a decision, related to a given initiative, is to come and, when needed, changes to that decision.

6. Ensure that all involved recognize the unique government-to-government relationship between MDHHS and the community based system and the foundational constructs of this relationship: Ensure that all involved in the leadership of the state's public mental health system – MDHHS and the community based system have a clear understanding of the fact that the MDHHS relationship with the CMHSPs and PIHPs is a government-to-government partnership relationship – one intentionally designed to be a system with each party playing a key role - and not a payer-to-vendor relationship.

This relationship is the foundation of the system and has been for been for the past fifty years. In addition to the description of this relationship in statute, this government-to-government relationship has been reiterated, since 1997, in the Medicaid managed care waivers that undergird the state's Medicaid managed behavioral healthcare system.

This relationship drives contracting, contract negotiations, system financing and every part of the work of the MDHHS-community based system partnership.

Additionally, it is key that the leaders and staff of MDHHS and the community based system have a sound grasp of core constructs of Michigan's unique system – constructs contained in a range of archival sources – including :

- The history and context of the state's Medicaid waivers
- The formation of the state's PIHP system (as public/governmental regional entities created and governed by the state's CMHSPs)
- The breadth of roles played by the CMHSP and PIHP systems, as outlined in statute, rule, Medicaid waivers, and contracts

- The value of the modern/pioneering capitation payment system that is at the heart of the financing of the state's community based system.

The development of such a common understanding could be done as part of the policy and practice co-development efforts or through dialogues built specifically around the development of this common understanding.

7. Ensure that all parties, within and outside of MDHHS, are aware of key initiatives and their development to avoid conflict or duplication: Develop cross-project communication and coordination systems to ensure that MDHHS-led initiatives are working complementarily and not at cross nor duplicative purposes.

8. Collaborative legislative advocacy between MDHHS and the community system: MDHHS, CMHA and its members and allies should plan and carry out joint legislative, public, and media advocacy on a range of issues.

9. MDHHS to ensure that it retains expertise and authority even when using outside consultants: It is key that MDHHS, in partnership with the community based system, works to retain the expertise and authority of MDHHS, even when outside consultants are used to provide technical expertise.

10. Use of external management and process consultants: Use ARPA and COVID-relief dollars to bring in consultants to strengthen the project management, cross-project communication, and co-development skills of MDHHS and the community based system.

11. Joint media relations touting strength of system: MDHHS to develop, jointly with CMHA, its members, and allies, a public education/media relations effort that highlights the performance, cutting edge practices, and positive impact of MDHHS and the community based system.

This effort could include the development of a description of the public mental health system that captures is full set of roles and responsibilities including its safety net and community convener roles, and its unique and central place in the life and health of the community.

12. Develop the relations and the political influence to impact the decisions, by other state departments, that directly impact Michigan's public mental health system: MDHHS and the community based system to develop intentional and coordinated approaches to improving cross-department collaboration – with LARA, MDE, MSP, and SCAO as the most frequent collaborators.

13. Process shepherding/oversight group: To support this effort, form an on-going group, made up of leaders within MDHHS and the community-based system, to shepherd this partnership strengthening effort. This group would work to ensure that key parties within MDHHS and the community based system are aware of this effort and to guide and rethink the design and processes of this effort as needed.

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Summary of recent discussion with CCBCHC team at MDHHS
Date: Friday, September 23, 2022 11:50:55 AM
Attachments: image001.png

To: CEOs of the CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMHA of Michigan
Re: Summary of recent discussion with CCBCHC team at MDHHS

CMHA staff met, earlier this week, with the CCBHC leadership team and a number of the staff from the MDHHS Actuarial and Finance Offices. Below is a summary of the major issues discussed during that meeting. Some of these issues may be covered during the MDHHS segment of the upcoming CMHA Directors Forum.

1. **CCBHC financing and use of unspent PPS dollars**: MDHHS agreed, to ensure a sound understanding, by CCBHC stakeholders of the financial risks and flexibility in the use of CCBHC PPS dollars to serve all community residents, to:

   - Clarifying, for all CCBHC stakeholders, the differences between the uses of PPS payments to CCBHCs from the uses of PPS dollars held by PIHPs at year's end:
     - The unspent PPS dollars held by a PIHP, at the year's end, must be returned to MDHHS by the PIHP
     - The PPS dollars received by a CCBHC are not cost settled at year's end. Any PPS dollars not used to serve Medicaid enrollees (the balance remaining after the PPS is applied to the costs of serving CCBHC enrollees) lose their Medicaid identity and become local dollars that can be used to serve those CCBHC enrollees who do not have Medicaid coverage

   MDHHS indicated that this clarity is not contained in the CCBHC Handbook but will be reflected (along with other issues) in a soon-to-be-issued FAQ. A series of CCBHC FAQs is planned as issues are raised by the field and answered by MDHHS. MDHHS also agreed to reflect this clarification in the CCBHC Handbook, once it is felt that all of the key refinements to this year-end close out of PPS dollars process are made.

2. **CCBHC State Demonstration:** The MDHHS CCBHC team will be working aggressively, in the next few months, to design the CCBHC State Demonstration in light of the recent CMS announcement that the cap on the number of CCBHC sites has been removed.

   Given this fast moving redesign of the CCBHC State Demonstration initiative, the MDHHS CCBHC team asked that CMHA provide them, by the end of October, with our association's recommendations around the CCBHC State Demonstration design.

   Additionally, it became clear that the design of the CCBHC State Demonstration initiative will become the design of the state's post-demonstration CCBHC system.

3. **Post pandemic CCBHC design and development**: The MDHHS CCBHC team indicated that there will be a substantial GF gap that will occur, when the CCBHC State Demonstration initiative ends and the federal match moves from 85% of the PPS costs (enhanced federal match (FMAP) during the demonstration) to the standard federal match of 65% provided to Michigan's Medicaid program.

The MDHHS CCBHC team indicated that the Department is leaning toward waiting to move ahead with a Medicaid waiver or state plan amendment, related to CCBHC, until the means to close this GF gap have been developed by MDHHS.

MDHHS agreed to have its federal government relations team work with CMHA and other allies to advocate with CMS and Congress to retain, permanently, the strong federal match (FMAP) for the CCBHC system.

4. **Regular meetings with leaders from State Demonstration CCBHCs**: The MDHHS CCBHC team agreed with CMHA's recommendation to hold regular meetings with the leaders from State Demonstration CCBHCs. The MDHHS CCBHC team explored ways in which they join a regularly scheduled CMHA event that involved CCBHC State Demonstration site leaders. MDHHS will consider the options outlined to them – chief among them: the morning of the first day of each quarter's CMHA Directors Forum; or a CMHA-sponsored CCBHC learning community series.

Robert Sheehan
Chief Executive Officer
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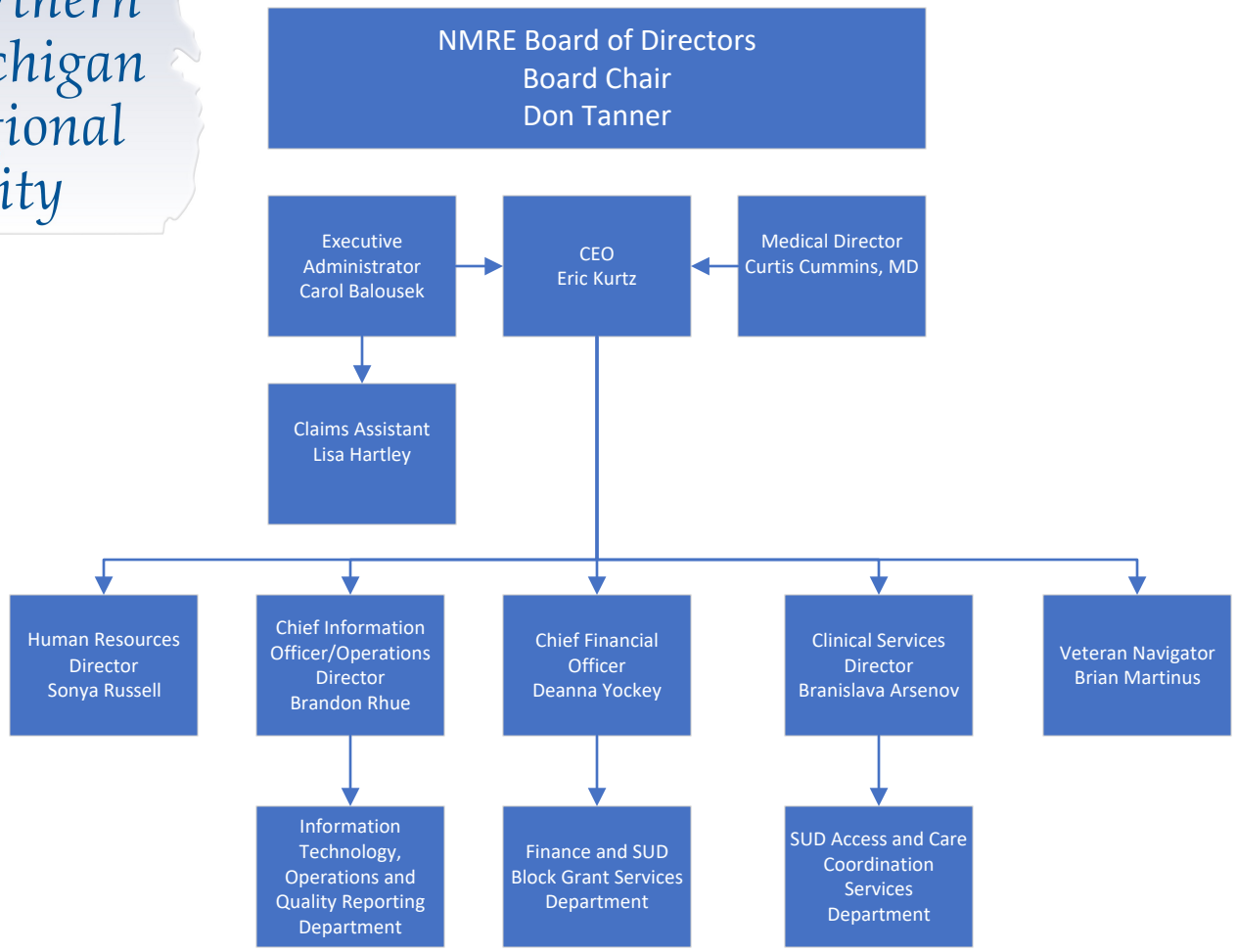
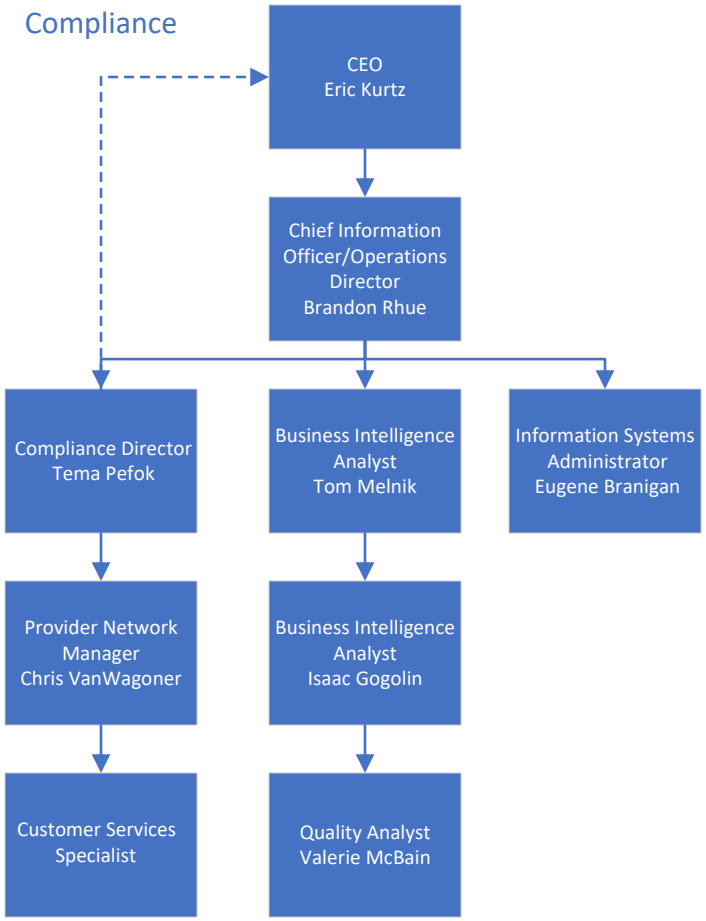
Northern Michigan Regional Entity

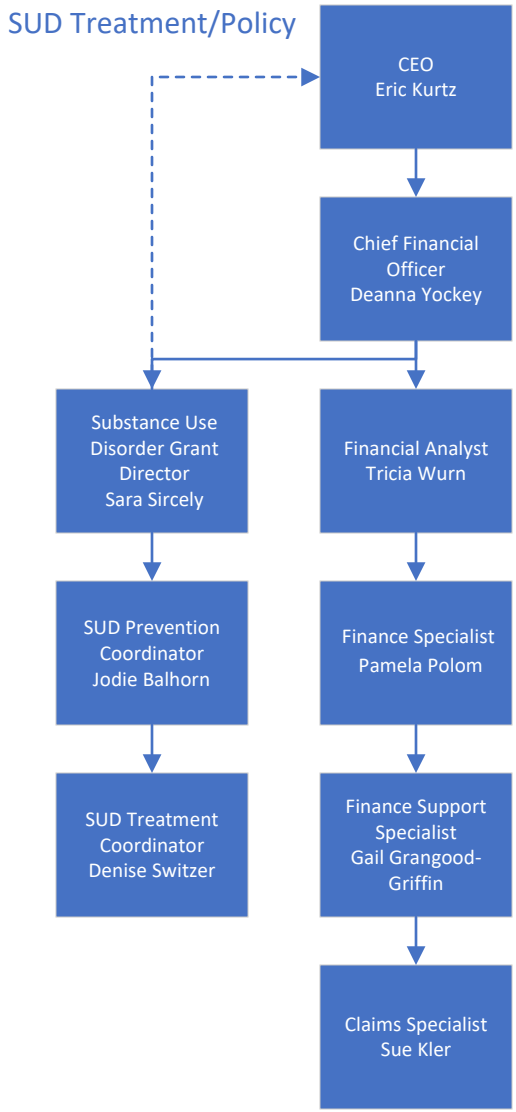
NMRE Board & Executive Office



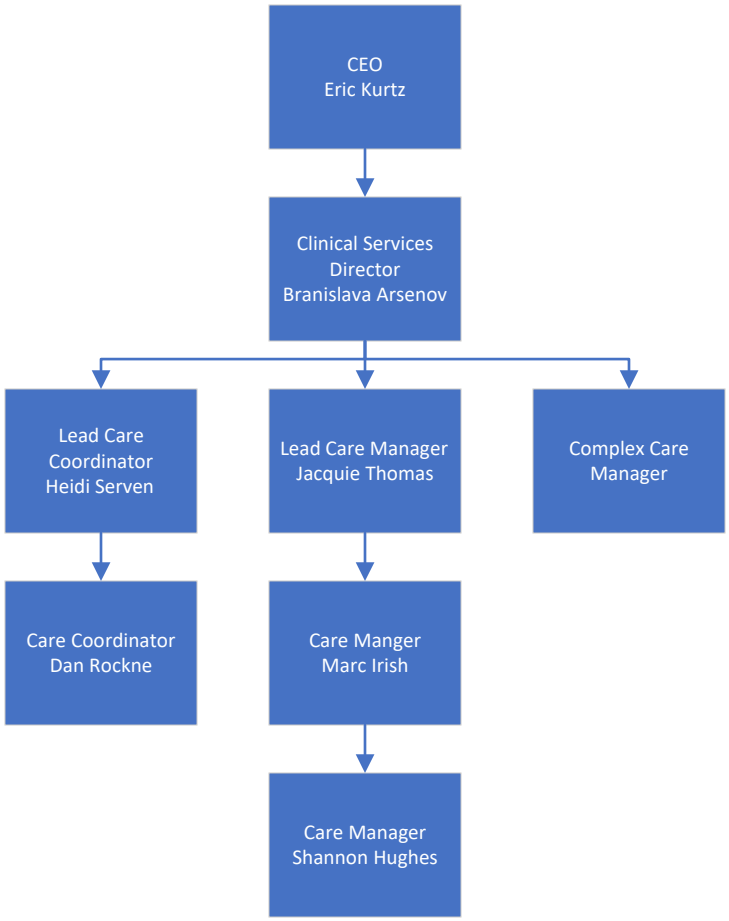
Information Technology, Operations and Quality Reporting Department



Finance and SUD Block Grant Services Department



SUD Access and Care Coordination Services



NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – OCTOBER 12, 2022
VIA TEAMS

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

REVIEW AGENDA & ADDITIONS
Larry requested a discussion of Michigan Budget Section 950. Lauri requested a discussion of reporting HCPCS code S0280 on the EQI.

REVIEW PREVIOUS MEETING MINUTES
The September 14th minutes were included in the materials packet for the meeting.

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE SEPTEMBER 14, 2022 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY ANN FRIEND. MOTION APPROVED.

MONTHLY FINANCIALS
August 2022

- Net Position showed net surplus Medicaid and HMP of $12,475,178. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $28,833,295. 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 $45,191,412.
- Traditional Medicaid showed $186,405,461 in revenue, and $171,709,461 in expenses, resulting in a net surplus of $14,696,000. 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 $29,858,005 in revenue, and $25,540,724 in expenses, resulting in a net surplus of $4,317,281. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,359,717 in revenue, and $1,168,106 in expenses, resulting in a net surplus of $191,611.
- SUD showed all funding source revenue of $23,280,348, and $19,949,895 in expenses, resulting in a net surplus of $3,330,453. Total PA2 funds were reported as $5,326,234.

The direct care wage surplus was estimated at $5,326,234. A potential lapse of $10M for FY22 is anticipated (not including the DCW). Lauri asked if Northern Lakes should accrue FY22 BHH claims revenue; Deanna replied yes.

MOTION BY LAURI FISCHER TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR AUGUST 2022; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

EDIT UPDATE

The next EDIT meeting is scheduled for October 20th. Planned agenda items include:

- Reporting 97153 & 97154 autism service codes under the BCBA NPI
- Supported Employment H2023 and H2025 service codes and modifiers
- COB subgroup update
- Housing support benefit code T2038
- Tiered rates for inpatient psychiatric services update
- Tiered rates for licensed residential services update

Donna will forward the October meeting minutes once they are distributed.

EQI UPDATE

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

HCPCS Code S0280

Lauri asked where to include the S0280 Behavioral Health Home code on the EQI. Erinn responded that she is including the S0280 on the "other expense" tab; the other CFOs agreed. It was noted that Managed Care Administration should not be included in the "Totals for Medicaid."

HSW OPEN SLOTS

Deanna reported that the region currently has 17 open waiver slots. The CMHSP HSW Leads have been informed of the need for packets.

SCA

Eric stated he had nothing new to report. Use of the template is optional. After discussion the decision was made to devote a portion of the November Regional Finance Committee meeting to reviewing the SCA Methodology document (Version 1.1). Richard Carpenter will be invited to join. Chip noted that if CMHSP administration is stripped from its agents/contractors then it should be stripped from its encounters as well. Megan Rooney has been very clear that CMHSP costs must be spread to all of its agents whether inside staff or contractors working on behalf of the CMHSP. She has instructed all her CMHs to report accordingly.

SECTION 950

Larry indicated that Northeast Michigan received a letter from Presque Isle County probate judge requesting the $50/month payment for court-appointed guardians pursuant to Michigan FY23 Budget Section 950. Donna stressed that the process hasn't yet been established. Centra Wellness does not intend to pay guardians until the department provides more clarity. Chip agreed noting that attorney Steve Burnham, who is working on it with the Guardianship Alliance, has said not to pay as there is no MDHHS process and they are lobbying for the law to be changed. Eric advised sending the invoice to the state.

OTHER

Connie asked if a date for the Interim FSR has been provided. Deanna responded that she hasn't heard anything to date.

NEXT MEETING

The next meeting was scheduled for November 9th at 10:00AM.

Chief Executive Officer Report

October 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.

Sept 23: Attended and participated in Regional BHH and OHH Summit.

Sept 28: Attended and participated in PIHP MIOG contract language call.

Sept 30: Met with NLCMHA Board Chair regarding interim CEO role.

Oct 3: Attended and participated in NL County Administrators Meeting.

Oct 4: Attended and participated in PIHP CEO Meeting.

Oct 6: Attended and participated in PIHP/MDHHS CEO Meeting.

Oct 12: Attended NMRE Regional Finance Committee Meeting.

Oct 14: Attended and participated in Gaylord CRU discussion.

Oct 18: Chaired NMRE Operations Committee Meeting.

Oct 21: Participated in contract compliance call regarding NLCMHA.

Oct 24 & 25: Plan to attend CMHAM Fall Conference.

Northern Michigan Regional Entity

August 2022 Finance Report

August 2022 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	14,696,000	11,296,867	9,298,368
Healthy Michigan	4,317,281	5,061,250	7,059,749
	$ 19,013,281	$ 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	1,109,420	2,486,659	3,613,960	3,292,071	(1,026,665)	2,404,172	595,560	$ 12,475,178
Medicaid Carry Forward								16,358,117
Total Med/HMP Current Year Surplus								$ 28,833,295
Medicaid & HMP Internal Service Fund								16,358,117
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 45,191,412

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through August 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 181,045,838	$ 4,345,744						$ 185,391,582
CMHSP Distributions	(173,786,273)		57,712,715	47,749,285	29,226,294	23,942,342	15,155,637	0
1st/3rd Party receipts			415,696	-	598,183	-	-	1,013,879
Net revenue	7,259,565	4,345,744	58,128,411	47,749,285	29,824,477	23,942,342	15,155,637	186,405,461
Expense								
PIHP Admin	2,228,193	45,072						2,273,265
PIHP SUD Admin		56,373						56,373
SUD Access Center		53,929						53,929
Insurance Provider Assessment	1,455,840	29,585						1,485,425
Hospital Rate Adjuster	2,548,084							2,548,084
Services		3,277,265	51,999,949	44,684,707	30,477,103	20,542,318	14,311,043	165,292,385
Total expense	6,232,117	3,462,224	51,999,949	44,684,707	30,477,103	20,542,318	14,311,043	171,709,461
Net Actual Surplus (Deficit)	$ 1,027,448	$ 883,520	$ 6,128,462	$ 3,064,578	$ (652,626)	$ 3,400,024	$ 844,594	$ 14,696,000

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 August 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 19,397,783	$ 10,453,658						$ 29,851,441
CMHSP Distributions	(17,117,988)		6,231,453	5,197,607	2,126,289	2,126,949	1,435,690	-
1st/3rd Party receipts			-	-	6,564	-	-	6,564
Net revenue	2,279,795	10,453,658	6,231,453	5,197,607	2,132,853	2,126,949	1,435,690	29,858,005
Expense								
PIHP Admin	207,619	107,376						314,995
PIHP SUD Admin		134,295						134,295
SUD Access Center		128,475						128,475
Insurance Provider Assessment	130,500	69,038						199,538
Hospital Rate Adjuster	1,859,704							1,859,704
Services		7,807,431	6,554,075	4,074,354	1,445,770	1,922,368	1,099,719	22,903,717
Total expense	2,197,823	8,246,615	6,554,075	4,074,354	1,445,770	1,922,368	1,099,719	25,540,724
Net Surplus (Deficit)	$ 81,971	$ 2,207,043	$ (322,622)	$ 1,123,253	$ 687,083	$ 204,581	$ 335,971	$ 4,317,281

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

Direct Care Wage Estimated Surplus	**(603,904)**	**(2,191,880)**	**(895,760)**	**(1,061,121)**	**(1,200,433)**	**(585,004)**	**$ (6,538,103)**
Net Surplus (Deficit) MA/HMP/DCW	**$ 1,109,420**	**$ 2,486,659**	**$ 3,613,960**	**$ 3,292,071**	**$(1,026,665)**	**$ 2,404,172**	**$ 595,560**	**$ 12,475,178**
Medicaid & HMP Carry Forward							**16,358,117**
Total Med/HMP Current Year Surplus							$ 28,833,295
Medicaid & HMP ISF - based on unaudited FSR							**16,358,117**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF							**$ 45,191,412**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2021 through August 31, 2022

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 219,484		445,702	146,531	90,375	57,275	400,349	$ 1,359,717
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	219,484	-	445,702	146,531	90,375	57,275	400,349	1,359,717
Expense								
PIHP Admin	15,682							15,682
BHH Admin	6,624							6,624
Insurance Provider Assessment	5,567							5,567
Hospital Rate Adjuster								
Services	0		445,702	146,531	90,375	57,275	400,349	1,140,233
Total expense	27,873	-	445,702	146,531	90,375	57,275	400,349	1,168,106
Net Surplus (Deficit)	$ 191,611	$ -	$ -	$ -	$ -	$ -	$ -	$ 191,611

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health
October 1, 2021 through August 31, 2022

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 4,345,744	$ 10,453,658	$ 3,475,545	$ 2,918,269	$ 2,087,132	$ 23,280,348
Expense						
Administration	101,445	241,671	93,094	178,448		614,657
OHH Admin			114,960	-		114,960
Access Center	53,929	128,475	-	29,364		211,768
Insurance Provider Assessment	29,585	69,038	20,107			118,730
Services:						
Treatment	3,277,265	7,807,431	3,007,495	1,784,475	2,087,132	17,963,798
Prevention	-	-	-	925,982	-	925,982
State targeted response	-	-	-	-	-	-
Total expense	3,462,224	8,246,615	3,235,656	2,918,269	2,087,132	19,949,895
PA2 Redirect			-	-	-	-
Net Surplus (Deficit)	$ 883,520	$ 2,207,043	$ 239,889	$ -	$ -	$ 3,330,453

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

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

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 181,045,838	$ 4,345,744	$ -	$ 185,391,582
Medicaid Savings	11,296,867	-	-	11,296,867
Healthy Michigan	19,397,783	10,453,658	-	29,851,441
Healthy Michigan Savings	5,061,250	-	-	5,061,250
Health Home	1,359,717	-	-	1,359,717
Opioid Health Home	-	3,475,545	-	3,475,545
Substance Use Disorder Block Grant	-	2,918,269	-	2,918,269
Public Act 2 (Liquor tax)	-	2,087,132	-	2,087,132
Affiliate local drawdown	899,600	-	-	899,600
Performance Incentive Bonus	1,363,500	-	-	1,363,500
Miscellanous Grant Revenue	-	21,087	-	21,087
Veteran Navigator Grant	102,493	-	-	102,493
SOR Grant Revenue	-	1,127,758	-	1,127,758
Gambling Grant Revenue	-	162,830	-	162,830
Other Revenue	960	-	6,808	7,768
Total operating revenue	220,528,008	24,592,023	6,808	245,126,839
Operating expenses				
General Administration	2,711,965	565,954	-	3,277,919
Prevention Administration	-	80,036	-	80,036
OHH Administration	-	114,960	-	114,960
BHH Administration	6,624	-	-	6,624
Insurance Provider Assessment	1,591,907	118,730	-	1,710,637
Hospital Rate Adjuster	4,407,788	-	-	4,407,788
Payments to Affiliates:				
Medicaid Services	161,001,241	3,277,265	-	164,278,506
Healthy Michigan Services	15,089,722	7,807,431	-	22,897,153
Health Home Services	1,140,233	-	-	1,140,233
Opioid Health Home Services	-	3,007,495	-	3,007,495
Community Grant	-	1,784,475	-	1,784,475
Prevention	-	845,946	-	845,946
State Disability Assistance	-	-	-	-
State Targeted Response	-	-	-	-
Public Act 2 (Liquor tax)	-	2,087,132	-	2,087,132
Local PBIP	2,801,252	-	-	2,801,252
Local Match Drawdown	899,600	-	-	899,600
Miscellanous Grant	-	21,087	-	21,087
Veteran Navigator Grant	102,493	-	-	102,493
SOR Grant Expenses	-	1,127,758	-	1,127,758
Gambling Grant Expenses	-	162,830	-	162,830
Total operating expenses	189,752,825	21,001,099	-	210,753,924
CY Unspent funds	30,775,183	3,590,924	6,808	34,372,915
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	2,254,458	6,231,624	16,358,117	24,844,199
Unspent funds - ending	$ 33,029,641	$ 9,822,548	$ 16,364,925	$ 59,217,114

Northern Michigan Regional Entity

Statement of Net Position

August 31, 2022

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 35,743,471	$ 8,817,299	$ 16,364,925	$ 60,925,695
Accounts Receivable	21,846,715	2,375,519	-	24,222,234
Prepaids	74,818	-	-	74,818
Total current assets	57,665,004	11,192,818	16,364,925	85,222,747
Noncurrent Assets				
Capital assets	-	-	-	-
Total Assets	57,665,004	11,192,818	16,364,925	85,222,747
Liabilities				
Current liabilities				
Accounts payable	24,375,932	1,370,270	-	25,746,202
Accrued liabilities	259,431	-	-	259,431
Unearned revenue	-	-	-	-
Total current liabilities	24,635,363	1,370,270	-	26,005,633
Unspent funds	$ 33,029,641	$ 9,822,548	$ 16,364,925	$ 59,217,114

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 192,931,092	$ 176,853,501	$ 181,045,838	$ 4,192,337	2.37%
Carryover	11,296,664	11,296,664	11,296,867	203	0
Healthy Michigan					
Capitation	20,566,272	18,852,416	19,397,783	545,367	2.89%
Carryover	5,061,832	5,061,832	5,061,250	(582)	(0.01%)
Health Home	506,772	464,541	1,359,717	895,176	192.70%
Affiliate local drawdown	1,204,388	1,204,388	899,600	(304,788)	(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	100,837	102,493	1,656	1.64%
Other Revenue	-	-	960	960	0.00%
Total operating revenue	233,011,551	215,168,710	220,528,008	5,359,298	2.49%
Operating expenses					
General Administration	3,021,688	2,744,519	2,711,965	32,554	1.19%
BHH Administration	-	-	6,624	(6,624)	0.00%
Insurance Provider Assessment	1,645,387	1,508,271	1,591,907	(83,636)	(5.55%)
Hospital Rate Adjuster	4,001,228	3,667,789	4,407,788	(739,999)	(20.18%)
Local PBIP	1,334,531	-	2,801,252	(2,801,252)	0.00%
Local Match Drawdown	1,204,388	1,204,388	899,600	304,788	25.31%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	208,136	178,651	102,493	76,158	42.63%
Payments to Affiliates:					
Medicaid Services	173,402,120	158,951,943	161,001,241	(2,049,298)	(1.29%)
Healthy Michigan Services	15,233,944	13,964,449	15,089,722	(1,125,273)	(8.06%)
Health Home Services	456,768	418,704	1,140,233	(721,529)	(172.32%)
Total operating expenses	200,508,190	182,638,714	189,752,825	(7,114,111)	(3.90%)
CY Unspent funds	$ 32,503,361	$ 32,529,996	30,775,183	$ (1,754,813)	
Transfers in			-		
Transfers out			-	189,752,825	
Unspent funds - beginning			2,254,458		
Unspent funds - ending			$ 33,029,641	30,775,183	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,398,744	$ 4,032,182	$ 4,345,744	$ 313,562	7.78%
Healthy Michigan	9,763,272	8,949,666	10,453,658	1,503,992	16.81%
Substance Use Disorder Block Grant	5,709,003	5,233,251	2,918,269	(2,314,982)	(44.24%)
Opioid Health Home	2,320,384	2,127,015	3,475,545	1,348,530	63.40%
Public Act 2 (Liquor tax)	1,533,979	1,022,653	2,087,132	1,064,479	104.09%
Miscellanous Grants	36,335	33,307	21,087	(12,220)	(36.69%)
SOR Grant	1,215,000	1,113,750	1,127,758	14,008	1.26%
Gambling Prevention Grant	200,000	183,333	162,830	(20,503)	(11.18%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	25,176,717	22,695,157	24,592,023	1,896,866	8.36%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,070,484	926,277	565,954	360,323	38.90%
Prevention Administration	90,144	82,632	80,036	2,596	3.14%
Insurance Provider Assessment	116,901	107,159	118,730	(11,571)	(10.80%)
Medicaid Services	3,387,649	3,105,345	3,277,265	(171,920)	(5.54%)
Healthy Michigan Services	7,453,459	6,832,337	7,807,431	(975,094)	(14.27%)
Community Grant	2,077,452	1,904,331	1,784,475	119,856	6.29%
Prevention	664,967	609,553	845,946	(236,393)	(38.78%)
State Disability Assistance	95,215	87,281	-	87,281	100.00%
State Targeted Response	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	114,960	(114,960)	0.00%
Opioid Health Home Services	2,117,226	1,940,796	3,007,495	(1,066,699)	(54.96%)
Miscellanous Grants	36,335	33,307	21,087	12,220	36.69%
SOR Grant	1,215,000	1,113,750	1,127,758	(14,008)	(1.26%)
Gambling Prevention	200,000	183,333	162,830	20,503	11.18%
PA2	1,533,978	1,022,652	2,087,132	(1,064,480)	(104.09%)
Total operating expenses	20,058,810	17,948,754	21,001,099	(3,052,345)	(17.01%)
CY Unspent funds	$ 5,117,907	$ 4,746,403	3,590,924	$ (1,155,479)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			6,231,624		
Unspent funds - ending			$ 9,822,548		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,729,068	$ 1,584,979	$ 1,432,493	$ 152,486	9.62%
Fringes	549,516	477,191	466,661	10,530	2.21%
Contractual	433,304	397,199	565,766	(168,567)	(42.44%)
Board expenses	16,100	14,762	17,756	(2,994)	(20.28%)
Day of recovery	14,000	14,000	4,917	9,083	64.88%
Facilities	152,700	139,975	124,613	15,362	10.97%
Other	127,000	116,413	99,759	16,654	14.31%
Total General Admin	$ 3,021,688	$ 2,744,519	$ 2,711,965	$ 32,554	1.19%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 482,208	$ 442,024	$ 203,979	$ 238,045	53.85%
Fringes	166,800	152,900	53,254	99,646	65.17%
Access Salaries	194,484	178,277	163,419	14,858	8.33%
Access Fringes	57,588	52,789	48,349	4,440	8.41%
Access Contractual	-	-	-	-	0.00%
Contractual	154,000	91,663	84,815	6,848	7.47%
Board expenses	5,000	4,587	3,295	1,292	28.17%
Facilities	-	-	-	-	0.00%
Other	10,404	4,037	8,843	(4,806)	(119.05%)
Total operating expenses	$ 1,070,484	$ 926,277	$ 565,954	$ 360,323	38.90%

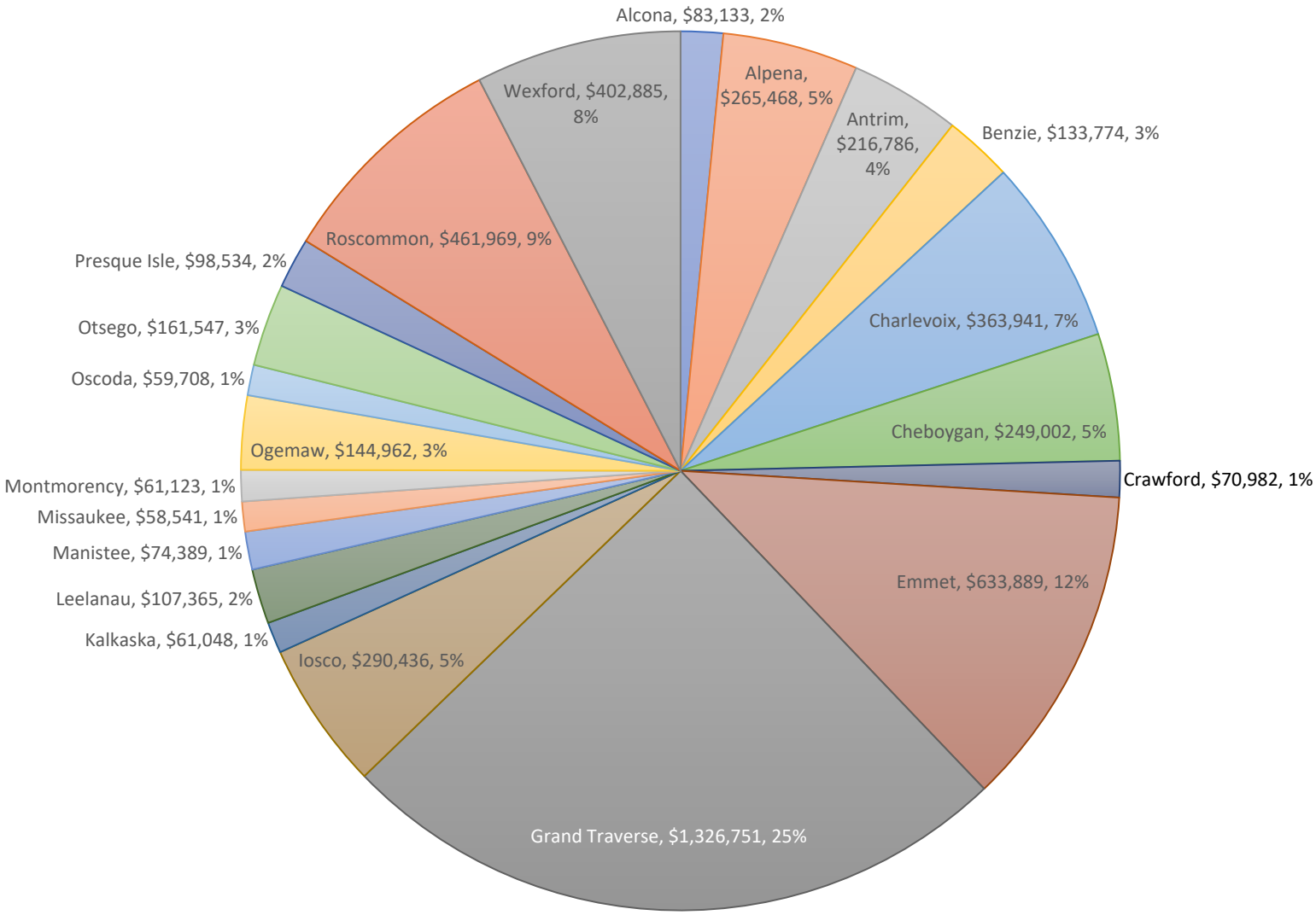
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2021 through August 31, 2022

County	Beginning Balance	FY22 Projected Revenue	Current Receipts	FY22 Approved Projects	County Specific Projects	Region Wide Projects by Population	Ending Balance
					Actual Expenditures by County		
Alcona	$ 83,635	$ 19,313	$ 19,260	$ 38,301	36,857	$ 888	$ 83,133
Alpena	315,554	66,080	65,235	160,005	106,634	2,440	265,468
Antrim	243,061	53,592	54,992	95,690	68,817	1,997	216,786
Benzie	144,391	49,804	51,000	27,891	16,962	1,507	133,774
Charlevoix	467,765	82,100	84,999	262,209	159,043	2,241	363,941
Cheboygan	280,756	68,778	71,908	176,925	146,126	2,175	249,002
Crawford	85,250	28,559	31,195	32,978	20,153	1,192	70,982
Emmet	754,134	145,253	157,175	278,987	167,818	2,846	633,889
Grand Traverse	1,615,220	376,032	383,335	909,582	620,543	7,872	1,326,751
Iosco	359,368	70,274	69,753	160,492	88,881	2,157	290,436
Kalkaska	73,813	33,023	33,605	42,665	28,969	1,512	61,048
Leelanau	131,774	48,924	52,996	97,254	75,061	1,857	107,365
Manistee	90,411	63,745	67,391	36,315	21,844	2,094	74,389
Missaukee	66,066	18,058	17,775	50,287	41,193	1,286	58,541
Montmorency	64,849	26,456	25,952	36,920	31,897	793	61,123
Ogemaw	164,571	54,659	50,933	80,483	55,349	1,799	144,962
Oscoda	76,895	17,086	17,185	43,817	26,017	711	59,708
Otsego	205,220	86,909	86,927	210,283	164,524	2,104	161,547
Presque Isle	102,301	20,617	20,148	47,065	41,731	1,097	98,534
Roscommon	488,633	75,491	73,418	63,178	32,392	2,049	461,969
Wexford	417,956	82,829	82,014	111,588	92,847	2,853	402,885
	6,231,626	1,487,584	1,517,189	2,962,916	2,043,658	43,471	5,326,234
PA2 Redirect							-
							5,326,234

PA2 Funds by County



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2021 through August 31, 2022

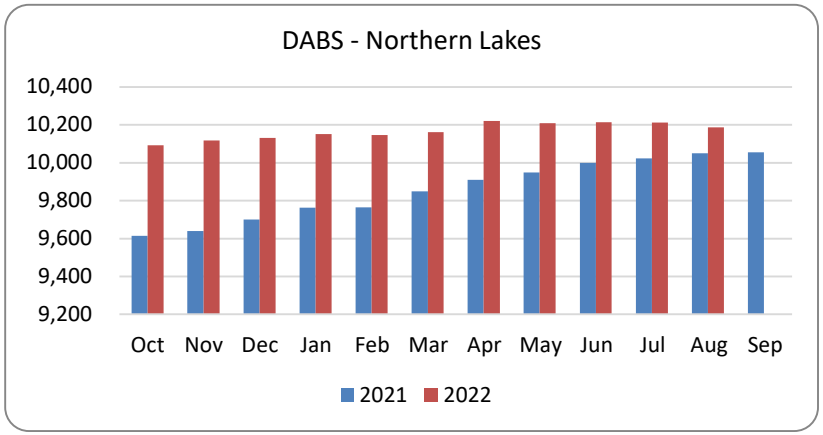
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	2,501	2,288	6,808	4,520	197.55%
Total operating revenue	2,501	2,288	6,808	4,520	197.55%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 2,501	$ 2,288	6,808	$ 4,520	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,358,117		
Unspent funds - ending			$ 16,364,925		

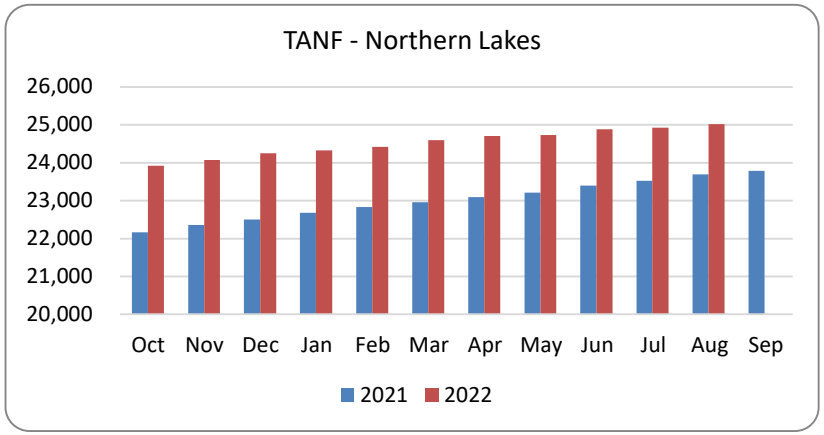
Northern Michigan Regional Entity

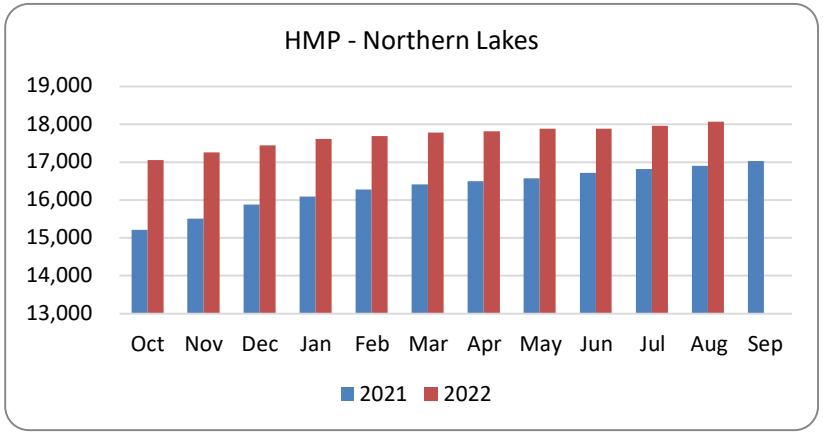
Narrative

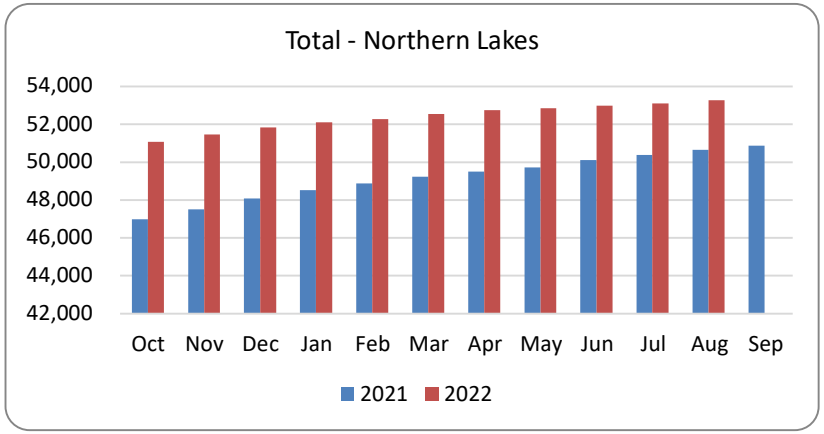
October 1, 2021 through August 31, 2022

Northern Lakes Eligible Trending - based on payment files







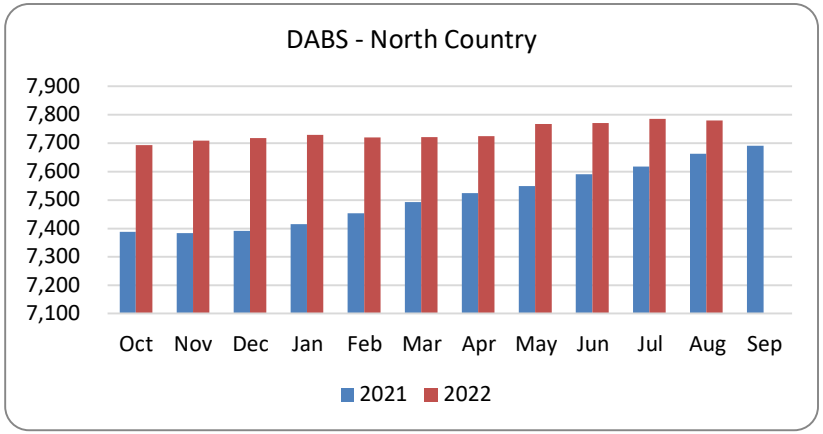


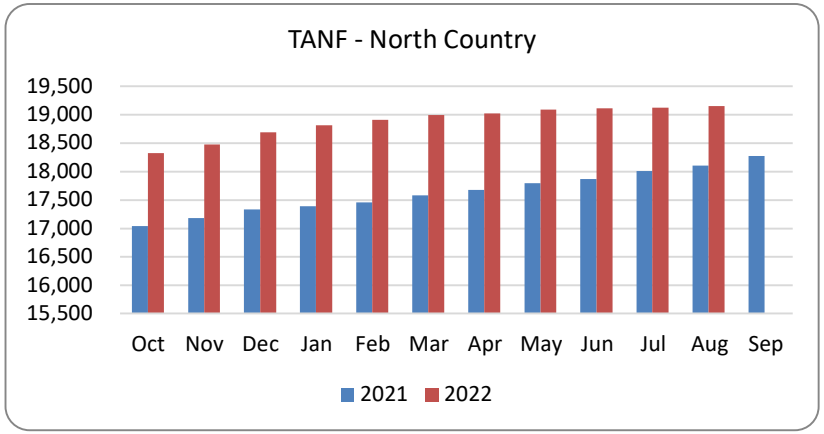
Northern Michigan Regional Entity

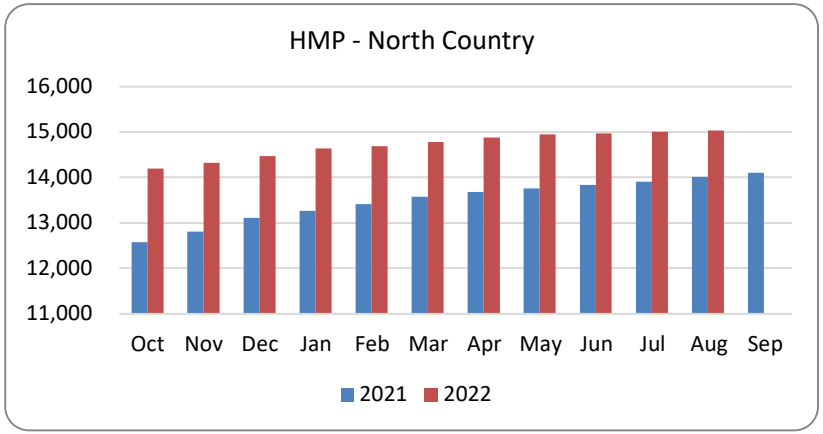
Narrative

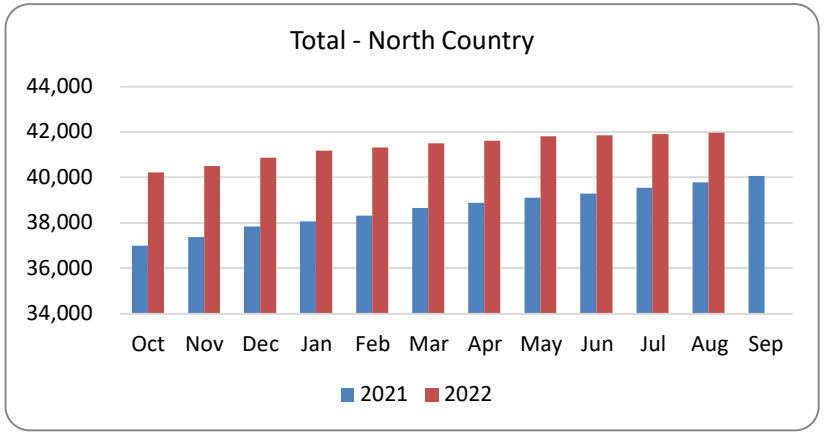
October 1, 2021 through August 31, 2022

North Country Eligible Trending - based on payment files







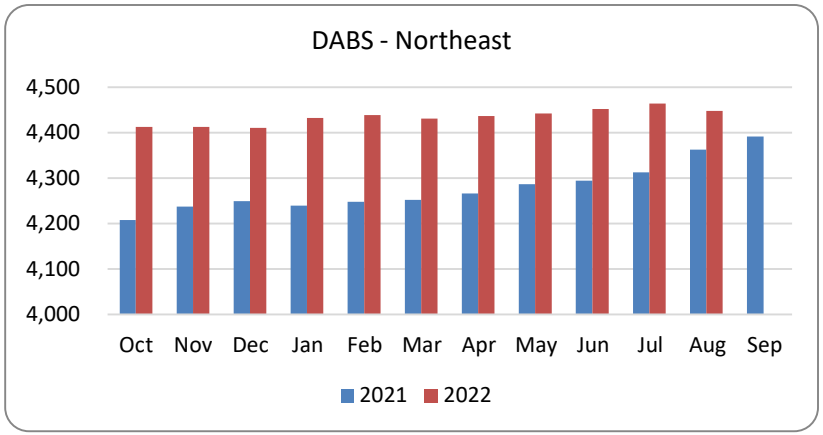


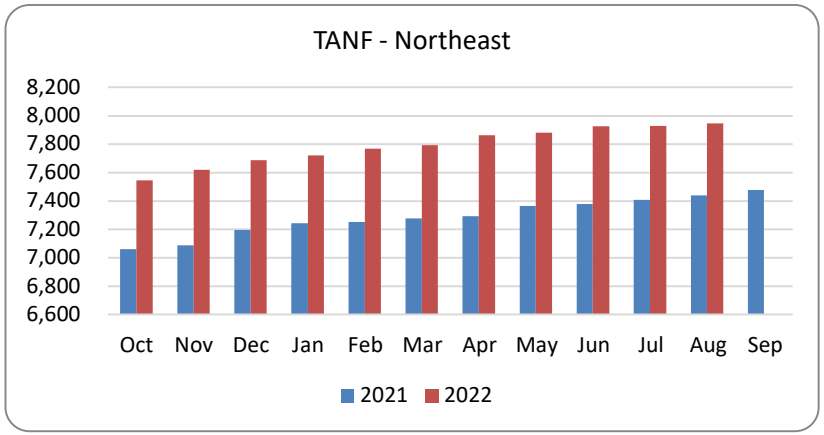
Northern Michigan Regional Entity

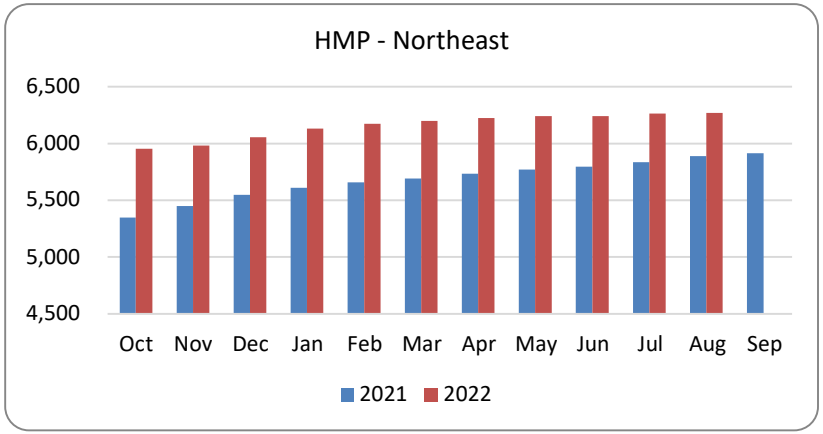
Narrative

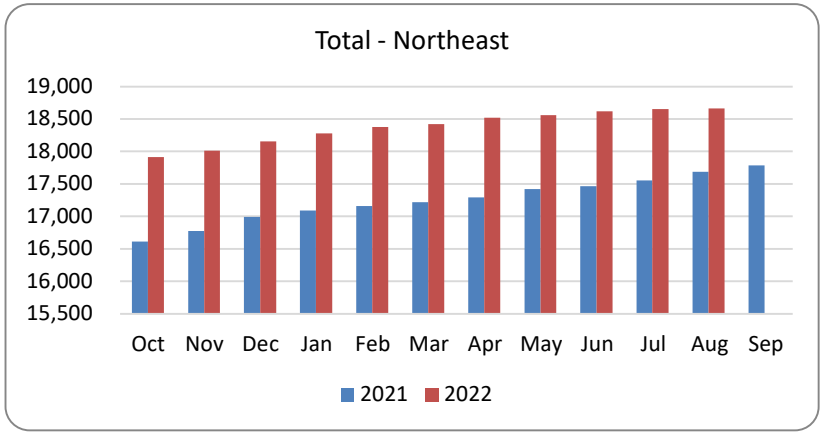
October 1, 2021 through August 31, 2022

Northeast Eligible Trending - based on payment files







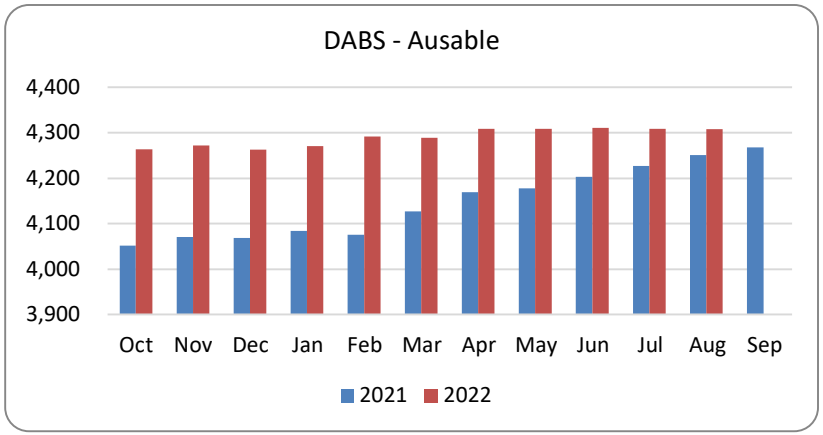


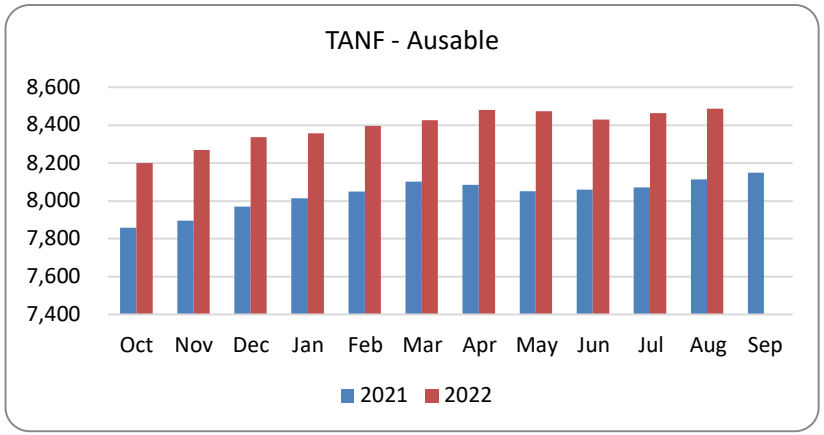
Northern Michigan Regional Entity

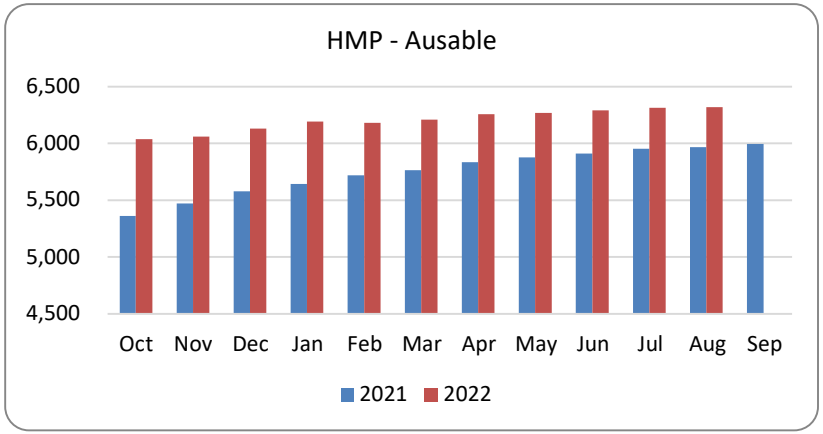
Narrative

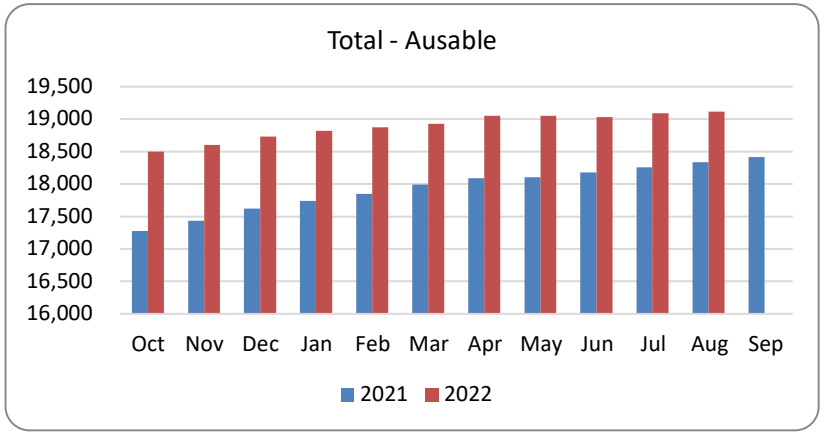
October 1, 2021 through August 31, 2022

Ausable Valley Eligibles Trending - based on payment files







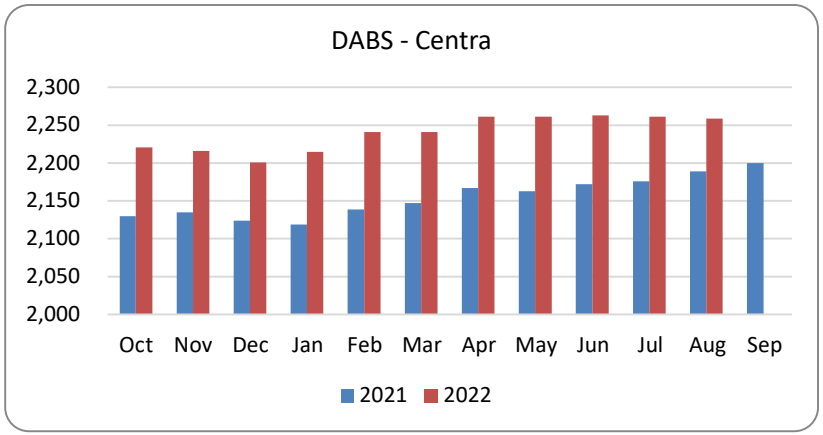


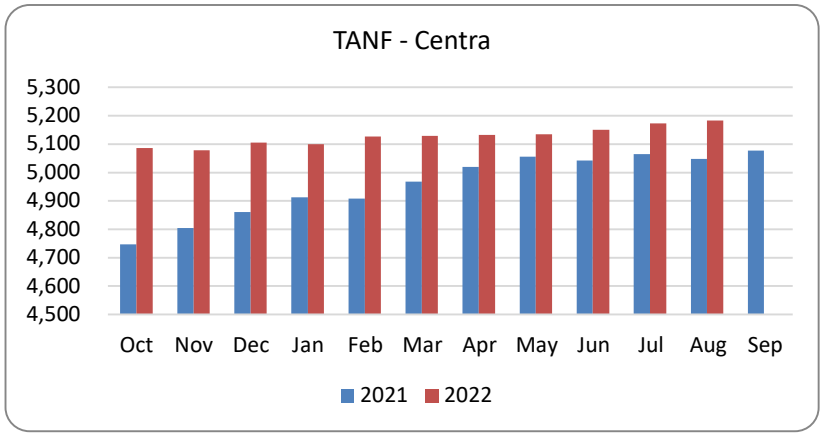
Northern Michigan Regional Entity

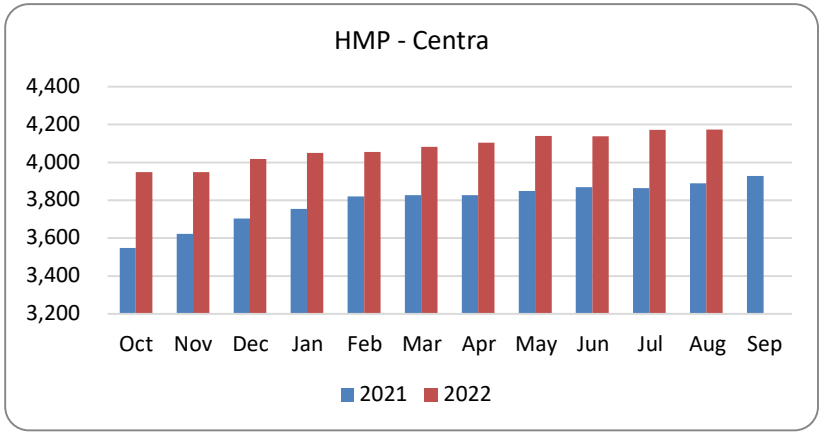
Narrative

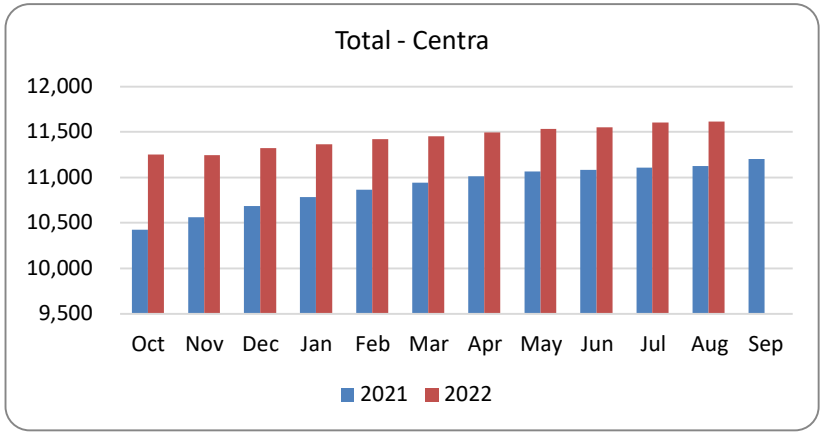
October 1, 2021 through August 31, 2022

Centra Wellness Eligibles Trending - based on payment files







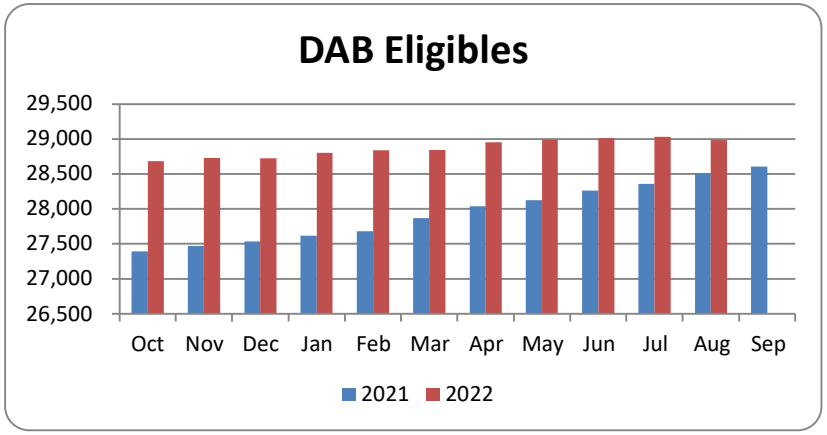


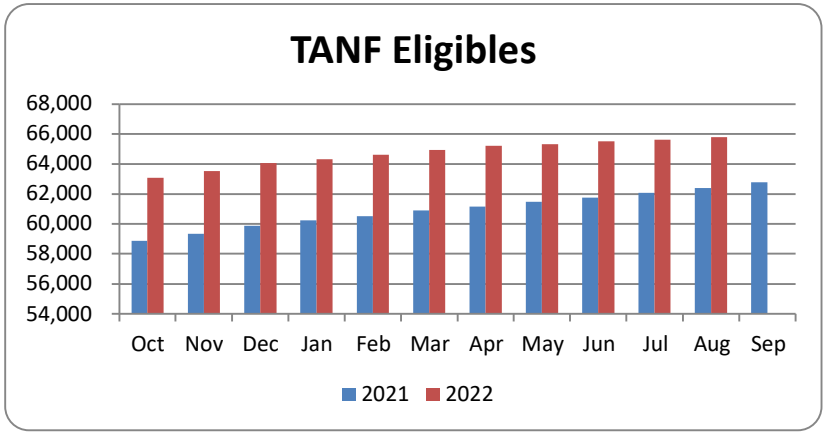
Northern Michigan Regional Entity

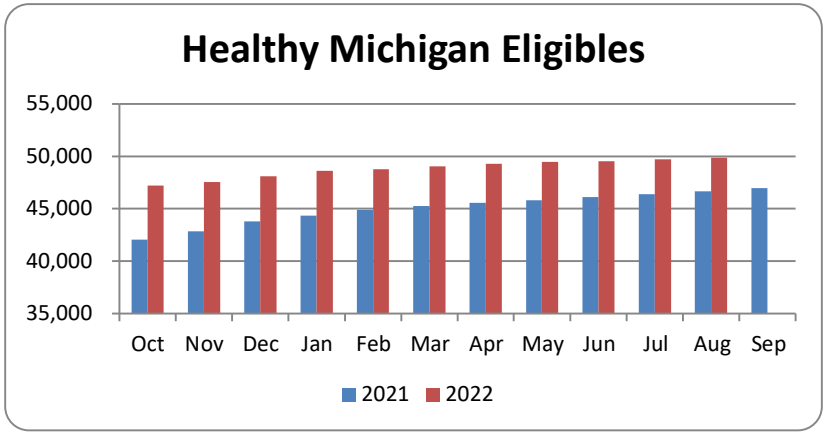
Narrative

October 1, 2021 through August 31, 2022

Regional Eligible Trending





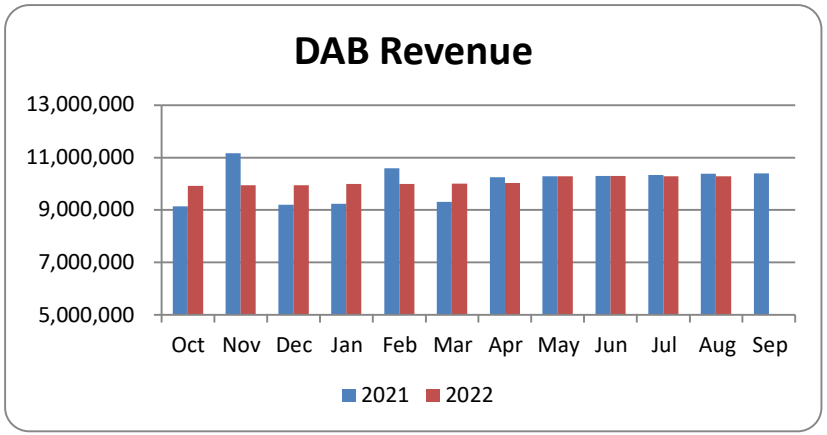


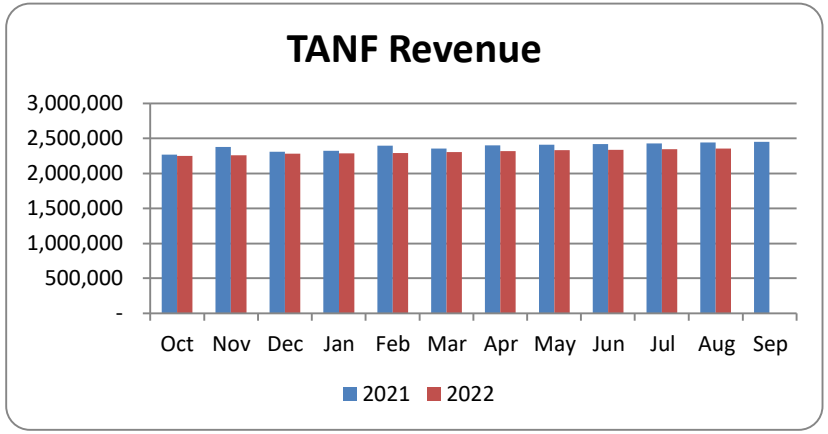
Northern Michigan Regional Entity

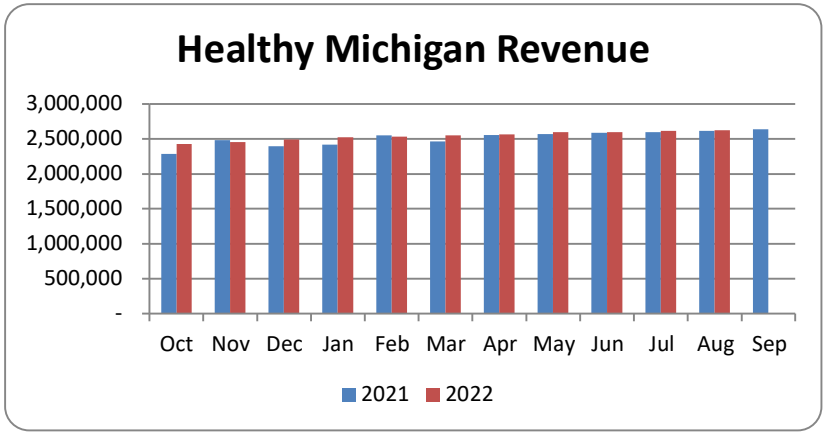
Narrative

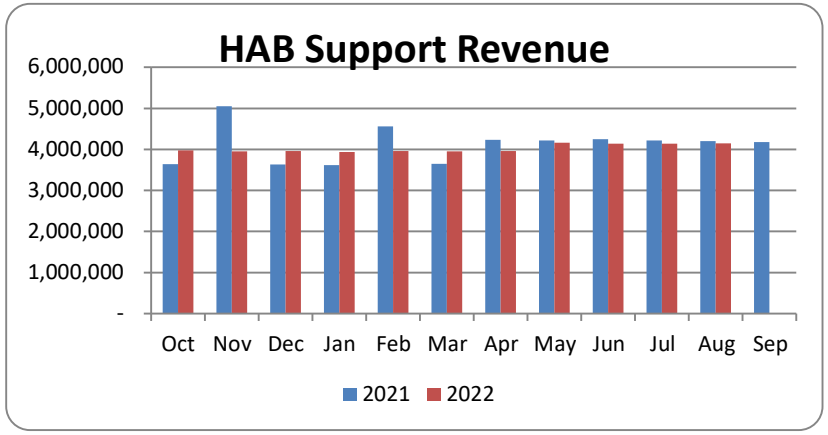
October 1, 2021 through August 31, 2022

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING MINUTES
9:30AM – OCTOBER 18, 2022
GAYLORD CONFERENCE ROOM

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

REVIEW OF AGENDA & ADDITIONS

Mr. Kurtz added a discussion of "rural issues" to be reported to Senator Stabenow's office to the meeting agenda. Ms. Sork asked that Section 950 of the state budget be added as a discussion topic.

APPROVAL OF PREVIOUS MINUTES

The minutes from September 20th were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE MINUTES OF THE SEPTEMBER 20, 2022 NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE MEETING; SUPPORT BY CHIP JOHNSTON. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

August Financials

- Net Position showed net surplus Medicaid and HMP of $12,475,178. Medicaid carry forward was reported as $16,358,117. The total Medicaid and HMP Current Year Surplus was reported as $28,833,295. 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 $45,191,412.
- Traditional Medicaid showed $186,405,461 in revenue, and $171,709,461 in expenses, resulting in a net surplus of $14,696,000. 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 $29,858,005 in revenue, and $25,540,724 in expenses, resulting in a net surplus of $4,317,281. HMP ISF was reported as $7,059,749 based on the unaudited FSR. HMP savings was reported as $5,061,250.
- Health Home showed $1,359,717 in revenue, and $1,168,106 in expenses, resulting in a net surplus of $191,611.
- SUD showed all funding source revenue of $23,280,348, and $19,949,895 in expenses, resulting in a net surplus of $3,330,453. Total PA2 funds were reported as $5,326,234.

The direct care wage surplus was estimated at $5,326,234. A potential lapse of $10M for FY22 is anticipated (not including the DCW).

Ms. Sork asked why the Financial Summary shows Northeast Michigan at a deficit. Clarification was made that Northeast Michigan has overspent all its PMPM by $1,026,665; this does not present a problem, however, since the NMRE is projecting a large lapse for the year.

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

FY22 Budget Stabilization

MR. Kurtz reported that stabilization payments have been paid to Bear River Health and Addiction Treatment Services.

SCA News

MR. Kurtz is diligently working on identifying administrative functions as outlined in the PIHP-CMHSP contract. A portion of the November Finance Committee meeting will be devoted to reviewing the SCA Methodology document (Version 1.1) to ensure consistent reporting throughout the region.

DEBRIEF FARAH HANLEY VISIT

The CEOs expressed that they felt the October 6th meeting with Farah Hanley and Kristen Jordan went well. Ms. Hanley and Ms. Jordan appeared to be listening, asked good questions, and didn't appear defensive. The concerns presented by NMRE were consistent with those expressed by NorthCare Network. It was noted that the PHE was extended through January; the 60-day notice is expected in November.

LAKEVIEW PROPOSAL FOR NLCMHA COUNTIES LISTENING SESSIONS

A proposal from Lakeview Consultants, LLC "to provide planning, facilitation, and report findings specific to the public mental health system in Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon and Wexford Counties" was included in the meeting materials. A series of listening sessions are planned to take place in each of the counties. Lakeview Consultants, LLC CEO, Sara Bannon, will be put in touch with Brian Martinus, Interim CEO for Northern Lakes CMHA regarding payment.

CONTRACT WITH CHRISTINE GEBHARD

Mr. Kurtz reached out to Christine Gebhard to determine whether she would be interested in taking on some projects on behalf of the region. Areas of focus were discussed as:

- Participation on the Northern Michigan CHIR
- General Advocacy
- Traverse City Crisis Services Unit
- Other as needed

Discussion of the sustainability of the Traverse City Crisis Services Unit followed. Mr. Kurtz will raise the topic with Grand Traverse County Administrator, Nate Alger, when they meet next.

MOTION BY CHIP JOHNSTON TO RECOMMEND ENGAGING CHRISTINE GEBHARD ON A CONTRACTED BASIS TO WORK ON BEHALF OF THE NORTHERN MICHIGAN REGIONAL ENTITY AT A RATE OF ONE HUNDRED DOLLARS ($100.00) PER HOUR; SUPPORT BY DIANE PELTS. MOTION CARRIED.

GRAND TRAVERSE COUNTY AND NORTHERN LAKES

All six counties have signed the Memorandum of Understanding to open the enabling agreement. Mr. Martinus has some suggestions to help make the Board run more smoothly. The CEO Search is getting started with assistance from the NMRE. The position will be posted in November for 45 days. The NLCMHA Board will be asked to revisit the salary range. A Search Committee meeting has been scheduled on November 3rd at the NMRE.

BHH AND OHH MYMICHIGAN

Mr. Kurtz reported that MyMichigan Health has contacted NMRE Clinical Services Director, Bea Arsenov, about becoming a Behavioral Health Home provider because they have over a hundred clients that the CMHSPs are refusing to see. It was noted that 60,000+ individuals within the NMRE catchment area have been identified as eligible for BHH. The CMHSPs were instructed to conduct the assessment through their access systems and open eligible clients to their own BHH or refer them to MyMichigan.

GAYLORD CRU

Mr. Kurtz has spoken with Dr. Ibrahim and the staff at the North Shores Center about the status of the Gaylord Crisis Residential Unit (Alpine CRU). The building is on track for a January 1, 2023 opening. A lease has been signed and licensing has given an unofficial "nod." Mr. Kurtz proposed beginning with a $^{1}/_{12th}$ payment and cost settling at the end of the year. The Boards requested an informational brochure to provide to staff.

OTHER

Sen Stabenow's Office's Request for Rural Issues

Mr. Kurtz reported that Melissa Fruge from Sen. Stabenow's office reached out to him requesting a list of rural issues. Mr. Johnson agreed to resurrect a document he prepared in 2021; this will be shared with the group for review and possible expansion prior to sending to Ms. Fruge.

Guardianship

Nena indicated that Northeast Michigan received a letter from Presque Isle County probate judge requesting the $50/month payment for court-appointed guardians pursuant to Michigan FY23 Budget Section 950. Payments cannot be sent at this time because no process for this has been established (though they will be retroactive to October 1, 2022). Attorney Steve Burnham is working with the Guardianship Alliance on the matter. There is uncertainty about what qualifies an individual as a CMH client.

Self-Determination Rates

PIHPs/CMHSPs must establish a cost schedule for each service to be used while developing the budget for self-determination arrangements; the hourly rate for staff should be in line with other hourly rates paid for staffing of other contracted providers. The development of rates for self-determination was discussed. The NMRE will explore Agency of Choice contracts that could be used as an alternative staffing in self-determined arrangements.

MOTION BY CHIP JOHNSON TO UNDERGO AN OPEN PANEL PROCUREMENT PROCESS TO SECURE AN AGENCY OF CHOICE TO BE USED FOR SELF-DETERMINED ARRANGEMENTS IN THE NORTHERN MICHIGAN REGIONAL ENTITY TWENTY-ONE COUNTY REGION; SUPPORT BY BRIAN BABBITT. MOTION CARRIED.

MDOC

In follow-up to the discussion held during the September meeting regarding individuals released from DOC into the community, Ms. Sork reported that she recently learned that only one individual has been identified in the Northeast Michigan CMHA area.

Ms. Sork noted that a meeting of regional Medical Directors is needed to discuss inpatient (and other) issues. Mr. Kurtz will contact Dr. Cummins & Dr. Monteith about scheduling.

FY23 COLAS

Ms. Sork asked what the Boards have planned for cost of living adjustments (COLA) to staff for FY23.

- **AuSable Valley** – A 4% COLA was given on Oct. 1st; an additional increase midyear (April) is being considered.
- **Centra Wellness** – A salary study was conducted in FY22 and adjustments were made; nothing else is planned for FY23.
- **North Country** – A 4% COLA was budgeted to begin on January 1st.
- **Northern Lakes** – Three separate union negotiations are currently underway.
- **NMRE** – A 3% COAL went into effect on October 1st.

NEXT MEETING

The November 15th @ 9:30AM will be rescheduled for early December.