Northern Michigan Regional Entity

Board Meeting

December 18, 2024

1999 Walden Drive, Gaylord

10:00AM

Agenda

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3.	Pledge of Allegiance	
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11.	New Business	
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12.	Old Business	
	a. Northern Lakes Update	
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14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – January 22, 2025 at 10:00AM	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – OCTOBER 23, 2024
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Tom Bratton, Ed Ginop, Gary Klacking, Eric Lawson, Mary Marois, Michael Newman, Gary Nowak, Jay O'Farrell, Ruth Pilon, Richard Schmidt, Karla Sherman, Don Smeltzer, Don Tanner, Chuck Varner**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brady Barnhill, Brian Babbitt, Carol Balousek, Lisa Hartley, Chip Johnston, Eric Kurtz, Brian Martinus, Brie Molaison, Diane Pelts, Brandon Rhue, Nena Sork, Denise Switzer, Chris VanWagoner, Deanna Yockey**
PUBLIC:	**Samantha Borowiak, Dave Freedman, Kevin Hartley, Madeline McConnell**

CALL TO ORDER
Let the record show that Board Chairman, Gary Klacking, called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that all NMRE Board Members were in attendance 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 no changes to the meeting agenda were requested.

MOTION BY RICHARD SCHMIDT TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR OCTOBER 23, 2024; SUPPORT BY DON TANNER. MOTION CARRIED.

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

MOTION BY DON TANNER TO APPROVE THE MINUTES OF THE SEPTEMBER 25, 2024 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY RICHARD SCHMIDT. MOTION CARRIED.

CORRESPONDENCE

1) The PIHP CEO Meeting Minutes from September 5, 2024.
2) The Michigan Department of Health and Human Services (MDHHS) Service Delivery Transformation Section Update dated August 2024.
3) Michigan Medicaid Provider L Letter 24-59 authorizing a FY25 $0.20 pay increase for direct care workers.
4) Michigan Medicaid Provider L Letter 24-63 requiring the use of the Michigan Child and Adolescent Needs and Strengths (MichiCANS) assessment tool.
5) Draft Memorandum dated September 24, 2024 from attorney Adam Falcone to Bob Sheehan, CEO of the Community Mental Health Association of Michigan (CMHAM) regarding Home and Community-Based Services Conflict-Free Access and Planning.
6) Email correspondence from Bob Sheehan (CMHAM) to PIHP and CMHSP CEOs and Provider Alliance Members dated October 11, 2024 urging media relations work around the need to close the system's revenue gap (and press release template).
7) Email correspondence from the Actuarial Division of the Bureau of Medicaid Policy, Operations & Actuarial Services, Behavioral and Physical Health and Aging Services Administration at MDHHS announcing a FY24 rate amendment, totaling $41.6M statewide.
8) The NMRE region's Quarter Three Fiscal Year 2024 Performance Indicator Report.
9) The Statewide Quarter Three Fiscal Year 2024 Performance Indicator Report.
10) The draft minutes of the October 9, 2024 regional Finance Committee meeting.

Mr. Kurtz drew attention to the Action Alert and continued advocacy regarding the state's $93M revenue gap.

The state has awarded an additional FY24 rate increase totaling 41.6M statewide. The NMRE's portion is likely to be $2M.

The regional and statewide Performance Indicator reports for Quarter 3 FY24 were shared with the Board for informational purposes. The region has surpassed the 50th percentile benchmark (57%) and is very close to meeting the 75th percentile (62%) benchmark for Table 2. The region is very close to meeting the 50th percentile benchmark (72.9%) for Table 3.

As the legal opinion from attorney Adam Falcone on Home and Community-Based Services Conflict-Free Access and Planning was marked "Privileged and Confidential," the decision was made to collect the document for shredding following the meeting.

ANNOUNCEMENTS

Let the record show that Mr. O'Farrell announced that this date marks his 25th wedding anniversary.

PUBLIC COMMENT

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

REPORTS

Executive Committee Report

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

CEO Report
The NMRE CEO Monthly Report for October 2024 was included in the materials for the meeting on this date. Mr. Kurtz met with Jill Lebourdais and Dr. Ibrahim to discuss Alpine CRU funding for FY25. The decision was made to extend the current 1/12th arrangement through December 31, 2024. The CMHSPs may pursue fee-for-service contracts beginning January 1, 2025. The occupancy rate for FY24 was roughly 50%.

The NMRE's FY24 block grant allocation was exhausted by the end of June. Treatment services for individuals who qualified for block grant funding will need to be billed to liquor tax funds for Quarter 4. The NMRE is working on methods to bill as much as possible to Medicaid and Healthy Michigan.

The NMRE is currently aware of 324 SUD Residential beds in the region, that are used 76% by out-of-area residents. There are also over 300 recovery/T-Home beds in the region which are utilized to transition individuals from residential treatment; these too are mainly occupied by individuals who lived outside the NMRE region prior to treatment. In these cases, the placing PIHP should continue to fund the treatment until permanent, independent residency is established; however, the NMRE is being asked to fund these placements, which is not feasible. A meeting was held between NMRE staff and MDHHS to address this issue. MDHHS has agreed to direct additional block grant funding to the region.

Mr. Kurtz noted that he was invited to join the Crawford County Opioid Steering Committee.

August 2024 Financial Report
- Net Position showed net deficit Medicaid and HMP of $7,758,515. Carry forward was reported as $11,624,171. The total Medicaid and HMP Current Year Surplus was reported as $3,865,656. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $24,441,812.
- Traditional Medicaid showed $190,483,155 in revenue, and $191,801,830 in expenses, resulting in a net deficit of $1,318,675. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $845,073.
- Healthy Michigan Plan showed $26,235,057 in revenue, and $32,674,897 in expenses, resulting in a net deficit of $6,439,840. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $10,779,098.
- Health Home showed $2,846,438 in revenue, and $2,487,581 in expenses, resulting in a net surplus of $358,857.
- SUD showed all funding source revenue of $26,709,246 and $24,603,696 in expenses, resulting in a net surplus of $2,105,550. Total PA2 funds were reported as $4,648,663.

Four of the five member CMHSPs are overspent on Medicaid and all five member CMHSPs are overspent on Healthy Michigan; Medicaid and HMP savings will be used to offset the deficit.

The preliminary Medicaid and HMP carryforward for FY24 was estimated at $2.8M. The October (FY24) rate increase will be distributed in a payment to the NMRE on October 31st.

The NMRE will continue to submit reports of unpaid Habilitation Supports Waiver (HSW) slots to MDHHS until the end of December; a fix is expected in January 2025. The issue was first spotted in July 2023, however, MHHS only committed retroactive payments back to October 1, 2023. The

NMRE finance department anticipates $1.7M - $2M owed to the NMRE. These funds were not reflected in the current (August) financial report.

Eight additional HSW slots were awarded to the NMRE effective October 1st, bringing the region's total to 697. There are currently four packets pending approval by MDHHS.

Effective October 1st, the NMRE's Opioid Health Home (OHH) and Alcohol Health Home (AHH) have merged to become the SUD Health Home program. Since October 1st, 87 individuals have been enrolled, bringing the total enrollment to 889.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHY FINANCIAL REPORT FOR AUGUST 2024; SUPPORT BY DON TANNER. MOTION CARRIED.

Enrollment Trending
The NMRE has been monitoring Medicaid disenrollments and movement of individuals from Disabled, Aged (65+) or Blind (DAB) to Temporary Assistance for Needy Families (TANF), and/or Plan First. Approximately 10% of DABs in the Region have moved to TANF during the enrollment period. The average payment for a DAB individual was provided as $426.67; the average payment for a TANF individual was provides as $39.49.

Mr. Kurtz stressed the need for beneficiaries to know they can appeal their Medicaid assignments. The NMRE will continue to run enrollment numbers.

Ms. Pilon asked if the NMRE has the ability to see in what waivers individuals are enrolled. Mr. Kurtz responded that the 1915(i) waiver and HSW have enrollment processes. For Medicaid, DHHS enrolls individuals in the DAB/TANF/HMP buckets.

Internal Service Fund (ISF) Analysis
Ms. Yockey reviewed the results of Milliman's 2024 analysis of the NMRE's ISF.
Based on Milliman's analysis, the NMRE's ISF should be funded at approximately 15% of annual revenue.

Mr. Kurtz noted that Milliman (for ISF analysis purposes only) may begin to establish the ISF amounts equal to two months' revenue rather than considering the 7.5% in the future.

The next analysis will take place in the Fall 2025/Spring 2026.

Operations Committee Report
The draft minutes from October 15, 2024 were included in the materials for the meeting on this date.

NMRE SUD Oversight Committee Report
The next meeting of the NMRE Substance Use Disorder Oversight Committee will take place on November 4th at 10:00AM.

NEW BUSINESS

NMRE CEO Evaluation Process

An evaluation of the NMRE CEO is needed for FY24. The survey template that has been used for the past several years was included in the meeting materials. Board Members agreed to use the tool for the FY24 evaluation without changes.

OLD BUSINESS

Northern Lakes CMHA Update

A meeting is scheduled at 3:00PM on this date to discuss the cost allocation findings in the forensic investigation report. A meeting of the NMRE Executive Committee may be convened to determine the need for next steps. Northern Lakes' FY23 financial close-out has been delayed due to the ongoing forensic investigation.

Ms. Marois reported that the Northern Lakes Board of Directors unanimously adopted a new (committee-based) governance model on October 17, 2024.

Mr. Bratton asked how information regarding the forensic investigation will be disseminated. Mr. Kurtz responded that the forensic investigation was initiated at the request of the NMRE Board, therefore, the report will be presented to the NMRE Board first. However, because of the sensitive nature of the subject matter, the report will be kept closed until it is final.

FY25 PIHP Contract Update

The NMRE was one of seven PIHPs that returned a red-line version of the FY25 PIHP Contract to the state. The seven PIHPs disagree with Waskul language and ISF cap at 7.5%. The modified contracts were not accepted by the Department. The PIHPs are actively engaging in good-faith negotiations with the state to resolve FY25 contract concerns. A meeting was held on October 18th, during which MDHHS asked the PIHPs to explain their issues (though they were included in the contract). A meeting is scheduled with CMHAM on October 25th to discuss next steps.

Ms. Sherman inquired about the status of the letter from attorney Chris Cooke to Elizabeth Hertel requested by the Board in July. Mr. Kurtz responded that it hasn't been drafted yet due to the FY25 Contract not being signed. It is likely that a letter from legal counsel is not needed. Mr. Kurtz offered to write the letter himself on behalf of the Board. In addition to outlining the region's opposition to FY25 Contact issues and other concerns (rates, conflict-free access and planning, multiple waivers), Mr. Kurtz will highlight the region's numerous strengths.

PA 152 Opt Out

A legal opinion on Public Act 152 of 2011 from attorney Steve Burnham to Chip Johnston dated October 12, 2011 was included in the meeting materials.

Public Act 152, the Publicly Funded Health Insurance Contribution Act, created a law that limits the amount that public employers pay toward employee medical benefit plans, effective January 1, 2012. Although the NMRE is not over the 80% cap currently, Mr. Kurtz asked the Board for permission to opt out of the Act. It was noted that a ⅔ vote of the governing body is needed to opt out.

MOTION BY DON TANNER TO ALLOW THE NORTHERN MICHIGAN REGIONAL ENTITY TO COMPLY WITH PUBLIC ACT 152 OF 2011, THE PUBLICLY FUNDED HEALTH INSURANCE CONTRIBUTION ACT, BY ADOPTING THE ANNUAL EXEMPTION OPTION

FOR THE MEDICAL BENEFIT PLAN COVERAGE FOR JANUARY 1, 2025 THROUGH DECEMBER 31, 2025; SUPPORT BY ERIC LAWSON. ROLL CALL VOTE.

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

"Nay" Votes: Nil

PRESENTATION

Customer Satisfaction Survey

NMRE Compliance and Customer Services Officer, Brie Molaison, was in attendance to present the NMRE regional Mental Illness and Intellectual/Developmental Disabilities Mental Health Services Satisfaction Survey Report to the Board.

The 2024 Region 2 NMRE Mental Illness and Intellectual/Developmental Disabilities Mental Health Services Satisfaction Survey took place from June 1, 2024 – June 30, 2024. The survey contained 18 questions and was available in paper or electronic (SurveyMonkey) format.

CMHSP Participation

CMHSP	Percentage	Number of Responses	Percentage of Total Individuals Served	Overall Satisfaction
AuSable Valley	36.94%	348	20%	98%
Centra Wellness	4.35%	41	5%	98%
North Country	30.89%	291	10.5%	99%
Northeast Michigan	2.55%	24	14%	92%
Northern Lakes	25.27%	238	<1%	80%
Total		**942**		

Highlights

- 96% if service recipients feel that they are actively involved in their healthcare decisions and the development of their treatment plan.
- 96% of service recipients are satisfied with the services they receive.
- 99% of service recipients feel that they are treated with dignity and respect.

Areas for Improvement

- Informing service recipients about their right to file a grievance and/or appeal.
- Informing service recipients about mediation services.
- Informing service recipients about sharing their health information with their medical providers.

Ms. Molaison intends to bring a group of regional staff together to discuss the survey process and questions prior to implementing the survey for FY25.

Ms. Pelts suggested that regional training be recorded for future viewing.

Mr. Babbitt applauded the high scores and recognized CMHSP staff for the work that they do.

COMMENTS

Board

Mr. Adrian inquired about Michigan Medicaid Provider L Letter 24-59 which authorized FY25 $0.20 pay increase for direct care workers. It was noted that the increase would set base pay for direct care workers at $14.48 per hour; the CMHSPs' contract rates already exceed this amount.

Mr. Tanner referenced the expression "May you live your life in interesting times," noting that he doesn't need times "to be quite this interesting."

Mr. Smeltzer suggested that, to get a higher satisfaction survey response rate, the NMRE reach out directly to individuals served.

Staff/CMHSP CEOs

Mr. Johnston reported that in an email dated October 10, 2024, Centra Wellness Network was approached about becoming a (rural) CCBHC. In a follow-up phone call Mr. Johnston highlighted several reasons why the CCBHC is not a viable service model in rural PIHP Regions 1 and 2.

MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on December 18, 2024.

ADJOURN

Let the record show that Mr. Klacking adjourned the meeting at 11:40AM.

Regional Entity CEO Group

Jim Johnson	Joseph Sedlock	Bradley Casemore
Vice Chair	Chair	Spokesperson

REGIONAL ENTITY CEO MEETING

Date: Tuesday, October 1, 2024, Time: 12:30 pm – 3:00 pm

DRAFT – Minutes

1. **Welcome / Introductions**

The meeting was called to order by Joe Sedlock at 12:32 pm.

Present In Person: None

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

Absent: None

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

CMHA Staff: Monique Francis

2. **Agenda Changes / Previous Minutes Approval**

Additions/changes to the agenda: FY25 Contract as Item 7, added by Megan, and CFAP as Item 8, added by Joe. **The group agreed by consensus** to accept the agenda for October 1, 2024, with additions, and approve the minutes from September 3, 2024.

Priority/Action Items

3. **ALJ Opinion (Jim)**

Jim Johnson reported that a person receiving services had a change in their IPOS due to the plan year ending. The person was going to file an appeal. The staff at Region 10 felt that the same levels of service were not required to be offered. The Administrative Law Judge did not agree with Region 10's position, stating that the request for continuation of services was prior to the plan ending and should be continued, so now that this opinion has been written, the person served has a copy of that and is appearing at their Board meeting. The case was dismissed so Region 10 feels the opinion should not be considered, and Region 10 is consulting with their legal counsel. Jim stated they have not received a response from the Department regarding this. Jim will send a copy of the ALJ's opinion to the group for their information.

4. **State Opioid Settlement Money to PIHPs (Brad)**

- SWMBH Document attached

Brad stated that many have advocated for boilerplate to have state funds be distributed to the PIHPs. He reported that the redline document shows feedback to the Department on this topic, but he was unsure as to what exactly ended up in the PIHP Contracts. Brad stated that Angie Smith-Butterwick told the SUD Directors that there were some forms that need to be filled out by the PIHPs for the Opioid Settlement Funds. Many felt that this was yet another set of barriers to obtaining this funding into the PIHP system. Brad will continue to advocate for the path of least resistance, through legislative measures, for obtaining these funds. He urged everyone to do the same. Stephanie VanDerKooi stated that to further complicate this matter, if the funds go into EGRAMS, our system will only have 2 weeks to request these funds. The group agreed to add this to the Operations Meeting agenda with Brad as lead.

5. **FY24 Rate Adjustment (Megan/All)**

Megan stated that she continues to feel there are geographic issues with the problems with the rates. She stated that if populations continue to trend declining, the outlook is pretty bleak.

6. **FY25 Rates (Megan/All)**

No further discussion beyond that in Item 5.

7. **FY25 Contract (added by Megan)**

Megan reported that the termination clause was cited due to 7 PIHPs doing strikeouts in their contracts. Megan stated she has engaged her legal counsel, and everyone needs to get on the same page prior to moving forward. Richard Carpenter reviewed the email sent to Traci Smith, which basically was to make the PIHP aware that they

must continue to provide services no matter what. The termination clause automatically extends the FY24 contract, but the Department is not accepting the strikethrough version submitted by those 7 PIHPs. Megan reviewed the actual verbiage in her email received from the Department. The group discussed whether the language in this email communication was perceived in a threatening manner. The group also discussed what the next steps may be in this matter. Richard proposed that the CEOs of those 7 PIHPs appoint someone as lead to speak with legal counsel from each PIHP. Megan and Richard will work with Greg Moore, along with Eric K. Dana offered Callana Ollie from Oakland to work with this group. Jim Johnson stated that his region has been diligent about building risk reserve and his Board does not see how they could sign this contract. Brad informed the group that SWMBH is one of the 3 that did sign the contract without strikeouts. James informed the group that Region 6 did close out FY18 and 19 with the Department. He stated that the Department pulled $7.5 Million out of a recent payment earlier this year, then his last payment was $0. Richard Carpenter clarified the group that work on continuing to negotiate acceptable contract language, and inform the Department that PIHPs will continue to do what they are statutorily required to do, and keep the finding flowing to the PIHPs. Megan Rooney and Eric K. will be the CEOs, with Richard Carpenter as a CFO representative, and Callana Ollie as Counsel, and will work with Greg Moore. The group discussed that they would like to keep the Association out of these discussions. Brad asked if the group wanted this added to the Operations meeting agenda. After discussion, the group decided not to add to that agenda. The group then discussed whether Joe, as Chair of this Regional CEO group, should step aside as spokesperson, to allow for another (such as legal counsel) to speak on this issue. After talking through several points, the group agreed that there were pros and cons. Appointing legal counsel as the spokesperson may indicate that the PIHP system is adversarial, but it may not appear that way to the Department if the advocacy was for the PIHPs as a group – not simply for the benefit of one PIHP. The group spoke about each Director being able to hold on to their ability to negotiate their own contracts. The group also discussed that having appointed legal counsel would benefit all PIHPs since one Director would not be perceived to be advocating for their own PIHP. An independent, third-party spokesperson would solve that potential problem.

8. CFAP (added by Joe)

The group discussed the need for clarity in roles and responsibilities for PIHPs in any conflict free access and planning initiative moving forward. Jim Johnson stated that he is hearing the Waiver has not been approved. Brad stated that he is hearing an extension of the current waiver to December 31, 2024, in order to work this through. Some have heard this was only for the 1115 Waiver (through 12/31/24). The group discussed whether anyone had seen the language that was submitted to CMS. None in the group had, other than in bits and pieces. Joe reiterated that if/when CFAP is implemented, the Department HAS to be clear with the roles and responsibilities in the actual implementation of this plan. The group discussed who in this group would be able to comply and who would not, and the legalities involved.

9. OPEN (this item left blank for additional items)

10. OPEN (this item left blank for additional items)

11. Michigan Opioid Task Force Updates (Brad)

Brad reported that the "four pillars" committees are finalizing their recommendations and sending them to MDHHS. He will continue to update the group on this each month.

12. Michigan Autism Council Updates (Dana)

Dana reported that there has been no meeting in the last month.

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

No update. No discussion.

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

- Update from meeting held on 9/27/24.
  Joe reported he has a written update to distribute to the group. Highlights included cleaning up the grid and tracking items. He asked if there were any items needed to be highlighted and discussed from the most recent meeting. Megan stated that Payment responsibility section is confusing RE: OBRA as a responsibility of the PIHP, which it is not. She asked if they would be adding clarification or corrections. Joe stated that the PIHPs can bring this back up on the next agenda.

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

- No update. No report.

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

- No update. No report.

16. Training Reciprocity (A. Dillon/Joe)

- No update. No report.

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

- Minutes attached. Discussion included rates, working with SG, lateness of information from the Department, volume of information decreasing, and Milliman's data being used to build rates.

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

- No update. No report.

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

- No update. No report.

20. Statewide Utilization Management Directors Group (Skye Pletcher/Mary)

- Meeting notes were provided in the packet. Joe stated that this group is working on a tiered rates implementation process. The group discussed and agreed that just having a group working on this issue and reporting back to the CEOs was reassuring.

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

- No meeting. No report.

22. MDHHS/PIHP Operations Meeting Planning (All)

- Next meeting is October 3rd.
- Topics to Add to Agenda (if any)
  - Section 250/Opioid Settlement Funds (Brad will be lead)

23. CMHA Legislation & Policy Committee (Jim)

- No update or report.

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

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

Topics for discussion provided by PIHP CEOs:

- Other as identified during meeting

Brad asked Bob about the Opioid Settlement Funds, specifically a Section 250 boilerplate report that would need to be submitted to the Legislature, to obtain settlement funds Alan will check with the House and Senate Fiscal representatives to see what that is about. After discussion, the group determined that Section 250 may be the Opioid Health and Healing section, and a budget and workplan may be needed to submit for funding.

Topics for discussion provided by Bob Sheehan:

- Closing FY24 revenue gap (Bob)
  - Heard anything from MDHHS? CMHA has heard, but have been asked to keep it under their hats David Knezek has been in touch with the Association and Bob is hopeful he can continue communications with him to correct determination methods.
  - Sequential advocacy around Medicaid capitation revenue:
    Bob Sheehan reported that there is still a $52 Million gap. Bob stated a 3-prong approach has been communicated to the Department. Dana reminded everyone that Spenddown has not been taken into consideration yet either. Bob then highlighted the 3 points of the Association's approach as listed below.
    - Focus on FY 24 gap closure
    - Followed by joint effort with MDHHS re: addressing misplacement of formerly DAB in Plan First, HMP, and other Medicaid programs
    - Request that PIHPs, as was done in 2014 with HMP start up, pull data measuring the number of persons who were on DAB prior to pandemic who were, via the unwinding process, moved out of DAB to Plan First, HMP, and others

    The group discussed different dynamics of the populations in redeterminations. The group also discussed whether the Budget Office was looking at ramifications of the Waskul Settlement to Michiganders in general. Alan felt that they were not looking at that. The group asked if the

Department was using emerging data for rate setting purposes. Richard asked if there was any opportunity to show the Department that they may be using outdated data. Bob stated that the Association will work with Keith White.

- Update on MDHHS-PIHP contract negotiations and/or contract signing
  Bob asked if the PIHPs were receiving close-out language type emails from the Department. Megan stated that PIHPs are meeting with Greg Moore later today and next steps are going to be determined. The PIHPs will come up with a more formalized response. Bob stated the Association is happy to help in any way that they can.
- FY25 Rates
  - PIHP views of those rates
    Bob stated that the Department and Wakely will need to get together to work on developing rates in the future.
  - Wakely's views of those rates
    Alan stated that the Association is willing to do whatever they need to in order to help the PIHPs move this discussion forward. Megan stated that she feels rates are definitely enhanced, but the populations seem to continue to decline. Joe reported that projections are still being developed at Mid-State.

OTHER:
James reported that MCHE invoices have been sent out regarding MCG. He urged all to submit payment ASAP.
ADD to future Agenda in November:
FY25 Contracts continued discussion – Legal Counsel as spokesperson.

The meeting adjourned at 2:14pm.

Respectfully Submitted,
Monique Francis, CMHA Committee Clerk

Service Delivery Transformation Section

September 2024 Update

CONTENTS

Service Delivery Transformation Section Overview

The Service Delivery Transformation Section is responsible for overarching strategic program policy development, implementation, and oversight for integrated health projects within Michigan's public behavioral health system. This includes behavioral health integration initiatives, Medicaid Health Homes, Certified Community Behavioral Health Clinics, SAMHSA integration cooperative agreements, and health integration technology initiatives to facilitate optimal care coordination and integration. Staff in this section collaborate with internal and external partners and provide training and technical support to the public behavioral health system and participants of integrated health projects. Lastly, this section focuses on quality-based payment for providers involved in behavioral health integration initiatives and oversees CCBHC Demonstration certification.

Our Team

Lindsey Naeyaert – Section Manager
Naeyaertl@michigan.gov
- Leads programmatic, policy, and implementation of integrated health projects within section

Danielle Hall – Behavioral Health Innovation Specialist
HallD32@michigan.gov
- Behavioral Health Home

Amy Kanouse – Behavioral Health Program Specialist
Kanousea@michigan.gov
- CCBHC Demonstration
- Emergency Grants to Address Mental Health and Substance Use During COVID-19

Hailey Mueller – CCBHC Analyst
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- CCBHC Programmatic Support

Jennifer Ruff – CCBHC Certification Manager
RuffJ3@michigan.gov
- CCBHC Certification and Monitoring

Chance Thick - Certification Specialist
ThickC1@michigan.gov
- CCBHC Site Monitoring and Oversight

Amanda Zabor - Certification Specialist
ZaborA@michigan.gov
- CCBHC Site Monitoring and Oversight

Behavioral Health Home

Behavioral Health Home Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes (BHH) 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.
- BHH services are available to beneficiaries in 63 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), 5 (Mid-State), 6 (Southeast Michigan), 7 (Wayne County), and 8 (Oakland County).

Current Activities

- As of October 1, 2024, there are 3,248 people enrolled:
    - Age range: 4-86 years old
    - Race: 26% African American, 68% 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).
- A State Plan Amendment to expand BHH in regions 3,4, and 9, add eligible codes to increase access for children and youth with SED, and add Youth Peer Support to the BHH staffing structure was submitted on July 16, 2024.

Certified Community Behavioral Health Clinic Demonstration

Certified Community Behavioral Health Clinic Demonstration 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. 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

- As of October 2, 2024, 103,443 Medicaid beneficiaries and 26,285 non-Medicaid individuals are assigned in the WSA to the 30 demonstration CCBHC sites.
- MDHHS conducted a health information technology survey amongst CCBHCs in 2023 to solicit feedback on the WSA operations and activities. Feedback resulted in stakeholders finding the WSA to be administratively burdensome, has frequent time outs and errors, as well as duplication of data entry between the EMR and the WSA. MDHHS has funding and is working with internal staff and contractors to develop a bidirectional EMR/WSA API Web Services benefit for stakeholders that will address feedback received. This project wrapped up on August 29th and is awaiting demo testing and onboarding of providers. MDHHS will continue working with state contractors on this effort.
- MDHHS continues to partner with evaluators at the Center for Healthcare Research Transformation at the University of Michigan on formal evaluation activities. CHRT has shared preliminary findings of key themes from interviews with PIHPs and CCBHCs and are beginning data review activities.
- A second draft version of the FY25 CCBHC Handbook was distributed for review by PIHPs and CCBHCs, detailing changes to certification criteria, PIHP/CCBHC responsibilities, and DCO policy guidelines in August. Feedback on the second draft will be reviewed by MDHHS and will be incorporated into the final version published in the beginning of October.
- As a result of the CCBHC recertification process, MDHHS is preparing a new TA series to address most frequently missed application standards.
- MDHHS put forth a CCBHC expansion announcement that identified eligibility requirements for sites interested in joining the CCBHC Demonstration with an application due date of July 1st, 2024. Application reviews are finalized and the CCBHC Demonstration Team was pleased to welcome 3 additional sites to the demonstration effective 10/1/24. An orientation was held in September to welcome all the new fully certified sites. The 3 new sites that joined on October 1, 2024 are Van Buren CMH, EasterSeals Morc Macomb, and Heigra Health, INC.
- Provisional Certification was achieved by 3 CCBHC Demonstration expansion sites. If these sites can satisfy all application deficiencies by November 22, 2024, they will join the CCBHC Demonstration on January 1, 2025.
- Preliminary and final Quality Bonus Payment awards for Demonstration Year 2 were shared with PIHPs, with the consultation period ending in early June and payment distributed on August 29. For DY2 awards, CCBHCs must meet benchmarks for all 6 CMS-designated measures to receive the quality bonus payment.

Questions or Comments

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https://www.9and10news.com/2024/11/12/club-cadillac-speaking-out-after-thousands-of-fundraised-dollars-discovered-stolen/

Club Cadillac speaking out after thousands of fundraised dollars discovered stolen

Jodi Miesen, **Jacob Johnson**

11-12-2024 at 07:02:38 PM EST| Updated 11-13-2024 at 12:57:18 PM EST

A Northern Michigan nonprofit is speaking out after they say tens of thousands of dollars was stolen.

Now, they're asking the community to help them keep critical programs going.

Club Cadillac serves people battling mental illness in Wexford and Missaukee counties.

Amy Kotulski, director of Club Cadillac said about $50,000 was stolen from three accounts that the board of directors holds, allowing them to raise extra money to support the non-day to day activities at Club Cadillac.

Although their operational budget is funded through Medicaid dollars from Northern Lakes Community Mental Health, this will have a big impact on what they can do this holiday season.

"It was very, very shocking, pretty devastating to our membership. We worked really, really hard to fundraise that money; to get those grants," said Kotulski.

Kotulski said this is crushing for the organization. The money in those accounts come mainly from fundraising and grants. She said she worries for their future.

"Some of the opportunities that they've had in the past aren't there right now until we're able to fundraise, to replenish some of that money, to get so that we can take advantage of some future opportunities," said Kotulski.

She said they use those funds for everything from housing needs, to sending members to conferences and trainings, to care packages for members for the holidays, and much more.

Kotulski said until they can replenish the funds, they are looking for monetary donations and donated items so they can make sure those holiday care packages still arrive.

"We're looking for socks, [which] are always our number one most requested item, but any warm weather things socks, hats, gloves, scarves and then toiletries, hygiene items, deodorant, shampoo, body wash, things like that," said Kotulski.

Board President Kristen Kenny said this isn't just a setback for the holiday support for members, but they had real plans to tackle the housing crisis.

She said they had been working on starting a housing development.

"This was our seed money. This was the money that we were going to use to start this housing development.

Kenny said people with mental health issues struggle with housing insecurity. "It's a huge issue, especially for people with mental illness because of stigma. They're in subpar housing. They're living in group homes when they don't belong in group homes," said Kenny.

She said this is a blow to everything they've been working for.

"That was a lofty goal in the first place. And now, you know, it's a major setback. It's gone, it's all gone. And we worked really hard," said Kenny.

She said it feels like a betrayal to find out the money was stolen.

The Wexford County Prosecutor's office is looking at the case and haven't yet said if they will file charges.

"I feel not only extremely angry, but I feel betrayed, extremely betrayed. I want the full extent of the law. This is just unacceptable," said Kenny.

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Seeking involvement of CEOs and their staff in the next phase in "Accurate Picture" Campaign
Date: Wednesday, November 6, 2024 7:56:18 AM
Attachments: image001.png

To: CEOs of CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Seeking involvement of CEOs and their staff in the next phase in "Accurate Picture" Campaign

BACKGROUND: As we have discussed over the past several years, there are very few channels for the public, the media, legislators, and MDHHS to hear about the successes and triumphs of Michigan's public mental health system.

While there are a large number of avenues for these audiences to hear about disappointments with or complaints about Michigan's public health system (avenues such as recipient rights system, appeals and grievances systems, Medicaid fair hearings and less formal means, including calls to the Department, to the offices of elected officials offices, to the press, and to MDHHS leadership there are very few avenues for highlighting our system's successes, innovation, and impact. While the former processes are essential channels for complaint and redress and for ensuring that Michiganders receive the services that they need and deserve – this unbalanced information sharing system gives this audience a picture of our system that is incredibly skewed and inaccurate. As a friend of mine says, if decisions related to the value of iPhones were made by those who staffed the Apple complaint desk, these staff would shut down the iPhone business.

MULTI-PHASE "ACCURATE PICTURE" INITIATIVE: You may remember that several years ago, in recognition of this disparate access to good and bad news, CMHA and you, its members, embarked on an **"Accurate Picture Campaign"** to provide these audiences with a clear and balanced picture of the state's public system. That campaign led to a set of **"Heroes" stories**, carried in CMHA's Weekly Update and on its website, describing the selflessness of the staff working in the public system in the face of the COVID pandemic. This campaign also led to the **partnership of CMHA and a number of its members with the Issue Media Group (IMG)** and the dozens of IMG-generated articles, underscoring the innovation and impact of Michigan's public mental health system. This partnership is going strong and growing. These articles are distributed to readers across the state through the IMG network of electronic newspapers and regularly carried in CMHA's Weekly Update. The most recent set of IMG articles can be found at CMHA's Newsroom webpage.

NEXT PHASE OF THE ACCURATE PICTURE INITIATIVE: The next phase of "Accurate Picture" initiative was recently kicked-off through a meeting that Alan Bolter and I had with David Knezek, Chief Operating Officer at MDHHS, and Laura Blodgett, Senior Deputy Director of Communications Administration within MDHHS. This meeting resulted in an agreement to develop and implement a joint effort, between MDHHS, CMHA, and its members, to provide the public, the media, key policy makers and legislators with a regular flow of information on the successes and high levels of performance of Michigan's public mental health system. This partnership holds great promise for giving Michiganders an accurate picture of our system.

SEEKING PARTNERS: CMHA is seeking partners, from within its membership, to join us in designing and implementing several components of this joint effort:

Component A: Gathering stories of:

- Individuals, families, or communities positively impacted by Michigan's CMHSPs, PIHPs, or private

providers in the CMHSP or PIHP networks

- Innovative efforts (clinical, partnering, fiscal, administrative) of Michigan's CMHSPs, PIHPs, or private providers in the CMHSP or PIHP networks

(These stories could be akin to those told by the CMHA members partnering with IMG [see examples of those stories at: CMHA's Newsroom webpage] or of any type.)

Component B: Designing and implementing a public-facing, layperson friendly, approach to highlighting the high performance of Michigan's public mental health system using measures currently collected and reported by the system. (Note that this component is key, given that far too many stakeholders are unaware of the performance of the system against long-established quality metrics)

If you would like be involved in either of these two efforts or if you have a staff member whom you would recommend be involved in this effort, please send me (rsheehan@cmham.org) your name and email address and/or that of your staff member, and the component (A or B, above) in which you or they want to be involved **by Friday, November 22, 2024**.

Once we receive these names, we will call these groups together to move these efforts forward.

Thank you, in advance, for your work on this front.

Robert Sheehan
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Lansing, MI 48933
517.374.6848 main
517.237.3142 direct
www.cmham.org

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: In media interview, CMHA provides context to DOJ investigation of Michigan"s state psychiatric hospitals
Date: Tuesday, November 19, 2024 9:40:45 AM
Attachments: image001.png

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: CMHA provides context, in media story, to DOJ investigation of Michigan's state psychiatric hospitals

As you may know, the US Justice Department announced, last week, that it has opened an investigation under the Americans with Disabilities Act (ADA) into whether the State of Michigan unnecessarily institutionalizes adults with serious mental illness in state psychiatric hospitals. DOJ indicated that it will investigate whether the state fails to provide necessary community-based mental health services to enable people to transition from the state psychiatric hospitals and remain stable in the community. The DOJ press release can be found here

In follow up to this press release a reporter from Gongwer, one of the most trusted Capitol news outlets, reached out to CMHA for comment. Below is the recent Gongwer article summarizing the discussions of the Gongwer reporter with CMHA staff regarding the DOJ investigation:

> After last week's announcement that the U.S. Department of Justice will investigate whether Michigan's state-run psychiatric hospitals are keeping patients for unnecessary amounts of time, community mental health advocates hope the new federal focus will bring attention to underlying issues that have been impacting the system for years.
>
> Community Mental Health Association of Michigan CEO Robert Sheehan said he sees the DOJ investigation as a positive for Michigan's mental health system, with the potential to push lawmakers towards solutions to the root causes of excessive hospitalizations, like staffing issues and the complex care required for patients with cognitive impairments and severe mental health conditions.
> "This could move the state to say that we have a direct care worker crisis, which the Direct Care Worker Coalition has been saying for over a decade, and there's no other way to solve this besides getting qualified people in who have the skills," Sheehan said. "It takes a lot of skills to deescalate, to avoid using physical management, it takes an incredibly skilled staff member, and if you pay fifteen bucks an hour, most people can work at lots of other jobs that are less complex."
> Examining the contributing factors of longer psychiatric hospital stays, Sheehan said the complexity of care needed for those with serious mental health issues and the lack of direct care workers to offer that help outside of the hospital setting makes it difficult for people to access the level of treatment they require.
>
> Beyond that, beds in intensive crisis stabilization treatment centers are paid for out of the General Fund as opposed to Medicaid, which Sheehan said further limits access for people hoping to transition out of longer-term hospital stays.
>
> "Our members actually have a hard time placing people in state hospitals who need them, because the beds are full of people who can't get out," Sheehan said. "It's called a flow through problem, which means there's no way to enter. So, our members are struggling with people in local hospitals really don't belong there."
>
> Sheehan said he imagines the DOJ investigation will turn up largely what community mental health

organizations in Michigan already know: despite best efforts to move people out of psychiatric hospitals and back into their communities, institutional boundaries make it difficult.
Most direct care workers in Michigan are making about $15 per hour, a minimum wage they've lobbied to see increased. Sheehan said in order to make a dent in the number of patients in state-run hospitals, direct care workers in community mental health facilities would have to see a wage increase of up to $28 per hour or higher, with competitive benefits.

"It becomes kind of obvious that people are sitting there because they don't have a place to go, and there's a lack of beds. And DOJ, I think, would say, 'what's causing you as a state not to have enough beds out in the community?' And I think it's pay," Sheehan said. "You'd have to really increase the pay to get people in. We're talking about a boost. People have asked us if we understand how much this is going to cost. And I say, because you've underfunded it for so long, it's hard to catch up in one fell swoop."

Direct care worker minimum wages have seen increases in the past several years to hit the $15 threshold, but Sheehan said more effort is needed from lawmakers. He hopes the DOJ investigation prompts further action.

"At this pace, (if we) keep coming back and getting Dixie cups worth of water to fight a forest fire, we're going to be back a lot of times," he said. "Well, I think DOJ will say you can't use the Dixie cup anymore."

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2025 Healing and Recovery Regional Appropriations – MDHHS and PIHP Contract

Support Infrastructure and Inventory:

Appropriations are one-time but comprise several years of settlement payments. Therefore, priority should be given to investments that produce benefits extending beyond the 2025 fiscal year. These investments should facilitate support and service delivery. Considerations for infrastructure support include:

- Real estate purchases, mortgage payments, and improvements for syringe service programs, recovery community organizations, recovery community centers, and recovery residences.
- Infrastructure improvements for treatment providers.
- Vehicle purchases for community-based organizations and providers.
- Anticipatory harm reduction supplies (safer use, wound care, communicable disease testing, and drug checking supplies).
- Advanced mass spectrometry analysis equipment (FTIR) for harm reduction programs.
- Narcan distribution boxes.

Community Engagement and Planning Activities:

Regional entities must collaborate with local governments to support community engagement and planning activities, such as those provided by the Technical Assistance Collaborative (TAC). County, municipal, and township governments should be encouraged to engage with their communities and neighboring subdivisions but should be considered autonomous entities that may or may not support regional approaches. Support should be provided rather than prescribed and may include:

- Providing cash incentives (equity) for participation in surveys, focus groups, planning meetings, and other engagement and planning efforts for community members with lived/living experience.
- Providing data and financial information on other PIHP SUD programs.
- Providing Matching/supplemental funds for local government initiatives.
- Providing staff, technical, and facilitation support to local planning groups.
- Providing communication support for the recruitment of planning committee members and subject matter experts, communicating funding opportunities, and communicating spend plans and reports.

Other Contract Component Considerations:

- PIHPs are required to meet quarterly with MDHHS to coordinate settlement investment efforts.
- Appropriated Healing and Recovery funds are not allowed to supplant other funding.

- PIHPs must follow all MDHHS interpretations of policy impacting the certification and employment of SUD workforce, billing for services, use of restricted funds, and prescribing and administration of medications related to SUD.
- PIHPs are required to submit regular (quarterly) reports on program progress and service delivery data and participate in a formal program evaluation/revision/amendment process with MDHHS.
- PIHPs must prioritize coordination with the TAC and local government associations to review work that has already occurred and utilize these organizations as resources in planning and implementation.
- PIHPs are required to establish clear performance metrics and outcomes for all funded initiatives to ensure accountability and measure success.
- PIHPs are required to develop and implement a sustainability plan for funded programs to ensure long-term benefits beyond the appropriations period.
- PIHPs are required to facilitate regular stakeholder meetings, including community members, providers, and local governments, to discuss progress, challenges, and opportunities for collaboration.
- PIHPs are required to implement a transparent reporting system accessible to the public to enhance accountability and community trust.
- PIHPs are encouraged to support innovative pilot programs that address emerging needs and that can be scaled up based on successful outcomes.
- Contract will be separate because of need to track these funds.

email correspondence

From: Michigan Department of Health and Human Services <MDHHS@govsubscriptions.michigan.gov>
Sent: Wednesday, November 20, 2024 10:04 AM
To: Branislava Arsenov (NMRE) <barsenov@nmre.org>
Subject: FOR IMMEDIATE RELEASE: MDHHS announces enhancements to improve substance use disorder treatment access

Press Release

FOR IMMEDIATE RELEASE: Nov. 20, 2024

CONTACT: Lynn Sutfin, 517-241-2112, Sutfinl1@michigan.gov

MDHHS announces enhancements to improve substance use disorder treatment access

New mapping tool helps residents find treatment and recovery providers

LANSING, Mich. – To help improve access for individuals seeking substance use disorder treatment (SUD) options, the Michigan Department of Health and Human Services (MDHHS) has developed several new enhancements to programs and a new mapping tool to help individuals across Michigan better access SUD treatment.

“I am especially proud of the work we have done to expand access to substance use disorder treatment,” said Elizabeth Hertel, MDHHS director. “Expanding Health Home services, ensuring reimbursement for alcohol use disorder treatment in primary care settings, and building a new tool for residents to find treatment and recovery locations across the state are just a few examples of how the department is continuing to build access and treatment options for Michigan residents.”

SUD mapping tool launched

MDHHS has launched a new tool that will identify licensed SUD treatment and recovery locations through a geographic search, available on the MDHHS website. Providers can be searched by ZIP code, city or county as well as type of services needed including inpatient, outpatient and medication- assisted treatment and if the provider accepts Medicaid.

Health Home services expanded

Health Homes are a proven model to increase access to coordinated and integrated care. They are centered on whole-person, team-based care, with peer recovery coaches at the center of care.

To help ensure more Michigan residents are eligible for Health Home services, MDHHS has transitioned Opioid Health Homes to SUD Health Homes and added the diagnoses of Alcohol Use Disorder and Stimulant Use Disorder to broaden eligibility for services.

- In FY 2023, 23,270 women entered treatment for substance use disorders. Of that number, 592 were pregnant.
- In FY2023, 29,472 people entered treatment for primary alcohol use disorder. Multiple regions of the state report that alcohol is the primary substance of abuse for people seeking treatment.

“The expansion of the Substance Use Disorder Health Home has allowed us to increase our enrollment and provide much needed care coordination services while improving our beneficiaries’ social determinants of health, said Branislava Arsenov, chief clinical officer of Northern Michigan Regional Entity. “These early enrollment trends speak to the need to grow this benefit in Northern Michigan to improve recovery outcomes and increase opportunities for beneficiaries and communities.”

SUD Health Homes are also now a statewide benefit as the services have expanded to seven new counties - Allegan, Kent, Lake, Mason, Muskegon, Oceana and Ottawa counties. These changes are expected to expand services to up to an additional 3,000 individuals.

Medicaid changes increase opportunities for services Within the Medicaid program, policy and reimbursement changes have led to more robust opportunities for individuals to receive care in their communities. Reimbursement has been expanded for office-based treatment for alcohol use disorder and opioid use disorder in the primary care setting. Additionally, the prior authorization requirement to prescribe medications to treat opioid use disorder (MOUD) for Medicaid beneficiaries has been removed, allowing for a 20% increase in the last four years of the number MOUDs prescribed by primary care physicians.

Over the past few years, MDHHS has also taken these additional actions to improve access to SUD treatment in Michigan:

- Expanded the number of Medicaid SUD providers by removing barriers for providers and offering incentives such as loan repayment to launch or expand services.
- Worked with physicians to increase the number of buprenorphine prescribers in the state.
- Launched early intervention treatment and referrals in select Federally Qualified Health

Centers, Rural Health Clinics and Child and Adolescent Health Centers.

- Improved the system of care for pregnant individuals in northern Michigan by providing support and education for physicians in the Opioid Home Health network.
- Supported substance-exposed babies and their families by expanding supports through rooming-in, which allows birthing individuals, caregivers and babies with Neonatal Abstinence Syndrome to stay together during treatment.
- Collaborated with Michigan Department of Corrections to support peers in parole/probation offices to assist individuals returning from incarceration.
- Provided more than 20,000 rides for SUD-related services. Transportation has been identified as a barrier in almost every community engagement related to SUD.
- Partnered with Michigan State Housing Development Authority to expand recovery housing to help meet the statewide demand. This resulted in an additional 27 recovery homes with 79 additional recovery beds, prioritizing counties and populations with the highest need.
- Expanded opioid treatment capacity at 10 Michigan Department of Corrections prisons which provide medications for opioid use disorder to 884 incarcerated individuals.

More information about programming and resources can be found on the SUD Resources website. Information about how the state's Opioid Healing and Recovering Fund is being spent can be found on the opioids settlement website.

# # #

STAY CONNECTED:

Community Mental Health Association of Michigan

Movement of Medicaid beneficiaries from DAB to TANF, HMP, and Plan First; 2020-2024: Significant negative fiscal impact

November 2024

SUMMARY OF ANALYSIS: The analysis, below, examines the findings of one of Michigan's ten Prepaid Inpatient Health Plans (PIHPs) relative to the substantial revenue lost by Michigan's public mental health system by the inappropriate movement of persons in Michigan's Disabled, Aged, and Blind (DAB) Medicaid program to other Medicaid programs with per enrollee per month (PEPM) rates far below those of DAB. In fact, one of the programs to which these DAB enrollees have been moved provides no revenues to the public mental health system and no mental health benefit to persons who were eligible for Michigan's full mental health benefit, before they were incorrectly moved to other Medicaid programs.

During this period, hundreds of persons with DAB coverage, statewide, were moved inappropriately out of that coverage and into other Medicaid programs.

The loss to the Prepaid Inpatient Health Plan (PIHP), Northern Michigan Regional Entity, which conducted the study was greater than $35 million over the past five years, with a loss of over $18 million occurring in FY 2024 alone. When extrapolated to the entire Michigan public mental health system, **the gross revenue loss over the last five years is estimated to be over $689 million with over $350 million lost in FY 2024 alone.**[1]

This analysis outlines the **magnitude of the revenue loss**, the methodology used to determine this revenue loss, the factors behind that revenue loss, and **identifies a potential cause for the inappropriate movement of persons in the DAB program to the Plan First program.**

INITIAL IDENTIFICATION OF THE ISSUE: With the end of the pandemic-related moratorium on Medicaid re-enrollment, Michigan's Medicaid beneficiaries were required to re-enroll to retain their Medicaid eligibility. During the post-moratorium/unwinding re-enrollment period, the state's Community Mental Health Services Programs (CMHSPs), Prepaid Inpatient Health Plans (PIHPs), and providers in the CMHSP and PIHP networks noticed that a large number of persons formerly enrolled in the Medicaid Disabled, Aged, and Blind (DAB) category, were being re-enrolled, not as DAB enrollees, but as enrollees in the Temporary Assistance for Needy Families (TANF), Healthy Michigan Plan (HMP), and Plan First Medicaid programs.

This movement from DAB to TANF, HMP, and Plan First was seen as out of the ordinary given that persons in the DAB Medicaid program have, in the main, conditions that are chronic and, in most cases, lifelong.

EXAMINATION OF THE DATA OF ONE REGION AS EMBLEMATIC OF STATEWIDE IMPACT: The identification of this re-enrollment anomaly occurred, initially, through anecdotes, albeit in large numbers related to individual Medicaid beneficiaries across the state.

To get a more systemic picture of this re-enrollment trend, the Northern Michigan Regional Entity (NMRE) conducted, in October and November of 2024, an examination of the DAB enrollment trends from FY 2020 through 2024.

[1] Note that this loss is the gross revenue loss and not net of the much smaller TANF and HMP PEPM revenues received for these former DAB beneficiaries. Because the development of the net loss would require a time intensive a cell by cell analysis of the TANF and HMP revenues, these revenues were not reflected in this study.

The findings, in table form, of that analysis are provided below.

A	B	C	D	E	F	G	H
Fiscal Year	Number of DAB Month Payments	DAB Revenues Received	Average DAB Payment Amount	Number of DAB Months Missing **	Growth in number of Missing DAB months	Growth in % in Missing DAB Months	Gross Revenue Lost +
FY2020	163,365	$55,566,827	$340.14	6,273			$2,133,693
FY2021	154,038	$57,126,789	$370.86	11,342	5,069	81%	$4,206,313
FY2022	161,132	$58,347,970	$362.11	14,930	3,588	32%	$5,406,345
FY2023	170,267	$55,899,203	$328.30	18,251	3,321	22%	$5,991,862
FY2024 *	166,527	$59,085,879	$354.81	51,431	33,180	182%	$18,248,367
Grand Total	815,329	$286,026,668	$350.81	102,227			$35,862,392
						-	
	**Indicates NON-DAB payment after having had a DAB payment + Note that this loss is the gross revenue loss and not net of the much smaller TANF and HMP PEPM revenues received for these former DAB beneficiaries.						
	* 29,729 of the 51,431 FY24 Missing DAB payments were Plan First; 21,702 FY24 DAB Missing Payments were not Plan First						

METHODOLOGY:

1. That analysis followed each DAB beneficiary, identifying those who moved, during the fiscal year, from DAB to another Medicaid program (TANF, HMP, or Plan First).

2. Note that movement out of the DAB program, due to leaving the Medicaid program (due to changes in income, relocation, death or other reason), is removed from this analysis. This analysis examined only those who retained Medicaid eligibility during the year yet moved from DAB to another Medicaid program.

   This movement from DAB to TANF, HMP, and Plan First is out of the ordinary given that persons in the Disabled, Aged, and Blind (DAB) Medicaid program have, in the main, conditions that are chronic and, in most cases, lifelong.

3. The number of months during which those formerly DAB beneficiaries were in other Medicaid programs during each fiscal year (lost DAB months) were counted and are captured in Row E.

4. The growth in the number and percentage of months during which DAB beneficiaries were in other Medicaid programs during each fiscal year (lost DAB months) are provided in Columns F and G.

5. The average DAB per enrollee per month (PEPM) payment received by this PIHP (Column D) was determined by dividing the DAB revenue received by this PIHP in the fiscal year (Column C) by the number of DAB months for which payment was received in that fiscal year (Column B).

6. The lost revenue due to this movement of DAB beneficiaries to non-DAB Medicaid programs, in each fiscal year, Column H, is determined by multiplying the number of months in which these former DAB enrollees were in Medicaid programs other than DAB (Column E) during the fiscal year by the average DAB payment amount (Column D). Note that this loss is the gross revenue loss and not net of the much smaller TANF and HMP PEPM revenues received for these former DAB beneficiaries. Because the development of the net loss would require a time intensive a cell by cell analysis of the TANF and HMP revenues, these revenues were not reflected in this study.

FINDINGS:

Note that the magnitude of the revenue loss found in this analysis is a function of the fact that the payments (PEPM) for a TANF and HMP enrollee is far lower than that for a DAB enrollee; with no payments being paid to the public mental health system for Plan First enrollees.

1. The number of DAB beneficiaries re-enrolled in non-DAB Medicaid programs (lost DAB months) grew every year from FY 2020 through FY 2024.

   This movement from DAB to TANF, HMP, and Plan First is out of the ordinary given that persons in the Disabled, Aged, and Blind (DAB) Medicaid program have, in the main, conditions that are chronic and, in most cases, lifelong

2. The rate of growth of these lost DAB months, through the first four years of this analysis, from FY 2020 through FY 2023, from FY 2020 through FY 2023**, during which re-enrollment was paused**, was 45% with the high being an 81% increase and the low being a 22% increase.

3. In addition to the four-year trend, FY 2020 through FY 2023, resulting in the out of the ordinary loss of significant DAB months during the re-enrollment moratorium, in FY 2024, the **number of lost DAB months jumped by 182%.** The bulk of this increase was caused by the movement of 29,729 of the 51,431 lost DAB months being the **result of DAB beneficiaries moving to Plan First.**

FISCAL HARM: [2]

1. The out-of-the-ordinary loss of DAB beneficiary months resulted in lost gross revenue to the Northern Michigan Regional Entity, from FY 2020 through FY 2025, was over **$35 million**.

2. Half of the five year loss of revenue, **nearly $18 million**, was experienced during the re-enrollment moratorium, from FY 2020 through FY 2023.

3. The loss of revenue increased dramatically in FY 2024, from an average loss of $4.4 million per year, in the prior years, to **over $18 million**.

[2] Note that these losses represent the gross revenue loss and not net of the much smaller TANF and HMP PEPM revenues received for these former DAB beneficiaries. Because the development of the net loss would require a time intensive a cell by cell analysis of the TANF and HMP revenues, these revenues were not reflected in this study.

CAUSES OF INAPPROPRIATE LOSS OF DAB ELIGIBILITY AND RELATED REVENUES: Several factors appear to be the cause of the dramatic loss of DAB eligibility for a significant number of Michiganders:

1. **Four year trend**: For the years of the pandemic, **FY 2020 through FY 2023, a large number of persons with DAB eligibility were moved, in error, to TANF, HMP, and Plan First.**

   While CMHA and its members cannot determine whether this movement out of the DAB program was due to the actions by the Medicaid enrollment staff in local MDHHS offices, the algorithms used to determine DAB eligibility, this movement is, on the face of it, inappropriate given that **persons in the Disabled, Aged, and Blind (DAB) Medicaid program have, in the main, conditions that are chronic and, in most cases, lifelong.**

2. **Increase in movement – permanent movement - to Plan First in 2024**: As noted above, in 2024, the number of persons moving out of DAB status increased dramatically, with an increase of 182% over that of the prior year. The bulk of that increase was due to the dramatically increased number of DAB beneficiaries moved out of the DAB program into other Medicaid programs.

   As the analysis below indicates, the movement of persons with DAB eligibility to Plan First appears to be temporary for a small group of DAB beneficiaries under the age of 55. One-hundred forty (140) of the 545 persons in this age range (25% of those in this age range) returned to DAB status in less than a year.

   However, the bulk of persons under age 55 (75%) and 100% of those age 55 and over on DAB who moved to Plan First remained on Plan First indefinitely.

   One potential cause of this incorrect and permanent movement from DAB to Plan First seems to be **that both DAB and Plan First are identified by the same code "M", albeit in different fields on the intake forms;** the two fields of Program Code and MAGI Program. Data entry – entering code "M" in the wrong cell on the intake form – would permanently move DAB beneficiaries into Plan First.

   Attached, as Appendix A, are the excerpts from the Milliman Rate Certification documents and the MAGI Code Reference document that underscores this point.

Plan First movement by age

Number of DAB enrollees moved to Plan First	Still enrolled in Plan First?	Age at Enrollment
19	No	55 to 60
12	No	61 to 65
81	No	over 65
28	No	under 55
347	Yes	55 to 60
514	Yes	61 to 65
1907	Yes	over 65
405	Yes	under 55

(iv) Eligibility criteria

The Medicaid eligibility file that Milliman receives from MDHHS's data administrator includes information regarding each of the benefit plans for which beneficiaries are eligible. This includes Medicaid behavioral health and HMP behavioral health for the MHP enrolled and MHP unenrolled populations as well as each of the 1915(c) Waiver programs covered under this certification. Individuals are considered eligible for the entire month if they have an eligible benefit plan in the eligibility file or received an eligible capitation payment during the month. We have included an exception for individuals who spend down their income and become eligible for Medicaid during the month. Only the portion of the month in which "spenddown" individuals become Medicaid eligible is considered eligible in the rate setting process. We have reviewed the SFY 2023 enrollment relative to the SFY 2023 capitation payment data and have included an adjustment to the capitation rates, illustrated in Appendix 5, to account for a lower number of capitation payments being made compared to those who were enrolled, referred to as the capitation payment to eligibility month ratio.

For the Medicaid benefit plans, we identified the DAB and TANF populations using the following program codes:

- DAB Program Codes: A, B, E, M, O, P, Q
- TANF Program Codes: C, L, N, T (MIChild), F (Flint)

MEDICAL SERVICES ADMINISTRATION

Michigan Department of Health and Human Services HIPAA
5010 EDI Companion Guide for ANSI ASC X12N 834 Benefit
Enrollment and Maintenance for PIHP , C-Waiver, and HomeHealth
Effective January 1, 2021

Appendix D: MAGI Indicators cont.

MAGI Program	MAGI Categories	CHAMPS MAGI Category Indicator Values	FPL % Test*	CHAMPS Description
MAGI-MIChild	CHIP (MIChild)	E	Old	CHIP (MIChild)
		J	New	CHIP (MIChild)
		F22	Old Flint	CHIP (MIChild) Old - Flint
		F23	New Flint	CHIP (MIChild) New - Flint
		F24	Flint with Comprehensive Insurance within FPL	Flint with Comprehensive Insurance within FPL
		F25	Flint Without Comprehensive Insurance	Flint Without Comprehensive Insurance
		F26	Flint with Comprehensive Insurance	Flint with Comprehensive Insurance
		F27	Flint with /or without Comprehensive Insurance	Flint with /or without Comprehensive Insurance
MAGI-FFC	Former Foster Care	L	N/A	Former Foster Care
		F28	Flint	Former Foster Care - Flint
MAGI-PlanFirst	Plan First	M	N/A	Plan First
		F29	Flint	Plan First - Flint
MAGI-APS	APS	K	Old	APS
		F30	Flint Old	APS old - Flint
		F31	Flint	APS - Flint
Non-MAGI		F32		Non-MAGI - Flint

Michigan Department of Health and Human Services
http://www.michigan.gov/mdhhs

Version Date: February 26, 2021

MIHealthyLife: Mental Health-Related Updates

November 22, 2024

Note: This presentation provides a preview of anticipated program changes. MDHHS reserves the right to change any requirements, dates or any other information deemed necessary. Some program changes may be subject to legislative approval and/or budget allocations.

Objective

Share updates on FY26 changes to mental health coverage for CHCP enrollees, organized under the Mental Health Framework (MHF), a MIHealthyLife initiative.

Vision for the Mental Health Framework

Mental Health Framework (MHF) Vision

The vision of the MHF is to provide more enrollee-centered, whole person care to CHCP enrollees.

Key Goals:

Ensure access to mental health care for all CHCP enrollees who need it

A more coordinated and seamless enrollee experience across the care continuum

Improved mental health outcomes

MHF Vision, Continued

How do MHF policy changes advance toward this vision?

WORKING MHF POLICY CHANGES

Integrated coverage of mental health (MH) and physical health for enrollees with mild-to-moderate MH needs

Clear, standardized criteria for assessing level of MH need & determining MH coverage responsibility, with consistent application & communication

Increased coordination between MHP & PIHP delivery systems

Strengthened plan accountability for assigned enrollees

ANTICIPATED OUTCOMES

Clarity on which delivery system is accountable for each CHCP enrollee's MH care at any given point

More holistic care coordination and management for enrollees across the breadth of their needs

Expanded networks of MH providers, including greater overlap between MHP & PIHP provider networks

INTENDED IMPACT

More enrollee-centered, whole person care, enabled by:

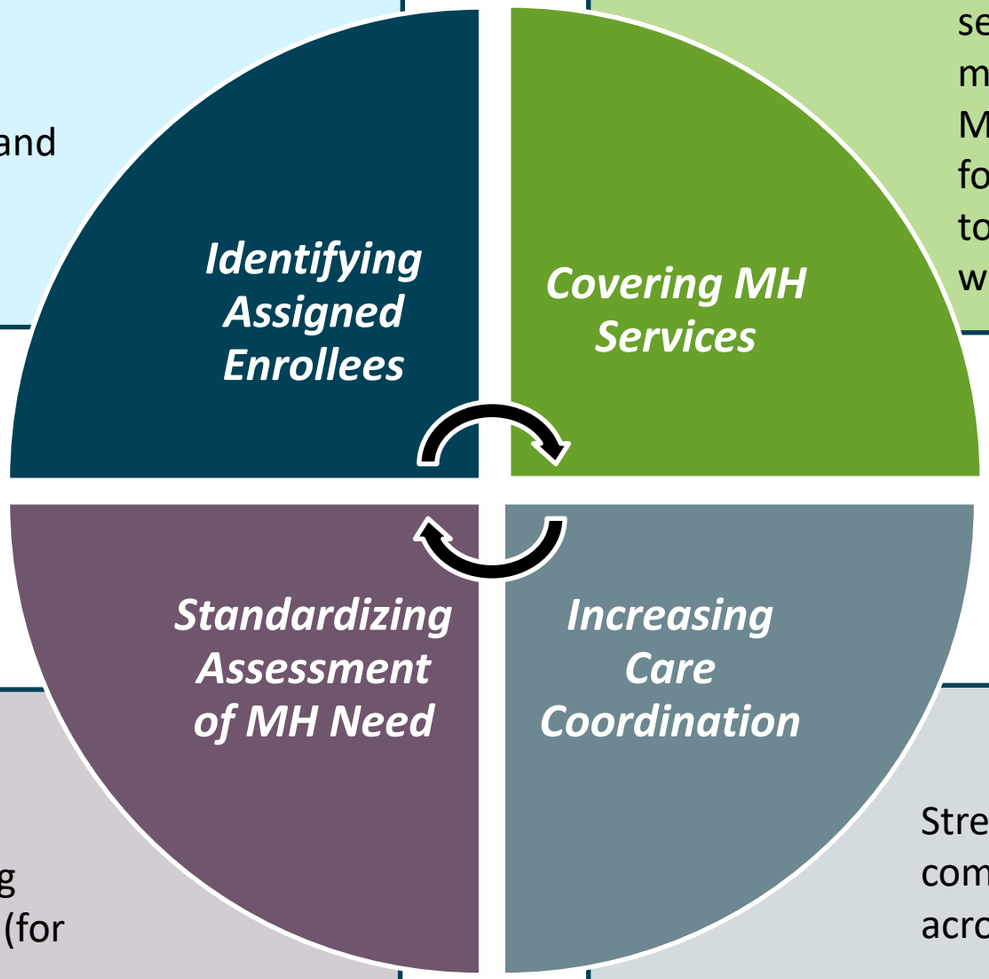
- Strong access to MH care
- A more coordinated and seamless enrollee experience across care continuum
- Improved MH outcomes

Key Elements of the Mental Health Framework

Key Elements of the MHF

Mental health (MH) coverage responsibility determined based on clear and consistent criteria and communicated to plans, providers, and enrollees (via new Benefit Plan)

MHPs responsible for new MH services for enrollees with mild-to-moderate MH needs, incorporating MH and physical health care coverage for those individuals; PIHPs continue to cover all MH services for enrollees with more intensive needs



Standardized assessment and reassessment of level of need using LOCUS (for adults) and MichiCANS (for children & adolescents)

Strengthened requirements on communication and coordination both across and within delivery systems

Identifying Which Enrollees Should be Responsibility of MHP vs. PIHP

MDHHS will implement standardized processes to identify enrollees with higher levels of BH need (SMI, SED, I/DD) and assign them to a new Benefit Plan, which will indicate that the PIHP is responsible for covering their MH care.
MHPs will be responsible for covering MH services for all other CHCP enrollees (i.e., enrollees *without* this new Benefit Plan).

- **New Benefit Plan in CHAMPS called "PIHP+" will be used to identify enrollees for whom PIHP is responsible for MH coverage. MHPs will be responsible for covering most MH care for enrollees *not* assigned to new Benefit Plan.**

- **Enrollees can be assigned the PIHP+ Benefit Plan through three distinct pathways:**
  1. Individual is enrolled in a 1915(c) HCBS waivers (SEDW, CWP, HSW) or 1915(i) State Plan BH benefit;
  2. Individual receives a high score/rating on assessment of functional impairment (LOCUS/MichiCANS); ***or***
  3. Individual meets utilization and diagnostic criteria (using Medicaid claims data) that indicates high level of need

- **PIHP+ Benefit Plan will go live on October 1, 2025.**
  - Once live, MDHHS will query data systems *nightly* to identify enrollees for PIHP+ on an ongoing basis.

Standardizing Assessment of Mental Health Need

One of the three "pathways" for enrollees to be assigned the new PIHP+ Benefit Plan (which indicates the PIHP is responsible for their MH) is assessment of level of MH needs. MDHHS is working to standardize this assessment process across plans and providers to ensure all enrollees are served by the most appropriate MH delivery system.

- **Use LOCUS screener for adults and MichiCANS screener for children and adolescents to determine MH coverage responsibility.**
  - For example, an adult receiving a LOCUS score of ≥ 17 will be assigned the PIHP+ Benefit Plan (so the PIHP will be responsible for their MH); adults receiving a LOCUS score below 17 will be the MHP's responsibility.
- **Complete assessment at the time enrollees present for MH care (as clinically appropriate); complete reassessments at least annually or when there is a change in condition meriting reassessment.**
  - *Note: MDHHS is currently considering which providers will conduct assessments for the purpose of determining MH coverage responsibility.*
- **Expand LOCUS and MichiCANS training and guidance to support standardization and fidelity to assessment tools.**

Covering Mental Health Services

In taking on responsibility for certain enrollees' mental health, MHPs will need to cover additional MH services and take steps to integrate mental health care with other types of care. PIHPs will continue to cover full range of MH services for enrollees with higher levels of need (i.e., enrollees assigned to PIHP+ Benefit Plan).

- **MHPs will newly cover specific MH services for enrollees with mild-to-moderate MH needs, such as inpatient psychiatric care and partial hospitalization.**
    - *Note: MDHHS is currently considering what additional MH services and settings should be covered by MHPs for non-PIHP+ enrollees, to enable coverage across the MH care continuum*
- **For a temporary transition period, emergency crisis services will continue to be covered exclusively by PIHPs, as MDHHS works to develop and refine its longer-term crisis coverage model.**
- **MDHHS will specify network, provider reimbursement, and other contracting requirements to smooth roll-out of new coverage requirements.**

Coordinating Care Across and Within Systems

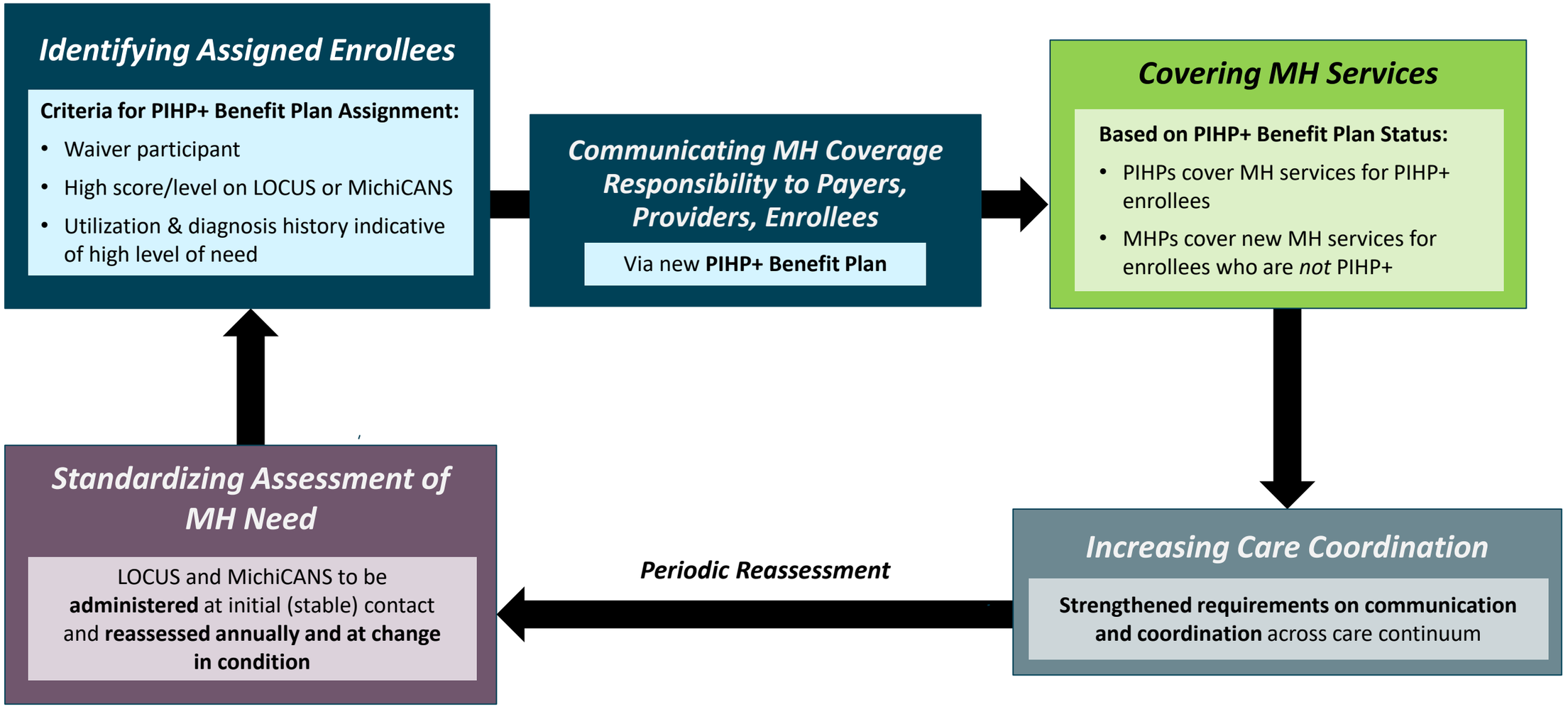
Robust care coordination *within* and *across* MHP and PIHP delivery systems is critical to enabling enrollee-centered, whole-person care.

Phase 1 of the MHF built on MIHealthyLife (the MHP procurement) to strengthen policies related to care coordination, in particular for mental health services across delivery systems, effective in FY25:

- **Strengthened information sharing between MHPs and PIHPs**, including following crisis service utilization as well as a standardized format, process and timeline for referrals across delivery systems for MH care
- Increased number of enrollees required to be offered **joint care planning**
- **Increased financial incentives** via stronger shared metrics benchmarks and the addition of MH-related MHP-only metrics to withhold programs
- Increased **accountability** of MHPs for MH service delivery, including via a stronger withhold

*Note: These changes are **effective FY25** (not FY26, like other changes described in this deck).*

Summary: Key Elements of the MHF



Q & A

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

SFY 2024 PIP Validation Report

The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service

for

Region 2—Northern Michigan Regional Entity

November 2024

For Validation Year 3

HSAG HEALTH SERVICES ADVISORY GROUP

Acknowledgements and Copyrights

1. Background

The Code of Federal Regulations (CFR), specifically 42 CFR §438.350, requires states that contract with managed care organizations (MCOs) to conduct an external quality review (EQR) of each contracting MCO. An EQR includes analysis and evaluation by an external quality review organization (EQRO) of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Michigan, Department of Health and Human Services, (MDHHS)—responsible for the overall administration and monitoring of the Michigan Medicaid managed care program. MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

For this year's PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[1-1] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

1. HSAG evaluates the technical structure of the PIP to ensure that **Region 2—Northern Michigan Regional Entity,** referred to as **NMRE** in this report, designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIHP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well **NMRE** improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the PIHP during the PIP.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Oct 1, 2024.

Rationale

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and non-clinical areas.

For this year's 2024 validation, **NMRE** continued its clinical PIP topic: ***The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service***. The PIP topic selected by **NMRE** addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Summary

The goal of this PIP is to increase Opioid Health Home (OHH) enrollment among members with an opioid use disorder (OUD). The OHH program provides comprehensive care management and coordination of services to those with OUD. Members work with an interdisciplinary team of providers to develop individualized recovery care plans to best manage their care.

Table 1-1 outlines the performance indicator for the PIP.

Table 1-1—Performance Indicator

PIP Topic	Performance Indicator
The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service	Client enrollment

Validation Overview

For State Fiscal Year (SFY) 2024, MDHHS required PIHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating effectiveness of the interventions

Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PHIP's compliance with each of the nine steps listed in the CMS EQR Protocol 1. With MDHHS' input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Table 1-2—CMS EQR Protocol 1 Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG obtains the information and data needed to conduct the PIP validation from **NMRE**'s PIP Submission Form. This form provides detailed information about **NMRE**'s PIP related to the steps completed and evaluated by HSAG for the SFY 2024 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

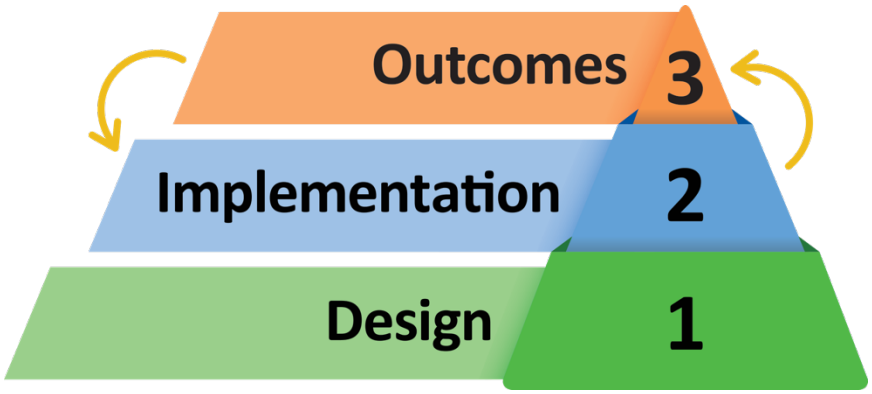
In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the PIHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met*

validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

Figure 1-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The steps in this section include development of the PIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP design is necessary.

Figure 1-1—Stages



Once **NMRE** establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7–8). During this stage, **NMRE** evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, **NMRE** should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

Validation Findings

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. Table 2-1 summarizes the PIHP's PIPs validated during the review period, with an overall confidence level of *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence* for the two required confidence levels identified below. In addition, Table 2-1 displays the percentage score of evaluation elements that received a *Met* validation score, as well as the percentage score of critical elements that received a *Met* validation score. Critical elements are those within the PIP Validation Tool that HSAG has identified as essential for producing a valid and reliable PIP.

Table 2-1 illustrates the validation scores and confidence levels for both the initial submission and resubmission.

Table 2-1—SFY 2024 PIP Validation Results for NMRE

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service	Initial Submission	75%	89%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the PIHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The ***Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service*** PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. **NMRE** received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement. The following subsections highlight HSAG's findings associated with each validated PIP stage.

Design

NMRE designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The PIHP's Aim statement set the focus of the PIP, and the eligible population was clearly defined. The technical design of the PIP was sufficient to measure and monitor PIP outcomes.

Implementation

NMRE met 100 percent of the requirements for the data analysis and implementation of improvement strategies. **NMRE** used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to their corresponding barriers.

Outcomes

NMRE demonstrated statistically significant improvement over the baseline performance for the targeted population during the first remeasurement period.

Analysis of Results

Table 2-2 displays baseline and Remeasurement 1 data for **NMRE**'s ***The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service*** PIP.

Table 2-2—Performance Improvement Project Outcomes for NMRE

Performance Indicator Results				
Performance Indicator	**Baseline (10/1/2020–9/30/2021)**	**Remeasurement 1 (10/1/2022–9/30/2023)**	**Remeasurement 2 (10/1/2023–9/30/2024)**	**Sustained Improvement**
Client enrollment	7.7%	14.6% ↑*		

↑* Designates statistically significant improvement over the baseline measurement period (p value < 0.05).

For the baseline, NMRE reported that 7.7 percent of its members with an OUD enrolled in the PIHP's OHH program. The goal of the PIP is to achieve significant improvement over the baseline performance during the first remeasurement period and sustain that improvement during a second remeasurement.

For the first remeasurement, NMRE reported that 14.6 percent of its members with an OUD enrolled in the PIHP's OHH program. The reported rate for the performance indicator met the goal for the PIP, which is to achieve significant improvement over the baseline performance during the first remeasurement period.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. The PIHP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the PIHP's overall success in achieving the desired outcomes for the PIP.

NMRE's causal/barrier analysis process involved monthly meetings with the plan's QI team to review current trends, barriers, actions, needs, and outcomes. The PIHP also utilized a PDCA (Plan, Do, Check, Act) method to discover and solve problems and manage change. Once identified, the barriers were prioritized based on home health partner reports and team discussions.

From these processes, NMRE determined the following barriers and interventions in order by priority.

Table 2-3 displays the barriers and interventions as documented by the PIHP.

Table 2-3—Interventions Implemented/Planned

Barriers	Interventions
Staff shortage	The PIHP advocated for MDHHS to expand qualifications to licensed practical nurses and registered nurses to provide qualifying services.
	The PIHP made funding available for providers to provide more training opportunities for community health workers to expand the workforce.
Provider capacity	The PIHP reached out to tribal entities and other settings to introduce the concept of expanding provider capacity.
Public health emergency ending	The PIHP provided education/resources and training at its monthly provider meetings regarding helping eligible clients from losing Medicaid benefits.
Clients concern regarding sharing their protected health information (PHI)	Clients are continuously educated to reassure that information is only shared securely for care coordination purposes.

Barriers	Interventions
Provider's concern around managing PHI.	The PIHP contracted with a third party to provide education to providers and their staff on how to safely share PHI for care coordination.
Clients are disenrolled in health home services if they move from one health home location to another.	The PIHP provided education to home health providers on transfers for health home versus disenrollment, which allows for the individual to remain enrolled without any disruption of service.
Complexity and lack of understanding of the enrollment process	The PIHP worked with representatives from the MDHHS to streamline the enrollment process to allow more providers to easily participate in the program.
Financial sustainability of Health Homes	The PIHP provides support to current providers, avoids inaccuracies that lead to delay in payment, monitors payment recoupments and providers who have no submitted claims.

3. Conclusions and Recommendations

Conclusions

The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service PIP received a *Met* validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements across the first eight steps validated, and a *High Confidence* validation status. The PIHP developed a methodologically sound improvement project. The causal/barrier analysis process included the use of appropriate QI tools to identify and prioritize barriers, and interventions were initiated in a timely manner. The PIP received a *Met* validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements for Step 9, and a *High Confidence* validation status. The performance indicator demonstrated a statistically significant improvement over the baseline for the first remeasurement period.

Recommendations

Based on the validation of the PIP, HSAG has the following recommendations:

- **NMRE** should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that require the development of interventions.
- **NMRE** should continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – DECEMBER 11, 2024
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Connie Cadarette, Ann Friend, Kevin Hartley, Chip Johnston, Nancy Kearly, Eric Kurtz, Brian Martinus, Allison Nicholson, Donna Nieman, Branon Rhue, Nena Sork, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

REVIEW AGENDA & ADDITIONS
Donna requested a discussion on administrative fees and the way in which they are calculated.

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

MOTION BY KEVIN HARTLEY TO APPROVE THE MINUTES OF THE NOVEMBER 13, 2024 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

MONTHLY FINANCIALS
There was no Financial Report to discuss this month. The November Financial report will be reviewed in January.

FY24 INTERIM FSR
The Interim FSR showed a $2.8M carry forward into FY25. The final FY24 FSR is due to MDHHS on February 28th. Reports have been requested from the CMHSPs by February 14th.

EDIT UPDATE
The next EDIT meeting is scheduled for January 16th at 10:00AM.

EQI UPDATE
The full FY24 EQI report is due to MDHHS on February 28th. The reporting template has not been distributed yet. No data pull date has been selected.

ELECTRONIC VISIT VERIFICATION (EVV)
Currently, the CMHSPs are using the EVV/HHAX portal as best they can, given the reported technical issues with internal modifiers, staff providing services to more than one client at a time, and other system glitches. Michelle Hill (MDHHS) has been very responsive when concerns are brought to her attention; HHAX has been much slower to respond. Brandon noted that MDHHS still intends to involve the HHAX system in the payment review process down the road.

HSW UPDATE
There are currently 5 open HSW slots (of 697) due to recent disenrollments. December data was received earlier on this date. The region received $424K in retroactive HSW payments for May through November.

MDHHS recouped November through May HSW payments for 1 client from Wellvance and 2 clients from Northern Lakes. The repayment for those individuals was included in the $424K, less the May payment which fell outside the 6-month recoupment timeframe.

The CHAMPS issue involving persons on HSW with spenddown is expected to be fixed this month, but it is likely that changes won't be evident until January. The NMRE is monitoring all payment activity.

On December 10th, Brandon secured agreements with all 10 PIHPs to collectively request that PCE conduct a statewide analysis to identify the many issues related to eligibility changes (movement of Medicaid beneficiaries from DAB to TANF, HMP, and Plan First). PCE will begin the project in January, with a target to have it completed in February. A subgroup of CIO Forum members has been formed to work with PCE.

The NMRE Finance Department will be processing an Accounts Payable run on this date; the HAB Waiver payment will be included. Tricia agreed to deposit details of the HAB Waiver payment in ShareFile.

DAB TRANSITION

CMHAM is using the data supplied by the NMRE to advocate on behalf of the hundreds of persons with DAB coverage who were moved (inappropriately) to TANF, HMP, and Plan First. For the NMRE, the revenue lost from 2020 – 2024 is greater than $35M ($18M for FY24). Systemwide, the loss may equate to as much as $689M ($35M in FY24).

ALPINE CRISIS RESIDENTIAL UNIT

The monthly 1/12th payment arrangement between the NMRE and Alpine CRU/North Shores Center will be ending on December 31, 2024. Beginning January 1, 2025, The CMHSPs will need to contract with the facility (amend the zero-payment contract) on a fee-for-service arrangement with per diem rates of $600 for crisis residential and $350 for respite; the NMRE will continue to pay 50% of the facility's costs ($49,229K per month/$443,061K total). A total of 952 units of Medicaid & HMP were billed in FY24. Eric agreed to send notification to the CMHSPs.

Ann noted a 30-unit discrepancy for North Country. Brandon responded that he's not seeing in on the NMRE side, so it is not being picked up in the data. Brandon advised checking to be sure the units are submitted in RECON using the correct facility provider and H0018 code. Brandon offered to work with North Country to resolve the issue.

For individuals paid with general funds, the NMRE will be discussing the cost settling process internally later on this date. Information will then be conveyed to CMHSPs along with a request to submit the number of units billed to GF in FY24.

NMRE TRANSITION TO BUSINESS CENTRAL FROM GREAT PLAINS

Because Microsoft will end support for Dynamics Great Plains (GP) on September 30, 2029, the NMRE is planning to move to Business Central in FY26.

CMHs Transitioning

North Country, Northern Lakes, and Wellvance are all tentatively planning to move to Business Central October 1, 2025. Northeast Michigan is considering making the move for FY27. Centra Wellness uses Sage and will not be making a change.

ADMINISTRATIVE FEES

Donna asked how the administrative fees are calculated. Deanna responded that the NMRE's FY25 approved budget showed the Medicaid managed care portion of administrative fees at $4,434,258 (which included $98K for the Alpine CRU) and $186,314K for Healthy Michigan. These numbers were divided by 12 months, proportional to each board based on PMPM. The $98K allocated for the Alpine CRU will be reduced by half in January.

BHH COSTING

Based on the NMRE's Interim, FSR, three of the CMHSPs are in a deficit for the Behavioral Health Home, which was intended to be fee-for-service full risk program. Variances in costing have identified been between CMHSPs. A cost settling process still being worked out, but it is likely that CMHSPs will be expected to cover overages with other funds (GF, local). This topic will be revisited in January.

OTHER

Connie reported that Northeast Michigan's request for GF transfers was determined to be warranted.

NEXT MEETING

The next meeting was scheduled for January 8, 2025 at 9:30AM. Deanna requested November expenditures early in January.

Chief Executive Officer Report

December 2024

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

Oct 28: Attended and participated in FY 25 contract discussion with PIHP CEOs.

Oct 30: Attended and participated in NMRE Day of Education.

Oct 31: Attended and participated in FY 25 contract discussions with legal and CEOs.

Nov 4: Attended and participated in NMRE SUD Oversight Committee Meeting.

Nov 5: Attended and participated in PIHP CEO Meetings.

Nov 6: Met with NMRE Government Relations Rep.

Nov 13: Attended and participated in NMRE Regional Finance Committee Meeting.

Nov 22: Attended and participated in MDHHS Mental Health Framework Discussion.

Nov 22: Attended and participated in CMHAM Rural Caucus.

Dec 2: Met with legal counsel regarding FY 25 contract and SUDHH.

Dec 3: Attended and participated in PIHP CEO Meetings.

Dec 5: Attended and participated in MDHHS and PIHP CEO Meeting.

Dec 10: Chaired NMRE Operations Committee Meeting.

Dec 11: Attended and participated in NMRE Regional Finance Committee Meeting.

Dec 13: Attended and participated in NMRE lunch and learn.

NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – DECEMBER 10, 2024
GAYLORD CONFERENCE ROOM

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

REVIEW OF AGENDA AND ADDITIONS
Information from Universal Health Services, and Forest View Hospital regarding mental health partial-hospitalization and intensive outpatient services was distributed during the meeting and will be discussed under "Provider Network."

APPROVAL OF PREVIOUS MINUTES
The minutes from October 15th were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE OCTOBER 15, 2024 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY CHIP JOHNSTON. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED
There was no Financial Report to discuss this month. The November Financial report will be reviewed in January.

DAB to TANF Migration Analysis
Mr. Kurtz distributed DAB enrollment analysis from CMHAM during the meeting.

CMHAM is using the data supplied by the NMRE to advocate on behalf of the persons with DAB coverage who were moved (inappropriately) to TANF, HMP, and Plan First. For the NMRE, the revenue lost from 2020 – 2024 is greater than $35M ($18M for FY24). Systemwide, the loss may equate to as much as $689M ($35M in FY24).

On December 10th, NMRE Chief Information Officer, Brandon Rhue secured agreements with all 10 PIHPs to collectively request that PCE conduct statewide analysis to identify the many issues related to eligibility changes (movement of Medicaid beneficiaries from DAB to TANF, HMP, and Plan First). PCE will begin the project in January, with a target to have it completed in February. A subgroup of CIO Forum members has been formed to work with PCE.

BHH Variance
Based on the NMRE's Interim, FSR, three of the CMHSPs are in a deficit for the Behavioral Health Home, which was intended to be fee-for-service full risk program. Variances in costing have been identified between CMHSPs. A cost settling process still being worked out, but it is likely that CMHSPs will be expected to cover overages with other funds (GF, local).

Mr. Kurtz clarified that the standard cost allocation only applies when it comports with 2 CFR, Part 200 per the NMRE/CMHSP contract.

ALPINE CRU

The monthly 1/12th payment arrangement between the NMRE and Alpine CRU/North Shores Center will be ending on December 31, 2024. Beginning January 1, 2025, The CMHSPs will need to contract with the facility (amend the zero-payment contract) on a fee-for-service arrangement with per diem rates of $600 for crisis residential and $350 for respite; the NMRE will continue to pay 50% of the facility's costs ($49,229K per month/$443,061K total). A total of 952 units were billed in FY24.

MENTAL HEALTH FRAMEWORK

PowerPoint slides for an MDHHS presentation titled, "MIHealthyLife: Mental Health-Related Updates," dated November 22, 2024 were included in the meeting materials. The presentation outlines the Department's vision for its Mental Health Framework. Medicaid Health Plans are intended to be responsible for new mental health services for enrollees with mild-to-moderate mental health needs, incorporating mental health and physical health care coverage for those individuals, including inpatient care (which violates the mental health code). PIHPs will continue to cover all mental health services for enrollees with intensive needs. A new benefit plan will be identified in CHAMPS called "PIHP+" to identify enrollees for whom the PIHP is responsible for mental health coverage (effective October 1, 2025). MHPs will be responsible for covering most mental health care to enrollees not assigned to the "PIHP+" benefit plan.

CAFAS/MichiCANS

A memorandum from Patricia Neitman (MDHHS) to PIHP and CMHSP Leadership dated November 19, 2024 was included in the meeting materials. Although Michigan Medicaid Provider L Letter 24-38 stated that use of the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) will no longer be required after the October 1st implementation of the Michigan Child and Adolescent Needs and Strengths (MichiCANS), Michigan Provider L Letter 24-63 requires PIHPs /CMHSPs to continue to use the CAFAS and PECFAS to support eligibility determinations for the 1915(i) SPA and SEDW only, until MDHHS receives approval of the waivers from CMS. The memorandum from Ms. Nietman clarified that MDHHS will require PIHPs/CMHSPs to use the CAFAS and PECFAS in addition to the MichiCANS to support eligibility determinations for the 1915(i) SPA and SEDW. Ms. Sork responded that Northeast Michigan will be providing the CAFAS/PECFAS or the MichiCANS, as appropriate, but not both.

HIGHLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLANS (HIDE SNPs)

The Department of Technology, Management, & Budget's Procurement office has completed an RFP to solicit responses for selection of Contractors to provide Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs). The term of this contract is seven (7) years, with up to three (3) renewal options. Awards for the 21-county NMRE service area were given to:

- Humana Medical Plan of Michigan, Inc.
- Meridian Health Plan of Michigan, Inc.
- Molina Healthcare of Michigan, Inc.

- Priority Health Choice, Inc.
- United Healthcare Community Plan, Inc.

APPLIED BEHAVIOR ANALYSIS (ABA) BHT RATE

Per communication from MDHHS, effective November 1, 2024, a rate of no less than $66 is required for ABA adaptive behavior treatment by a behavioral technician (procedure code 97153). Mr. Kurtz advised the CMHSPs to pay the $66 rate for contracted providers. Mr. Johnston stressed that this mandate violates procurement law. Mr. Kurtz added language regarding the $66 rate will be included in Amendment No.1 to the MDHHS/PIHP FY25 Contract.

INPATIENT TIERED RATES

Email correspondence from Crystal Williams (MDHHS) dated December 4th regarding Inpatient Tiered Rates was included in the meeting materials. The Department is looking to find a minimally invasive way to report inpatient tiered rates beginning in Quarter 2 or Quarter 3 of FY25. The following revenue codes are proposed for the tiers:

- Tier 1 – No baseline staff prescribed: 0119 – Semi-Private (three and four beds) – Other
- Tier 2 – 1 Staff to 2 Patient: 0129 – Semi-Private (two beds) – Other
- Tier 3 – 1 Staff to 1 Patient: 0139 – Private (one bed) – Other
- Tier 4 – 2 Staff to 1 Patient: 0149 – Deluxe Private – Other

PIHP FY25 CONTRACT

Five of the state's 10 PIHPs signed a FY25 contract with redline strike and cap replacement language related to the Waskul legal settlement, ISF retention cap of 7.5%, and CCBHC language that MDHHS did not accept or negotiate further.

The NMRE was later notified that the expansion of the Opioid Health Home Program to a SUD Health Home Program would not be allowed without a fully executed FY25 contract. Mr. Kurtz noted that this change by the state could potentially affect additional services to approximately 7886 eligible beneficiaries (as of December), which is completely inappropriate and unrelated to the three contract disagreement areas.

PROVIDER NETWORK

HealthSource Hospital Contract

HealthSource has requested an update to boilerplate language to state that the hospital will not be responsible for transportation and any cost reimbursements will be from the CMH. The hospital's view is when the contract stays silent on transportation (as it now does) the hospital has been stuck paying for transportation in many situations in the past. The CMHSPs responded that they already arrange for transportation and no changes to boilerplate language are warranted.

Needs Assessment

Correspondence from NMRE Provider Network Manager, Chris VanWagoner, regarding CMHSP Needs Assessments was included in the meeting materials. During the NMRE's monitoring activites of the CMHSPs, CMHSP staff were unable to provide evidence that the Needs Assessments had

been conducted. The CMHSPs responded that they conduct Needs Assessments annually. They requested that, in the future, the request should be made directly to the CEOs.

Hospital Partial-Hospitalization and Intensive Outpatient (IOP) Programs
Letters were received from Steve Vernon of Universal Health Services, Inc. and Forest View CEO, Michael Nanzer both stating that outpatient mental health partial hospitalization and intensive outpatient services will be provided by Cedar Creek Hospital, 3645 E. Jolly Road, Suite A, Lansing, MI, 48910, and Forest View Hospital, 2172 East Paris Ave., Suite A, Kentwood, MI, 49546.

Although the CMHSPs do not intend to authorize the IOP services, the did not object to them being included in the hospital contracts.

OTHER

Behavior Treatment Plans
Michigan Medicaid Provider L Letter 24-78 outlines the provider qualifications for Behavioral Health Treatment (BHT) services including Applied Behavior Analysis (ABA). BHT, including ABA, must be provided by individuals meeting the following requirements.

Board Certified Behavior Analyst – Doctoral (BCBA-D/LBA), and Board Certified Behavior Analyst (BCBA/LBA)
- Certification as a BCBA through the Behavior Analyst Certification Board (BACB). Licensed by the Michigan Licensing and Regulatory Affairs (LARA).
- Services Provided: Behavioral assessment, behavioral interventions, and behavioral observation and direction.

Licensed Psychologist (LP or LLP)
- Must be licensed as a BCBA and LBA by September 30, 2025.
- Services Provided: Behavioral assessment, behavioral interventions, and behavioral observation and direction.

Qualified Behavioral Health Professional (QBHP):
- Must be licensed as a BCBA and LBA by September 30, 2025.
- Services Provided: Behavioral assessment, behavioral interventions, and behavioral observation and direction.

Behavior Technician or Registered Behavior Technician (RBT):
- A license or certification is not required.
- Services provided: Behavioral Intervention

The FY25 code chart modified 97151 as it is no longer allowed for non-ABA. A row was added for H0031-6Y for Behavior Identification Assessment (BPT) for non-ABA customers.

Mr. Babbitt spoke about the effect these changes will have on staffing and service delivery.

NEXT MEETING
The next meeting was scheduled for January 21st at 9:30AM.

NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING
10:00AM – NOVEMBER 4, 2024
GAYLORD CONFERENCE ROOM & MICROSOFT TEAMS

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

Staff	☒ Bea Arsenov	Chief Clinical Officer
	☒ Jodie Balhorn	Prevention Coordinator
	☒ Carol Balousek	Executive Administrator
	☒ Lisa Hartley	Claims Assistant
	☒ Eric Kurtz	Chief Executive Officer
	☒ Pamela Polom	Finance Specialist
	☐ Brandon Rhue	Chief Information Officer/Operations Director
	☒ Denise Switzer	Grant and Treatment Manager
	☒ Deanna Yockey	Chief Financial Officer
Public	Chip Johnston, Diane Pelts, Nichole Scott	

CALL TO ORDER
Let the record show that Committee Chair, Richard Schmidt, called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that David Comai, Sherry Powers, and Pam Singer were absent for the meeting on this date; all other SUD Oversight Committee Members were in attendance either in Gaylord or virtually.

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

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

MOTION BY TERRY NEWTON TO APPROVE THE MINUTES OF THE SEPTEMBER 9, 2024 NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING; SUPPORT BY DOUG JOHNSON. MOTION CARRIED.

APPROVAL OF AGENDA

Let the record show that an additional liquor tax from Centra Wellness Network was added to the meeting agenda.

MOTION BY JAY O'FARRELL TO APPROVE THE AGENDA FOR THE NOVEMBER 4, 2024 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE AS AMENDED; SUPPORT BY TERRY NEWTON. MOTION CARRIED.

ANNOUNCEMENTS

During the meeting on September 9, 2024, Mr. Newton requested that a document be drafted advocating for additional block grant funding to be signed by the members of the NMRE SUD Oversight Committee, to which Mr. Kurtz agreed. Mr. Newton inquired about the status of the document. Ms. Arsenov responded that a document to be signed by NMRE Substance Use Disorder Oversight Committee members has been delayed due to ongoing discussions with the state; to date there have been two official communications with the Department. Mr. Kurtz added that, due in part to the number of individuals placed for SUD treatment services in the region from downstate, MDHHS has agreed to direct additional block grant funding to the region in FY25. Further discussion on the number of individuals served in the NMRE region from other areas of the state will occur under "FY24 Admissions."

Mr. Freedman asked whether there have been any updates regarding payment for transportation. Ms. Arsenov responded that there have not been any updates to date.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST

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

INFORMATIONAL REPORTS

FY24 Admissions

NMRE Chief Clinical Officer, Bea Arsenov, provided the following information regarding FY24 SDUD admissions.

- In FY24 NMRE providers served 1,422 beneficiaries in Withdrawal Management and SUD Residential settings.
- 88% of the beneficiaries served received their services within the NMRE region from the following providers:

Provider	Utilization Percentage
Addiction Treatment Services – Detox	36.63%
Bear Rver Health – Boyne Falls	15.06%
Harbor Hall Residential	10.27%
Bear River Health	10.23%
Sunrise Centre	9.38%
Addiction Treatment Services – Men	8.35%
Bear River Health – Gaylord	7.08%
Addiction Treatment Services - Women	2.53%

- Providers in the NMRE region have 414 beds:
  - 368 Residential beds (3.1 and 3.5 Levels of Care for Men and Women)
  - 46 Withdrawal Management beds (3.2WM and 3.7WM Level of Care for Men and Women)
  - An additional provider that was recently licensed is looking to expand Withdrawal management beds to as many as 60.
- Only 22.4% (33,815/151,110) of capacity in the NMRE region is used for individuals who reside in the NMRE's service area. 77.6% (117,295/151,110) of capacity in the NMRE region is used by other PIHPs. Most of these providers have very limited or no contracts with third party liability insurance programs.

Mr. Newton asked whether individuals placed in the NMRE region from other areas of the state are funded with Medicaid or Block Grant. Mr. Kurtz responded that individuals with both funding sources are placed in the region for services. The placing agencies should continue to fund treatment until permanent, independent residency is established; however, after an arbitrary period, their care is often transitioned to the NMRE.

FY24 Admissions Report
The admissions report through September 30, 2024 was included in the materials for the meeting on this date. Fiscal year 2024 admissions were down 9.08% from the same period in FY23, likely due to individuals losing Medicaid and Healthy Michigan (HMP) after the resumption of redeterminations. The data showed that outpatient was the highest level of treatment admissions at 46%, and alcohol was the most prevalent primary substance at 59%, all opiates (including heroin) and methamphetamine were the second most prevalent primary substances at 17%. It was noted that stimulant use has risen sharply throughout the 21-county region.

County-specific reports were also included in the meeting materials. The county-specific reports are intended to be shared with Boards of Commissioners and other community stakeholders.

Mr. Freedman suggested that targeted interventions be established to combat alcohol misuse.

August Financial Report
All SUD funding showed revenue of $26,709,246 and $24,603,696 in expenses, resulting in a net surplus of $2,105,550. Total PA2 funds were reported as $4,648,663.

PA2/Liquor Tax was summarized as follows:

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

Actual FY24 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,220,509	$1,218,276	$1,790,122	$4,648,663

The NMRE's FY24 block grant allocation was exhausted by the end of June. Treatment services for individuals who qualified for block grant funding are being billed to liquor tax for Quarter 4. Currently, $267K in liquor tax funds have been used to supplement block grant; this total will likely

be $300 - $400 once all FY24 claims have been received and paid. The NMRE has utilized other funding sources when appropriate.

Mr. Markey asked whether the PA2 Ending Balance amounts reflected in the August Financial report reflect the amounts needed to cover SUD Treatment costs to maintain a one-year fund balance. Ms. Arsenov responded that it may be necessary to dip somewhat into the one-year fund balances for some counties. Funds will be taken from the beneficiaries' counties of residence at admission to treatment.

LIQUOR TAX PARAMETERS

The Liquor Tax funds parameters approved by the NMRE Board of Directors on April 24, 2024 were included in the meeting materials to inform the SUD Oversight Committee's decision whether to recommend approval of the liquor tax requests brought before the Committee on this date.

FY25 LIQUOR TAX REQUESTS

1.	217 Recovery	"Tipping the Pain Scale" Movie Screening	Grand Traverse	$2,000	New Request

Meets PA2 Parameters? ☒ Yes ☐ No

MOTION BY DAVE FREEDMAN TO APPROVE THE REQUEST FROM 217 RECOVERY FOR GRAND TRAVERSE COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF TWO THOUSAND DOLLARS ($2,000.00) TO SCREEN THE FILM "TIPPING THE PAIN SCALE" IN TRAVERSE CITY; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

2.	Centra Wellness Network	Safenet Prevention Program	Multi County	$55,000	New Request

Benzie	$	23,012.26
Manistee		$31,987.74
Total	**$**	**55,000.00**

Meets PA2 Parameters? ☒ Yes ☐ No

MOTION BY TIM MARKEY TO APPROVE THE REQUEST FROM CENTRA WELLNESS NETWORK FOR LIQUOR TAX DOLLARS FROM BENZIE AND MANISTEE COUNTIES IN THE TOTAL AMOUNT OF FIFTY-FIVE THOUSAND DOLLARS ($55,000.00) TO FUND THE SAFENET PREVENTION PROGRAM; SUPPORT BY TERRY NEWTON. MOTION CARRIED.

3.	Sunrise Centre	Building and Enhancing Recovery Capital	Muli County	$70,305	Continuation Request

Alcona	$	7,716.90
Alpena	$	21,219.06
Iosco	$	18,758.83
Montmorency	$	6,896.08
Oscoda	$	6,178.14

Presque Isle	$	9,535.98
Total	**$**	**70,305.00**

Meets PA2 Parameters? ☒ Yes ☐ No

Mr. Labar noted that request Sunrise Center states that it provides residential treatment and outpatient treatment services to clients in the 21-county NMRE service area, however, the request lists only six counties. Ms. Arsenov responded that the Recovery Coach Position will be restricted to the six counties listed.

It was requested that the three boxes in the application that begin with "I Understand," "I understand," and "I certify" be initialed, rather than merely checked.

MOTION BY BURT FRANCISCO TO APPROVE THE REQUEST FROM SUNRISE CENTRE FOR LIQUOR TAX DOLLARS FROM ALCONA, ALPENA, IOSCO, MONTMORENCY, OSCODA, AND PRESQUE ISLE COUNTIES IN THE TOTAL AMOUNT OF SEVENTY THOUSAND THREE HUNDRED FIVE DOLLARS ($70,305.00) TO FUND THE BUILDING AND ENHANCING RECOVERY CAPITAL PROGRAM; SUPPORT BY DON EDWARDS. MOTION CARRIED.

4.	Centra Wellness Network	Medication Assisted Treatment Program Transition	Multi County	$46,000	New Request

Benzie	$	19,246.62
Manistee	$	26,753.38
Total	**$**	**46,000.00**

Meets PA2 Parameters? ☒ Yes ☐ No

MOTION BY TIM MARKEY TO APPROVE THE REQUEST FROM CENTRA WELLNESS NETWORK FOR LIQUOR TAX DOLLARS FROM BENZIE AND MANISTEE COUNTIES IN THE TOTAL AMOUNT OF FORTY-SIX THOUSAND DOLLARS ($46,000.00) TO FUND THE MEDICATION ASSISTED TRATEMENT PROGRAM TRANSITION; SUPPORT BY BURT FRANCISCO. MOTION CARRIED.

County Overviews

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

	Projected FY25 Available Balance	Amount Approved November 4, 2024	Projected Remaining Balance
Alcona	$41,418.74	$7,716.90	$33,701.84
Alpena	$174,798.30	$21,219.06	$153,579.24
Benzie	$251,324.05	$42,258.88	$209,065.17
Grand Traverse	$393,539.47	$2,000.00	$391,539.47
Iosco	$92,595.50	$16,009.25	$73,836.67

Manistee	$244,155.73	$58,741.12	$185,414.61
Montmorency	$60,218.47	$6,896.08	$53,322.39
Oscoda	$36,939.44	$6,178.14	$30,761.30
Presque Isle	$35,274.17	$9,535.98	$25,738.19
Total	**$1,330,263.87**	**$170,555.41**	**$1,156.958.88**

The "Projected Remaining Balance" reflects funding available for projects while retaining a fund balance equivalent of one year's receivables.

PRESENTATION

57th Emmet County Recovery Program

Nichole Scott, Director of Community Corrections and 57th Emmet County Recovery Program Project Coordinator was in attendance to provide an update on the 57th Emmet County Recovery Program (ECRP) to the Committee. Ms. Scott noted that interviews for a full-time Recover Program Project Coordinator are taking place on this date.

Program Overview

The 57th Emmet County Recovery Program (ECRP) is a recovery program with intensive court supervision for high risk/high needs individuals who are over 18 years old, have a pending felony case, and a validated substance use disorder verified by clinical assessment.

The 57th ECRP is a voluntary, non-adversarial judicial response to non-violent offenders.
A person referred to the 57th ECRP must complete a validated legal and clinical screening and assessment to determine their eligibility for admission.

Program Requirements

The 57th ECRP Curriculum is an 18-to-24-month minimum program that consists of 5 Phases:
Phase 1: Stabilization-12 weeks
Phase 2: Engagement Phase-12 weeks
Phase 3: Pro-Social– 14 weeks
Phase 4: Prevention-14 weeks
Phase 5: Maintenance-6 Months

The Program utilizes community resources with a evidence-based approach to participants to gain recovery capital skills. The 57th ECRP team recognizes that for some participants the journey will take longer than eighteen months based on their individualized journey to recovery.
It was noted that the development phase of the planning phase of 57th Emmet County Recovery Program lasted approximately 30 months prior to implementation.

Qualifications for Admission

1) Must be a resident of Emmet County;
2) Must be age 18 or older;
3) The offense or offenses committed by the individual must be related to the abuse, illegal use, or possession of a controlled substance or alcohol. MCL 600.1068(1)(a);
4) The individual must plead guilty to the charge or charges on the record MCL 600.1068(1)(c);
5) The individual must be assessed by the Project Coordinator and/or designated staff and determined as criminogenically "high risk";
6) Qualify for substance use treatment at the level of 1.0 Outpatient (OP) or higher according to the American Society of Addiction Medicine (ASAM).

Legal Eligibility Requirements

1) The participant shall not have unresolved charges/obligations in other jurisdictions (plea agreements or delay of sentencing with other jurisdictions may be considered on prosecutorial discretion) upon entry into the program.
2) Participant must not meet criteria for the Federal or State statutes regarding "violent" offender prohibitions.
3) Participant may be denied admission for current charges or past convictions involving domestic violence. Such cases will be reviewed by the team on a case-by-case basis and in accordance with the validated risk assessment.

PUBLIC COMMENT

Chip Johnston, Executive Director of Centra Wellness Network, thanked the committee for supporting the liquor tax requests from Centra Wellness Network.

NEXT MEETING

The next meeting was scheduled for January 6, 2025 at 10:00AM.

ADJOURN

Let the record show that Mr. Schmidt adjourned the meeting at 11:20AM.

MOTION BY TERRY NEWTON TO ADJOURN THE MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING FOR NOVEMBER 4, 2024; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

“TIPPING THE PAIN SCALE” MOVIE SCREENING - NEW

Organization/Fiduciary:	**217 Recovery**
County:	**Grand Traverse**
Project Total:	**$ 2,000.00**

DESCRIPTION:

In August of 2023, 217 Recovery bought the rights to the movie "Tipping the Pain Scale" and are allowed to show free screenings to the public. We plan to rent the Alluvion in Traverse City on November 5th to host our showing. They have a discount price for non-profits of $150 per hour. It's a two-hour movie and we plan to have a Q&A after so we will be renting the space for 4 hours. This will help people with SUD and their families understand they're not alone. The movie is full of celebrities and athletes who are in recovery and who have a SUD. It will also bring people together for a chance to socialize and be included in an open discussion.

Meets Parameters for PA2 Funding:	Yes

County	Project	Requested Budget
Grand Traverse	“Tipping the Pain Scale” Movie Screening	$2,000.00

MEDICATION ASSISTED TREATMENT (MAT) CLINIC TRANSITION - NEW

Organization/Fiduciary:	**Centra Wellness Network**
County:	**Multi County**
Project Total:	**$ 46,000**

DESCRIPTION:

Funding is requested to provide transition of care services for current Medication Assisted Treatment (MAT) clients in Manistee and Benzie counties. Since implementation of CWN MAT Services in 2018, CWN provided MAT services to our community members both in office/clinic and via telehealth due to the lack of other MAT community services. Currently, there are other community resources available that can provide these important services. Funding will allow CWN to provide transition of care services to current community members that are not currently supported by Medicaid. Funding would support 90 days of transition of care for clients not supported by Medicaid. This would include: coordination of transition to another MAT program provider, nurse to nurse collaboration, medication consultation, and updating the client record.

Meets Parameters for PA2 Funding:	Yes

County	Project	Requested Budget
Benzie	MAT Clinic Transition	$19,246.62
Manistee	MAT Clinic Transition	$26,753.38

SAFENET PREVENTION PROGRAM - NEW

Organization/Fiduciary:	**Centra Wellness Network**
County:	**Multi County**
Project Total:	**$ 55,000**

DESCRIPTION:

Funding is requested to continue to provide Safenet prevention services in Manistee and Benzie Counties. Safenet prevention services provide education of elementary age youth (grades K-5) with coping skills, problem solving, relationship building, psychoeducation related to topics such as identifying and validating feelings, counteracting negative thoughts, making friends, social skills, and more to increase protective factors and decrease risk factors associated with school, family, and individual which lead to substance misuse, truancy, and other risk factors. Safenet services provides direct support to any student showing need (not attending regularly, withdrawn, mild to moderate outbursts, grades dropping, etc.) and bridging any communication needs that impact the student attending school. Family support is a component of Safenet which staff will be receiving additional training on working with families, parenting, and how to support the family-school relationship. Staff meet with the child and family to determine needs, create a prevention goal/objectives, and then monitor progress. Staff use tools including the schools social emotional learning curriculum, so adding in training around supporting families will increase staff's ability to effectively engage and support students' success.

Meets Parameters for PA2 Funding:	Yes

County	Project	Requested Budget
Benzie	Safenet Prevention Program	$23,012.26
Manistee	Safenet Prevention Program	$31,987.74

BUILDING AND ENHANCING RECOVERY CAPITAL - CONTINUATION

Organization/Fiduciary:	**Sunrise**
County:	**Multi County**
Project Total:	**$ 70,305**

DESCRIPTION:

Sunrise Centre is a Substance Use Disorder Treatment facility in northeast Michigan serving 42 Michigan Counties. SC provides residential treatment services and provides outpatient treatment services to clients in the 21 northern Michigan Counties. SC is strengthening, enhancing, and expanding the types of and quality of support offered to our outpatient clients and the recovery community and is planning to expand access to recovery supportive activities, diverse peer support led meeting types, and strengthen recovery capital in rural communities. SC has several residential technician staff that are trained as recovery coaches and support the coaching needs of our inpatient population through provision of groups during residential stay, but without sustained grant funds we do not have a recovery coach employed to strengthen community engagement, outreach, and recovery capital in rural communities. Healthy and engaging continuation of care and more access to recovery supportive events in rural communities is a vital part of sustaining recovery and is one of the missing components of recovery resources available to our clients. This request for funding for a staffing grant will provide the needed funds to continue to build and establish this added layer of care, which will then be absorbed by Sunrise Centre to sustain this service at the point in time when grant funds are no longer available to sustain the position. The full time recovery coach will support the development and expansion of recovery supportive activities and resources in the region with a focus on counties that do not have as many recovery supportive resources, will support the growth of and access to recovery capital for those navigating recovery in the region, will attend community events and coalitions to strengthen the presence of and engagement of Sunrise Centre with our community partners, will support the development of promotional materials that support healthy recovery messaging and aims to reduce stigma for the population we serve, and will participate in and support training of staff and community members on topics relevant to recovery coaching and recovery supportive messaging and community support. This grant will allow for stronger community engagement and recovery coach presence in coalitions, community events, fairs, outreach and prevention opportunities, and will allow for the start-up of new non-12 step peer support groups that do not currently exist in this region.

Meets Parameters for PA2 Funding:	Yes

County	Project	Requested Budget
Alcona	Building and Enhancing Recovery Capital	$7,716.90
Alpena	Building and Enhancing Recovery Capital	$21,219.06
Iosco	Building and Enhancing Recovery Capital	$18,758.83
Montmorency	Building and Enhancing Recovery Capital	$6,896.08
Oscoda	Building and Enhancing Recovery Capital	$6,178.14
Presque Isle	Building and Enhancing Recovery Capital	$9,535.98

Learning Credits
Proposal & Order Acknowledgement

Created For:
Northern Michigan Regional Entity

Created By:
Karen Forester
Major Accounts Manager
616-574-7523 Direct / 616-318-8864 Cell
Karen.forester@newhorizons.com

New Horizons

Learning Credit Proposal and Order Acknowledgement

Customer Information

Customer Name:	Northern Michigan Regional Entity
Address:	1999 Walden Dr
City, State & Zip:	Gaylord, Mi 49735
Contact Name:	Brandon Rhue
Phone:	231-383-6557
Email:	brhue@nmre.org
Pricing Expiration Date:	

Learning Credit Investment and New Horizons Subsidy Information

Number of Learning Credits Purchased	20,000
New Horizons Subsidy %	100%
Number of New Horizons Subsidy Credits Provided	20,000
Total Number of Learning Credits on Account	40,000
Total Invoice Amount	$20,000

Program Details

- Your organization will purchase New Horizons Learning Credits and in turn, we will add additional Learning Credits to your account. The more Learning Credits you buy, the more we add. This investment will provide an easy way to request classes all year round and avoid the administrative costs of individual purchases.
- Learning Credits can be used to meet the needs of each learner on your team. Whether that is enrollment into one of the hundreds of classes on our public schedule, to purchase an e-learning library or to fund a private team training event, you are in control of how your credits are used.
- The remainder of this document outlines the specifics of Learning Credits. We appreciate your consideration of our proposal and look forward to partnering with you to achieve your learning and professional development objectives.

Terms and Conditions

- For every one dollar invested by the customer, the customer purchases one Learning Credit.
- Each subsidy Learning Credit provided by New Horizons is also worth one Learning Credit.
- All Learning Credits expire one year from the date of invoice.
- Invoices are sent at the time of signature of this agreement and payment terms are Net-30.
- Customer Learning Credits will be utilized prior to utilizing any Subsidy Credits.
- All solutions are deducted from Learning Credits at retail rates for all eligible classes and products.
- All sales are final. If you need to cancel any part of this training engagement, we will collaborate to apply the value of the investment as a credit on your account for future use.
- Sales tax will be added to the invoice, where required by law.
- Learning Credits can be used for enrollments into our public schedule, private delivery of our courses, e-learning libraries, available practice exams, assessments, and exam vouchers.
- A complete list of eligible products can be found on our website at www.newhorizons.com/eligible. Note that some courses listed are only available for private delivery.

- Products found on our website, but not listed as eligible, can also be funded with Learning Credits. These products will be deducted at retail, plus an amount equal to the percentage of subsidy provided on page two.
- Private Events are deducted at the per-student retail price found on our website with a minimum deduction of 8 students.
- All delivery must be completed by expiration date.
- All exam vouchers must be requested by expiration date.
- Travel for in-person private events will be deducted from the Learning Credit Account at our cost, plus an amount equal to the percentage of subsidy provided above.
- Learning Credits cannot be used for managed learning services projects such as Curriculum Design, Consulting, or Staff Augmentation.
- In the event there are Learning Credits remaining at the time of expiration, an investment of equal or greater value of the remaining customer purchased credits can be made to renew the expired credits. Subsidy Credits are not renewable.
- Additional Learning Credits can be purchased within 6 months of this agreement and will be subsidized at the same percentage. Excludes promotional pricing.
- Cancellation and No-Show Policy
    - Public Enrollments: Should you need to cancel or reschedule, please notify New Horizons more than (10) business days in advance of your scheduled class. If a customer cancels less than (10) business days prior to the scheduled training date, or does not show, the Learning Credits will be deducted for the total amount due.
    - Private Events: The cancellation policy for private events varies by event type. Most require notice of (35) or more days to cancel. Private Events cancelled in fewer days as described here or not attended without notice will result in a full deduction of Learning Credits.
- Late Arrivals to Public Enrollment Classes: Students arriving more than 15-minutes late to class may forfeit their seat to a standby student. To allow for the highest quality experience for all students, any students arriving more than 30-minutes late to class may not be admitted. Late arrivals of 30-minutes or more, that are not admitted to class, are subject to our no-show policy.
- Class Retakes for Public Enrollment Classes: Many, but not all our classes, offer a complimentary retake for up to 6-months after the original date of class. If the retake requires updated courseware or labs, an additional charge may apply.
- Class Recordings: Many, but not all our classes, are recorded. If a class is recorded, the recording is available to access in our LMS for up to 3-months from the date of class completion.
- This agreement confirms that the signer has read and agrees to comply with the policies and terms information located on all pages of this document, is authorized to sign on behalf of the Customer and that no other terms written, or verbal are valid.

New Horizons

Learning Credit Proposal and Order Acknowledgement

Customer to Complete this Section:

Accounts Payable Contact

Contact Name	Phone Number	Email Address
Brandon Rhue	231-383-6557	brhue@nmre.org
Billing Address	**Billing Suite**	**Billing City, State Zip Code**
1999 Walden Dr		Gaylord, Mi 49735

Method of Payment

☐	**Credit Card**	Payment link will be sent with the invoice.
☐	**Purchase Order**	Please include a copy of Purchase Order.
☐	**ACH or Wire**	Banking Information can be requested from your Account Manager.
☐	**Invoice**	Invoice sent via email. Net-30 Payment Terms from the date of invoice.
Payment Remit to Address:	PO Box 679244, Dallas Texas 75267-9244	

Customer Acceptance and Approval to Invoice

Authorized Signature:		**Title:**	
Printed Name:		**Date:**	

Internal Use Only

Manager Approval:	Joshua Teixidor	**Date:**	11/1/24

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY, NORTHERN MICHIGAN REGIONAL ENTITY, and REGION 10 PIHP

Plaintiffs,

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, a Michigan State Agency, and its Director, ELIZABETH HERTEL, in her official capacity,

Defendants.

Case No. 24- -MZ

Hon.

TAFT, STETTINIUS & HOLLISTER, LLP
Christopher J. Ryan (P74053)
Gregory W. Moore (P63718)
27777 Franklin Road, Suite 2500
Southfield, MI 48034
(248) 727-1553
cryan@taftlaw.com
Attorneys for Plaintiffs

THERE IS NO OTHER PENDING OR RESOLVED CIVIL ACTION ARISING OUT OF THE SAME TRANSACTION OR OCCURRENCE AS ALLEGED IN THIS COMPLAINT.

VERIFIED COMPLAINT

Plaintiffs, by and through counsel, TAFT, STETTINIUS & HOLLISTER, LLP, state for their Verified Complaint:

OVERVIEW

1. Defendants are trying to strong-arm Plaintiffs into a "take it or leave it" contract that contains illegal and detrimental provisions that reduce Plaintiffs' ability to provide necessary behavioral health services to the residents of Michigan.

2. Plaintiffs are 3 of Michigan's 10 Prepaid Inpatient Health Plans that facilitate the delivery of behavioral health services for individuals with mental illness, developmental disabilities, and substance use disorders in 40 counties across the State.

3. In an attempt to bully Plaintiffs into agreeing to unreasonable and illegal provisions in its FY25 contract ("FY25 Contract" – Exhibit A), MDHHS threatened that if Plaintiffs did not sign by October 31, 2024, MDHHS would terminate its relationship with Plaintiffs and cut off the funding Plaintiffs need to ensure recipients in their respective regions continue to receive behavioral health services. Plaintiffs each signed the FY25 Contract after modifying the offending provisions, but MDHHS refused to counter-sign. As explained in more detail below, Defendants are now making good on their threat by withholding Medicaid funds from Plaintiffs to the detriment of the beneficiaries Plaintiffs serve.

4. On behalf of all Plaintiffs, this suit seeks a declaration that three aspects of MDHHS's form FY25 Contract are void.

5. First, Schedule A – Statement of Work, § 4, relates to Plaintiffs' ability to fund and manage an Internal Service Fund ("ISF"). Certain provisions in that section violate state and federal law because they purport to restrict Plaintiffs' ability to fund and utilize their respective ISF accounts. More specifically, Defendants placed an arbitrary 7.5% limit on the amount Plaintiffs can contribute their respective ISF accounts and a 7.5% limit on the balance that can be held in an ISF account. The limits are not set based on recognized accounting standards or principles, are not actuarially sound, and therefore fail to comply with federal regulations. Defendants further purport to prohibit Plaintiffs from using ISF funds to pay for services rendered during a prior fiscal year. This prohibition also violates federal law.

6. Second, Schedule A - Statement of Work, § 1, ¶ R.20., purports to require Plaintiffs to abide by a settlement agreement involving MDHHS and certain non-parties (the "Waskul Settlement"). But the Waskul Settlement has not even been finalized or received necessary federal court approval. Even if it had, requiring Plaintiffs to abide by the contemplated Waskul Settlement would permit the State to illegally direct Plaintiffs' Medicaid expenditures. More importantly, requiring Plaintiffs to abide by the Waskul Settlement would benefit a select subset of Medicaid recipients, while detrimentally hurting the vast majority of recipients who receive the same services.

7. Third, Schedule A – Statement of Work, § 1, ¶ G.14., is an attempt by MDHHS to shift the financial burden of managing Certified Community Behavioral Health Clinics ("CCBHCs") to Plaintiffs without State funding in violation of Article 9, § 25 and § 29 of the Michigan Constitution. Defendants' own auditor concluded that the FY25 arrangement would require Plaintiffs to undertake 11 categories of "major new responsibilities" without "any increase to the variable administrative percentages" (i.e., without any funding).

8. This suit also seeks a declaration that even in the absence of a contract, MDHHS is statutorily obligated to continue providing funding to Plaintiffs.

9. Defendants recently retaliated against Plaintiffs by stating MDHHS will not provide Medicaid dollars to fund the Substance Use Disorder Health Home ("SUDHH") programs in their respective regions. The SUDHH program has absolutely nothing to do with the parties' dispute. While this shameful negotiation tactic will harm Plaintiffs, who have each expended resources in reliance on Defendants fulfilling their obligation to provide the funding, the most significant harm will come to the citizens eligible to receive SUDHH services. MDHHS's pronouncement means all of the individuals currently enrolled in the SUDHH program will no

longer receive SUDHH services. And it means that the thousands of Michiganders who are eligible to enroll to receive SUDHH services are no longer able to enroll. Those residents were directed by Defendants to contact Plaintiffs to obtain SUDHH services, and now Plaintiffs are being directed to turn them away. Plaintiffs seek injunctive relief prohibiting Defendants from cutting off funding for the SUDHH program.

FACTS COMMON TO ALL CLAIMS FOR RELIEF

I. The Parties and Jurisdiction.

10. Plaintiffs are Prepaid In-Patient Health Plans ("PIHPs") created by MCL § 330.1204b and related statutes.

11. Plaintiffs help facilitate delivery of behavioral health services for individuals with mental illness, developmental disabilities, and substance disorders in the counties in their respective regions.

12. Defendant Michigan Department of Health and Human Services ("MDHHS") is an agency of the State of Michigan.

13. Elizabeth Hertel is the Director of MDHHS.

14. Pursuant to MCL 600.6419, this Court has jurisdiction over this action because it seeks declaratory relief against the State of Michigan, a department of the State of Michigan (MDHHS), and an officer of the State of Michigan (Director of MDHHS); seeks a writ of mandamus; and alleges violations of the Headlee Amendment to the Michigan Constitution.

II. Background.

15. Medicaid is a joint federal/state program that provides medical assistance to qualifying individuals who are unable to pay or do not have private insurance.

16. To qualify to receive federal Medicaid funds, states are required to create a Medicaid State Plan that complies with various federal requirements.

17. Each state's Medicaid State Plan must be approved by the Centers for Medicare and Medicaid Services ("CMS").

18. After approval of the Medicaid State Plan, states receive federal money to spend on services covered by the Medicaid program.

19. In Michigan, the Medicaid program is administered by MDHHS.

20. Pursuant to Michigan law, behavioral health services are provided at the county level through community mental health services programs ("CMHs"). To be sure, MCL 330.1116(2)(b) requires MDHHS to "shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program…."

21. MDHHS is required to "promote and maintain an adequate and appropriate system of community mental health services programs throughout the state." MCL 330.1116(2)(b).

22. The State is required to financially support CMHs. MCL 330.1202(1) ("The state shall financially support…community mental health services programs….")

23. In fact, the State "shall pay 90% of the annual net cost of a community mental health services program…." MCL 330.1308(1).

24. The "purpose of a community mental health services program" is to "provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay." MCL 330.1206.

25. CMHs must be a county community mental health agency, a community mental health organization, or a community mental health authority.

26. CMHs have numerous statutory rights set forth in the Mental Health Code. Among those rights, CMHs have the right to organize together and form a regional entity.

27. MCL 330.1204b(1) states that a "combination of community mental health organizations or authorities may establish a regional entity by adopting bylaws that satisfy the requirements of this section."

28. Plaintiffs are regional entities.

29. Regional entities help manage services that are provided by individual CMHs, thus reducing administrative burden on the CMHs that form the regional entity.

30. Regional entities are public governmental entities separate from the county, authority, or organization that establishes them. MCL 330.1204b(3).

31. CMHs and regional entities are units of Local Government for purposes of Const. 1963, Art. 9, § 29. See Const. 1963, Art. 9, § 33.

32. After organizing into a regional entity, the regional entity has all of the "power, privilege, or authority that the participating community mental health services programs share in common and may exercise separately under the act…." MCL 330.1204b(2).

33. The State is required to financially support each regional entity. MCL 330.1202(1); MCL 330.1204b(2).

34. MDHHS is required to provide Medicaid-covered specialty services and supports through PIHPs. MCL 400.109f(1).

35. CMHs and regional entities can operate as PIHPs, which is true of each of the Plaintiffs. MCL 330.1232b(1).

36. PIHPs are public managed care organizations that receive funding from the State and arrange to pay for Medicaid services. MCL 400.109f(2).

37. The State of Michigan has 10 PIHPs (regions), and Plaintiffs collectively represent 3 of the 10 regions:

a. Plaintiff NorthCare Network Mental Health Care Entity ("NorthCare") is the PIHP for Region 1, and was formed by Pathways CMH (serving Alger, Delta, Luce, and Marquette counties), Copper Country CMH (serving Baraga, Houghton, Keewanaw, and Ontonagon counties), Hiawatha CMH (serving Chippewa, Mackinac, and Schoolcraft counties), Northpointe CMH (serving Menominee, Dickinson, and Iron counties), and Gogebic CMH (serving Gogebic county).

b. Plaintiff Northern Michigan Regional Entity ("NMRE") is the PIHP for Region 2, and was formed by AuSable CMH (serving Oscoda, Ogemaw, and Iosco counties), Manistee-Benzie CMH (serving Manistee and Benzie counties), North Country CMH (serving Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego counties), Northern Lakes CMH (serving Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford counties), and Northeast CMH (serving Alcona, Alpena, Montmorency, and Presque Isle counties).

c. Plaintiff Region 10 PIHP ("Region 10") is the PIHP for Region 10, and was formed by Genesee Health Systems (serving Genesee county), Lapeer CMH (serving Lapeer county), Sanilac CMH (serving Sanilac county), and St. Clair CMH (serving St. Clair county).

38. Because MDHHS is required to provide services through PIHPs, Michigan law restricts MDHHS's ability to terminate its relationship with a PIHP.

39. MCL 330.1232b requires that as a condition for receiving Medicaid dollars, a PIHP shall certify that (a) it is in substantial compliance with the standards promulgated by the department and with applicable federal regulations, and (b) that the PIHP has established policies and procedures to monitor compliance with the standards promulgated by the department and with applicable federal regulations and to ensure program integrity. Each Plaintiff has done so.

40. MDHHS may only sanction or terminate a PIHP if the PIHP is not in substantial compliance with promulgated standards and with established federal regulations, if the PIHP has misrepresented or falsified information reported to the state of the federal government, or if the PIHP has failed substantially to provide necessary covered services to recipients. None of the Plaintiffs have done so.

41. According to the Mental Health Code, before imposing a sanction on a PIHP, MDHHS is required to provide that PIHP with notice of the basis and nature of the sanction and an opportunity for hearing to contest or dispute MDHHS's findings and intended sanction.

42. Historically, Plaintiffs and MDHHS have been parties to annual PIHP contracts ("PIHP Contracts").

43. In the simplest of terms, the PIHP Contracts provide that MDHHS will make capitated payments to Plaintiffs, which Plaintiffs use to pay administrative expenses and fund services provided by CMHs in the counties represented within each respective region.

44. Michigan's Medicaid State Plan, as approved by CMS, relies heavily on MDHHS's representations that Medicaid services will be provided by CMHs, through PIHPs. For example, the approved Medicaid State Plan for Michigan states:

a. that for Home and Community Based Services (HCBS) benefit functions, MDHHS "contracts with regional managed care Pre-paid Inpatient Health Plans (PIHP), as the other contracted entity, to assist in monitoring functions of the HCBS benefit….. The PIHP…and local non-state entities/Community Mental Health Service Programs (CMHSP) will all be actively involved in assuring quality and implementation of identified quality improvement activities…."

b. "MDHHS/BHDDA as the state Medicaid agency will deliver 1915(i) SPA services through contracted arrangements with its managed care PIHPs regions. The PIHPs have responsibility for monitoring person-centered service plans and the network's implementation of the 1915 (i) SPA services, which require additional conflict of interest protections including separation of entity and provider functions within provider entities."

c. that to meet federal requirements that HCBS benefits eligibility be determined by an independent evaluation/reevaluation, MDHHS relies on assessments provided by the "PIHP provider network."

d. that to meet federal requirements concerning individualized, person-centered service plans, MDHHS relies on PIHPs to "monitor quality of implementation of person-centered planning" and places responsibility for "the development and implementation of the Individual Plan of Services" on the CMHSP under contract with the PIHP.

III. FY25 PIHP Contract Negotiations.

45. In the Summer/Fall of 2024, leading up to the filing of this Complaint, negotiations concerning the FY25 Contract between MDHHS and Plaintiffs broke down, centered primarily around three provisions detailed below.

46. After much negotiation, Plaintiffs each signed MDHHS's form FY25 Contract after modifying/redlining the offending provisions. MDHHS refused to counter-sign.

47. On October 23, 2024, MDHHS stated it would not negotiate the contract any further. Instead, MDHHS stated the:

> PIHPs will have until 5:00 PM EST on October 31, 2024, to electronically sign the FY 25 contract using the State of Michigan's authorized electronic signature software application, e-Signature. Should any contracts remain unsigned by after this deadline, those PIHPs will be required to adhere to the Transition Responsibilities Language contained in Standard Contract Term 26 of the FY24 contract.

48. In other words, MDHHS stated that Plaintiffs were required to either sign the form FY25 Contract as presented by MDHHS without modification, or MDHHS would terminate its relationship with Plaintiffs.

49. Plaintiffs refused to sign the FY25 Contract because it contains illegal provisions that will hurt the region, the CMHs within the region, and most importantly, negatively impact their ability to properly and adequately serve the recipients of services within the region.

IV. Void Provisions in the form FY25 Contract.

A. ISF – Schedule A – Statement of Work, § 4.

50. The relationship between MDHHS and the PIHPs is a "shared risk" arrangement.

51. The historic PIHP Contracts contain risk-sharing provisions between Plaintiffs and MDHHS, whereby Plaintiffs are responsible for expenses that exceed capitated payments, up to a certain amount.

52. Risk-sharing is permitted by federal regulations, provided the arrangement meets certain requirements.

53. Federal law and the PIHP contracts (both historically and as proposed by MDHHS in the FY25 Contract) permit PIHPs to establish an Internal Service Fund ("ISF") as part of its risk corridor as a "method for securing funds as part of the overall strategy for covering risk exposure." Exhibit A.

54. An ISF account is like a savings account or reserve account, "established for the purpose of securing funds necessary to meet expected risk corridor financing requirements under the State/Contractor Contract." Exhibit A.

55. In other words, when capitated payments from MDHHS exceed a PIHP's expenses, PIHPs add excess funds to their ISF so that they have money in reserve. On the other hand, when expenses exceed the amount of the MDHHS capitated payments, PIHPs use the funds in their ISF to make up the shortfall.

56. Federal regulations require that "all applicable risk-sharing mechanisms…be developed in accordance with…generally accepted actuarial principles and practices." 42 C.F.R. § 438.6(b)(1).

57. In addition, all ISF accounts must be established in compliance with GASB [Government Accounting Standards Board] Statement No. 10, Accounting and Financial Reporting for Risk Financing and Related Insurance Issues. (Exhibit A, Page 115.)

58. GASB Statement No. 10 states that "the total charge by the internal service fund to the other funds may also include a reasonable provision for expected future catastrophe losses." (GASB Statement No. 10, ¶ 66c.)

59. Among other things, Schedule A – Statement of Work, § 4 of the FY25 Contract states that "[t]he ISF cannot be funded more than 7.5% of the annual operating budget in any given year...the ISF balance cannot be less than $0." (Exhibit A, Page 112.)

60. The FY25 Contract also states the PIHPs "may not reflect an ISF that exceeds 7.5% in any of [the PIHP's] reporting requirements contained in this contract. If the Department determines that the ISF is over-funded, the ISF must be reduced within one fiscal year through the abatement of current charges. If such abatements are inadequate to reduce the ISF to the appropriate level, it must be reduced through refunds…." (Exhibit A, Page 113.)

61. In other words, if at any time a Plaintiff's ISF exceeds 7.5% of its annual operating budget, that Plaintiff would be required to give the money back to MDHHS, irrespective of whether the 7.5% limit is actuarially sound.

62. Rather than develop the risk-sharing mechanisms in accordance with generally acceptable actuarial principles and practices, the FY25 Contract imposes an arbitrary 7.5% limit on the amount of funds Plaintiffs may hold in their respective ISF accounts.

63. Plaintiffs have determined that the 7.5% limit is not actuarially sound. Likewise, Plaintiffs have determined that the arbitrary 7.5% limit does not constitute a reasonable limit sufficient to cover future catastrophic losses.

64. Plaintiffs' conclusion is supported by federal law. For example, 2 CFR Pt. 200, App. V states: "Internal service funds are dependent upon a reasonable level of working capital reserve to operate from one billing cycle to the next. Charges by an internal service activity to provide for the establishment and maintenance of a reasonable level of working capital reserve, in addition to the full recovery of costs, are allowable. A working capital reserve as part of retained

earnings of up to 60 calendar days cash expenses for normal operating purposes is considered reasonable."

65. 60 calendar days equates to an ISF limit of 16.4%, far in excess of the arbitrary 7.5% limit contained in the FY25 Contract.

66. Accordingly, the FY25 Contract does not comply with 42 CFR § 438.6(b)(1).

67. The FY25 Contract also purports to prohibit PIHPs from using ISF funds to pay for services rendered during previous fiscal years.

68. It is basic accounting that during some years, a PIHP (and in turn the ISF) may operate in a deficit, whereas in other years, a PIHP (and in turn the ISF) may operate in a surplus.

69. GASB Statement No. 10 makes it clear that at times, an ISF may even have a negative balance: "The total charge by the internal service fund to the other funds is based on an actuarial method or historical cost information and adjusted over a reasonable period of time so that internal service fund revenues and expenses are approximately equal." (GASB Statement No. 10, ¶ 66b.)

70. GASB Statement No. 10 also states that deficits do not need to be funded in any one year, but rather, can be funded over a reasonable period: "Deficits, if any, in the internal service fund…do not need to be charged back to the other funds in any one year, as long as adjustments are made over a reasonable period of time."

71. The FY25 Contract provisions purporting to prohibit Plaintiffs from using ISF funds to pay for services rendered incurred in previous years violates GASB Statement No. 10 and 42 CFR § 438.6(b)(1).

72. The FY25 Contract provisions purporting to prohibit Plaintiffs from using ISF funds to pay for services rendered in previous years also violates 42 CFR 438.6(c)(1), which prohibits the State from directing a PIHP's Medicaid expenditures.

B. Waskul Settlement – Schedule A – Statement of Work, § 1, ¶ R.20.

73. Community Living Supports ("CLS") services are designed to allow individuals with disabilities to live independently in their communities, rather than in institutions. The vast majority of Michigan's CLS recipients receive services through agency providers.

74. Pursuant to a Medicaid Waiver—known as the Habilitation Supports Waiver—separate funding is allocated to a program that allows the individuals receiving CLS services to participate in the decision-making process about what CLS services they will receive. This process of selecting services is known by several names including participant-direction, self-direction, or self-determination.

75. Recipients develop participant-centered service plans, which Michigan calls Individual Plans of Service ("IPOS"). Each IPOS sets forth medically necessary services designed to permit the beneficiary to achieve community inclusion, community participation, and independence.

76. After the IPOS is developed, it is implemented through a budging process. The cost of services set forth in the IPOS are determined and a budget is created. The budgeting process is handled between the participant and the PIHP.

77. After the budget is created, the participants may select any provider he or she wishes to furnish the actual services. The amount the providers are paid is determined through negotiations between the participant (or his/her family/guardian) and the provider. In other words, providers are not necessarily paid the amount set forth in the IPOS budget.

78. On March 15, 2016, Derek Waskul, by his guardian Cynthia Waskul, and others filed a lawsuit against MDHHS and others, Eastern District of Michigan Case No. 2:16-cv-10936 (the "Waskul Case").

79. In a nutshell, the plaintiffs in the Waskul Case took issue with the budgeting process for CLS self-directed services. The lawsuit claimed that before 2015, an IPOS was created for each participant, and then a budget was created by multiplying staff hours by a prescribed rate. The amount and cost of other items needed in the budget that were not based on staff hours were then added separately to the budget. Plaintiff alleged that in 2015, the PIHP flipped the process, requiring participants to start with a fixed rate of $13.88 per hour, inclusive of workers compensation, transportation, community participation, taxes, and training. Plaintiffs alleged that the new budgeting procedure reduced the amount recipients could pay staff, which in turn reduced CLS services available to enrollees.

80. Apparently, the State and the Waskul plaintiffs reached a proposed settlement that would increase the rates to be applied during the budgeting process for CLS services via the self-determination modality ("Waskul Settlement Agreement" – Exhibit B).

81. Although the object of the settlement is apparently to increase funding for those participants who take advantage of the self-determination modality, many believe the settlement would adversely impact the vast majority of CLS recipients who do not elect self-determination.

82. Among other things, the proposed Waskul Settlement Agreement requires MDHHS to amend its contract with the PIHPs, and requires PIHPs to create the CLS budget using a minimum fee schedule that is set forth in the Waskul Settlement Agreement.

83. The Waskul Settlement Agreement does not set forth any minimum fee schedule that the PIHPs or the participants are *actually* required to pay providers. In other words, the

minimum fee schedule only impacts the calculation of the budget and payment to the recipient, *not* payments to providers.

84. The FY25 Contract being proposed by MDHHS contains a provision purporting to require Plaintiffs to comply with the Waskul Settlement Agreement.

85. Specifically, the FY25 Contract states: "Contractor must comply with all terms and conditions of the Waskul Settlement Agreement once it is approved, and all contingencies have been met." (Exhibit A, Page 80.)

86. Among the numerous problems with the FY25 Contract is that it does not take into account that the currently proposed Waskul Settlement Agreement may not be the same as what is eventually approved by the Court.

87. Nor does the FY25 Contract account for the fact that not a single one of the Plaintiff PIHPs are parties to the Waskul Settlement Agreement.

88. Most importantly, the currently proposed Waskul Settlement Agreement violates federal regulations because it illegally directs PIHPs expenditures.

89. 42 CFR 438.6(c)(1) states that a State may not direct a PIHP's Medicaid expenditures.

90. Subpart (iii)(A) (42 CFR 4.386.6(C)(1)(iii)(A)) contains a limited exception allowing a State to require a PIHP to "adopt a minimum fee schedule for providers that provide a particular service under the contract using State plan approved rates."

91. 42 CFR 4.386.6(C)(1)(iii)(A) does not apply because the Waskul Settlement Agreement incorporated into the FY25 Contract does not require PIHPs to pay providers any minimum rate. Instead, the Waskul Settlement Agreement only requires the PIHPs to use the rate when calculating and creating a budget with self-directed CLS recipients.

92. Moreover, even if 42 CFR 438.6(C)(1)(iii)(A) applied to the budget rates in the Waskul Settlement Agreement, where a State directs a payment, it must "[d]irect expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract." 42 CFR 438.6(C)(2)(ii)(B).

93. In other words, the State cannot create a minimum fee schedule and then treat providers providing the same services differently. And that is exactly what the State proposes to do by treating providers providing services via the self-determination modality different than providers providing the exact same services, using the exact same billing codes, via a different modality.

94. Because the Waskul Settlement Agreement is not finalized, and as-drafted violates federal law, the requirement in the FY25 Contract purporting to require the PIHPs to abide by the Waskul Settlement Agreement is void.

C. CCBHCs – Schedule A – Statement of Work, § 1, ¶ G.14.

95. Federal legislation created the Certified Community Behavioral Health Clinic ("CCBHC") Medicaid Demonstration Program, designed to provide funding to help expand access to substance use disorder and mental health services.

96. States must apply to CMS to receive funding. Michigan did so and became a CCBHC Demonstration state in 2020, with a start date in 2021. The initial two-year demonstration was set to expire in 2023, but additional legislation extended the demonstration by another 4 years.

97. CCBHC clinics are designed to expand services and ensure coordinated, comprehensive behavioral care. CCBHCs have requirements unique to those clinics that are not required of other providers: (1) 24/7/365 crisis response services, (2) screening, assessment, and diagnosis/risk management, (3) patient-centered treatment planning, (4) outpatient mental health and substance use disorder services, (5) outpatient clinic primary care screening, (6) case

management, (7) psychiatric rehabilitation, (8) peer support and counseling services, and (9) intensive community-based care for members of the armed forces and veterans.

98. The State of Michigan, and more specifically MDHHS, is responsible for certifying and monitoring CCBHCs and ensuring that the State is complying with the demonstration waiver. The State is responsible for overseeing the demonstration program, including clinic certification, payment, and compliance with federal reporting requirements. 42 USC § 1396a.

99. Under State and Federal law, Plaintiffs bear no responsibility for running, administering, or otherwise having any involvement in the CCBHC demonstration.

100. Nonetheless, over the past several years, MDHHS has systematically shifted responsibility for running the CCBHC program to Plaintiffs without providing appropriate funding.

101. The FY25 Contract and MDHHS policy purport to shift even more of the State's administrative responsibilities to Plaintiffs without providing Plaintiffs any funding for the new responsibilities.

102. The FY25 Contract states that Plaintiffs with a CCBHC Demonstration Site in their region must execute the PIHP duties and responsibilities set forth in the "MDHHS MI CCBHC Demonstration Handbook Version 2.0," (Exhibit C) which MDHHS claims it can amend as and when MDHHS deems fit.

103. Among the responsibilities MDHHS attempts to shift to the PIHPs per the FY25 Contract are: CCBHC oversight and support, CCBHC enrollment and assignment, CCBHC coordination and outreach, CCBHC payment, CCBHC reporting, CCBHC grievance monitoring, and encounter and review submissions.

104. Through the FY25 Contract, MDHHS is compelling and/or attempting to compel Plaintiffs to undertake new and additional activities and services without appropriating any funds to compensate Plaintiffs for the increased costs being imposed upon them.

105. Historically, the amount of the "supplemental payment" made by MDHHS to Plaintiffs was 1% of the rates paid pursuant to the CCBHC Demonstration.

106. To support the alleged actuarial soundness of the payments made to Plaintiffs, MDHHS retained the services of Milliman, Inc. to provide actuarial and consulting services.

107. On or about September 23, 2024, Milliman published its "State Fiscal Year 2024 Behavioral Health Capitation Rate Certification" for the period of October 1, 2024 through September 30, 2025 ("FY25 Milliman Rate Certification" – Exhibit D).

108. The FY25 Milliman Rate Certification acknowledges MDHHS is shifting additional responsibility for managing the CCBHC Demonstration to PIHPs via the CCBHC Handbook starting in FY25, yet specifically acknowledges there will be no corresponding increase in funding.

109. To be sure, the FY25 Milliman Rate Certification sets forth 11 categories of "major new responsibilities" being shifted to Plaintiffs, while simultaneously acknowledging that Defendants are not providing any additional funding:

> *Section 223 CCBHC Demonstration*
>
> We have reviewed the CCBHC handbook developed by MDHHS that outlines the roles and responsibilities of the PIHPs and CCBHCs to operationalize the demonstration program and utilized this information to support the PIHP administrative percentage of 1.0% added to the SFT 2025 CCBHC PPS-1 rates.
>
> Many of the PIHP responsibilities for the CCBHC Demonstration are currently being performed as part of the existing program. <u>The following are some of the major new responsibilities included in the CCBHC Handbook:</u>
>
> - Provide information about CCBHC benefits to all potential enrollees (community referral, peer support specialist/recovery coach networks other

providers, courts, health departments, law enforcement, schools, other community-based settings), including informational brochures, posters, outreach materials, identify and assign beneficiaries to the pertinent CCBHC site within Waiver Supports Application (WSA); includes verifying beneficiary consent to share information

- Review and process all CCBHC recommended potential enrollees; verify enrollment and attestation for eligibility
- Reimbursing CCBHC's at their PPS-1 rate for each valid CCBHC Medicaid daily visit in a timely manner
- PIHP-CCBHC quarterly reconciliation of actual to projected expense and utilization by CCBHC (may be separate reconciliations based on operational plan of PIHP)
- MDHHS-PIHP annual reconciliation of actual to projected expense and daily visits by CCBHC
- Reporting and distribution for quality bonus payments
- Additional contracting requirements related specifically to CCBHCs
- Establishing an infrastructure to support CCBHCs in care coordination and providing required services, including coordinated crisis services with the Michigan Crisis and Access Line (MiCAL), when available
- Additional trainings and technical assistance to support CCBHC delivery of services
- Distribution, review, validation, and submission of CCBHC data requests, quality metrics, level of care (LOC) data, and ad-hoc requests from MDHHS
- Monitor, collect, and report grievance, appeal, and fair hearing information as it relates to CCBHC services

(Exhibit D at pages 46-47 – emphasis added).

110. The FY25 Milliman Rate Certification makes it clear that despite MDHHS shifting responsibilities to the PIHPs—which Milliman characterizes as "major new responsibilities"—MDHHS is not providing *any* additional funding to the PIHPs: "We have reviewed the historical

administrative expenditures reported in the EQI reports and *have not included any increase to the variable administrative percentages* based on this data." (Emphasis added.)

V. Substance Use Disorder Health Home ("SUDHH") Program.

111. The SUDHH Program is designed to "provide comprehensive care management and coordination services to Medicaid beneficiaries" with opioid use disorder ("OUD"), alcohol use disorder ("AUD"), and stimulant use disorder ("StUD"). The program previously existed only for individuals with OUD and was known as the Opioid Health Home program ("OHH"). Michigan, with the approval of CMS, expanded the program to include AUD and StUD, and thus OHH became SUDHH.

112. On Wednesday, November 27, 2024, NorthCare received an email from MDHHS, stating that because it refused to sign the FY25 Contract, MDHHS would not be providing Medicaid funds NorthCare needs to provide SUDHH benefits to recipients:

> I apologize that we didn't make this connection sooner, but without a signed Medicaid contract Northcare is not able to implement the SUDHH with Medicaid funds. You can continue with OHH activities and any billable services for those with AUD or StUD, but those SUDHH beneficiaries will have to be removed from the WSA. Please work with Kelsey to get the beneficiary list updated.
>
> Exhibit E.

113. NMRE and Region 10 received substantively the same email as was received by NorthCare.

114. As of December, 2024, NorthCare's region contains 4,080 individuals who are eligible for SUDHH benefits. NMRE's region contains 7,886. Region 10's region contains 19,039.

115. Without SUDHH funding, the over 31,000 Michigan residents in Plaintiffs' regions who are entitled to receive the benefits of the SUDHH program will no longer be eligible to enroll.

COUNT I: DECLARATORY RELIEF RE: ISF
(ON BEHALF OF ALL PLAINTIFFS)

116. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

117. Defendants claim they can restrict Plaintiffs' ability to fund their respective ISF accounts above 7.5% of their respective capitated Medicaid & Healthy Michigan Plan revenues. Defendants also claim they can prevent Plaintiffs from using ISF funds to pay for services rendered in prior fiscal years.

118. On the other hand, Plaintiffs' maintain that Defendants' position violates federal law, that they can fund their respective ISF up to an amount determined to be actuarially sound, that Defendants' 7.5% limit is arbitrary and not based on any acceptable actuarial method, that Defendants have no ability to otherwise restrict Plaintiffs' ability to fund their ISF, and that Defendants have no ability to restrict Plaintiffs from using ISF funds to pay for services rendered in prior fiscal years.

119. Thus, there is an actual and present controversy between the parties.

120. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide Plaintiffs' future conduct to preserve their legal rights, and to settle the dispute between the parties.

COUNT II: DECLARATORY RELIEF RE: WASKUL SETTLEMENT
(ON BEHALF OF ALL PLAINTIFFS)

121. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

122. Defendants claim they can require Plaintiffs to create a CLS budget using a minimum fee schedule set forth in the proposed Waskul Settlement Agreement, and that doing so does not violate federal law.

123. On the other hand, Plaintiffs maintain that Defendants' attempt to compel Plaintiffs to create a CLS budget using the rates set forth in the proposed Waskul Settlement violates federal

law including because it improperly directs Plaintiffs' expenditures under the contract, and otherwise fails to direct expenditures equally for providing the same services.

124. Thus, there is an actual and present controversy between the parties.

125. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide Plaintiffs' future conduct to preserve their legal rights, and to settle the dispute between the parties.

COUNT III: DECLARATORY RELIEF RE: ADDED RESPONSIBILITIES RELATED TO THE CCBHC DEMONSTRATION BEING IMPOSED IN FY25 (ON BEHALF OF PLAINTIFF REGION 10)

126. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

127. Via the FY25 Contract and MDHHS MI CCBHC Demonstration Handbook Version 2.0, Defendants claim they can require Region 10 to undertake various additional duties that are otherwise Defendants' responsibility.

128. On the other hand, Region 10 maintains Defendants cannot require it to undertake various additional duties imposed upon Defendants pursuant to the CCBHC Demonstration via the FY25 Contract, including those set forth in the MDHHS MI CCBHC Demonstration Handbook Version 2.0, because Defendants have not appropriated any funds to pay for the necessary increased costs of those additional duties in violation of the Headlee Amendment and MCL 21.235.

129. Thus, there is an actual and present controversy between the parties.

130. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide Region 10's future conduct to preserve its legal rights, and to settle the dispute between the parties.

COUNT IV: VIOLATION OF THE HEADLEE AMENDMENT RE: ADDED RESPONSIBILITIES RELATED TO THE CCBHC DEMONSTRATION BEING IMPOSED IN FY25 (ON BEHALF OF PLAINTIFF REGION 10)

131. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

132. Cost. 1963, Art. 9, § 25, part of the Headlee Amendment, states in part:

> The state is prohibited from requiring any new or expanded activities by local governments without full state financing, from reducing the proportion of state spending in the form of aid to local governments, or from shifting the tax burden to local government.

133. Const. 1963, Art. 9, § 29, also part of the Headlee Amendment, states:

> The state is hereby prohibited from reducing the state financed proportion of the necessary costs of any existing activity or service required of units of Local Government by state law. A new activity or service or an increase in the level of any activity or service beyond that required by existing law shall not be required by the legislature or any state agency of units of Local Government, unless a state appropriation is made and disbursed to pay the unit of Local Government for any necessary increased costs. The provision of this section shall not apply to costs incurred pursuant to Article VI, Section 18.

134. MCL 21.235 requires the legislature to appropriate an amount sufficient to make disbursements for the necessary cost of each state requirement. An initial disbursement is required to be made in advance, at least 30 days prior to the effective date of the requirement. MCL 21.235(1) & (2).

135. Defendants, including through the FY25 Contract and the MDHHS MI CCBHC Demonstration Handbook Version 2.0, are shifting new activities and services, and increasing the level of other activities and services, related to administering and running the CCBHC Demonstration, to Region 10, without making any appropriation at all for any of the necessary increased costs.

136. The new activities and services relate to the administration of the CCBHC Demonstration, and include the new "major responsibilities" referenced in the FY25 Milliman Rate Certification (Exhibit D, Pages 46-47) and the new activities and services to be rendered by Region 10 as set forth in the MDHHS MI CCBHC Demonstration Handbook Version 2.0.

137. Defendants are in violation of the prohibition of unfunded mandates ("POUM") provisions of the Headlee Amendment (i.e., the second sentence of Const. 1963, Art. 9, § 29), Const. 1963, Art. 9, § 25, and MCL 21.235.

138. Region 10 does not need to plead and prove the extent of the harm caused, because neither the Legislature nor MDHHS have made any appropriation or disbursements necessary to cover the cost of the increased mandates. *Adair v Michigan*, 497 Mich 89, 96; 860 NW2d 93 (2014).

139. Region 10 does not anticipate any particular factual questions that require resolution by the Court related to this Count. MCR 2.112(M).

140. There are no ordinances or municipal charter provisions involved. Available documentary evidence supportive of this claim includes the MDHHS CCBHC Handbook Version 2.0 (Exhibit C) and the FY25 Milliman Rate Certification (Exhibit D).

141. Plaintiffs reserve the right to supplement this pleading with additional documentary evidence as it becomes available. MCR 2.112(M).

COUNT V: DECLARATORY RELIEF RE: CONTINUED FUNDING (ON BEHALF OF ALL PLAINTIFFS)

142. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

143. Defendants claim they can terminate their contractual relationship with Plaintiffs simply because Plaintiffs refused to sign the FY25 Contract inclusive of the illegal/void provisions contained therein. Defendants further claim that they can withhold SUDHH Medicaid funds from Plaintiffs.

144. On the other hand, Plaintiffs maintain that State and Federal law require Defendants to continue funding, including by providing SUDHH funding to, Plaintiffs even in the absence of a signed FY25 Contract.

145. In addition, Plaintiffs maintain that the steps Defendants have taken to terminate MDHHS's contractual relationship with Plaintiffs constitutes an action for which Plaintiffs are entitled to notice and opportunity for hearing to contest the proposed action. MCL 330.1232b.

146. Thus, there is an actual and present controversy between the parties.

147. Declaratory relief is necessary in order to adjudicate the rights of the parties, guide Plaintiffs future conduct to preserve their legal rights, and to settle the dispute between the parties.

COUNT VI: WRIT OF MANDAMUS
(ON BEHALF OF ALL PLAINTIFFS)

148. Plaintiffs incorporate the foregoing paragraphs as though fully set forth herein.

149. Defendants have a non-discretionary statutory duty to continue funding Plaintiffs, even in the absence of a signed contract. MCL 330.1202(1); MCL 330.1204b(2); MCL 330.1116; MCL 400.109f.

150. Defendants also have a non-discretionary statutory duty to supply Plaintiffs with a hearing prior to terminating their relationship. MCL 330.1232b.

151. Defendants' obligations are ministerial acts, leaving nothing to the exercise of discretion or judgment.

152. Plaintiffs have no adequate remedy at law.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs request:

1. A declaration that:

   a. Plaintiffs can fund their respective ISF accounts up to an amount determined to be actuarially sound despite any contractual provision to the contrary;

   b. Defendants cannot restrict Plaintiffs from using ISF funds to pay for services rendered in prior fiscal years despite any contractual provision to the contrary;

   c. Plaintiffs are not required to comply with the proposed Waskul Settlement Agreement despite any contractual provision to the contrary;

d. Region 10 is not required to undertake any added administrative responsibilities related to the CCBHC Demonstration imposed starting in FY25, or alternatively, that Defendants must provide adequate funding before requiring Region 10 to undertake said administrative responsibilities;

e. Defendants must continue to provide Medicaid and general funding to Plaintiffs; and

f. Defendants must provide Plaintiffs with notice and an opportunity for hearing prior to attempting to terminate their relationship with Plaintiffs.

2. A Writ of Mandamus compelling Defendants to:

a. continue to provide Medicaid and general funds to Plaintiffs;

b. retract all communications and actions taken to terminate the relationship between MDHHS and Plaintiffs; and

c. supply Plaintiffs with the opportunity for a hearing to contest and dispute MDHHS's proposed termination.

3. Compensatory damages in the amounts that should have been appropriated to Plaintiffs but for Defendants' violation of the Headlee Amendment.

4. An award in favor of Plaintiffs granting them all attorneys' fees, expenses, and costs incurred in bringing this action.

5. All other relief as the Court deems just and proper.

TAFT, STETTINIUS & HOLLISTER, LLP

Dated: December 9, 2024

By: */s/Christopher J. Ryan*

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Attorneys for Plaintiffs

VERIFICATION

I declare under penalties of perjury that this Verified Complaint has been examined by me and that its contents are true to the best of my information, knowledge, and belief. MCR 1.109(D)(3).

NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY

Signed by:
By: Megan Rooney
48ED892AE4934FC...
Megan Rooney

Subscribed and sworn to before me this 12/9/2024 day of 12/9/2024, 2024

DocuSigned by:
Deborah Gutierrez
6BA59119555B41A...
Deborah Gutierrez, Notary Public
Wayne County, Michigan
My Commission Expires: 08/22/2025

NORTHERN MICHIGAN REGIONAL ENTITY

Signed by:
By: Eric Kurtz
14403AB16461439...
Eric Kurtz

Subscribed and sworn to before me this 12/9/2024 day of 12/9/2024, 2024

DocuSigned by:
Deborah Gutierrez
6BA59119555B41A...
Deborah Gutierrez, Notary Public
Wayne County, Michigan
My Commission Expires: 08/22/2025

REGION 10 PIHP

Signed by:
By: Jim Johnson
1566D15A15F4490...
Jim Johnson

Subscribed and sworn to before me this 12/9/2024 day of 12/9/2024, 2024

DocuSigned by:
Deborah Gutierrez
6BA59119555B41A...
Deborah Gutierrez, Notary Public
Wayne County, Michigan
My Commission Expires: 08/22/2025

DEBORAH GUTIERREZ
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County of Wayne
My Commission Expires Aug. 22, 2025

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STATE OF MICHIGAN
IN THE COURT OF CLAIMS

NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY, NORTHERN MICHIGAN REGIONAL ENTITY, and REGION 10 PIHP	Case No. 24- -MZ Hon.
Plaintiffs, v	
STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, a Michigan State Agency, and its Director, ELIZABETH HERTEL, in her official capacity,	
Defendants.	

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12/09/2024 PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

*****ORAL ARGUMENT REQUESTED*****

Plaintiffs, by and through counsel, TAFT, STETTINIUS & HOLLISTER, LLP, for the reasons more particularly described in the accompanying Brief in Support, request that the Court issue a preliminary injunction prohibiting MDHHS from withholding critical Medicaid funding from Plaintiffs. Defendants are withholding the funds in order to try to force Plaintiffs to sign a contract that contains various provisions that violate state and federal law. The consequence of Defendants' withholding of funds is that thousands of citizens are no longer eligible to receive

Substance Abuse Disorder Health Home ("SUDHH") services. Those individuals are statutorily and constitutionally entitled to receive the services, and the Court should not permit Defendants to put those individuals in the middle of the parties' dispute.

WHEREFORE, Plaintiffs respectfully request that this Court enter a preliminary injunction prohibiting Defendants from withholding SUDHH funding from Plaintiffs during the pendency of this action.

Respectfully Submitted,

TAFT, STETTINIUS & HOLLISTER, LLP

Dated: December 9, 2024

By: */s/Christopher J. Ryan*

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BRIEF IN SUPPORT

INTRODUCTION

The Court should enjoin Defendants from withholding critical Medicaid funding needed to provide Substance Use Disorder Health Home ("SUDHH") services to the citizens located within each of the Plaintiffs' respective regions. Defendants brazenly admit they are only withholding the funds because Plaintiffs refused to sign Defendants' form FY25 Contract, which contain numerous provisions that violate federal and state law as detailed in Plaintiffs' Verified Complaint. But the fact remains that regardless of whether the parties' agree on the form of a FY25 contract, Defendants are legally obligated to provide the funding.

FACTS

Plaintiffs represent 3 of Michigan's 10 Prepaid Inpatient Health Plans ("PIHPs") that facilitate the delivery of behavioral health services for individuals with mental illness developmental disability, and substance use disorders in 40 counties across the State.[1] (Verified Complaint, ¶ 2.)

To say the least, Michigan's system for funding behavioral health services is complex. After approving a Medicaid State Plan, the State receives federal money to spend on services covered by the Medicaid program, which is administered by the Department of Health and Human Services ("MDHHS"). The State is required to fund 90% of behavioral health services that are not covered under the Medicaid program (MCL 330.1308(1)) and the counties fund the remaining 10%. The actual services (Medicaid and non-Medicaid) are provided at the county level through community mental health services programs ("CMHs"). MCL 330.1116(2)(b). The Legislature recognized the importance of community mental health services programs, mandating that MDHHS "promote and maintain an adequate and appropriate system of community mental health services programs throughout the state" and requiring MDHHS to "financially support…community mental health services programs…." MCL 330.1116(2)(b); MCL 330.1202(1) ("The state shall financial support…community mental health services programs…."). CMHs have the right to organize together to form a "regional entity." Plaintiffs are all regional entities. Regional entities are public governmental entities separate from the county, authority, or organizations that establish them, but have all of the rights and authority of their constituent CMHs. MCL 330.1204b(3).

[1] Plaintiff NorthCare Network Mental Health Care Entity is referred to as "NorthCare." Plaintiff Northern Michigan Regional Entity is referred to as "NMRE." Plaintiff Region 10 PIHP is referred to as "Region 10."

The State of Michigan is divided into 10 PIHPs, and Plaintiffs constitute 3 of those PIHPs. (Verified Complaint, ¶ 37.) After the State receives Medicaid money from the federal government, the State then distributes those funds on a capitated basis to the 10 PIHPs, who fund the CMHs and the services they provide. MCL 330.1232b requires that the condition for contracting and receiving Medicaid dollars is that a PIHP shall certify that (a) it is in substantial compliance with the standards promulgated by the department and with applicable federal regulations, and (b) that the PIHP has established policies and procedures to monitor compliance with the standards promulgated by the department and with applicable federal regulations and to ensure program integrity. MCL 330.1232b(2). Each Plaintiff has done so. (Verified Complaint, ¶ 39.)

On an annual basis, MDHHS is required to review the PIHPs to ensure compliance with promulgated standards and federal regulations. MCL 330.1232b(3). MDHHS may also review a PIHP in response to beneficiary complaints, financial status considerations, or for health and safety concerns. MCL 330.1232b(4). However, MDHHS may only sanction or terminate a PIHP if the PIHP is not in substantial compliance with promulgated standards and with established federal regulations, if the PIHP has misrepresented or falsified information reported to the state or federal government, or if the PIHP has failed substantially to provide necessary covered services to recipients. MCL 330.1232b(5). None of the Plaintiffs have done so. (Verified Complaint, ¶ 40.) Moreover, prior to imposing a sanction or terminating a relationship with a PIHP, MDHHS is required to provide notice explaining the basis and nature of the sanction, as well as an opportunity to contest the department's findings prior to imposition of the sanction via a hearing in accordance with the Administrative Procedures Act, MCL 24.201 et seq.

One of the programs offered through Plaintiffs is the SUDHH Program. (Verified Complaint, ¶¶ 111-115.) The SUDHH Program is a Medicaid program designed to "provide

comprehensive care management and coordination services to Medicaid beneficiaries" with opioid use disorder ("OUD"), alcohol use disorder ("AUD"), and stimulant use disorder ("StUD").[2] The program previously only existed for individuals with OUD and was known as the Opioid Health Home program ("OHH"). (Verified Complaint, ¶ 111.) Michigan, with the approval of CMS, expanded the program to include AUD and StUD, and thus, OHH became SUDHH. *Id*.

The parties have been embroiled in a lengthy and contentious negotiation for many months over the terms of a new contract for FY25. (Verified Complaint, ¶¶ 45-46.) Plaintiffs maintain that certain provisions in Defendants' form FY25 Contract ("FY25 Contract" – Exhibit A to Verified Complaint) are unreasonable and violate state/federal law. (*Id*.) Plaintiffs each signed the FY25 Contract after redlining the unreasonable and illegal provisions, but MDHHS refused to counter-sign. (Verified Complaint, ¶ 46.) In an attempt to bully Plaintiffs to agree to MDHHS's version of the FY25 Contract, MDHHS threatened that if Plaintiffs did not sign by October 31, 2024, MDHHS would terminate its relationship with Plaintiffs and cut off the funding Plaintiffs need to ensure recipients in their respective regions continue to receive behavioral health services. (Verified Complaint, ¶ 47.)

On Wednesday, November 27, 2024, MDHHS executed on its threat by informing Plaintiffs that because they refused to sign the FY25 Contract, MDHHS was going to withhold Medicaid funds needed to provide SUDHH benefits to recipients:

[2]https://www.michigan.gov/mdhhs/assistance-programs/medicaid/substance-use-disorder-health-home (last accessed December 5, 2024).

> I apologize that we didn't make this connection sooner, but without a signed Medicaid contract Northcare is not able to implement the SUDHH with Medicaid funds. You can continue with OHH activities and any billable services for those with AUD or StUD, but those SUDHH beneficiaries will have to be removed from the WSA. Please work with Kelsey to get the beneficiary list updated.
>
> (Verified Complaint, ¶ 112.)

NMRE and Region 10 received substantively the same email as was received by NorthCare. (Verified Complaint, ¶ 113.)

While Defendants' negotiation tactic will harm Plaintiffs, the most significant harm will come to the citizens entitled to receive SUDHH services. (Verified Complaint, ¶¶ 113-115.) Defendants' pronouncement means that all of the individuals currently enrolled to receive SUDHH benefits will no longer receive them. *Id*. And it means that the thousands upon thousands of Michiganders who are eligible to enroll to receive SUDHH services will no longer be eligible to enroll. *Id*. Those residents were already directed by Defendants to contact Plaintiffs (see, e.g., Exhibit A) to obtain SUDHH services, and now Plaintiffs are being directed to turn them away. (*Id*, ¶¶ 112-113.)

ARGUMENT

MCR 3.310(A) gives the Court authority to issue an order to show cause why a preliminary injunction should not be issued. "In determining whether to issue a preliminary injunction, a court must consider four factors: (1) harm to the public interest if the injunction issues; (2) whether harm to the applicant in the absence of temporary relief outweighs the harm to the opposing party if relief is granted; (3) the likelihood that the applicant will prevail on the merits; and (4) a demonstration that the applicant will suffer irreparable injury if the relief is not granted." *Thermatool Corp v Borzym*, 227 Mich App 366, 376; 575 NW2d 334 (1998). These factors "guide the discretion of the court; they are not meant to be rigid and unbending requirements." *Johnson v Michigan Minority Purchasing Counsel*, 341 Mich App 1, 25; 988 NW2d 800 (2022).

I. The public interest favors entering an injunction, and thousands of Michigan residents will suffer irreparable harm without injunctive relief.

The first and fourth factors strongly favor issuing an injunction that prohibits MDHHS from withholding Medicaid funds needed to provide medical services to citizens of Michigan.

There is no dispute that the services provided via the SUDHH program are critical to those with substance abuse disorders. MDHHS's website extols the numerous benefits of the program:

- **Background**

  Under Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA), the Health Home service model is meant to help chronically ill Medicaid and Healthy Michigan Plan beneficiaries manage their conditions through an intensive level of care management and coordination. The Substance Use Disorder Health Home is centered on whole-person, team-based care, with peer recovery coaches at the center of care.

- **Program Overview**

  The SUDHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder. For enrolled beneficiaries, the SUDHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. The model will also elevate the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

  Substance Use Disorder Health Home receives reimbursement for providing the following federally mandated core services:

  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and social support services

- **Program Objectives**

  Substance Use Disorder Health Home providers are also required to utilize health information technology to coordinate the care of Substance Use Disorder Health

Home patients. Through the delivery of the core health homes services, Substance Use Disorder Health Home has the following objectives:

- Improve patient outcomes and long-term recovery
- Provide efficient, coordinated, and integrated behavioral and physical healthcare
- Increase access to healthcare
- Increase hospital post-discharge follow up
- Create a continuum of care
- Reduce healthcare costs
- Reduce unnecessary hospital admissions and readmissions
- Reduce unnecessary emergency room visits
- Increase the use of health information technology

https://www.michigan.gov/mdhhs/assistance-programs/medicaid/substance-use-disorder-health-home (last accessed December 5, 2024).

To help qualifying individuals obtain SUDHH benefits, MDHHS published a directory that instructs individuals who to call to obtain services depending on where the individual resides. For those individuals residing in the 40 counties represented by the Plaintiffs, citizens were directed by MDHHS to contact Plaintiffs. Exhibit A.

While not all individuals who are eligible for Medicaid are eligible for SUDHH benefits (the benefits are only available to those with OUD, AUD, and StUD diagnoses), the number of eligible individuals in the regions served by Plaintiffs is not slight:

Region	**Individuals Eligible for SUDHH**
NorthCare	4,080
NMRE	7,886
Region 10	19,039
Total	***31,005***

(Verified Complaint, ¶ 114.)

Plaintiffs have already taken substantial steps and expended resources in reliance on receiving the funds necessary to provide SUDHH services. But the harm to Plaintiffs pales in comparison to the harm that would come to the 31,000+ individuals served by Plaintiffs that are eligible to receive SUDHH services. (Verified Complaint, ¶¶ 114-115.) It is harm to imagine a

better example of irreparable harm than depriving individuals of medical services, especially those services needed by persons in crisis or attempting to overcome addiction; numerous courts have held as much. See, e.g., *Cole v ArvinMeritor, Inc*, 516 F Supp 2d 850, 876 (ED Mich, 2005) ("Alteration and elimination of retiree health benefits causes retirees and dependents health risk, uncertainty, anxiety, financial hardship, and other irreparable harm."); *Detroit Police Officers Ass'n v City of Detroit*, 142 Mich App 248, 253; 369 NW2d 480 (1985) ("Forced deferral of medical treatment may cause irreparable harm."); *Welch v Brown*, 935 F Supp 2d 875, 888 (ED Mich, 2013) (irreparable harm found where access to health care may be threatened by modification to health care benefits); *Markva v Haveman*, 168 F Supp 2d 695, 719 (ED Mich, 2001), aff'd 317 F3d 547 (CA 6, 2003) ("denial or delay in benefits which effectively prevents plaintiffs from obtaining needed medical care constitutes irreparable harm.")

II. Harm to Plaintiff without an injunction outweighs harm to Defendants if an injunction is issued.

The only harm that Defendants will sustain if an injunction is issued is that they will lose what they believe is leverage over Plaintiffs. But that is not the type of harm that this Court should take into account when deciding whether to issue an injunction. On the other hand, as stated above, Plaintiffs (and more importantly, the citizens Plaintiffs serve) will be significantly harmed, because without an injunction, the entire SUDHH program in 40 counties across the State will disappear. (Verified Complaint, ¶¶ 111-115.)

III. Plaintiff is likely to prevail on the merits.

Plaintiff's Verified Complaint outlines the myriad provisions of the State's proposed FY25 contract that violate state and federal law. (Verified Complaint.) More importantly to this Motion, Plaintiff is likely to prevail on its claim that the State has a statutory duty to continue funding Plaintiffs, even in the absence of a signed contract. (Verified Complaint, Counts V and VI.)

Defendants have a non-discretionary statutory duty to provide funding to Plaintiffs. As indicated above, Plaintiffs are regional entities. (Verified Complaint, ¶ 28.) Regional entities have all of the "power, privilege, or authority that the participating community mental health services programs share in common and may exercise separately under the act…." MCL 330.1204b(2). The State is statutorily required to provide funding to CMHs: "The state shall financially support…community mental health services programs…." MCL 330.1116(2)(b). Moreover, MDHHS is required to provide Medicaid specialty services and supports services through PIHPs. MCL 400.109f ("Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans…").

Not only are Defendants required to provide Medicaid funding to Plaintiffs, MCL 330.1232b sets forth the only conditions precedent necessary to receive that funding. Specifically, MCL 330.1232b requires that as a condition for receiving Medicaid funding, a PIHP shall certify that (a) it is in substantial compliance with the standards promulgated by the department and with applicable federal regulations, and (b) that the PIHP has established policies and procedures to monitor compliance with the standards promulgated by the department and with applicable federal regulations and to ensure program integrity. There is no question that each Plaintiff has done so. (Verified Complaint, ¶ 39.)

The same statute also sets forth the restrictions on Defendants' ability to terminate Medicaid funding. MDHHS may only sanction or terminate a PIHP if the PIHP is not in substantial compliance with promulgated standards and with established federal regulations, if the PIHP has misrepresented or falsified information reported to the state of the federal government, or if the PIHP has failed substantially to provide necessary covered services to recipients. There is no question that none of the Plaintiffs have done so. (Verified Complaint, ¶ 40.)

Moreover, according to the Mental Health Code, before terminating a PIHP, MDHHS is required to provide that PIHP with notice of the basis and nature of the sanction and an opportunity for hearing to contest or dispute MDHHS's findings and intended sanction. MCL 330.1232b. There is no question that Defendants have failed to comply with the requirements of MCL 300.1232b, and are instead simply cutting off SUDHH Medicaid funding without any prior notice as a means of trying to force Plaintiffs to sign Defendants' form FY25 Contract. (Verified Complaint, ¶¶ 47 & 112.)

Thus, Plaintiffs are likely to succeed on the merits of their claim that the State is prohibited from withholding Medicaid funding.

CONCLUSION

The parties disagree on a lot, as outlined in Plaintiffs' Verified Complaint requesting declaratory relief. However, as public entities intended to serve Michiganders, the parties should not disagree over whether the citizens of the State should receive necessary services. By cutting off SUDHH Medicaid funding, Defendants thrust individual Medicaid beneficiaries, and the ability of those beneficiaries to receive SUDHH services, into the middle of the parties' dispute. The Court should enjoin this conduct, and ensure that services are not disrupted through Defendants' wrongful withholding of Medicaid funds.

TAFT, STETTINIUS & HOLLISTER, LLP

Dated: December 9, 2024

By: */s/Christopher J. Ryan*

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Exhibit A

Substance Use Disorder Health Home (SUDHH) – PIHP and Designated Providers

Prepaid Inpatient Health Plan (PIHP)

- NorthCare Network

Address: 1230 Wilson St.
City: Marquette
State: MI
Zip: 49855
Phone: 1-800-305-6564

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Great Lakes Recovery Center	1009 W. Ridge St. Suite C	Marquette	906-228-6545
	1101 Ludington Street	Escanaba	906-789-3528
	100 Malton Road Suite 7	Negaunee	906-485-2347
	1115 S. Hemlock Street	Iron Mountain	906- 774-2561
	2655 Ashmun St. - South	Sault Ste. Marie	906-632-9809
Upper Great Lakes Family Health Center	1414 W Fair Ave Suite 242	Marquette	906-449-2900
	56720 Calumet Avenue	Calumet	906-483-1177

Opioid Treatment Program (OTP)

OHH Provider Name	Locations	City	Phone
Sacred Heart Rehabilitation Center	248 Ferry Lane	St. Ignace	906-984-2080

Health Home Partners

OHH Provider Name	Locations	City	Phone
Catholic Social Services of the U.P Escanaba	1100 Ludington St. Suite 401	Escanaba	906-7867212

Prepaid Inpatient Health Plan (PIHP)

- Northern Michigan Regional Entity

Address: 1999 Walden Drive
City: Gaylord
State: MI
Zip: 49735
Phone: 800-834-3393
Email: support@nmre.org

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Alcona Health Center	1185 US 23 North	Alpena	989-356-4049
	740 South Main Street	Cheboygan	231-627-7118

	3434 M-119, Suite C	Harbor Springs	231-348-9900
	205 North State Street, Suite A	Harrisville	989-724-5655
	6135 Cressey Street	Indian River	231-238-8908
	177 N. Barlow Road	Lincoln	989-736-8157
	5671 N. Skeel Avenue	Oscoda	989-739-2550
	1175 US 23 South	Ossineke	989-471-2156
	421 Stimpson Drive	Pellston	231-844-3051
Bear River Health	1619 W. M-32	Gaylord	231-751-0070
	2594 Springvale Road	Boyne Falls	231-535-2822
	2329 Center Street	Boyne Falls	231-535-2822
	8446 M-119 Plaza	Harbor Spring	231-751-0070
	218 Water Street	Cheboygan	231-751-0070
	101 Hurlbut	Charlevoix	231-758-2551
Centra Wellness Network	6051 Frankfort Highway, Suite 800	Benzonia	877-398-2013
	2198 US Highway 31 South	Manistee	877-3982013
Harbor Hall	2236 E. Mitchell Road	Petoskey	231-347-9880
	520 N. Main Suite 202	Cheboygan	231-597-9235
Addiction Treatment Services	1010 S. Garfield Avenue	Traverse City	231-346-5207
Thunder Bay Community Health Services	11899 M-32	Atlanta	989-785-4855
	15774 State Street	Hillman	989-742-4583
	21258 West M-68	Onaway	989-733-2082
	205 South Bradley	Rogers City	989-734-2052
Traverse Health Clinic	1719 South Garfield Avenue	Traverse City	231-935-0799
MidMichigan Community Health Services	9249 West Lake City Rd	Houghton Lake	989-422-5689
	565 Progress Street	West Branch	989-422-5689
Best Medical	814 S Garfield Ave Suite C	Traverse City	231-675-4808
Grand Traverse Women's Clinic	1200 6th St. Suite 400	Traverse City	231-392-0650

Health Home Partners: Opioid Treatment Program (OTP)

OHH Provider Name	Locations	City	Phone
NMSAS Recovery Center	2136 W. M-32	Gaylord	989-732-1791

Health Home Partners

OHH Provider Name	Locations	City	Phone
Catholic Human Services	1000 Hastings Street.	Traverse City	231-470-8110
	154 S. Ripley Blvd.	Alpena	989-356-6385
	829 W. Main Street	Gaylord	989-732-6761
	106 Fifth Street	Harrisville	989-356-6385
	205 S. Bradley Hwy, Parkwood Plaza	Rogers City	989-356-6385
	11899 M-32	Atlanta	989-356-6385

	200 Hemlock Road	Tawas City	989-356-6385
	3440 West M-76	West Branch	9889-732-6761
	209 W. 8th Street	Mio	989-732-6761
	421 South Mitchell Street	Cadillac	231-775-6581
	6051 Frankfort Highway	Benzonia	231-775-6581
	205 Grove Street	Mancelona	989-732-6761
	2198 US 31 South	Manistee	231-775-6581
	206 Health Parkway	Houghton Lake	989-732-6761

Prepaid Inpatient Health Plan (PIHP)

- **Lakeshore Regional Entity**

Address: 5000 Hakes Dr.
City: Norton Shore
State: MI
Zip: 49441
Phone: 231-769-2050
Email: customerservice@lsre.org

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Ottawa County Community	12251 James St Ste 100	Holland	616-392-1873

Prepaid Inpatient Health Plan (PIHP)

- **Southwest Michigan Behavioral Health**

Address: 5250 Lovers Lane Suite 200
City: Portage
State: MI
Zip: 49002
Phone: 1-800-676-0423

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Calhoun County Community Mental Health Authority dba Summit Pointe	3630 S Capital Ave SW	Battle Creek	269-979-8333

Health Home Partners: Opioid Treatment Program (OTP)

OHH Provider Name	Locations	City	Phone
Victory Clinic - Calhoun County	842 E. Columbia Street	Battle Creek	269-753-1710
Victory Clinic - Kalamazoo County	401 Howard Street	Kalamazoo	269-344-4458
Harbortown Treatment Center	1022 E Main Street	Benton Harbor	269-926-0015
	3134 Niles Rd C	St. Joseph	269-408-8235

Prepaid Inpatient Health Plan (PIHP)

- **Mid-State Health Network**

Address: 530 West Ionia Street Suite F
City: Lansing
State: MI
Zip: 48933
Phone: 517-253-7525

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Recovery Pathways	1009 Washington Ave.	Bay City	989-928-3566
MidMichigan Community Health Services	9249 W Lake Road	Houghton Lake	989-422-5122

Health Home Partners: Office Based Opioid Treatment Providers (OTPs)

OHH Provider Name	Locations	City	Phone
Victory Clinic	508 Shattuck Road	Saginaw	989-752-7867
	3300 Lansing Ave	Jackson	517-784-2929
	4902 S Cedar St.	Lansing	517-394-7867

Prepaid Inpatient Health Plan (PIHP)

- **C.M.H Partnership of Southeast Michigan**

Address: 3005 Boardwalk Dr. Suite #200
City: Ann Arbor
State: MI
Zip: 48108
Phone: 1-855-571-021

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Packard Health	2650 Carpenter Rd	Ann Arbor	734-971-1073
	200 Arnet St. Suite 150	Ypsilanti	734-985-7200
Passion of the Mind Healing Center	14930 Laplaisance Rd #127	Monroe	734-344-5269
Family Medical Center of Michigan	8765 Lewis Avenue	Temperance	734-654-2169
	1200 N. Main St.	Adrian	(517) 263-1800
	130 Medical Center Dr.	Carleton	(734) 654-2169
	901 N. Macomb	Monroe	(734) 654-2169

Health Home Partners: Opioid Treatment Program (OTP)

OHH Provider Name	Locations	City	Phone
Therapeutics	4673 Washtenaw Avenue	Ann Arbor	734-547-5009
	1010 E. West Maple, Suite 200	Walled Lake	248-525-6832
	3250 N. Monroe St. Suite 2	Monroe	734-384-3121

Prepaid Inpatient Health Plan (PIHP)

- Detroit Wayne Integrated Health Network

Address: 707 W. Milwaukee Ave.
City: Detroit,
State: MI
Phone: 800-630-1044

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Hegira Health Inc.	8623 N Wayne Rd Ste 200	Westland	734-425-0636
The Guidance Center	13101 Allen Rd.	Southgate	989-734-2052

Health Home Partners: Opioid Treatment Program (OTP)

OHH Provider Name	Locations	City	Phone
Metro East Drug Treatment Corp.	13929 Harper Ave.	Detroit	313-371-0055
New Light Recovery	300 West McNicols	Detroit	313-867-8015
Quality Behavioral Health Inc.	6821 Medbury	Detroit	(313) 922-2222
Star Center Inc.	13575 Lesure	Detroit	(313) 493-4410
Nardin Park Recovery Center	9605 Grand River Ave.	Detroit	313-834-5930
Rainbow Center	12501 Hamilton Ave.	Highland Park	313-865-1580
Sobriety House	2081 W. Grand Blvd.	Detroit	231-935-0799

Prepaid Inpatient Health Plan (PIHP)

- Oakland Community Health Network

Address: 5505 Corporate Drive
City: Troy
State: MI
Zip: 48098
Phone: 248-858-1210

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Meridian Health	269 Summit Drive	Waterford	248-599-8999
Easter Seals	24445 Northwestern Hwy suite 100	Southfield	248-475-6400
Oakland Family Services	114 Orchard Lake Road	Pontiac	248-858-7766

Health Home Partners: Opioid Treatment Program (OTP)

OHH Provider Name	Locations	City	Phone
Therapeutics	1685 Baldwin Ave Ste 400	Pontiac	(248) 977-3758
Sacred Heart Rehabilitation Center	28303 Dequindre Road	Madison Hts.	248-658-1116

Prepaid Inpatient Health Plan (PIHP)

- **Macomb County C.M.H Services**

Address: 22550 Hall Road
City: Clinton Township
State: MI
Zip: 48036
Phone: 1-855-996-2264

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
Gammons Medical	28477 Hoover	Warren	586-250-4040
	1223 Washington Ave	Royal Oak	248-439-1060
MyCare Health Center	18 Market St # C,	Mt Clemens	586-783-2222

Health Home Partners: Opioid Treatment Program (OTP)

OHH Provider Name	Locations	City	Phone
Bio Med Behavioral Healthcare	31581 Gratiot Road	Roseville	586-783-4802
Sacred Heart Rehabilitation Center	19611 E. 8 Mile Road	St. Clair Shores	586-541-9550
	400 Stoddard Road	Richmond	810-392-2167
	28303 Dequindre Road	Madison Hts.	248-658-1116
Quality Behavioral Health	37490 Dequindre Road	Sterling Heights	586-480-1438

Health Home Partners

OHH Provider Name	Locations	City	Phone
Judson Center	12200 13 Mile Rd #200	Warren	586-573-1810

Prepaid Inpatient Health Plan (PIHP)

- **Region 10 PIHP**

Address: 3111 Electric Avenue, Suite A
City: Port Huron
State: MI
Zip: 48060
Phone: 810-966-3399

Health Home Partners: Office Based Substance Use Treatment Service Providers

OHH Provider Name	Locations	City	Phone
New Paths	765 East Hamilton	Flint	810-233-5340

Health Home Partners: Opioid Treatment Providers (OTP)

OHH Provider Name	Locations	City	Phone
Sacred Heart Rehabilitation Center	2091 Professional Drive Ste. D.	Flint	810-732-1652
	400 Stoddard Road	Richmond	810-392-2167
	1406 8th Street	Port Huron	810-987-1258
Bio Med Behavioral Healthcare	1044 Gilbert St	Flint	586-783-4802
	31582 Gratiot Ave	Roseville	586-783-4802

Arbor Recovery Michigan	5085 W. Bristol Road	Flint	810-243-5085

Health Home Partners

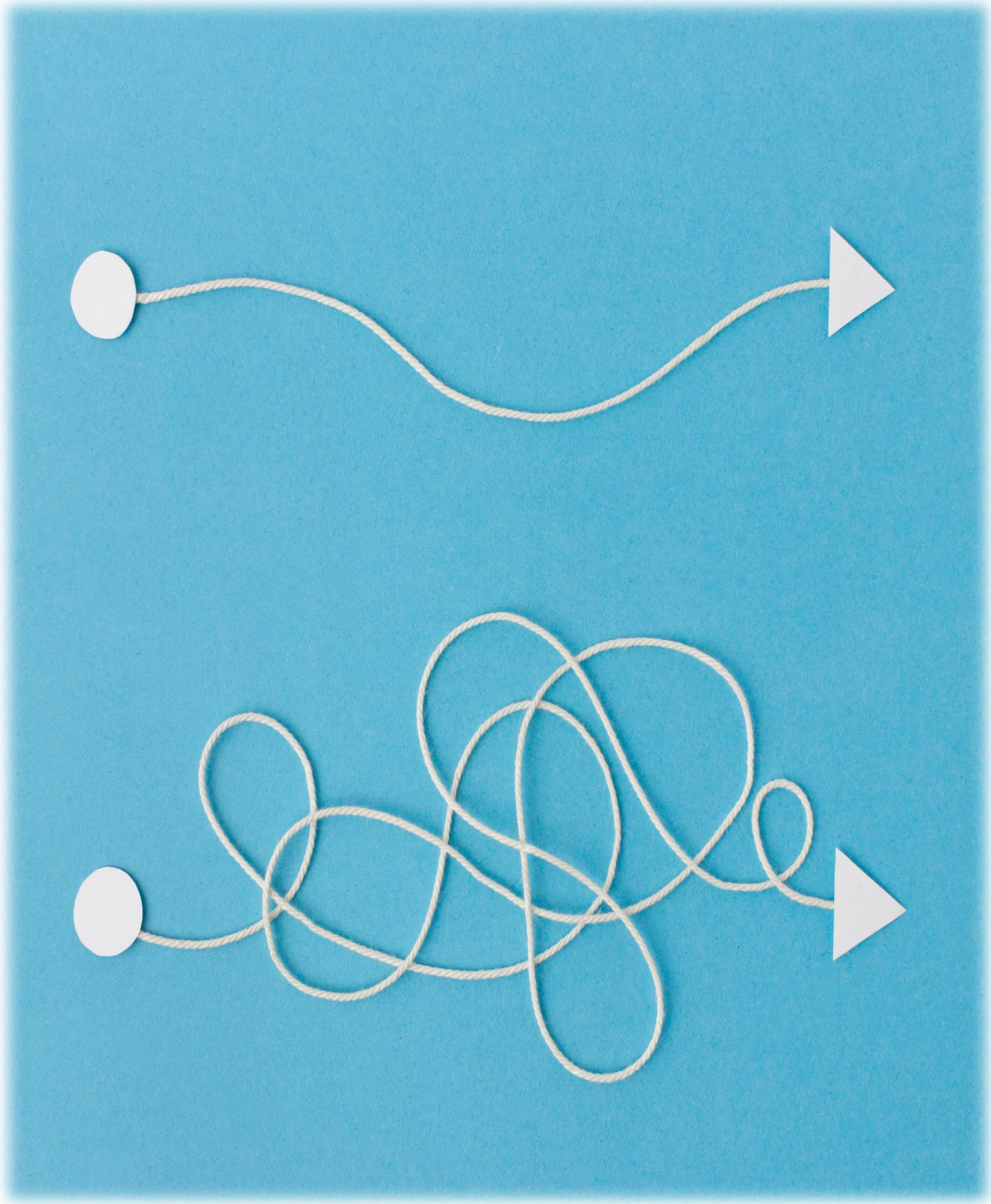
OHH Provider Name	Locations	City	Phone
Flint Odyssey House	1108 Lapeer Rd	Flint	810-232-7919

NMRE FY24 QAPIP UPDATE

NMRE Board Meeting

12/18/2024

THE STATE OF MICHIGAN REQUIRES THAT EACH PREPAID INPATIENT HEALTH PLAN (PIHP) HA A QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP).



PURPOSE

THE QAPIP IS INTENDED TO SERVE SEVERAL FUNCTIONS, INCLUDING BUT NOT LIMITED TO:

- SERVE AS THE QUALITY IMPROVEMENT STRUCTURE FOR THE MANAGED CARE ACTIVITIES OF THE NMRE AS THE PIHP FOR THE TWENTY-ONE-COUNTY AREA.

- PROVIDE OVERSIGHT OF THE CMHSPS' QUALITY IMPROVEMENT STRUCTURES AND ENSURE COORDINATION WITH PIHP ACTIVITIES, AS APPROPRIATE.

- PROVIDE LEADERSHIP AND COORDINATION FOR THE PIHP PERFORMANCE IMPROVEMENT PROJECTS (PIPS).

- COORDINATE WITH THE REGIONAL COMPLIANCE COORDINATOR AND REGIONAL COMPLIANCE COMMITTEE FOR VERIFICATION OF MEDICAID CLAIMS SUBMITTED.

- DESCRIBE HOW THESE FUNCTIONS WILL BE EXECUTED WITHIN THE NMRE'S ORGANIZATIONAL STRUCTURE.

NMRE FY24 QAPIP HAS 13 GOALS

PERFORMANCE IMPROVEMENT PROJECT
GOAL 1 OBJECTIVE 1

WSA OHH Breakout: Eligible versus Enrolled						
Time Period	**Running Date** ▲	**Enrolled**	**Eligible**	**% of PE/Enrolled**	**% Enrolled Change**	**% Eligible Change**
Pre-Baseline	<=2020-09-30	284	5372	5.29%	0.00%	0.00%
Baseline	<=2021-09-30	587	7603	7.72%	106.69%	41.53%
Post-Baseline	<=2022-09-30	890	8398	10.90%	51.62%	10.46%
Year1 (NEW)	<=2023-09-30	936	6400	14.63%	5.17%	-23.79%
Year2 (NEW)	<=2024-09-30	820	7142	11.48%	-12.39%	11.59%
Year3 SUDHH	<=2025-09-30	986	7174	13.74%	5.34%	12.09%

TO IMPROVE THE NUMBER OF
INDIVIDUALS ENROLLED IN THE OPIOID HEALTH HOME (OHH) PROGRAM BY 9/2024 (DATA 12/4/24)

GOAL 1 OBJECTIVE 2

HHBH Comparison of Receiving HHBH Waiver Services versus Potential Enrollees			
Receiving BHH Waiver Services	**Enrolled + Potential Enrollees who are actively enrolled w/CMHSP**	**Percent Enrolled**	**CMHSP** ▲
155	907	17.09%	Centra Wellness Network
88	2662	3.31%	North Country CMH
97	1560	6.22%	Northeast Michigan CMH
170	3858	4.41%	Northern Lakes CMH
84	1774	4.74%	Wellvance
594	**10761**	**5.52%**	

TO IMPROVE THE NUMBER OF INDIVIDUALS ENROLLED IN THE CMHSP BEHAVIORAL HEALTH HOME (BHH) PROGRAM FROM 3.56% TO 5% BY 9/2024 (DATA 12/4/2024) WE WERE AT 4.57% IN JANUARY2024

Goal #2 progression:

The NMRE QOC, as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. The QOC will also work on improving the data quality and timeliness in reporting events.

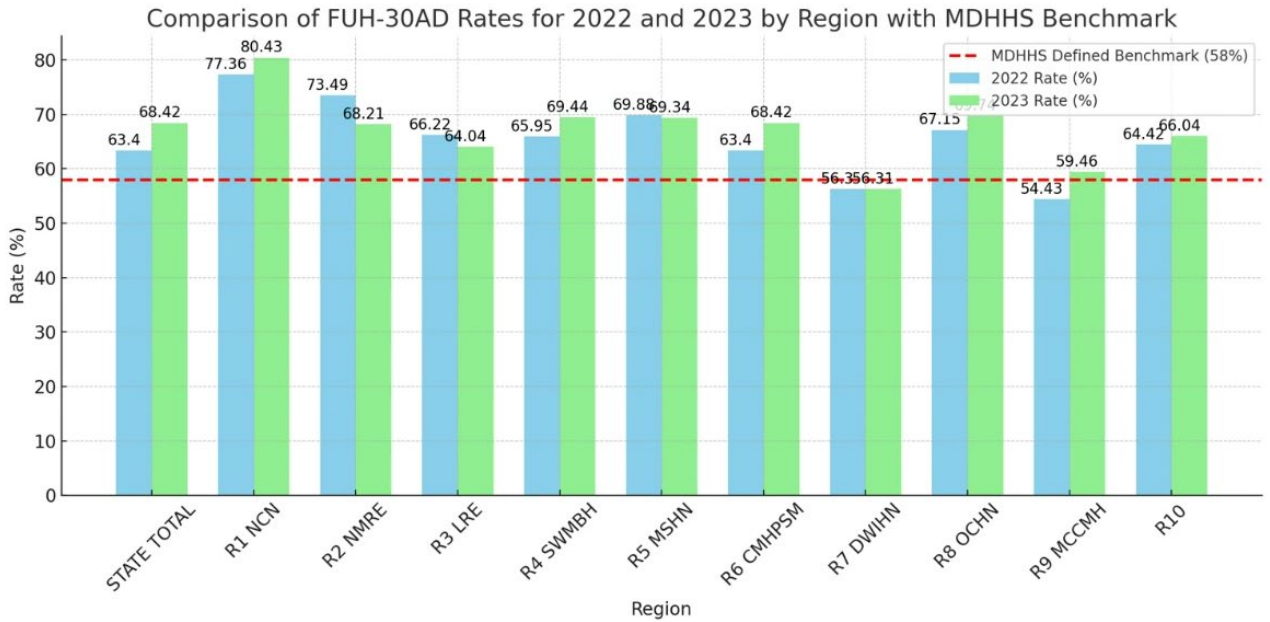
Jan 2024: An ITR has been created in order to make the changes necessary in the PCE system to allow for timely and accurate reporting of the events.

December 2024: Changes are in place and active in the system.

GOAL 6 OBJECTIVE 2

THE NMRE WILL ESTABLISH REGIONAL HEDIS MEASURES TO DEMONSTRATE THE EFFECTIVENESS OF IMPROVEMENTS IN THE QUALITY OF HEALTH CARE AND SERVICES FOR MEMBERS.

FUH - Follow-up After Hospitalization for Mental Illness



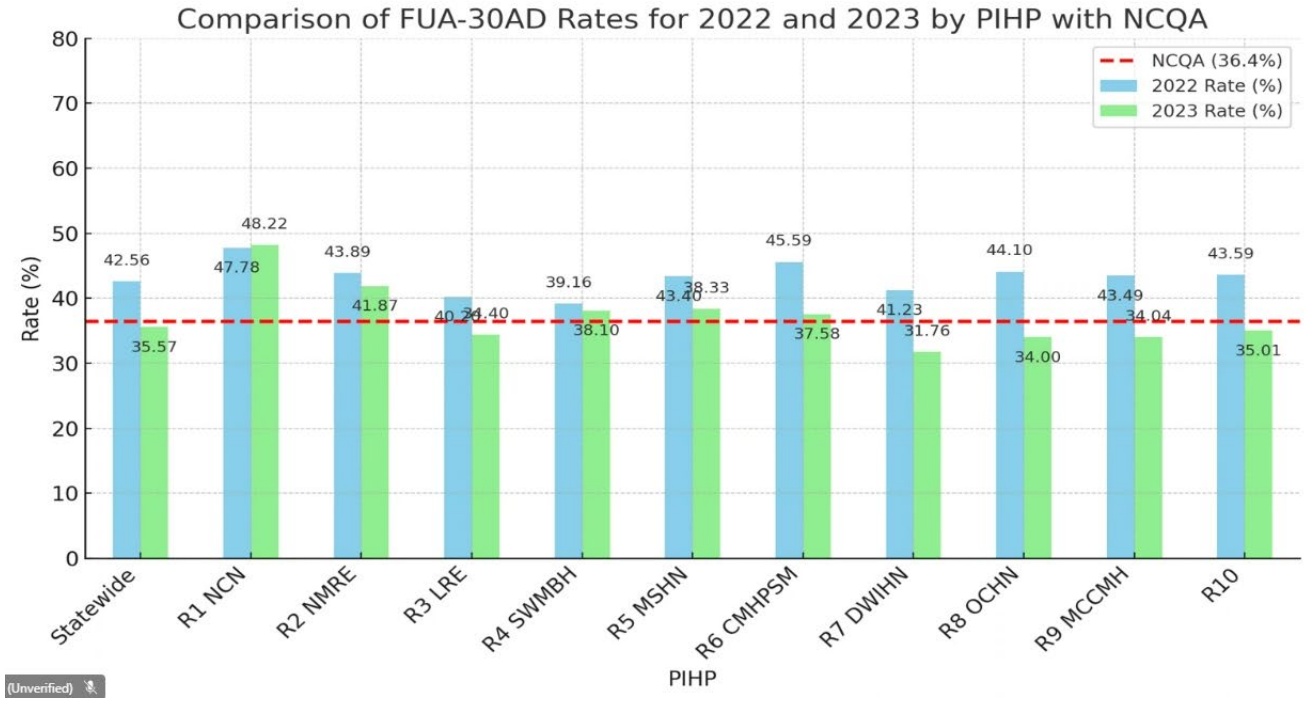
MDHHS Benchmark = 58%

FOLLOW-UP AFTER HOSPITALIZATION (FUH) FOR MENTAL ILLNESS WITHIN 30 DAYS, BENCHMARK 58%.

GOAL 6 OBJECTIVE 2

THE NMRE WILL ESTABLISH REGIONAL HEDIS MEASURES TO DEMONSTRATE THE EFFECTIVENESS OF IMPROVEMENTS IN THE QUALITY OF HEALTH CARE AND SERVICES FOR MEMBERS.

FUA - Follow-up after Emergency Department Visit for Substance Use



FOLLOW-UP AFTER (FUA) EMERGENCY DEPARTMENT VISIT FOR ALCOHOL AND OTHER DRUG DEPENDENCE.

THANK YOU

Questions?