Northern Michigan Regional Entity

Board Meeting

March 22, 2023

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – February 22, 2023	Pages 2 – 6
7.	Correspondence	Pages 7 – 44
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – No report	
	c. CEO's Report – March 2023	Page 45
	d. Financial Report – January 2023	Pages 46 – 67
	c. Operations Committee Report – Next meeting is March 21st	
	e. NMRE SUD Oversight Board Report – March 6th meeting	Pages 68 – 73
11.	New Business	
	a. FY2023 Changes to Approved PA2 Projects	Pages 74 – 75
	b. PA2 Requests	Pages 75 – 77
	c. Review of SUD Oversight Policy Board Bylaws (Discussion)	
12.	Old Business	
	a. Grand Traverse County and Northern Lakes	
13.	Presentation/Discussion	
	NMRE Information Technology (IT) Security Assessment	Pages 78 – 94
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – April 26, 2023	
16.	Adjourn	

Join Microsoft Teams Meeting

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – FEBRUARY 22, 2023
GAYLORD BOARDROOM

ATTENDEES:	**Kate Dahlstrom, Ed Ginop, Eric Lawson, Michael Newman, Gary Nowak, Richard Schmidt, Karla Sherman, Don Tanner**
VIRTUAL ATTENDEES:	**Terry Larson, Mary Marois**
ABSENT:	**Gary Klacking, Jay O'Farrell, Don Smeltzer, Chuck Varner**
NMRE/CMHSP STAFF:	**Brian Babbitt, Chip Johnston, Eric Kurtz, Brian Martinus, Diane Pelts, Brandon Rhue, Sara Sircely, Nena Sork, Deanna Yockey, Carol Balousek, Lisa Hartley**
PUBLIC:	**Madeline McConnell, Sue Winter**

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

ROLL CALL
Let the record show that Gary Klacking, Jay O'Farrell, Don Smeltzer, and Chuck Varner were excused from the meeting on this date; all other NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

APPROVAL OF AGENDA
Let the record show that no changes to the meeting agenda were proposed.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR FEBRUARY 22, 2023; SUPPORT BY ED GINOP. MOTION CARRIED.

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

MOTION BY ERIC LAWSON TO APPROVE THE MINUTES OF THE JANUARY 25, 2023 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY GARY NOWAK. MOTION CARRIED.
CORRESPONDENCE

1) The minutes from the January 5th MPHI PIHP CEO meeting.
2) The minutes from the February 2nd MDHHS PIHP CEO meeting.
3) The MDHHD Michigan Behavioral Health Crisis System Update for February 2023.
4) The MDHHS Service Delivery Transformation Section Update for February 2023.
5) MDHHS L Letter 23-04 dated February 14, 2023 regarding Direct Care Worker Wage Increases.
6) Memorandum from Farah Hanley, Chief Deputy Director for Health, to PIHP and CMHSP CEOs and medical Directors dated February 14, 2023 regarding the MI-SMART Medical Clearance Process.
7) Slide deck from Cara Poland, MD, of the Michigan Opioid Advisory Commission dated February 7, 2023.
8) A letter from the Community Mental Health Association of Michigan (CMHAM) dated January 31, 2023 regarding the 2023 Annual PAC Campaign.
9) Slide deck from CMHAM detailing "Winter 2023 Public Policy Updates."
10) NMRE "FY22 Performance Bonus Incentive Pool (PBIP) Contractor-only and MHP/Contractor Joint Metrics Deliverables/Narratives Scoring" report.
11) Letter from Jackie Sproat at MDHHS to Eric Kurtz dated February 10, 2023 accepting the NMRE's FY23 Risk Management Strategy.
12) Letter from Roslund, Prestage, and Company (RPC) to the NMRE Board of Directors dated February 7, 2023 regarding the process of the FY22 financial audit.
13) Slide deck from Eric Kurtz titled "Michigan Medicaid and Federal Waivers" given during the regional Hab Supports Waiver Training on January 26, 2023.
14) The draft minutes of the February 8, 2023 regional Finance Committee meeting.

Mr. Kurtz drew attention to the Opioid Advisory Commission report that was presented during the CMHAM Winter Conference.

CMHAM has asked for 100% participation in the Annual PAC Campaign; the five member CMHSPs and the NMRE will be submitting donations for the silent auction during June Conference.

Mr. Kurtz noted that the NMRE 100% on the FY22 Pay for Performance measures resulting in a Performance Bonus Incentive Payment of $1,725,420.19.

Clarification was made that an individual's ability to pay (as referenced in the January 5th PIHP CEO meeting minutes) is addressed in Chapter 8 of the Mental Health Code. Michigan Public Act 91 of 2022 changed the state's ability to pay standards to match to Federal guidelines for mental health and substance use disorder services.

ANNOUNCEMENTS

Let the record show that new Board Member, Michael Newman, representing North County CMHA was introduced to the group.

PUBLIC COMMENT

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

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

CEO Report
The NMRE CEO Monthly Report for February 2023 was included in the materials for the meeting on this date. Mr. Kurtz mentioned his participation at the North Country CMHS Board retreat on February 16th.

December 2022 Financial Report
- Net Position showed net surplus Medicaid and HMP of $3,517,563. Medicaid carry forward was reported as $16,367,583. The total Medicaid and HMP Current Year Surplus was reported as $19,885,146. Medicaid and HMP combined ISF was reported as $16,357,583; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $36,252,729.
- Traditional Medicaid showed $49,200,717 in revenue, and $46,777,769 in expenses, resulting in a net surplus of $2,422,948. Medicaid ISF was reported as $9,302,629 based on the interim FSR. Medicaid Savings was reported as $10,911,722.
- Healthy Michigan Plan showed $8,353,822 in revenue, and $7,259,207 in expenses, resulting in a net surplus of $1,094,615. HMP ISF was reported as $7,064,954 based on the interim FSR. HMP savings was reported as $5,455,861.
- Health Home showed $507,741 in revenue, and $372,597 in expenses, resulting in a net surplus of $135,144.
- SUD showed all funding source revenue of $7,102,768, and $5,851,495 in expenses, resulting in a net surplus of $1,251,273. Total PA2 funds were reported as $5,341,057.

Ms. Yockey drew the Board's attention to the "Schedule of PA2 by County" page of the Financial Report. Additional columns were added to provide a more accurate representation of available funds by county. Ms. Dahlstrom requested a list of projects that have been approved using Grand Traverse County liquor tax dollars, which Ms. Sircely agreed to provide.

Medicaid eligibles (number) and revenue (dollars) per category (DAB, TANF, HSW, HMP) were reviewed.

MOTION BY KARLA SHERMAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2022; SUPPORT BY ERIC LAWSON. MOTION CARRIED.

Operations Committee Report
The minutes from February 21, 2023 were distributed during the meeting. Mr. Kurtz reported that the Alpine CRU may open as early as March 2023. The region is going to pursue a similar crisis residential facility for children. Clarification was made that the Alpine CRU will be available to Medicaid beneficiaries. CMHSPs may choose to use general funds for their non-Medicaid consumers.

The Medicaid Enrollee-to-Provider ratio standards related to crisis residential capacity were reviewed:
- Adult = 16 beds pre 500,000 total population
- Children = 8 – 12 beds per 500,000 total population

It was noted that Medicaid policies are often not representative of rural areas. A meeting with the UP (and potentially members of the Northern Caucus) to discuss a rural exemption regarding Medicaid policy/service fidelity is being pursued.

NMRE SUD Oversight Board Report
Let the record show that the next meeting of the NMRE Substance Use Disorder Oversight Board is scheduled for March 6, 2023 at 10:00AM.

NEW BUSINESS
Let the record show that there was no New Business to present to the Board during the meeting on this date.

OLD BUSINESS
Grand Traverse County and Northern Lakes CMHA
Mr. Kurtz reported that the new Commissioners within the NLCMHA catchment area are getting up to speed on the issue with Northern Lakes CMHA. They have expressed a strong commitment to getting the Enabling Agreement rewritten in a timely manner. The next meeting of the six County Administrators (Crawford, Grand Traverse, Missaukee, Leelanau, Roscommon, and Wexford) is scheduled for March 3rd at 9:30AM.

PRESENTATION
Public Act 2/Liquor Tax Funding
NMRE SUD Grant Director, Sara, Sircely was in attendance give a presentation on Public Act 2 (liquor tax) funding.

- Pursuant to Public Act 206 of 1893, Regional Entities (previously Coordinating Agencies) receive liquor tax funds/PA2 funds from each of the counties in their regions. The funds are to be used for the express purpose of substance use disorder prevention, treatment, and recovery support services within the county from which the funds originated.
- Licensed providers (or governmental entities) may apply for liquor tax funds at any time; the application is located on the NMRE.org website. Applications must be received by the first of the month prior to scheduled NMRE SUD Oversight Board meetings.
- Prior to being brought before the NMRE SUD Oversight Board for consideration, applications are reviewed by NMRE staff and CMHSP CEOs.
- Applications approved by the NMRE SUD Oversight Board are presented to the NMRE Governing Board/Board of Directors for consideration.

Mr. Tanner noted the value in providing an annual report on initiatives funded with liquor tax dollars to the counties.

COMMENTS
Board Members
Ms. Dahlstrom announced that State Representatives and Senators are holding "coffees" in the region. She encouraged Board Members to attend and advocate for resources to secure mental health workers.

Mr. Schmidt acknowledged that State Legislators have much to learn about mental health issues. Mr. Kurtz added that a Legislative Champion is needed to move a rural exemption forward. He

expressed the need for Medicaid policy to be reviewed by a panel representing rural areas prior to promulgation.

Staff/CMHSP CEOs
Mr. Johnston noted that the Upper Peninsula (Region 1 PIHP) has concerns similar to those of the NMRE (chronic lack of staff, rural capacity issues, etc.) Conversations are occurring between the two regions to discuss rural needs and current practices.

Public
NMSAS Recovery Center Executive Director, Sue Winter, informed the Board that NMSAS currently has 300 peer recovery coaches; this coming weekend, 27 additional individuals will graduate from the program.

NEXT MEETING DATE
The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on March 22, 2023.

ADJOURN
Let the record show that Mr. Tanner adjourned the meeting at 11:36AM.

Regional Entity CEO Group

Jim Johnson	Joseph Sedlock	Bradley Casemore
Vice Chair	Chair	Spokesperson

REGIONAL ENTITY CEO MEETING

Date: Tuesday, January 3, 2023
Time: 12:30 pm – 3:30 pm

DRAFT – Minutes

1. Welcome / Introductions

The meeting was called to order by Joe Sedlock at 12:30pm.

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

Absent: None

Guests (selected/applicable portions): Alan Bolter & Bob Sheehan (CMHA – 1:30pm), Dave Schneider, Julie Andrews & Suzanna Tritt (Wakely – 12:30pm), Anya Eliassen (Region 8)

CMHA Staff: Monique Francis

2. Agenda Changes / Previous Minutes Approval

Additions/changes to the agenda: Add Ability to Pay as Item 6B (added by Dave).

Group agreed by consensus to accept the agenda with additions/changes for January 3, 2023 and approve the minutes from December 6, 2022.

Priority/Action Items

3. Wakely Actuarial – Follow-up Discussion (Dave Schneider, Suzanna Tritt, Julie Andrews)

- Potential Scope of Work; specifics for proposal development

Group discussed the list of scope of work created by Brad. Group agreed to use this to begin discussions for Wakely to create a scope of work with costs associated with that. Joe Sedlock thanked Wakely for their previous presentation on these efforts. He explained that the PIHPs are interested in possibly contracting with Wakely for actuarial services depending on the proposed scope of work and costs from Wakely. Dave Schneider explained that Wakely is speaking with the Association and wanted everyone to understand that they do not want to double dip or be redundant in services offered that may extend to PIHPs as Association members. He stated that he fully understands that PIHPs have different needs actuarially than other members of the Association. Joe Sedlock stated that the PIHPs do have some differences in interests of other CMHA members, but sometimes they do align. Julie Andrews from Wakely stated that she has experience with MCOs through the Aged Association and other organizations in Michigan as well. Suzanna Tritt stated that she also has worked with clients on rate negotiations and rate setting process for BH rates, physical health and pharmacies. She also does Medicare bids and quality/value-based care.

Joe stated that he is interested in having an actuarial firm to perform a service of identifying trouble spots with the State's current rate setting process and how to solve any of those issues. Suzanna wondered where the biggest source of dissonance was. Joe stated that sometimes PIHP and CMH matters are treated the same. This presents issues with the financing mechanism for the PIHPs. Dave Schneider agreed, stating that some items (such as risk reserves, for example) are more important to the PIHPs than the CMHs. Joe explained that the Department uses a variety of ways to finance the PIHP system – Rate setting, CCBHCs, possible tiered rates for residential and hospital inpatient populations. Eric Doeh explained that the CCBHC is a perfect example of the differences in PIHP and CMH funding dynamics. Joe explained that Detroit-Wayne, Macomb and Oakland are the only 3 CMH/PIHPs eligible to be CCBHCs – the other 7 Regions are strictly PIHPs therefore cannot become a CCBHC. Macomb County is already a CCBHC. Suzanna stated that as far as putting forth a proposal, she wondered if she should create 10 separate contracts and would there be 10 separate meetings with Milliman. Joe stated that it will

likely be a contract with each of the participating PIHPs. It may not be all 10. He stated that all 10 CEOs realize that we are trying to impact the statewide system, and those who don't contract with Wakely will still likely benefit from any work done with Wakely. Dave stated that the pricing will likely be based on how many of the 10 contracts with Wakely – shared costs between those who do contract with them. Joe stated that a known price point would be helpful and appreciated. Tim Kangas stated that Wakely will likely find that those who choose to participate will have similar, common needs in the scope of work expected. Eric Doeh stated that he felt the scope of work presented by Wakely should represent those more common needs for the entire system of PIHPs as a whole would benefit from. Dave stated that CCBHC payment model and risk reserves would be included. Joe stated that participation in the rate setting process (pre and post work) would need to be included. Mary stated that with LRE already entering into a contract with Wakely, and if/when the scope of work intersects with the Association's work with Wakely, that is when she will stop her contract with Wakely. Joe clarified that the PIHPs are in a process, and it is likely that similarities with the Associations contract will occur. Julie Andrews wondered if some Ad Hoc work should be included in the proposal. James Colaianne stated that he felt this may be needed due to the differences discussed earlier in this conversation. He referenced percentage swing factors chosen by Milliman to be used in the past. Mary stated that risk analysis is needed to determine if 7.5% is truly enough. Dave stated that Wakely won't advocate for one methodology or another… they will help determine which is more sound. Joe clarified that this is what the PIHPs want – they just want Wakely to let the PIHPs know, and THEY will advocate as they feel appropriate.

Group debrief after discussion:

Eric Doeh felt that the discussion went well to show Wakely that the PIHPs needed a unified, whole system approach. Joe asked the group when it would be appropriate to discuss possible contracting with Wakely with the Association. Tim felt that after a proposal was forthcoming from Wakely would be a good time to discuss with CMHA. Dana stated that the Association may already have some knowledge of discussions taking place. James felt that we could let Bob Sheehan know what scope of work the PIHPs are looking for. Eric Doeh stated that Bob likely knows discussions are taking place, but no benefit is apparent for speaking with Bob prior to the proposal. Group agreed.

4. February Meeting: Resolve Conflict with Association Winter Conference (All)

Group discussed options (cancel, hold meeting at conference, alternate date, etc.). Joe suggested to cancel, with the understanding that the group can convene on site if any items arise that call for the need to NOT cancel the meeting. Joe will let the group know via email by January 25, 2023. James suggested moving the meeting to January 31, 2023. Group voted and decided to tentatively cancel the February meeting, with the option to hold if needed.

5. H0020 ($19/bundled rate) – Redux (Jim)

Jim Johnson asked if everyone has implemented this rate and how they are doing this. He reported that Region 10 has not implemented this yet. Regions 4, 5 and 6 are implementing and doing a retro payment back to October. Regions 3 and 7 has put an inquiry into the Department and has not implemented. Region 3 is as well. Regions 1 and 2 have implemented. Region 8 has not implemented.

6A. Mental Health Diversion Council (Brad and Eric D.)

Minutes were shared with the group which included the strategic plan. No discussion.

6B. Ability to Pay Schedule (added by Dave)

Dave Pankotai stated that Richard Carpenter wrote the State to let them know that PIHPs were holding off on this. Dave would like to invite Richard to the meeting on Thursday with the State. None objected. Dave will extend that invitation and let Jeff Wieferich know.

7. Michigan Opioid Advisory Commission Updates (Brad)

- Communications Interfaces

Brad stated that these interfaces are up for review at next week's meeting. He stated that the Opioid dollars for local municipalities are being held up due to them being a party of the class action suit. These dollars cannot be moved until that suit is settled. Brad stated that Dr. Kara Poland is doing one of the keynotes at the CMHA Winter Conference in Kalamazoo. He encouraged everyone to attend if they could.

8. Michigan Autism Council Updates (Dana)

Dana provided updates to everyone via email.

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

- No update – Next meeting is 1/27/2023.

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

- Inpatient

No Update.

- SUD Provider Performance Monitoring Reciprocity:

Update provided in packet. No discussion.

11. Training Reciprocity (A. Dillon/Joe)

- Update attached. No discussion.

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

- No report.

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

- December notes provided in packet.
- Discussion: DEI reporting request

  Jim stated that the group has discovered this was not mandatory. The group is pushing to find out the purpose and value of this request. Network adequacy was discussed. Jim urged all CEOs to discuss with their SUD Directors. Joe asked if the CEOs need to intervene on the DEI topic. Jim stated that the SUD Directors are still in discussions with the State, so no action needs to be taken by CEOs at this time. Brad stated that this request was flawed in content and format. He felt there was no basis for it and it appeared to be a waste of time. Group discussed and agreed that this did NOT need to be brought up at the Department meeting this week.

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

- No update.

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

- No update.

16. PIHP Parity Workgroup – Update/Status (A. Ittner/James)

- November notes provided in packet.

17. Provider Alliance Update (Joe)

- No update.

18. MDHHS/PIHP Operations Meeting Planning (All)

- Next meeting is January 5, 2023.
- Topics to Add to Agenda (if any)
  - Hope Not Handcuffs (lead will be Dave)
  - H0020 (lead will be James)
  - Non-negotiable change amendment
    - Group discussed. Mary informed the group that LRE will NOT be signing this amendment as this is primarily what her lawsuit with the State is based on. Her court hearing is coming up on January 23, 2023, and she will keep the group informed on this.

19. CMHA Legislation & Policy Committee (Jim)

- No Update/No Report.

20. CMHA Coordination (A. Bolter, B. Sheehan – not available to attend this meeting)

- Legislative Update (Alan Bolter)

  Alan reported that committee assignments will not be know for the next couple of weeks. Swearing in will be on January 11, 2023. The Governor will have her State of the State on January 25, 2023. He reported that a Mental Health sub-committee may be created under the Health Appropriations committee.
- Health Plan Rebid (Bob Sheehan)

  Covered in other discussions.
- DSNP (Bob Sheehan)

Bob asked that if anyone heard any rumors, please share with him… Joe Sedlock emailed Erin Emerson for a status update. Erin stated that a response should be expected by late January. Bob stated that a guest speaker has been invited to speak the afternoon of the January Directors Forum on this issue.

- Re-emergence of continued momentum around movement of the Medicaid benefit (physical and behavioral health) for children in the state's foster care system to the private health plans (Bob Sheehan)
- Bob Sheehan spoke about the Foster Care Medicaid benefit. He stated that he spoke with Director Hertel and it became clear that they did not understand how this benefit worked. Connie Conklin and others will meet next week to discuss the following (among many other topics):
  Roles of foster parents
  Workforce shortage issues
  Foster child long term residential
  Hospital beds and availability
  Services to children in CCI
- Joe Sedlock asked what we are doing to provide a public option or PIHP alternative to make an improvement in Foster Care. Bob stated that we are advancing ideas and developing a potential role for a private partnership. Joe stated that we need to help the State understand that the public system is here to help solve the placement problems, not fight against them. Brad stated that maybe the PIHPs could propose Care Management/Coordination for this population. The previous proposal for the Unenrolled could be converted to a different population with the constructs being so similar. Joe stated that the proposal could be repackaged to show that PIHPs are ready to do this now. Eric Doeh stated that recently the Department has reached out to them on issues where doctors had already made their rulings and conversations were taking place where favors were asked to place children when they weren't supposed to. Eric has told them to put the request in writing to cover their backs, but it was just inappropriate. The Department does not understand that this is not our role – we can do it, but we're not the ones that are supposed to be doing it. Sometimes there isn't even a code to accomplish what is being asked of the PIHPs. The Department is viewing this is resistance to help the situation. Jim Johnson gave examples of the State going to foster families without the PIHP even knowing it.
- A potential April date for the end of the federal PHE
  Bob asked if anyone hears anything different, please let him know.
- James asked Bob and Alan to keep in mind the Convention Center bonds, stating that he would like to make sure this does not come out of PA2 dollars.

OTHER: No other business.

ADD to March Agenda:

1. None identified.

Meeting adjourned at 2:25pm.

Respectfully Submitted,
Monique Francis, CMHA Committee Clerk

PIHP CEO Meeting
March 2, 2023
9:30 a.m. – 12:00 p.m.
Microsoft Teams Meeting

Contents

Attendees

Pre-Paid Inpatient Health Plans (PIHPs)

Megan Rooney (NorthCare Network)	Region 1
Eric Kurtz (Northern MI Regional Entity)	Region 2
Stacia Chick (Lakeshore Regional Entity)	Region 3
Brad Casemore (Southwest Michigan Behavioral Health)	Region 4
Joe Sedlock (Mid-State Health Network)	Region 5
James Colaianne (CMH Partnership of Southeast Michigan)	Region 6
Shama Faheem (Detroit Wayne Integrated Health Network (DWIHN))	Region 7
Dana Lasenby (Oakland Community Health Network)	Region 8
Callana Ollie (Oakland Community Health Network)	Region 8
Dave Pankotai (Macomb County CMH Services)	Region 9
Kelly VanWormer	Region 10

Michigan Department of Health & Human Services (MDHHS)

Debi Andrews
Kelsey Bowen
Alicia Cosgrove
Erin Emerson
Farah Hanley
Darrell Harden
Belinda Hawks
Stephanie Heywood
Nicole Hudson
Kristen Jordan
Leah Julian
Brian Keisling
Phil Kurdunowicz
Dana Moore
Lindsey Naeyaert
Ernest Papke
Ashley Seeley
Angie Smith-Butterwick
Jackie Sproat
Brenda Stoneburner
June White
Keith White
Jeffery Wieferich
Amanda Zabor

Michigan Department of Technology, Management & Budget (MDTMB)

Herve Mukuna

University of Michigan

Sarah Clark

Next Steps in the Evaluation of the 1115

1. Sarah Clark from University of Michigan was present to talk about next steps in the evaluation of the 1115. In September 2023, the interim evaluation report for the 1115 Behavioral Health Waiver will be submitted to CMS.
    a. There is a CMS approved evaluation plan in place.
    b. Phone interviews with SUD enrollees continue. Part of the evaluation process also includes interviews with PIHP SUD staff and SUD Providers around the state. That will be starting soon, with discussion focused on implementation of the ASAM continuum, treatment placement recommendations, and facilitating treatment (both initial and between levels). Capacity issues, hiring and retention issues, and the use of health IT tools will also be subjects of discussion.
    c. There will be an announcement about this at the March 24, 2023, SUD Directors meeting, and then interview appointments will be scheduled. The March 24 meeting will serve as a kickoff for this process.
    d. A PIHP asked about the relationship, if any, between the MDHHS site reviews and the reviews under the 1115?
        i. The connection is somewhat limited because the MDHHS site review process is focused on the block grant requirements and the MDHHS obligation to report to CMS. There is potentially overlap in terms of some items that are reviewed, but the reviews have two (2) different focuses. Additionally, there are elements in the standard terms and conditions of the 1115 that MDHHS is required to review, which is combined into the block grant review.

Tribal Meeting Debrief

1. Jeff Wieferich updated the group on the Tribal meeting that happened on March 1. He expressed appreciation to the PIHPs for attending the meeting, adding that it was received well by the Tribal representatives. The focus of the meeting was to look at systemic issues and potential solutions. The meeting evolved into discussion surrounding issues with specific CMHSPs or PIHPs.
    a. Jeff agreed that it was informative to hear the perspective to make some connections and address some issues. However, he would like to know from the PIHPs what could be done to better address them systemically to improve things over time.
    b. A PIHP suggested that a structure be put in place whereby Tribal Nation staff and PIHP staff have regular contact, whether be at a separately scheduled meeting from this forum, or at this forum. The PIHP feels a statewide approach would be helpful for everyone.
    c. A PIHP suggested an overview of the Tribal/PIHP/CMH Link and the processes behind that. Perhaps a primer for this group.
    d. A PIHP expressed understanding of the Tribal Nations' point of view, as they are a different than every other kind of referral source. They are governments and have a unique relationship with the State. However, at the clinical level, the PIHPs can't just "take someone's word" for the condition of an enrollee who is coming into the PIHP system where the PIHP will then be responsible. The PIHPs would look at the Tribal assessment, but the PIHPs are ethically obligated to complete their own assessment and order treatment based on the PIHPs understanding of the enrollee's condition.
    e. A PIHP shared the concern with the Tribal Nation that there is more the PIHPs can be doing to position pre-admission screening staff for a more successful interview of the enrollee with a warm transfer sort of protocol, perhaps with video and the Tribal Nation Healthcare System representative.
    f. A PIHP indicated there is a lack of understanding on both the side of the Tribal Nations and the PIHPs about which entity is responsible for what.

g. A PIHP suggested, that if meetings with Tribal Nations occur again, an agenda to keep discussion focused on the issues at hand would be helpful to drive the conversation. The suggestion was also made to have Tribal Nation and PIHP contact information shared with each other.
h. A PIHP reminded the group that cultural competency training was also discussed at the meeting with the Tribal Nations and how that would be helpful for the PIHPs to engage in to learn more.

Children's Bureau Update

1. Alicia Cosgrove introduced Phil Kurdunowicz, who presented Children's Bureau updates on MIKids Now, Home-Based Services certifications, Autism services, and new staff joining the Bureau.
    a. The Bureau is working FY2024 funding for MIKids Now.
        i. The goal is a three (3) year program, but the funding is being handled annually.
        ii. Best practices for mobile response are being learned and will be incorporated into Medicaid policy.
        iii. There is a Cohort 2 being developed and the timeline will be shared as soon as it is available.
    b. Home-based recertifications will be starting in April 2023. A memo is being developed to provide details on the timeline for the certification process.
        i. The intent is to transition into the new customer relationship management platform (CRM), and information regarding that will be included in the memo.
        ii. PIHPs and CMHs are being trained in the new CRM platform.
        iii. The certification information is not due on April 1. The process will be kicking off in April, allowing for a longer timeline.
    c. There has been a lot of change surrounding the management of the Medicaid funded autism services benefit.
        i. These changes have prevented proactive review of Medicaid policies as it relates to Autism services.
        ii. The Bureau is in the position now to revisit Autism service policies and identify gaps/missing areas that can be strengthened.
        iii. The goal as a Bureau is to develop an Autism services regulatory agenda, which will take the form of a PowerPoint and will spell out the work that will be completed with Autism service policies.
        iv. It is hoped a presentation will be made in the next couple of months on this new agenda.
    d. There is an update related to the structure of the Bureau. A new Home and Community Based Services Policy and Implementation Section Manager has been hired in the Access Standard, Service Array, and Policy Division.
        i. Dr. Amanda Lopez has experience with the CMH system and working for Central Michigan University. She will be joining MDHHS on March 19, 2023.
    e. A PIHP asked MDHHS to revise and republish a staff listing for the PIHPs.

Strategic Behavioral Health Integration and Coordination Initiatives

1. Lindsey Naeyaert shared that three (3) new staff have been brought on board since the last PIHP CEO meeting, including Danielle Hall (Behavioral Health Innovation Specialist), Jennifer Ruff (CCBHC Certification Specialist), and Hailey Dziegelewski (CCBHC Analyst).
2. Lindsey updated the group on CCBHC, Behavioral Health Homes (BHH).
    a. CCBHC states received expansion guidance. Michigan will not be expanding during FY2023. It is being considered for FY2024.

b. In terms of BHH, staff are working on policies and state plan documents for upcoming BHH expansion and will be hosting a kickoff for a new region on March 23/24.

HCBS Update

1. Belinda Hawks provided the HCBS update, including the sun setting of the Supports Intensity Scale contract.
    a. The contract will end on March 23, 2023. A meeting with the Steering Committee will take place next week to talk through next steps.
    b. There are assessments in progress and scheduled. Once the contract terminates, the current assessment tool will not/cannot be used.
    c. MDHHS is working to ensure continued access to data through what was available online and through the warehouse.
    d. More information will be shared at the PIHP Contract Negotiation Meeting on March 24.
    e. A PIHP commented about staffing issues that will need to be considered since there are dedicated staff for the assessment and asked about the sudden change.
        i. Belinda indicated that, during the renewal process of the contract with the vendor, other factors such as privacy and security upgrades were being considered. Some serious concerns surrounding privacy and security were raised.
        ii. There was also feedback statewide that the ability to maintain an assessor pool and quality lead pool for the fidelity of the assessment tool was being challenged significantly.
    f. A PIHP asked about a timeline to announce a replacement tool and/or the staff qualifications for administering the assessment.
        i. Belinda indicated they want to have a plan formalized by March 23.
    g. Two (2) PIHPs asked for clarification to ensure understanding that all assessments currently in progress need to be completed by March 23, 2023, and that on March 24, 2023, and beyond, the assessment is not required. The current assessment tool cannot be used, and assessments cannot be completed. Belinda confirmed that understanding.

Public Health Emergency Unwind

1. Nicole Hudson provided information surrounding the Public Health Emergency Unwind. In December 2022, Congress passed the Consolidated Appropriations Act that included the delinking and the decoupling of the Medicaid continuous enrollment requirement from the public health emergency. MDHHS has been working with CMS to get more guidance on what the continuous enrollment decoupling looks like with the goal of maximizing Medicaid coverage. MDHHS will begin redeterminations in June 2023 with "passive renewals" beginning in April 2023.
    a. Nicole shared information on the MDHHS website 2023 Benefit Changes (michigan.gov)
    b. Specific renewal timelines are also located on the MDHHS website Eligibility Notification Timeline (michigan.gov)
    c. There is a comprehensive communications plan happening, with radio ads, audio streaming, mobile phone ads, social media ads, and work with minority media outlets. Additionally, staff have been working closely with Medicaid Health Plans, providing them with guidance on permissible outreach.
    d. Efforts are underway to enhance and train staffing at local DHHS offices to ensure that the redetermination packets will be processed timely.
    e. Staff are also working to ensure enrollees who are no longer eligible for Medicaid has a smooth transition to the Marketplace.

f. Nicole shared information on the stakeholder toolkit, which is located on the website Stakeholder Toolkit (michigan.gov).
g. Nicole's email is hudsonn2@michigan.gov.

MPCIP & MI CAL Update

1. A written update will be sent to the PIHPs.

PIHP Contract Update

1. Jeff Wieferich indicated that the MDHHS/PIHP contract is moving back to an annual agreement.
    a. There have been some challenges with managing amendments, as well as confusion in other areas.

Ability to Pay

1. Debi Andrews introduced herself. She is the Manager for the Data Payment and Integrity section under the Division of Contracts and Quality Management and will be leading the Ability to Pay workgroup.
    a. The first meeting will be as soon as possible, hopefully the week of March 13, 2023.

While the entire document is open for editing, the sections in which considerable additional development and detail are needed, by leaders of rural CMHs and PIHPs, are highlighted.

Community Mental Health Association of Michigan

Proposal for rural-oriented public mental health policies and practices in Michigan

February 2023

Summary

This paper identifies the need for a concerted and permanent set of actions to ensure that policies and practices, binding upon and used by the state's public mental health system, are flexible enough to ensure that the needs of Michigan's rural and frontier communities and regions are met.

Background

Michigan's communities are extremely diverse along a number of dimensions. One of those dimensions – the theme of this paper - centers around the diversity across Michigan's urban (large and small), suburban, rural, and frontier communities. The rural vs urban diversity (simplified to this two-segment framework for ease in communication and analysis) is reflected in the very different strengths, cultures, approaches, relationships, and challenges of these community types.

Understanding this rural vs urban diversity is key when designing and implementing policies that guide and practices that are used by the state's public mental health system. [1] Failing to reflect, in policy and practice, the unique qualities (strengths, cultures, approaches, relationships, and challenges) of Michigan's rural and frontier communities and regions, and the public mental health system serving them, results in ineffective or inefficient (or, at times, impossible to meet) mandates and approaches to serving the mental health needs of these communities and regions.

Issues unique, in kind or degree, to rural and frontier communities and mental health organizations who serve them; and initial thoughts on methods to address them

A. Behavioral health workforce shortage – Need to outline uniquely high vacancy and turnover rates and factors that make it especially difficult to recruit and retain behavioral health staff in rural and frontier communities. **That this has been the case long before the recent pandemic**

Initial thoughts on approaches to address issue: Need thoughts/recommendations. **I believe Eric mentioned the Idea that before the State initiates or agrees to EBPs or systemic programmatic approaches that they are run through or approved by a Rural/Frontier Caucus? I would defer to Eric here. My thoughts would be similar in that there must be rural EBPs and the list of those is painfully short. But you mentioned this below.**

[1] The terms "mental health" and "behavioral health" are used interchangeably in this paper and refer (for simplicity in communication) to a system that serves the need of persons with mental health illness, children and adolescents with emotional disturbance, persons with intellectual/developmental disabilities, and/or persons with substance use disorders.

Also I think it would be wise for MDHHS to establish an "Office of Rural Affairs" or something along this line that would look at all rural health including Behavioral Health.

B. Mental health clinical models, designed for urban/suburban communities, that need to be tailored the needs of rural and frontier communities. Examples include:

- ACT teams
- Psychosocial Rehabilitation units (clubhouses)
- Consumer-run drop in centers
- Mobile crisis teams
- Crisis Stabilization Unites
- Adult and Children's Crisis Residential

Initial thoughts on approaches to address issue:
1. Revise the following to ensure flexibility in the clinical models allowed and/or required to carry out the clinical/service delivery purposes of the modalities listed above (and others), to allow for the tailoring of these service delivery/clinical models to meet the needs of rural/frontier communities:

  - Michigan Medicaid Provider Manual
  - Michigan's Medicaid State Plan and relevant Medicaid waivers
  - MDHHS-CMHSP and MDHHS-PIHP contracts

2. Include, in statute or rule, that Medicaid behavioral health policies be provided to the CMHA Rural Caucus for review and comment prior to the promulgation of the final policy.

C. Additional issues:

Proposed approach to further the development and implementation of these of methods.

1. Form a rural and frontier caucus, within CMHA, to:
  - Further refine this document and its purpose
  - Serve to continually identify and make recommendations to address rural issues.

2. Submit to and discuss with MDHHS, the recommendations in this document

3. Ally with other health and human services providers serving rural and frontier communities and regions in Michigan to advocate for the adoption of these recommendations by MDHHS. Potential allies include:
  - Michigan Association of Counties
  - Four major statewide advocacy groups (NAMI, Arc, MHAM, ACMH)
  - Michigan Health and Hospital Association and its staff working to support the work of Critical Care Hospitals (rural hospitals)
  - Michigan Center for Rural Health at Michigan State University
  - Michigan Sheriffs Association

4. Identify and enlist the support of Michigan legislators representing rural and frontier communities in the advocacy effort around the adoption of these recommendations by MDHHS

5. Additional actions

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

February 8, 2023

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

Dear Mr. Engelhardt,

The Centers for Medicare & Medicaid Services (CMS) released a final rule, CMS 4192-F, that significantly impacts Michigan's MI Health Link (MIHL) program. Under the rule all State Medicare-Medicaid Plans (MMPs), like MIHL, will terminate on December 31, 2023, unless the program is converted to an "integrated" Dual Eligible Special Needs Plan (D-SNP). To convert to the new program structure/model, Michigan submitted its initial "transition plan" to CMS on September 30, 2022.

MDHHS has solicited input from key stakeholders and plans to transition its MI Health Link program to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) that integrates long-term service and supports (LTSS). In this new model, contracted managed care plans will provide most covered benefits for their dual-eligible enrollees, but specialty behavioral health services will remain carved out. This decision reflects current state statute that requires a carve out of specialty behavioral health services. This option does incorporate a degree of integration (physical health + LTSS, including Home and Community Based Services (HCBS) and Long-term care (LTC)), though not the full integration afforded under the Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) given the limitations due to existing statute.

In order to seamlessly transition to a HIDE + LTSS SNP model, MDHHS leadership is exploring the following:

- Facilitate a phased approach by first transitioning the MI Health Link program on January 1, 2026, and pursuing statewide expansion thereafter.
- Develop a new Managed Care program for the HIDE + LTSS SNP model that directly contracts with, and capitates, participating plans to allow for stronger quality oversight at the State level.
- Procure HIDE + LTSS SNPs by October 31, 2024, for a January 1, 2026, contract effective date.
- Limit coordination-only D-SNPs to regions that do not have procured HIDE + LTSS D-SNPs to promote integration.

- Require Exclusively Aligned Enrollment in the new HIDE + LTSS SNP model.
- Limit enrollment in the new HIDE + LTSS SNP to full benefit duals who are 21 years or older.
- Maintain the current MI Health Link benefit package to the extent possible through the contracting process, including 1915(c) Home and Community Based Services (HCBS).
- Develop and require integrated materials, including appeals and grievance materials, for new HIDE + LTSS SNP model.
- Develop a robust quality oversight program, similar to the existing MI Health Link program, that evaluates the HIDE + LTSS SNPs at the plan level rather than the parent organization level.
- Organize a Beneficiary Advisory Committee for the new HIDE + LTSS SNP model to inform program improvements and quality initiatives.
- Maintain an Ombudsman Program to support beneficiaries through the transition to the new model and with the new model moving forward.
- Continue to facilitate stakeholder engagement opportunities to gather input and inform the new program's constructs.

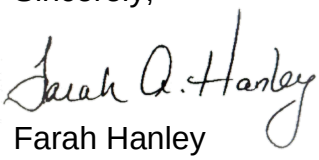
MDHHS is committed to working with CMS and stakeholders through the transition and looks forward to next steps in the program design process.

Critical Timelines:

Procurement of HIDE + LTSS SNPs to be completed by **October 31, 2024**
Procured HIDE + LTSS SNPs to submit D-SNP applications to CMS by **November 2024**
Program transition to the HIDE + LTSS SNP must be completed **by January 1, 2026**

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

Sincerely,



Farah Hanley
Chief Deputy Director for Health

ar/sw/FAH

Attachment

cc: Scott Wamsley, Director, Bureau of Aging, Community Living, and Supports
Erin Emerson, Director, Strategic Partnerships and Medicaid Administrative Services
Meghan Groen, Senior Policy Advisor to the Director
Nicole Hudson, State Assistant Administrator
Pam Gourwitz, Director, Integrated Care Division
Allison Repp, Section Manager, Integrated Management Programs

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

DATE: February 28, 2023

TO: Executive Directors of Pre-Paid Inpatient Health Plans (PIHP) and
Executive Directors of Community Mental Health Services Programs (CMHSP)

FROM: Jeffery L. Wieferich, M.A., LLP JW
Director
Bureau of Specialty Behavioral Health Services
Behavioral and Physical Health and Aging Service Administration (BPHASA)

SUBJECT: Support Intensity Scale Contract

Michigan Department of Health and Human Services (MDHHS) has had a contract with the American Association on Intellectual and Developmental Disabilities (AAIDD) for the use of their assessment tool, the Supports Intensity Scale (SIS-A) since 2014. The current contract is due to expire on March 23, 2023. This memo is to inform you of MDHHS's decision to not pursue a renewal of the contract with AAIDD for the use of the Supports Intensity Scale (SIS-A). We will be meeting with the vendor, AAIDD on February 28th and will develop a phase out plan by March 15th.

We will continue to work with the PIHP's, CMHSP's, and SIS steering committee members to communicate any updates as appropriate. We expect this decision will be seen as a welcomed change as we continue to respond to critical feedback from our external partners, ongoing workforce challenges and review efficiencies gained in aligning our efforts across the behavioral health system.

c: Farah Hanley
Belinda Hawks
Lyndia Deromedi

Bulletin Number: MMP 23-10

Distribution: Practitioners, Hospitals, Nursing Facilities, Federally Qualified Health Centers (FQHC), Local Health Departments (LHD), Rural Health Clinics (RHC), Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHP), Medicaid Health Plans (MHP), Indian Health Centers (IHC), School Services Program (SSP) Providers, Dentists, Dental Clinics, Dental Health Plans, Hearing Aid Dealers, Cochlear Implant Manufacturers, Audiologists/Hearing Centers, Vision Providers

Issued: March 2, 2023

Subject: Telemedicine Policy Post-COVID-19 Public Health Emergency

Effective: May 12, 2023

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services (MOMS), MIChild

The purpose of this bulletin is to update program coverage of telemedicine services after the conclusion of the federal COVID-19 Public Health Emergency (PHE) and to clarify which bulletins are now discontinued as of the date indicated. **NOTE:** MSA 20-09 and MSA 21-24 are permanent policy and remain in effect unless indicated per this policy. These two policies should be considered alongside this policy when considering MDHHS Post-PHE Telemedicine Policy as a whole.

I. General Telemedicine Policy Updates

Telemedicine is the use of telecommunication technology to connect a beneficiary with a Medicaid-enrolled health care professional in a different location. The Michigan Department of Health and Human Services (MDHHS) covers both synchronous (real-time interactions) and asynchronous (over separate periods of time) telemedicine services. MDHHS requires that all telemedicine policy provisions within this policy and other current policy are established and maintained within all telemedicine services.

Along with general telemedicine policy, specific program considerations (as listed within this policy) must be upheld during all telemedicine visits unless otherwise stated. The specific program section provides additional requirements and offers further clarification as needed. These should always be considered in combination with all general telemedicine policy.

Recognizing that telemedicine can never fully replace in-person care, MDHHS has established the following principles to be used by MDHHS-enrolled providers during the provision of telemedicine services:

A. Effectual services – a service provided via telemedicine should be as effective as its in-person equivalent, ensuring convenient and high-quality care.

B. Improved and appropriate access – the right visit, for the right beneficiary, at the right time by minimizing the impact of barriers to care, such as transportation needs or availability of specialty providers in rural areas.

C. Appropriate beneficiary choice – the beneficiary is an active participant in the decision for telemedicine as a means for service delivery as appropriate (e.g., Does the beneficiary prefer telemedicine to an in-person visit? What is the optimal combination of ongoing service delivery for the individual? etc.).

D. Appropriate utilization – ensure providers are utilizing telemedicine appropriately and that items A-C above are taken into consideration when offering these services.

E. Value considerations – telemedicine visits should yield the desired outcomes and quality measures; health outcomes should be improving and remain consistent with in-person care at a minimum.

F. Privacy and security measures – providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy/security regulations as applicable.

II. Determination of Appropriateness/Documentation

Telemedicine must only be utilized when there is a clinical benefit to the beneficiary. Examples of clinical benefit include:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services.
- Treatment option for a beneficiary population without access to clinically appropriate in-person treatment options.
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- Decreased number of future hospitalizations or physician visits.
- More rapid beneficial resolution of the disease process treatment.
- Decreased pain, bleeding, or another quantifiable symptom.

Furthermore, telemedicine must only be utilized when the beneficiary's goals for the visit can be adequately accomplished, there exists reasonable certainty of the beneficiary's ability to effectively utilize the technology, and the beneficiary's comfort with the nature of the visit is ensured. Telemedicine must be used as appropriate regarding the best interests/preferences of the beneficiary and not merely for provider ease. Appropriate guidance must be provided to the beneficiary to ensure they are prepared and understand all steps to effectively utilize the technology prior to the first visit. Beneficiary consent must be obtained prior to service provision (see policy for "Consent for Telemedicine Services" in MSA 20-09 for further information).

As standard practice, in-person visits are the preferred method of service delivery; however, in cases where this option is not available or in-person services are not ideal or are challenging for the beneficiary, telemedicine may be used as a complement to in-person services. Telemedicine services cannot be continued indefinitely for a given beneficiary without reasonably frequent and periodic in-person evaluations of the beneficiary by the provider to personally reassess and update the beneficiary's medical treatment/history, effectiveness of treatment modalities, and current medical/behavioral condition and/or treatment plan. Applicable beneficiary records must contain documentation regarding the reason for the use of telemedicine and the steps taken to ensure the beneficiary was provided utilization guidance in an appropriate manner.

In special situations, depending upon the needs of the beneficiary, providers may opt to deliver the majority of services via telemedicine. If this situation occurs, it must be documented in the beneficiary's record or in their individual plan of service (IPOS). This situation should be the exception, not the norm. (Refer to the program-specific subsections of this policy for specific guidance regarding this benefit.)

All services provided via telemedicine must meet all the quality and specifications as would be if performed in-person. Furthermore, if while participating in the visit the desired goals of the beneficiary and/or the provider are not being accomplished, either party must be provided the opportunity to stop the visit and schedule an in-person visit instead (refer to the "Contingency Plan" section of bulletin MSA 20-09 for such instances). This follow-up visit must be provided within a reasonable time and be as easy as possible to schedule.

III. Prior Authorization Requirements

There are no prior authorization (PA) requirements when providing services via telemedicine for Fee-for-Service (FFS) beneficiaries or for those accessing Behavioral Health Services through Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) unless the equivalent in-person service requires PA. Authorization requirements for beneficiaries enrolled in Medicaid Health Plans (MHPs) may vary. Providers must refer to individual MHPs for any authorization or coverage requirements.

IV. Face-to-Face Definition

When referenced within MDHHS Telemedicine Policy, face-to-face refers to either an in-person visit, or a visit performed via simultaneous audio/visual technology.

V. Privacy and Security Requirements

When providing services via telemedicine, sufficient privacy and security measures must be in place and documented to ensure confidentiality and integrity of beneficiary-identifiable information. This includes, but is not limited to, ensuring any tracking technologies used by websites, mobile applications, or any other technology used, comply with applicable law regarding use or disclosure of beneficiary-identifiable information. Transitions, including beneficiary email, prescriptions, and laboratory results, must be secure within existing technology (i.e., password protected, encrypted electronic prescriptions, or other reliable authentication, techniques). All beneficiary-physician email, as well as other beneficiary-related electronic communications, should be stored and filed in the beneficiary's medical record, consistent with transitional recordkeeping policies and procedures.

VI. Telemedicine Reimbursement Rate

Effective as indicated, the reimbursement rate for allowable telemedicine services will be the same (also known as "at parity") as in-person services. This means that all providers will be paid the equivalent amount, no matter the physical location of the beneficiary during the visit. To effectuate this policy, the provider must report the place of service as they would if they were providing the service in-person. See the "Telemedicine Billing Requirements" section of this policy for further details.

This policy supersedes and discontinues bulletin MSA 20-09 (Facility Rate subsection) and bulletin MSA 20-42 (Telemedicine Reimbursement Rate Change section) per the date indicated.

VII. Audio-Only Telemedicine Policy

MDHHS supports the use of simultaneous audio/visual telemedicine service delivery, as a primary method of telemedicine service, but in situations where the beneficiary cannot access services via a simultaneous audio/visual platform, either due to technology constraints or other concerns, MDHHS will allow the provision of audio-only services for a specific set of procedure codes.

These procedure codes include the telephone only CPT/HCPCS codes (99441-99443 and 98955-98968) along with the following codes:

1. Physical Health/Mild-to-Moderate Behavioral Health:
    a. Psychotherapy services for adult or child (up to 45 minutes) (90832, 90834, 90839, 90840 and 90785)

   b. Genetic and preventative counseling services (96040)
   c. Risk Assessments (96160 and 96161)
   d. Office visits for established patients up to 19 minutes (99212)
   e. Preventative counseling (99401, 99402, 99403 and 99404), Behavioral Change Counseling for smoking (99406, 99407) and diabetes management (G0108)
   f. Screening Brief Intervention and Referral to Treatment Services (SBIRT) (99408 and 99409)
   g. Transitional Care Management Services (99495, 99496)
   h. Inpatient Follow-up Services (G0406, G0407 and G0408)
2. Specialty Behavioral Health Services:
   a. Psychotherapy services for adult or child (up to 45 minutes) (90832, 90834, 90839, 90840 and 90785)
   b. Assertive Community Treatment (ACT) (psychiatric services only) (H0039)
   c. Crisis Intervention (H2011) Note: does not include H2011 ICSS for Children
   d. Office visits for established patients up to 19 minutes (Psychiatrist) (99212)
   e. Assessments—Interpretation or explanation of results (90887)
   f. Substance Use Disorder Individual Assessment (H0001)
   g. Substance Use Disorder Outpatient Treatment (H0004)
   h. Substance Use Disorder Early Intervention (H0022)
   i. Substance Abuse—Outpatient Care-Recovery Supports (T1012)
   j. Supportive Employment Services for Individuals (including job coaching) (H2023 and H2025)
   k. Clubhouse Psychosocial Rehabilitation Programs (H2030)

NOTE: Current Procedural Terminology (CPT) coding changes occur frequently. Providers should consult with MDHHS fee schedules for current allowable codes which can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information. The Medicaid Code and Rate Reference Tool, located via the External Links menu in CHAMPS, may also be used to determine eligible reimbursement codes.

Additional guidelines for audio-only service include:

1. Visits that include an assessment tool—the tool must be made available to the beneficiary and the provider must ensure the beneficiary can access the tool.
2. When a treatment technique or evidence-based practice requires visualization of the beneficiary, it must be performed via simultaneous audio/visual technology.
3. Audio-only must be performed at the preference of the beneficiary, not the provider's convenience.
4. Privacy and security of beneficiary information must always be established and maintained during an audio-only visit.

To effectuate this in perpetuity, MDHHS will publish audio-only databases that will include all codes MDHHS is permitting via audio-only. These databases will be created for both

FFS/MHP providers and for those providers within the PIHP/CMHSP system and will be maintained on the MDHHS website. MDHHS will, on a regular and ongoing basis, assess the audio-only databases and will add/remove codes as needed. Some of the criteria used to determine addition/removal from the audio-only database include provider/stakeholder feedback, new coding guidelines, utilization data and quality reports.

Based upon this updated policy, bulletin MSA 20-13 – COVID-19 Response: Telemedicine Policy Expansion; Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) Implications, allowing the provision of audio-only services for the codes listed on the telemedicine database, is discontinued per the date indicated.

Since MDHHS is discontinuing the provision of audio-only telemedicine services indicated in bulletin MSA 20-13, and replacing this with an audio-only database, this policy philosophy applies to the provision of services within the School Services Program (SSP) as well. These programs also have the allowance to provide the audio-only codes as described above. As such, bulletin MSA 20-15 - COVID-19 Response: Behavioral Health Telepractice; Telephone (Audio Only) Services, Telephone (Audio Only) Services section is discontinued with the enactment of this policy per the date indicated.

Additionally, MDHHS is continuing bulletin MSA 20-34 - COVID-19 Response: Telemedicine Reimbursement for Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers, in that it allows identified audio-only services (those represented on the audio-only fee schedule and that are identified as qualifying visits) to generate the Prospective Payment System/All-Inclusive Rate (PPS/AIR) for applicable clinics. Clinics will be permitted to submit for reimbursement allowable audio-only service codes, as indicated above, if appropriate for the interaction with the beneficiary. Medicaid clinic billing and reimbursement requirements apply. The provider must be employed by or contracted with the FQHC, RHC, or THC and the procedure code billed must appear on the clinic qualifying visit list located on the MDHHS website at www.micigan.gov/medicaidproviders >>Provider Specific Information.

The allowance for payment of the AIR for Indian Health Centers is contingent upon successful approval from the Centers for Medicare and Medicaid Services (CMS). The provision of bulletin MSA 20-34 which allows providers to work from home, is also allowable per bulletin MSA 20-09, which defines the parameters for the distant site to include “the provider’s office, or any established site considered appropriate by the provider, so long as the privacy of the beneficiary and security of the information shared during the telemedicine visit are maintained”.

Clinics are also permitted to submit for reimbursement telemedicine services (using simultaneous audio/visual technologies) per bulletin MSA 20-09 if all other provisions of telemedicine policy are maintained. Simultaneous audio/visual telemedicine services, as indicated by CPT/HCPCS codes listed on the telemedicine fee schedule and considered qualifying visits, will also be considered face-to-face and will trigger the PPS/AIR if the service billed is listed as a qualifying visit.

MDHHS will be discontinuing audio-only allowances across dental providers, as stated in bulletin MSA 20-21 - COVID-19 Response: Limited Oral Evaluation via Telemedicine, which will be discontinued with the enactment of this policy per the date indicated. MDHHS will continue other telemedicine dental services (see below for further details).

VIII. Telemedicine Billing Requirements

All telemedicine visits are required to ascribe to correct coding requirements equivalent to in-person services, including ensuring that all aspects of the code billed are performed during the visit.

A. Allowable Services

Allowable telemedicine services for synchronous telemedicine are listed on the telemedicine fee schedules which can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Asynchronous telemedicine service codes are listed on the corresponding provider-specific fee schedules. Additional program-specific coverage will be represented on individual program fee schedules and will be indicated in the program-specific sections below as indicated.

Where in-person visits are required (such as End Stage Renal Disease [ESRD] and nursing facility-related services), the telemedicine service may be used in addition to the required in-person visit but cannot be used as a substitute. There must be at least one in-person hands-on visit (i.e., not via telemedicine) by a physician, physician's assistant, or advanced practice registered nurse per month to examine the vascular site for ESRD services.

For PIHP/CMHSP service providers, where in-person visits are required, the telemedicine service may be used in addition to the required in-person visit but cannot be used as a substitute. Refer to the MDHHS Bureau of Specialty Behavioral Health Services Telemedicine Database which can be accessed on the MDHHS website at www.michigan.gov/bhdda >> Reporting Requirements >> Bureau of Specialty Behavioral Health Services Telemedicine Database for services allowed via telemedicine.

B. Place of Service (POS), Modifier 95 and Modifier 93

All audio/visual telemedicine services, as allowable on the telemedicine fee schedule and submitted on the professional invoice, must be reported with the Place of Service (POS) code that would be reported as if the beneficiary were in-person for the visit

along with modifier 95—"Synchronous Telemedicine Service rendered via a real-time interactive audio and video telecommunications system".

All audio-only telemedicine services, as represented on the audio-only telemedicine fee schedule and submitted on the professional invoice, must be reported with the Place of Service (POS) code that would be reported as if the beneficiary were in-person for the visit along with modifier 93 - "Synchronous Telemedicine Service rendered via telephone or other real-time interactive audio-only telecommunications system".

For services submitted on the Institutional invoice, the appropriate National Uniform Billing Committee (NUBC) revenue code, along with the appropriate telemedicine Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure code and modifier 95 or Modifier 93, must be used.

PIHP/CMHSP providers must submit encounters for audio/visual telemedicine with POS 02 or 10 (as applicable) and for audio-only POS 02 or 10 (as applicable) and Modifier 93.

Covered asynchronous telemedicine services (as defined above, represented on corresponding fee schedules, and outlined in bulletin MSA 21-24 – Asynchronous Telemedicine Services) should be billed with applicable POS and modifiers as standard practice.

Telemedicine claims without these indicators may be denied.

This policy supersedes and discontinues bulletin MSA 20-09 (Place of Service and GT Modifier subsection), bulletin MSA 20-42 (Telemedicine Reimbursement Rate Change section) and bulletin HASA 22-03 (Telemedicine Coding Changes section), per the date indicated.

For PIHP/CMHSP service providers, refer to the Bureau of Specialty Behavioral Health Services Telemedicine Database and Audio-Only Telemedicine Database, which can be accessed on the MDHHS website at www.michigan.gov/bhdda >> Reporting Requirements >> Bureau of Specialty Behavioral Health Services Telemedicine Database for services allowed via both audio/visual and audio-only telemedicine.

This information should be used in conjunction with the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters of the MDHHS Medicaid Provider Manual, as well as the Medicaid Code and Rate Reference tool and other related procedure databases/fee schedules located on the MDHHS website.

IX. Specific Program/Service Site Considerations

A. Outpatient Hospital

When the outpatient facility provides administrative support for a telemedicine service, the outpatient hospital facility may bill the hospital outpatient clinic visit on the institutional claim with modifier 95 or modifier 93 and the appropriate revenue code.

B. Behavioral Health

i. PIHP/CMHSP

The MDHHS Bureau of Specialty Behavioral Health Services requires all the requirements of Telemedicine policy are attained and maintained during all beneficiary visits. In addition to the Determination of Appropriateness/Documentation section of this policy, the Bureau of Specialty Behavioral Health Services would like to reiterate that services delivered to the beneficiary via telemedicine be done at the convenience of the beneficiary, not the convenience of the provider. In addition, these services must be a part of the person-centered plan of service and available as a choice, not a requirement, to the beneficiary.

If the individual (beneficiary) is not able to communicate effectively or independently they must be provided appropriate on-site support from natural supports or staff. This includes the appropriate support necessary to participate in assessments, services, and treatment.

The CMHSP/PIHP must guarantee the individual is not being influenced or prompted by others when utilizing telemedicine.

Use of telemedicine should ensure and promote community integration and prevent isolation of the beneficiary. Evidence-based practice policies must be followed as appropriate for all services. For services within the community, in-person interactions must be prioritized.

Requirements for Visit:

Telemedicine is allowed for all services indicated in the Bureau of Specialty Behavioral Health Services Telemedicine Database. The features of what will be counted as a telemedicine visit need to align with the same standards of an in-person visit. Any phone call or web platform used to schedule, obtain basic information or miscellaneous work that would have been billed as a non-face-to-face and therefore non-billable contact, will remain non-billable. Telemedicine visits must include service provision as indicated in the IPOS and should reflect work towards or review of goals and objectives indicated forthwith.

Populations:

This policy applies to all populations served within PIHPs/CMHSPs and does not supersede any federal regulations that must be followed for SUD treatment.

ii. Outpatient Mental Health Services Providers

Medicaid beneficiaries whose needs do not render them eligible for specialty services and supports through the PIHPs/CMHSPs may receive outpatient mental health services through Medicaid Fee-for-Service (FFS) or Medicaid Health Plans as applicable. These FFS/MHP enrolled non-physician behavioral health services may be provided via telemedicine when performed by Medicaid-enrolled psychologists, social workers, counselors, and marriage and family therapists. Services are covered when performed in a non-facility setting or outpatient hospital clinic. All applicable services are listed in the telemedicine audio/visual and audio-only databases.

C. Physical Therapy, Occupational Therapy and Speech Therapy Services

MDHHS will allow select therapy services to be provided via telemedicine when performed by Medicaid-enrolled private practice and outpatient hospital physical therapy (PT), occupational therapy (OT) and speech therapy (ST) providers. PT, OT and ST services allowed via telemedicine will be represented by applicable CPT/HCPCS codes on the telemedicine fee schedule. Therapy services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate for the individual beneficiary

Documentation re-evaluation, performance, and treatment elements that typically require hands-on contact for measurement or assessment must include a thorough description of how the assessment or performance findings were established via telemedicine. This includes, but is not limited to, such elements as standardized tests, strength, range of motion, and muscle tone.

Initial physical therapy and occupational therapy evaluations and oral motor/swallowing services are not allowed telemedicine and should be provided in-person.

Services that require utilization of equipment during treatment and/or physical hands-on interaction with the beneficiary cannot be provided via telemedicine.

Therapy re-evaluations performed via telemedicine must be provided by a therapist whose facility/clinic has previously evaluated and/or treated the beneficiary in-person.

Durable Medical Equipment (DME) re-assessments performed via telemedicine must be provided by a therapist who has previously evaluated and/or treated the beneficiary in-person, otherwise an in-person visit is required.

This policy supplements existing PT, OT, and ST services policy. All current therapy referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether the service is provided through telemedicine. All telemedicine therapy services will count toward the beneficiary's therapy service limits. (Refer to the Therapy Services chapter of the MDHHS Medicaid Provider Manual for complete information.)

i. Billing Considerations

Modifier 95 should be used in addition to the required modifiers for therapy services as outlined in therapy policy.

ii. Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)/Tribal Health Center (THC)/ Tribal Federally Qualified Health Centers (Tribal FQHC) Considerations

PT, OT and ST, when provided in accordance with this policy using both audio/visual modalities, will be considered face-to-face and will trigger the PPS AIR if the service billed is listed as a qualifying visit.

For FQHCs, RHCs, THCs and Tribal FQHCs, the appropriate CPT/HCPCS code, PPS/AIR payment code (if the service generates a Qualifying Visit), and modifier 95 – synchronous telemedicine must be used. Refer to www.michigan.gov/medicaidproviders >> Provider Specific Information for additional information.

iii. School Services Program Considerations

School Services Program (SSP) PT and OT services, as outlined in this policy, will also be allowed via telemedicine. These services must meet all other telemedicine policies as outlined.

This policy ends bulletin MSA 20-22 - COVID-19 Response: Telemedicine Policy Changes, Updates to Coverage for Physical Therapy, Occupational Therapy and Speech Therapy per the date indicated, but continues some of the allowances permanently with the changes indicated.

D. Audiology Services

MDHHS will allow speech therapy, auditory rehabilitation, select hearing device adjustments, programming, device performance evaluations, and education or counseling to be performed via telemedicine (simultaneous audio/visual). Remote device programming must be provided in compliance with current U.S. Food and Drug Administration (FDA) guidelines. Auditory brainstem response **(**ABR) and auditory

evoked potential (AEP) testing may also be conducted via telemedicine when performed using remote technology located at a coordinating clinical site with appropriately trained staff (i.e., mobile unit, office/clinic, or hospital).

Reimbursable procedure codes are limited to the specific set of audiology codes listed in the telemedicine fee schedule. Audiology services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate.

Audiological diagnostic tests (other than those mentioned above), hearing aid examinations, surgical device candidacy evaluations, and other audiology and hearing aid services conducted via telemedicine are not reimbursable by Michigan Medicaid and should be provided in-person.

This policy supplements the existing audiology, hearing aid dealer and speech therapy services policies. All current referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether the service is provided through telemedicine. Providers should refer to the Hearing Services chapter in the MDHHS Medicaid Provider Manual for complete information.

This policy ends bulletin MSA 20-53 - COVID-19 Response: Telemedicine Policy Changes for Audiology Services per the date indicated but continues the allowance permanently with the changes outlined within this section.

E. Dentistry

MDHHS will allow dentists to provide the limited oral evaluation (Current Dental Terminology [CDT] code D0140) via telemedicine (simultaneous audio/visual) technology so long as all other telemedicine policy is followed. D9995 teledentistry-synchronous; real-time encounter, must be reported in addition to the applicable CDT code.

All requirements of the general telemedicine policy described in bulletin MSA 20-09 and the MDHHS Medicaid Provider Manual must be followed when providing the limited oral evaluation via telemedicine, including scope of practice requirements, contingency plan, and the use of both audio/visual service delivery unless otherwise indicated by federal guidance.

Services delivered to the beneficiary via telemedicine must be done for the convenience of the beneficiary, not the convenience of the provider. Services must be performed using simultaneous audio/visual capabilities. All services using telemedicine must be documented in the beneficiary's record, including the date, time, and duration of the encounter, and any pertinent clinical documentation required per CDT code description. The provider is responsible for ensuring the safety and quality of services provided with telemedicine technologies.

Billing instructions depend upon the claim format used:

- American Dental Association (ADA) Claim Format: Use POS 02 or POS 10; report D9995 with the procedure code.
- Institutional Claim Format: POS 02 and POS 10 are not required; Use modifier 95; report D9995 with the procedure code.

This policy ends bulletin MSA 20-21 - COVID-19 Response: Limited Oral Evaluation via Telemedicine per the date indicated but continues other telemedicine dental services as outlined within this section.

F. Vision

Telemedicine vision services can be provided through a Medicaid-enrolled physician or other qualified health care professional who can report evaluation and management (E/M) services as listed in the telemedicine fee schedules.

An intermediate ophthalmological exam can be provided via telemedicine for an established patient with a known diagnosis. The provider must have a previous in-person encounter with the beneficiary to ensure the provider is knowledgeable of the beneficiary's current medical history and condition. For cases in which the provider must refer the beneficiary to another provider, a consulting provider is not required to have a pre-existing provider-patient relationship if the referring provider shares medical history, past eye examinations, and any related beneficiary diagnosis with the consulting provider. Intermediate ophthalmological exam codes should not be used to diagnose eye health conditions (an initial diagnosis). When medically necessary, providers must refer beneficiaries for an in-person encounter to receive a diagnosis and/or care. Telemedicine cannot act as a replacement for recommended in-person interactions.

G. School Services Program

Because of the unique circumstances regarding the delivery of services within the School Services Program, telemedicine may be the primary delivery modality for some beneficiaries; however, the decision to use telemedicine should be based on the needs or convenience of the beneficiary, and not those of the provider.

In cases where the beneficiary is unable to use telemedicine equipment without assistance, an attendant must be provided by the provider. The attendant must be trained in the use of the telemedicine equipment to the point where they can provide adequate assistance. The attendant must also be available for the entire telemedicine session; however, they should also ensure the beneficiary's privacy to the greatest extent possible. When the originating site for the service is the student's home, any cost for an attendant is not reimbursable.

Billing and reimbursement for telemedicine services are accomplished using the same methodology as other services; however, the service must be billed using POS 03—school and modifier 95 or modifier 93. Telemedicine claims for the School Services Program are paid according to the Centers for Medicare & Medicaid Services (CMS) approved cost-based methodology used for other services provided within the program and not the information provided previously in this policy. School Services Program providers are not eligible for the facility fee as the facility is an integral part of the service provided and is covered under the service claim. A database of allowable telemedicine services for SSP can be found on the SSP website.

This policy ends bulletin MSA 20-15 - COVID-19 Response: Behavioral Health Telepractice; Telephone (Audio Only) Services per the date indicated but continues telemedicine SSP services as indicated.

H. Durable Medical Equipment (DME) Providers

All DME Providers must reference the DME chapter of the MDHHS Medicaid Provider Manual for specific requirements in the provision of services via telemedicine.

Manual Maintenance

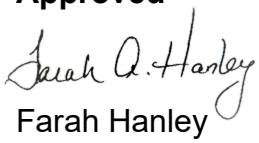
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

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

Approved



Farah Hanley
Chief Deputy Director for Health

From: Michigan Department of Health and Human Services <MDHHS@govsubscriptions.michigan.gov>
Sent: Wednesday, March 8, 2023 10:32 AM
To: Branislava Arsenov (NMRE) <barsenov@nmre.org>
Subject: [EXTERNAL]FOR IMMEDIATE RELEASE: MDHHS launches OpiRescue smartphone app to help Michigan residents prevent and reduce opioid overdoses

Press Release

FOR IMMEDIATE RELEASE: March 8, 2023

CONTACT: Chelsea Wuth, 517-241-2112, WuthC@michigan.gov

MDHHS launches OpiRescue smartphone app to help Michigan residents prevent and reduce opioid overdoses

LANSING, Mich. – In an effort to reduce the occurrence of overdoses and help residents learn to treat an overdose, the Michigan Department of Health and Human Services (MDHHS) is launching OpiRescue, a smartphone app aimed at reducing harm.

The OpiRescue app helps anyone, including first responders, prevent opioid misuse and reduce opioid overdose deaths by addressing education, prevention and tracking of overdose reversals.

“Preventing opioid deaths includes offering a variety of strategies to provide residents tools when and where they need them,” said Dr. Natasha Bagdasarian, MDHHS chief medical executive. “The OpiRescue app will support those who may encounter an overdose to immediately begin life-saving treatment to an affected individual.”

The OpiRescue app provides:

- Educational content to identify and reverse overdoses.
- A Naloxone finder to locate the medication nearby.
- A treatment locator.
- Information on how to report an overdose reversal.

The OpiRescue app is available statewide in Michigan on both Android and iOS platforms. It is free to use and anonymous. It can be downloaded at Apple iOS app store or through Google Play.

MDHHS partners, including Prepaid Inpatient Health Plans and Syringe Service Programs, actively involved in caring for members of the public experiencing opioid use disorder will have access to a dashboard for their region. The dashboard will allow those partners to view overdose reversal data in near real time and allocate additional resources as needed to areas with increased reports of overdose reversals.

For more information on Naloxone and how to obtain the medication, visit Michigan.gov/Naloxone.

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- OpiRescue Press Release.pdf

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

March 15, 2023

TO Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Program (CMHSPs)

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

SUBJECT: Intensive Community Transition Services (ICTS)

Over the past couple of years, you have all been made aware of, and many of you have worked with, the Michigan Community Transition Program (commonly just referred to by its acronym MCTP) that is managed through the State Hospital Administration (SHA). The goal of that program is to facilitate the discharge of individuals from a state facility who no longer meet state hospital level of care but still require a temporary, more intensive level of care before they can be successful in a traditional, home and community-based setting. A key component of this program is that it is funded with General Fund and is not subject to Medicaid rules and regulations, especially those surrounding the Home and Community Based Services rule.

The MCTP is in the process of expanding to Intensive Community Transition Services (ICTS) which will be managed by a new section within the Bureau of Specialty Behavioral Health Services (BSBHS) within the division of Adult Home and Community Based Services. We are in the process of standing up that section and plan to have it fully functional by the end of this fiscal year. This expansion will also be supported by the General Fund.

The expansion of this program will not change the process that has been put in place to support the discharge of individuals from state facilities and builds upon the success of that work. It is expanding to address situations in the community where individuals cannot get access to an inpatient or specialized residential bed. The intent is to provide options for individuals who are stuck in an emergency department, or a medical bed or some other location where appropriate care and support cannot be provided.

At this time, BSBHS wanted to share the ICTS policy (attached) with all of you. As BSBHS initiates this changeover, SHA will be adopting the relevant components of this policy into MCTP and operating under them going forward. Once the new section is fully established, BSBHS will announce the formal start of the community support section of the policy, so those components are not functional at this time.

Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and
Community Mental Health Services Program (CMHSPs)
March 15, 2023

Please review the policy and the roles and expectations that have been established for the Community Mental Health Services Programs. You are welcome to share any feedback you have on this policy and can send those to WieferichJ@michigan.gov through April 7th, 2023.

Attachment: ICTS Policy

c: Farah Hanley
Dr. George Mellos
Al Jansen
Kristen Jordan
Belinda Hawks
Jackie Sproat
Bob Sheehan
Patricia Neitman
Nick Norcross
Krista Hausermann
Phil Kurdunowicz
Wanda Washington-Jones
Brenda Henige

— MICHIGAN STATEWIDE —
HOUSING PLAN

Regional Housing Partnership Kick-Off

Join the State of Michigan to learn about the role your region can play in the implementation of Michigan's first Statewide Housing Plan (Plan). Participate in a facilitated work session to start laying the groundwork for the formation of a formal Regional Housing Partnership (RHP), and learn how this regional collaborative process can support the advancement of the Plan.

Who Should Attend

Municipalities, Developers, Land Banks, Community Development Organizations, Service Providers, Businesses, and Community Stakeholders

RHP A: Western Upper Peninsula Housing Partnership
March 22, 1– 4:30 p.m.
Hancock, MI

RHP B: Central Upper Peninsula Housing Partnership
March 23, 1– 4:30 p.m.
Presque Isle Marquette, MI

RHP C: Eastern Upper Peninsula Housing Partnership
March 24, 9 a.m. – 12:30 p.m.
Sault Ste. Marie, MI

RHP D: Northwest Housing Partnership
March 13, 1– 4:30 p.m.
Traverse City, MI

RHP E: Northeast Housing Partnership
April 6, 1– 4:30 p.m.
Gaylord, MI

RHP F: West Michigan Housing Partnership
March 21, 8:30 a.m. – 12 p.m.
Grand Rapids, MI

RHP G: East Central Michigan Housing Partnership
More information soon

REGISTER

RHP H: East Michigan Housing Partnership
March 23, 9 a.m. – 12:30 p.m.
Flint, MI

RHP I: South Central Housing Partnership
March 28, 1– 4:30 p.m.
East Lansing, MI

RHP J: Southwest Housing Partnership
March 28, 9 a.m. – 12:30 p.m.
Kalamazoo, MI

RHP K: Southeast Housing Partnership
March 31, 1– 4:30 p.m.
Ann Arbor, MI

RHP L: Oakland Housing Partnership
March 30, 9 a.m. – 12:30 p.m.
Troy, MI

RHP M: Macomb Housing Partnership
March 31, 9 a.m. – 12:30 p.m.
Eastpointe, MI

RHP N: Wayne Housing Partnership
March 20, 9 a.m. – 12:30 p.m.
Livonia, MI

RHP O: Detroit Housing Partnership
March 20, 1– 4:30 p.m.
Detroit, MI

If you require a reasonable accommodation to participate, please contact MSHDA at 517-241-4322 or wardl10@michigan.gov

MSHDA™ MICHIGAN STATE HOUSING DEVELOPMENT AUTHORITY

Day of ReCOVERy Education

COVER yourself in strength • COVER yourself in positivity • COVER yourself in support

The Northern Michigan Regional Entity (NMRE) is sponsoring a **FREE Day of Recovery Education** for individuals who are seeking recovery or are in recovery from a substance use disorder

When: May 8, 2023 from 9:30AM—3:30PM

Where: Treetops Resort Convention Center
3962 Wilkinson Road, Gaylord

The day's events will include:

- Light Breakfast
- Speakers
  - Thomas Overett, CPRA—Peer Support Specialist
  - Carrie Zeigler, CPRC, CPRM—Peer Recovery Coach
- Full Lunch
- Breakout Sessions
- AcuDetox Demonstration
- Yoga
- Entertainment
- Door Prizes

Register Online at Eventbrite or Scan the QR Code:

https://www.eventbrite.com/e/nmre-day-of-recovery-education-tickets-569818902677

or Contact NMRE Customer Services at 833.285.0050

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

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

REVIEW AGENDA & ADDITIONS
Ann noted that when she attempts to email the finance group she gets a response that her message has been blocked. Brandon agreed to investigate the issue.

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE FEBRUARY 8, 2023 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

MONTHLY FINANCIALS
January 2023

- Net Position showed net surplus Medicaid and HMP of $3,370,898. Medicaid carry forward was reported as $16,369,542. The total Medicaid and HMP Current Year Surplus was reported as $19,740,440. Medicaid and HMP combined ISF was reported as $16,369,542; the total Medicaid and HMP net surplus, including carry forward and ISF was reported as $36,109,982.
- Traditional Medicaid showed $66,143,817 in revenue, and $64,187,913 in expenses, resulting in a net surplus of $1,955,904. Medicaid ISF was reported as $9,306,578 based on the current FSR. Medicaid Savings was reported as $10,913,028.
- Healthy Michigan Plan showed $11,674,745 in revenue, and $10,259,752 in expenses, resulting in a net surplus of $1,414,993. HMP ISF was reported as $7,062,964 based on the current FSR. HMP savings was reported as $5,456,514.
- Health Home showed $692,197 in revenue, and $583,200 in expenses, resulting in a net surplus of $108,997.
- SUD showed all funding source revenue of $9,593,085, and $8,195,611 in expenses, resulting in a net surplus of $1,397,474. Total PA2 funds were reported as $5,200,852.

Deanna reported that four months into FY23, revenue is above projections and spending is in line with estimates.

Lauri asked if January Health Home payments have been processed; Tricia responded that they will be included in the current week's payables.

Deanna reviewed the PA2 page of the report, noting projected vs. actual numbers for FY23.

Projected FY23 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$5,413,044	**$1,568,386**	**$2,720,209**	**$4,261,221**

Actual FY23 Activity			
Beginning Balance	Current Receipts	Expenditures	Ending Balance
$5,413,044	**240,837**	**$453,029**	**$5,200,852**

Lauri noted that Northern Lakes shows a $710,500 deficit for Medicaid and HMP; she asked if this includes the portion of the carry-forward allotted to Norther Lakes. The amount of the carry-forward allotted to Northern Lakes was provided as $3,694,950 for Medicaid and $1,224,392 for HMP for a total of $4,919,342. Deanna agreed to provide the carry-forward/benefits stabilization amounts on the Finance Report for all five CMHSP beginning in April.

Lauri discussed the proposed crisis and welcoming center in Traverse City, which would be (primarily) funded and run as part of Northern Lakes. Eric proposed that Northern Lakes and Munson work together to develop the center for all individuals with the six counties that comprise Northern Lakes' region regardless of income or insurance.

MOTION BY DONNA NIEMAN TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JANUARY 2023; SUPPORT BY LAURI FISCHER. MOTION APPROVED.

EDIT UPDATE

The next meeting is scheduled for April 20th. The Telemedicine Policy (post COVID) will go into effect on May 12th; Donna shared communication from state containing accepted telemedicine codes. Audio only services will no longer be allowed.

Guidance has been requested regarding what constitutes "Applicable Experience" under Supported Employment. This topic will be discussed further during the April meeting.

Input is being sought from clinical staff regarding independent facilitation and wraparound services.

FSR

Deanna reported that the FSR showed a DCW lapse of $6.8M.

The ISF is currently fully funded.

The region has a carry-forward of $16.3M and an anticipated lapse $10.8M.

Lauri asked if the FSR was consistent among the five Boards; Deanna responded that it was for the most part and she reached out to Boards for clarification when not.

Clarification was made that the Behavioral Health Home Incentive Payment should be reported as BHH revenue.

L 23-04 Direct Care Wage
Correspondence from MDHHS dated February 14, 2023 regarding the direct care worker wage increase was discussed. The DCW can now be embedded permanently in staff hours.

The DCW increase may be added to base pay per Jackie Sprout. Though the DCW will no longer be cost settled, it does need to be tracked.

It was noted that the job coaching code was pulled out of the codes related to the DCW (the H2025 portion of H2023 code). The decision was made to continue to pay the DCW for the H2025, track it, but not report it.

EQI UPDATE
Tricia reported that no inconsistencies were observed with the EQI and it balanced to FSR totals. Tricia thanked the Boards for their efforts. The EQI for period 1 of FY23 is due May 31st. A pull date will be decided in April. Reports will be due from the CMHSPs in mid-May.

HSW OPEN SLOTS
Deanna reminded the Boards that there are currently 39 open HSW slots in the region; this equates to $234K in missed revenue monthly. The Boards reported that they have several packets in the process of being approved.

OTHER
The requirement for the SIS Assessments will be ending with a hard stop on March 23, 2023. The SIS Assessment code (H0031HW) can be billed up until that date. Chip noted that a replacement assessment is coming, possibly an adult version of the Child and Adolescent Needs and Strengths (CANS) tool. Eric stated that the Adult Needs and Strengths Assessment (ANSA) is also being considered.

NEXT MEETING
The next meeting was scheduled for April 12th at 10:00AM.

Chief Executive Officer Report

March 2023

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

Feb 21: Chaired NMRE Regional Operations Committee meeting.

Feb 27: Attended and participated in NLCMHA/Munson Crisis Workgroup.

Feb 28: Attended and participated in CMHAM Advocacy meeting.

March 1: Attended and participated in State Tribal Liaison meeting.

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

March 2: Attended and participated in MDHHS Region 2 Beneficiary Concerns meeting.

March 3: Attended and participated in NLCMHA six county administrator/commissioner group.

March 6: Attended and participated in NMRE SUD Oversight Board meeting.

March 7: Attended and participated in PIHPCEO meeting.

March 8: Attended and participated in NMRE Regional Finance Committee meeting.

March 8: Attended and participated in NMRE Internal Operations Committee meeting.

March 10: Attended and participated in NLCMHA/Munson Crisis subgroup meeting.

March 15: Attended and participated in MDHHS Region 2 Beneficiary Concerns meeting.

March 15: Attended and participated in Northern and UP Rural Mental Health Workgroup.

March 17: Plan to attended and participated in NLCMHA/Munson Crisis Workgroup.

January 2023 Finance Report

January 2023 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	1,955,904	10,913,028	9,306,578
Healthy Michigan	1,414,993	5,456,514	7,062,964
	$ 3,370,898	$ 16,369,542	$ 16,369,542

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	506,521	1,179,482	(710,500)	1,443,985	425,381	704,554	(178,525)	$ 3,370,898
Medicaid Carry Forward								16,369,542
Total Med/HMP Current Year Surplus								$ 19,740,440
Medicaid & HMP Internal Service Fund								16,369,542
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 36,109,982

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2022 through January 31, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 63,896,410	$ 2,109,426						$ 66,005,836
CMHSP Distributions	(61,486,113)		20,110,691	16,938,075	10,397,890	8,683,467	5,355,990	-
1st/3rd Party receipts			137,981	-	-	-	-	137,981
Net revenue	2,410,297	2,109,426	20,248,672	16,938,075	10,397,890	8,683,467	5,355,990	66,143,817
Expense								
PIHP Admin	813,596	19,489						833,085
PIHP SUD Admin		25,587						25,587
SUD Access Center		17,579						17,579
Insurance Provider Assessment	574,061	12,853						586,914
Hospital Rate Adjuster	555,016							555,016
Services		1,454,397	21,009,196	15,969,459	10,276,720	7,992,537	5,467,423	62,169,732
Total expense	1,942,673	1,529,905	21,009,196	15,969,459	10,276,720	7,992,537	5,467,423	64,187,913
Net Actual Surplus (Deficit)	$ 467,624	$ 579,521	$ (760,524)	$ 968,616	$ 121,170	$ 690,931	$ (111,433)	$ 1,955,904

Notes

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

Medicaid Savings - $10,913,028

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2022 through January 31, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 7,358,122	$ 4,316,623						$ 11,674,745
CMHSP Distributions	(6,712,166)		2,444,416	2,033,913	832,073	843,261	558,503	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	645,956	4,316,623	2,444,416	2,033,913	832,073	843,261	558,503	11,674,745
Expense								
PIHP Admin	79,544	47,350						126,894
PIHP SUD Admin		62,165						62,165
SUD Access Center		42,710						42,710
Insurance Provider Assessment	52,580	30,884						83,464
Hospital Rate Adjuster	474,936							474,936
Services		3,533,553	2,394,392	1,558,543	527,862	829,638	625,595	9,469,583
Total expense	607,060	3,716,662	2,394,392	1,558,543	527,862	829,638	625,595	10,259,752
Net Surplus (Deficit)	$ 38,897	$ 599,961	$ 50,024	$ 475,370	$ 304,211	$ 13,623	$ (67,092)	$ 1,414,993

Notes
HMP ISF - $7,062,964 - based on current FSR
HMP Savings - $5,456,514

Net Surplus (Deficit) MA/HMP	**$ 506,521**	**$ 1,179,482**	**$ (710,500)**	**$ 1,443,985**	**$ 425,381**	**$ 704,554**	**$ (178,525)**	**$ 3,370,898**
Medicaid & HMP Carry Forward								**16,369,542**
Total Med/HMP Current Year Surplus								$ 19,740,440
Medicaid & HMP ISF - based on current FSR								**16,369,542**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 36,109,982**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2022 through January 31, 2023

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 135,559		209,529	101,781	21,409	47,732	176,187	$ 692,197
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	135,559	-	209,529	101,781	21,409	47,732	176,187	692,197
Expense								
PIHP Admin	7,539							7,539
BHH Admin	13,056							13,056
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	5,967		209,529	101,781	21,409	47,732	176,187	562,605
Total expense	26,562	-	209,529	101,781	21,409	47,732	176,187	583,200
Net Surplus (Deficit)	$ 108,997	$ -	$ -	$ -	$ -	$ -	$ -	$ 108,997

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2022 through January 31, 2023

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 2,109,426	$ 4,316,623	$ 1,500,564	$ 1,213,443	$ 453,029	$ 9,593,085
Expense						
Administration	45,076	109,515	37,310	80,533		272,434
OHH Admin			41,440	-		41,440
Access Center	17,579	42,710	-	9,734		70,024
Insurance Provider Assessment	12,853	30,884	-			43,737
Services:						
Treatment	1,454,397	3,533,553	1,203,821	805,329	453,029	7,450,129
Prevention	-	-	-	288,098	-	288,098
ARPA Grant	-	-	-	29,749	-	29,749
Total expense	1,529,905	3,716,662	1,282,571	1,213,443	453,029	8,195,611
PA2 Redirect			-	(0)	0	-
Net Surplus (Deficit)	$ 579,521	$ 599,961	$ 217,993	$ -	$ 0	$ 1,397,474

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2022 through January 31, 2023

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 63,896,410	$ 2,109,426	$ -	$ 66,005,836
Medicaid Savings	-	-	-	-
Healthy Michigan	7,358,122	4,316,623	-	11,674,745
Healthy Michigan Savings	-	-	-	-
Health Home	692,197	-	-	692,197
Opioid Health Home	-	1,500,564	-	1,500,564
Substance Use Disorder Block Grant	-	1,213,443	-	1,213,443
Public Act 2 (Liquor tax)	-	453,028	-	453,028
Affiliate local drawdown	148,704	-	-	148,704
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	667	-	667
Veteran Navigator Grant	35,669	-	-	35,669
SOR Grant Revenue	-	523,876	-	523,876
Gambling Grant Revenue	-	-	-	-
Other Revenue	960	-	2,738	3,698
Total operating revenue	72,132,062	10,117,627	2,738	82,252,427
Operating expenses				
General Administration	1,004,503	238,634	-	1,243,137
Prevention Administration	-	38,974	-	38,974
OHH Administration	-	41,440	-	41,440
BHH Administration	13,056	-	-	13,056
Insurance Provider Assessment	626,641	43,737	-	670,378
Hospital Rate Adjuster	1,029,952	-	-	1,029,952
Payments to Affiliates:				
Medicaid Services	60,577,354	1,454,397	-	62,031,751
Healthy Michigan Services	5,936,030	3,533,553	-	9,469,583
Health Home Services	562,605	-	-	562,605
Opioid Health Home Services	-	1,203,821	-	1,203,821
Community Grant	-	805,329	-	805,329
Prevention	-	249,124	-	249,124
State Disability Assistance	-	-	-	-
ARPA Grant	-	29,749	-	29,749
Public Act 2 (Liquor tax)	-	453,029	-	453,029
Local PBIP	-	-	-	-
Local Match Drawdown	148,704	-	-	148,704
Miscellanous Grant	-	667	-	667
Veteran Navigator Grant	35,669	-	-	35,669
SOR Grant Expenses	-	523,876	-	523,876
Gambling Grant Expenses	-	-	-	-
Total operating expenses	69,934,514	8,616,330	-	78,550,844
CY Unspent funds	2,197,548	1,501,297	2,738	3,701,583
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	18,086,051	8,555,698	16,365,593	43,007,342
Unspent funds - ending	$ 20,283,599	$ 10,056,995	$ 16,368,331	$ 46,708,925

Northern Michigan Regional Entity

Statement of Net Position

January 31, 2023

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 41,855,032	$ 8,910,006	$ 16,368,331	$ 67,133,369
Accounts Receivable	2,741,978	2,324,963	-	5,066,941
Prepaids	65,928	-	-	65,928
Total current assets	44,662,938	11,234,969	16,368,331	72,266,238
Noncurrent Assets				
Capital assets	125,002	-	-	125,002
Total Assets	44,787,940	11,234,969	16,368,331	72,391,240
Liabilities				
Current liabilities				
Accounts payable	24,241,643	1,177,974	-	25,419,617
Accrued liabilities	262,698	-	-	262,698
Unearned revenue	-	-	-	-
Total current liabilities	24,504,341	1,177,974	-	25,682,315
Unspent funds	$ 20,283,599	$ 10,056,995	$ 16,368,331	$ 46,708,925

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2022 through January 31, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 62,584,236	$ 63,896,410	$ 1,312,174	2.10%
Carryover	11,400,000	11,400,000	-	(11,400,000)	(1)
Healthy Michigan					
Capitation	19,683,372	6,561,124	7,358,122	796,998	12.15%
Carryover	5,100,000	5,100,000	-	(5,100,000)	(100.00%)
Health Home	1,451,268	483,756	692,197	208,441	43.09%
Affiliate local drawdown	594,816	148,704	148,704	-	0.00%
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	36,668	35,669	(999)	(2.72%)
Other Revenue	-	-	960	960	0.00%
Total operating revenue	227,426,695	86,314,488	72,132,062	(14,182,426)	(16.43%)
Operating expenses					
General Administration	3,591,836	1,190,752	1,004,503	186,249	15.64%
BHH Administration	-	-	13,056	(13,056)	0.00%
Insurance Provider Assessment	1,897,524	632,508	626,641	5,867	0.93%
Hospital Rate Adjuster	4,571,328	1,523,776	1,029,952	493,824	32.41%
Local PBIP	1,737,753	-	-	-	0.00%
Local Match Drawdown	594,816	148,704	148,704	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	30,572	35,669	(5,097)	(16.67%)
Payments to Affiliates:					
Medicaid Services	176,618,616	58,872,872	60,577,354	(1,704,482)	(2.90%)
Healthy Michigan Services	17,639,940	5,879,980	5,936,030	(56,050)	(0.95%)
Health Home Services	1,415,196	471,732	562,605	(90,873)	(19.26%)
Total operating expenses	208,177,013	68,750,896	69,934,514	(1,183,618)	(1.72%)
CY Unspent funds	$ 19,249,682	$ 17,563,592	2,197,548	$ (15,366,044)	
Transfers in			-		
Transfers out			-	69,934,514	
Unspent funds - beginning			18,086,051		
Unspent funds - ending			$ 20,283,599	2,197,548	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2022 through January 31, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 1,559,544	$ 2,109,426	$ 549,882	35.26%
Healthy Michigan	11,196,408	3,732,136	4,316,623	584,487	15.66%
Substance Use Disorder Block Grant	6,467,905	2,155,966	1,213,443	(942,523)	(43.72%)
Opioid Health Home	3,419,928	1,139,976	1,500,564	360,588	31.63%
Public Act 2 (Liquor tax)	1,533,979	-	453,028	453,028	0.00%
Miscellanous Grants	4,000	1,333	667	(666)	(49.98%)
SOR Grant	2,043,984	681,328	523,876	(157,452)	(23.11%)
Gambling Prevention Grant	200,000	66,667	-	(66,667)	(100.00%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	9,336,950	10,117,627	780,677	8.36%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	340,860	238,634	102,226	29.99%
Prevention Administration	118,428	39,476	38,974	502	1.27%
Insurance Provider Assessment	113,604	37,868	43,737	(5,869)	(15.50%)
Medicaid Services	3,931,560	1,310,520	1,454,397	(143,877)	(10.98%)
Healthy Michigan Services	10,226,004	3,408,668	3,533,553	(124,885)	(3.66%)
Community Grant	2,074,248	691,416	805,329	(113,913)	(16.48%)
Prevention	634,056	211,352	249,124	(37,772)	(17.87%)
State Disability Assistance	95,215	31,743	-	31,743	100.00%
ARPA Grant	-	-	29,749	(29,749)	0.00%
Opioid Health Home Admin	-	-	41,440	(41,440)	0.00%
Opioid Health Home Services	3,165,000	1,055,000	1,203,821	(148,821)	(14.11%)
Miscellanous Grants	4,000	1,333	667	666	49.98%
SOR Grant	2,043,984	681,328	523,876	157,452	23.11%
Gambling Prevention	200,000	66,667	-	66,667	100.00%
PA2	1,533,978	-	453,029	(453,029)	0.00%
Total operating expenses	25,222,653	7,876,231	8,616,330	(740,099)	(9.40%)
CY Unspent funds	$ 4,322,183	$ 1,460,719	1,501,297	$ 40,578	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			8,555,698		
Unspent funds - ending			$ 10,056,995		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2022 through January 31, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 640,604	$ 547,325	$ 93,279	14.56%
Fringes	666,212	211,208	187,604	23,604	11.18%
Contractual	683,308	227,772	146,404	81,368	35.72%
Board expenses	18,000	6,000	4,443	1,557	25.95%
Day of recovery	14,000	9,000	-	9,000	100.00%
Facilities	152,700	50,900	46,494	4,406	8.66%
Other	135,804	45,268	72,233	(26,965)	(59.57%)
Total General Admin	$ 3,591,836	$ 1,190,752	$ 1,004,503	$ 186,249	15.64%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration

October 1, 2022 through January 31, 2023

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 502,752	$ 167,584	$ 97,898	$ 69,686	41.58%
Fringes	145,464	48,488	26,139	22,349	46.09%
Access Salaries	220,620	73,540	50,965	22,575	30.70%
Access Fringes	67,140	22,380	19,059	3,321	14.84%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	25,000	36,990	(11,990)	(47.96%)
Board expenses	5,000	1,668	2,190	(522)	(31.29%)
Facilities	-	-	-	-	0.00%
Other	12,600	2,200	5,393	(3,193)	(145.14%)
Total operating expenses	$ 1,082,576	$ 340,860	$ 238,634	$ 102,226	29.99%

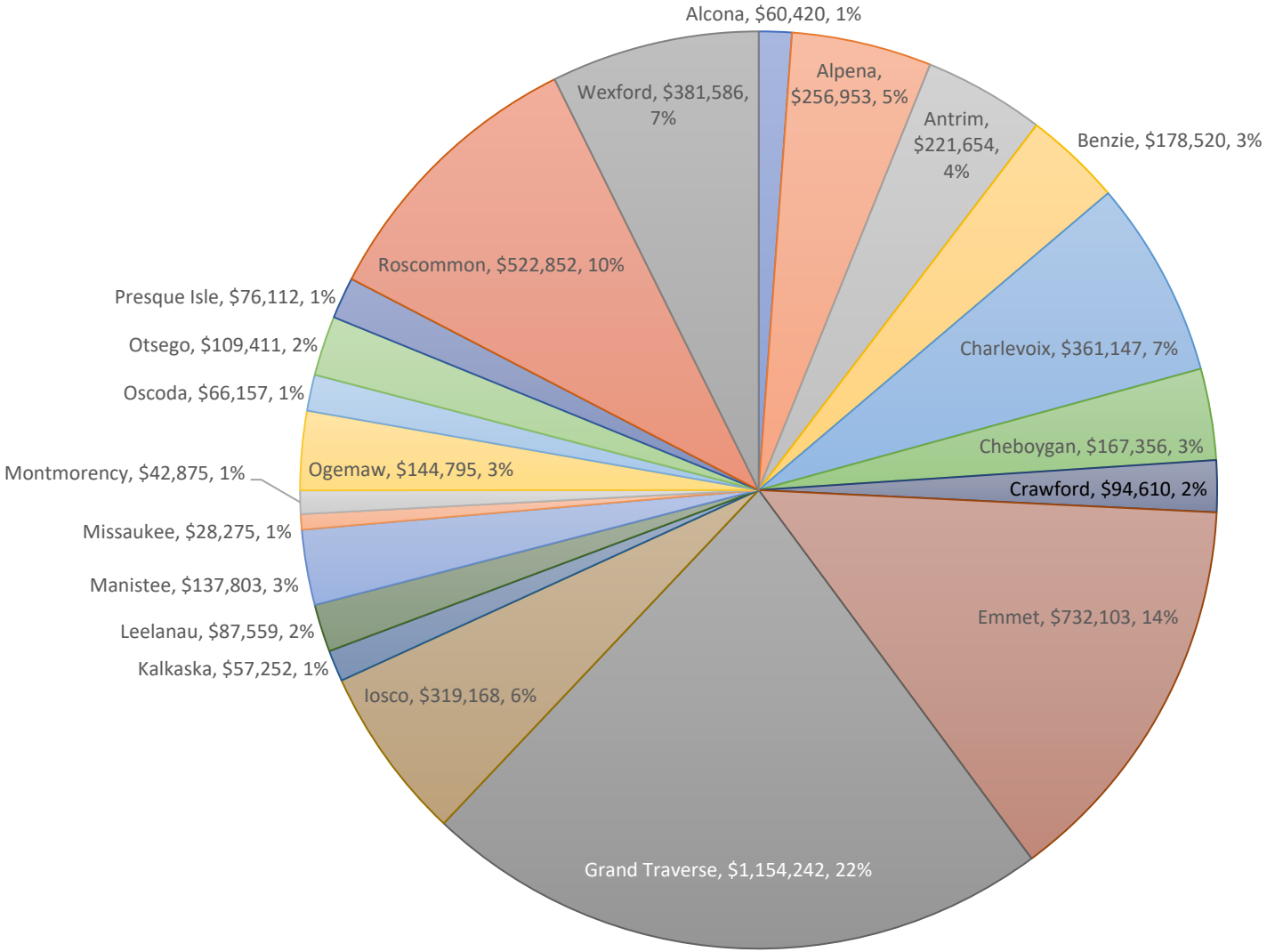
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2022 through January 31, 2023

	Projected FY23 Activity				Actual FY23 Activity			
	Beginning Balance	FY23 Projected Revenue	FY23 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 59,376	$ 20,389	$ 4,410	$ 75,355	$ 3,048	2,004	$ -	$ 60,420
Alpena	263,254	69,040	45,317	286,976	10,701	17,002	-	256,953
Antrim	219,249	59,729	80,820	198,158	9,075	6,670	-	221,654
Benzie	173,705	52,923	14,857	211,771	8,217	3,402	-	178,520
Charlevoix	359,548	89,334	110,699	338,183	13,685	12,086	-	361,147
Cheboygan	191,247	74,954	138,728	127,472	11,422	35,312	-	167,356
Crawford	92,406	31,228	17,903	105,731	4,902	2,698	-	94,610
Emmet	716,610	155,245	115,175	756,679	24,999	9,506	-	732,103
Grand Traverse	1,282,987	406,430	1,248,209	441,208	61,007	189,752	-	1,154,242
Iosco	329,202	70,865	180,735	219,332	10,979	21,012	-	319,168
Kalkaska	74,226	31,700	83,823	22,103	5,320	22,294	-	57,252
Leelanau	102,658	56,613	117,817	41,454	8,508	23,607	-	87,559
Manistee	131,924	68,873	10,407	190,390	10,608	4,729	-	137,803
Missaukee	37,771	18,044	48,883	6,931	2,797	12,292	-	28,275
Montmorency	54,974	27,338	42,322	39,990	3,920	16,019	-	42,875
Ogemaw	154,130	50,286	142,919	61,497	8,557	17,891	-	144,795
Oscoda	65,061	20,039	36,568	48,532	2,701	1,604	-	66,157
Otsego	108,477	88,483	94,620	102,340	13,434	12,500	-	109,411
Presque Isle	75,221	22,256	5,450	92,027	3,367	2,476	-	76,112
Roscommon	524,550	74,697	72,090	527,157	11,202	12,900	-	522,852
Wexford	396,468	79,925	108,457	367,936	12,392	27,273	-	381,586
	5,413,044	1,568,386	2,720,209	4,261,221	240,837	453,029	-	5,200,852
PA2 Redirect								-
								5,200,852

PA2 Funds by County



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2022 through January 31, 2023

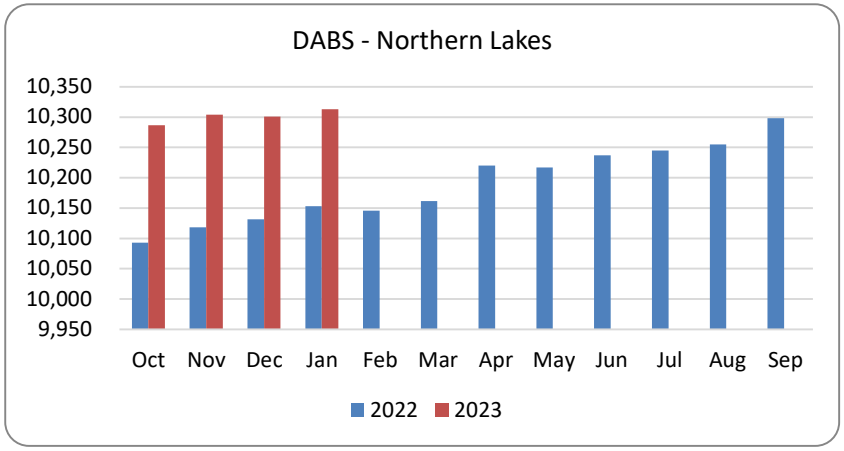
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	2,500	2,738	238	9.52%
Total operating revenue	7,500	2,500	2,738	238	9.52%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 2,500	2,738	$ 238	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			16,365,593		
Unspent funds - ending			$ 16,368,331		

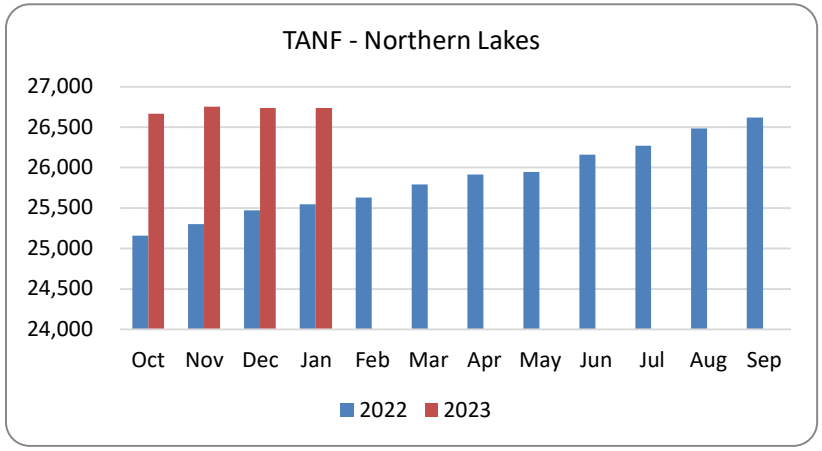
Northern Michigan Regional Entity

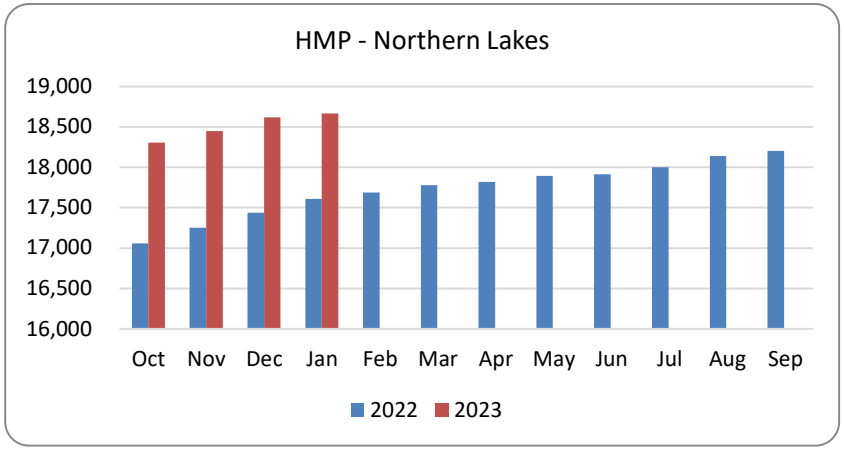
Narrative

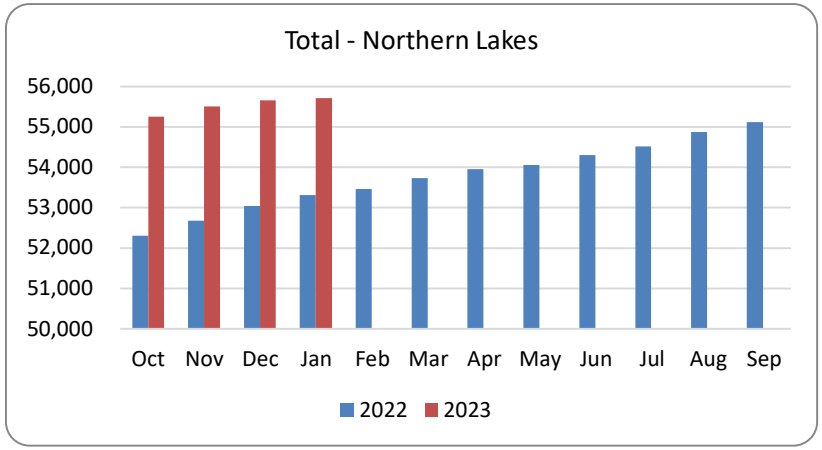
October 1, 2022 through January 31, 2023

Northern Lakes Eligible Members Trending - based on payment files







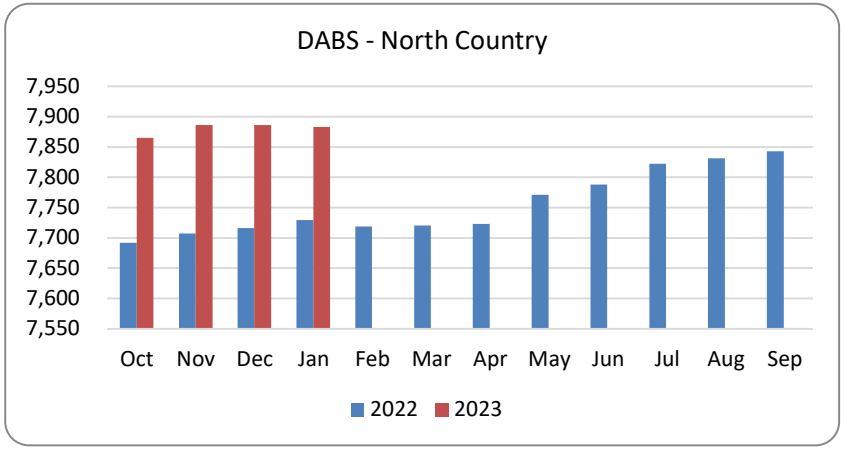


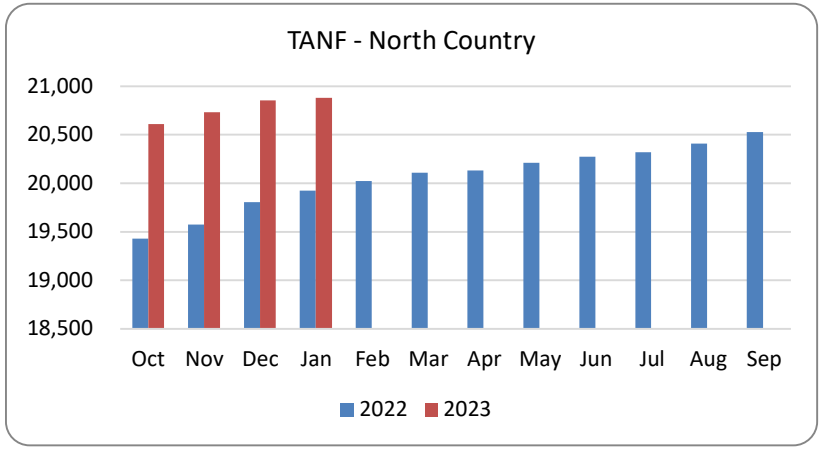
Northern Michigan Regional Entity

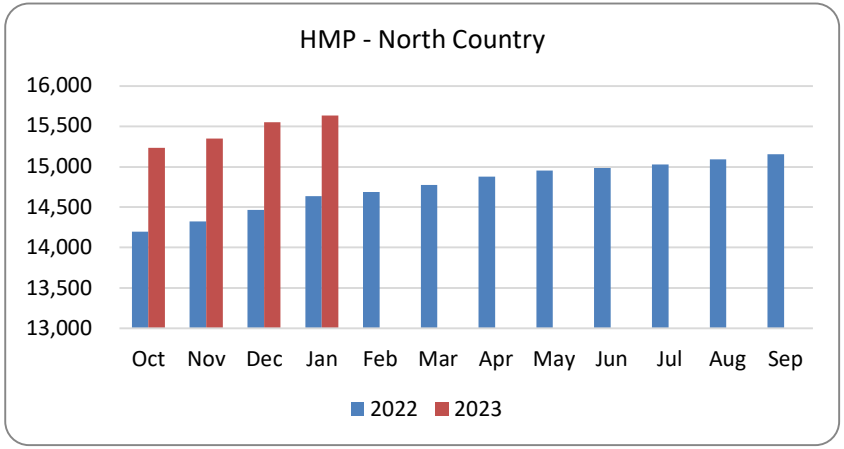
Narrative

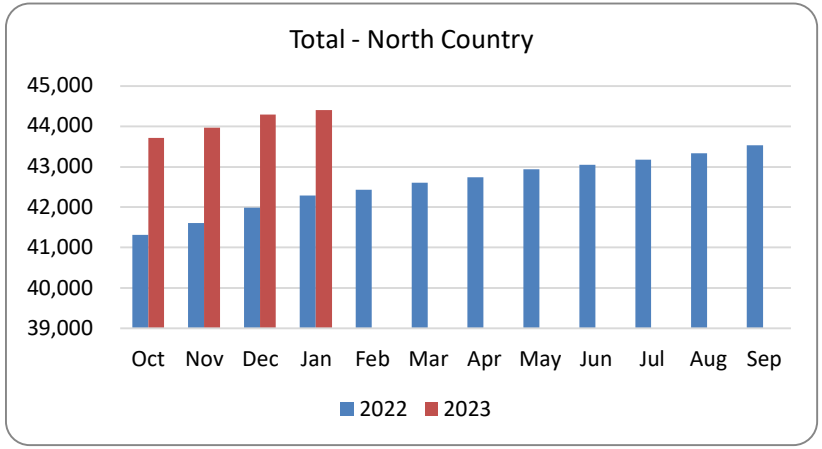
October 1, 2022 through January 31, 2023

North Country Eligible Members Trending - based on payment files







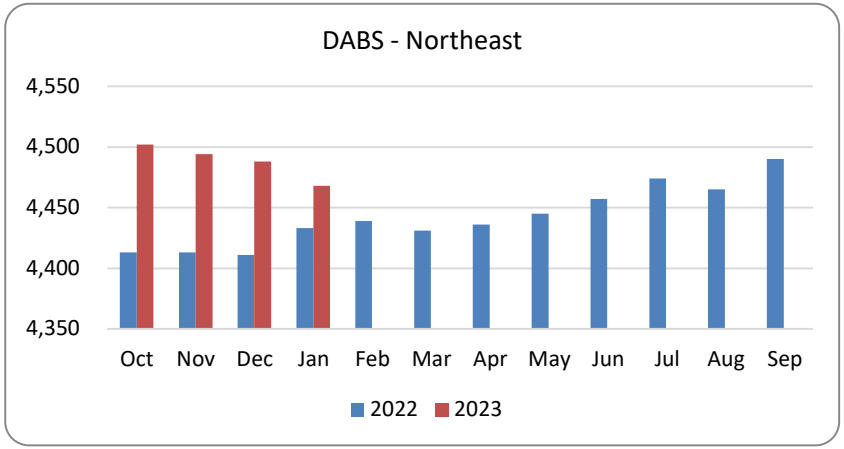


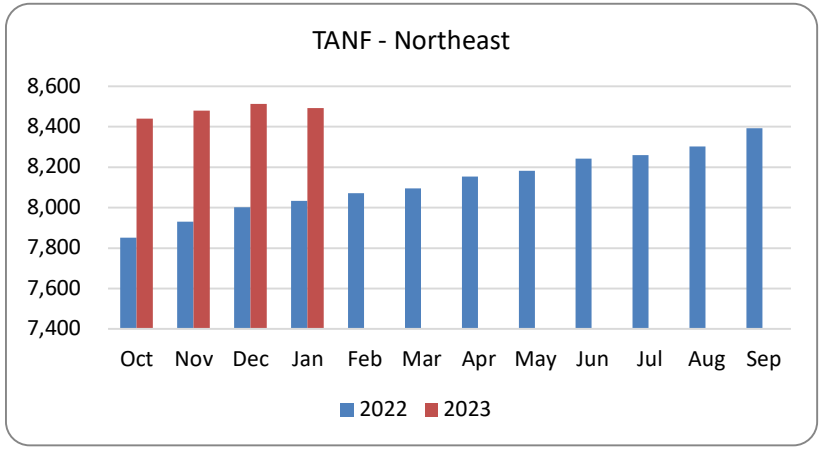
Northern Michigan Regional Entity

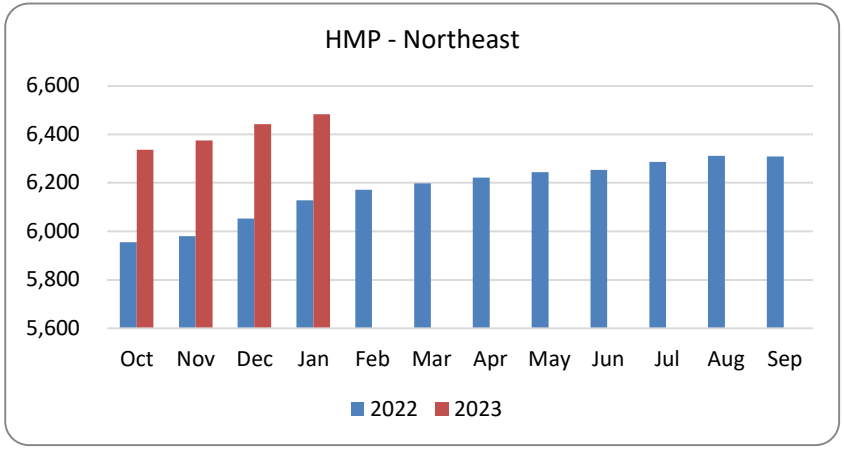
Narrative

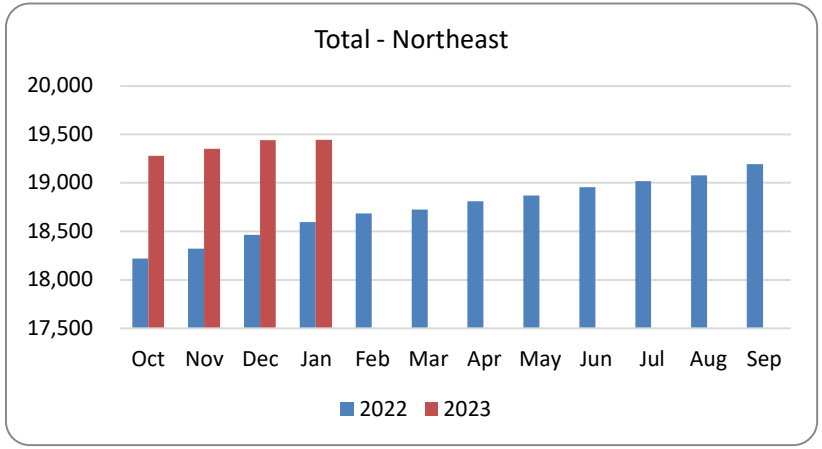
October 1, 2022 through January 31, 2023

Northeast Eligible Members Trending - based on payment files







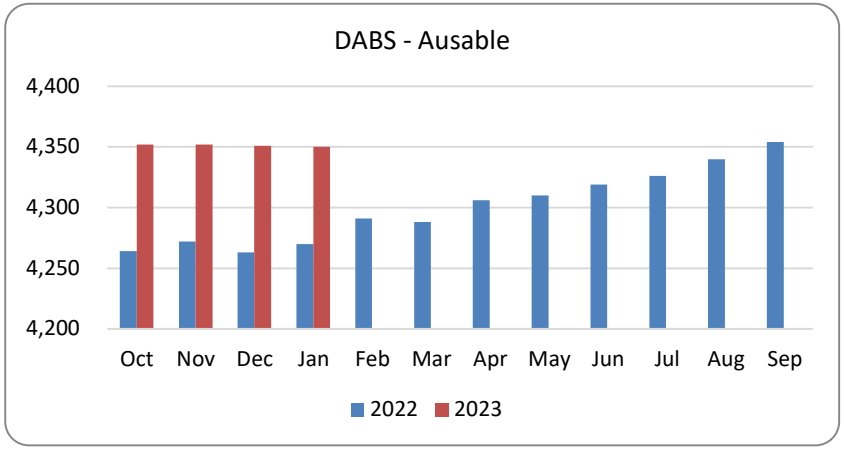


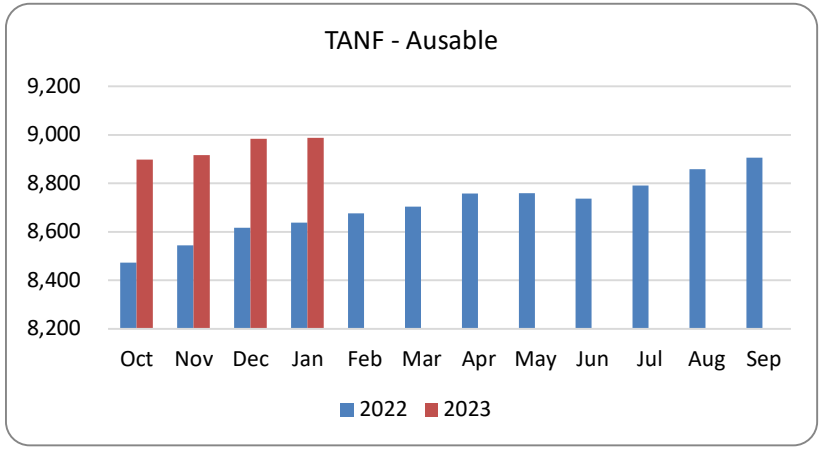
Northern Michigan Regional Entity

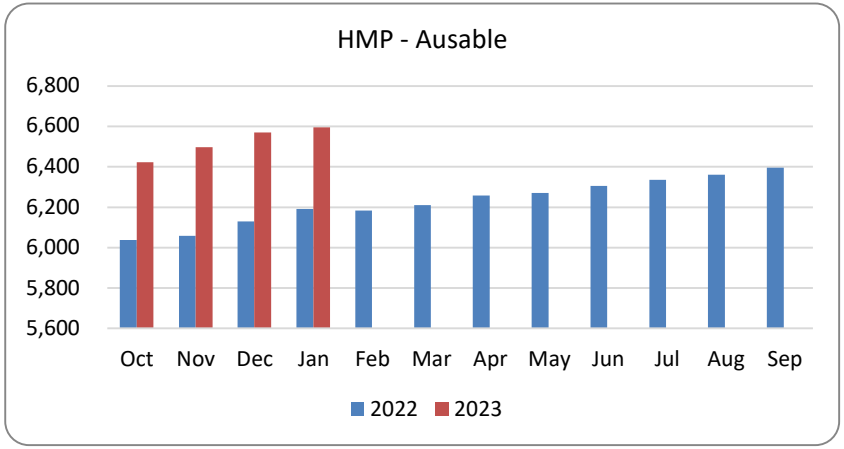
Narrative

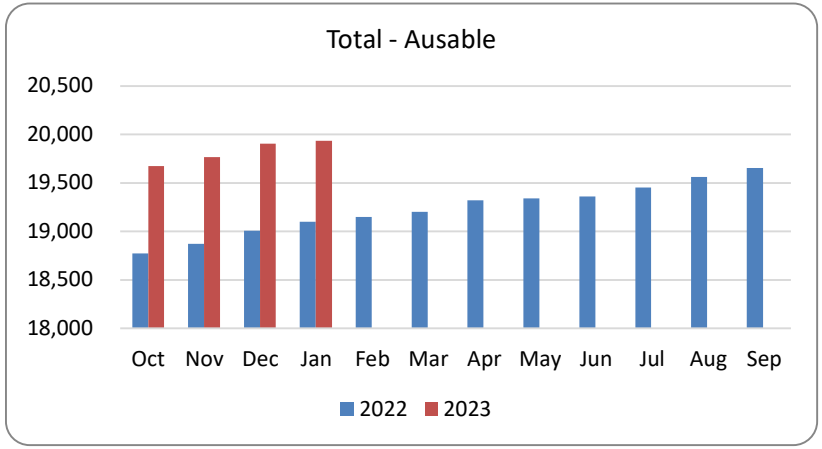
October 1, 2022 through January 31, 2023

Ausable Valley Eligible Members Trending - based on payment files







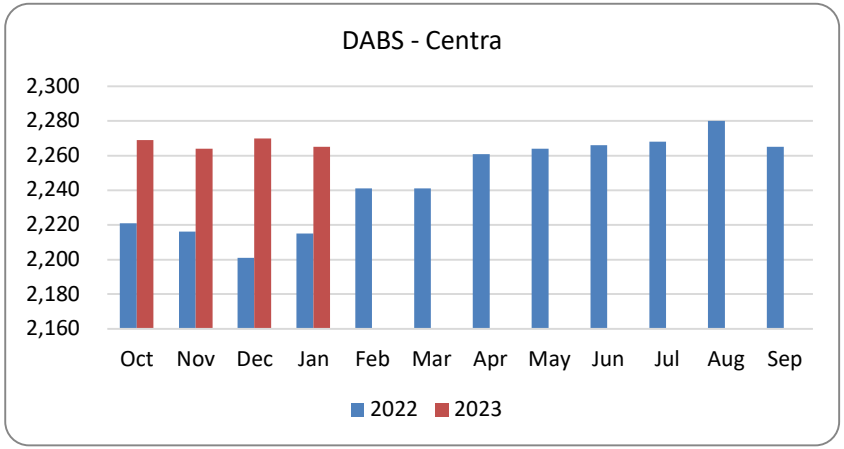


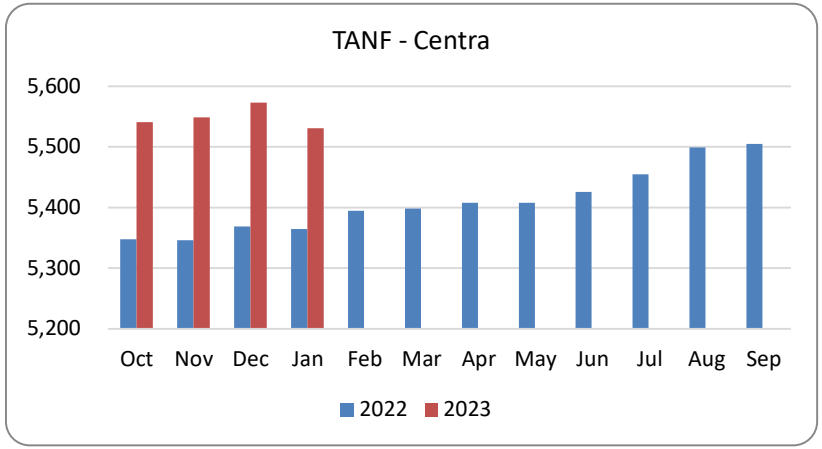
Northern Michigan Regional Entity

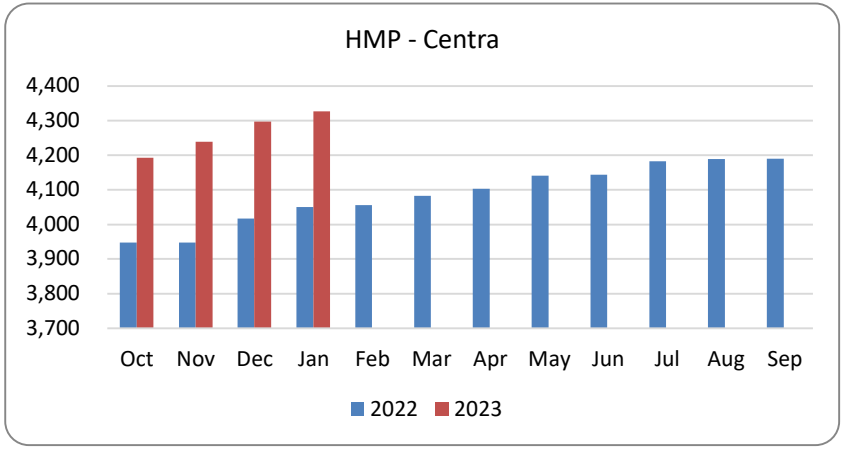
Narrative

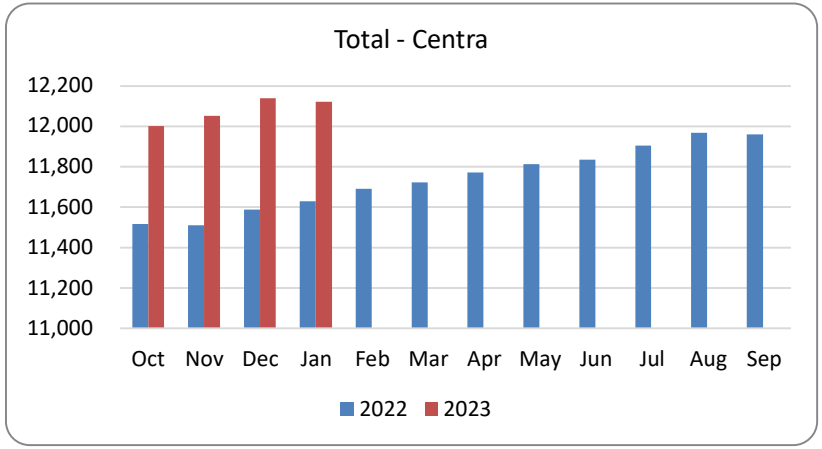
October 1, 2022 through January 31, 2023

Centra Wellness Eligible Members Trending - based on payment files







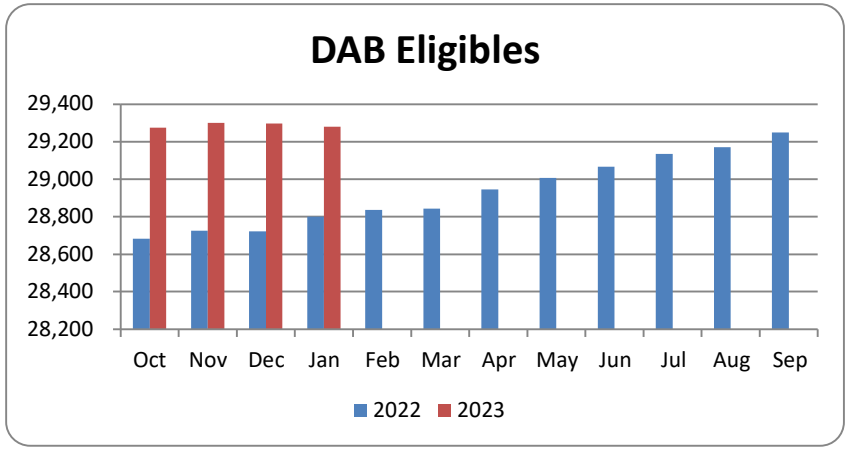


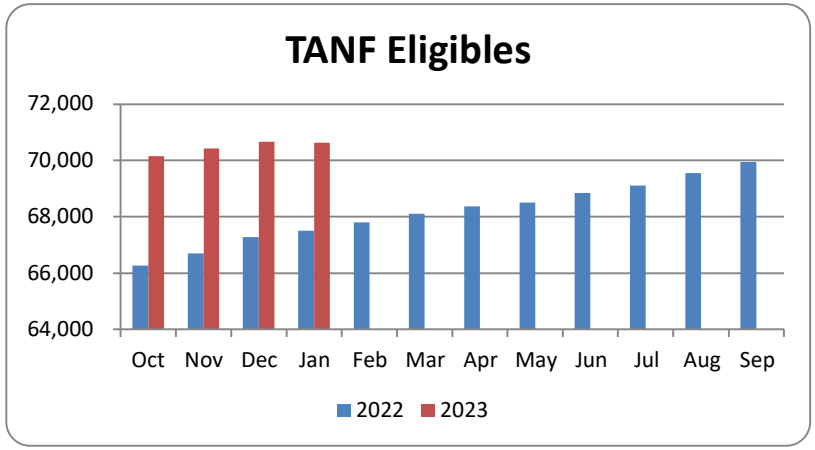
Northern Michigan Regional Entity

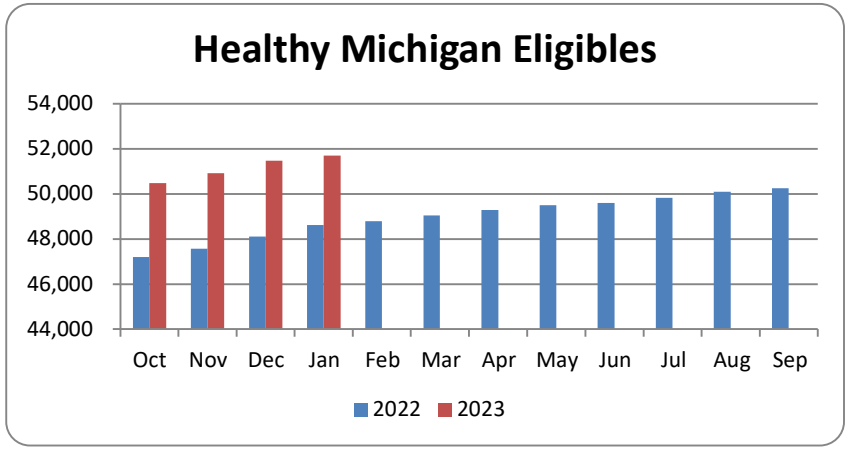
Narrative

October 1, 2022 through January 31, 2023

Regional Eligible Trending





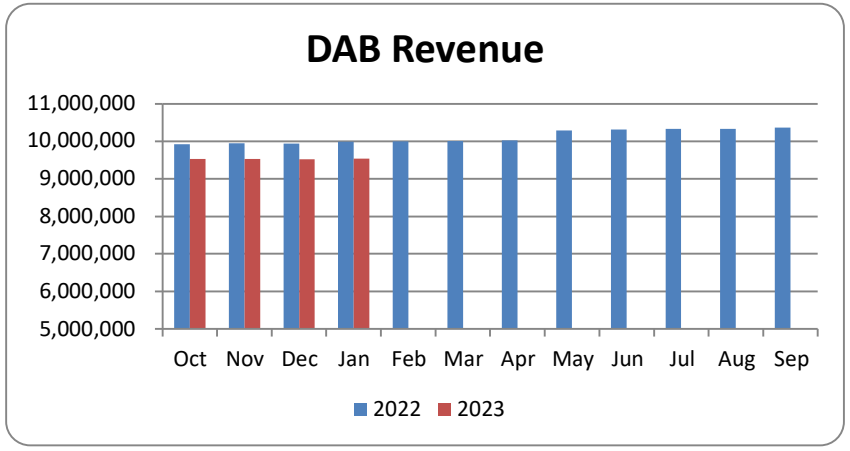


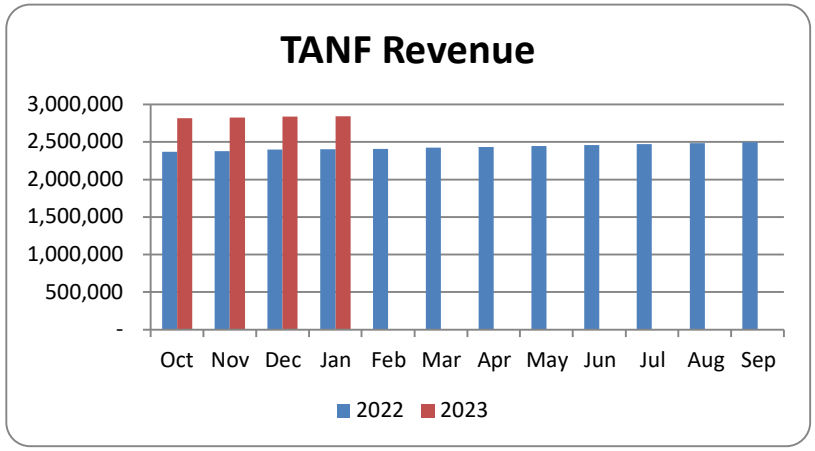
Northern Michigan Regional Entity

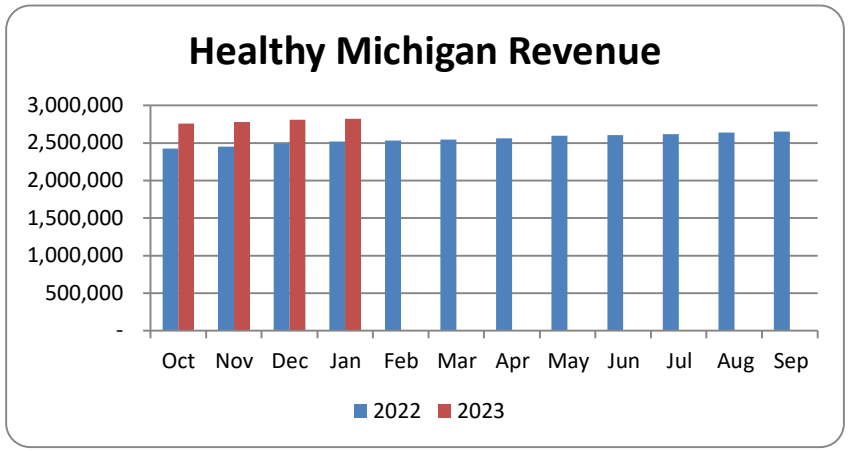
Narrative

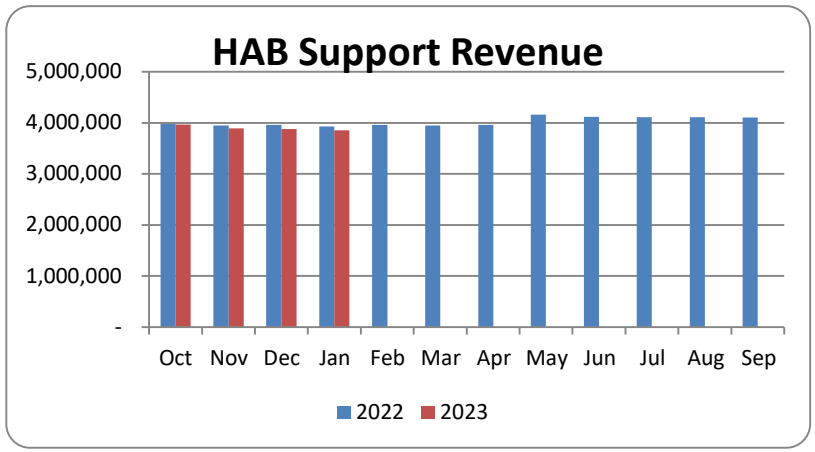
October 1, 2022 through January 31, 2023

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING
10:00AM – MARCH 6, 2023
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Burt Francisco (Alpena), John Wallace (Cheboygan), Dave Freedman (Grand Traverse), Jay O'Farrell (Iosco), Greg McMorrow (Leelanau), Richard Schmidt (Manistee), Chuck Varner (Oscoda), Terry Larson (Presque Isle), Gary Taylor (Wexford)**
VIRTUAL ATTENDEES:	**Carolyn Brummund (Alcona), Tim Markey (Benzie), Joshua Chamberlain (Charlevoix), Sherry Powers (Crawford), Ron Quackenbush (Ogemaw), Doug Johnson (Otsego), Darlene Sensor (Roscommon)**
ABSENT:	**Melissa Zelenak (Antrim), Terry Newton (Emmet), David Comai (Kalkaska), Don Edwards (Montmorency)**
STAFF:	**Bea Arsenov, Jodie Balhorn, Carol Balousek, Lisa Hartley, Eric Kurtz, Pamela Polom, Sara Sircely, Tricia Wurn, Deanna Yockey**
PUBLIC:	**Madeline McConnell**

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

ROLL CALL
Let the record show that David Comai, Don Edwards, Terry Newton, and Melissa Zelenak were absent from the meeting on this date; all remaining Substance Use Disorder Oversight Board Members were in attendance either in Gaylord or remotely.

It was recognized that, with nine SUD Oversight Board Members in attendance in person, there was not a quorum. Because the SUD Oversight Board is advisory in nature, the decision was made to continue to review agenda items rather than adjourning. No votes will be taken, but recommendations will be made to the NMRE Governing Board. The question of whether the NMRE SUD Oversight Board is subject to the Open Meeting Act was raised; Mr. Kurtz agreed to seek a legal opinion.

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

APPROVAL OF PAST MINUTES
The January 9, 2023 minutes were included in the materials for the meeting on this date; no changes to the January minutes were requested.

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

ANNOUNCEMENTS

Let the record show that new NMRE SUD Oversight Board member Burt Francisco, representing Alpena County, was introduced to the group.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST

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

INFORMATIONAL REPORTS

Admissions

The admissions report through January 31, 2023 was included in the materials for the meeting on this date. Admissions in the first four months of FY23 were up 4.3% from Quarter 1 FY22. The data showed that outpatient was the highest level of treatment admissions at 48%, and alcohol was the most prevalent primary substance at 54%, methamphetamine was second at 17%, and heroin was the third most prevalent primary substance at 14%.

Finance

December 2022 Monthly Report

SUD services through December 31, 2022 showed all funding source revenue of $7,102,768 and $5,851,495 in expenses, resulting in a net surplus of $1,251,273. Total PA2 funds were reported as $5,341,057. Final numbers for FY22 will be reviewed under the next agenda item.

It was noted that the COVID Public Health Emergency (PHE) will be ending on May 11, 2023. Michigan is set to restart Medicaid eligibility renewals effective April 1, 2023; renewals will be staged over a 12-month period beginning in June. Renewal packets will be sent to beneficiaries one month prior to their renewal month. It is anticipated that 500,000 individuals may fall off Medicaid or HMP which will result in a substantial increase in individuals needing block grant funding. It was noted that expenditures over the block grant allocation may be paid with liquor tax funding.

LIQUOR TAX ITEMS

Final FY22 Liquor Tax Amounts

A report showing the final liquor tax amounts for FY22 was included in the meeting materials.

FY22 Beginning Balance	FY22 Revenue	FY22 Expenditures	FY22 Ending Balance
$6,231,626	$1,523,119	$2,348,242	$5,406,503

Mr. Wallace requested that the Cheboygan Prevention Coalition give a presentation to the Cheboygan County Board of Commissioners; NMRE Prevention Coordinator, Jodie Balhorn, agreed to relay the request.

FY23 Approved Projects

An updated list of approved liquor tax funded projects, sorted by county, was included in the meeting materials for informational purposes.

FY23 Changes to Approved Projects

A list of proposed changes to FY23 approved liquor tax funded projects, sorted by county, was included in the meeting materials.

Funding adjustments REDUCING liquor tax funds:					
County	**Project**	**Provider**	**Approved Amount**	**Updated Amount**	**Notes**
Kalkaska	Opioid Use Prevention and Stigma Reduction Campaign	Catholic Human Services		-13,000.00	Funding is not available for Kalkaska. Cuts to the project will minimize the impact to the fund balance.
Leelanau	Opioid Use Prevention and Stigma Reduction Campaign	Catholic Human Services		-18,500.00	Funding is not available for Leelanau. Cuts to the project will minimize the impact to the fund balance.
Missaukee	Jail Services	Catholic Human Services	$26,779.79	-$11,000.00	

Funding adjustments ADDING liquor tax funds:					
County	**Project**	**Provider**	**Approved Amount**	**Updated Amount**	**Notes**
Grand Traverse	Opioid Use Prevention and Stigma Reduction Campaign	Catholic Human Services	$90,218.31 (Original request was for $106,139.19)	+$17,967.25	Additional funding is available for Grand Traverse.
Grand Traverse	Recovery Coach Patient Engagement with Healthcare Practices	Munson	$86,908.50 (Original request was for $173,817.00)	+$10,000.00	Additional funding is available for Grand Traverse.
Grand Traverse	Best Medical SBIRT	Catholic Human Services		+$1,100.50	Additional funding is available for Grand Traverse.
Cheboygan	Coalition	Catholic Human Services	$127,919.24 (Original request was for $136,084.00)	+$8,164.76	Additional funding is available for Cheboygan.

The recommendation by the NMRE SUD Oversight Board members present was to approve.

FY23 New Requests
A list of new liquor tax requests for FY23, sorted by county, was included in the meeting materials for informational purposes.

FY23 Liquor Tax Request Recommendations
A summary of the liquor tax requests that submitted for review on this date was included in the meeting materials.

PA2 Fund Use Requests

1) 53rd Circuit Recovery Court – Drug Testing Equipment and Supplies

Cheboygan	$	6,500.00

The recommendation by NMRE and the NMRE SUD Oversight Board members present was to approve.

2) Bear River Health – Substance Use Recovery Focused (SURF) Club

Antrim	$	28,852.54
Charlevoix	$	32,379.21
Crawford	$	17,227.04
Emmet	$	41,117.22
Total	**$**	**119,576**

The recommendation by NMRE and the NMRE SUD Oversight Board members present was to approve.

3) Bear River Health – Peer Recovery Coach Services

Charlevoix	$	41,684.00
Emmet		34,196.00
Total	**$**	**75,880.00**

The recommendation by NMRE and the NMRE SUD Oversight Board members present was to approve.

4) 13th Circuit Court Community Corrections – Peer Recovery Coach Services

Antrim	$	5,170.00
Grand Traverse	$	10,000.00
Total	**$**	**15,170.00**

The recommendation by NMRE and the NMRE SUD Oversight Board members present was to approve.

5) Bear River Health – Jail Case Management

Cheboygan	$	23,364.00

The recommendation by NMRE and the NMRE SUD Oversight Board members present was to approve.

6) Health Department of Northwest Michigan (on behalf of the Drug-Free Northern Michigan 21 County Alliance) – Vaping Prevention Media Campaign

Alcona	$	1,316.87
Alpena	$	3,620.98
Antrim	$	2,963.25
Benzie	$	2,235.67
Charlevoix	$	3,325.45
Cheboygan	$	3,227.49
Crawford	$	1,769.27
Emmet	$	4,222.87
Grand Traverse	$	11,679.84
Iosco	$	3,201.15
Kalkaska	$	2,243.43
Leelanau	$	2,755.24
Manistee	$	3,107.64
Missaukee	$	1,908.07
Montmorency	$	1,176.80
Ogemaw	$	2,669.24
Oscoda	$	1,054.29
Otsego	$	3,121.77
Presque Isle	$	1,627.29
Roscommon	$	3,039.96
Wexford	$	4,233.43
Total	**$**	**64,500.00**

The recommendation by NMRE and the NMRE SUD Oversight Board members present was to approve.

Updated Liquor Tax Policy and Procedure

The NMRE updated "Use of Liquor Tax Funding for Substance Use Disorder (SUD) Services" Policy and Procedure was included in the meeting materials in draft form. Mr. Wallace suggested adding a flowchart. Mr. Freedman suggested that some language be revised to clarify the use pf liquor tax funds for individuals residing in the county from which the funds originated or for services provided in the county from which the funds originated. Mr. Freedman asked that clarification be made under section B(3)(b) of the procedure as to whether renovations to structures are allowed. Mr. Freedman noted that in the second sentence under section (C) of the policy should read "and" instead of "in." Additional feedback may be sent to Ms. Sircely's attention.

PUBLIC COMMENT

SUD Oversight Board

Mr. McMorrow thanked NMRE staff for the work they do.

Staff

Mr. Kurtz stated that a review of the SUD Oversight Board Bylaws is needed; he proposed that a group be formed with representation from NMRE, the NMRE Governing Board, and the NMRE SUD Oversight Board.

It was announced that the NMRE is holding a Day of Recovery Education on May 8th at Treetops Resort for people seeking recovery or in recovery from a substance use disorder.

NEXT MEETING
The next meeting was scheduled for May 1, 2023 at 10:00AM.

ADJOURN
Let the record show that Ms. Brummund adjourned the meeting at 11:16AM.

Northern Michigan Regional Entity
Substance Use Disorder Services
March 6, 2023

PUBLIC ACT 2 (LIQUOR TAX) REQUESTS

SUMMARY OF SUBSTANCE USE DISORDER POLICY OVERSIGHT BOARD

ADJUSTMENTS – FUNDING IS NOT AVAILABLE

COUNTY	PROJECT	PROVIDER	APPROVED AMOUNT	UPDATE AMOUNT	NOTE
Kalkaska	Opioid Use Prevention and Stigma Reduction Campaign	CHS		- $13,000.00	Funding is not available for Kalkaska. Cuts to the projects will minimize impact to the fund balance
Leelanau	Opioid Use Prevention and Stigma Reduction Campaign	CHS		- $18,500.00	Funding is not available for Leelanau. Cuts to the projects will minimize impact to the fund balance
Missaukee	Jail Services	CHS	$26,779.79	- $11,000.00	

ADJUSTMENTS – FUNDING IS NOW AVAILABLE

COUNTY	PROJECT	PROVIDER	APPROVED AMOUNT	UPDATE AMOUNT	NOTE
Grand Traverse	Opioid Use Prevention and Stigma Reduction Campaign	CHS	$90,218.31 Original Request: $106,139.19	+ $17,967.25	Additional funding is available for Grand Traverse
Grand Traverse	Recovery Coach Patient Engagement Within Healthcare Practices	Munson	$86,908.50 Original Request: $173,817	+ $10,000	Additional funding is available for Grand Traverse
Grand Traverse	Best Medical SBIRT	CHS		+ $1,100.50	Additional funding is available for Grand Traverse

Cheboygan	Coalition	CHS	$127,919.24 Original Request: $136,084	+ $8,164.76	Additional funding is available for Cheboygan

Drug Testing Equipment and Supplies - NEW		
53rd Circuit Recovery Court		
	Total Request: $6,500	Total Recommended for Approval by Those in Attendance: $6,500
Cheboygan	$6,500	$6,500
Comments:	The request is for the purchase of a Fingerprint Drug Testing machine and test strips for this machine. This allows for an additional form of testing to ensure participants are honest and are provided treatment services as needed.	
Recommendation:	Recommended for Approval by those in attendance, Cheboygan Representative supported	

Drug Testing Equipment and Supplies - NEW		
53rd Circuit Recovery Court		
	Total Request: $6,500	Total Recommended for Approval by Those in Attendance: $6,500
Cheboygan	$6,500	$6,500
Comments:	The request is for the purchase of a Fingerprint Drug Testing machine and test strips for this machine. This allows for an additional form of testing to ensure participants are honest and are provided treatment services as needed.	
Recommendation:	Recommended for Approval by those in attendance, Cheboygan Representative supported	

Substance Use Recovery Focused (SURF) Club - UPDATED		
Bear River Health		
	Total Request: $119,576	Total Recommended for Approval by Those in Attendance: $119,576
Antrim	$28,852.54	$28,852.54
Charlevoix	$32,379.21	$32,379.21
Crawford	$17,227.04	$17,227.04
Emmet	$41,117.22	$41,117.22
Comments:	The request indicates that the Substance Use Recovery Focused (SURF) Club will become a "…pathway and eventual Recovery Community Organization…". The goal of the group is to "raise awareness of addiction as	

	a treatable chronic disease; to help stem addiction stigma; and to promote prevention as a first step in the battle for ongoing sobriety." In addition, the club will work daily to contact and check in on people who have recently been involved in treatment as they acclimate back into their lives outside of treatment.
Recommendations:	Recommended for Approval by those in attendance. Representatives from the counties included in the request were not in attendance.

Peer Recovery Coaches - UPDATED		
Bear River Health		
	Total Request: $75,880	Total Recommended for Approval by Those in Attendance: $75,880
Charlevoix	$41,684	$41,684
Emmet	$34,196	$34,196
Comments:	These funds would support the salaries and wages for Peer Recovery Coaches. would be provided to current outreach clients, potential outreach clients, and community. Services provided would be to support clients with connection to community resources, provide recovery resources, assist transferring individuals, assisting individuals released from jail or MDOC, provide outreach to the community, provide peer services, and provide life skills trainings for individuals at the BRH sober living houses.	
Recommendations:	Recommended for Approval by those in attendance. Representatives from the counties included in the request were not in attendance.	

Peer Recovery Coaches - UPDATED		
13th Circuit Court Community Corrections		
	Total Request: $15,170	Total Recommended for Approval by Those in Attendance: $15,170
Antrim	$5,170	$5,170
Grand Traverse	$10,000	$10,000
Comments:	These funds would pay for two part time recovery coaches to work with the Sobriety Court and Drug Court.	
Recommendations:	Recommended for Approval by those in attendance, Grand Traverse Representative supported	

Jail Case Management Services – RE-SUBMISSION		
Bear River Health		
	Total Request: $23,364	Total Recommended for Approval by Those in Attendance: $23,364
Cheboygan	$23,364	$23,364
Comments:	This request would continue Jail Case Management Services in the Cheboygan County Jail. In previous years, grant funding has been available to support this service. However, at this point, there is not enough funding to cover Cheboygan County Jail services.	

Recommendation:	Recommended for Approval by those in attendance, Cheboygan Representative supported

Vaping Prevention Media Campaign – RE-SUBMISSION		
Health Department of Northwest Michigan on behalf of Drug Free Northern Michigan 21 County Alliance		
	Total Request: $64,500	Total Recommended for Approval by Those in Attendance: $64,500
Alcona	$ 1,316.87	$ 1,316.87
Alpena	$ 3,620.98	$ 3,620.98
Antrim	$ 2,963.25	$ 2,963.25
Benzie	$ 2,235.67	$ 2,235.67
Charlevoix	$ 3,325.45	$ 3,325.45
Cheboygan	$ 3,227.49	$ 3,227.49
Crawford	$ 1,769.27	$ 1,769.27
Emmet	$ 4,222.87	$ 4,222.87
Grand Traverse	$ 11,679.84	$ 11,679.84
Iosco	$ 3,201.15	$ 3,201.15
Kalkaska	$ 2,243.43	$ 2,243.43
Leelanau	$ 2,755.24	$ 2,755.24
Manistee	$ 3,107.64	$ 3,107.64
Missaukee	$ 1,908.07	$ 1,908.07
Montmorency	$ 1,176.80	$ 1,176.80
Ogemaw	$ 2,669.24	$ 2,669.24
Oscoda	$ 1,054.29	$ 1,054.29
Otsego	$ 3,121.77	$ 3,121.77
Presque Isle	$ 1,627.29	$ 1,627.29
Roscommon	$ 3,039.96	$ 3,039.96
Wexford	$ 4,233.43	$ 4,233.43
Comments:	With the increase of teen vaping, a media campaign would aim to prevent this from occurring. MacDonald Garber would create and oversee the media campaign. However, each coalition would bring forward a Photovoice for the coalition. Photovoice is an evidence based practice that engages teens to create their own photo and story in their perspective on what influences youth to start vaping, what keeps youth from vaping, and how youth vaping impacts their community.	
Recommendation:	Recommended for Approval by those in attendance.	

NORTHERN MICHIGAN REGIONAL ENTITY

INFORMATION TECHNOLOGY SECURITY ASSESSMENT

BOARD OF DIRECTORS REPORT
JANUARY 2023

PROVIDED BY:

OPEN SYSTEMS TECHNOLOGIES

An Information Technology Security Assessment was conducted for Northern Michigan Regional Entity on the 25th of January 2022. This report summarizes the ratings and recommendations related to this assessment.

Fifty-Six (56) network devices were comprehensively scanned using a variety of tools. The team has determined that 24 high/critical vulnerabilities exist within the NMRE network environment. A weighted vulnerability index of 0.345 has been assigned and a determination has been made that the exploitability related to the reported vulnerabilities is “Elevated”.

OST has provided the organization with detailed recommendations and information on how to reduce the risks that were identified from this assessment process.

Overall, NMRE has been assigned a security rating of 7.8. A potential rating of 8.5 is possible. Improvements to the Final Security Rating will occur as IT related risk is removed from the organization.

A Periodic Security Assessment is scheduled for January 2023.

Sincerely,

W. Scott Montgomery
Security Practice Manager
Open Systems Technologies

INFORMATION TECHNOLOGY SECURITY ASSESSMENT

JANUARY 2023

FINDINGS AND RECOMMENDATIONS

1

Northern Michigan Regional Entity

Presentation Agenda

- Findings and Recommendations
- Discussion
- Information Technology Security Assessment Project Sign-off

2

Findings and Recommendations

This presentation provides a summary of the activity that was performed as part of the Information Technology Security Assessment.

Specific technical details have purposely been left out of this presentation.

Please refer to the accompanying digital deliverable for all detail related to the information presented here.

3

Acknowledgements

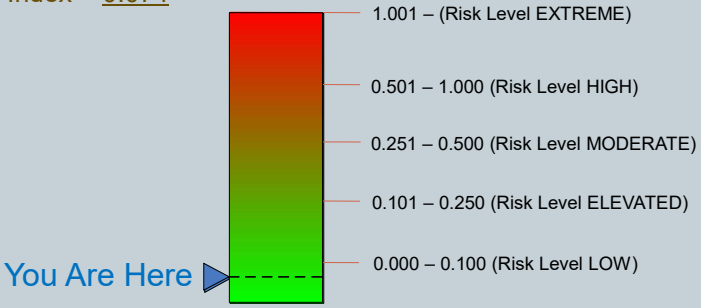
- Improved vulnerability index rating.

4

Findings and Recommendations

4 High/Critical Vulnerabilities identified on 51 IP Addresses

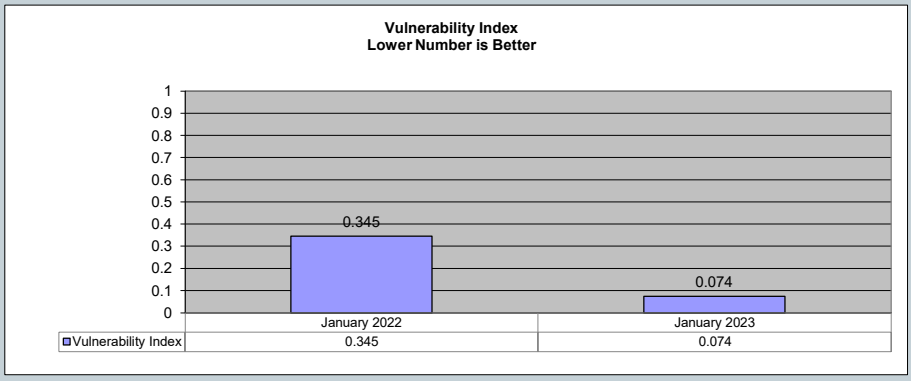
Vulnerability Index = 0.074



5

Findings and Recommendations

Vulnerability Index History



6

Findings and Recommendations

Security Issues

- Default credentials on two devices.
- Unsupported version of SQL Server.
- SSL Version 2 and 3 Detected.
- SNMP Community String of “public” identified.
- Third party application vulnerabilities including Oracle Java and Microsoft Silverlight.

7

Findings and Recommendations

Virus Protection

Antivirus software was detected and up-to-date on each system.

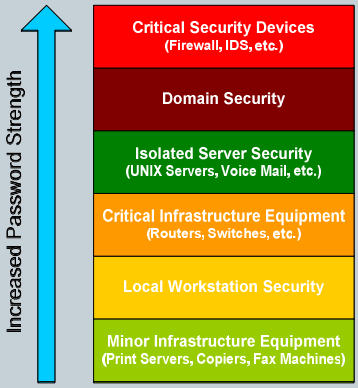
8

Findings and Recommendations

Classification

Provide unique passwords at all security levels within an enterprise.

Strong passwords should be used at all levels, but should also increase in complexity as the device(s) becomes more critical to overall security.



9

Findings and Recommendations

SpyWare

Spyware (Malware) protection: Workstations with internet access are prone to spyware infection. Spyware is quickly becoming a serious issue and is difficult to block. Spyware detection and removal tools are necessary to reduce the risk from this new threat.

Spyware can cause a wide variety of issues from slow, sluggish computer operation to key-logging.

Antivirus and web filtering installations are working to reduce this security threat by blocking and detecting many SpyWare variants.

10

Findings and Recommendations

External Exposure

No High or Critical vulnerabilities identified.

11

Findings and Recommendations

System/Software Updates

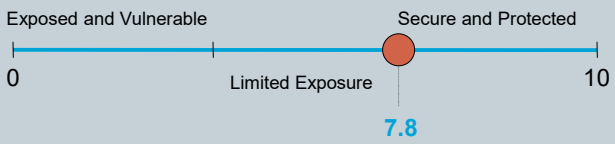
Organizations should ensure that all operating systems, applications, and network devices are up-to-date and supported by the vendor.

100% of reviewed workstations and servers are running supported versions of their operating systems.

12

Final Security Rating

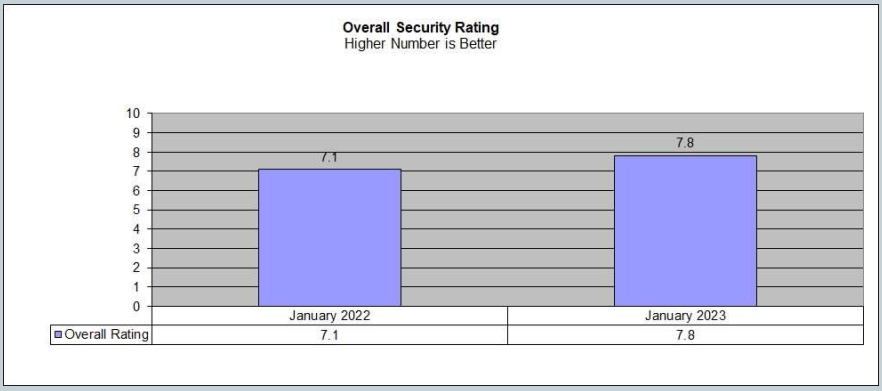
Final Security Rating



13

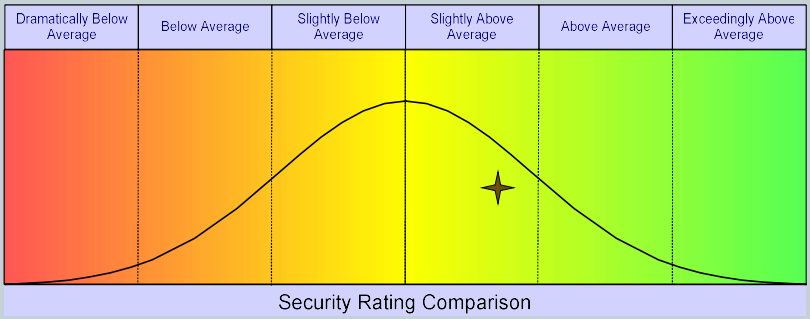
Final Security Rating

Final Security Rating History



14

Statistical Distribution



When compared to the overall security of similar organizations, you are rated Slightly Above Average.

15

Potential Security Rating

Final Security Rating can be increased upon implementation of recommendations shown on the next slide.

16

Recommendations (Prioritized)

- Implement a visitor and contractor sign-in process.
- Ensure that network-attached devices have strong and unique passwords assigned.
- Update the Microsoft SQL Server to a supported version.
- Configure secure web servers to utilize TLS 1.2 or higher.
- Review authenticated scanning reports and install updates as reported. Microsoft January Security Updates, Oracle Java updates, etc.
- Change the SNMP Community String from "Public" to a unique variable.

17

Recommendations (Advisable)

- A Periodic Security Assessment is scheduled for January 2024.

Optimum security can be achieved by implementing these recommendations.

18

Discussion

19

Project Sign-Off

- Sign-Off document provides authorization for OST to close this project.
- Communicates satisfaction with project deliverables.

20

Conclusion

- Next steps?....

Thank You

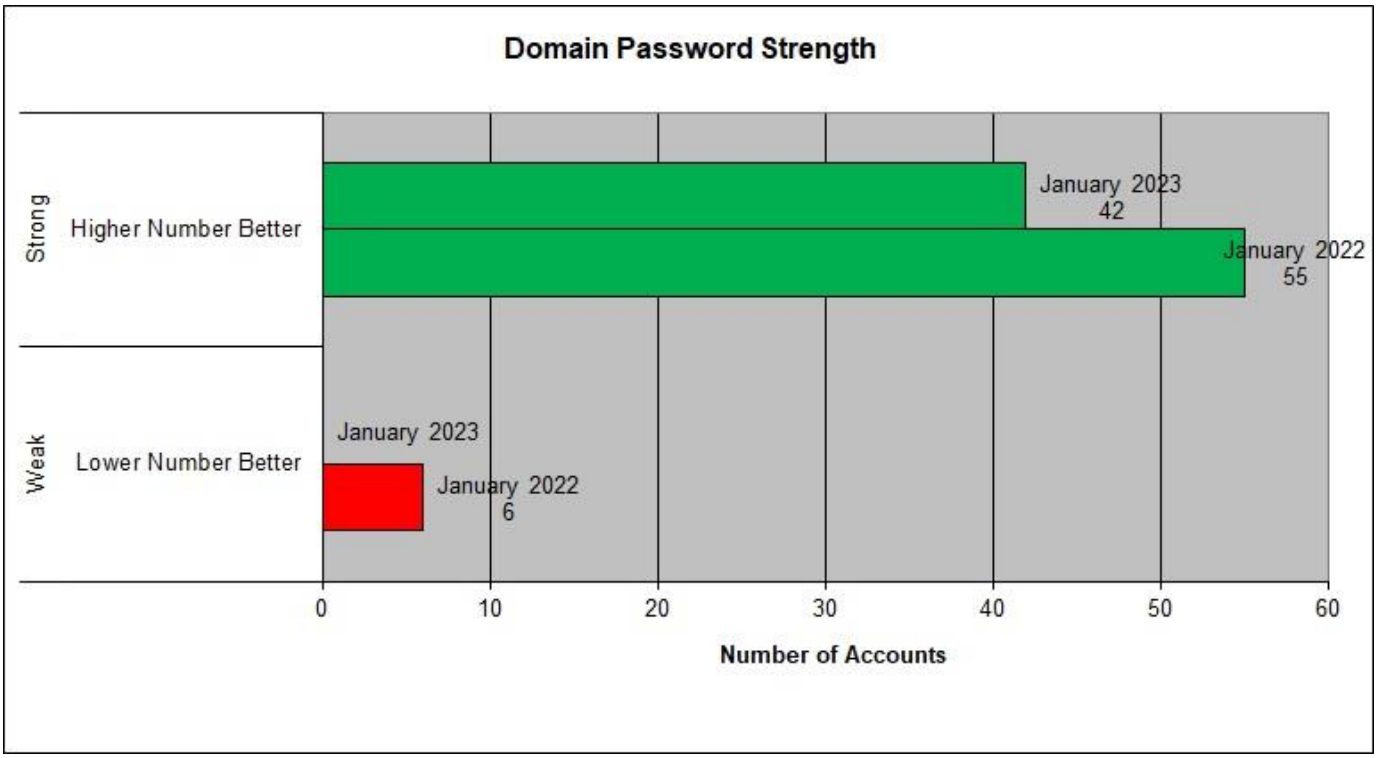
21

The following ratings have been assigned to the organization based on the information gathered and analyzed during this assessment process.

Password Strength

Security Risk Level Low

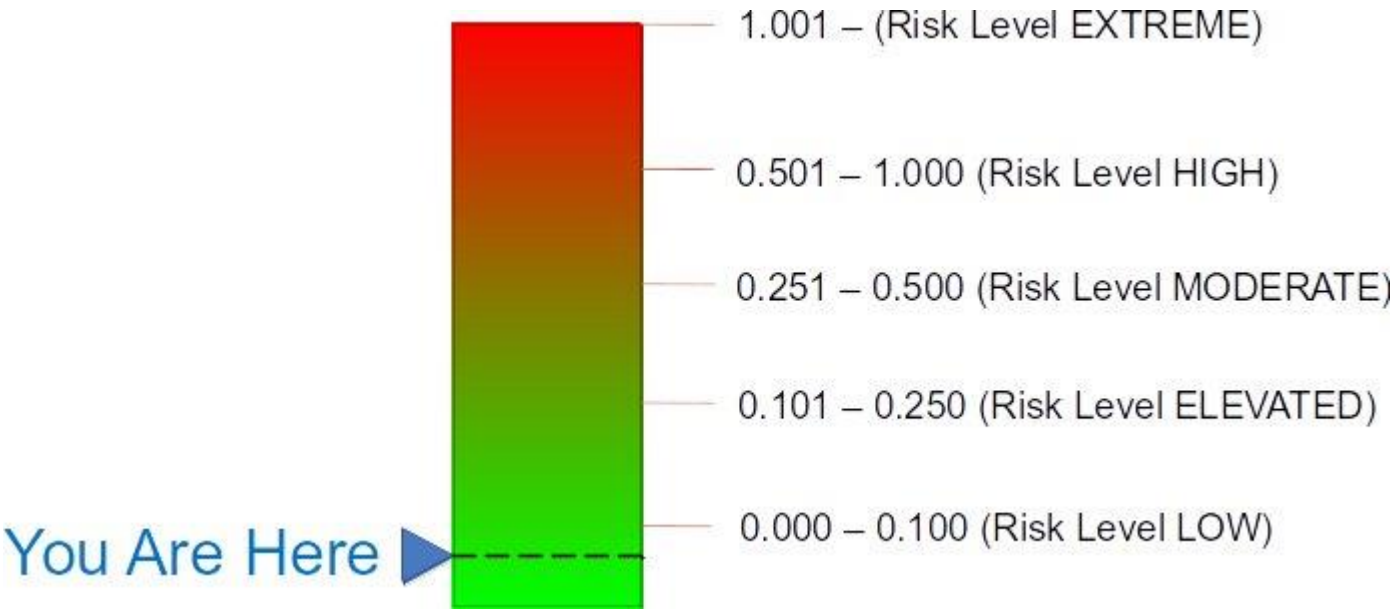
Password Strength History



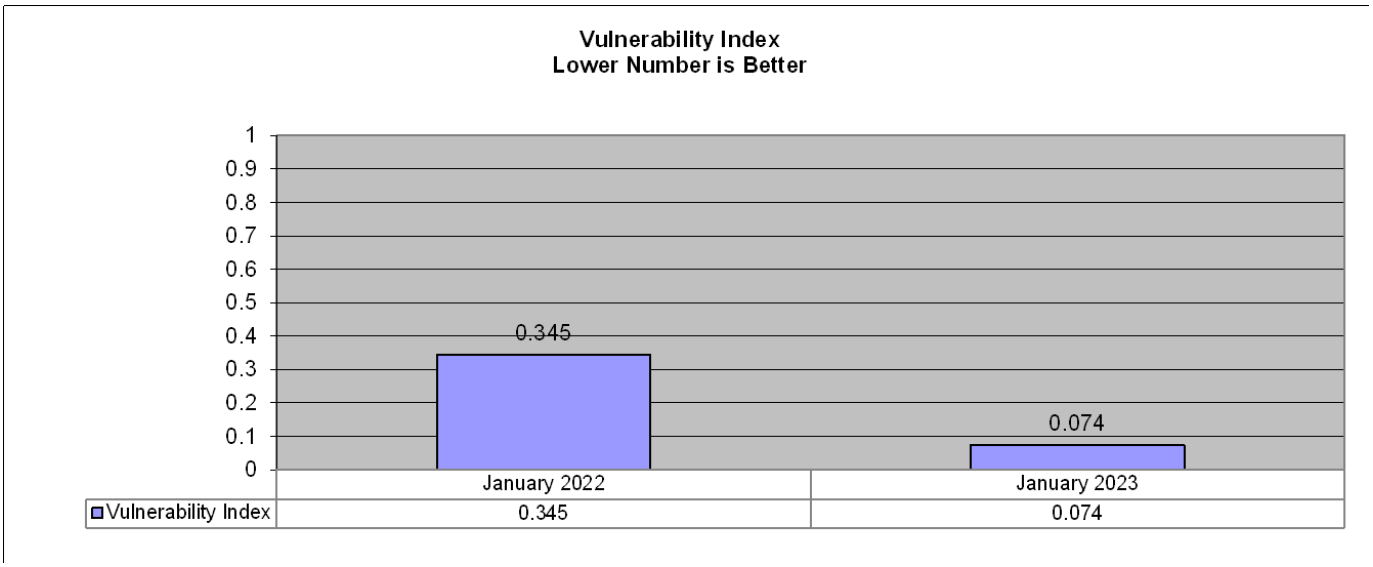
Physical Security

Security Risk Level Low

System Vulnerability Index (Current 0.074)



System Vulnerability Index History



Exploitability

Wireless Networking Risk

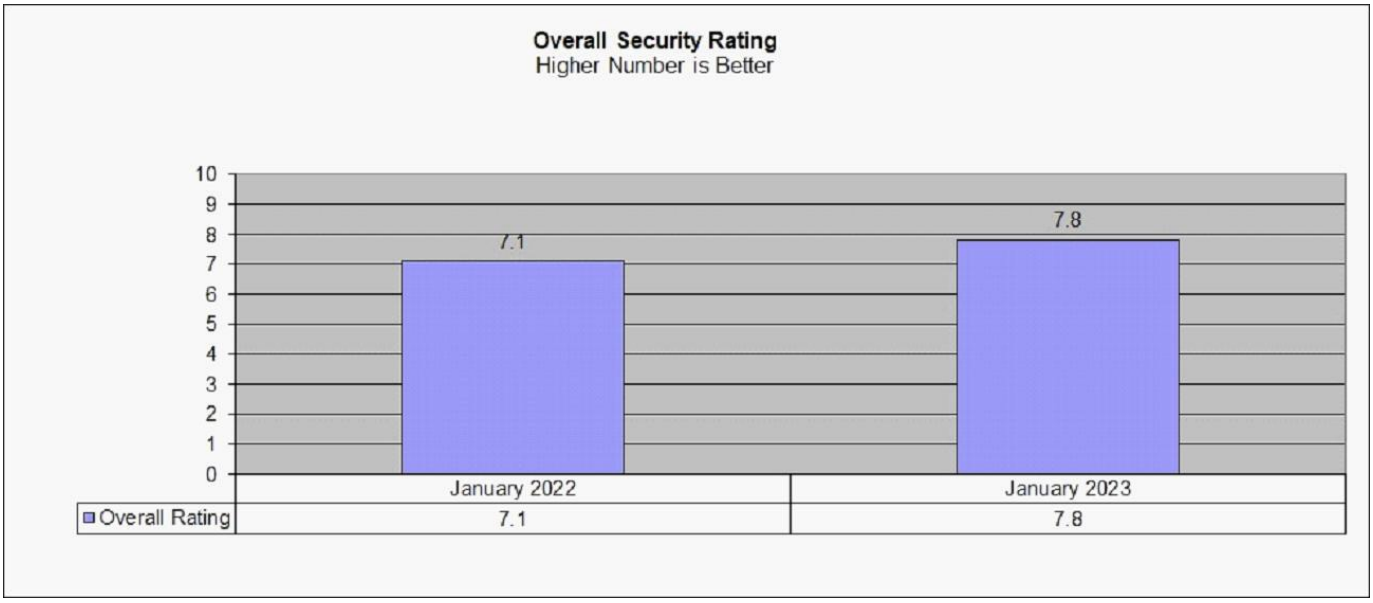
Security Risk Level Low

MalWare/Zero-Day Virus Risk

Security Risk Level Elevated

Final Security Rating (Possible Maximum Rating of 8.5)

Final Security Rating History



Comparative Results by Industry