**Northern Michigan Regional Entity**

**Board Meeting**

**April 23, 2025**

**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 – March 26, 2025 | Pages 2 – 7 |
| 7. | Correspondence | Pages 8 – 120 |
| 8. | Announcements | |
| 9. | Public Comments | |
| 10. | Reports | |
| | a. Executive Committee Report – Has Not Met | |
| | b. CEO's Report – April 2025 | Page 121 |
| | c. Financial Report – February 2025 | Pages 122 – 143 |
| | d. Operations Committee Report – April 15, 2025 | Pages 144 – 147 |
| | e. NMRE SUD Oversight Board Report – Next Meeting is May 5th | |
| 11. | New Business | |
| | a. Election of Officers (Nominating Committee Report) | |
| | b. MCG Indicia PCE Interface | Pages 148 – 150 |
| 12. | Old Business | |
| | a. Northern Lakes Update | |
| | b. FY25 PIHP Contract Injunction and Complaint - Update | Pages 151 - 170 |
| 13. | Presentation | |
| | DAB Analysis Summary | |
| 14. | Comments | |
| | a. Board | |
| | b. Staff/CMHSP CEOs | |
| | c. Public | |
| 15. | Next Meeting Date – May 28, 2025 at 10:00AM | |
| 16. | Adjourn | |

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**NORTHERN MICHIGAN REGIONAL ENTITY**
**BOARD OF DIRECTORS MEETING**
**10:00AM – MARCH 26, 2025**
**GAYLORD BOARDROOM**

| | |
|---|---|
| **ATTENDEES:** | **Bob Adrian, Tom Bratton, Ed Ginop, Gary Klacking, Eric Lawson, Mary Marois, Michael Newman, Gary Nowak, Jay O'Farrell, Ruth Pilon, Don Smeltzer, Don Tanner, Chuck Varner** |
| **VIRTUAL ATTENDEES:** | **Karla Sherman** |
| **NMRE/CMHSP STAFF:** | **Bea Arsenov, Brian Babbitt, Jodie Balhorn, Carol Balousek, Eugene Branigan, Ann Friend, Lisa Hartley, Chip Johnston, Eric Kurtz, Diane Pelts, Pamela Polom, Brandon Rhue, Nena Sork, Denise Switzer, Deanna Yockey** |
| **PUBLIC:** | **Erin Barbus, Hannah Driver, Dave Freedman, Lou Gamalski, Kevin Hartley, Justin Reed,** |

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

ROLL CALL
Let the record show all NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

APPROVAL OF AGENDA
Let the record show that no additions to the meeting agenda were requested.

**MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR MARCH 26, 2025; SUPPORT BY DON SMELTZER. MOTION CARRIED.**

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

**MOTION BY MARY MAROIS TO APPROVE THE MINUTES OF THE FEBRUARY 26, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY ED GINOP. MOTION CARRIED.**

CORRESPONDENCE

1) A letter to Eric Kurtz dated January 31, 2025 from Cynthia Brooks-Jones at MDHHS approving the NMRE's 2025 Guide to Services brochure.
2) The MDHHS Prepaid Inpatient Health Plan (PIHP) Operations Meeting Playbook for the first PIHP Operations meeting scheduled for April 3rd at 10:00AM.
3) MDHHS flyer inviting individuals to apply to join the Michigan Beneficiary Advisory Council (BAC) by Monday, April 14th at 5:00PM.
4) The MDHHS MiABLE Community Toolkit.
5) A document from the Community Mental Health Association of Michigan (CMHAM) listing potential Medicaid reductions.
6) A document from CMHAM dated March 2025 describing the work being done by association members and allies to protect core system funding from federal Medicaid and block grant cuts.
7) An Action Alert from CMHAM urging the public to contact legislators to protect Medicaid.
8) A document from CMHAM dated December 2024 regarding the Contract negotiations stalemate between MDHHS and Michigan's public specialized mental health plans.
9) A document from CMHAM dated March CMHA describing advocacy strategies around system refinement and potential PIHP procurement.
10) The draft minutes of the March 12, 2025 regional Finance Committee meeting.

Mr. Kurtz drew attention to the Prepaid Inpatient Health Plan (PIHP) Operations Meeting Playbook. MDHHS has created a recurring monthly meeting involving subject matter experts from all 10 PIHP and MDHHS staff, totaling 122 individuals, to discuss upcoming department priorities and express questions or concerns.

Mr. Kurtz next drew attention to the document from CMHAM listing Potential Medicaid Reductions as an informational resource.

ANNOUNCEMENTS

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

PUBLIC COMMENT

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

Traverse House Clubhouse member, Justin Reed, referenced an article in the Traverse City Record Eagle by Peter Kobs dated March 22, 2025, in which a potential FY25 financial deficit for Northern Lakes was estimated at $7M–$8M. Mr. Reed asked how funds due to the NMRE are likely to be paid. Mr. Kurtz responded that funds would likely be paid with Northern Lakes' reserves.

Mr. Reed advocated on behalf of clubhouse programs and urged that they not be cut. Traverse Clubhouse Director, Hanna Driver, echoed this position stating that she is hopeful that current monetary over-expenditures and recoupments do not affect Clubhouse programs and/or other essential services.

REPORTS

**Executive Committee Report**

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

**CEO Report**
The NMRE CEO Monthly Report for March 2025 was included in the materials for the meeting on this date. Mr. Kurtz highlighted March 10th meeting with MDHHS budget office regarding the Section 928 local match, which he would like to see removed. Mr. Kurtz drew attention to the advocacy meeting on March 11th regarding PIHP procurement. It was noted that advocacy efforts are currently limited.

**January 2025 Financial Report**
- Net Position showed net deficit Medicaid and HMP of $1,262,818. Carry forward was reported as $736,656. The total Medicaid and HMP Current Year Deficit was reported as $526,162. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $20,049,994.
- Traditional Medicaid showed $70,058,058 in revenue, and $70,167,096 in expenses, resulting in a net deficit of $109,038. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $8,777,317 in revenue, and $9,931,097 in expenses, resulting in a net deficit of $1,153,780. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $ 1,137,542 in revenue, and $897,826 in expenses, resulting in a net surplus of $239,716.
- SUD showed all funding source revenue of $9,499,506 and $7,433,987 in expenses, resulting in a net surplus of $2,065,519. Total PA2 funds were reported as $4,462,844.

Ms. Yockey reported that the region has $736K in carry-forward funds from FY24. The ISF is currently overfunded by $3.1M. The CMHSPs are over-expended on Medicaid and HMP by $5.37M. All Boards are looking at cost cutting measures.

PA2/Liquor Tax was summarized as follows:

| Projected FY25 Activity | | | |
|---|---|---|---|
| Beginning Balance | Projected Revenue | Approved Projects | Projected Ending Balance |
| $4,765,231 | $1,847,106 | $2,150,940 | $4,461,397 |

| Actual FY25 Activity | | | |
|---|---|---|---|
| Beginning Balance | Current Receipts | Current Expenditures | Current Ending Balance |
| $4,765,231 | $92,609 | $394,996 | $4,462,844 |

**MOTION BY CHUCK VARNER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JANUARY 2025; SUPPORT BY DON TANNER. MOTION CARRIED.**

**Operations Committee Report**
The draft minutes from March 18, 2025 were included in the materials for the meeting on this date. The NMRE's Risk Management and Fiscal Solvency Process will be discussed under "Old Business."

**NMRE SUD Oversight Committee Report**
The draft minutes from March 3, 3035 were included in the materials for the meeting on this date. Liquor tax requests will be presented for approval under the following agenda item.

NEW BUSINESS

**PA2 Requests**

The following liquor tax requests were recommended for approval by the NMRE Substance Use Disorder Oversight Committee on March 3, 2025.

| | Requesting Entity | Project | County | Amount |
|---|---|---|---|---|
| 1. | 217 Recovery | Recovery Stories: Message of Hope Part V | Grand Traverse | $5,800 |

**MOTION BY DON TANNER TO APPROVE THE REQUEST FROM THE 217 RECOVERY FOR GRAND TRAVERSE COUNTY LIQUOR TAX DOLLARS IN THE AMOUNT OF FIVE THOUSAND EIGHT HUNDRED DOLLARS ($5,800.00) TO SPONSOR PART FIVE OF THE RECOVERY STORIES: MESSAGE OF HOPE SERIES; SUPPORT BY BOB ADRIAN. MOTION CARRIED.**

| | Requesting Entity | Project | County | Amount |
|---|---|---|---|---|
| 2. | Harm Reduction Michigan | Front Line Support to Combat the Opioid Epidemic | Antrim, Benzie, Kalkaska, Leelanau | $52,700 |

Discussion: During the SUD Oversight Committee meeting on March 3rd, the representative from Benzie County asked that Benzie be removed from the proposal until he had ample time to review the request. The Benzie County representative contacted Mr. Tanner and requested that he ask what, specifically, the $11,553 in PA2 funding will be spent on in Benzie County.

Lou Gamalski from Harm Reduction Michigan responded that the funding would be used to provide safe supplies to those actively engaged in drug use, which protects the community from HIV and Hepatitis. Harm Reduction Michigan also supplies naloxone distribution boxes throughout the region, along with 5 different types of test strips, and wound care supplies.

Harm Reduction Michigan has locations in Traverse City, Cadillac, Petoskey, and Manistee. A mobile unit is also used to conduct community outreach. Individuals' counties of residence are recorded at intake, but not at each visit. Because of this, it is difficult to ensure that the supplies that are given to individuals are paid with liquor tax funds tied to their counties of residence. Ms. Marois suggested that the first two digits of individuals' identification numbers correspond to a county code.

**MOTION BY GARY NOWAK TO APPROVE THE REQUEST FROM HARM REDUCTION MICHIGAN FOR LIQUOR TAX DOLLARS FROM ANTRIM, BENZIE, KALKASKA, AND LEELANAU COUNTIES IN THE TOTAL AMOUNT OF FIFTY-TWO THOUSAND SEVEN HUNDRED DOLLARS ($52,700.00) TO FUND ACTIVITIES TO COMBAT THE OPIOID EPIDEMIC; SUPPORT BY DON SMELTZER. MOTION CARRIED. MOTION CARRIED.**

Let the record show that the total liquor tax funding approved during the meeting on this date was **$58,500**.

**NMRE Board Nominating Committee**
The election of NMRE Board Officers is scheduled to occur during the April meeting. The following Members of were appointed to the Nominating Committee.

- Don Smeltzer representing Centra Wellness Network
- Michael Newman representing North Country Community Mental Health Authority
- Eric Lawson representing Northeast Michigan Community Mental Health Authority
- Tom Bratton representing Northern Lakes Community Mental Health Authority
- Jay O'Farrell representing Wellvance

A meeting of the Nominating Committee will take place prior to the April Board meeting at 9:30AM.

OLD BUSINESS

**Northern Lakes CMHA Update**
Mr. Bratton reported that the Northern Lakes CMHA Board approved the Myers Group as its CEO Search Firm during the March 20th Board meeting. Prior to responding to the RFP, the firm did extensive research on Northern Lakes and was familiar with the current environment. The firm will be paid 27.5% of the CEO's intended salary, which hasn't been determined yet.

**FY25 PIHP Contract Injunction and Complaint Update**
Mr. Kurtz confirmed that Chris Ryan, attorney with Taft, Stettinius & Hollister, LLP, has filed the second amended motion to the complaint against the State of Michigan, State of Michigan Department of Health and Human Services, a Michigan State Agency, and its Director, Elizabeth Hertel, in her official capacity (Defendants). A response is expected by April 7th.

**Risk Management and Fiscal Solvency Process**
Based on a discussion that occurred during the Operations Committee meeting on February 18th, and with the full Board on February 26th, the NMRE Board of Directors voted to move the CMHSPs to risk-based contracts. Draft language was added to NMRE/CMHSP contracts and reviewed by the regional Operations Committee on March 18th. The new language allows the NMRE to decide whether it will cover cost overruns beyond prepaid subcapitation funding. If the NMRE is unable to cover either part or all the cost overruns, the CMHSPs must cover the deficit with local or other funding sources.

Mr. Kurtz explained that the CMHSPs are currently under an extension of the FY24 contract; the new language will be included in the FY25 contract, which will be sent to the CMHSPs in April 2025.

It is likely that the NMRE's ISF will be fully expended at the end of FY25. Because if this, the CMHSPs agreed that the NMRE should develop a cost containment process. The NMRE's Risk Management and Fiscal Solvency Process document was included in the materials for the meeting on this date.

Cost Containment Plans will be requested from the CMHSPs by May 1st; these should address measures to bring spending in line with PE/PM within 18 months. The CMHSPs were encouraged to make what cuts they can in the reminder of FY25.

To manage utilization more effectively based on national standards, the NMRE plans to enhance its subscription to the Manage Care Guidelines (MCG) platform and require integration and implementation within each CMHSP's electronic medical record.

The CMSHPs will also be asked to regularly run productivity studies to manage staffing and caseload ratios.

PRESENTATION

**NMRE IT Security Assessment and Proposal**

NMRE Chief Information Officer and Operations Manager, Brandon Rhue, provided an update on the NMRE's FY45 security assessment.

Security Testing or Penetration "Pen" testing is a crucial security practice where a hired company simulates real-world cyberattacks to identify vulnerabilities and assess an organization's security posture before malicious actors exploit them.

In FY24, the NMRE scored 7.8 out of a possible 8.5.

The NMRE is looking for a new firm to conduct the FY25 Security Assessment. Proposals from Avalon and Silent Sector were reviewed.

After conducting an internal analysis, it was determined that both companies have solid reputations and made good offers. Both offer a full suite of services that extend beyond the engagements that were requested. The lower cost for similar services and greater flexibility for retests made Avalon stand out.

The NMRE's recommendation was to engage Avalon to perform security testing and any post-remediation testing needed.

COMMENTS

**Board**

Mr. Nowak announced that this will be his last meeting as he will not seek reappointment to the Northeast Michigan CMHA Board of Directors. Mr. Klacking thanked Mr. Nowak for his many years of service and stressed that he would be missed.

Mr. Adrian shared that, in Utah, Medicaid is attempting to recoup $4M in Medicaid from the families of two deceased beneficiaries.

**Public**

Mr. Reed reiterated his previous request that Clubhouse programs in the region not be cut in efforts to reduce spending. Mr. Reed also noted that he does not think it is the right time for Northern Lakes CMHA to conduct a CEO search.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on April 23, 2025.

ADJOURN

Let the record show that Mr. Klacking adjourned the meeting at 11:41AM.

**Community Mental Health Association of Michigan**
**DIRECTORS FORUM**
March 26-27, 2025

# Summary of Discussion

**Legislative and policy status report; Advocacy around MDHHS PIHP competitive procurement proposal; Advocacy around Medicaid revenue gap:** The legislative and policy update included a discussion of the following:

1. Federal budget: The slides that MDHHS presented to the Senate Appropriations Committee, around the impact, on Michigan, of the major Medicaid reductions were cited. These slides will be sent out to Directors Forum members to supplement the related materials in the Directors Forum packet which described those potential reductions.
2. FY 2026 state budget development: While not much has occurred around policy issues of interest to CMHA members on the Senate, the House passed a bill to reduce the state income tax rate (which reduces state revenue by $540 million in FY 26 growing to over $700 million in the coming years; and a road funding bill that costs $3 billion without offsetting revenues. This latter bill would require substantial budget cuts in the MDHHS budget – a budget that makes up over half of the state's budget.

   CMHA staff and a number of CMHA members testified at a recent meeting of the House Medicaid and Behavioral Health Appropriations Subcommittee on the factors behind the funding gap experienced by the system and the administrative burden borne by the system. During a very productive meeting of CMHA staff and the staff of Speaker of the House Hall, that staff indicated a strong interest in reducing the administrative burden borne by the system. The latest news the state budget passage timeline indicates that the House is not expected to pass a state budget until August 2025.

   The House passed, along with the FY 2024 supplemental budget, a very slim FY 2026 contingency budget for "essential services" that represents a very slimmed down state budget – a proposed budget that the House leadership indicated would be put forward if FY 2026 budget negotiations do not reach an agreement. That contingency budget

CMHA staff outlined the components of the advocacy effort, around the MDHHS proposal for a **competitive procurement of the state's PIHPs**, that CMHA, its members, and allies have developed and have been implementing. In addition to the executive, legislative, judicial/legal, and media components outlined by CMHA, Directors Forum members. It was pointed out that the Connecticut model that some of the advocates are proposing involves an ASO that is a for-profit managed care company with the savings coming completely from the movement of the system from a private health plan managed system to a private ASO. It was pointed out that much of the work done by the state's PIHPs was historically done by the staff of MDHHS, thus the administrative costs of carrying out that work. It was indicated that the state's

waivers, protections, and, unfortunately, administrative burdens are put in place to justify the sole source arrangement that the state's PIHPs and CMHs have with MDHHS**. It was underscored that access to care, one of the aims that MDHHS claims is at the heart of the competitive procurement proposal, is addressed by increased funding and an adequate workforce and not through the pursuit of a competitive procurement.** The issues around which the advocates desire improvement (and which will not be addressed through a competitive procurement process) include: increased funding, choice of providers, uniformity of available services, and the perceived conflict in the governance structure of the PIHPs. The bias in the questions included in the on-line survey was seen as an impediment to real improvement and only to harm the image of the public system. The urgency of the Department to implement the procurement was questioned with the best guess being that the two-year transition (contract termination) process, being imposed on the PIHPs who are still in negotiations with MDHHS. The value of the public system to Michiganders in contrast to the criticism and unnecessary increased administrative burden laid on the system was pointed out.

CMHA staff underscored and added to the advocacy gameplan that CMHA issued over the past several weeks:

- The use of the talking points developed by CMHA and its members over the last several weeks as the basis for much of advocacy actions outlined below.
- A legislative component to oppose the competitive procurement promoting dialogue of CMHA and its members with their legislators. To support this effort, CMHA will be issuing an infographic, in the coming days, that contains the talking points provided by CMHA over the past several weeks
- Pressure on MDHHS via the voice of stakeholders (using an action alert to be sounded in the coming days) to ensure that a competitive procurement process, if it goes forward, does not privatize (by for-profit or non-profit health plans) the management of the system
- A media campaign including editorials by allies of CMHA and its members.
- A legal strategy centered around the legal analysis carried out by CMHA legal counsel relative to the requirements for closing out and rebidding the PIHP contracts and the prohibitions against arbitrary and capricious contract termination actions by MDHHS.
- Continued dialogue with the Whitmer administration and MDHHS in opposition to the competitive procurement process

CMHA will look at the possibility of offering a pre-con at summer or fall CMHA conference around the historical, statutory, waiver, and philosophic foundations of Michigan's public mental health system.

It was proposed that, building on the partnership that CMHA and its members have with the state's major advocacy groups, a concerted effort be undertaken by CMHA and its members, with the advocates, to address common issues. Such a call for action would help to apply the energy of the advocates on real system change. The advocacy groups could be rallied two core issues: the need for adequate funding and the need to reduce the administrative burden on the system.

Additionally, it was recommended that CMHA member organizations **boycott some requirements**, by MDHHS, that are not related to the provision of high quality service delivery. CMHA has requested that a small group of Directors Forum members join CMHA in examining each of the demands that are issued by MDHHS and determine those for which CMHA and this team are recommending that CMHA members not comply.

The Governor's lack of interest in mental health is clear to CMHA members and stakeholders as is her lack of influence on the decisions of MDHHS Director Hertel.

**Status of Administrative Burden Relief initiative** Amanda Day, Public Sector Consultants, outlined the work and status of the CMHA Administrative Burden Relief Initiative – an initiative funded by the Michigan Health Endowment Fund. The slides used during this discussion will be sent to Directors Forum members.

**Seeking views of Directors Forum re: design proposals related to Michigan's CCBHC** based on the MDHHS announcements made during the most recent meeting of MDHHS with the state's CCBHCs and PIHPs. The key announcements were: MDHHS to pay CCBHC sites directly; CCBHC RFP for areas not currently served by CCBHCs; CCBHCs to have direct access to CC360. The Directors Forum members' comments included:

- The need to close the revenue gap for services to persons without Medicaid

CMHA recommended that CMHSPs who are not CCBHCs consider becoming one for a number of reasons:

1. Being a CCBHC puts the CMHSP at the table to guide MDHHS in refining the CCBHC standards
2. MDHHS appears to be using CCBHC identity as a protection of the system in the face of the potential federal Medicaid cuts
3. Private organizations are likely to bid on becoming a CCBHC to serve communities in which the CMH is not a CCBHC.
4. The expansion of CCBHC sites, after 2027, is unlikely given the increase in the state share that will be required to sustain the sites that exist on that date.

**Discussion, with MDHHS leadership, of a range of policy, contractual, practice, and statutory issues**: As has been done over the past year, the items on the MDHHS segment of the Directors Forum will only be those around which dialogue, in this venue, will serve to foster decision making or a greater understanding of complex issues.

Information that can be or has been communicated in writing, issues or initiatives that have not changed since the last Directors Forum update, or those better addressed in other venues (e.g., topic specific workgroups, etc.) will not be placed on the MDHHS segment of the Directors Forum.

**Discussion of the preliminary thinking around MDHHS's work to expand Medicaid-funded IDD treatment residential capacity – preliminary name: Intensive Residential Habilitation program**: Alex Kruger and Kristen Morningstar outlined the development of Medicaid-funded IDD treatment residential facilities akin to the PRTF and ICTS services – time limited, treatment focused. As with PRTF, this service will be a fee-for-service modality, with MDHHS holding the contracts with the provider organizations. The length of stay in these sites is expected to be longer than those in PRTF and ICTS settings with both children and adults to be served at these sites. Focus groups of CMHs, providers, persons served, and families will be involved in providing guidance to this development effort. HMA, the consultant working with the Department on this effort, will be calling for focus group membership in the next few months. The program Intensive Residential Habilitation. MDHHS is using state hospital denial data to determine the geographic distribution of the need for this service; a distribution akin to PRTF/ICTS. FY 26 is the target start, probably after the start of the fiscal year. The number of beds will be akin to those found in the PRTF network.

Two new divisions being created within the Behavioral Health unit of MDHHS: Substance use, gambling, and epidemiology (Angela Smith Butterwick to lead) and Intensive Specialty Services (Alex Kruger to lead).

**Children's Transitions of Care Program:** Patty Neitman outlined the Children's Transitions of Care program, designed to walk alongside the CMH, PIHP, provider system in serving: children in state hospitals who are experiencing barriers to discharge, those in other congregate care settings for whom discharge barriers exist, teenage transition-age youth (many of whom are in the child welfare system) who are moving from the children's system to the adult system. Dr. Mellos is the sponsor of this initiative and led by Stacy Farrell. This will be akin to the transition support work done earlier, led by the Guidance Center, with lessons learned from that experience. Those lessons learned have guided the design of this program to ensure that transition plans will be jointly developed and carried out by the CMH/provider team and this Transitions of Care team; joint identification of the care givers in the community to whom the children will be transferred  Referrals to this program will come from CMHs, PIHPs, local MDHHS offices, and the newly relocated children's placement office to the Children's Bureau. The program will be built to ensure strong coordination with local CMH and PIHP staff, early intervention (as they enter the state hospital or residential treatment). Will be up and running in April 2025. The referral process will be outlined in the early days of that effort. This service is not a Medicaid service with the CMHs nor PIHPs paying for this service. Stacy's team has already seen very strong partnering between her Transitions of Care team and local CMH clinicians in working with children in need of these transition support systems.

**Update on recent hire, by MDHHS, of a staff member dedicated to IDD policy efforts**: Belinda Hawks provided an IDD specialist position, filled by Amel Mansour, reporting to Belinda Hawks. She will be: leading the National Core Indicator initiative, and the implementation of a new IDD assessment tool (HUDA, to replace SIS), a member of the DD Council, and conduct policy review and development related to IDD services. CMHA is willing to call together the IDD leads within its membership, through invitations through the CEOs of those members, to meet Ms. Mansour and learn more about her portfolio.

**Update on state facility waiting lists and related issues**: Jeff Wieferich clarified that the waiting list for state hospitals is seen, by MDHHS, as persons who are appropriate for admission to the state hospital and who will be admitted within several weeks. Chapter 5 admissions will be done, albeit MDHHS does not favor many of these. It was underscored that persons with primary diagnoses of SUD, IDD, or personality disorders; and those in need of placement/housing but not treatment for SMI nor SED need will not be admitted to the state hospital. This list of admission criteria will be sent to the field in the coming days (underscoring the current criteria)

The USDOJ investigation, centered around the need for ready access to and appropriate discharge from state hospitals, will continue, even with the change in the federal administration.

The responsibilities of the NGRI committee and the local CMHSP will be strengthened in the NGRI process and the CMH contract. MDHHS agreed to send a draft version of the proposed responsibilities and practices along with models and templates for reporting the status of NGRI clients.

**Debriefing from MDHHS discussion:** CMHA will ask Jeff Wieferich who can be admitted to the new Caro state hospital. It was reinforced that even when mental health issues are primary, yet a person has an IDD diagnosis, they are denied admission to the state hospitals. It was indicated that hearing the Department's

vision on the aim of state hospital services and rebuilds and its relationship with the community system would be helpful to CMHA members in working with those hospitals. CMHA will ask HSA if there is another hospital being built to replace Reuther and Hawthorne or is this the hospital that we knew was being rebuilt. The lack of clarity as to the roles of offices within MDHHS and the lack of a clear and stable hierarchy of the Department was cited as a significant barrier to the partnership work of the CMH, PIHP, and provider system with MDHHS.

**Provider Alliance 2025 Priority Issues:** Mike Thompson, Provider Alliance Chair, described the Provider Alliance and highlighted the priorities of the Provider Alliance for 2025. Those priorities include:

- MichiCANS: The treatment recommendations that result from the MichiCANS are seen as far too broad, making children and families appear eligible for services for which medical necessity criteria would not make them eligible. The MichiCANS is not designed to make level of care determinations yet is seen by MDHHS and persons served as such.
- ABA tech rate increase and Waskul Lawsuit Implications: Concerns over the skewing of the workforce supply given much higher ABA tech rate when CLS workers, doing similar work yet at a much lower wage; concern over the cost of this expansion of services and whether these costs will be covered through increased capitation payments to PIHPs and CMHSPs and in rates to providers.
- TBD Solutions update on Department Initiatives including CFAP Update (ongoing): CFAP appears to be moving, with CMS approval.
- Mental Health Parity-Addiction Equity Act (Emily/Rep. VanderWall?): Dialogue around and enforcement of this appears to be in abeyance.
- Use of a uniform statewide contract for CMHSPs and PIHPs for use with their provider contractors: Providers are seeking the contract, reporting, and requirement uniformity statewide across the CMH and PIHP system in its work with private providers.
- SUD Issues including LARA regulatory changes, Access patterns and referrals, impacts of CCBHCs, and differences in short-term and long-term residential patterns with disproportionate growth in short-term residential: Some theories on the causes of SUD demand reduction: the provision of SUD services by CCBHCs may be causing a reduction in SUD services; the implementation of the complex and time-consuming ASAM continuum may be driving persons to co-occurring service providers where the ASAM is not required. Co-occurring demand has increased dramatically for CMHs/CCBHCs, yet not an increase in SUD demand.

The change in the state minimum wage, without offsetting payments, is causing some private adult foster care providers to close down – eliminating housing for high risk persons and causing the CMHs to find residential beds for these persons of an already scarce residential capacity.

It was pointed out that the word is that the Social Security Administration will be recouping overpayments to SSI and SSDI recipients, at one time rather than, as is the current approach, a recoupment over time.

**Taking the pulse of our system:**

**Discussion of the fiscal condition of the state's PIHPs, CMHSPs, and providers and the impact of that fiscal condition**: It was noted that the revenue gaps have never been so bad. CMHA indicated that it is putting together an omnibus fact sheet that highlights the causes of this fiscal distress. This document will draw from: NMRE and PCE analysis of the impact of DAB mis-enrollment, contrast revenues with Medical

CPI, actuarially derived rates falling $200 million below the appropriation amounts during FY 2023, 2024, and 2025; only half of the increased autism-related rates were covered by the mid-year rate adjustment; Wakely analysis that MLR spending in 2023 was above 100% for a number of PIHPs.

The dramatic increases in the costs of psychiatric inpatient services, specialized residential, homebased CLS (increased costs with the move to the 15-minute H2015), and staff wages are in stark contrast in the reduction in the administrative rates of CMHs and PIHPs. The impact of these cost increases is compounded by dramatically reduced Medicaid payments due to falling Medicaid enrollment.

The advocacy effort around the need to close the fiscal gap includes continued pressure on MDHHS (the behavioral health and actuarial office) and building support in the State Legislature for appropriations to close this gap and for changes to the rate setting process.

CMHs reported that MDHHS is seeking changes to the Autism services diagnosis and level of care determination process to allow decisions, on these fronts, to be made by primary care physicians rather than using the ADOS and medical appropriateness and efficacy structures that are in place and need to be underscored.

**Discussion of the behavioral health workforce shortage, its impact, and steps being taken, locally, to address that shortage**: Most wage gaps: MSW, Children's Homebased Therapists, LPCs, Crisis services, Masters level Children's Therapists.

Causes of staff leaving our system: non-traditional work hours (24/7 on-call), exhausted providing intern supervision, staff leaving to work with MDHHS for better pay and ability to work at home anywhere in the state.

The traditional approaches to recruitment and retention – sound wages and benefit packages, signing bonuses, loan repayment.

Newer employees appear to be seeking higher wages, without benefits, more time off, flexible hours, recognition (as noted in employee surveys).

Retention successes: behavioral health loan forgiveness program has helped CMHA members to retain a number of Masters level staff.

**CMHA and members work around preparation for implementation of Conflict Free Access and Planning:** While MDHHS is awaiting the 1115 waiver approval for the state's CFAP plan, CMHA has raised a number of logistical questions regarding the implementation of CFAP segment of the waivers. These logistics appear to be causing MDHHS to see the complexity of implementing the MDHHS CFAP plan-work which is slowing the implementation of CFAP across the state.

CMHA will continue to identify the impact of the competitive procurement process on the implementation of CFAP.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

Date: April 1, 2025

Deanna Yockey
Northern Michigan Regional Entity
1999 Walden Drive
Gaylord, MI 49735

RE: HHS COVID-19 Grant Termination

Deanna Yockey,

The federal government has sent the Michigan Department of Health and Human Services notice of cancellation of federal funding, which states in relevant part:

> **Termination**: The purpose of this amendment is to terminate the use of any remaining COVID-19 funding associated with this award. The termination of this funding is for cause. HHS regulations permit termination if "the non-Federal entity fails to comply with the terms and conditions of the award", or separately, "for cause." The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of use of funding under the listed document number(s) is effective as of the date set out in your Notice of Award. Impacted document numbers are included on page 2 of this Notice of Award (NoA). No additional activities can be conducted, and no additional costs may be incurred, as it relates to these funds. Unobligated award balances of COVID-19 funding will be deobligated by CDC. Award activities under other funding may continue consistent with the terms and conditions of the award.

This impacts your work under the following agreement(s):

| Grant/Contract Name | Project Name | Agreement Number |
|---|---|---|
| CSUGS-2025 PREVCV | COVID-19 Substance Use and Gambling Services-2025 Prevention 3 ARPA | E20253903-00 |
| CSUGS-2025 TRMTCV | COVID-19 Substance Use and Gambling Services-2025 Treatment 3 ARPA | E20253922-00 |

Section 10(C) of your agreement states:

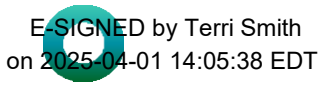
> Based on the availability of funding, the Department may specify the amount of funding the Grantee may expend during a specific time period within the Agreement Period.

Under that section, and based upon the lack of funding, beginning on April 1, 2025, you must not spend funds under the above-named grants/contracts until further notice.

MDHHS is working to evaluate the activities using these federal funds and this guidance may change. MDHHS is currently exploring options to address these federal funding cuts and that we hope may allow you to resume your important work. MDHHS will keep you informed of developments.

Allowable costs incurred before the effective date of this letter may be submitted to MDHHS for reimbursement. Please see the FAQs for further details. If you have any questions, please contact your MDHHS grant administrator.

Respectfully,




Terri Smith
Director, Bureau of Grants and Purchasing

CC:
Jeanette Hensler
Director, Grants Division, Bureau of Grants and Purchasing

Project File

# email correspondence

**From:** Monique Francis
**To:** Monique Francis
**Cc:** Robert Sheehan; Alan Bolter
**Subject:** LLBSW and LBSW carrying out pre-admission screenings and crisis intervention
**Date:** Tuesday, April 15, 2025 3:29:00 PM
**Attachments:** image001.png
image002.png
image003.png

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To: CEOs of CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: LLBSW and LBSW carrying out pre-admission screenings and crisis intervention

Below is an email that CMHA recently sent to our colleagues at MDHHS regarding concerns, expressed by many of you, regarding the potential limitations on the clinicians who can carry out pre-admission screenings and crisis intervention services. Note that this email is the second communication on this issue; the first sent in August of last year.

Thank you to all of you who identified this issue and provided guidance in our work with MDHHS.

We will let you know what we hear from MDHHS. Please do the same.

Thanks.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
2nd Floor
507 South Grand Avenue
Lansing, MI 48933
517.374.6848 main
517.237.3142 direct
www.cmham.org

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**From:** Robert Sheehan
**Sent:** Monday, April 7, 2025 11:39 AM
**Subject:** LLBSW and LBSW carrying out pre-admission screenings and crisis intervention

Kristen, Krista, Patty,

Last August (see email below), CMHA was hearing rumors relative to MDHHS proposing that LLBSWs (those staff with a Bachelors in Social Work who have not completed the 2 years of full time work post-graduation) be prohibited from providing crisis intervention (H2011) or pre-admission screenings (T1023).

Additionally, CMHA was hearing that this same discussion would prohibit LBSWs (fully licensed clinicians with Bachelors in Social Work) from providing these screenings (bill T1023) unless the LBSW receives real-time consultation from a master's level clinician for all decisions not to hospitalize. While supervision by a LMSW or other licensed professional is required, the requirement for real-time consultation presents an insurmountable barrier to the ability of the state's crisis centers and pre-admission screening sites to adequately staff their sites.

Those rumors continue.

This change, if made, would dramatically limit the ability of pre-admission screening units to complete pre-screens (causing significant delays in resolving crises) given that many pre-admission screening units are staffed by LBSWs and LLBSWs. All are supervised by clinicians with advanced degrees. Such a change only exacerbates the deep and prolonged behavioral health workforce shortage and unnecessarily delays the provision of crisis intervention services.

The Michigan Mental Health Code and the Behavioral Health Code Charts and Provider Qualifications are in alignment in recognizing LBSWs as providers of pre-admission screenings (T1023) and crisis intervention services (H2011).

Additionally, the Michigan Administrative Rules are clear that "The applicant (a person with a LLBSW, applying for a LBSW) shall function as a licensed bachelor's social worker using generally accepted applications of social work knowledge and techniques acquired during the applicant's education and training. "

If helpful, we have provided, below, the relevant excerpts from the: MDHHS Behavioral Health Code Charts and Provider Qualifications, Michigan Mental Health Code, Michigan Public Health Code, and the Michigan Administrative Rules.

We are hoping that these rumors are inaccurate.

If a discussion around this issue would be helpful, we would welcome such a discussion.

**Behavioral Health Code Charts and Provider Qualifications**

| HCPCS & Revenue Codes | Service Description (Chapter III & PIHP Contract) | Reporting Code Description from HCPCS and CPT Manuals | Reporting Units/ Duplicate Threshold "DT" | Previous Provider Qualifications | SFY 2022 Provider/Staff Qualifications |
|---|---|---|---|---|---|
| T1023 | **Assessments Health Psychiatric Evaluation Psychological testing Other assessments, tests** | Pre-screening for inpatient program<br><br>T1023: Screening for inpatient program See Appendix for detailed guidance on reporting rules for T1023. | Encounter | Mental Health Professional or licensed bachelor's social worker, limited-licensed bachelor's social worker, limited-licensed master's social worker under the supervision of a fully licensed master's social worker | Psychiatrist<br>Physician<br>Psychologist<br>Bachelor's social worker<br>Master's social work<br>Licensed professional counselor<br>Marriage and family therapist<br>Psychologist<br>Clinical nurse specialist<br>Licensed physician's assistant |

| HCPCS & Revenue Codes | Service Description (Chapter III & PIHP Contract) | Reporting Code Description from HCPCS and CPT Manuals | Reporting Units/ Duplicate Threshold "DT" | Previous Provider Qualifications | SFY 2022 Provider/Staff Qualifications |
|---|---|---|---|---|---|
| H2011 | Crisis Intervention | Crisis Intervention Service<br><br>Use this code for all Intensive Crisis Stabilization for Children 0-21. This code is billed in 15- minute units and must meet requirements according to the General Rule for Reporting in the Encounter Code Chart. This service must be initially reported at 30 minutes and in 15-minute increments thereafter. Programs must be enrolled by MDHHS to provide this mobile intensive crisis stabilization service for children.<br><br>H2011 – can be used for crisis intervention related to Child Care Expulsions/Infant Early Childhood Mental Health Consultation (IECMHC) | 15 minutes | Mental Health Professional or limited-licensed master's social worker, licensed bachelor's social worker, or limited-licensed bachelor's social worker acting within their scope of practice and supervised by a Mental Health Professional who is a licensed master's social worker. | Physician<br>Psychologist<br>Master's social worker<br>Licensed professional counselor<br>Marriage and family therapist<br>Bachelor's social worker<br>Registered Nurse |

**Michigan Mental Health Code**

330.1409 Preadmission screening unit.

Sec. 409.

1. Each community mental health services program must establish 1 or more preadmission screening units with 24-hour availability to provide assessment and screening services for individuals being considered for admission into hospitals, assisted outpatient treatment programs, or crisis services on a voluntary basis. The community mental health services program shall employ mental health professionals or licensed bachelor's social workers licensed under part 185 of the public health code, 1978 PA 368, MCL 333.18501 to 333.18518, to provide the preadmission screening services or contract with another agency that meets the requirements of this section. Preadmission screening unit staff shall be supervised by a registered professional nurse or other mental health professional possessing at least a master's degree.

**Michigan Public Health Code**

Sec. 18501. (1) As used in this part: (a) "Health facility" means a health facility or agency licensed under article 17 or a hospital, psychiatric hospital, or psychiatric unit licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106. (b) "Licensed bachelor's social worker" means an individual licensed under this article to engage in the practice of social work at the bachelor's level. (c) "Licensed master's social worker" means an individual licensed under this article to engage in the practice of social work at the master's level. (d) "Practice of medicine" means that term as defined in section 17001. (e) "Practice of osteopathic medicine and surgery" means that term as defined in section 17501. (f) "Practice of social work at the bachelor's level" means, subject to subsections (2) and (4), all of the following applied within the scope of social work values, ethics, principles, and skills:

**Michigan Administrative Rules**

R 338.2941 (Excerpts)

Bachelor's social worker license by examination; educational requirements; supervised work experience

requirements.

Rule 41.
(3) Supervised work experience may be earned only while holding a Michigan limited bachelor's of social work license issued pursuant to R 338.2939. The supervised work experience for a bachelor's social worker license must meet all of the following requirements:
(b) The experience must be completed under the supervision of a Michigan-licensed master's social worker whose license is in good standing throughout the period of supervision.
(4) The supervised work experience must comply with all of the following:

(a) The applicant shall meet with his or her supervisor using any of the following methods:
(i) Individually and in person.
(ii) Individually using a telecommunications method that provides for live and simultaneous contact.
(iii) In a group modality that provides for 50% of the supervision to include individual contact during which active work functions and records of the applicant are reviewed.
(b) Supervisory review must be conducted for at least 4 hours per month with at least 2 hours being conducted between the applicant and the supervisor using either of the following methods:
(i) Individually and in person.
(ii) Individually using a telecommunications method that provides for live and simultaneous contact.

(e) The applicant shall function as a licensed bachelor's social worker using generally accepted applications of social work knowledge and techniques acquired during the applicant's education and training.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
2nd Floor
507 South Grand Avenue
Lansing, MI 48933
517.374.6848 main
517.237.3142 direct
www.cmham.org

**From:** Robert Sheehan
**Sent:** Monday, August 26, 2024 1:34 PM
**To:** Neitman, Patricia (DHHS) <NeitmanP@michigan.gov>; Kristen Jordan <JordanK4@michigan.gov>; Hawks, Belinda (DHHS) <HawksB@michigan.gov>; Hausermann, Krista (DHHS-Contractor) <HausermannK@michigan.gov>
**Cc:** Alan Bolter <ABolter@cmham.org>
**Subject:** LLBSW and LBSW carrying out pre-admission screenings

Patty, Kristen, Belinda, Krista,

We are hearing rumors about some within MDHHS proposing that LLBSWs (those staff with a Bachelors in Social Work who have not completed the 2 years of full time work pos graduation) be prohibited from providing pre-admission screenings (screenings done to determine if admission to an inpatient psychiatric unit should be considered; T1023). Additionally we are hearing that this same discussion would prohibit LBSWs (fully licensed clinicians with Bachelors in Social Work) from providing these screenings (bill T1023) unless the LBSW receives consultation from a master's level clinician for all decisions not to hospitalize.

This change, if made, would dramatically limit the ability of pre-admission screening units to complete pre-screens (causing significant delays in resolving crises) given that many pre-admission screening units are staffed by LBSWs and LLBSWs. All are supervised by clinicians with advanced degrees. Such a change only exacerbates the deep and prolonged behavioral health workforce shortage and unnecessarily delays the provision of crisis intervention services.

We are hoping that these rumors are inaccurate.

Can you give us a sense of what discussions are occurring around this topic, if any?

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
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507 South Grand Avenue
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517.374.6848 main
517.237.3142 direct
www.cmham.org

# email correspondence

**From:** MDHHS-CCBHC
**Subject:** Request for information and interest in MDHHS CCBHC Demonstration Survey
**Date:** Thursday, March 20, 2025 4:29:21 PM
**Attachments:** CCBHC Rural Proposal- Feb2025.pdf

Good afternoon,

The Michigan Department of Health and Human Services (MDHHS) is seeking to request information and gauge interest from providers located in a county not currently served by a CCBHC Demonstration site or in a Rural or Frontier designated location (more recently defined as Micro, Rural, and Counties with Extreme Access Consideration (CEAC)) in participating in the MDHHS Certified Community Behavioral Health Clinic (CCBHC) Demonstration.

CCBHCs are non-profit or local government agencies that provide comprehensive and coordinated behavioral health services to all Michiganders, regardless of their insurance, ability to pay, place of residence, or age. CCBHCs are federally required to provide nine (9) comprehensive behavioral health services, including 24/7/365 mobile crisis response and medication assisted treatment (MAT) for substance use disorders (SUD). Nationally, the CCBHC model has been shown to substantially increase access to care, advance physical health integration, strengthen community partnerships, address health inequities, and improve the quality of behavioral health services.

Qualifying providers interested in participation must complete a survey indicating their interest by **April 11, 2025** by clicking here:

**Provider interest in MDHHS Certified Community Behavioral Health Clinic Demonstration**

Please visit www.michigan.gov/ccbhc and Certified Community Behavioral Health Clinics (CCBHCs) | SAMHSA for more information on the CCBHC model, demonstration requirements, and state expectations. MDHHS has included a Rural flexibility proposal with this correspondence as a reference. Although this language is not yet finalized, it can be used as a guide for sites designated as Micro, Rural or CEAC to help meet CCBHC Demonstration certification standards.

Results of this survey will help to inform planning and next steps for MDHHS. MDHHS will communicate next steps and any opportunities for technical assistance to further clarify the CCBHC Demonstration and Rural flexibilities as quickly thereafter as possible.

Pursuant to requirements in the FY25 budget, MDHHS is conducting a spatial analysis study to gain actionable insights into the extent of cannibalization and to support decision making

processes related to CCBHC site selection, network optimization, and future CCBHC expansion. Due to this ongoing work, current CCBHC Demonstration sites and providers located in service areas already served by a CCBHC Demonstration site are excluded from this request for information survey.

Questions for the CCBHC team can be sent to mdhhs-ccbhc@michigan.gov.

**The Michigan CCBHC Demonstration Team**
Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health and Human Services
MDHHS-CCBHC@Michigan.gov

# CCBHC Rural Certification Flexibilities

*Proposed Certification Changes Effective October 1, 2025*

MDHHS
Michigan Department of Health & Human Services

# FY2026 CCBHC Demonstration Sites

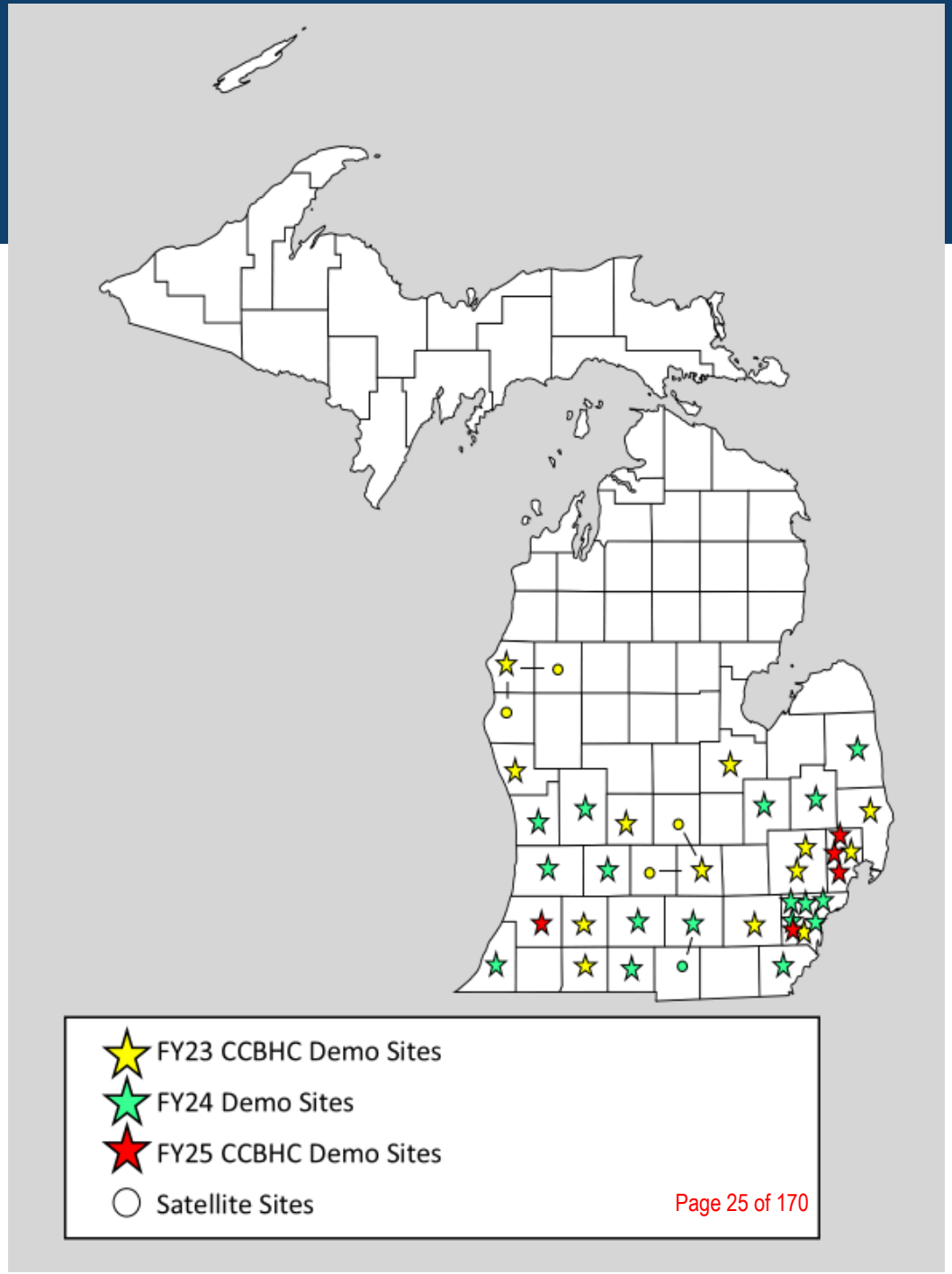
- **Priority:** Community Mental Health Service Providers (CMHSPs) and eligible providers located in Rural and Frontier designated locations (most recently defined as Micro, Rural, and Counties with Extreme Access Consideration (CEAC)).



*Eligible providers are defined in section 223(a)(2)(f) of the Protecting Access to Medicare Act of 2014, public law 113-93

# Current CCBHCs
## January 2025

- Arab Community Center for Economic and Social Services (Wayne)
- Barry County CMH Authority (Barry)
- CEI CMH (Clinton, Eaton, Ingham)
- CNS Healthcare (Oakland)
- CNS Healthcare (Wayne)
- CNS Healthcare (Macomb)
- Community Mental Health of Ottawa County (Ottawa)
- Development Centers, Inc. (Wayne)
- Easter Seals MORC (Oakland)
- Easter Seals MORC (Macomb)
- Elmhurst Home (Wayne)
- Genesee Health System (Genesee)
- HealthWest (Muskegon)
- Hegira Health, Inc. (Wayne)
- Integrated Services of Kalamazoo (Kalamazoo)
- Judson Center, Inc. (Macomb)
- Lapeer County Community Mental Health (Lapeer)
- LifeWays (Jackson and Hillsdale)
- Macomb County CMH (Macomb)
- Monroe Community Mental Health Authority (Monroe)
- Network180 (Kent)
- OnPoint (Allegan)
- Pines Behavioral Health Services (Branch)
- Pivotal (St. Joseph)
- Riverwood Center (Berrien)
- Saginaw County CMH (Saginaw)
- Sanilac Community Mental Health (Sanilac)
- Southwest Counseling Solutions (Wayne)
- St. Clair County CMH (St. Clair)
- Summit Pointe (Calhoun)
- The Guidance Center (Wayne)
- The Right Door for Hope and Wellness (Ionia)
- Van Buren Community Mental Health (Van Buren)
- Washtenaw County CMH (Washtenaw)
- West Michigan CMH (Mason, Lake, Oceana)



# Service Area and Timeline

## Service Area Selection

- Rural/Frontier sites may define their Community Needs Assessment to focus on one physical service delivery location and a limited, defined service area. CCBHCs may ramp up services at additional sites to allow for a slower ramp up period at outlying service sites.

## Prolonged Implementation Timeline

- Rural CCBHCs will have additional time to ramp up their services, dependent on their level of readiness and community needs assessments.
  - 1 year to meet staffing requirements, with optional extension year
  - 3 years to meet crisis service requirements

# Crisis Services

Crisis requirements on Day 1 *(Mental Health Code mandated crisis services)*

- 24/7/365 phone line
- Inpatient screening units providing emergency crisis intervention services
- Walk in face-to-face crisis services

Within 3 years, CCBHCS must meet crisis requirements, including 24/7/365 mobile crisis. CCBHCs can propose alternate models to meet the mobile crisis requirements, including *co-response models* and *virtual options*.

Additional funding opportunities are available to support mobile crisis infrastructure, which can be sustained through PPS.

# Evidence Based Practices

| Required Practices | Waiver Eligible with Justification and Approval from MDHHS Program Area |
|---|---|
| Must implement:<br>• Air Traffic Control (ATC)<br>• Dialectical Behavior Therapy (DBT)<br>• Cognitive Behavioral Therapy (CBT)<br>• Medication Assisted Treatment (MAT)<br>• Motivational interviewing (MI)<br>• Screening, Brief Intervention, and Referral to Treatment (SBIRT)<br>• Zero Suicide<br>• Trauma-informed EBP of choice | • Assertive Community Treatment (ACT)<br>• Infant Mental Health (IMH)<br>• Integrated Dual Disorder Treatment (IDDT)<br>• Parent Management Training – Oregon (PMTO) and/or Parenting through Change (PTC)<br>• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) |

# Evidence Based Practices

## Additional Information

Zero Suicide- Does not have to be fully implemented at time of certification.

MIFAST Visit Reminder- MIFAST visits are required for Dialectal Behavior Therapy, Assertive Community Treatment, and Integrated Dual Diagnosis Treatment. This will ensure fidelity of each of the Evidence Based Practices.

Infant Mental Health implementation- Provider must be endorsed by Michigan Association for Infant Mental Health (MI-AIMH).

# Other Considerations

## Health Homes

- CCBHC and Health Homes are complementary models that can coexist to the benefit of both the providers and the persons served

## Designated Collaborating Organizations (DCOs)

- DCO agreements can be established to meet any certification criteria
- DCO agreements can be telehealth-based and could be with CCBHCs

## Financial Support

- MDHHS will provide extensive technical assistance around cost reporting and PPS rate setting
- Cost reporting may allow 2 years of anticipated costs to support development, or midyear rebase in Year 2 to more accurately reflect costs

## Payment Methodology for PPS-1 Rate

- MDHHS will directly pay CCBHCs who enter the demonstration in FY26 the PPS-1 rate for eligible daily visits

# Next Steps

**Request for interest in CCBHC Demonstration Survey**

Qualifying providers interested in participating in the demonstration must complete an interest survey

(March)

**Technical Assistance Opportunities**

MDHHS offers program and financial TA sessions for interested sites.

(March – October)

**CCBHC OMB Cost Report**

Determination of rates using total annual allowable CCBHC costs / anticipated CCBHC daily visits.

(July)

**CCBHC Certification Application**

Potential CCBHCs must provide justification of meeting CCBHC criteria and upload supporting documentation verifying that standards have been met in the MDHHS Customer Relationship Management (CRM) database

(July)

Please send questions to:
mdhhs-ccbhc@michigan.gov

MDHHS
Michigan Department of Health & Human Services

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*FY2025 Q1 PIHP Final PI Numbers*

# CMHSP Medicaid Only & SUD All-Funding

*10/01/2024 – 12/31/2024*

# FY2025 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2024 – 12/31/2024

## NORTHERN MICHIGAN REGIONAL ENTITY

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 178 | 175 | **98.31%** |
| **Adults** | 607 | 597 | **98.35%** |
| **Total** | **785** | **772** | **98.34%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 300 | 159 | **53.00%** |
| **MIA** | 539 | 297 | **55.10%** |
| **DDC** | 86 | 55 | **63.95%** |
| **DDA** | 31 | 14 | **45.16%** |
| **Total** | **956** | **525** | **54.92%** |

### Table 2b – Access – Timeliness/First Request - Substance Use Disorder

| Population | Admissions | Expired | In 14 Days | % In 14 Days |
|---|---|---|---|---|
| **SA** | Calculated | **239** | Calculated | Calculated **%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 213 | 138 | **64.79%** |
| **MIA** | 311 | 210 | **67.52%** |
| **DDC** | 92 | 67 | **72.83%** |
| **DDA** | 23 | 12 | **52.17%** |
| **Total** | **639** | **427** | **66.82%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 81 | 25 | 56 | 52 | **92.86%** |
| **Adults** | 219 | 86 | 133 | 122 | **91.73%** |
| **Total** | **300** | **111** | **189** | **174** | **92.06%** |

### Table 4b – Access – Continuity of Care - Substance Use Disorder

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **SA** | 213 | 89 | 124 | 121 | **97.58%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 81 | 0 | 81 | 5 | **6.17%** |
| **Adults** | 219 | 4 | 215 | 20 | **9.30%** |
| **Total** | **300** | **4** | **296** | **25** | **8.45%** |

Produced by: Valerie McBain

# FY2025 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2024 – 12/31/2024

## NMRE Substance Use Disorder

### Table 2b – Access – Timeliness/First Request - Substance Use Disorder

| Population | Expired |
|---|---|
| **SA** | 239 |

### Table 4b – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **SA** | 213 | 89 | 124 | 121 | **97.58%** |

# FY2025 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2024 – 12/31/2024

## CWN - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 4 | 4 | **100.00%** |
| **Adults** | 15 | 13 | **86.67%** |
| **Total** | **19** | **17** | **89.47%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 14 | 14 | **100.00%** |
| **MIA** | 37 | 34 | **91.89%** |
| **DDC** | 3 | 3 | **100.00%** |
| **DDA** | 1 | 1 | **100.00%** |
| **Total** | **55** | **52** | **94.55%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 9 | 8 | **88.89%** |
| **MIA** | 28 | 18 | **64.29%** |
| **DDC** | 3 | 2 | **66.67%** |
| **DDA** | 1 | 0 | **0.00%** |
| **Total** | **41** | **28** | **68.29%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 6 | 2 | 4 | 4 | **100.00%** |
| **Adults** | 12 | 6 | 6 | 5 | **83.33%** |
| **Total** | **18** | **8** | **10** | **9** | **90.00%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 6 | 0 | 6 | 0 | **0.00%** |
| **Adults** | 12 | 0 | 12 | 0 | **0.00%** |
| **Total** | **18** | **0** | **18** | **0** | **0.00%** |

# FY2025 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2024 – 12/31/2024

## NCCMH - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 35 | 34 | **97.14%** |
| **Adults** | 104 | 100 | **96.15%** |
| **Total** | **139** | **134** | **96.40%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 66 | 41 | **62.12%** |
| **MIA** | 104 | 62 | **59.62%** |
| **DDC** | 29 | 23 | **79.31%** |
| **DDA** | 5 | 3 | **60.00%** |
| **Total** | **204** | **129** | **63.24%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 35 | 25 | **71.43%** |
| **MIA** | 41 | 25 | **60.98%** |
| **DDC** | 31 | 18 | **58.06%** |
| **DDA** | 2 | 1 | **50.00%** |
| **Total** | **109** | **69** | **63.30%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 23 | 8 | 15 | 13 | **86.67%** |
| **Adults** | 27 | 7 | 20 | 19 | **95.00%** |
| **Total** | **50** | **15** | **35** | **32** | **91.43%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 23 | 0 | 23 | 2 | **8.70%** |
| **Adults** | 27 | 0 | 27 | 5 | **18.52%** |
| **Total** | **50** | **0** | **50** | **7** | **14.00%** |

Produced by: Valerie McBain

# FY2025 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2024 – 12/31/2024

## NEMCMH - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 28 | 28 | **100.00%** |
| **Adults** | 105 | 105 | **100.00%** |
| **Total** | **133** | **133** | **100.00%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 71 | 25 | **35.21%** |
| **MIA** | 62 | 19 | **30.65%** |
| **DDC** | 4 | 1 | **25.00%** |
| **DDA** | 6 | 1 | **16.67%** |
| **Total** | **143** | **46** | **32.17%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 56 | 33 | **58.93%** |
| **MIA** | 32 | 20 | **62.50%** |
| **DDC** | 3 | 2 | **66.67%** |
| **DDA** | 4 | 1 | **25.00%** |
| **Total** | **95** | **56** | **58.95%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 10 | 3 | 7 | 7 | **100.00%** |
| **Adults** | 25 | 1 | 24 | 24 | **100.00%** |
| **Total** | **35** | **4** | **31** | **31** | **100.00%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 10 | 0 | 10 | 2 | **20.00%** |
| **Adults** | 25 | 0 | 25 | 2 | **8.00%** |
| **Total** | **35** | **0** | **35** | **4** | **11.43%** |

# FY2025 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2024 – 12/31/2024

## NLCMH - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 63 | 61 | **96.83%** |
| **Adults** | 288 | 284 | **98.61%** |
| **Total** | **351** | **345** | **98.29%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 89 | 31 | **34.83%** |
| **MIA** | 211 | 99 | **46.92%** |
| **DDC** | 35 | 18 | **51.43%** |
| **DDA** | 15 | 6 | **40.00%** |
| **Total** | **350** | **154** | **44.00%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 65 | 36 | **55.38%** |
| **MIA** | 109 | 69 | **63.30%** |
| **DDC** | 42 | 33 | **78.57%** |
| **DDA** | 13 | 7 | **53.85%** |
| **Total** | **229** | **145** | **63.32%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 30 | 9 | 21 | 19 | **90.48%** |
| **Adults** | 135 | 67 | 68 | 59 | **86.76%** |
| **Total** | **165** | **76** | **89** | **78** | **87.64%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 30 | 0 | 30 | 0 | **0.00%** |
| **Adults** | 135 | 4 | 131 | 9 | **6.87%** |
| **Total** | **165** | **4** | **161** | **9** | **5.59%** |

# FY2025 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2024 – 12/31/2024

## Wellvance - Medicaid Only

### Table 1 – Access – Timeliness/Inpatient Screening

| Population | Emergency Referral | # Less Than 3 Hrs. | % Less Than 3 Hrs. |
|---|---|---|---|
| **Children** | 48 | 48 | **100.00%** |
| **Adults** | 95 | 95 | **100.00%** |
| **Total** | **143** | **143** | **100.00%** |

### Table 2a – Access – Timeliness/First Request

| Population | New Clients | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 60 | 48 | **80.00%** |
| **MIA** | 125 | 83 | **66.40%** |
| **DDC** | 15 | 10 | **66.67%** |
| **DDA** | 4 | 3 | **75.00%** |
| **Total** | **204** | **144** | **70.59%** |

### Table 3 – Access – Timeliness/First Service

| Population | New Clients Start Services | In 14 Days | % In 14 Days |
|---|---|---|---|
| **MIC** | 48 | 36 | **75.00%** |
| **MIA** | 101 | 78 | **77.23%** |
| **DDC** | 13 | 12 | **92.31%** |
| **DDA** | 3 | 3 | **100.00%** |
| **Total** | **165** | **129** | **78.18%** |

### Table 4a – Access – Continuity of Care

| Population | # Discharges | Exceptions | Net Discharges | In 7 Days | % In 7 Days |
|---|---|---|---|---|---|
| **Children** | 12 | 3 | 9 | 9 | **100.00%** |
| **Adults** | 20 | 5 | 15 | 15 | **100.00%** |
| **Total** | **32** | **8** | **24** | **24** | **100.00%** |

### Table 6 – Outcomes – Inpatient Recidivism

| Population | # Discharges | Exceptions | Net Discharges | Readmit In 30 Days | % Readmit In 30 Days |
|---|---|---|---|---|---|
| **Children** | 12 | 0 | 12 | 1 | **8.33%** |
| **Adults** | 20 | 0 | 20 | 4 | **20.00%** |
| **Total** | **32** | **0** | **32** | **5** | **15.63%** |

## Northern Michigan Regional Entity – Region 2

## FINAL

# FY24 Performance Bonus Incentive Pool (PBIP)
# Contractor-only and MHP/Contractor Joint Metrics
# Deliverables/Narratives Scoring

This communication serves as the response to your PIHP regarding the FY2024 performance bonus, contract section 8.4.2.
Scoring is based on Contractor-only and MHP/Contractor Joint Metrics deliverables.

| TOTAL WITHHOLD | TOTAL WITHHOLD UNEARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|
| $1,736,971.94 | $21,712.15 | $1,675,416.68 | $3,390,676.47 |

**CONTRACTOR-only Pay for Performance Measures (45% of total Withhold)**

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| P.1 Implement data driven outcomes measurement to address social determinants of health | $312,654.95 | $0 | 40 | 40 | $0 | $312,654.95 |
| **NARRATIVE REVIEW:** | | | | | | |
| **NA** | | | | | | |

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| P.2 Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) | $78,163.74 | $0 | 10 | 10 | $0 | $78,163.74 |
| **NARRATIVE REVIEW:** | | | | | | |
| **NA** | | | | | | |

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| P.3 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)-Initiation | **$195,409.34** | **$21,712.15** | **25** | **22** | **$0** | **$173,697.19** |

| | CY2022 | | CY2023 | | Disparity year 1 | Disparity year 2 | Disparity change |
|---|---|---|---|---|---|---|---|
| **RACE** | **M rate** | **W rate** | **M rate** | **W rate** | **Test 1** | **Test 2** | **Test 3.3** |
| African American/ Black | 30% | 32% | 39% | 28% | No disparity in year 1 | No disparity in year 2 | No change in disparity from year 1 to year 2 |
| American Indian/ Alaska Native | 34% | 32% | 35% | 28% | No disparity in year 1 | No disparity in year 2 | No change in disparity from year 1 to year 2 |
| Hispanic | 17% | 32% | 31% | 28% | Minority rate was significantly lower in year 2 | No disparity in year 2 | No change in disparity from year 1 to year 2 |

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| P.3 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)-Engagement | **$195,409.34** | **$0** | **25** | **25** | **$967,943.69** | **$1,163,353.03** |

| | CY2022 | | CY2023 | | Disparity year 1 | Disparity year 2 | Disparity change |
|---|---|---|---|---|---|---|---|
| **RACE** | **M rate** | **W rate** | **M rate** | **W rate** | **Test 1** | **Test 2** | **Test 3.3** |
| African American/ Black | 13% | 14% | 12% | 11% | No disparity in year 1 | No disparity in year 2 | No change in disparity from year 1 to year 2 |
| American Indian/ Alaska Native | 15% | 14% | 11% | 11% | No disparity in year 1 | No disparity in year 2 | No change in disparity from year 1 to year 2 |
| Hispanic | 7% | 14% | 13% | 11% | No disparity in year 1 | No disparity in year 2 | No change in disparity from year 1 to year 2 |

## CONTRACTOR-only Pay for Performance Measures (25% of total Withhold)

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| P.4 PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes | **$434,242.99** | **$0** | **100** | **100** | **$0** | **$434,242.99** |
| **NARRATIVE REVIEW:** | | | | | | |
| **NA** | | | | | | |

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| **CONTRACTOR -only TOTAL** | **$1,215,880.36** | **$21,712.15** | **200** | **197** | **$967,943.69** | **$2,162,111.90** |

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## MHP/Contractor Joint Metrics (30% of total withhold)

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| J.1 Implementation of Joint Care Management Processes. | **$182,382.05** | **$0** | **35** | **35** | **$0** | **$182,382.05** |

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| J.2.1 Follow-up after Hospitalization (FUH) within 30 days. | **$104,218.32** | **$0** | **20** | **20** | **$23,649.42** | **$127,867.74** |

| AGES | STANDARD | AET | BCC | HAP | MCL | MER | MOL | PRI | UNI | UPP | HCS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6-20 | 70% | N/S | N/S | N/S | 84 | 80 | N/S | N/S | N/S | N/S | N/S |
| 21-64 | 58% | N/S | N/S | N/S | 72 | 67 | 69 | N/S | 65 | N/S | N/S |

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| J.2.2 Follow-up after Hospitalization (FUH) within 30 days stratified by race/ethnicity. | **$104,218.32** | **$0** | **20** | **20** | **$224,689.53** | **$328,907.85** |

| | CY2022 | | CY2023 | | Disparity year 1 | Disparity year 2 | Disparity change |
|---|---|---|---|---|---|---|---|
| **RACE** | **M rate** | **W rate** | **M rate** | **W rate** | **Test 1** | **Test 2** | **Test 3.3** |
| American Indian/ Alaska Native | 83% | 76% | 80% | 70% | No disparity in year 1 | No disparity in year 2 | No change in disparity from year 1 to year 2 |

Please note: confidence intervals are used to score year to year comparisons to address disparities.

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| J.3 Follow-up after (FUA) Emergency Department visit for Alcohol and Other Drug Dependency within 30 days stratified by race/ethnicity. | **$130,272.90** | **$0** | **25** | **25** | **$459,134.04** | **$589,134.04** |

| | CY2022 | | CY2023 | | Disparity year 1 | Disparity year 2 | Disparity change |
|---|---|---|---|---|---|---|---|
| **RACE** | **M rate** | **W rate** | **M rate** | **W rate** | **Test 1** | **Test 2** | **Test 3.3** |
| American Indian/ Alaska Native | 38% | 45% | 45% | 42% | No disparity in year 1 | No disparity in year 2 | No change in disparity from year 1 to year 2 |

Please note: confidence intervals are used to score year to year comparisons to address disparities.

| | TOTAL WITHHOLD AMOUNT | TOTAL WITHHOLD UNEARNED AMOUNT | AVAILABLE POINTS | POINTS EARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|---|---|---|
| **MHP/CONTRACTOR JOINT METRICS TOTAL** | **$521,091.58** | **$0** | **100** | **100** | **$707,472.99** | **$1,228,564.57** |

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

| | Percentage | Number of Emergency Referrals for Children | Number Completed in Three Hours for Children |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 97.06 | 715 | 694 |
| Lakeshore Regional Entity | 98.65 | 445 | 439 |
| Macomb Co CMH Services | 97.84 | 278 | 272 |
| Mid-State Health Network | 98.09 | 837 | 821 |
| Northcare Network | 100 | 49 | 49 |
| Northern Michigan Regional Entity | 98.31 | 178 | 175 |
| Oakland Co CMH Authority | 100 | 342 | 342 |
| Region 10 | 98.26 | 287 | 292 |
| CMH Partnership of Southeast MI | 99.37 | 158 | 157 |
| Southwest MI Behavioral Health | 99.52 | 208 | 207 |
| **Statewide Total** | | **3,497** | **3,438** |

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

| | Percentage | Number of Emergency Referrals for Adults | Number Completed in Three Hours for Adults |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 97.28 | 2,541 | 2,472 |
| Lakeshore Regional Entity | 98.80 | 1,499 | 1,481 |
| Macomb Co CMH Services | 96.15 | 961 | 924 |
| Mid-State Health Network | 99.70 | 2,341 | 2,334 |
| Northcare Network | 100 | 256 | 256 |
| Northern Michigan Regional Entity | 98.35 | 607 | 597 |
| Oakland Co CMH Authority | 98.10 | 1,209 | 1,186 |
| Region 10 | 97.73 | 883 | 863 |
| CMH Partnership of Southeast MI | 99.50 | 598 | 595 |
| Southwest MI Behavioral Health | 99.63 | 812 | 809 |
| **Statewide Total** | | **11,707** | **11,517** |

11707

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

| | Percentage | # of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment | # of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 51.81 | 2,708 | 1,403 |
| Lakeshore Regional Entity | 65.25 | 1,341 | 875 |
| Macomb Co CMH Services | 63.27 | 972 | 615 |
| Mid-State Health Network | 58.29 | 4,030 | 2,349 |
| Northcare Network | 62.76 | 537 | 337 |
| Northern Michigan Regional Entity | 54.92 | 956 | 525 |
| Oakland Co CMH Authority | 54.25 | 977 | 530 |
| Region 10 | 52.68 | 2,014 | 1,061 |
| CMH Partnership of Southeast MI | 48.01 | 1,056 | 507 |
| Southwest MI Behavioral Health | 74.14 | 2,243 | 1,663 |
| **Statewide Total** | | **16,834** | **9,865** |

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

| | Percentage | # MI Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment | # MI Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 52.86 | 681 | 360 |
| Lakeshore Regional Entity | 63.45 | 591 | 375 |
| Macomb Co CMH Services | 64.75 | 278 | 180 |
| Mid-State Health Network | 58.89 | 1,384 | 815 |
| Northcare Network | 67.42 | 221 | 149 |
| Northern Michigan Regional Entity | 53.00 | 300 | 159 |
| Oakland Co CMH Authority | 51.17 | 385 | 197 |
| Region 10 | 50.08 | 607 | 304 |
| CMH Partnership of Southeast MI | 55.41 | 296 | 164 |
| Southwest MI Behavioral Health | 72.90 | 620 | 452 |
| **Statewide Total** | | **5,363** | **3,57155** |

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

| | Percentage | # MI Adults Who Requested Mental Health or I/DD Services and are Referred for a Biopsychosocial Assessment | # MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 57.30 | 1,384 | 793 |
| Lakeshore Regional Entity | 67.51 | 554 | 374 |
| Macomb Co CMH Services | 63.13 | 556 | 351 |
| Mid-State Health Network | 59.26 | 2,290 | 1,357 |
| Northcare Network | 58.78 | 279 | 164 |
| Northern Michigan Regional Entity | 55.10 | 539 | 297 |
| Oakland Co CMH Authority | 61.85 | 519 | 321 |
| Region 10 | 55.03 | 1,143 | 629 |
| CMH Partnership of Southeast MI | 42.72 | 646 | 276 |
| Southwest MI Behavioral Health | 74.41 | 1,477 | 1,099 |
| **Statewide Total** | | **9,387** | **5,661** |

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

| | Percentage | # DD Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment | # DD Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 35.84 | 558 | 200 |
| Lakeshore Regional Entity | 74.58 | 118 | 88 |
| Macomb Co CMH Services | 57.84 | 102 | 59 |
| Mid-State Health Network | 47.29 | 258 | 122 |
| Northcare Network | 52.00 | 25 | 13 |
| Northern Michigan Regional Entity | 63.95 | 86 | 55 |
| Oakland Co CMH Authority | 21.43 | 28 | 6 |
| Region 10 | 48.56 | 208 | 101 |
| CMH Partnership of Southeast MI | 62.65 | 83 | 52 |
| Southwest MI Behavioral Health | 76.24 | 101 | 77 |
| **Statewide Total** | | **1,567** | **773** |

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

| | Percentage | # DD Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment | # DD Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 58.82 | 85 | 50 |
| Lakeshore Regional Entity | 48.72 | 78 | 38 |
| Macomb Co CMH Services | 69.44 | 36 | 25 |
| Mid-State Health Network | 56.12 | 98 | 55 |
| Northcare Network | 91.67 | 12 | 11 |
| Northern Michigan Regional Entity | 45.16 | 31 | 14 |
| Oakland Co CMH Authority | 13.33 | 45 | 6 |
| Region 10 | 48.21 | 56 | 27 |
| CMH Partnership of Southeast MI | 48.39 | 31 | 15 |
| Southwest MI Behavioral Health | 77.78 | 45 | 35 |
| **Statewide Total** | | **517** | **276** |

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

| | | Admissions | | | |
|---|---|---|---|---|---|
| | Percentage | # of Non-Urgent Admissions to a Licensed SUD Treatment Facility as Reported in BH TEDS | # of Expired Requests Reported by the PIHP | Total | # of Persons Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request |
| Detroit Wayne Mental Health Authority | 69.13 | 3,456 | 933 | 4,389 | 3,034 |
| Lakeshore Regional Entity | 69.42 | 1,307 | 266 | 1,573 | 1,092 |
| Macomb Co CMH Services | 72.02 | 1,254 | 365 | 1,619 | 1,166 |
| Mid-State Health Network | 69.63 | 2,393 | 534 | 2,927 | 2,038 |
| Northcare Network | 60.57 | 426 | 175 | 601 | 364 |
| Northern Michigan Regional Entity | 66.67 | 952 | 239 | 1,191 | 794 |
| Oakland Co CMH Authority | 81.54 | 759 | 140 | 899 | 733 |
| Region 10 | 79.55 | 1,659 | 302 | 1,961 | 1,560 |
| CMH Partnership of Southeast MI | 52.54 | 788 | 274 | 1,062 | 558 |
| Southwest MI Behavioral Health | 70.96 | 879 | 199 | 1,078 | 765 |
| **Statewide Total** | | **13,873** | **3,427** | **17,300** | **12,104** |

**Indicator 3: Percentage of New Persons During the Quarter Starting any Medically Necessary Ongoing Covered Service within 14 Calendar Days of Completing a Non-Emergent Biopsychosocial Assessment**

| | Percentage | # of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services | # of Persons Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 94.11 | 2,123 | 1,998 |
| Lakeshore Regional Entity | 58.50 | 1,212 | 709 |
| Macomb Co CMH Services | 63.06 | 785 | 495 |
| Mid-State Health Network | 61.76 | 3,041 | 1,878 |
| Northcare Network | 62.76 | 435 | 273 |
| Northern Michigan Regional Entity | 66.82 | 639 | 427 |
| Oakland Co CMH Authority | 99.12 | 796 | 789 |
| Region 10 | 78.19 | 1,385 | 1,083 |
| CMH Partnership of Southeast MI | 69.00 | 742 | 512 |
| Southwest MI Behavioral Health | 66.47 | 1,900 | 1,263 |
| **Statewide Total** | | **13,058** | **9,427** |

**Table 3a: The Percentage of New Children with Emotional Disturbance During the Quarter Starting any Medically Necessary Ongoing Service within 14 Calendar Days of Completing a Non-Emergent Biopsychosocial Assessment**

| | Percentage | # MI Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services | # MI Children Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 93.28 | 551 | 514 |
| Lakeshore Regional Entity | 56.34 | 536 | 302 |
| Macomb Co CMH Services | 50.23 | 221 | 111 |
| Mid-State Health Network | 54.86 | 1,070 | 587 |
| Northcare Network | 62.98 | 181 | 114 |
| Northern Michigan Regional Entity | 64.79 | 213 | 138 |
| Oakland Co CMH Authority | 98.77 | 326 | 322 |
| Region 10 | 78.73 | 409 | 322 |
| CMH Partnership of Southeast MI | 68.86 | 228 | 157 |
| Southwest MI Behavioral Health | 69.72 | 535 | 373 |
| **Statewide Total** | | **4,270** | **2,940** |

**Indicator 3b: The Percentage of New Adults with Mental Illness During the Quarter Starting any Medically Necessary Ongoing Service within 14 Calendar Days of Completing a Non-Emergent Biopsychosocial Assessment**

| | Percentage | # MI Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services | # MI Adults Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 93.56 | 1,072 | 1,003 |
| Lakeshore Regional Entity | 56.85 | 482 | 274 |
| Macomb Co CMH Services | 63.64 | 429 | 273 |
| Mid-State Health Network | 63.24 | 1,616 | 1,022 |
| Northcare Network | 62.21 | 217 | 135 |
| Northern Michigan Regional Entity | 67.52 | 311 | 210 |
| Oakland Co CMH Authority | 99.74 | 389 | 388 |
| Region 10 | 76.54 | 793 | 607 |
| CMH Partnership of Southeast MI | 65.46 | 414 | 271 |
| Southwest MI Behavioral Health | 65.33 | 1,223 | 799 |
| **Statewide Total** | | **6,946** | **4,982** |

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

| | Percentage | # DD Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services | # DD Children Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 96.01 | 426 | 409 |
| Lakeshore Regional Entity | 68.42 | 114 | 78 |
| Macomb Co CMH Services | 83.16 | 95 | 79 |
| Mid-State Health Network | 78.31 | 272 | 213 |
| Northcare Network | 60.00 | 25 | 15 |
| Northern Michigan Regional Entity | 72.83 | 92 | 67 |
| Oakland Co CMH Authority | 96.77 | 31 | 30 |
| Region 10 | 87.50 | 144 | 126 |
| CMH Partnership of Southeast MI | 78.95 | 76 | 60 |
| Southwest MI Behavioral Health | 61.05 | 95 | 58 |
| **Statewide Total** | | **1,370** | **1,135** |

**Indicator 3d: The Percentage of New Adults with Developmental Disabilities During the Quarter Starting any Medically Necessary ongoing Service within 14 Calendar Days of Completing a Non-Emergent Biopsychosocial Assessment**

| | Percentage | # DD Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services | # DD Adults Who Started a Face-to-Face Service within 14 Calendar Days of the Completion of the Biopsychosocial Assessment |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 97.30 | 74 | 72 |
| Lakeshore Regional Entity | 68.75 | 80 | 55 |
| Macomb Co CMH Services | 80.00 | 40 | 32 |
| Mid-State Health Network | 67.47 | 83 | 56 |
| Northcare Network | 75.00 | 12 | 9 |
| Northern Michigan Regional Entity | 52.17 | 23 | 12 |
| Oakland Co CMH Authority | 98.00 | 50 | 49 |
| Region 10 | 71.79 | 39 | 28 |
| CMH Partnership of Southeast MI | 100 | 24 | 24 |
| Southwest MI Behavioral Health | 70.21 | 47 | 33 |
| **Statewide Total** | | **472** | **370** |

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

| | Percentage | # Children Discharged from Psychiatric Inpatient Unit | # Children Seen for Follow-Up Care within 7 Days |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 98.36 | 61 | 60 |
| Lakeshore Regional Entity | 97.58 | 124 | 121 |
| Macomb Co CMH Services | 82.81 | 64 | 53 |
| Mid-State Health Network | 95.48 | 155 | 148 |
| Northcare Network | 95.65 | 23 | 22 |
| Northern Michigan Regional Entity | 92.86 | 56 | 52 |
| Oakland Co CMH Authority | 96.88 | 32 | 31 |
| Region 10 | 100 | 91 | 91 |
| CMH Partnership of Southeast MI | 97.62 | 42 | 41 |
| Southwest MI Behavioral Health | 95.45 | 66 | 63 |
| **Statewide Total** | | **714** | **682** |

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

| | Percentage | # Adults Discharged from Psychiatric Inpatient Unit | # Adults Seen for Follow-Up Care within 7 Days |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 97.56 | 614 | 599 |
| Lakeshore Regional Entity | 98.51 | 335 | 330 |
| Macomb Co CMH Services | 80.89 | 293 | 237 |
| Mid-State Health Network | 95.61 | 615 | 588 |
| Northcare Network | 98.41 | 63 | 62 |
| Northern Michigan Regional Entity | 91.73 | 133 | 122 |
| Oakland Co CMH Authority | 85.83 | 127 | 109 |
| Region 10 | 95.91 | 269 | 258 |
| CMH Partnership of Southeast MI | 83.52 | 182 | 152 |
| Southwest MI Behavioral Health | 94.48 | 326 | 308 |
| **Statewide Total** | | **2,957** | **2,765** |

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

| | Percentage | # SA Discharged from Substance Abuse Detox Unit | # SA Seen for Follow-Up Care within 7 Days |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 97.18 | 568 | 552 |
| Lakeshore Regional Entity | 100 | 88 | 88 |
| Macomb Co CMH Services | 100 | 237 | 237 |
| Mid-State Health Network | 95.27 | 169 | 161 |
| Northcare Network | 100 | 23 | 23 |
| Northern Michigan Regional Entity | 97.58 | 124 | 121 |
| Oakland Co CMH Authority | 100 | 157 | 157 |
| Region 10 | 90.48 | 63 | 57 |
| CMH Partnership of Southeast MI | 100 | 85 | 85 |
| Southwest MI Behavioral Health | 100 | 146 | 146 |
| **Statewide Total** | | **1,660** | **1,627** |

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

| | Percentage | Total Medicaid Beneficiaries Served | # of Area Medicaid Recipients |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 6.66 | 46,516 | 698,829 |
| Lakeshore Regional Entity | 6.47 | 18,006 | 278,170 |
| Macomb Co CMH Services | 5.47 | 12,222 | 223,606 |
| Mid-State Health Network | 8.44 | 34,057 | 403,733 |
| Northcare Network | 8.38 | 5,443 | 64,917 |
| Northern Michigan Regional Entity | 8.65 | 10,199 | 117,958 |
| Oakland Co CMH Authority | 8.74 | 17,152 | 196,180 |
| Region 10 | 8.66 | 17,569 | 202,869 |
| CMH Partnership of Southeast MI | 7.51 | 9,729 | 129,598 |
| Southwest MI Behavioral Health | 8.59 | 18,336 | 213,552 |
| **Statewide Total** | | **189,229** | **2,529,412** |

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

| | Percentage | # of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination | Total Number of HSW Enrollees |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 95.85 | 971 | 1,013 |
| Lakeshore Regional Entity | 93.29 | 598 | 641 |
| Macomb Co CMH Services | 95.44 | 398 | 417 |
| Mid-State Health Network | 95.98 | 1,410 | 1,469 |
| Northcare Network | 97.85 | 364 | 372 |
| Northern Michigan Regional Entity | 96.27 | 646 | 671 |
| Oakland Co CMH Authority | 89.64 | 675 | 753 |
| Region 10 | 97.63 | 495 | 507 |
| CMH Partnership of Southeast MI | 94.36 | 653 | 692 |
| Southwest MI Behavioral Health | 97.51 | 667 | 684 |
| **Statewide Total** | | **6,877** | **7,219** |

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

| | Percentage | # of Children Discharged from Inpatient Care | # Children Discharged that were Readmitted within 30 Calendar Days |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 10.57 | 227 | 24 |
| Lakeshore Regional Entity | 12.67 | 150 | 19 |
| Macomb Co CMH Services | 8.89 | 90 | 8 |
| Mid-State Health Network | 8.56 | 222 | 19 |
| Northcare Network | 11.54 | 26 | 3 |
| Northern Michigan Regional Entity | 6.17 | 81 | 5 |
| Oakland Co CMH Authority | 2.86 | 35 | 1 |
| Region 10 | 9.72 | 144 | 14 |
| CMH Partnership of Southeast MI | 6.00 | 50 | 3 |
| Southwest MI Behavioral Health | 6.06 | 99 | 6 |
| **Statewide Total** | | **1,124** | **102** |

**Indicator 10b (old #12b): The Percentage of Adults Readmitted to Inpatient Psychiatric Units within 30 Calendar Days of Discharge from a Psychiatric Inpatient Unit – 15% of Less Standard**

| | Percentage | # of Adults Discharged from Inpatient Care | # Adults Discharged that were Readmitted within 30 Calendar Days |
|---|---|---|---|
| Detroit Wayne Mental Health Authority | 16.94 | 1623 | 275 |
| Lakeshore Regional Entity | 13.19 | 508 | 67 |
| Macomb Co CMH Services | 16.67 | 522 | 87 |
| Mid-State Health Network | 10.12 | 1087 | 110 |
| Northcare Network | 10.00 | 80 | 8 |
| Northern Michigan Regional Entity | 9.30 | 215 | 20 |
| Oakland Co CMH Authority | 9.38 | 192 | 18 |
| Region 10 | 13.32 | 548 | 73 |
| CMH Partnership of Southeast MI | 10.53 | 266 | 28 |
| Southwest MI Behavioral Health | 12.70 | 559 | 71 |
| **Statewide Total** | | **5,600** | **757** |

# Michigan's Medicaid Program

Meghan Groen, Senior Deputy Director

March 20, 2025

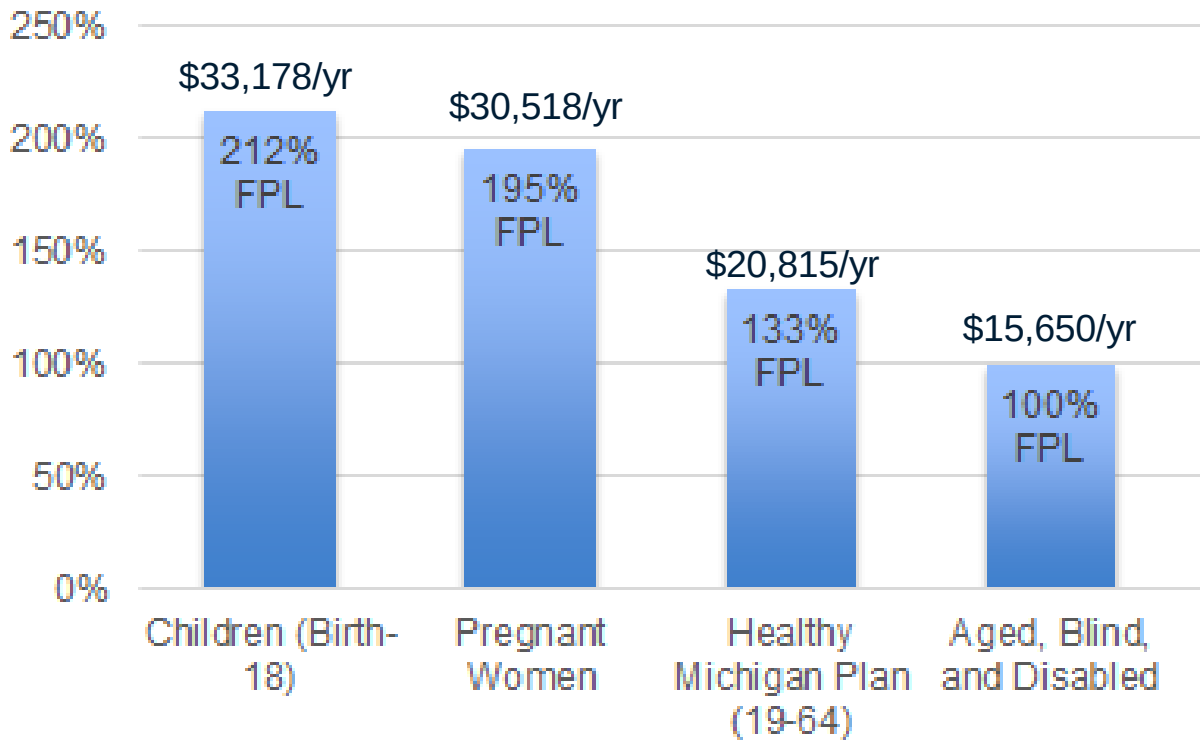
MDHHS
Michigan Department of Health & Human Services

# Medicaid Background

# Medicaid Program Background

- Medicaid is the **largest health insurance program** in the U.S.
- A means-tested entitlement program providing **comprehensive health coverage for eligible populations**, including:
  - Low-income children and families.
  - Elderly and disabled individuals.
  - Pregnant women.

## Medicaid Income Limit by Population



# Michigan's Medicaid Program has a Vast Reach

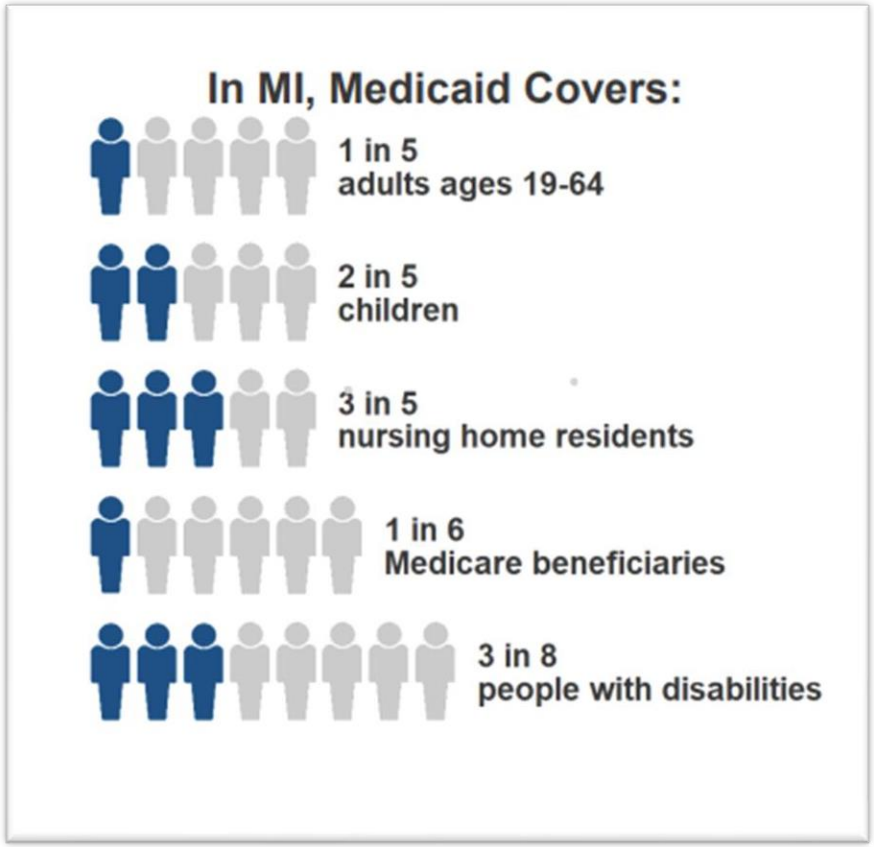
Medicaid covers 1 in 5 individuals living in the U.S.

In Michigan, the coverage rate is even higher — **1 in 4 Michiganders**.

Michigan's Medicaid program affords health coverage to more than **2.6 million Michiganders** each month, including:

- **1 million children**;
- **300,000 people** living with **disabilities**;
- **168,000 seniors**; and,
- Nearly **725,000 adults** in the **Healthy Michigan Plan**.

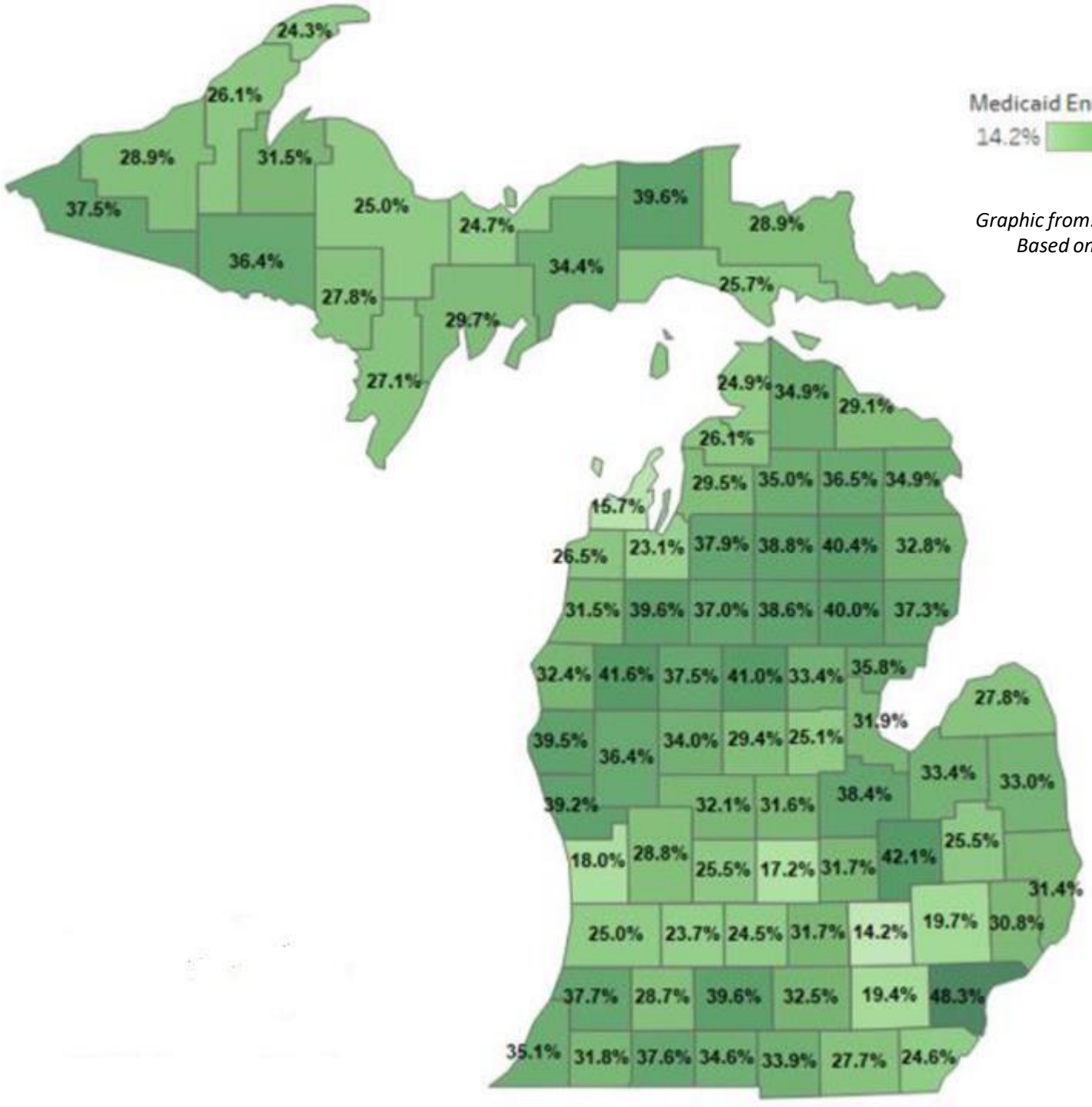
**45% of births** in Michigan are covered by Medicaid.




*Graphic from: Kaiser Family Foundation*
*August 2024 Michigan Fact Sheet*

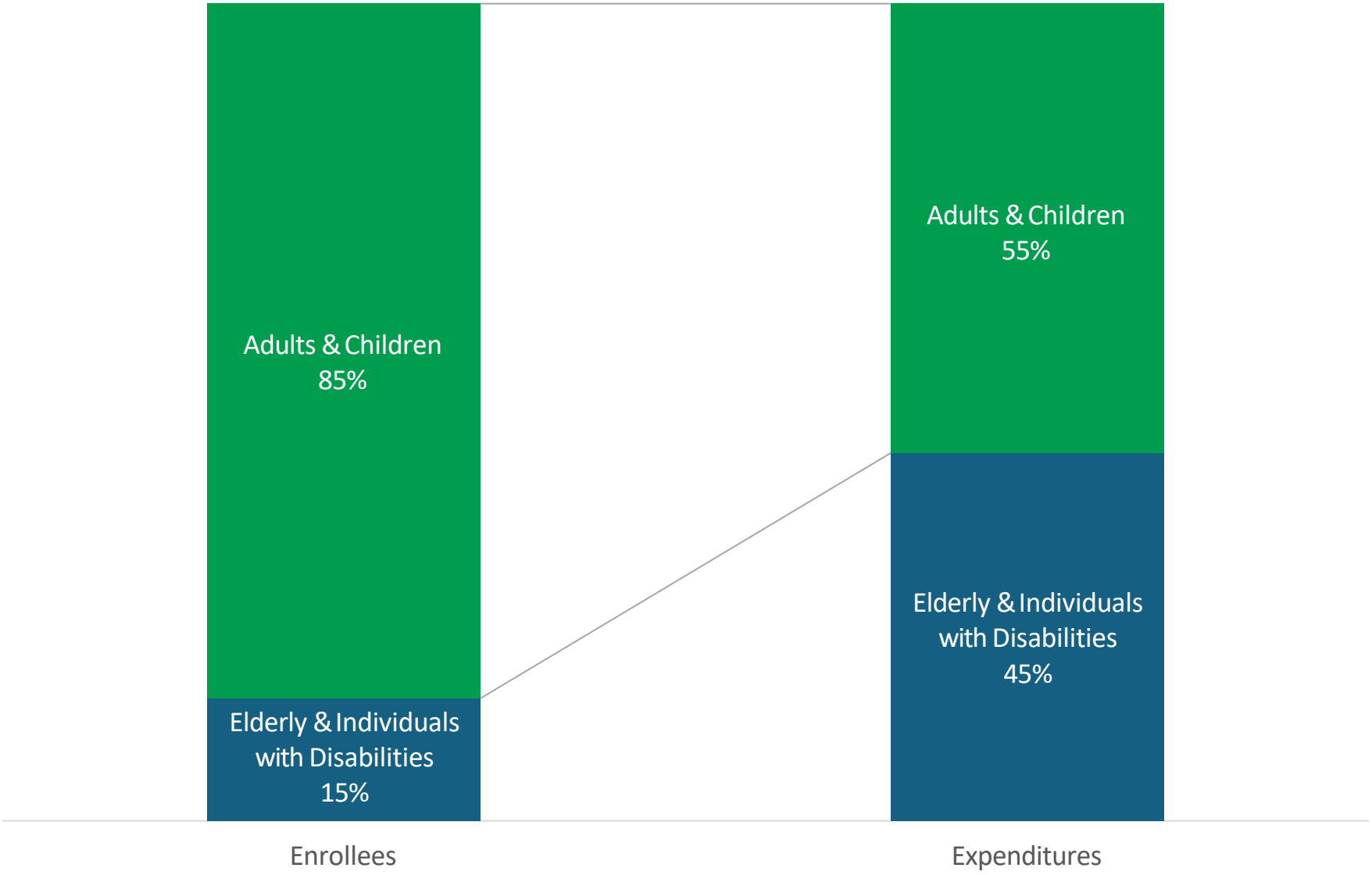
# Medicaid Enrollment

*Percentage of County Population*




*Graphic from: Michigan Health & Hospital Association*
*Based on January 2023 Medicaid Enrollment*

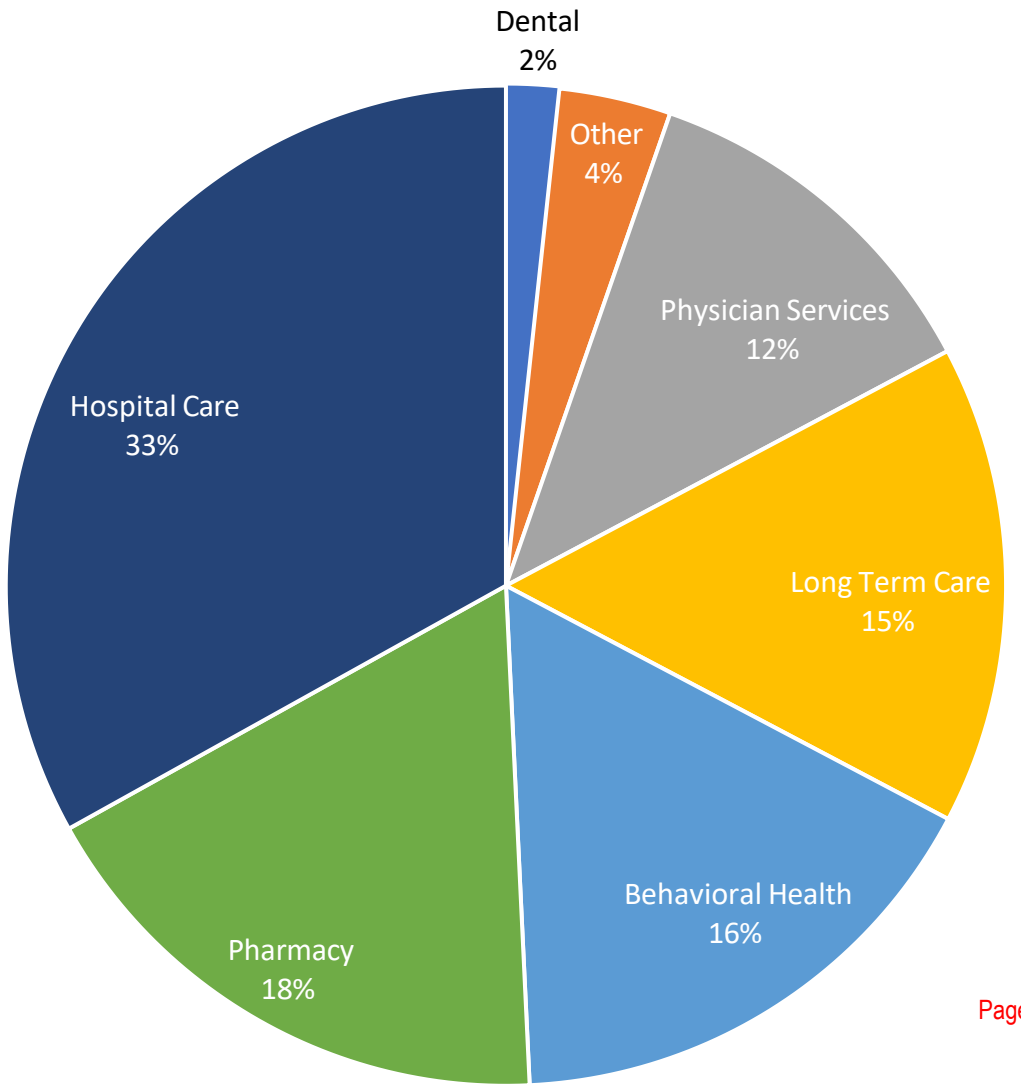
# Medicaid Enrollees and Expenditures



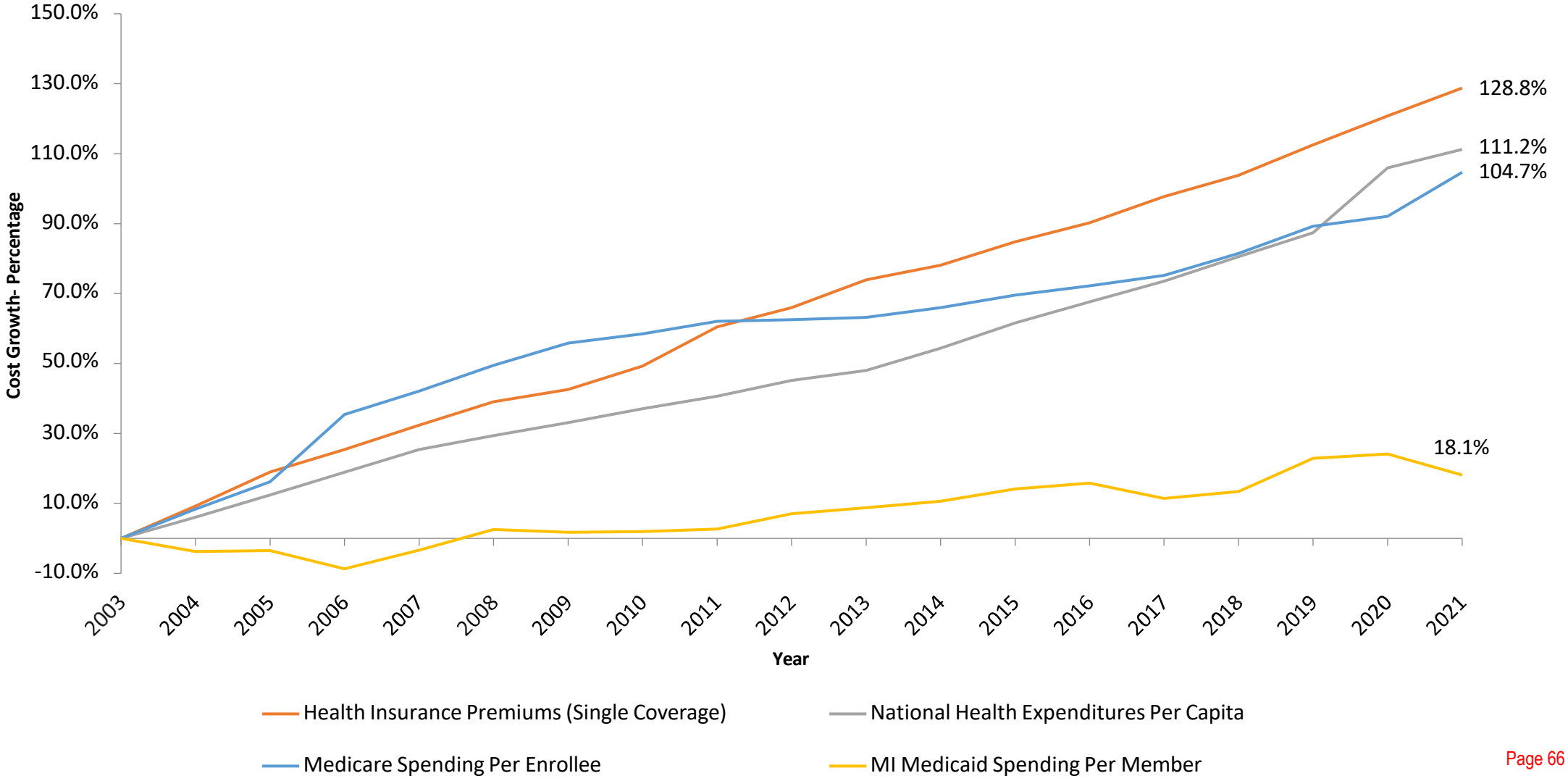
# Medicaid is a Major Payer in the Health Care System

- Nationally, Medicaid accounts for one-fifth of all health care spending, and over half of spending on long-term care.
- It is largest payer of mental health services, long-term care services, and births.
- As such, it plays a critical role in assuring the sustainability of hospitals, community health centers, physicians, and nursing homes.

**Michigan Medicaid Expenditures by Service**



# Medicaid is Cost Effective

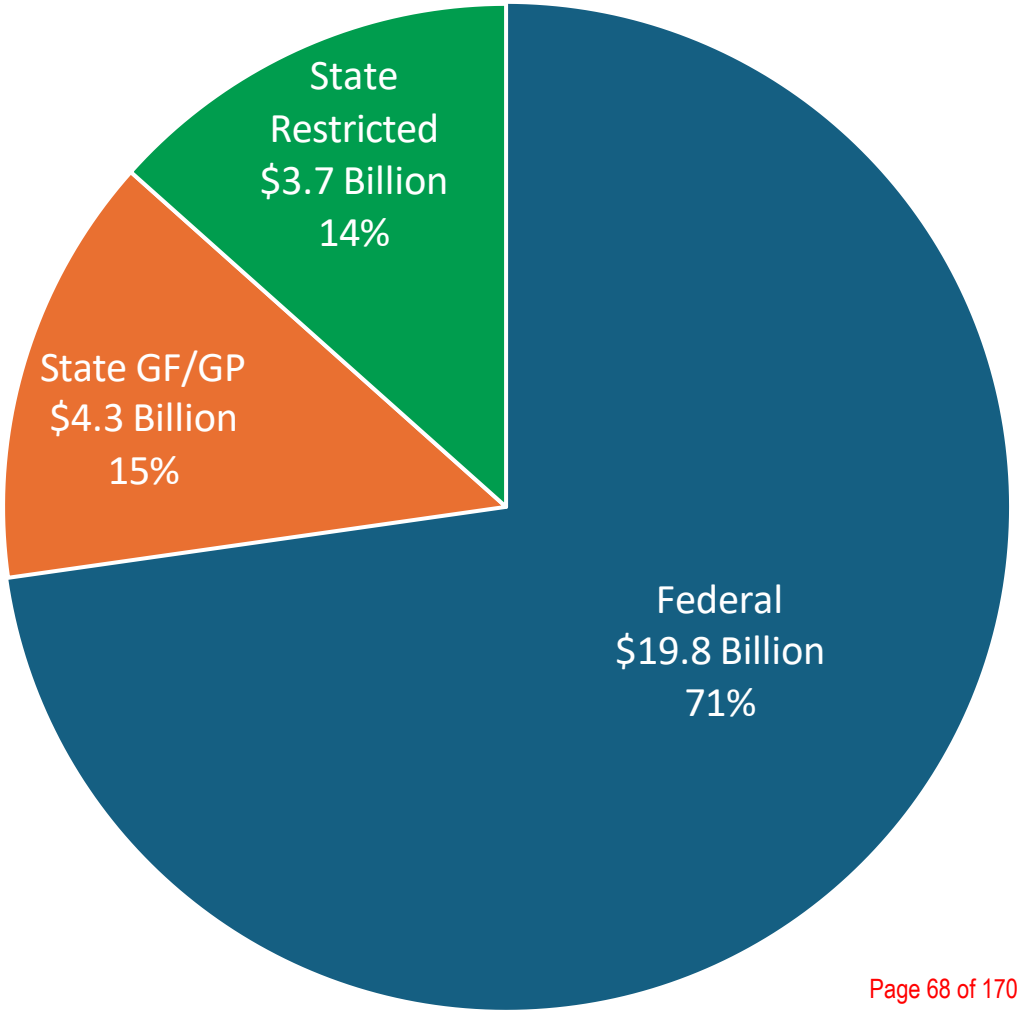


# How Michigan Medicaid is Financed

- Medicaid is **jointly funded** by the state and federal governments.
- The federal match rates for most Medicaid enrollees vary by state following a federal formula that provides a **higher federal match rate for states with lower per capita income**.
  - Michigan's FY25 **federal match rate is ~65%**.
  - The remaining **~35% is covered by the state** through a combination of state appropriations, provider taxes and local revenue.
- **Healthy Michigan Plan**, Michigan's Medicaid expansion program, qualifies for **90% federal match**.
- Medicaid **administrative expenditures** are covered by the federal government at **50%, 75% or 90%, depending on the type of expenditure**.

# Michigan Medicaid Budget

- Michigan's FY25 Medicaid budget is approximately $27.8 billion.
  - 34% of the state's overall budget.
- More than 70% of the Medicaid budget comes from federal funding.
- The state share is comprised of:
  - State General Fund/General Purpose Revenue: $4.3 billion.
  - Provider Taxes: $2.32 billion.
  - Insurance Provider Assessment: $651.1 million.
  - Tobacco Taxes/Settlement: $335.0 million.
  - Public/University Hospital and Long-Term Care Special Financing: $246.8 million.



# Medicaid Helps Hospitals

- With Medicaid covering a quarter of the state's population, Michigan's **uninsured rate** continues to improve and is now **among the best in the country** (4.4% in Michigan compared to 8% nationally).
- Since the launch of Medicaid expansion in 2014, **hospital uncompensated care** has fallen dramatically – **decreasing by more than 50%.**
- Michigan's hospitals receive **nearly $7 billion** in Medicaid funding annually, which accounts for **almost one-fifth of the net patient revenue for hospitals in the state.**

# Medicaid Helps Rural Communities

- **37.3% of small town and rural** Michiganders are covered by Medicaid.
- States that did not expand Medicaid experienced **more hospital closures, especially in rural communities**. Hospitals are six times more likely to close in non-expansion states.
- If Medicaid payments are reduced, rural hospitals will struggle to keep **labor and delivery** units open.
- The local hospital is often the **largest employer in many of Michigan's rural communities.**

# Medicaid Helps the Economy

- According to the Michigan Health and Hospital Association, Michigan's health care industry has a total economic impact of **$77 billion** per year — **greater than any other industry in the state.**
- A University of Michigan study found that Medicaid expansion alone sparked the creation of **more than 30,000 new jobs every year**.
  - One-third in health care and 85% in the private sector.
- These jobs boost the **personal spending power** for Michigan residents by about **$2.3 billion each year** and result in an additional **~$150 million in tax revenue annually.**

# Medicaid is Good for our Future

## *Medicaid Kids* → *High Earners*

- Medicaid enrollment for children has been shown to:
  - Increase **positive health outcomes**.
  - Increase **educational attainment**.
  - Increase **wages** in adulthood.
  - Increase **future tax revenue** from increased earnings.

- Increasing the proportion of low-income pregnant women on Medicaid improved the **economic mobility outcomes** of their children in adulthood.
- The Congressional Budget Office estimates that **long-term** fiscal effects of Medicaid spending on children could **offset half or more** of the program's initial outlays.

# Potential Federal Medicaid Changes

MDHHS
Michigan Department of Health & Human Services

# Impact of Potential Federal Cuts to Michigan's Medicaid Program

- **Reducing the 90% federal match rate for Medicaid expansion (HMP)**:
  - Aligning the expansion match rate with Michigan's traditional federal match of ~65% would cost the state $1.1 billion annually. Absent this additional state investment, 30% of Michigan's Medicaid population would lose their health coverage.
- **Limiting provider taxes:**
  - Would result in cuts to hospital, nursing facility and ambulance reimbursement. The loss of federal revenue would also likely necessitate broad-based cuts to benefits or already low reimbursement rates.
- **Imposing work requirements:**
  - Would add administrative costs to the state and a burden on beneficiaries, and it would lead to unnecessary coverage losses including for individuals who are already working.
- **Ending enhanced federal match for certain administrative expenditures:**
  - Would result in the need for considerable additional state dollars to backfill loss of funds for administrative activities such as IT maintenance and operations, nursing home certification and survey activities, and program integrity efforts.
- **Per capita caps or block grants:**
  - Would cap federal funding available to support the state's Medicaid program over time. National estimates modeled to date project that Michigan could see a reduction in federal funding of $16 billion between FY2025 and FY2034.

# Questions?

MDHHS
Michigan Department of Health & Human Services

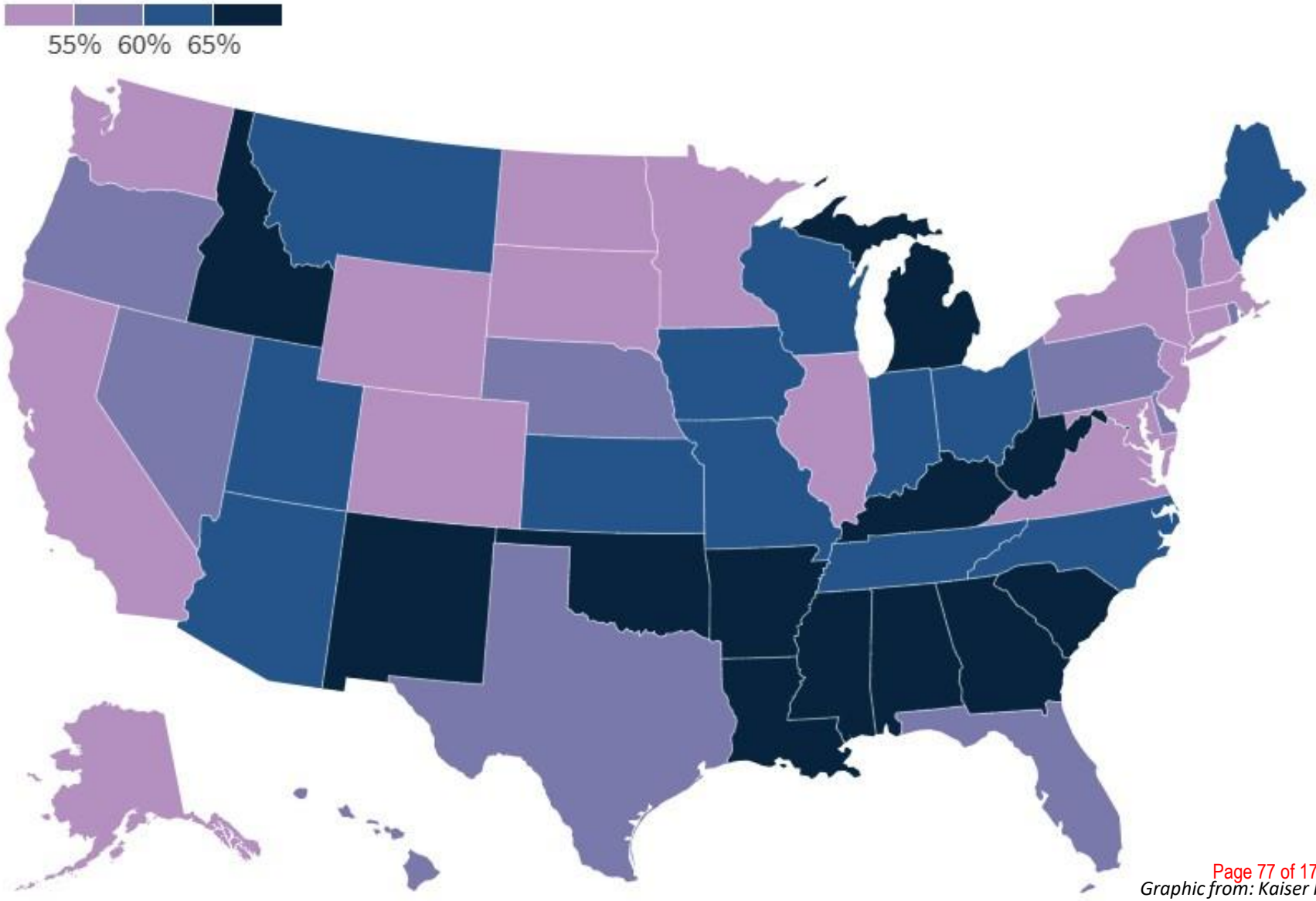
# Supplemental Materials

MDHHS
Michigan Department of Health & Human Services

# Michigan Brings in More Federal Dollars

**States With Lower Per Capita Incomes Have a Higher Federal Matching Rate for Medicaid**

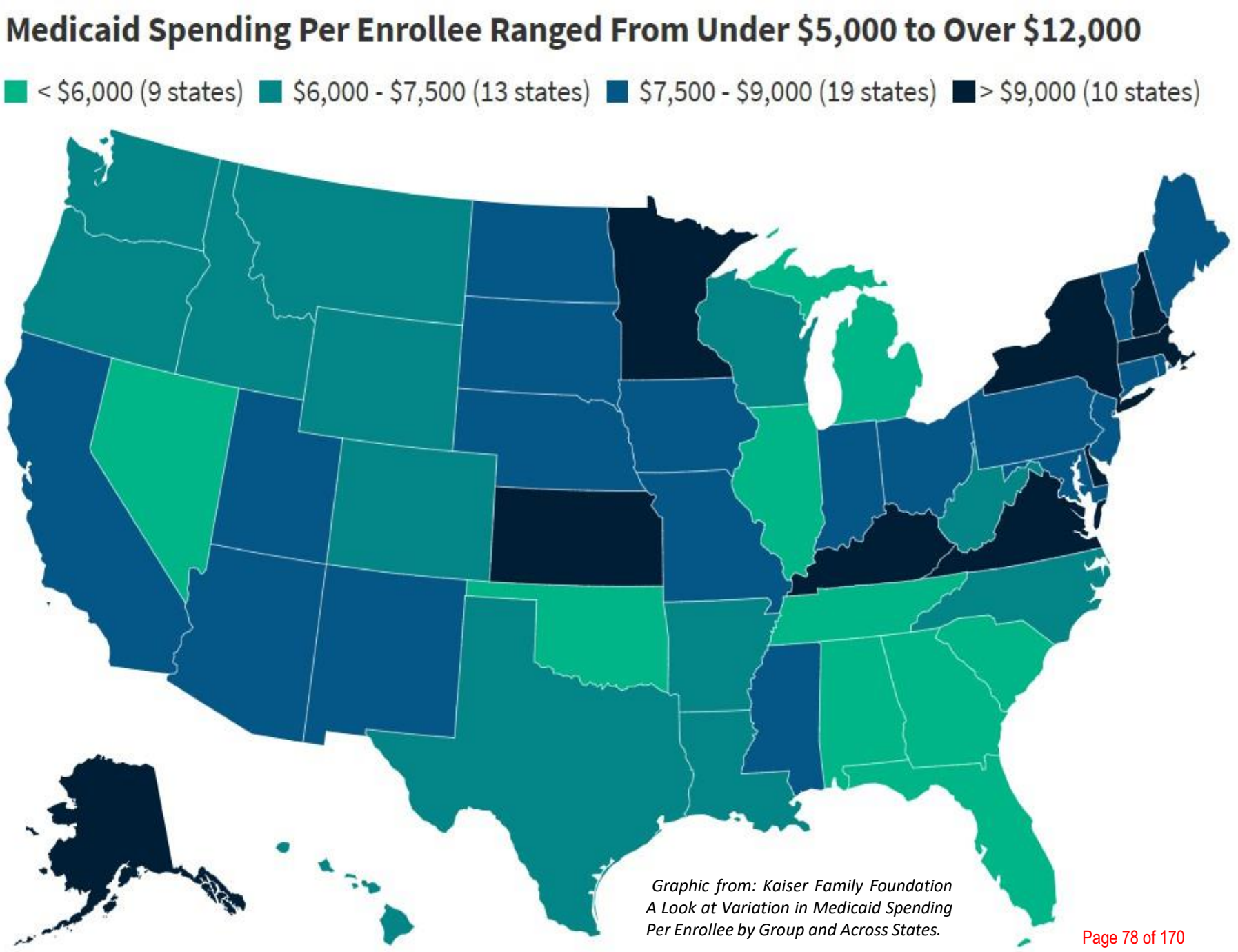
Federal Medicaid Assistance Percentages (FMAPs) for Traditional Medicaid Spending Effective for FFY 2026






*Graphic from: Kaiser Family Foundation Medicaid Financing: The Basics.*

# Michigan Spends Less per Medicaid Enrollee




*Graphic from: Kaiser Family Foundation*
*A Look at Variation in Medicaid Spending Per Enrollee by Group and Across States.*

# Mandatory Medicaid Populations and Benefits

**Who must be covered under federal law?**

- Older adults (age 65 and older) who receive Medicare and also qualify for Medicaid.
- Individuals who are blind.
- Individuals with disabilities.
- SSI recipients.
- Pregnant women.
- Children under age 1.
- Children in foster care.
- Very low-income families with children.
- Non-citizens for limited emergency services only.

**What services must be covered under federal law?**

- Inpatient and outpatient hospital services.
- Nursing facility services.
- Physician services.
- Lab and X-ray services.
- Home health services.
- Non-Emergency Medical Transportation (NEMT).
- Federally Qualified Health Centers & Rural Health Centers.
- Family planning services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (under 21).
- Medication Assisted Treatment (MAT).

# Changing Federal Matching Assistance Percentage (FMAP) Rates

- There are several potential policy changes under consideration relative to changing the current FMAP structure:
  - **Reducing the 90% federal match rate for Medicaid expansion population to the traditional Medicaid match rate (~65% for MI).**
    - CBO estimate: $561 billion reduction nationally over the next 10 years.
    - Michigan impact: $1.1 billion annual cost to the state.
    - Puts at risk the health coverage of ~725,000 individuals or 30% of Michigan's Medicaid population.
  - **Ending the enhanced federal match for certain administrative expenditures.**
    - CBO estimate: $69 billion reduction nationally over the next 10 years.
    - Michigan impact: Minimum of $115 million in state funds needed simply to maintain current IT operations/projects.
  - **Removing the 50% FMAP floor.**
    - No impact to Michigan absent broader FMAP formula adjustments.

# Limiting Provider Taxes

- Michigan has three provider taxes today:
  - Hospitals.
  - Nursing homes.
  - Ambulance providers.
- We also have a Managed Care Organization tax – the Insurance Provider Assessment.
- Together, these taxes are leveraged to make up **nearly $3 billion** of Michigan's state share of Medicaid costs.
- The tax dollars fund both the base Medicaid program and broader state budget (through state retention) and increased reimbursement to the taxed provider classes.

# Limiting Provider Taxes

- There are several options rumored to be under consideration relative to limiting provider taxes:
  - Reducing the provider tax limit from 6% of providers' net patient revenue to 3% or 4%.
  - Capping provider taxes as a share of state general funding.
  - Eliminating entirely the state's ability to leverage provider tax revenue to finance their Medicaid program.
  - Taking administrative action through rulemaking to require wholesale restructuring of managed care organization taxes.
- CBO estimate: $48-612 billion reduction nationally over the next 10 years.

# Imposing Work Requirements

- U.S. House and Senate Republicans have begun introducing legislative proposals to impose work requirements in Medicaid.
- When Michigan implemented Healthy Michigan Plan (HMP) work requirements in 2020, MDHHS incurred more than **$30 million** in administrative costs.
- Before a federal court blocked Michigan's work requirements in March 2020, MDHHS was on track to lose **~80,000 HMP enrollees** in the first month that coverage terminations were to occur and **more than 100,000** in the first year.
- The estimated impacts of work requirements and how these may or may not align with Michigan's prior experience are highly dependent on policy details that have yet to be released.
- CBO estimate: $110 billion reduction nationally over the next 10 years.

# Capping Medicaid Funds to States

- Medicaid is currently an entitlement program wherein states must cover all eligible individuals, and the federal government must provide the federal share of funding for the costs of that coverage.
- Per capita caps and block grants are mechanisms to shift financial costs and risk to states.
  - **Per-capita caps:** Limits federal funding to a fixed amount per enrollee. This amount would be adjusted annually by a set amount/inflationary factor. Because funding is set on a per enrollee basis, federal funding available to states under this model would adjust for enrollment fluctuations.
  - **Block grants:** Limits federal funding to a fixed amount for the entire Medicaid program. This amount would be adjusted annually by a set amount/inflationary factor but would not adjust for enrollment fluctuations.

# Capping Medicaid Funds to States

- The estimated impacts of a per capita cap or block grant structure are highly dependent on policy details that have yet to be released, which limits the ability of the state to effectively model such a shift.
- CBO estimate – Per-capita Caps: $588-$893 billion reduction nationally over the next 10 years.
- CBO estimate – Block Grants: $459-$742 billion reduction nationally over the next 10 years.

Community Mental Health Association of Michigan

# Reducing administrative and paperwork burden on Michigan's public mental health system

April 2022 (revised May 2022)

The **"high leverage" recommendations** are boxed, below, and are of two types, both which are recommended to be kicked-off simultaneously, with two different time horizons.

Those items viewed as part of an **overall process change** (longer time horizon) to addressing this issue are boxed and in straight type; those seen as **concrete and discrete steps** (shorter time horizon) that could be taken concurrently to the overall process change, rather than waiting for the completion of this more far-reaching and slower process, are boxed and in italics.

## Summary of issue to be addressed

The administrative and paperwork burden borne by Michigan's public mental health system:

- Draws staff time and resources away from providing services to Michiganders
- Hinders staff recruitment and retention efforts
- Inflates the cost of care

## Recommendations for reducing administrative burden

**A. Increase the use of formalized, regular, and early involvement of the community-based system in the development of paperwork and administrative requirements:** With the co-development of and input from, early in the development of statewide policy, requirement, and practices, those with the deep working knowledge of the processes of the state's provider and payer systems and the impact of state policies on these processes - the state's community-based system (CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks) and the state's major advocacy groups – the administrative requirements of the system can be developed to ensure system effectiveness and efficiency. Without such involvement, these statewide policies can lead to unnecessary demands, system ineffectiveness and inefficiency, and work-arounds.

Additionally, lack of clarity around when statewide standards and policies are required and when local discretion is allowed or encouraged, by all involved, causes confusion for persons served, community partners, MDHHS, elected officials, and the community-based system.

**Recommendations:**

1. MDHHS to call upon the state's community-based system (CMHSPs, PIHPs, and providers in the CMHSP and PIHP system – often through the Community Mental Health Association of Michigan (CMHA), a practice that has been done periodically for years) to appoint staff to join in the co-development of statewide policies. This involvement should reflect a co-development approach, as with any partnership, with the roles of the representatives of the community-based clearly articulated at the start of the design process.

When the process is not one of co-development, but one of MDHHS seeking advice - what should be a rare occurrence - that should be clearly stated early in the process.

2, Clarity provided, in writing, by MDHHS and the community-based system, as when a policy or process is required to be uniform, statewide, and when local, regional, population, or person served-specific differences are allowed or encouraged.

3. Annually, the MDHHS and the community-based system to review the administrative and paperwork demands on the system with the aim of refining or eliminating these demands in light of their relevance and value-added nature.

**B. Reduce clinical and contractual paperwork demands:** The paperwork demands required of clinicians within Michigan's public mental health system are far greater than mental health practitioners in schools and those in private practices. These paperwork demands reduce the amount of time for skilled practitioners, in the public mental health system, to serve Michiganders while also driving these clinicians out of the public mental health system – thus seriously damaging the recruitment and retention of this behavioral health workforce.

Additionally, because the electronic platforms to which many of the required assessment and waiver enrollment tools are tied lie outside of the electronic health records of the community based system, clinicians and support staff spend an inordinate amount of time in duplicative data entry into systems that do not allow for an integrated clinical monitoring tool.

**Recommendations**:

1. An in-depth examination of the clinical paperwork required of the practitioners, and persons served, in the public mental health system with the aim of reducing this burden – carried out by a workgroup made up of MDHHS staff and representatives of the state's CMH, PIHP, and Provider system – the latter recruited by the CMH Association of Michigan.

As an example of the work that could be done in this area, Attachment A contains the recommendations of a group of leaders, within the state's public mental health system (the leaders of a number of CCBHCs), around the development of a streamlined clinical record.

However, even this slimmed-down clinical record contains interviewing and recording requirements that harm client engagement and impede prompt access to care.

While a benefit to all served by the community system, a lean clinical recordkeeping system that supports rapid engagement and immediate access to care is especially key for persons with episodic and brief needs for mental health services.

2. Work with the community-based system to develop technical links of the free-standing clinical assessment and waiver enrolment tools into the electronic health records of the community-based system. Examples of these tools that are based on stand-alone platforms include: CAFAS, PECFAS, ASAM Continuum, WSA, and the newly emerging Open Beds/statewide psychiatric bed search process.

3. Allow assessment tool information to satisfy the Personal Care script for T1020 services (AFC home). The SIS, Psychosocial Assessment, and DLA-20 can show the level of care needs such as level of independence/dependence needs with bathing, grooming, toileting, eating/feeding, dressing, etc. without the need to get a script. This will reduce redundant effort for case managers, supports coordinators, and physicians.

*4. SHORT TERM CHANGE IN LIGHT OF DEEP AND PROLONGED WORKFORCE SHORTAGE: Pause on SIS assessments for persons with intellectual or developmental disabilities. Staff vacancies mean that cases are being transferred to SIS assessors who do not know the persons served and so cannot be one of the two persons needed to accurately inform the SIS assessments.*

5. Develop and foster the use, via liability protections and other means, of a single provider contract for use by the state's CMHs and PIHPs.

**C. Overhaul the large number of site visits and reporting requirements on Michigan's public mental health system:** Michigan's public mental health system is burdened by a large number of reporting requirements, many with little or no value. MDHHS has the power, internally, or via recommended changes to the budget boilerplate language that requires many of these reports (Section 904 being the most obvious), to dramatically reduce this burden.

A picture of these reporting and site visit demands can be found here:

- Attachment B contains the list of the audits, site visits, and reports required by Michigan's CMHs.
- Attachment C contains the list of reports required by Michigan's PIHPs.
- Attachment D contains the list of areas reviewed by one or more of the some of the most thorough of the site visits experienced by the community-based system.
- Section 904 of the MDHHS budget bill requires extensive reporting to the Michigan Legislature which applies to MDHHS as well as the CMHSPs and PIHPs. Completion of the various required reports necessitate a major time commitment for MDHHS, CMHSPs and PIHPs. The required reports include but are not limited to providing the following data:

  - Demographic description of service recipients
  - Per capita expenditures in total and by population group and cultural and ethnic groups of the services area
  - Detailed financial information
  - Data describing service outcomes
  - Performance indicators

**Recommendations:**

*1. A review, by MDHHS and representatives of the community-based system, of the reporting requirements with which Michigan's community-based system must comply, with the aim of refining some and eliminating others that are not essential. Of those seen as essential, re-examine the frequency of those reports. Examples include:*

- *Reduce to one the number of HCBS Heightened Scrutiny documents required of residential providers. The burden of having to respond to three reviews of heightened scrutiny for HCBS – by MSU, MDHHS and PIHPs - is inefficient and burdensome to providers.*

- *Eliminate or replace performance indicators not seen as useful nor indicative of system performance by MDHHS nor the community-based system.*

2. Identify the MDHHS site visits or significant portions of these site visits that can be eliminated when a site is accredited by a nationally recognized accrediting body (often known as deemed status). The deficits identified by an accrediting body would also help to focus on the MDHHS site visits on these areas of deficit.

3. While the views of site visitors can be helpful, it is key that MDHHS ensure, via policy and training of site reviewers, that the findings of a site visit must be limited to compliance, by the site, with the written standards and not the interpretation of the site reviewer.

4. Require that compliance with standards can be demonstrated through observation, dialogue with the staff of the site being reviewed, or oral reporting of practices without requiring that those practices be in writing. Requiring that a practice, which is deeply imbedded in the work of an organization, to be captured in writing (often only via the review of electronic documents) for a site to be in compliance with the standard is a wasteful and artificial approach to ensuring quality.

**D. Streamline training and credentialing requirements for clinicians:** The training requirements on the system's clinical staff and clinical supervisors draw them away from providing services and supports to Michigander. A number of these requirements can be modified while not reducing the clinical skills of the system's practitioners.

**Recommendations:**

1. Develop the necessary liability protections and clarity on the use of training reciprocity agreements and single-point of credentialing across the CMH, PIHP, and provider system – using, as one source of guidance, the training reciprocity procedure developed by the state's PIHPs and their partners.

*2. Examine the number of hours required of staff – especially clinical and service delivery staff and their supervisors – weighing these requirements with loss of productive time lost by staff attending these trainings. Examples include:*

- *Allow substitute trainings for the annual required ACT training. Examples: Motivational Interviewing, Cognitive Behavioral Therapy, Cognitive Enhancement Therapy, Suicide Risk Assessment, and Crisis Management using online platforms such as Relias Learning to allow for greater flexibility in clinical growth and timing for trainings.*
- *Defer the annually required ACT training to every other year.*
- *Reduce, temporarily or permanently, the 24 hours of training required, per year, of clinicians providing children's mental health services.*
- *Reduce CAFAS reliable trainer and reliable rater training frequencies*
- *CAFAS reliable trainer sessions are required every 2 years. For those who have been a trainer for 4 years, please consider deferring the next trainer training for 4 years.*

- *CAFAS reliable rater sessions are also required every 2 years. For those who have been a reliable rater for CAFAS for 6 years (done self-train and booster 1 and 2), please consider retraining every 3 years instead of every 2 years.*
- *Waive the requirement for assessment staff to be at each Trauma informed Cognitive Behavioral Therapy initial cohort training when the organization has already been through intensive Trauma informed Cognitive Behavioral Therapy cohort trainings.*
- *Some EBPs require supervisors to attend trainings with each candidate and then take on a case. Given the number of EBPs being used by clinicians in the public system (a very good thing), reduce the number of EBP trainings in which a clinical supervisor would have to participate.*

*3. Retain, post-pandemic, online/virtual training for Recipient Rights and other topics, when appropriate, in place of the in-person training requirements. Virtual training greatly reduces the loss of scarce staff time.*

**E. Reverse the recent explosion in the number of procedure codes required of the community-based system:** Two developments on this front are in immediate attention:

**MDHHS and Milliman-led move to 15-minute codes for community living supports (CLS):** MDHHS eliminated the per diem H0043 Service Code (used to record community living support encounters, effective October 1, 2020 for supports provided in settings which do not require licensure including self-directed living arrangements. The H0043 per diem code has been replaced with the H2015 code which requires the entry of encounter codes and progress notes in **15-minute increments**.

A high percentage of individuals living in non-licensed settings require an extensive amount of community living supports on a daily basis. For individuals requiring 24-hour supports, the H0043 per diem code provided a straightforward and easy-to-manage system of recording only one (1) encounter code and set of progress notes per day. By contrast, implementation of the H2015 Service Code has resulted in an unmanageable process that **requires the entry of 96 encounter codes and set of progress notes (every 15 minutes) for individuals requiring 24-hour supports – when, prior to this change, only 1 encounter code and set of progress notes were required**. Similar recording challenges exist for supporting other individuals with an intensive level of needs which is less than 24-hour supports. In addition to this change leading to the need to record 96 encounters for each day of care rather than the single encounter under the previous system, the is change exploded the number of codes used to record this work from 5 to 86. Attachment D illustrates this contrast.

Additionally, the administrative challenges from the elimination of the H0043 per diem code are having a discriminatory impact upon persons choosing to live in non-licensed residential settings as lessees or owners of the property. More specifically, the ability of persons living in their own apartments or homes to find providers willing to provide community living supports is harmed by the administrative burdens of the H2015 system in the midst of a severe staffing crisis.

**MDHHS and Milliman-led dramatic increase in service code combinations:** Over the past year, as part of the overhaul of the financial reporting system, led by MDHHS and Milliman, the complexity and burden on the clinicians and other service delivery staff, finance, and information technology staff of the community-based system have grown exponentially – with little to no value added to the system not the persons it serves. This explosion in the number of codes has led (see Service UNC tab in the attached SFY

2022 P1 BH EQU Template - CMHSP to **7,169 combinations of unit costs that must reported by the community-based system**.

Additionally, the accuracy of cost projections, using these combinations is weak, given that the payer source for persons served by the community-based system is often not know until year's end, when the Medicaid eligibility is finalized. The IT and financial reporting systems of the state's CMHSPs, PIHPs, and providers in their networks have been working to breakdown the costs into these combinations. However, the cost and staff time used in this work is drawn away from the value-added work of these staff.

**Recommendations**:

*1. Rather than the use of the H2015 (15 minute) code reinstate the H0043 (per diem) code for individuals receiving eight (8) or more hours of community living supports (CLS) on a daily basis.*

*2. Dramatically reduce the number of encounter code combinations (7,169 code combinations) to those that are useful to the provision of care and the accurate reporting of financial and encounter data.*

3. Limit changes, co-developed by MDHHS and community-based system representatives, to the encounter codes combinations, to an annual frequency, with a 3 to 6 month notice of the exact changes being made. Such a frequency and notice timeframe allow for the retooling of electronic health records and encounter/claims systems and staff training.

**F. Eliminate Event Visit Verification (EVV) requirement for licensed settings and 24/7 non-licensed settings:** The Centers for Medicare & Medicaid Services (CMS) is responsible for the enforcement of the electronic visit verification (EVV) requirements that Michigan must implement for Medicaid funded personal care services (PCS). In a June 2019 CMS document, the following guidance is provided regarding personal care services:

*"CMS is aware that PCS are provided in a variety of settings, including in congregate residential programs such as group homes, assisted living facilities, etc. Stakeholders have questioned whether the EVV requirements apply to PCS provided in those settings offering 24 hour service availability. CMS interprets the reference in the statute to an "in-home visit" to exclude PCS provided in congregate residential settings where 24 hour service is available. This interpretation recognizes inherent differences in service delivery model where an employee of a congregate setting furnishes services to multiple individuals throughout a shift, and services provided to an individual during an in home "visit" from someone coming to a home to provide PCS as specified in the EVV statute. Consistent with this difference in service delivery model, typical reimbursement for services provided in these congregate settings utilizes a per diem methodology, rather than discrete per "visit" or per service payment structures. Therefore, CMS finds that services provided in a congregate residential setting are distinct from an "in home visit" subject to EVV requirements under the statute."*

**Recommendations**:

*1. As allowed by CMS, Michigan should interpret the EVV statute as not applicable to licensed residential settings as well as non-licensed settings where 24 hour service is available.*

**G. Halt and revisit the aims and methods of MDHHS and Milliman-led overhaul of the system's financial reporting system:** The Michigan Department of Health and Human Services (MDHHS) and Milliman (the actuarial firm on contract with MDHHS) have been overhauling the financial reporting system used by the state's community-based system. This overhaul involves the reports cited above and others (Standard Cost Allocation, Encounter Quality Initiative, Independent Rate Determination, Medical Loss Ratio).

The impact of this overhaul includes:

- Tremendous amounts of rework by CMHSP, PIHP, and provider staff without offsetting value added from this effort
- Significant administrative costs with a corresponding reduction in the funds available for services
- Drawing clinicians and direct support staff away from providing services to persons with disabilities by burdening them with unnecessary paperwork
- In conflict with the financial reporting approaches of the emerging Certified Community Behavioral Health Clinic (CCBHC) - a centerpiece in the next generation in the development of Michigan's nationally recognized public mental health system.
- In conflict governmental accounting and standard cost allocation standards
- Based on a lack of understanding of the services provided by and financing of the system

**Recommendation**:

*1. A halt to this process is necessary which should be followed with a series of in-depth discussions and planning sessions around this initiative. The various stakeholders should be involved in this review process including MDHHS, the leadership of the CMH, PIHP, and provider community and the Community Mental Health Association of Michigan. The objective is to develop a sound footing - with clear aims and methods - upon which the CMH/PIHP/Provider/MDHHS financial reporting can be advanced.*

CCBHC Demonstration Pilot
Mild to Moderate Recordkeeping Workgroup

Recommendations to MDHHS

It is the recommendation of the workgroup that participating CCBHC Demonstration agencies have the option to use a **modified or "skinny" record** when serving people with Mild to Moderate diagnoses.

A "skinny record" must include:

- Basic demographic information and presenting needs
    - including veteran/military status
    - including questions about trauma
    - including key physical health indicators and vitals
- Guardianship status
- Primary Care Physician status
- Biopsychosocial assessment (abridged from traditional CMH version)
    - Less history, more current info
    - Include current symptoms and meds
    - Include core BH-TEDS components
    - Include trauma assessment
- Mental Status
- Risk Assessment for homicidal and suicidal ideation
- Crisis Plan
- SUD Assessment
- Legal involvement status
- Jail diversion status
- Screening tools:
    - LOCUS for adults
    - ASAM for adult substance use (there is also an adolescent version for ages 12-17)
    - CAFAS for children 7-17
    - PECFAS for children 4-6
    - E-DECA for children 0-3
    - PHQ-9 for adults or PHQ-A for ages 11-17
    - Columbia-Suicide Severity Rating Scale (C-SSRS) for ages 11 and up
    - GAD-7 to assess anxiety level in people 12 and up
    - AUDIT for assessing alcohol use or AUDIT-C for ages 11-19
    - It's recommended that while LOCUS, CAFAS, and PECFAS may be used to help determine level of care, they should not be used on an ongoing basis with people whose diagnoses fall in the mild to moderate range since they were not normed on this population. The PHQ-9/A, C-SSRS, GAD-7, and AUDIT are better to use on a recurring basis.
- Diagnostic formulation, including Co-Occurring quadrant
- Treatment Plan/Recommendations (include any barriers to treatment)

The workgroup recommends that **Training Requirements** remain consistent for staff serving the Mild to Moderate and traditional CMH populations.

The workgroup requests that MDHHS clarify to the PIHPs what **documents** are truly required for the traditional CMH population since many have added additional assessments and/or expanded existing forms multiple times over the years without ever removing anything.

During the two-year pilot, it is recommended that CCBHC leaders collaborate to develop a **master list/spreadsheet of all the federal, state, PIHP, and accrediting agency requirements** that would need to be taken into account and incorporated into foundational EHR modules.

# Sample of audits and reports required of Michigan's Community Mental Health Services Programs

2022

## Audits

MDDHS Substance Abuse License Renewal
MIFAST Review Trauma Informed
Contract Audits monitoring
MDDHS annual audit - Family Support Subsidy Program
MDDHS CMHSP Recertification
MIFAST Review LOCUS
PIHP Annual UM/QI/Provider Network Review
PIHP Data Audit and POC Progress Update
PIHP QISMC Data Review Project
Compliance Audit
Financial Audit
PIHP Prevention Audit
DDCHMT Fidelity Review
MDDHS ACT Program Approval
MDDHS CDTSP Wraparound Program Approval
MDDHS Home Based Approval
MDDHS Site Review – HSW/CWP
MIFAST Review ACT
PIHP/review of CMH Behavior Treatment Committee
Recipient Rights (MDDHS)
Accreditation (CARF, JCAHO, COA, etc.)
CMH Certification site review (MDHHS)
HSAG - EQR Review

## Reports and data submission

BH-TEDS Reporting
Children's Mobile Crisis
Clinical Record  Review Data
CMHSP Annual Submission
Community Inpatient and State Facility
Compliance Verification Run
Critical Incident Reporting
Death Report
Encounter 837 Institutional
Encounter 837 Professional
Family Support Subsidy Survey/Report
Intensive Crisis Stabilization Services
Medicaid Claims Data Review

Medicaid Interoperability
MMBPIS (Performance Indicator Report) CMHSP data (all persons served)
MMPBIS (Performance Indicator) PIHP data (Medicaid enrollees only)
PIHP / CMHSP Quality Improvement Plan Revision/Annual Report
PIHP /CMHSP Compliance Plan Review
PIHP Satisfaction Surveys
Administrative Cost Report (within EQI)
BH Fee Screen
Block Grant FSR
Executive Compensation Report
Final - FSR
Final - State Services Reconciliation
Final GF Cash Settlement
EQI (replaced GF cost report, MUNC, sub-element cost report)
Standard Cost Allocation
Executive Administrative Expenditures survey
HMP Cost Report
Interim - GF Cash Settlement
Interim - State Services Reconciliation
Interim FSR
Mid-Year Status Report
PIHP Encounter Reconciliation
PASARR Monthly Billing
Projection - FSR
Projection - State Services Reconciliation
Projection GF Cash Settlement
CAFAS / PECFAS for FY
DHIP CAFAS/PECFAS
Grievance & Appeals
Annual Rights Submission

| FY 22 PIHP MDHHS Report Schedule & Tracking | | |
|---|---|---|
| **Department** | **Report Name** | **Frequency** |
| | Follow-up to Hospitalization (FUH) data (admissions/discharges) | Weekly |
| SUD Treatment | SUD Budget Report | Projection/Initial |
| | Medicaid YEC Accrual | Final |
| SUD Treatment | SUD YEC Accrual | Final |
| SUD Treatment | SUD Budget Report | Projection |
| | Follow-up to Hospitalization (FUH) data (admissions/discharges) | Weekly |
| | Follow-up to Hospitalization (FUH) data (admissions/discharges) | Weekly |
| | Follow-up to Hospitalization (FUH) data (admissions/discharges) | Weekly |
| | Intensive Crisis Stabilization Service (ICSS) for children Annual Data Report | Annually |
| SUD Treatment | Children Referral Report | Quarterly |
| SUD Treatment | SUD - Injecting Drug Users 90% Capacity Treatment Report | Quarterly |
| SUD Prevention | SUD - Youth Access to Tobacco Activity Annual Report | Annually |
| Veteran Navigator | Veteran Services Navigator (VSN) Data Collection Form | Quarterly |
| | Sentinel Events Data Report | Quarterly |
| | PIHP Medicaid FSR Bundle MA, HMP, Autism, & SUD | Interim (Use Tab in FSR Bundle) |
| | Complete Subcontracted Entity List | Annually |
| | Program Integrity Activities | Quarterly |
| Finance | Performance Bonus Incentive Narrative on "Increased Population in patient-centered medical homes characteristics" | Annually |
| SUD Treatment | SUD - Communicable Disease (CD) Provider Information Report (Must submit only of PIHP funds CD Services). | Annually |

| | | |
|---|---|---|
| SUD Treatment | Women Specialty Services (WSS) Report | Annually |
| Quality | Performance Indicators | Quarterly |
| SUD Treatment | SUD - Priority Populations Waiting List Deficiencies Report | Monthly |
| IT | SUD - Behavioral Health Treatment Episode Data Set (BH-TEDS) | Monthly |
| IT | Encounters Submission to MDHHS | Monthly |
| Quality | Critical Incidents Data Submissions | Monthly |
| Finance | Risk Management Strategy | Annually |
| Quality | Medicaid Services Verification Report | Annually |
| SUD Treatment | SUD - Priority Populations Waiting List Deficiencies Report | Monthly |
| IT | SUD - Behavioral Health Treatment Episode Data Set (BH-TEDS) | Monthly |
| | Program Integrity Activities | Quarterly |
| IT | Service Authorization Denials | Quarterly |
| IT | Grievances | Quarterly |
| IT | Member Appeals | Quarterly |
| Finance | Direct Care Wage Attestation Form | Annually |
| SUD Prevention | SUD - Primary Prevention Expenditures by Strategy Report | Annually |
| SUD Treatment | SUD Budget Report | Final |
| SUD Treatment | SUD - Legislative Report/Section 408 | Annually |
| Finance | PIHP Medicaid FSR Bundle MA, HMP, Autism, & SUD | Final (Use tab in FSR Bundle) |
| Finance | Encounter Quality Initiative Report (EQI) | Annually |
| Finance | PIHP TIN Expenditure Summary | With ea EQI report? |
| Finance | PIHP Executive Administration Expenditures Survey for Sec. 904 (2)(k) | Annually |

| | | |
|---|---|---|
| Finance | Medical Loss Ratio | Annually |
| IT | Attestation to accuracy, completeness, and truthfulness of claims and payment data | Annually |
| Finance | DHHS Incentive Payment DHIP Report | Annually |
| Quality | Performance Indicators | Quarterly |
| Quality/IT | Narrative Report on findings and any actions taken to improve data quality on BH-TEDS military and veterans fields (PBIP) | Annually |
| SUD Prevention | Compliance Check Report (CCR) | |
| SUD Prevention | Michigan Gambling Disorder Prevention Project (MGDPP) 3Q Narrative Report | Quarterly |

## SITE REVIEW COMPARISON CHART

| MI Department of Community Health - Review Dimensions | MDHHS | CARF | PIHP | HSAG (required by Fed HHS) | Comments |
|---|---|---|---|---|---|
| A. Consumer Involvement | X | X | X | X | |
| B.1. Services General | X | X | X | X | CMH recert. - 3yrs |
| B.2. Peer Delivered & Operated Drop In Centers | X | X | X | | Not a Medicaid srvc. |
| B. 3. Home Based | X | X | X | X | CDTSP cert. - 3yrs |
| B.4. Assertive Community Treatment | X | X | X | | ACT cert. - 3yrs |
| B.5. Clubhouse Psycho-Social Rehabilitation Program | X | X | X | | |
| B.6. Crisis Residential Services | X | X | X | | |
| B.7. Targeted Case Management | X | X | X | X | |
| B.8. Personal Care in Licensed Residential Settings | X | X | X | X | |
| B.9. Inpatient Psychiatric Hospital Admission | X | X | X | X | |
| B.10. Intensive Crisis Stabilization Services | X | X | | | |
| B.12. Habilitation Supports Waiver | X | X | X | X | DCH approves ea. HSW |
| B.13. Additional Mental Health Services [(b)(3)s] | X | X | X | | |
| B.14. Jail Diversion | X | X | X | | |
| B.15. Co-Occurring Mental Health and Substance Disorders Treatment | X | X | X | X | |
| B.16. Substance Abuse Access and Treatment | X | X | X | X | DCH license review |
| C.1. Implementation of Person-Centered Planning | X | X | X | X | |
| C.2. Plan of Service and Documentation Requirements | X | X | X | X | |
| C.3. Implementation of Arrangements that Support Self-Determination | X | X | X | X | |
| D.1. Administrative Functions - Provider Networks | X | X | X | X | |
| D.2. Administrative Functions - Quality Improvement | X | X | X | X | |
| D.3. Administrative Functions - Health and Safety | X | X | X | | |
| D.4. Administrative Functions - Access Standards | X | X | X | X | PPG needs assessment |
| D.5. Administrative Functions - Behavior Treatment Plan Review Committee | X | X | X | X | Rec. Rights cert. - 3 yrs |
| D.6. Administrative Functions - Coordination | X | X | X | X | |
| F.1. Staffing and Supervision Requirements | X | X | X | X | |
| F.1. Staff Training | X | X | X | X | |

CARF - The Commission on Accreditation of Rehabilitation Facilities

PIHP - Prepaid Inpatient Health Plan

HSAG - Health Services Advisory Group

CMH - Community Mental Health

CDTSP - Children's Diagnostic Treatment Services Program

ACT - Assertive Community Treatment Team

HSW - Habilitative Services Wavier

PPG - Program Planning and Guidance (Mental Health Code Required)

Rec. Rights Cert. - Recipient Rights Certification

| **# of Audits/Reviews in 1 CMH – October 2009 thru June of FY 2011** | **# of Reviews** |
|---|---|
| DCH Site Review (included CSDTP certification in FY2009) | 3 |
| Substance Abuse Licensing Audit | 1 |
| Assertive Community Treatment site review program certification | 1 |
| Finance Compliance Audit | 2 |
| PIHP UM/QI/Provider Network | 2 |
| PIHP Information Systems Audit | 2 |
| COD-IDDT Fidelity Review | 1 |
| MDCH CMHSP Certification Process | 1 |
| PIHP (Substance Abuse) Prevention Audit | 3 |
| PIHP Financial Compliance Site Review | 1 |
| HSAG/ISCAT - Data Collection and system information review | 1 |
| DCH Children's Waiver Program Review | 1 |
| CARF National Accreditation | 1 |
| Office of Recipient Rights Site Review | 1 |
| TOTALS | 20 |

# Comparison of the number and complexity of codes that are used to record the provision of Community Living Supports in unlicensed settings: prior structure compared to present structure

A. Prior service recording structure:

**5 codes** - **1 required to be reported per day** - that correlated to the number of hours of CLS provided per day to each person served

| |
|---|
| H0043- L1 Comprehensive Community Supports Services per Diem - (Staff intensity: 5 to 7 hours per day.) |
| H0043- L2 Comprehensive Community Supports Services per Diem - (Staff intensity: 8 to 10 hours per day.) |
| H0043- L3 Comprehensive Community Supports Services per Diem - (Staff intensity: 11 to 14 hours per day.) |
| H0043- L4 Comprehensive Community Supports Services per Diem - (Staff intensity: 15 to 20 hours per day.) |
| H0043- L5 Comprehensive Community Supports Services per Diem – (Staff intensity: 21 to 24 hours per day, or alternative arrangement) |

B. Current recording structure:

**86 codes** – **potentially 96 units required to be reported per day per person** - that correlates to the number of co-workers present, the number of people who live in the setting present, whether provided in the day time or overnight, and whether a wheelchair van was used to provide transportation while these services were provided. The below code list is not inclusive of all modifiers to be applied to these codes (i.e. HK for HAB Waiver services, U7 for self-directed supports)

| |
|---|
| H2015 / S1 - Comprehensive Community Support Services - One Member/One Staff |
| H2015 / 21 - Community Living Support Services - Two Staff/One Member |
| H2015 / UN S1 - Comprehensive Community Support Services - 2 Members; 1 Staff |
| H2015 / UN S2 - Comprehensive Community Support Services - 2 Members; 2 Staff |
| H2015 / UN S3 - Comprehensive Community Support Services - 2 Members; 3 Staff |
| H2015 / UN S4 - Comprehensive Community Support Services - 2 Members; 4 Staff |

| |
|---|
| H2015 / UP S1 - Comprehensive Community Support Services - 3 Members; 1 Staff |
| H2015 / UP S2 - Comprehensive Community Support Services - 3 Members; 2 Staff |
| H2015 / UP S3 - Comprehensive Community Support Services - 3 Members; 3 Staff |
| H2015 / UP S4 - Comprehensive Community Support Services - 3 Members; 4 Staff |
| H2015 / UQ S1 - Comprehensive Community Support Services - 4 Members; 1 Staff |
| H2015 / UQ S2 - Comprehensive Community Support Services - 4 Members; 2 Staff |
| H2015 / UQ S3 - Comprehensive Community Support Services - 4 Members; 3 Staff |
| H2015 / UQ S4 - Comprehensive Community Support Services - 4 Members; 4 Staff |
| H2015 / UR S1 - Comprehensive Community Support Services - 5 Members; 1 Staff |
| H2015 / UR S2 - Comprehensive Community Support Services - 5 Members; 2 Staff |
| H2015 / UR S3 - Comprehensive Community Support Services - 5 Members; 3 Staff |
| H2015 / UR S4 - Comprehensive Community Support Services - 5 Members; 4 Staff |
| H2015 / US S1 - Comprehensive Community Support Services - 6 or More Members; 1 Staff |
| H2015 / US S2 - Comprehensive Community Support Services - 6 or More Members; 2 Staff |
| H2015 / US S3 - Comprehensive Community Support Services - 6 or More Members; 3 Staff |
| H2015 / US S4 - Comprehensive Community Support Services - 6 or More Members; 4 Staff |
| H2015 / S1 UJ - Comprehensive Community Support Services, Night Time - One Member/One Staff |
| H2015 / 21 UJ- Community Living Support Services, Night Time - Two Staff/One Member |
| H2015 / UN S1 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 1 Staff |
| H2015 / UN S2 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 2 Staff |
| H2015 / UN S3 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 3 Staff |
| H2015 / UN S4 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 4 Staff |
| H2015 / UP S1 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 1 Staff |
| H2015 / UP S2 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 2 Staff |
| H2015 / UP S3 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 3 Staff |
| H2015 / UP S4 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 4 Staff |
| H2015 / UQ S1 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 1 Staff |
| H2015 / UQ S2 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 2 Staff |

| |
|---|
| H2015 / UQ S3 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 3 Staff |
| H2015 / UQ S4 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 4 Staff |
| H2015 / UR S1 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 1 Staff |
| H2015 / UR S2 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 2 Staff |
| H2015 / UR S3 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 3 Staff |
| H2015 / UR S4 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 4 Staff |
| H2015 / US S1 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 1 Staff |
| H2015 / US S2 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 2 Staff |
| H2015 / US S3 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 3 Staff |
| H2015 / US S4 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 4 Staff |
| T2027 / S1 - Overnight Health and Safety Supports - One Member/One Staff (HAB Waiver Only) |
| T2027 / 21 - Overnight Health and Safety Supports - Two Staff/One Member (HAB Waiver Only) |
| T2027 / UN S1- Overnight Health and Safety Supports - 2 Members; 1 Staff (HAB Waiver Only) |
| T2027 / UN S2 - Overnight Health and Safety Supports - 2 Members; 2 Staff (HAB Waiver Only) |
| T2027 / UN S3 - Overnight Health and Safety Supports - 2 Members; 3 Staff (HAB Waiver Only) |
| T2027 / UN S4 - Overnight Health and Safety Supports - 2 Members; 4 Staff (HAB Waiver Only) |
| T2027 / UP S1 - Overnight Health and Safety Supports - 3 Members; 1 Staff (HAB Waiver Only) |
| T2027 / UP S2 - Overnight Health and Safety Supports - 3 Members; 2 Staff (HAB Waiver Only) |
| T2027 / UP S3 - Overnight Health and Safety Supports - 3 Members; 3 Staff (HAB Waiver Only) |
| T2027 / UP S4 - Overnight Health and Safety Supports - 3 Members; 4 Staff (HAB Waiver Only) |
| T2027 / UQ S1 - Overnight Health and Safety Supports - 4 Members; 1 Staff (HAB Waiver Only) |
| T2027 / UQ S2 - Overnight Health and Safety Supports - 4 Members; 2 Staff (HAB Waiver Only) |
| T2027 / UQ S3 - Overnight Health and Safety Supports - 4 Members; 3 Staff (HAB Waiver Only) |
| T2027 / UQ S4 - Overnight Health and Safety Supports - 4 Members; 4 Staff (HAB Waiver Only) |
| T2027 / UR S1 - Overnight Health and Safety Supports - 5 Members; 1 Staff (HAB Waiver Only) |
| T2027 / UR S2 - Overnight Health and Safety Supports - 5 Members; 2 Staff (HAB Waiver Only) |
| T2027 / UR S3 - Overnight Health and Safety Supports - 5 Members; 3 Staff (HAB Waiver Only) |
| T2027 / UR S4 - Overnight Health and Safety Supports - 5 Members; 4 Staff (HAB Waiver Only) |

| |
|---|
| T2027 / US S1 - Overnight Health and Safety Supports - 6 Members; 1 Staff (HAB Waiver Only) |
| T2027 / US S2 - Overnight Health and Safety Supports - 6 Members; 2 Staff (HAB Waiver Only) |
| T2027 / US S3 - Overnight Health and Safety Supports - 6 Members; 3 Staff (HAB Waiver Only) |
| T2027 / US S4 - Overnight Health and Safety Supports - 6 Members; 4 Staff (HAB Waiver Only) |
| H2015 / UN S1 WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 1 Staff |
| H2015 / UN S2WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 2 Staff |
| H2015 / UN S3 WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 3 Staff |
| H2015 / UN S4 WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 4 Staff |
| H2015 / UP S1 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 1 Staff |
| H2015 / UP S2 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 2 Staff |
| H2015 / UP S3 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 3 Staff |
| H2015 / UP S4 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 4 Staff |
| H2015 / UQ S1 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 1 Staff |
| H2015 / UQ S2 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 2 Staff |
| H2015 / UQ S3 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 3 Staff |
| H2015 / UQ S4 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 4 Staff |
| H2015 / UR S1 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 1 Staff |
| H2015 / UR S2 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 2 Staff |
| H2015 / UR S3 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 3 Staff |
| H2015 / UR S4 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 4 Staff |
| H2015 / US S1 WV- Wheelchair Adapted Van, IDD Residential - 6 or More Members; 1 Staff |
| H2015 / US S2 WV- Wheelchair Adapted Van, IDD Residential - 6 or More Members; 2 Staff |
| H2015 / US S3 WV- Wheelchair Adapted Van, IDD Residential - 6 or More Members; 3 Staff |
| H2015 / US S4 WV- Wheelchair Adapted Van, IDD Residential 6 or More Members; 4 Staff |

**Subject:** ACTION ALERT: Tell MDHHS to Maintain Public Management of Michigan"s Mental Health Services

**Date:** Tuesday, April 8, 2025 2:48:43 PM

Community Mental Health Association of Michigan

On February 28, the Michigan Department of Health and Human Services announced it is seeking public input through an online survey as the department moves to a competitive procurement process for the state's Pre-Paid Inpatient Health Plan (PIHP) contracts.

While CMHA and its members are continually involved in system improvements, and so support this component of the Department's announcement, CMHA and its members are strongly opposed to any procurement process that could open the door to the privatization of the system. We strongly believe that if MDHHS goes ahead with the competitive procurement of the state's PIHP system, that it opens the opportunity to bid only to public organizations with experience in managing Michigan's public mental health system and prohibit bids from private for-profit and private non-profit organizations.

Competitive procurement causes system chaos at a time when there is so much uncertainty at the federal level and does not address any of the core issues facing the system. We believe the state needs to take meaningful action, such as ensure sufficient funding, protect local voice, reduce administrative overhead, and increase workforce and network capacity – all items that lead to improved access to care and services and none of which require a procurement process.

REQUEST FOR ACTION: We are asking you to reach out to Governor Whitmer and Lt. Governor Gilchrist and express your concerns with the department's competitive procurement process for the state's PIHP contracts. What is the intended goal of this procurement and why are we doing it at a time of such uncertainty? Let them know you do not support this procurement process, however if they decide to move forward with it you insist that the opportunity to bid only goes to public organizations with experience in managing Michigan's public mental health system and prohibit bids from private for-profit and private non-profit organizations.

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

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

ACTION ALERT: Tell MDHHS to Maintain Public Management of Michigan's Mental Health Services

# Protecting People Over Profit

Public Management of Michigan's Behavioral Health System

Community Mental Health Association of Michigan

On February 28, 2025 the Michigan Department of Health and Human Services (MDHHS) announced that they are seeking public input through an online survey as the department moves to a competitive procurement process for the state's Pre-Paid Inpatient Health Plan (PIHP) contracts. **Our concern is that such bid-out plans, in the past, have opened the door to the privatization of Michigan's public mental health system.**

## Unmandated Competitive Procurement: A Risky Proposal That Adds Chaos to Care

**Potential funding cuts on the horizon**

**Disrupts care and creates confusion for those relying on critical services**

**Procurement process is NOT being driven by Federal rules or requirements**

## Rather Than a Chaotic Competitive Procurement Process, Take Real Steps to Collectively Solving Core Issues

**HOW BEST TO IMPROVE ACCESS TO CARE & SERVICES FOR PEOPLE IN NEED**

**Sufficient Funding** + **Ensure & Enhance Local Voice** + **Reduce Administrative Overhead** + **Increase Workforce & Network Capacity**

- **Sufficient Funding**
  Funding for the core mental health and I/DD services has remained FLAT over the past 5 fiscal years (including $0 general fund increase) while medical inflation has increased by over 10%* and Medicaid expenses have increased by nearly 25%. **Inadequate funding leads to shortages in available services, long wait times, and a lack of quality mental health providers.**
- **Ensure & Enhance Local Voice**
  Only a publicly managed system protects local input. **Privatization removes people's power, shifting care decisions to out-of-state boards with no direct ties to Michigan communities.**
- **Reduce Administrative Overhead**
  Collectively PIHPs have a MLR (Medical Loss Ratio) of 96.3%. The ONLY way to reduce layers and ensure more money goes directly into services is by reducing administrative overhead, which has dramatically increased over the past 5 years. **More bureaucracy means longer wait times, more hoops to jump through, and fewer resources for essential care.**
- **Increase Workforce & Network Capacity**
  3/4 of Michigan's public mental health organizations are experiencing workforce gaps despite salary increases or retention bonuses. Top reasons people leave the public mental health field: (1) too much paperwork / administrative hoops to jump through, and (2) better pay and work life balance. **A shortage of mental health workers means longer wait times, fewer available services—leaving Michigan's most vulnerable without the support they need.**

*According to the U.S. Bureau of Labor Statistics

Community Mental Health Association of Michigan

# CMHA advocacy strategy
# MDHHS survey related to system improvement and potential PIHP procurement

March 2025

## Background:

As CMHA members know, MDHHS recently issued a press release, announcing both a public comment period, centered on improvements to Michigan's public mental health services and the Department's intention to implement a competitive procurement process for the state's Prepaid Inpatient Health Plans (PIHPs).

While CMHA and its members are continually involved in system improvements, and so support this component of the Department's announcement, **the Association and its members are strongly opposed to any procurement process that could open the door to the privatization of the system.**

## Advocacy plan

In response to this press release, CMHA immediately took a number of actions in partnership with CMHA members and allies across the state. The actions already taken by CMHA to date are included in the advocacy plan below.

This advocacy plan reflects proven advocacy approaches used by CMHA to successfully thwart past attempts to privatize Michigan's public mental health system; foundational tools used in successful advocacy efforts; and the recommendations of the CEOs of Michigan's CMHSPs and PIHPs who attended a recent, mid-March, meeting of those CEOs.

### A. Talking points for use in any or all of the advocacy efforts outlined below:

1. **Strong support for seeking views of persons served and stakeholders of the system**. CMHA and its members applaud this effort to collect the views, from the diverse set of stakeholders of Michigan's public mental health system, around approaches to refine and improve this system.

2. **State needs to take meaningful action, rather than the procurement process, to address views collected in this and prior efforts to gather the views of persons served and other stakeholders**. We expect the views of those who respond to the survey to amplify the views, long expressed, of persons served, the state's advocacy groups, the CMHs, PIHPs, and providers who make up the state's public mental health system around the following needs:
    - Access to behavioral health services and supports, where and when persons served need and desire them
    - High quality care
    - Availability of behavioral health staff (network capacity) across the full range of disciplines and modalities
    - Choice in key dimensions of the services and supports they receive, by persons served
    - Person Centered Planning processes that provide all persons served with the ability to exercise self determination
    - Coordination of care between behavioral health and physical health
    - Widespread use of peers in the provision of services and supports

- Conflict free systems – casemanagement, fair and unbiased appeals processes, including the recipient rights appeals process
- Effective contract oversight and enforcement of all parts of the system
- Strong voice of persons served and advocacy organizations on the governance bodies of the organizations that make up this system
- Funding sufficient to meet the actual demand for and cost of services. While services, populations, and rate floors are added to the Medicaid benefit, the funding to cover those required benefits has been insufficient statewide, with wide variation in that insufficiency across regions
- Structures that ensure local control of the system and its public nature while ensuring that these local service delivery systems are responsive to the needs of the persons and communities that they serve and that some level of uniformity exists, statewide, relative to access to and intensity of services.
- Reducing administrative and paperwork demands thus maximizing the share of the Medicaid funds provided to the system are used to fund services and supports and freeing staff time to be spent serving persons and communities

3. **No single solution to these issues**: The solutions to these issues do not lie in a single solution, including the competitive procurement of the public management care organization (PIHP) contract.

   Rather than a single action, a number of parallel, concrete, and earnestly pursued efforts are needed to address these issues. Some of these efforts are currently underway (and need to be bolstered) with new efforts implemented, each specific to an issue of concern.

4. **A competitive procurement causes system chaos, does not address any of the core issues facing the system (those listed above as examples), and could be used to privatize the system**:
   While we look forward to system refinement fueled by this public dialogue initiative, we are concerned that the procurement process being considered will:
   - Add chaos to a system and those served by the system in the face of a deep and prolonged workforce shortage, state budget constraints, impending federal Medicaid reductions
   - Open the door to privatize Michigan's public mental health system.

   Earlier proposals to privatize this system were met by vocal and widespread opposition from Michiganders from across the state. This anti-privatization sentiment remains strong among the large and vocal stakeholders of Michigan's public mental health system.

**B. Actions making up advocacy plan**

1. Encourage a clear and strong voice of persons served, staff, and other allies in responding to the on-line survey, fostering their free expression of:
    a. A complete picture of their experience with the public mental health system. That means describing what needs to be improved and what is going well and how the system has benefited you.
    b. Their views relative to proposals to move this system under the management of private health insurance companies. Because this survey is part of a process in which some policy makers and lobbyists are proposing such a change, MDHHS needs to know your views on this privatization proposal.
2. Executive branch advocacy
    a. Dialogue by CMHA, members, and allies with MDHHS leadership
    b. Dialogue by CMHA, members, and allies with the Governor and her staff
3. Legislative advocacy
    a. CMHA and members reach out to State Legislators, in both parties expressing concerns over the proposed competitive procurement
    b. CMHA providing talking points to CMHA members and allies for use in this effort
4. Media advocacy (By CMHA; its Media/PR consultant, Lambert; CMHA members and allies)
    a. Social media
    b. Traditional statewide and local media
    c. Capitol news services (Gongwer and MIRS)
5. Allying with traditional partners to join in this effort
    a. State's leading advocacy organizations
    b. Michigan Association of Counties
    c. Other partners vital to prior efforts to combat privatization
6. Legal strategy
    - Obtain legal counsel relative to the legal barriers to competitive procurement of the state's PIHPs
    - CMHA to share this legal information with members
    - CMHA to take legal action, if needed, using legal arguments developed by counsel

# email correspondence

**From:** Monique Francis
**To:** Monique Francis
**Cc:** Robert Sheehan; Alan Bolter
**Subject:** Weaknesses and harm of privately managed Medicaid behavioral health systems
**Date:** Friday, April 11, 2025 12:58:42 PM
**Attachments:** image001.png

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To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan

Re: Weaknesses and harm of privately managed Medicaid behavioral health systems

As you may know, the MDHHS proposal to competitively procure the state's PIHP contract, if it goes forward, can have only one of two outcomes. The contracts will go to a smaller number of public PIHPs, drawn from the current set of PIHPs or a merger of current PIHPs, or to a private health plan/health insurance company.

We are hearing that the latter outcome is being favored by some with in MDHHS.

In light of this threat, this email is coming your way so that you, the leaders of the state's public mental health system, have ready access to the analyses done, over the past several years, underscoring the weaknesses and harm of privately managed Medicaid behavioral health systems. Those analyses are provided below. Feel free to share this information with your staff, boards of directors, and community partners.

1. **Immediate loss of over half-a-billion dollars to the system:** The dramatically higher managed care overhead (expenses that reduce the dollars available for services) of the private Medicaid health plans, an overhead rate of 15%, when compared to that of the state's PIHPs, with an overhead rate of 2%, will result in a **loss of $520 million per year** in the funding available for Medicaid behavioral health services to Michigander.
2. **Negative impact, across the country, of private health plan/insurance company management of Medicaid behavioral health**: A set of studies, conducted over the past several years, underscores the negative impact that the management of a state's Medicaid behavioral health system by private health plan has on persons served and the provider network serving them. Those studies include:
    - Impact of the Movement to Private Managed Care System for Publicly Sponsored Mental Health Care: Perspectives from Other States (2022)
    - Medicaid funding consolidation: Key themes identified in an examination of the experience of other states (2016)
    - Beyond Appearances: Behavioral Health Financing Models and the Point of Care (2016)
3. **Significant opposition, among Michiganders, to the private management of Michigan's public mental health system:** Earlier proposals to privatize this system were met by vocal and widespread opposition from Michiganders from across the state. This anti-privatization sentiment remains strong among the large and vocal stakeholders of Michigan's public mental health system. (See the summary of the results of the statewide poll, conducted by the respected Michigan-based polling group, EPIC-MRA.)

Robert Sheehan

# Sample Board Resolution

**WHEREAS**, the State of Michigan currently operates a publicly managed and community-based system for the delivery of specialty behavioral health services through 10 Prepaid Inpatient Health Plans (PIHPs), which are responsible for managing Medicaid mental health, developmental disability, and substance use disorder services; and

**WHEREAS**, the current PIHP system has consistently demonstrated value, local accountability, and community engagement, while successfully managing costs and improving health outcomes for vulnerable populations; and

**WHEREAS**, the Michigan Department of Health and Human Services (MDHHS) recently announced plans to initiate a competitive procurement process for the management of PIHP functions, which may open the door to private, non-profit health plans or managed care organizations (MCOs) assuming control over behavioral health services; and

**WHEREAS**, such privatization could disrupt longstanding relationships between local mental health authorities, providers, and the communities they serve, and jeopardize the person-centered, recovery-oriented approach that has been cultivated under the public system; and

**WHEREAS**, many stakeholders, including individuals receiving services, advocates, local officials, and providers have expressed significant concerns about the potential impact of a competitive procurement process on care quality, access, local control, and transparency; and

**WHEREAS**, counties across Michigan have historically played a vital role in the governance, funding, and oversight of the public behavioral health system, and any change to that structure without meaningful county input undermines the principle of local governance; and

**WHEREAS**, maintaining a publicly accountable and locally governed behavioral health system is essential to ensuring that individuals with mental health and substance use needs receive timely, appropriate, and high-quality care.

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**NOW, THEREFORE, BE IT RESOLVED**, that the [County Name] Board of Commissioners formally opposes the Michigan Department of Health and Human Services' (MDHHS) plan to implement a competitive procurement process for Prepaid Inpatient Health Plans (PIHPs); and

**BE IT FURTHER RESOLVED**, that the Board urges Governor Whitmer, the Michigan Department of Health and Human Services (MDHHS), and the Michigan Legislature to halt any plans for privatization and instead work collaboratively with counties, PIHPs,

Community Mental Health Services Programs (CMHSPs), service users, and other stakeholders to strengthen and improve the public behavioral health system, by only allowing public organizations with experience in managing Michigan's public mental health system to be part of any bid process should one occur; and

**BE IT FURTHER RESOLVED**, that a copy of this resolution be transmitted to Governor [Name], MDHHS Director [Name], members of the Michigan Legislature representing [County Name], and the Michigan Association of Counties (MAC).

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**Adopted by the [County Name] Board of Commissioners this [Date].**
**[Chairperson's Name]**
Chairperson, [County Name] Board of Commissioners
**[Clerk's Name]**
County Clerk

**NORTHERN MICHIGAN REGIONAL ENTITY**
**FINANCE COMMITTEE MEETING**
**10:00AM – APRIL 9, 2025**
**VIA TEAMS**

| | |
|---|---|
| **ATTENDEES:** | **Brian Babbitt, Connie Cadarette, Ann Friend, Kevin Hartley, Nancy Kearly, Eric Kurtz, Donna Nieman, Allison Nicholson, Brandon Rhue, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek** |

REVIEW AGENDA & ADDITIONS
Donna requested a discussion about the MDHHS draft policy for Intensive Crisis Stabilization Services. Kevin requested a discussion about an audit RFP for fiscal years 2025–2027.

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

**MOTION BY KEVIN HARTLEY TO APPROVE THE MINUTES OF THE MARCH 12, 2025 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.**

MONTHLY FINANCIALS
**February 2025**

- Net Position showed a net deficit for Medicaid and HMP of $635,186. Carry forward was reported as $736,656. The total Medicaid and HMP Current Year surplus was reported as $101,470. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $20,677,626.
- Traditional Medicaid showed $87,603,922 in revenue, and $86,692,238 in expenses, resulting in a net surplus of $911,684. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $11,036,552 in revenue, and $12,583,422 in expenses, resulting in a net deficit of $1,546,870. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $1,417,931 in revenue, and $1,110,977 in expenses, resulting in a net surplus of $306,954.
- SUD showed all funding source revenue of $11,854,303 and $9,175,155 in expenses, resulting in a net surplus of $2,679,148. Total PA2 funds were reported as $4,360,589.

An update on the retro activity for missing HSW payments will be provided under the "HSW Open Slots Update."

PA2/Liquor Tax was summarized as follows:

| **Projected FY25 Activity** | | | |
|---|---|---|---|
| Beginning Balance | Projected Revenue | Approved Projects | Projected Ending Balance |
| $4,765,231 | $1,847,106 | $2,150,940 | $4,461,397 |

| Actual FY25 Activity | | | |
|---|---|---|---|
| Beginning Balance | Current Receipts | Current Expenditures | Current Ending Balance |
| $4,765,231 | $92,609 | $497,251 | $4,360,589 |

**MOTION BY KEVIN HARTLEY TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR FEBRUARY 2025; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.**

EDIT UPDATE

The next EDIT meeting is scheduled for April 17th at 10:00AM. A status update on the H0043 per diem code has been requested. Brandon added that a change to the code chart will be coming in July to remove H2022 (community-based wrap-around services, per diem). The CMHSPs were advised to start using H2021 (community-based wrap-around services, 15 min). According to the NMRE's encounter data, the H2022 code is still being used. This topic will be discussed at the regional QOC meeting on May 6th.

EQI UPDATE

Templates for P1 2025 were distributed. The EQI for P1 is due to MDHHS on May 30th. Reports will be due to the NMRE by May 19th. Data will be pulled on May 5th. It was noted the CMHSPs will be required to complete additional tabs for the reporting period. A statewide EQI meeting is scheduled for April 10th at 1:00PM. Tricia will report back to the group following the meeting.

ELECTRONIC VISIT VERIFICATION (EVV)

Ann has been attending payor portal meetings with MDHHS and HHAX. Donna reported that the state is working to include the payment process in the EVV. The setup in PCE was reviewed during a meeting held the week of March 31st. No overview showing how it's expected to work was provided. The expectation is that the EVV will generate the 837 file.

Centra Wellness has experienced issues involving services to three individuals living in the same apartment complex. In the past, staff used the H0043 service code for supports provided site. Currently, the H2015 code is being used for medication set-ups, etc. Staff spend a few hours providing these supports for the three individuals, moving between apartments. For proper documentation, staff will need to clock in and out between the apartments, which seems unreasonable and distracts from the provision of services.

HSW OPEN SLOTS UPDATE

All 697 HSW slots are currently filled. The CMHSPs were asked to continue to send packets as slots routinely open.

The NMRE received $1,888,658 in retroactive HSW payments earlier on this date; these funds will be paid out to CMHSPs on April 17th.

Brandon explained the issue that occurred in the CHAMPS system that resulted in PIHPs not being paid for HSW beneficiaries. The NMRE was the first PIHP to bring the matter to the state's attention. A fix was expected in December 2024; however, it was not an actual solution but did allow the state to build a specially formatted file in CMAMPS to trigger the system to review old payments and reprocess them. This replaced the need for PIHPs to send files to the state monthly. The NMRE continued to send filed but received error messages. Brandon then scheduled a meeting with the state which provided a clearer understanding of the requirements

for the file; after that, the NMRE received confirmation from the state that the files were received.

The state has confirmed the ability to pay retroactivity beyond six months. A permanent fix is expected between April and June. The NMRE is focusing its efforts on any activity prior to March 2025 and is working directly with the state to be sure every missing payment is paid. Reasons are now provided for failed member month payments so they can be resubmitted. Many failed due to no coverage for that member month. Others were not paid due to coding issues in the system, which the NMRE will correct and resubmit.

Brandon stressed the amount of work this has taken. The NMRE is confident in the process that has been put into place. CMHSPs' detail sheets will be posted to ShareFile following the meeting. The total estimate owed to the region before this morning's payment was $2.9M. Approximately $1M is still owed. Brandon is working on a way to make reports available to CMHSP staff.

Monthly reports from CMHSPs (showing individuals not paid) are no longer needed but it was advised that CMHSPs continue to track the information.

DAB TRANSITION

The NMRE created a report that can be used to analyze the DAB migration data, which was shared with CIO Forum members. The report has been posted to NMRE website at: DAB Analysis 2020-2024 | NMRE. Regions 1 (NorthCare Network) and 2 (NMRE) have been disproportionately impacted. The report will be used in the creation of a statewide impact statement. Brandon welcomed feedback from the CMHSPs.

NMRE REVENUE & ELIGIBLES ANALYSIS

An analysis of November 2023 – March 2025 Revenue and Eligibles was emailed to the committee.

| **Children's Waiver Program** | | | |
|---|---|---|---|
| | November 2023 | March 2025 | % Change |
| Revenue | $37,040 | $10,144* | -72.61%* |
| Enrollees | 11 | 3* | 72.73%* |

*Numbers reflect a recoupment for one client going back several months

| **DAB** | | | |
|---|---|---|---|
| | November 2023 | March 2025 | % Change |
| Revenue | $9,796,214 | $10,043,407 | 2.52% |
| Enrollees | 27,979 | 25,312 | -9.53% |
| Average Payment per Enrollee | $350 | $47 | 13.33% |

| **HMP** | | | |
|---|---|---|---|
| | November 2023 | March 2025 | % Change |
| Revenue | $2,286,849 | $2,240,130 | -2.04% |
| Enrollees | 45,924 | 34,120 | -25.70% |
| Average Payment per Enrollee | $50 | $16 | 31.85% |

| HSW | | | |
|---|---|---|---|
| | November 2023 | March 2025 | % Change |
| Revenue | $4,692,308 | $5,090,138 | 8.48% |
| Enrollees | 663 | 677 | 2.11% |
| Average Payment per Enrollee | $7,077 | $7,519 | 6.24% |

| SED | | | |
|---|---|---|---|
| | November 2023 | March 2025 | % Change** |
| Revenue | $43,326 | $21,437 | -50.52 |
| Enrollees | 22 | 31 | 40.91 |
| Average Payment per Enrollee* | $1,969 | $692 | -64.89% |

**SED revenue was moved into DAB October 1, 2024.

| TANF | | | |
|---|---|---|---|
| | November 2023 | March 2025 | % Change |
| Revenue | $2,763,76 | $2,895,192 | 4.76% |
| Enrollees | 65,030 | 55,018 | -15.40% |
| Average Payment per Enrollee | $42 | $53 | 23.82% |

| TOTAL | | | |
|---|---|---|---|
| | November 2023 | March 2025 | % Change |
| Monthly Total Revenue | $19,619,501 | $20,300,448 | 3.47% |

Brandon referenced MDHHS policy effective February 1, 2025, which established asset limits for Supplemental Security Income (SSI) Related Medicaid Programs. The policy change increased the asset limits from $2,000/individual and $3,000/couple to the higher Medicare Savings Program's asset limits which are currently $9,430/individual and $14,130/couple. The policy may be viewed in its entirety by visiting: 2449-Eligibility-P.pdf.

97153 CODE AND $16.50 PER UNIT

It was noted that some CMHSP in the state have not implemented the $66/hour rate for code 97153 (one-on-one adaptive behavior treatment delivered by a behavior technician under the supervision of a Board-Certified Behavior Analyst without real-time modifications to the intervention plan) because the cost exceeds retroactive payments received by the state. Eric was asked by MDHHS to supply data showing the difference between the $66/hour rate vs. the amount of revenue received by the CMHSPs. A status update was provided as:

**Centra Wellness** – N/A (Services are provided by CWN staff)
**North Country** – North Country is paying the $66.hour rate to the extent possible with the amount of funding received, retroactive to November 1, 2024 rate retro to Nov. 1, 2024.
**Northeast Michigan** – The $66/hour rate, retroactive to November 1, 2024, was pushed out to the one or two providers that weren't already receiving a rate equivalent to or above that amount.
**Northern Lakes** – The $66/hour rate, retroactive to November 1, 2024, was pushed out to the one or two providers that weren't already receiving a rate equivalent to or above that amount.
**Wellvance** – Wellvance intends to push out only the amount of funds that have been received.

Eric requested that the Boards send to his attention the amounts needed for the CMHSPs to implement the $66/hour rate.

DRAFT POLICY FOR INTENSIVE CRISIS STABILIZATION SERVICES

Donna referenced the MDHHS proposed policy on Intensive Crisis Stabilization Services which has an expected effective date of July 1, 2025; comments are due by May 5th. The policy provides an outline of Intensive Crisis Stabilization Services (ICSS), encompassing the development of regional crisis hubs and clear guidance on community crisis stabilization services, inclusive of mobile crisis. To use Medicaid funds, each ICSS program must receive MDHHS approval through a certification process initially and every three years thereafter.

ICSS must be provided by a treatment team of Crisis Professionals under the supervision of a psychiatrist. Crisis Professionals must meet MDHHS-approved training competencies. The treatment team must include one or more certified peer support or certified recover specialists who meet the established criteria for adult and/or children's services.

PIHPs, CMHSPs, and MHPs must partner as needed in coordinating a crisis stabilization plan. Crisis stabilization plans must be developed for individuals and their family/caregivers who are not yet receiving specialty behavioral health services but are eligible for such services.

Under the ICSS benefit, the following emergency intervention services must be provided 24 hours per day/7 days per week:

- Crisis hub (staffed by a Crisis Professional) ICSS programs must have the capacity to deploy Someone to Respond services through the crisis hub on a continuous basis.
- Mobile crisis or a combination of mobile crisis and community crisis response services. Mobile crisis services must be provided by a two-person treatment team consisting of at least one Crisis Professional and a second Crisis Professional, paraprofessional, or certified peer. Mobile crisis stabilization teams must be able to travel to the individual in crisis for a face-to-face contact within 1 hour or less in urban counties and within 2 hours or less in rural counties.

ICSS programs must provide continuing crisis stabilization services to the individual following resolution of the immediate situation. Crisis stabilization plans must include transition planning to ongoing behavioral health services as necessary and facilitate connections to community services.

Donna expressed concern with costs related to implementing the policy. She asked whether others have reviewed it and/or provided comment. Eric responded that he hasn't reviewed the policy yet, but it is likely that MDHHS is overinterpreting the mental health code. No additional funding is expected. The topic will be placed on the April 15th Operations Committee meeting agenda and the April 25th Clinical Directors meeting agenda.

AUDIT RFPS

The NMRE conducted an RFP for audit firms in 2021 to select an audit firm for fiscal years 2021, 2022, and 2023. Roslund, Prestage & Company, PC was awarded the contract for AuSable Valley CMHA (now Wellvance), Centra Wellness Network, North Country CMHA, Northern Lakes CMHA, and the NMRE. Northeast Michigan CMHA selected the firm of Straley Lamp & Kraenzlein, PC. A one-year extension was awarded to these firms to conduct financial audits for FY24.

The NMRE will conduct a new RFP and collect bids for financial audits for fiscal years 2025, 2026, and 2027 in May of this year. The submission deadline will likely be June 30, 2025. As in previous years, the NMRE will open packets and send them to the CMHSPs along with a brief summary of the submissions.

NEXT MEETING

The next meeting was scheduled for May 14th at 10:00AM.

**Chief Executive Officer Report**

**April 2025**

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

**March 25:** Attended and participated in CMHAM Advocate Meeting.

**March 27:** Attended and participated in CMHAM Directors Forum.

**April 1:** Attended and participated in PIHP CEO Meeting.

**April 3:** Attended and participated in MDHHS PIHP Operations Meeting.

**Aprill 9:** Attended and participated in Regional Finance Committee Meeting.

**April 11:** Attended and participated in Crawford County Opioid Advisory Committee.

**Aprill 14:** Attended and participated in MDHHS audit division meeting regarding NLCMHA and NMRE FY 20 audit closeouts.

**April 15:** Chaired NMRE Operations Committee Meeting.

**Aprill 16:** Attended and participated in NMRE Internal Operations Committee Meeting.


# February 2025 Finance Report

# February 2025 Financial Summary

| Funding Source | YTD Net Surplus (Deficit) | Carry Forward | ISF |
|---|---|---|---|
| Medicaid | 911,684 | - | 13,514,675 |
| Healthy Michigan | (1,546,870) | 736,656 | 7,068,394 |
| | $ (635,186) | $ 736,656 | $ 20,583,069 |

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Wellvance | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| Net Surplus (Deficit) MA/HMP | 1,441,548 | 2,429,116 | (3,533,376) | (1,293,283) | (393,317) | 737,874 | (23,747) | $ (635,186) |
| Carry Forward | | - | - | - | - | - | - | 736,656 |
| Total Med/HMP Current Year Surplus | 1,441,548 | 2,429,116 | (3,533,376) | (1,293,283) | (393,317) | 737,874 | (23,747) | $ 101,470 |
| Medicaid & HMP Internal Service Fund | | | | | | | | 20,576,156 |
| Total Medicaid & HMP Net Surplus | | | | | | | | $ 20,677,626 |

# Northern Michigan Regional Entity

## Funding Source Report - PIHP

Mental Health

October 1, 2024 through February 28, 2025

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Wellvance | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| **Traditional Medicaid (inc Autism)** | | | | | | | | |
| **Revenue** | | | | | | | | |
| Revenue Capitation (PEPM) | $ 84,715,164 | $ 2,888,758 | | | | | | $ 87,603,922 |
| CMHSP Distributions | (80,892,242) | | 26,375,481 | 21,661,185 | 13,616,143 | 11,839,099 | 7,400,333 | 0 |
| 1st/3rd Party receipts | | | - | - | - | - | - | - |
| **Net revenue** | 3,822,922 | 2,888,758 | 26,375,481 | 21,661,185 | 13,616,143 | 11,839,099 | 7,400,333 | 87,603,922 |
| **Expense** | | | | | | | | |
| PIHP Admin | 1,179,571 | 22,094 | | | | | | 1,201,665 |
| PIHP SUD Admin | | 59,625 | | | | | | 59,625 |
| SUD Access Center | | - | | | | | | - |
| Insurance Provider Assessment | 753,447 | 15,177 | | | | | | 768,624 |
| Hospital Rate Adjuster | - | | | | | | | - |
| Services | 393,832 | 1,556,603 | 28,160,278 | 22,679,477 | 13,820,978 | 10,899,514 | 7,151,642 | 84,662,324 |
| **Total expense** | 2,326,850 | 1,653,499 | 28,160,278 | 22,679,477 | 13,820,978 | 10,899,514 | 7,151,642 | 86,692,238 |
| **Net Actual Surplus (Deficit)** | $ 1,496,072 | $ 1,235,259 | $ (1,784,797) | $ (1,018,292) | $ (204,835) | $ 939,585 | $ 248,691 | $ 911,684 |

**Notes**

**Medicaid ISF - $13,514,675 - based on current FSR**

**Medicaid Savings - $0**

# Northern Michigan Regional Entity

## Funding Source Report - PIHP

Mental Health
October 1, 2024 through February 28, 2025

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Wellvance | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| **Healthy Michigan** | | | | | | | | |
| **Revenue** | | | | | | | | |
| Revenue Capitation (PEPM) | $ 5,925,720 | $ 5,110,832 | | | | | | $ 11,036,552 |
| CMHSP Distributions | (5,788,832) | | 2,123,892 | 1,652,913 | 750,321 | 788,865 | 472,842 | - |
| 1st/3rd Party receipts | | | | - | - | - | - | - |
| **Net revenue** | 136,888 | 5,110,832 | 2,123,892 | 1,652,913 | 750,321 | 788,865 | 472,842 | 11,036,552 |
| **Expense** | | | | | | | | |
| PIHP Admin | 120,291 | 52,349 | | | | | | 172,641 |
| PIHP SUD Admin | | 141,277 | | | | | | 141,277 |
| SUD Access Center | | - | | | | | | - |
| Insurance Provider Assessment | 71,121 | 35,118 | | | | | | 106,239 |
| Hospital Rate Adjuster | - | | | | | | | - |
| Services | - | 3,688,231 | 3,872,471 | 1,927,904 | 938,803 | 990,577 | 745,280 | 12,163,266 |
| **Total expense** | 191,412 | 3,916,975 | 3,872,471 | 1,927,904 | 938,803 | 990,577 | 745,280 | 12,583,422 |
| **Net Surplus (Deficit)** | $ (54,524) | $ 1,193,857 | $ (1,748,579) | $ (274,991) | $ (188,482) | $ (201,712) | $ (272,438) | $ (1,546,870) |

**Notes**
**HMP ISF - $7,068,394 - based on current FSR**
**HMP Savings - $736,656**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Net Surplus (Deficit) MA/HMP** | **$ 1,441,548** | **$ 2,429,116** | **$ (3,533,376)** | **$ (1,293,283)** | **$ (393,317)** | **$ 737,874** | **$ (23,747)** | **$ (635,186)** |
| **Medicaid/HMP Carry Forward** | | | | | | | | **736,656** |
| Total Med/HMP Current Year Surplus | | | | | | | | $ 101,470 |
| **Medicaid & HMP ISF - based on current FSR** | | | | | | | | **20,576,156** |
| **Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF** | | | | | | | | **$ 20,677,626** |

## Northern Michigan Regional Entity

### Funding Source Report - PIHP

Mental Health

October 1, 2024 through February 28, 2025

| | NMRE MH | NMRE SUD | Northern Lakes | North Country | Northeast | Wellvance | Centra Wellness | PIHP Total |
|---|---|---|---|---|---|---|---|---|
| **Health Home** | | | | | | | | |
| **Revenue** | | | | | | | | |
| Revenue Capitation (PEPM) | $ 551,385 | | 228,131 | 150,917 | 169,519 | 82,829 | 235,150 | $ 1,417,931 |
| CMHSP Distributions | - | | | | | | | - |
| 1st/3rd Party receipts | | | | | | | | - |
| **Net revenue** | 551,385 | - | 228,131 | 150,917 | 169,519 | 82,829 | 235,150 | 1,417,931 |
| **Expense** | | | | | | | | |
| PIHP Admin | 15,318 | | | | | | | 15,318 |
| BHH Admin | 16,449 | | | | | | | 16,449 |
| Insurance Provider Assessment | - | | | | | | | - |
| Hospital Rate Adjuster | | | | | | | | |
| Services | 212,664 | | 228,131 | 150,917 | 169,519 | 82,829 | 235,150 | 1,079,210 |
| **Total expense** | 244,431 | - | 228,131 | 150,917 | 169,519 | 82,829 | 235,150 | 1,110,977 |
| **Net Surplus (Deficit)** | $ 306,954 | $ - | $ - | $ - | $ - | $ - | $ - | $ 306,954 |

# Northern Michigan Regional Entity

## Funding Source Report - SUD

Mental Health

October 1, 2024 through February 28, 2025

| | Medicaid | Healthy Michigan | Opioid Health Home | SAPT Block Grant | PA2 Liquor Tax | Total SUD |
|---|---|---|---|---|---|---|
| **Substance Abuse Prevention & Treatment** | | | | | | |
| **Revenue** | $ 2,888,758 | $ 5,110,832 | $ 1,797,363 | $ 1,560,101 | $ 497,249 | $ 11,854,303 |
| **Expense** | | | | | | |
| Administration | 81,719 | 193,626 | 75,480 | 66,745 | | 417,570 |
| OHH Admin | | | 34,096 | - | | 34,096 |
| Block Grant Access Center | - | - | - | - | | - |
| Insurance Provider Assessment | 15,177 | 35,118 | - | | | 50,295 |
| Services: | | | | | | |
| Treatment | 1,556,603 | 3,688,231 | 1,437,755 | 690,876 | 497,249 | 7,870,714 |
| Prevention | - | - | - | 354,446 | - | 354,446 |
| ARPA Grant | - | - | - | 448,034 | - | 448,034 |
| **Total expense** | 1,653,499 | 3,916,975 | 1,547,331 | 1,560,101 | 497,249 | 9,175,155 |
| **PA2 Redirect** | | | - | - | | - |
| **Net Surplus (Deficit)** | $ 1,235,259 | $ 1,193,857 | $ 250,032 | $ (0) | $ - | $ 2,679,148 |

## Northern Michigan Regional Entity

### Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2024 through February 28, 2025

| | PIHP MH | PIHP SUD | PIHP ISF | Total PIHP |
|---|---|---|---|---|
| **Operating revenue** | | | | |
| Medicaid | $ 84,715,164 | $ 2,888,758 | $ - | $ 87,603,922 |
| Medicaid Savings | - | - | - | - |
| Healthy Michigan | 5,925,720 | 5,110,832 | - | 11,036,552 |
| Healthy Michigan Savings | 736,656 | - | - | 736,656 |
| Health Home | 1,417,931 | - | - | 1,417,931 |
| Opioid Health Home | - | 1,797,363 | - | 1,797,363 |
| Substance Use Disorder Block Grant | - | 1,560,101 | - | 1,560,101 |
| Public Act 2 (Liquor tax) | - | 497,246 | - | 497,246 |
| Affiliate local drawdown | 297,408 | - | - | 297,408 |
| Performance Incentive Bonus | - | - | - | - |
| Miscellanous Grant Revenue | - | 4,000 | - | 4,000 |
| Veteran Navigator Grant | 35,761 | - | - | 35,761 |
| SOR Grant Revenue | - | 598,415 | - | 598,415 |
| Gambling Grant Revenue | - | 79,145 | - | 79,145 |
| Other Revenue | - | - | 1,336 | 1,336 |
| **Total operating revenue** | 93,128,640 | 12,535,860 | 1,336 | 105,665,836 |
| **Operating expenses** | | | | |
| General Administration | 1,417,088 | 315,662 | - | 1,732,750 |
| Prevention Administration | - | 49,931 | - | 49,931 |
| OHH Administration | - | 34,096 | - | 34,096 |
| BHH Administration | 16,449 | - | - | 16,449 |
| Insurance Provider Assessment | 824,568 | 50,295 | - | 874,863 |
| Hospital Rate Adjuster | - | - | - | - |
| Payments to Affiliates: | | | | |
| Medicaid Services | 83,105,721 | 1,556,603 | - | 84,662,324 |
| Healthy Michigan Services | 8,475,035 | 3,688,231 | - | 12,163,266 |
| Health Home Services | 1,079,210 | - | - | 1,079,210 |
| Opioid Health Home Services | - | 1,437,755 | - | 1,437,755 |
| Community Grant | - | 690,876 | - | 690,876 |
| Prevention | - | 304,515 | - | 304,515 |
| State Disability Assistance | - | - | - | - |
| ARPA Grant | - | 448,034 | - | 448,034 |
| Public Act 2 (Liquor tax) | - | 497,249 | - | 497,249 |
| Local PBIP | - | - | - | - |
| Local Match Drawdown | 297,408 | - | - | 297,408 |
| Miscellanous Grant | - | 4,000 | - | 4,000 |
| Veteran Navigator Grant | 35,761 | - | - | 35,761 |
| SOR Grant Expenses | - | 598,415 | - | 598,415 |
| Gambling Grant Expenses | - | 79,145 | - | 79,145 |
| **Total operating expenses** | 95,251,240 | 9,754,807 | - | 105,006,047 |
| **CY Unspent funds** | (2,122,600) | 2,781,053 | 1,336 | 659,789 |
| **Transfers In** | - | - | - | - |
| **Transfers out** | - | - | - | - |
| Unspent funds - beginning | 3,466,474 | 4,765,230 | 20,583,069 | 28,814,773 |
| **Unspent funds - ending** | $ 1,343,874 | $ 7,546,283 | $ 20,584,405 | $ 29,474,562 |

# Northern Michigan Regional Entity

## Statement of Net Position

February 28, 2025

| | PIHP MH | PIHP SUD | PIHP ISF | Total PIHP |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current Assets** | | | | |
| Cash Position | $ 51,870,986 | $ 7,477,561 | $ 20,584,405 | $ 79,932,952 |
| Accounts Receivable | 4,099,812 | 1,583,932 | - | 5,683,744 |
| Prepaids | 59,521 | - | - | 59,521 |
| **Total current assets** | 56,030,319 | 9,061,493 | 20,584,405 | 85,676,217 |
| **Noncurrent Assets** | | | | |
| Capital assets | 563,178 | - | - | 563,178 |
| **Total Assets** | 56,593,497 | 9,061,493 | 20,584,405 | 86,239,395 |
| **Liabilities** | | | | |
| **Current liabilities** | | | | |
| Accounts payable | 55,033,161 | 1,515,210 | - | 56,548,371 |
| Accrued liabilities | 216,462 | - | - | 216,462 |
| Unearned revenue | - | - | - | - |
| **Total current liabilities** | 55,249,623 | 1,515,210 | - | 56,764,833 |
| **Unspent funds** | $ 1,343,874 | $ 7,546,283 | $ 20,584,405 | $ 29,474,562 |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2024 through February 28, 2025

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **Operating revenue** | | | | | |
| Medicaid | | | | | |
| * Capitation | $ 187,752,708 | $ 78,230,295 | $ 84,715,164 | $ 6,484,869 | 8.29% |
| Carryover | 11,400,000 | - | - | - | - |
| Healthy Michigan | | | | | |
| Capitation | 19,683,372 | 8,201,405 | 5,925,720 | (2,275,685) | (27.75%) |
| Carryover | 5,100,000 | - | 736,656 | 736,656 | 0.00% |
| Health Home | 1,451,268 | 604,695 | 1,417,931 | 813,236 | 134.49% |
| Affiliate local drawdown | 594,816 | 297,408 | 297,408 | - | 0.00% |
| Performance Bonus Incentive | 1,334,531 | - | - | - | 0.00% |
| Miscellanous Grants | - | - | - | - | 0.00% |
| Veteran Navigator Grant | 110,000 | 45,835 | 35,761 | (10,074) | (21.98%) |
| Other Revenue | - | - | - | - | 0.00% |
| Total operating revenue | 227,426,695 | 87,379,638 | 93,128,640 | 5,749,002 | 6.58% |
| **Operating expenses** | | | | | |
| General Administration | 3,591,836 | 1,486,190 | 1,417,088 | 69,102 | 4.65% |
| BHH Administration | - | - | 16,449 | (16,449) | 0.00% |
| Insurance Provider Assessment | 1,897,524 | 790,635 | 824,568 | (33,933) | (4.29%) |
| Hospital Rate Adjuster | 4,571,328 | 1,904,720 | - | 1,904,720 | 100.00% |
| Local PBIP | 1,737,753 | - | - | - | 0.00% |
| Local Match Drawdown | 594,816 | 297,408 | 297,408 | - | 0.00% |
| Miscellanous Grants | - | - | - | - | 0.00% |
| Veteran Navigator Grant | 110,004 | 38,215 | 35,761 | 2,454 | 6.42% |
| Payments to Affiliates: | | | | | |
| Medicaid Services | 176,618,616 | 73,591,090 | 83,105,721 | (9,514,631) | (12.93%) |
| Healthy Michigan Services | 17,639,940 | 7,349,975 | 8,475,035 | (1,125,060) | (15.31%) |
| Health Home Services | 1,415,196 | 589,665 | 1,079,210 | (489,545) | (83.02%) |
| Total operating expenses | 208,177,013 | 86,047,898 | 95,251,240 | (9,203,342) | (10.70%) |
| **CY Unspent funds** | $ 19,249,682 | $ 1,331,740 | (2,122,600) | $ (3,454,340) | |
| **Transfers in** | | | - | | |
| **Transfers out** | | | - | 95,251,240 | |
| Unspent funds - beginning | | | 3,466,474 | | |
| **Unspent funds - ending** | | | $ 1,343,874 | (2,122,600) | |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2024 through February 28, 2025

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **Operating revenue** | | | | | |
| Medicaid | $ 4,678,632 | $ 1,949,430 | $ 2,888,758 | $ 939,328 | 48.18% |
| Healthy Michigan | 11,196,408 | 4,665,170 | 5,110,832 | 445,662 | 9.55% |
| Substance Use Disorder Block Grant | 6,467,905 | 2,694,958 | 1,560,101 | (1,134,857) | (42.11%) |
| Opioid Health Home | 3,419,928 | 1,424,970 | 1,797,363 | 372,393 | 26.13% |
| Public Act 2 (Liquor tax) | 1,533,979 | - | 497,246 | 497,246 | 0.00% |
| Miscellanous Grants | 4,000 | 1,667 | 4,000 | 2,333 | 140.00% |
| SOR Grant | 2,043,984 | 851,660 | 598,415 | (253,245) | (29.74%) |
| Gambling Prevention Grant | 200,000 | 83,333 | 79,145 | (4,188) | (5.03%) |
| Other Revenue | - | - | - | - | 0.00% |
| Total operating revenue | 29,544,836 | 11,671,188 | 12,535,860 | 864,672 | 7.41% |
| **Operating expenses** | | | | | |
| Substance Use Disorder: | | | | | |
| SUD Administration | 1,082,576 | 426,075 | 315,662 | 110,413 | 25.91% |
| Prevention Administration | 118,428 | 49,345 | 49,931 | (586) | (1.19%) |
| Insurance Provider Assessment | 113,604 | 47,335 | 50,295 | (2,960) | (6.25%) |
| Medicaid Services | 3,931,560 | 1,638,150 | 1,556,603 | 81,547 | 4.98% |
| Healthy Michigan Services | 10,226,004 | 4,260,835 | 3,688,231 | 572,604 | 13.44% |
| Community Grant | 2,074,248 | 864,270 | 690,876 | 173,394 | 20.06% |
| Prevention | 634,056 | 264,190 | 304,515 | (40,325) | (15.26%) |
| State Disability Assistance | 95,215 | 39,677 | - | 39,677 | 100.00% |
| ARPA Grant | - | - | 448,034 | (448,034) | 0.00% |
| Opioid Health Home Admin | - | - | 34,096 | (34,096) | 0.00% |
| Opioid Health Home Services | 3,165,000 | 1,318,750 | 1,437,755 | (119,005) | (9.02%) |
| Miscellanous Grants | 4,000 | 1,667 | 4,000 | (2,333) | (140.00%) |
| SOR Grant | 2,043,984 | 851,660 | 598,415 | 253,245 | 29.74% |
| Gambling Prevention | 200,000 | 83,333 | 79,145 | 4,188 | 5.03% |
| PA2 | 1,533,978 | - | 497,249 | (497,249) | 0.00% |
| Total operating expenses | 25,222,653 | 9,845,287 | 9,754,807 | 90,480 | 0.92% |
| **CY Unspent funds** | $ 4,322,183 | $ 1,825,901 | 2,781,053 | $ 955,153 | |
| Transfers in | | | - | | |
| Transfers out | | | - | | |
| Unspent funds - beginning | | | 4,765,230 | | |
| **Unspent funds - ending** | | | $ 7,546,283 | | |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration

October 1, 2024 through February 28, 2025

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **General Admin** | | | | | |
| Salaries | $ 1,921,812 | $ 800,755 | $ 820,509 | $ (19,754) | (2.47%) |
| Fringes | 666,212 | 264,010 | 260,551 | 3,459 | 1.31% |
| Contractual | 683,308 | 284,715 | 201,992 | 82,723 | 29.05% |
| Board expenses | 18,000 | 7,500 | 8,020 | (520) | (6.93%) |
| Day of recovery | 14,000 | 9,000 | - | 9,000 | 100.00% |
| Facilities | 152,700 | 63,625 | 50,210 | 13,415 | 21.08% |
| Other | 135,804 | 56,585 | 75,806 | (19,221) | (33.97%) |
| Total General Admin | $ 3,591,836 | $ 1,486,190 | $ 1,417,088 | $ 69,102 | 4.65% |

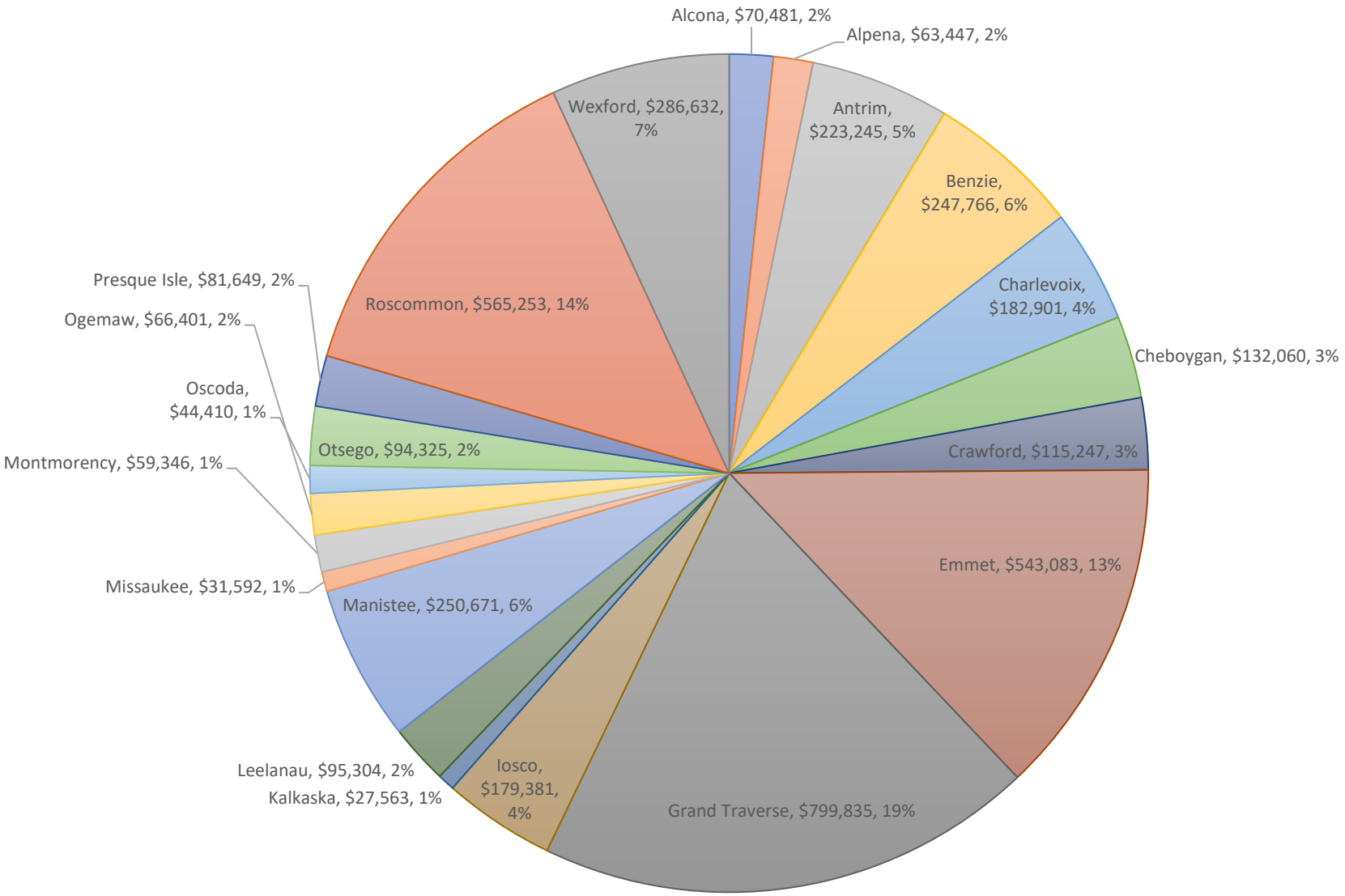
## Northern Michigan Regional Entity

### Schedule of PA2 by County

October 1, 2024 through February 28, 2025

| | Projected FY25 Activity | | | | Actual FY25 Activity | | | |
|---|---|---|---|---|---|---|---|---|
| | Beginning Balance | FY25 Projected Revenue | FY25 Approved Projects | Projected Ending Balance | Current Receipts | County Specific Projects | Region Wide Projects by Population | Ending Balance |
| County | | | | | | Actual Expenditures by County | | |
| Alcona | $ 71,885 | $ 23,013 | $ 21,562 | $ 73,336 | $ 1,098 | 2,502 | $ - | $ 70,481 |
| Alpena | 276,605 | 81,249 | 115,352 | 242,502 | 4,214 | 17,372 | - | 263,447 |
| Antrim | 225,891 | 71,430 | 37,276 | 260,045 | 3,747 | 6,393 | - | 223,245 |
| Benzie | 257,777 | 64,021 | 52,479 | 269,320 | 3,245 | 13,257 | - | 247,766 |
| Charlevoix | 240,410 | 106,977 | 204,773 | 142,613 | 5,172 | 62,682 | - | 182,901 |
| Cheboygan | 141,238 | 85,508 | 65,816 | 160,930 | 4,496 | 13,674 | - | 132,060 |
| Crawford | 126,884 | 36,205 | 68,993 | 94,096 | 1,986 | 13,623 | - | 115,247 |
| Emmet | 604,860 | 182,951 | 363,695 | 424,117 | 9,149 | 70,927 | - | 543,083 |
| Grand Traverse | 947,150 | 464,163 | 558,074 | 853,238 | 22,760 | 170,074 | - | 799,835 |
| Iosco | 186,997 | 84,319 | 73,780 | 197,537 | 4,287 | 11,904 | - | 179,381 |
| Kalkaska | 25,843 | 41,796 | 2,436 | 65,203 | 2,070 | 349 | - | 27,563 |
| Leelanau | 97,166 | 63,811 | 39,737 | 121,240 | 3,101 | 4,963 | - | 95,304 |
| Manistee | 259,014 | 82,480 | 104,210 | 237,284 | 4,089 | 12,432 | - | 250,671 |
| Missaukee | 30,683 | 22,352 | 20,908 | 32,127 | 1,202 | 293 | - | 31,592 |
| Montmorency | 59,540 | 30,318 | 8,457 | 81,401 | 1,449 | 1,643 | - | 59,346 |
| Ogemaw | 64,110 | 68,787 | 11,101 | 121,797 | 3,416 | 1,126 | - | 66,401 |
| Oscoda | 44,727 | 21,668 | 7,577 | 58,818 | 1,156 | 1,473 | - | 44,410 |
| Otsego | 112,969 | 105,067 | 98,424 | 119,612 | 5,328 | 23,973 | - | 94,325 |
| Presque Isle | 82,660 | 24,977 | 11,701 | 95,936 | 1,268 | 2,279 | - | 81,649 |
| Roscommon | 576,714 | 87,317 | 55,007 | 609,024 | 4,377 | 15,839 | - | 565,253 |
| Wexford | 332,107 | 98,696 | 229,583 | 201,220 | 4,997 | 50,473 | - | 286,632 |
| | 4,765,231 | 1,847,106 | 2,150,940 | 4,461,397 | 92,609 | 497,251 | - | 4,360,589 |
| PA2 Redirect | | | | | | | | - |
| | | | | | | | | 4,360,589 |

# PA2 FUND BALANCES BY COUNTY



# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration

October 1, 2024 through February 28, 2025

| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **SUD Administration** | | | | | |
| Salaries | $ 723,372 | $ 301,405 | $ 184,016 | $ 117,389 | 38.95% |
| Fringes | 212,604 | 88,585 | 59,342 | 29,243 | 33.01% |
| Access Salaries | - | - | - | - | 0.00% |
| Access Fringes | - | - | - | - | 0.00% |
| Access Contractual | - | - | - | - | 0.00% |
| Contractual | 129,000 | 31,250 | 48,633 | (17,383) | (55.63%) |
| Board expenses | 5,000 | 2,085 | 1,825 | 260 | 12.47% |
| Day of Recover | - | - | 10,128 | (10,128) | 0.00% |
| Facilities | - | - | - | - | 0.00% |
| Other | 12,600 | 2,750 | 11,718 | (8,968) | (326.11%) |
| Total operating expenses | $ 1,082,576 | $ 426,075 | $ 315,662 | $ 110,413 | 25.91% |

# Northern Michigan Regional Entity

## Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2024 through February 28, 2025

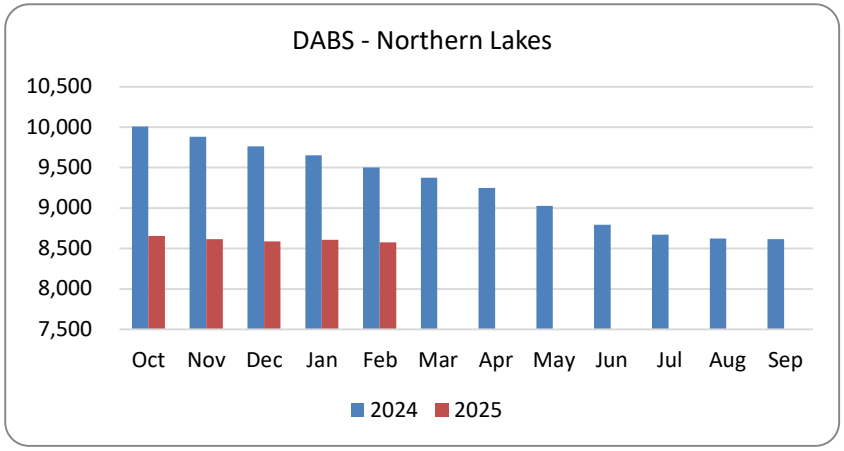
| | Total Budget | YTD Budget | YTD Actual | Variance Favorable (Unfavorable) | Percent Favorable (Unfavorable) |
|---|---|---|---|---|---|
| **Operating revenue** | | | | | |
| Charges for services | $ - | $ - | $ - | $ - | 0.00% |
| Interest and Dividends | 7,500 | 3,125 | 1,336 | (1,789) | (57.25%) |
| Total operating revenue | 7,500 | 3,125 | 1,336 | (1,789) | (57.25%) |
| **Operating expenses** | | | | | |
| Medicaid Services | - | - | - | - | 0.00% |
| Healthy Michigan Services | - | - | - | - | 0.00% |
| Total operating expenses | - | - | - | - | 0.00% |
| **CY Unspent funds** | $ 7,500 | $ 3,125 | 1,336 | $ (1,789) | |
| Transfers in | | | - | | |
| Transfers out | | | - | - | |
| Unspent funds - beginning | | | 20,583,069 | | |
| **Unspent funds - ending** | | | $ 20,584,405 | | |

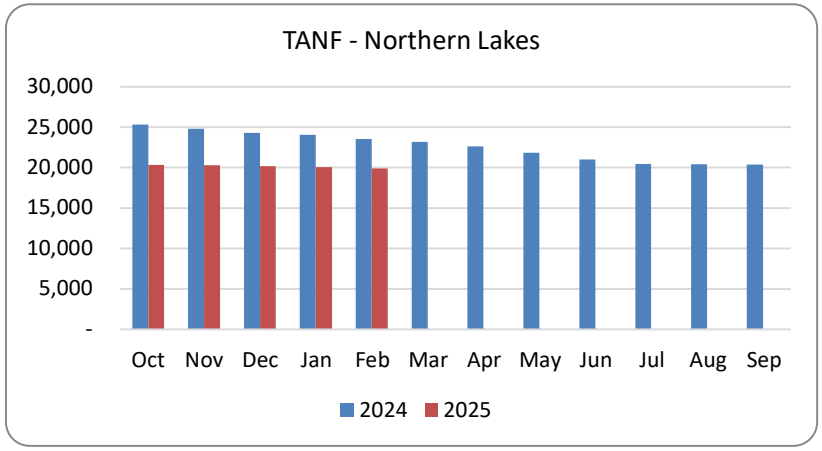
# Northern Michigan Regional Entity

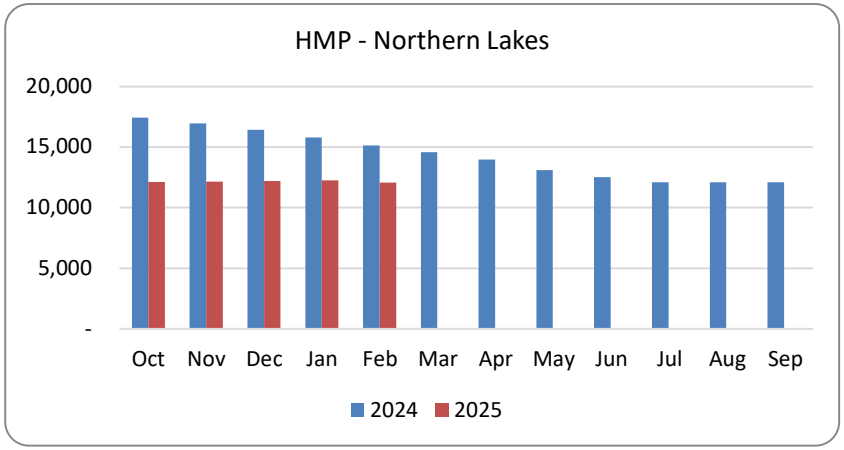
## Narrative

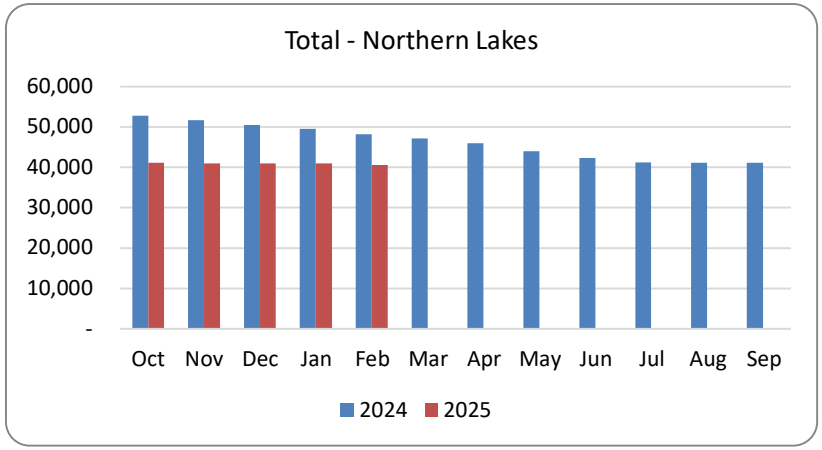
October 1, 2024 through February 28, 2025

## Northern Lakes Eligible Members Trending - based on payment files



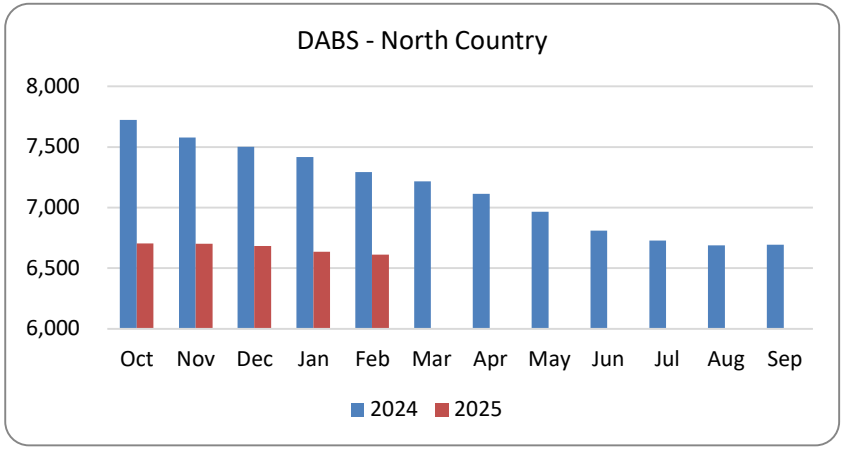



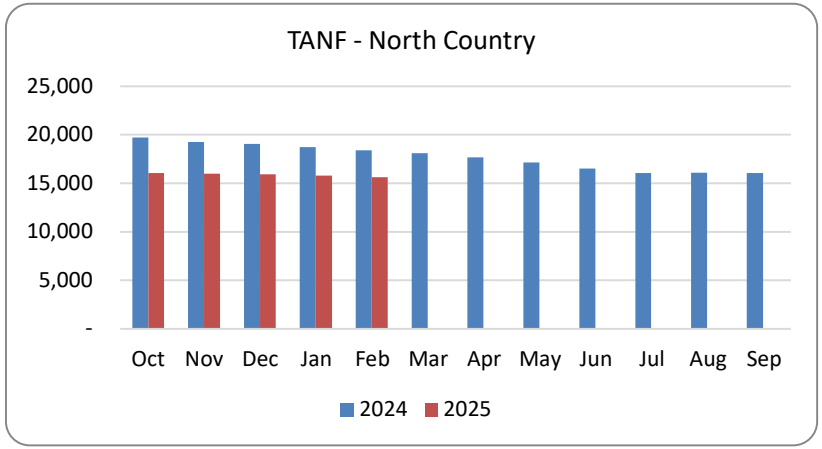
# Northern Michigan Regional Entity

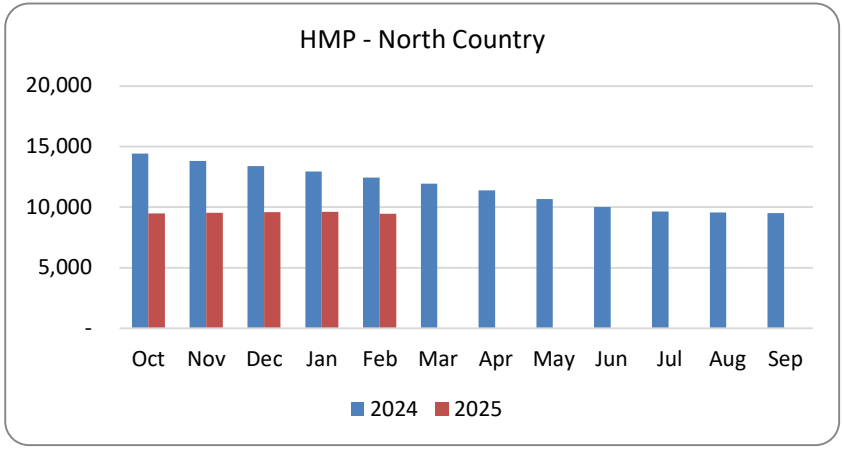
## Narrative

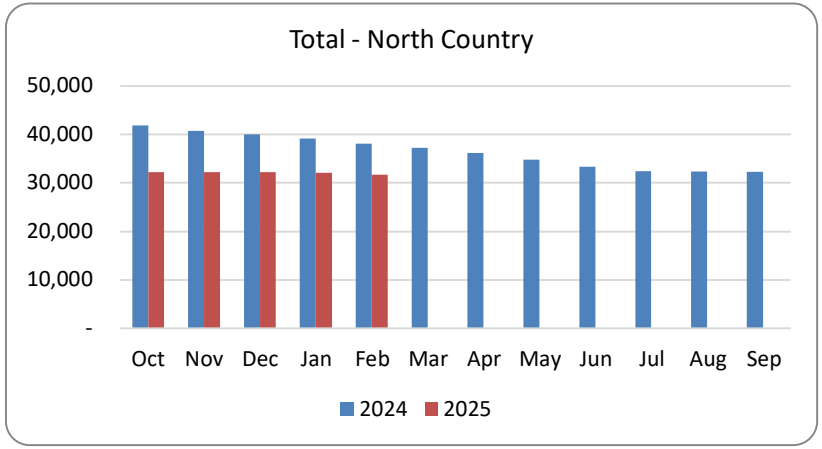
October 1, 2024 through February 28, 2025

## North Country Eligible Members Trending - based on payment files



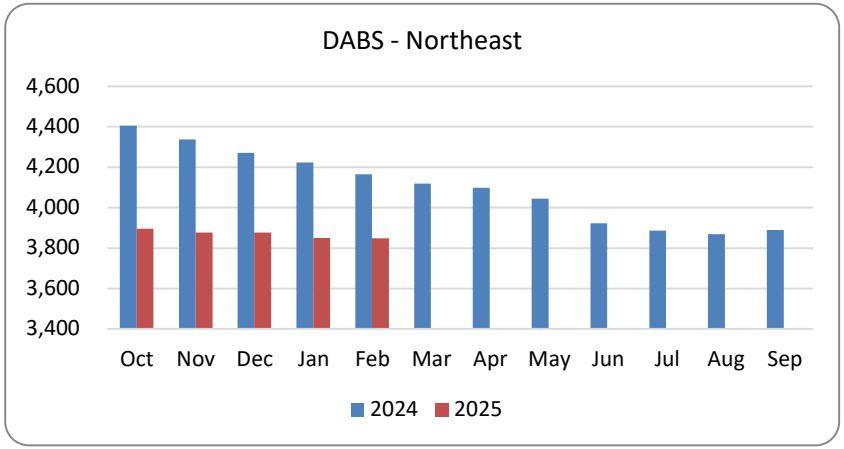



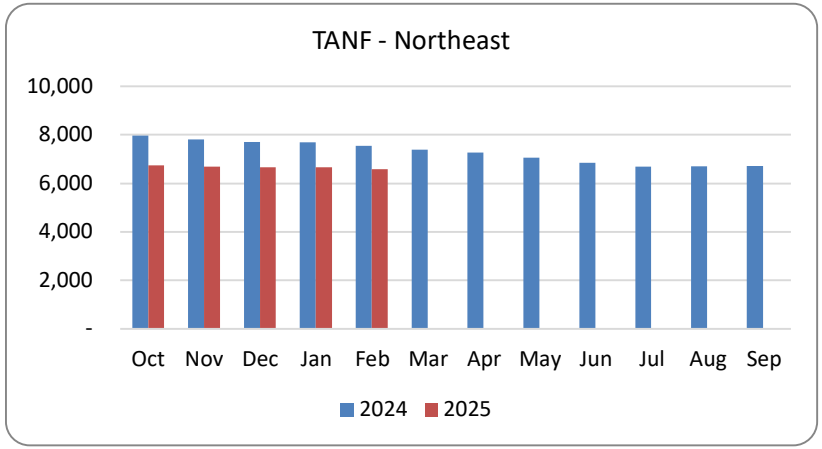
# Northern Michigan Regional Entity

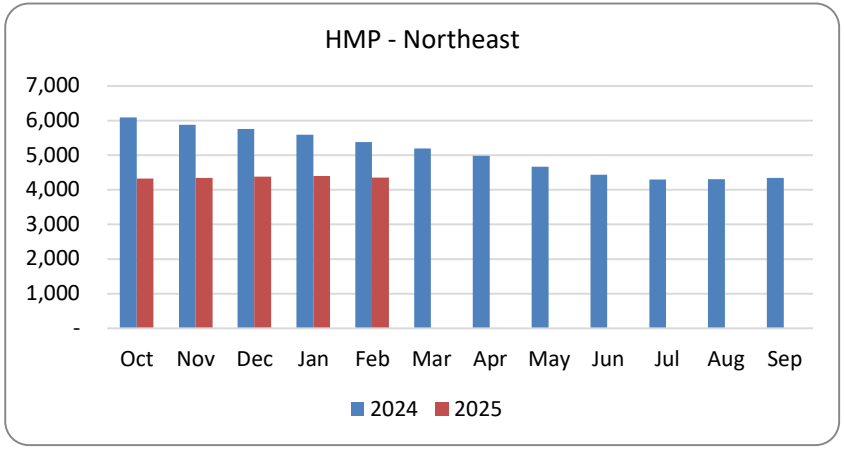
## Narrative

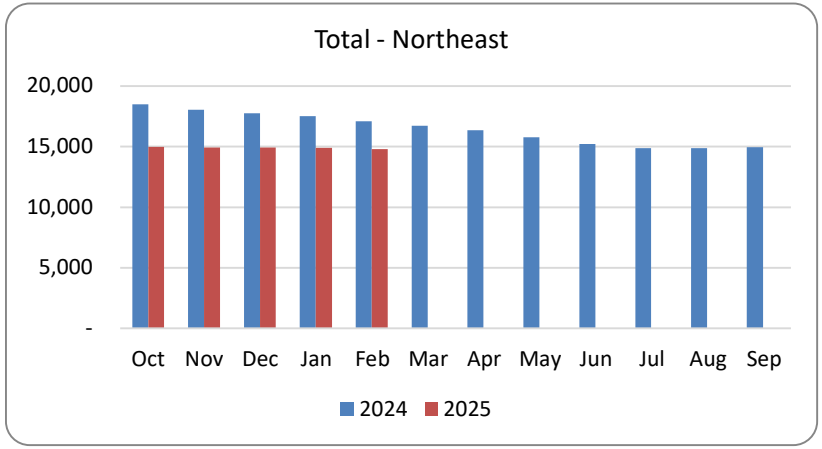
October 1, 2024 through February 28, 2025

## Northeast Eligible Members Trending - based on payment files



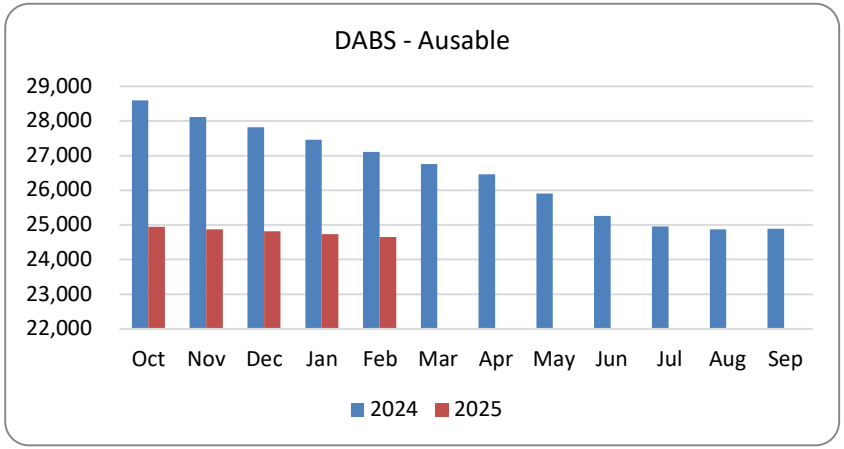



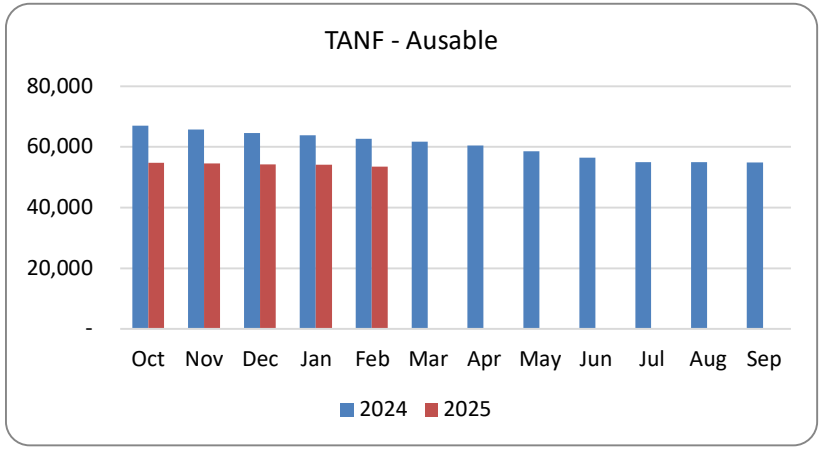
# Northern Michigan Regional Entity

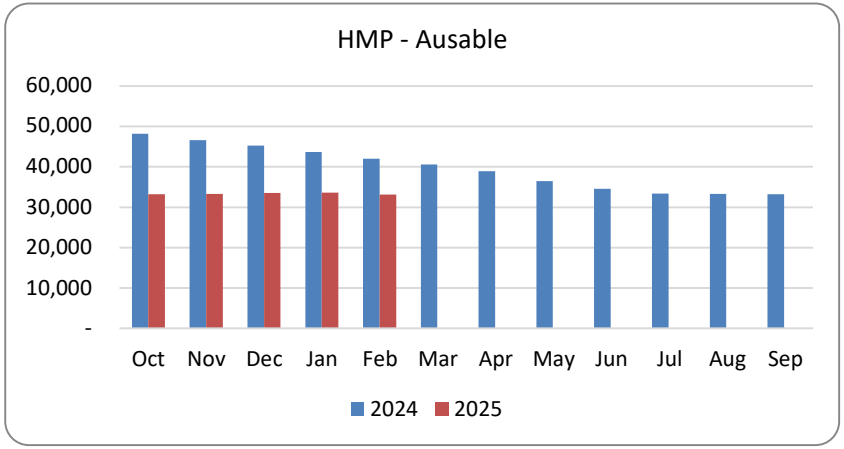
## Narrative

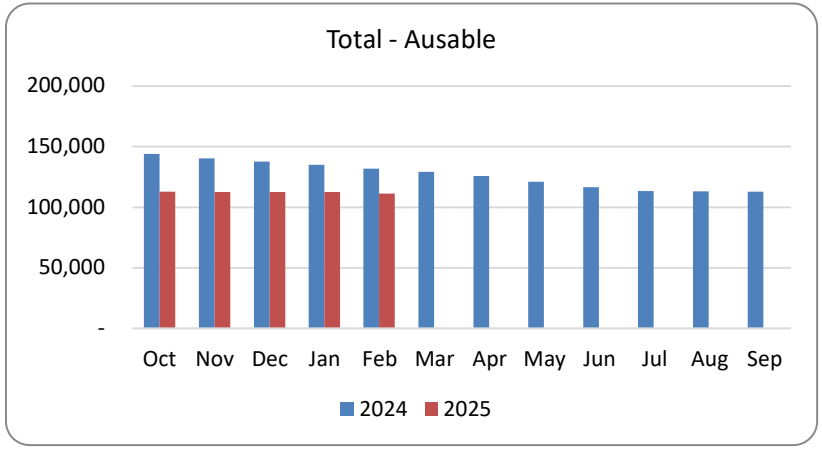
October 1, 2024 through February 28, 2025

## AuSable Valley Eligible Members Trending - based on payment files



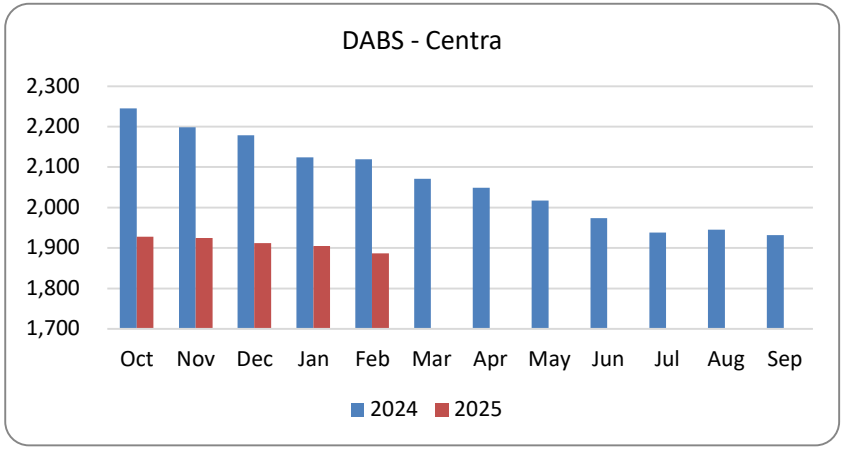



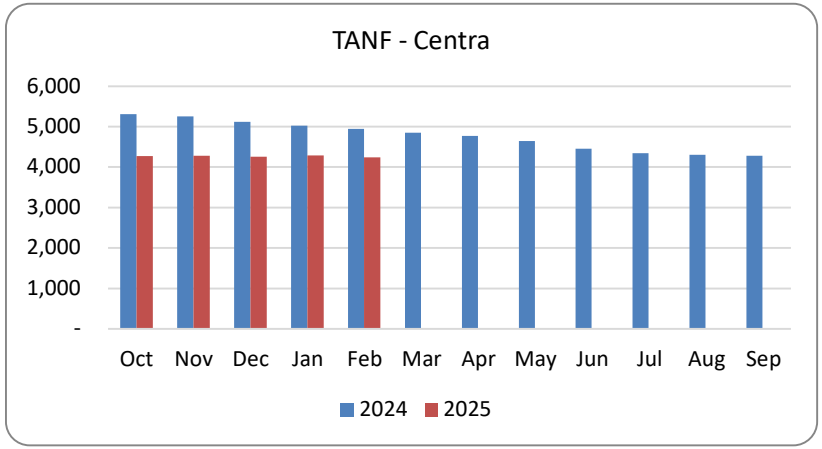
# Northern Michigan Regional Entity

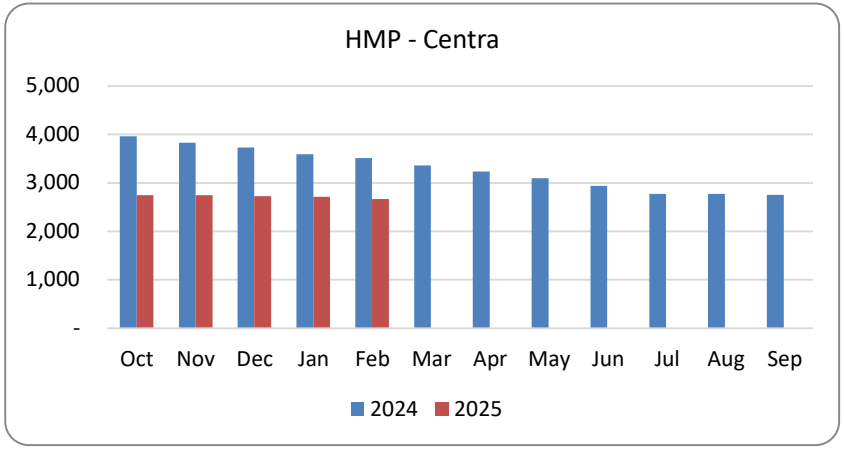
## Narrative

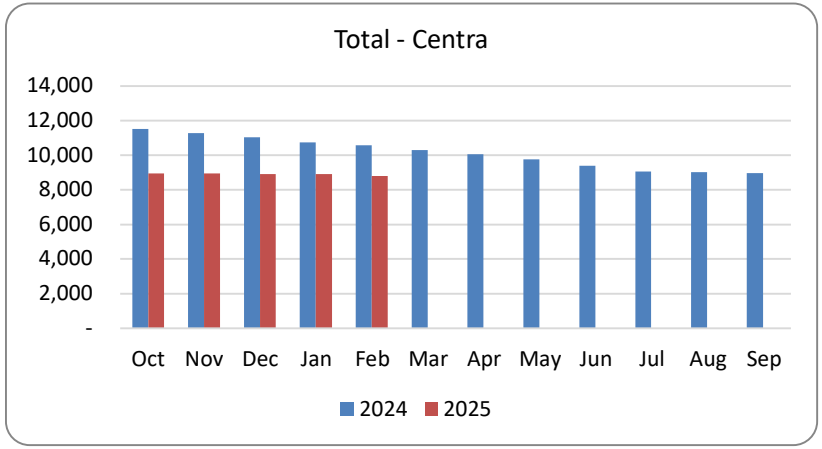
October 1, 2024 through February 28, 2025

## Centra Wellness Eligible Members Trending - based on payment files



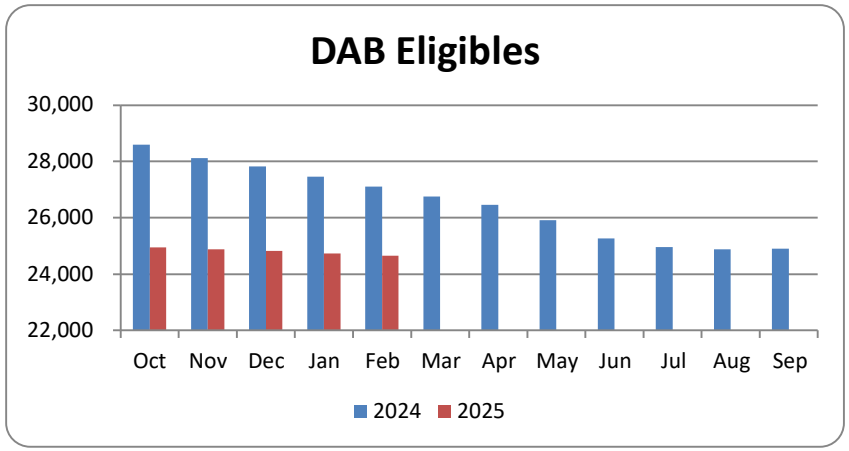



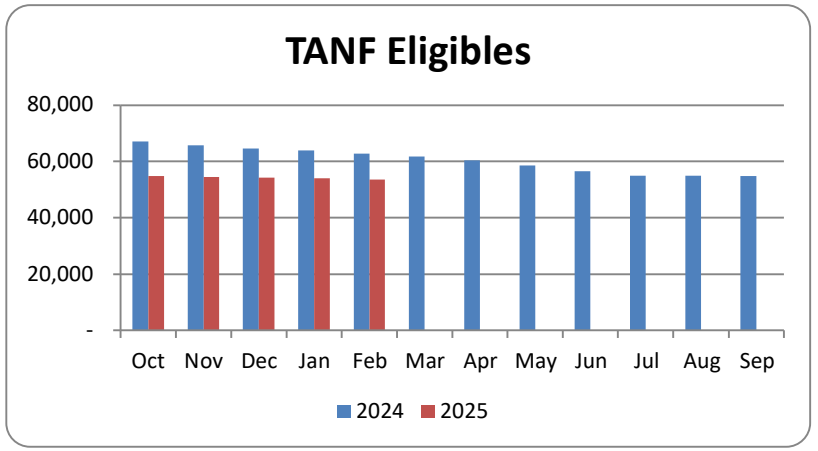
## Northern Michigan Regional Entity

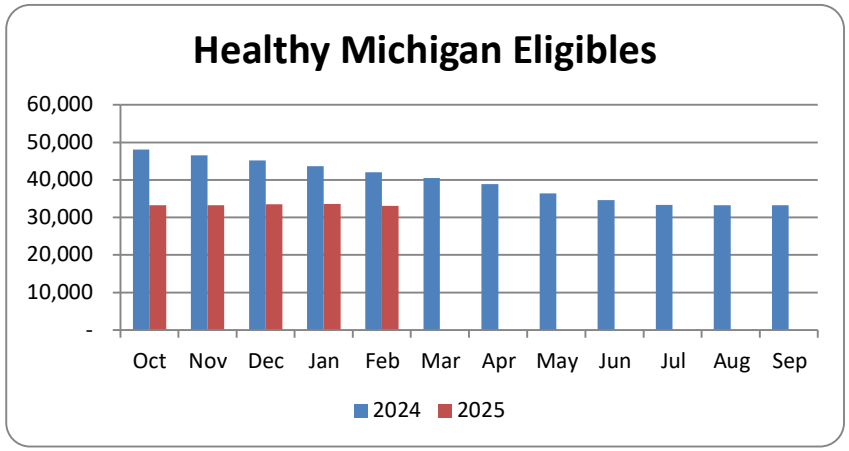
### Narrative

October 1, 2024 through February 28, 2025

### Regional Eligible Trending



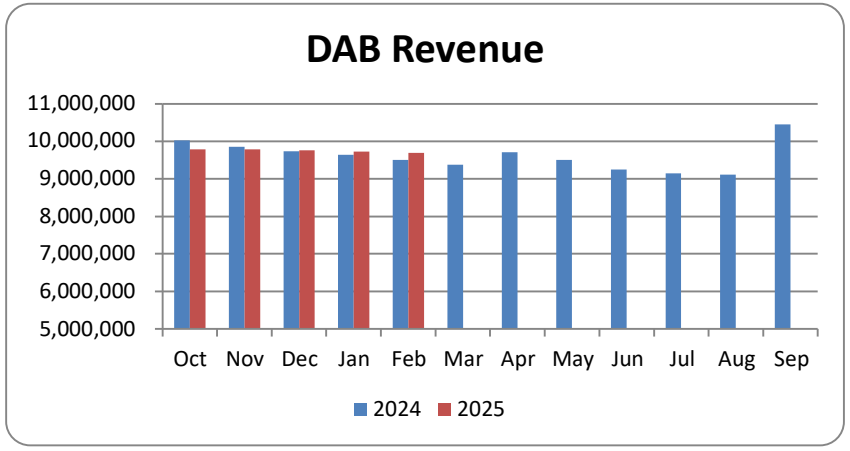



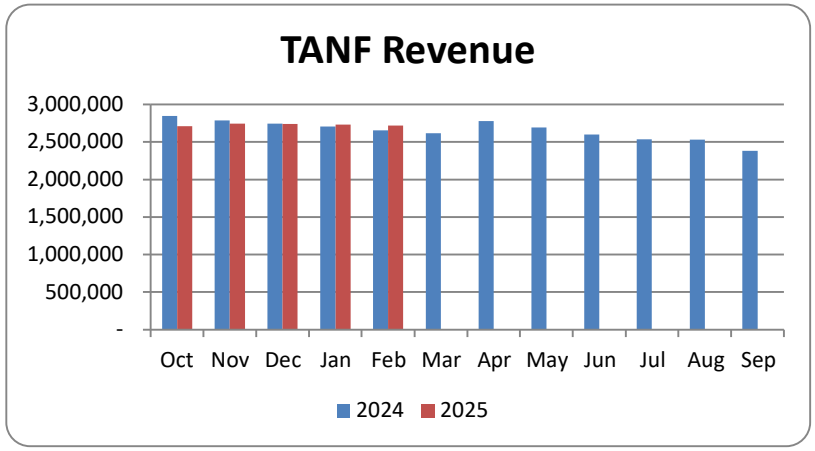
## Northern Michigan Regional Entity

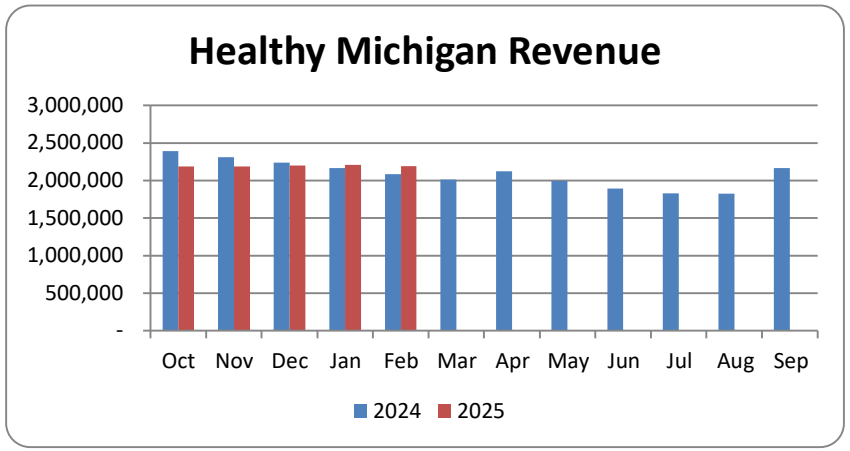
### Narrative

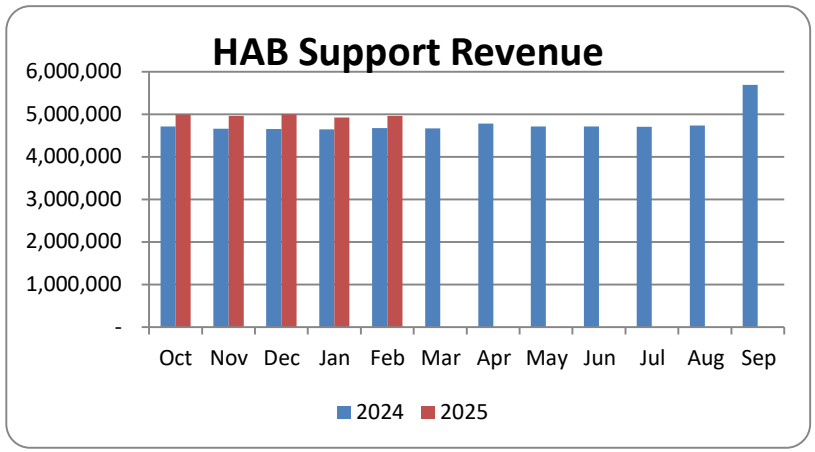
October 1, 2024 through February 28, 2025

### Regional Revenue Trending



**NORTHERN MICHIGAN REGIONAL ENTITY**
**OPERATIONS COMMITTEE MEETING**
**9:30AM – APRIL 15, 2025**
**GAYLORD CONFERENCE ROOM**

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

REVIEW OF AGENDA AND ADDITIONS

Mr. Johnston asked that the group discuss a response to a request by MDHHS that it be given access to the CMHSPs' PCE electronic health records so that MDHHS can review MichiCANS scoring and how it ties into treatment recommendations.

Ms. Pelts requested an update on the CMHSPs' cost containment plans.

RESPONSE TO MDHHS REQUEST FOR ACCESS TO PCE

Ms. Pelts and Ms. Sork responded that Wellvance and Northeast Michigan declined the request from MDHHS. Mr. Johnston indicated that Centra Wellness will be declining the request due to HIPAA concerns.

APPROVAL OF PREVIOUS MINUTES

The minutes from March 18th were included in the meeting materials.

**MOTION BY DIANE PELTS TO APPROVE THE MARCH 18, 2025 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY NENA SORK. MOTION CARRIED.**

FINANCE COMMITTEE AND RELATED

**February 2025 Financial Report**

- Net Position showed a net deficit for Medicaid and HMP of $635,186. Carry forward was reported as $736,656. The total Medicaid and HMP Current Year Deficit was reported as $101,470. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $20,677,626.
- Traditional Medicaid showed $87,603,922 in revenue, and $86,692,238 in expenses, resulting in a net surplus of $911,684. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $11,036,552 in revenue, and $12,583,422 in expenses, resulting in a net deficit of $1,546,870. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $1,417,931 in revenue, and $1,110,977 in expenses, resulting in a net surplus of $306,954.
- SUD showed all funding source revenue of $11,854,303 and $9,175,155 in expenses, resulting in a net surplus of $2,679,148. Total PA2 funds were reported as $4,360,589.

The CMHSPs' total Medicaid and Healthy Michigan Plan (HMP) current year surpluses/(deficits) were provided as:

| | Centra Wellness | North Country | Northeast MI | Northern Lakes | Wellvance |
|---|---|---|---|---|---|
| **Medicaid** | $248,691 | ($1,018,292) | ($204,835) | ($1,784,797) | $939,585 |
| **HMP** | ($272,438) | ($274,991) | ($188,482) | ($1,748,597) | ($201,712) |
| **Total** | ($23,747) | ($1,293,283) | ($393,317) | ($3,533,376) | $737,874 |

Ms. Sork noted that Northeast Michigan is owed approximately $400K in retroactive HSW payments. Missing HSW payments were discussed in greater detail under the following agenda item.

**MOTION BY DIANE PELTS TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR FEBRUARY 2025; SUPPORT BY NENA SORK. MOTION APPROVED.**

**HAB Waiver Payments**

The NMRE received $1,888,658 in retroactive HSW payments on April 9th, which will be paid out to CMHSPs on April 17th. About half of the funds were for FY25 and half for FY24 missed payments. An additional HSW payment is expected on April 17th.

In addition to lost revenue due to missed HSW payments, the migration of individuals from the DAB population to lower paying categories has accounted for a substantial loss in revenue statewide. A DAB analysis prepared by PCE with an executive summary and narrative from NMRE is being sent to the state to address.

**FY25 Revenue/Expenditure Outlook**

An analysis of November 2023 – March 2025 Revenue and Eligibles was included in meeting materials for informational purposes. Current monthly revenue is 3.47% higher than in November 2023. Mr. Kurtz reported that Milliman is considering a mid-year revenue adjustment for FY25 but there are no guarantees.

**Autism Rates**

For services rendered on and after November 1, 2024, the MDHHS reimbursement rate for CPT code 97153 (Behavioral Health Treatment-Applied Behavior Analysis) is a state-directed payment of not less than $16.50 per unit or $66.00 per hour.

The CMHSPs discussed where they stand currently with the implementing the MDHHS-established rate. Centra Wellness staff provide the service directly; therefore, the increased rate is not applicable. Northeast Michigan and Northern Lakes have implemented the rate to the few providers that were not already receiving a rate of $66/hour or above. It was noted that although the state set the $66/hour rate, it has only paid a portion of the funding needed for it to be implemented.

Ms. Pelts reported that Wellvance will not increase rates to the full amount of $66/hour until the full funding has been received.

Mr. Babbitt reported that North Country is applying the $66/hour rate retroactive to November 2024 up to the point at which the funding is expired (approximately 60% of what is required).

During the regional Finance Committee meeting on April 9th, Mr. Kurtz requested that the amounts needed for the CMHSPs to implement the $66/hour rate be sent to his attention.

CCBHC

The topic of CCBHCs was raised during the CMHAM Board meeting on April 11th. CMHSPs who are not participating are being pressured to do so. It was noted that the CCBHC program is fee-for-service, at full risk, and not covered under governmental immunity for the mild/moderate population.

ICSS

The MDHHS proposed policy on Intensive Crisis Stabilization Services was included in the meeting materials. The policy has an expected effective date of July 1, 2025; the comment period is open through May 5th. The policy provides an outline of Intensive Crisis Stabilization Services (ICSS), encompassing the development of regional crisis hubs and clear guidance on community crisis stabilization services, inclusive of mobile crisis. To use Medicaid funds, each ICSS program must receive MDHHS approval through a certification process initially and every three years thereafter.

Mr. Johnston questioned the consequences if a CMHSP chooses not to be certified. He added that crises are treated by the CMHSP's emergency services. It was noted that no additional funding has been allocated to implement the policy.

PBIP

The final report of the FY24 Performance Bonus Incentive Pool payment was included in the meeting materials.

| TOTAL WITHHOLD | TOTAL WITHHOLD UNEARNED | TOTAL DISTRIBUTION OF UNEARNED | TOTAL EARNED |
|---|---|---|---|
| $1,736,971.94 | $21,712.15 | $1,675,416.68 | $3,390,676.47 |

Mr. Kurtz proposed that the NMRE keep the $3,390,676.47 earned to fund 5% of the risk corridor if needed (as PIHPs don't have local funds).

A document showing the CMHSPs' over/(under) PMPM amounts for FY17 – FY24 was sent to committee members during the meeting. Mr. Johnston proposed that the NMRE retain the $1,675,416.68 that was unearned by other PIHPs and distribute $1,693,547.64 to the CMHSPs. It was noted that the $1,675,416.68 retained by the NMRE may be paid to the CMHSPs at a later date.

**MOTION BY CHIP JOHNSTON TO ALLOW THE NORTHERN MICHIGAN REGIONAL ENTITY TO RETAIN ONE MILLION SIX HUNDRED SEVENTY-FIVE THOUSAND FOUR**

**HUNDRED SIXTEEN DOLLARS AND SIXTY-EIGHT CENTS OF PERFORMANCE BONUS INCENTIVE POOL FUNDS FOR FISCAL YEAR 2024 AND DISTRIBUTE THE REMAINING FUNDS TO THE MEMBER COMMUNITY MENTAL HEALTH SERVICES PROGRAMS; SUPPORT BY NENA SORK. MOTION CARRIED.**

FY25 PIHP CONTRACT

The Defendants' request to dismiss the Second Amended Complaint filed by Plaintiffs (NorthCare Network Mental Health Care Entity, Northern Michigan Regional Entity, Community Mental Health Partnership of Southeast Michigan, and Region 10 PIHP), dated April 3, 2025 was included in the meeting materials. A third response by the Plaintiffs will be sent to the judge. The matter will then be up to the court to decide.

NLCMHA UPDATE

Mr. Martinus reported that the CEO search is in progress. The Meyers Group search firm has been surveying Northern Lakes staff and a walk-through is scheduled for April 16th. Mr. Martinus discussed recent appointments to the Northern Lakes Board of Directors.

CMHSP COST CONTAINMENT PLANS

The CMHSPs' Cost Containment Plans are due to the NMRE by May 1st. Mr. Martinus stated that Northern Lakes' plan will be presented to its Board of Directors on April 17th. Mr. Kurtz is collecting plans from the other Boards.

OTHER

- To comply with parity laws, the NMRE is planning to purchase the Managed Care Guidelines (MCG) Indicia/PCE Interface. Implementing the Indicia interface allows users to access the state required tool from within their clinical documentation. Staff will not have to log into a separate system and complete duplicate data entry of basic demographic information. Users will be able to electronically retrieve into their PCE system, the Indicia summary information, which provides enhanced clinical documentation based on evidence-based care guidelines.

- The CMHSPs received an email dated April 14, 2025, stating the need to post the KB Lawsuit on their websites. It was noted that the request included the wording "if applicable," which was left up to the CMHSPs to interpret.

NEXT MEETING

Due to a conflict on May 20th, the next meeting was scheduled for May 13th at 9:30AM.

# MCG Indicia/PCE Interface

## General Overview

In 2019, in preparation for our clients' federal and state mental health parity mandates, PCE developed, and underwent successful certification for an interface with Indicia. Indicia is the clinical decision support tool created by MCG (https://www.mcg.com/how-we-help/ehr-emr-partners/ ) that the PIHPs have contracted to use to ensure behavioral health parity requirements. The interface allows for PCE clients to incorporate the use of the Indicia tool from their PCE system, providing users a more efficient method to utilize the tool. Each year when required by MCG, PCE re-certifies to ensure the latest updates of the product are incorporated into the interface. Our most recent certification is for the **Indicia 12.0 / 24th Edition.**

## Reasons to Implement

Implementing the Indicia interface in your agency's PCE system allows users to access the state required tool from within their clinical documentation. Staff will not have to log into a separate system and complete duplicate data entry of basic demographic information. Users will be able to electronically retrieve into their PCE system, the Indicia summary information, which provides enhanced clinical documentation based on evidence-based care guidelines.

## Description of Functionality

There are three options for implementing the interface within a PCE system:

1. Add an additional screen to crisis/emergency services documentation (e.g. PreScreen, Continued Stay Review, and Hospital Discharge/End of Episode) that includes the links for Indicia. (Note: it is PCE's understanding that the current focus is on inpatient / acute care only. We understand that Indicia may be used in the future for other levels of care. At that time, additional screens with similar functionality may be added to other documentation.)
2. Add an MCG link to the Screening Record List screen. This will allow the user to add an Indicia episode outside of the clinical documentation while still including the Indicia data within the PCE system. Some agencies choose to do a retrospective review using the Indicia tool after the crisis/emergency service episode of care is completed. This MCG link would allow for that option.
3. A combination of option 1 and 2 above. The MCG screen is added to crisis/emergency services documentation allowing Indicia to be used at the time of the emergency service **OR** a user can access the Indicia tool after the service and/or episode of care.

Below is an example of the screen that can be added to crisis/emergency services documentation (option 1 and 3 above) **OR** the screen that is accessed from the MCG link on the Screening History list screen (option 2 and 3 above)


The link in Step 1 opens an Indicia episode and pre-fills, from your system, basic demographic information and current diagnoses for the individual. The user completes all necessary documentation in Indicia, then saves and exits the tool which returns the user back to the screen of the PCE document. The link in Step 2 inserts a *read-only* copy of the Indicia episode summary into the PCE document.

By default, there are no validations in the PCE system to require the use of the Indicia tool. This means that an agency could choose to implement the interface in their PCE system and gradually incorporate the use of it in the workflow. Depending on the workflow and clinical priorities, an agency may also choose to have validations added to the system to require the use of the Indicia tool. Either option is available.

## Pre-Requisite to Implementation

- Staff Training on the Indicia tool, for all applicable users, led by MCG Staff

## Agency Level of Effort

The level of effort is an estimate for the agency to guide decision-making when determining if this feature should be implemented within your PCE system.

Low: Implementation will have little to no impact on staff and will require minimal staff training or communication.

Moderate: Requires staff training but aligns with current process workflows and the estimated burden on the staff is perceived to be minimal.

High: Requires new process workflows within the organization, re-allocating staff or responsibilities, and/or significant staff training.

### Project Management Level of Effort

Project Management refers to level of engagement within the agency needed to implement this feature, such as creating a team, designing workflows, documents, communication efforts and development of Staff training.

Estimated Level of Effort for Project Management – HIGH

### Deployment/Implementation Level of Effort

Deployment/Implementation refers to staff training on workflow (new processes and/or changes in process), and initial and on-going support for the module.

Estimated Level of Effort for Deployment/Implementation – MODERATE

## Agency Decision Points/Responsibilities

If your agency chooses to implement the Indicia interface within your PCE system, the following table with decision points and responsibilities will provide guidance. Please note, these are not necessarily in sequential order. Your implementation team should determine the order in which they are completed. Common implementations or approaches, as applicable, have been provided as example resources.

| Implementation Item | Common Implementation |
|---|---|
| 1. Determine which of the three options your agency will implement. | Option 1 from above |
| 2. Discuss and plan with the MCG staff when and how Indicia training will be conducted, if needed. | Users receive Indicia instruction from MCG staff utilizing the training environment of their agency's PCE system. |
| 3. Discuss and plan with the MCG staff what set up work may be needed in order to provide realistic data for the training and who will be responsible for completing the set up work | This historically has involved extensive data entry set up work needed for every trainee. |
| 4. Determine and develop exact specifications for changes to documentation (including screenshots, if needed) and submit to your PCE Project Manager for programming. | Clients that have chosen Option 1 above most often are adding a MCG/Parity screen to their Pre-Admission Screening document. It is placed after the Provisional Diagnosis screen and before the Disposition screen. There is also a MCG/Parity section added to the Continued Stay Review and End of Episode (discharge) documents after the diagnosis section. |
| 5. Determine if any screen or signature validations need to be programmed into the documents that will be using your PCE system to required Staff to use the Indicia interface; communicate decision and specifications with your PCE Project Manager. | If staff are required to use the Indicia tool, then document signature validations are used. Staff are required to complete Step 1 and 2 on the MCG screen/section of the document in order to sign off on it (which allows it to be billable). Validation should only be considered if all staff providing the service have been trained on Indicia. |
| 6. Discuss and determine with your PCE Project Manager the timing for implementation into a test environment of your PCE system. | Depending on what other outstanding system requests your agency has, the programming changes can usually be completed within a couple of weeks. |
| 7. Discuss and determine with your PCE Project Manager the timing of implementation into the production environment of your PCE system; the 'Go Live' date for the interface | This depends on your agency's ability to provide resources for testing and when your staff have completed MCG training. If no changes are needed from the testing phase, and all training is complete, the interface can be part of the system's next deployment as determined by you and your PCE Project manager. |
| 8. Discuss, determine and execute a communication plan for staff to learn and understand the many facets of the new interface functionality. | Common plans include: Multiple staff emails, training handouts, and agenda time during staff meetings. |

STATE OF MICHIGAN
COURT OF CLAIMS

| | |
|---|---|
| NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY, NORTHERN MICHIGAN REGIONAL ENTITY, REGION 10 PIHP, AND COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN,<br><br>Plaintiffs,<br><br>v<br><br>STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, A MICHIGAN STATE AGENCY, AND DIRECTOR, ELIZABETH HERTEL, IN HER OFFICIAL CAPACITY,<br><br>Defendants. | COC No. 24-000198-MZ<br><br>HON. SIMA G. PATEL |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**DEFENDANTS' 04/03/2025 MOTION FOR SUMMARY DISPOSITION AND BRIEF IN SUPPORT**

NOW COME Defendants, State of Michigan, Michigan Department of Health and Human Services (MDHHS), and Elizabeth Hertel, by and through the undersigned counsel, and hereby move for this Court to dismiss the Second Amended Complaint filed by Plaintiffs, four Prepaid In-Patient Health Plans (PIHPs), NorthCare Network Mental Health Care Entity (NorthCare), Northern Michigan Regional Entity (NMRE), Community Mental Health Partnership of Southeast Michigan (CMHPSM), and Region 10 PIHP (Region 10), under MCR 2.116(C)(5) and (8) for the reasons stated in the accompanying Brief in Support.

Pursuant to Court of Claims Local Rule 2.119(A)(2), Defendants requested opposing counsels' concurrence in the relief sought in this motion on April,1, 2025, and opposing counsel did not acquiesce in the relief sought, thereby necessitating this motion.

Respectfully submitted,

*/s/ Heather L. Sneden*
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Dated: April 3, 2025

## BRIEF IN SUPPORT OF DEFENDANTS' 04/03/2025 MOTION FOR SUMMARY DISPOSITION

## INTRODUCTION

This case boils down to a simple contract dispute. Specifically, Plaintiffs are four entities that formerly contracted with MDHHS to provide PIHP services. But Plaintiffs declined to sign the fiscal year 2025 (FY25) Contract by the required deadline. As a result, the fiscal year 2024 (FY24) Contract expired, and Plaintiffs are currently operating under the FY24 Contract transition clause. Now, rather than accept the consequences of their decision, Plaintiffs—which serve less than one-third of Michigan's PIHP service recipients—filed this suit. Relying on references to inapplicable law and mischaracterizations of fact, Plaintiffs falsely allege a termination of their contractual relationship with MDHHS and ask this court to strike provisions from the unsigned FY25 contract. They also argue that they are not required to follow certain aspects of the FY24 Contract because it is illegal and that MDHHS must continue funding without a contract and provide notice and a hearing.

Plaintiffs' claims fail for three reasons. First, all claims pertaining to the FY25 Contract fail because Plaintiffs are not a real party in interest, or have standing, to challenge the FY25 Contract or any other future contracts. Second, Plaintiffs' FY24 Contract claims for declaratory relief fail because Plaintiffs are required to abide by FY24 Contract transition clause and Medicaid policies thereby failing to state a legal claim. Third, because there is no actual controversy or clear legal duty for MDHHS to continue funding without a contract or provide notice and a hearing, Plaintiffs' claims for declaratory relief and for mandamus should be denied. Accordingly, Plaintiffs' Second Amended Complaint is ripe for dismissal.

## STATEMENT OF FACTS

**MDHHS selects and contracts with PIHPs thereby providing them funding for predicted costs of services.**

Medicaid, a jointly funded federal-state program, provides reimbursement for covered healthcare services for eligible individuals. 42 USC § 1396, *et seq*.; MCL 400.1, *et seq*. In Michigan, MDHHS is the "single state agency" charged with administering the Medicaid program. 42 USC § 1396a(a)(5). Under approval by the federal Centers for Medicare and Medicaid Services (CMS), MDHHS operates a 1115 Behavioral Health Demonstration Waiver. (2d Am Compl, Ex B, FY24 Contract, Schedule A, p 29.) Under this waiver, selected Medicaid State plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been "carved out" from traditional Medicaid physical health care plans and arrangements. (*Id*.) Pursuant to MCL 400.109f, MDHHS selects and contracts with PIHPs to provide these "carved out" specialty services. Under the contract, MDHHS provides funds to PIHPs as a capitated payment based upon a per eligible per month methodology. (2d Am Compl, Ex B, FY24 Contract, p 105.) In essence, this means that MDHHS estimates and prepays the amount PIHPs will need to fund future Medicaid services to recipients within their geographic region. (*Id*. at 101–102.) PIHPs, in turn, contract with local community mental health services programs (CMHs) to deliver services. (2d Am Compl, ¶¶ 15–39.)

**The parties' contract expired after Plaintiffs chose not to sign the FY25 Contract.**

PIHP contracts are subject to annual renewals on a fiscal year calendar. (See 2d Am Compl, Ex B, FY24 Contract, p 4.) The FY24 Contract was effective October 1, 2023 and expired on September 30, 2024. (*Id.*) Negotiations began in 2024 regarding the terms of the FY25 Contract. But after months of discussions, Plaintiffs declined to sign the FY25 Contract as

proposed by MDHHS. (2d Am Compl, ¶¶ 54–56.) The period for PIHPs to sign the FY25 Contract closed on October 31, 2024. (*Id.* at ¶ 56.) But under the terms of the FY24 Contract, the Plaintiffs are obligated to continue their responsibilities to provide services until the end of an up-to-two-year transition period. (*Id.* at Ex B, FY24 Contract, p 10.)

**Plaintiffs initiate the instant declaratory and mandamus action.**

On January 13, 2025, Plaintiffs filed their First Amended Complaint alleging six counts. In response, Defendants filed a Motion for Summary Disposition on February 7, 2025. Thereafter, the parties stipulated to allow Plaintiffs to file a Second Amended Complaint. On March 6, 2025, Plaintiffs filed their Second Amended Complaint updating the six counts to: (1) declaratory relief regarding the Internal Service Fund (ISF) limit in the FY24 and FY25 Contracts; (2) declaratory relief regarding the *Waskul* Settlement provision in the FY25 Contract; (3) declaratory relief regarding Certified Community Behavioral Health Clinics (CCBHCs) (Plaintiffs CMHPSM and Region 10); (4) violation of the Headlee Amendment and MCL 21.235 regarding CCBHCs (Plaintiffs CMHPSM and Region 10); (5) declaratory relief for MDHHS to continue Medicaid and SUDHH funding absent a contract and provide a hearing prior to sanctioning and terminating the relationship; (6) writ of mandamus to force MDHHS to continue Medicaid and SUDHH funding in the absence of a contract and provide a hearing prior to sanctioning and terminating the relationship. (2d Am Compl, ¶¶ 141–179.)

## STANDARD OF REVIEW

MCR 2.605 provides that courts may declare the rights and other legal relations of an interested party in a case of actual controversy. MCR 2.605(A)(1). Mandamus is appropriate "[w]here an official has a clear legal duty to act and fails to do so." *Jones v Dep't of Corrections*, 468 Mich 646, 658 (2003).

MCR 2.116(C)(5) allows for summary disposition where the party asserting the claim lacks the legal capacity to sue. *Pontiac Police & Fire Prefunded Group Health & Ins Trust Bd of Trustees v Pontiac No 2*, 309 Mich App 611, 619 (2015). A motion brought under MCR 2.116(C)(8) tests the legal sufficiency of a claim. *Mays v Governor*, 506 Mich 157, 173 (2020). If a plaintiff's allegations fail to state a legal claim, summary disposition pursuant to MCR 2.116(C)(8) is appropriate. *Radtke v Everett*, 442 Mich 368, 373 (1993).

## ARGUMENT

### I. All FY25 Contracts, and any other future contract claims, should be dismissed because Plaintiffs are not the real party in interest and lack standing.

To be abundantly clear, MDHHS *never terminated* a FY25 Contract between the parties. Plaintiffs' allegations hinge on *failed negotiations* between the parties as to the FY25 Contract. And because MDHHS could not change contractual requirements to Plaintiffs' preferred contract terms, Plaintiffs filed suit asking the Court to strike FY25 Contract provisions as void. But there is no enforceable FY25 Contract, so Plaintiffs' claims pertaining to that contract, or any future contracts, must be rejected.

Here, Plaintiffs are not a real party in interest to assert any claims of injury flowing from the FY25 Contract or any other future contracts. MCR 2.201(B) provides that "[a]n action must be prosecuted in the name of the real party in interest. . . ." The real party in interest is a party who is vested with a right of action in a given claim, although the beneficial interest may be with another. *In re Beatrice Rottenberg Living Trust*, 300 Mich App 339, 356 (2013). Plaintiffs must assert their own legal rights and cannot rest their claims on the rights or interests of third parties. *Barclae v Zarb*, 300 Mich App 455, 483 (2013). Once again, Plaintiffs never signed the proposed FY25 Contract. Thus, Plaintiffs are not a real party in interest as to FY25 Contract or any future contracts. (2d Am Compl, Ex A, Unsigned FY25 Contract, p 2); *Stillman v Goldfarb*,

172 Mich App 231, 251 (1988) (no real party in interest status when plaintiff had no contract with defendant).

In addition, Plaintiffs' FY25 Contract claims should be dismissed pursuant to MCR 2.116(C)(5) as Plaintiffs lack standing and legal capacity to sue Defendants. Nor do Plaintiffs have standing based upon future contracts to which they are not a party. (2d Am Compl, ¶ 139.) The "purpose of the standing doctrine is to assess whether a litigant's interest in the issue is sufficient to ensure sincere and vigorous advocacy." *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 355 (2010) (citation omitted). Here, Plaintiffs lack standing to sue Defendants on the FY25 contractual agreement between MDHHS and five *other* PIHPs which did sign the FY25 Contract. (2d Am Compl, Ex A, Unsigned FY25 Contract, p 2); MCR 2.116(C)(5); *UAW v Cent Michigan Univ Trustees*, 295 Mich App 486, 496 (2012) (no standing to challenge draft procedures as "speculative and hypothetical"); *Mate v Wolverine Mut Ins Co*, 233 Mich App 14, 24 (1999) (third parties lack standing to reform contract). Consequently, there is no actual controversy, and MCR 2.605(A)(1) prevents courts from deciding hypothetical issues, as is the case here. Thus, Plaintiffs' claims (part of Count I and possibly Counts II, III, IV) should be dismissed related to the FY25 Contract and any other future contracts pursuant to MCR 2.116(C)(5) and (8), as Plaintiffs are not the real party in interest and for lack of standing, as Plaintiffs are without the legal capacity to sue Defendants.

## II. All claims pertaining to the FY24 Contract should be dismissed under MCR 2.116(C)(8) as Plaintiffs fail to state a claim on the merits.

Since Plaintiffs are not a real party in interest and lack standing to challenge the FY25 Contract, their claims are limited to the FY24 Contract transition clause. But even under the FY24 Contract, dismissal would still be appropriate because Plaintiffs' arguments challenging the contractual provisions are entirely without merit. Accordingly, Plaintiffs are not entitled to

declaratory relief under the FY24 Contract for multiple reasons. First, the FY24 Contract unambiguously limits the ISF to 7.5% on annual contributions and account balances for future liabilities based on actuarial soundness, principles, and practices in compliance with federal law. Second, Plaintiffs are required to abide by the *Waskul* Settlement provisions under the FY24 Contract and Medicaid policy in compliance with federal law. Third, the two Plaintiffs bringing claims regarding the CCBHC program fail to state a claim that Defendants increased responsibilities with inadequate funding and that they do not have to abide by the current CCBHC Handbook. Thus, all FY24 Contract claims should be dismissed pursuant to MCR 2.116(C)(8).

### A. The plain language of the FY24 Contract is unambiguous; it limits the ISF annual contributions and account balance based on actuarial soundness, principles, and practices that comply with federal regulations.

In Count I, Plaintiffs raise three separate challenges to FY24 Contract ISF, alleging: (1) the contract does not contain a 7.5% limit on the amount that can be annually contributed or the balance present in an ISF account; (2) the ISF limit violates federal law, accounting standards and is not actuarially sound; and (3) the ISF limit can be used for prior deficits and any restriction on the use violates federal law. (2d Am Compl, ¶¶ 60–95, 141–146.) Plaintiffs' request for declaratory relief should be dismissed as the challenges to the ISF are without merit. Several FY24 contractual mechanisms exist to mitigate the overall financial risk for PIHPs. One such mechanism is the ISF. "An ISF account is like a savings account or reserve account, established for the purpose of securing funds necessary to meet expected risk corridor financing requirements...." (2d Am Compl, ¶ 64.) However, to ensure Medicaid funds are primarily allocated for beneficiary services, the ISF account is limited to 7.5% of PIHP's total risk exposure. The FY24 Contract has multiple provisions that reference the ISF, including limitations on the amount transferred and maintained and risk corridor of up to 7.5% for each.

Plaintiffs argue that these limitations violate federal law. For these reasons, discussed in more details below, Count I should be dismissed.

**1. The plain language of the FY24 Contract limits ISF annual contributions and account balance maintained to 7.5%.**

Plaintiffs argue the FY24 Contract does not limit the ISF annual contribution or account balance to 7.5% of their total capitation payments. (2d Am Compl, ¶¶ 70–74.) This Court should decline to allow such an unreasonable result on MDHHS, which is tasked with protecting Medicaid beneficiaries and the limited funds allotted by the federal government. In support of their position, Plaintiffs cite to two sentences in the FY24 Contract: "Contractor may transfer Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization to the ISF in any given year. Contractor may not transfer any funds in excess of that percentage to the ISF in any year." (*Id.* at ¶ 70 (citing Ex B, p 110).) While it is true that this language limits yearly contributions and not the ISF balance at any given time, it is not the end of the analysis. Contrary to well established legal precedent, Plaintiffs turn a blind eye to the remaining contractual provisions against their position. *Smith v Smith*, 292 Mich App 699, 702 (2011) (internal citation omitted) (contracts must be read and construed as a whole). In fact, Plaintiffs' interpretation directly disregards the remaining terms of the FY24 Contract. Such an isolated reading would result in an absurd conclusion that the remainder of the contract would be invalid. See *Hastings Mut Ins Co v Safety King, Inc,* 286 Mich 287, 297 (2009).

Elsewhere in the FY24 Contract, the parties agreed that Plaintiffs "must be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted." (2d Am Compl, Ex B, p 103.) Additionally, Plaintiffs are "responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted." (*Id*.) The combined effect

of these provisions mandates that Plaintiffs, and not the State, are financially responsible for 107.5% of their liabilities (meaning Plaintiffs are responsible for 100% of the liabilities up to the total amount of capitation payments MDHHS made to them during a fiscal year, as well as 7.5% of additional liabilities). Only after Plaintiffs have met this financial responsibility is the State responsible for liabilities under the FY24 Contract beyond what the State already paid in capitation payments. (*Id*.) Thus, the plain language of the FY24 Contract limits the amount to 7.5% that can be *contributed* and *present* in an ISF account, rather than allowing Plaintiffs to stock pile funds in their ISF accounts (which the purpose of these *limited Medicaid funds* is to be spent on vital behavioral and mental health services for beneficiaries) by contributing 7.5% of their annual operating budgets *each year*.

**2. The FY24 Contract ISF limit is actuarially sound and complies with accounting standards and federal law.**

Next, Plaintiffs contend that the FY24 Contract 7.5% ISF account balance limit is not actuarially sound in violation of 42 CFR § 438.4(a), which requires actuarially soundness, and 42 CFR § 438.6(b)(1), which requires that all risk sharing mechanisms be developed in accordance with generally accepted actuarial principles and practices. (2d Am Compl, ¶¶ 66–78; 82–87.) Here, Plaintiffs point to 2 CFR Pt. 100, App V to advance their argument.[1] Plaintiffs argue that this regulation allows for a working capital reserve of 60 calendar days, equal to an ISF limit of 16.4%, which is more than the 7.5% ISF limit provided for in the FY24 Contract. (*Id.* at ¶¶ 65–66.) But this argument entirely misses the point. 2 CFR Pt. 100 has nothing to do with an ISF

[1] Plaintiffs refer to an independent review of Plaintiff NorthCare's ISF account that it "…*should be* funded to 12.3%." (2d Am Compl, ¶¶ 85–86.) (emphasis added.) But this independent review does not state the 7.5% limit is not actuarially sound. In addition, Plaintiffs also claim that MDHHS waived its position on the 7.5% limit by accepting two of Plaintiffs' Risk Management Strategies. (2d Am Compl, ¶¶ 76–78.) However, any acceptance by MDHHS is not an admission that the 7.5% limit is not actuarially sound.

limit, because the 7.5% ISF limit at issue here is not a "working capital reserve" for Plaintiffs' operation from one billing cycle to the next. Rather, as outlined below, the FY24 Contract ISF is intended to pay for *future* liabilities. Aside from their own reference to 2 CFR Pt. 100, there is simply no indication that this regulation is intended to apply to any provisions in the FY24 Contract. Moreover, Plaintiffs argue that the 7.5% ISF limit violates GASB Statement No. 10 because the FY24 Contract prohibits Plaintiffs from using ISF funds to pay for services rendered in previous years. (*Id.* at ¶¶ 92–94) (citing GASB Statement No. 10: "Deficits, if any, in the internal service fund…do not need to be charged back to the other funds in any one year, as long as adjustments are made over a reasonable period of time."). But Plaintiffs fail to acknowledge that GASB Statement No. 10 does not mandate *how* an ISF is used, rather it provides permissive language that deficits *can* be funded over a reasonable period. Importantly, nothing in GASB Statement No. 10 *prohibits* future use of the ISF funds. Instead, that requirement is dictated by the FY24 Contract, which expressly requires that the ISF be established for future liabilities. See Section II.A.3; (2d Am Compl, Ex B, FY24 Contract, Schedule A, p 101).

Plaintiffs' argument that the ISF limit violates 42 CFR § 438.6(c)(1) is similarly flawed. (*Id.* at ¶¶ 89, 94–95.) Here, Plaintiffs stretch the plain meaning of § 438.6(c)(1) to fit within their desired outcome. That federal regulation provides that the State may not direct contracting PIHP *expenditures*. However, the FY24 Contract, including the ISF limit, does not direct PIHPs *what* to pay for services; rather it sets forth a maximum amount that may be held in the ISF. Nor does the FY24 Contract dictate *which* CMHs the contracting PIHPs use or the providers that offer services. This regulation, therefore, does not render the ISF limit invalid.

Finally, Plaintiffs assert that they are entitled to notice and hearing regarding FY24 bonus payments. (2d Am Compl, ¶¶ 76–80.) Plaintiffs rely on an email wherein MDHHS notified

PIHPs that if their FY24 ISF balances were greater than 7.5% of the annual operating budgets, MDHHS would reject the submissions, and any rejected submission would be considered late for bonus payments. (2d Am Compl, ¶ 76.) Plaintiffs allege that this is a sanction because MDHHS would issue a financial penalty even though the Contract only limits annual contributions and balances. To the contrary, the FY24 Contract Performance Bonus is not an entitlement. Instead, this Performance Bonus is an award to support program initiatives based on yearly metrics which determines the amount received by each PIHP. (2d Am Compl, Ex B, FY24 Contract, pp 110–111.) Because any action by MDHHS related to the bonus payment is not associated with any promulgated rule, standard, or federal requirement, Plaintiffs are not entitled to notice and a hearing. See MCL 330.1232b(6). And pursuant to MCL 330.1232b(5), failure to pay a bonus is not a "sanction" which includes "a monetary *penalty* imposed on the administrative and management operation" of PIHPs (emphasis added). Moreover, this bonus structure is entirely consistent with the language in the FY24 Contract limiting the ISF to 7.5%. See Section II.A.1.

Additionally, from a practical perspective, Plaintiffs' argument falls short because PIHP contracts must be reviewed and approved by CMS. Here, Plaintiffs cannot and do not challenge the fact that CMS reviewed and approved the FY24 Contract. Accordingly, the agency that is responsible for creating and administering the regulations Plaintiffs rely on found the FY24 Contracts followed relevant federal laws and regulations.

**3. MDHHS is not illegally directing the use of PIHP Medicaid expenditures with the contractual requirement that ISF can only be used to finance future liabilities.**

Lastly, Plaintiffs dispute whether the ISF can be used to fund prior deficits. Plaintiffs further argue that MDHHS is illegally directing their use of Medicaid expenditures by not allowing the ISF to pay for services rendered during previous years. (2d Am Compl, ¶¶ 90–95.)

But to the contrary, MDHHS is not directing any PIHP Medicaid expenditures. Indeed, Plaintiffs agreed to this shared risk arrangement under the FY24 Contract. (2d Am Compl, ¶ 60.) And the plain language of the FY24 Contract provides that contractors are expressly limited to use the ISF for *future* liabilities:

> The purpose of the ISF is to ensure that Contractor has a reserve of funds to pay any liabilities that Contractor may incur in a future year that are in excess of the 100% of the risk-corridor-related operating budget . . . *Contractor may not use funds in the ISF to pay liabilities incurred in the previous years*.

(2d Am Compl, Ex B, FY24 Contract, Schedule A, p 101) (emphasis added).

Under the FY24 Contract, Plaintiffs maintain all Medicaid risk up to the total capitation revenue from MDHHS. The ISF is used to cover Medicaid shortfalls to the extent a Plaintiff enters the risk corridor. But Plaintiffs cannot simply negate their risk calculation after funding current year shortfalls or deficits. The risk corridor section further elucidates this requirement, stating contractors must return unexpended risk corridor related funds over 7.5%. (*Id.* at p 103.) Importantly, like the capitated payments that Plaintiffs receive, Plaintiffs' potential liabilities are similarly prospective, based on the very nature of the funding methods and risk arrangements under the FY24 Contract. This structure serves as the entire basis of the shared-risk contracts that utilize a risk corridor.

Again, the FY24 Contract does not direct PIHP Medicaid expenditures on *what* to pay for services; rather it sets the requirement that the ISF can be used to pay for future liabilities. Nor does the FY24 Contract dictate *which* CMHs the contracting PIHPs use or the providers that offer services. This regulation, therefore, does not render this FY24 Contract requirement of limiting the ISF to paying for future liabilities invalid. See II.A.2. Accordingly, there is no active case or controversy about the ISF terms and declaratory relief should be denied. See MCR 2.116(C)(8); (2d Am Compl, ¶ 60).

### B. Plaintiffs fail to state a claim as to compliance with the *Waskul* Settlement.

*Waskul, et al v Washtenaw Cnty Comm Mental Health, et al*, Case No. 16-cv-10936 (*Waskul* Settlement), was settled in the Eastern District of Michigan. Here, in Count II, Plaintiffs challenge having to comply with the *Waskul* Settlement under the FY24 transition clause for three reasons: (1) the *Waskul* Settlement violates 42 CFR § 438.6 because it improperly directs PIHP expenditures; (2) none of the Plaintiffs are parties to the *Waskul* Settlement; and (3) because the *Waskul* Settlement violates federal law, Defendants' attempts to require Plaintiffs' to abide by the *Waskul* Settlement, including labeling "Medicaid policy" or via provisions in the FY24 Contract, are void. (2d Am Compl, ¶¶ 107–117.) But all of Plaintiffs' challenges fail and their request for declaratory relief should be denied.

First, Plaintiffs' claim that the *Waskul* Settlement violates 42 CFR § 438.6 is without merit. Plaintiff CMHPSM made this same argument in objection to the *Waskul* Settlement, and the federal court judge approved the settlement over those objections. Nothing in the *Waskul* Settlement directs PIHPs what to pay for *services*; rather it sets forth a statewide minimum rate that must be used in calculating certain portions of beneficiaries' self-determination budgets. (2d Am Compl, Ex D, Settlement Agreement, pp 13–29.) Nor do (or can) Plaintiffs point to anything showing CMS finds the *Waskul* Settlement runs afoul of 42 CFR § 438.6.

Second, the fact that none of the Plaintiffs are parties to the *Waskul* Settlement is irrelevant. PIHPs have no authority to pick and choose which of MDHHS's Medicaid policy decisions they will follow. 42 CFR § 431.10(e); (2d Am Compl, Ex B, FY24 Contract, p 71).

Third, Plaintiffs' argument that Medicaid policy resulting from the *Waskul* Settlement violates the Administrative Procedures Act (APA), MCL 24.201, *et seq.*, also falls flat. MDHHS is solely responsible for developing Medicaid policy as the single state agency in charge of

Michigan's Medicaid program. 42 CFR § 431.10(e). Michigan law is clear that formal rulemaking is not required for Medicaid Provider Manual policies (MPM). Michigan's APA and Mental Health Code (MHC) have provisions that mirror one another in that regard. MCL 24.207(o); MCL 400.6(4). Specifically, MCL 24.207(o) excludes from the definition of a "rule" any policy developed by MDHHS under MCL 400.6(4) to implement requirements that are mandated by federal statute or regulations as a condition of receipt of federal funds. MCL 400.6(4) allows MDHHS, without going through formal rule promulgation procedures, to adopt policies to implement requirements that are mandated by federal statute or regulations as a condition of receipt of federal funds.

It also bears noting that every policy provision of the *Waskul* Settlement implements a Medicaid statute or regulation setting forth a condition of receipt of federal Medicaid funds that Michigan follows those provisions in the Social Security Act. 42 USC 1396a; 42 USC 1396b; 42 USC 1396c; 42 USC 1396n(c)(2)(A), (C). Accordingly, MPM policy amendments are exempt from formal rulemaking, yet they are still effective and binding on those affected by the program including Plaintiffs. MCL 400.6(4). As a condition of receiving state and federal funding under the FY24 Contract transition clause, Plaintiffs must comply with all MPM policies. Therefore, Plaintiffs have failed to state a claim that the terms of the *Waskul* Settlement are invalid. See MCR 2.116(C)(8). And since there is no active case or controversy about its terms, declaratory relief should be denied.

### C. Plaintiffs' CMHPSM and Region 10 fail to state a Headlee Amendment claim.

In Counts III and IV, Plaintiffs CMHPSM and Region 10 claim that MDHHS is shifting additional responsibilities onto them under the FY24 Contract for administering the CCBHC program without providing additional funding in violation of the Headlee Amendment, Const

1963, art 9 §§ 25, 29, MCL 21.235, and the APA. (2d Am Compl, ¶¶ 153–164.) But Plaintiffs mischaracterize the actuarial findings and law, both of which directly contradict these assertions.

First, Plaintiffs fail to state a claim in violation of Headlee Amendment, Const 1963, art 9, § 25, because that constitutional provision cannot be independently enforced. *Taxpayers for Michigan Const Gov't v Dep't of Tech, Mgmt & Budget*, 508 Mich 48, 63 (2021) ("…§ 25 of the Headlee Amendment is a preface meant to provide context to the amendment as a whole, not an independent statement of a substantive right.").

Second, "Headlee, at its core is intended to prevent attempts by the Legislature to *shift* responsibility for services to the local government . . . in order to save the money it would have had to use to provide the services itself." *Adair v State*, 470 Mich 105, 112 (2004) (internal quotations omitted) (emphasis added). MCL 21.235 requires the legislature to appropriate enough funds necessary to implement state requirements. But here, any change to the CCBHC administrative duties in the FY25 Contract was simply to *clarify* responsibilities, but did not *shift* or require *additional* responsibilities of the participating PIHPs. And despite Plaintiffs' conclusory allegations, the claim that they are not receiving adequate funding is simply wrong. This is directly confirmed by Milliman's actuarial report, which provides, "[m]any of the PIHP responsibilities for the CCBHC Demonstration are currently being performed as part of the existing program. . . . [W]e have reviewed the historical administrative expenditures reported in the EQI reports and *have not included any increase* to the variable administrative percentages *based on this data.*" (2d Am Compl, Ex E, p 46) (emphasis added).

Third, Plaintiffs' argument that the CCBHC Handbook is illegal because it does not comply with the APA also fails. MCL 330.1232b(1) requires MDHHS to establish standards for CMHs designated as PIHPs under MCL 400.109f. Those standards must be published in a

departmental bulletin or by an updating insert to a department manual. MCL 330.1232b(1). CCBHC demonstration program standards are published in the CCBHC Handbook. As such, as "a condition for contract and for receiving payment under the Medicaid manage care program," MCL 330.1232b(2), a CMHSP designated as a PIHP shall certify that it is in substantial compliance with those standards and with applicable federal regulations, and that the program has established monitoring and compliance standards to ensure program integrity.

Finally, when Plaintiffs signed the FY24 Contract, they agreed to implement the CCBHC Demonstration in accordance with Section 223 of the Protecting Access to Medicare Act of 2014 and follow the most current version of the CCBHC Demonstration Handbook. (2d Am Compl, Ex B, 14, pp 47–48, 71.) Therefore, Plaintiffs CMHPSM and Region 10 fail to state a claim as there is no active case or controversy, and declaratory relief should be denied.[2]

## III. Counts V and VI fail because there is no actual controversy or clear legal duty, and MDHHS is not required to fund Plaintiffs or provide notice and a hearing in the absence of a contract.

Again, no contract was terminated. To that end, there is no actual controversy or clear legal duty requiring MDHHS to continue to provide funding to Plaintiffs, or notice and a hearing, in the absence of a contract. Accordingly, Plaintiffs' Counts V and VI seeking declaratory and mandamus relief must fail.

A declaratory judgment must be "needed to guide a party's future conduct in order to preserve that party's legal rights." *League of Women Voters of Michigan v Secretary of State*, 506 Mich 561, 586 (2020). An "actual controversy" under MCR 2.605(A)(1) exists when a declaratory judgment is necessary to guide a plaintiff's future conduct in order to preserve legal rights. Here, Plaintiffs seek a declaration that MDHHS must continue to provide Medicaid and

[2] To the extent Plaintiffs allege tort liability, Defendants are immune under MCL 691.1407.

SUDHH funding in the absence of a contract pursuant to the MHC and the Social Welfare Act (SWA) and seek injunctive relief prohibiting Defendants from cutting off funding without an end. (2d Am Compl, ¶¶ 161; 169–174.) In addition, Plaintiffs want a declaration that MDHHS provide notice and a hearing prior to terminating the relationship. Defendants agree under the FY24 Contract transition provision, the parties are obligated to continue their responsibilities to provide services and funding until the end of the up-to-two-year transition period. (*Id*. at Ex B, FY24 Contract, p 10.) But upon the expiration of the transition period, neither party has any contractual obligations, and MDHHS is not required to provide notice or a hearing. Thus, there is no actual controversy.

Michigan law supports this conclusion because there are no requirements in the MHC or the SWA that MDHHS must continue to contract with Plaintiffs. The MHC provides MDHHS with broad authority to provide mental health services. MCL 330.1116(2)(e). This broad authority extends to the SWA, which states that "Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans *chosen* by the department." MCL 400.109f (emphasis added). Because this statutory language is unambiguous, judicial construction is not required or permitted. *Petersen v Magna Corp,* 484 Mich 300, 307 (2009) (citation omitted). While Plaintiffs can operate as PIHPs with the power to contract with MDHHS, MDHHS is not required to choose them. MCL 330.1204b(1); MCL 330.1204b(2)(b); MCL 400.109f. Thus, there is no legal duty for MDHHS to continue Medicaid and SUDHH funding in the absence of a contract.

Likewise, there is no actual controversy as to the issue of notice and a hearing prior to contract termination. Plaintiffs' arguments rely on mischaracterization of their unilateral modifications of the three FY25 Contract provisions and signing as termination of a contract

even though MDHHS did not countersign. (2d Am Compl, ¶ 3.) However, "[s]imply put, one cannot unilaterally modify a contract because by definition, a unilateral modification lacks mutuality. *Quality Prods & Concepts Co v Nagel Precision, Inc,* 469 Mich 362, 373 (2003). And now Plaintiffs further allege that the MHC does not support annual contracts because Plaintiffs' relationship can only be terminated under the procedures set forth in MCL 330.1232b entitling them to a hearing. MCL 330.1232b(5); MCL 330.1232b(6). Such an interpretation would produce an absurd result where MDHHS would be required to provide notice and a hearing before "terminating" negotiations on a proposed contract. See *People v Reed*, 294 Mich App 78, 84 (2011). ("[S]tatutes should be construed so as to avoid absurd results.") Here, Plaintiffs are conflating termination—a permissible contract sanction to address outstanding contract violations or performance concerns—with the expiration of the FY24 Contract term. (2d Am Compl, Ex B, FY24 Contract, p 35.) But the expiration of the FY24 Contract is not a sanction. And since MDHHS did not sanction Plaintiffs, MDHHS has no legal duty to provide notice and a hearing. Thus, any claims for declaratory relief beyond the transition period or related to false allegations of a contract termination should be dismissed pursuant to MCR 2.116(C)(8).

Not only does Plaintiffs' request for declaratory relief fail, but any claim of mandamus similarly fails. Plaintiffs assert they are entitled to a writ of mandamus because MDHHS has a "non-discretionary" duty to continue funding Plaintiffs even in the absence of a signed contract and that MDHHS is to supply Plaintiffs with a hearing prior to issuing a sanction or terminating their relationship. (2d Am Compl, ¶¶ 175–179.) But without any legal requirement under the MHC or the SWA to continue to provide funding to Plaintiffs in the absence of a contract, MDHHS has no legal duty to which to adhere. MCL 400.109(f)(1), MCL 330.1116; MCL

330.1202(1) MCL 330.1204b(2). See *Jones*, 468 Mich at 658 (where an official has a clear legal duty to act and fails to do so mandamus is appropriate). Further, Plaintiffs are not entitled to notice or a hearing. The clear language of MCL 330.1232b(5) supports a process that MDHHS provide notice and a hearing when "…it makes a determination that a specialty prepaid health plan is not in substantial compliance with promulgated standards and with established federal regulations..." Here, a hearing would be moot, because MDHHS did not sanction Plaintiffs with termination of a contract for not being in substantial compliance. *Ziegler v Brown*, 339 Mich 390, 395 (1954) (internal citation omitted) (mandamus should be denied where the question is moot and the granting of writ of mandamus would serve no purpose). Thus, Plaintiffs' claims for declaratory and mandamus relief should be dismissed pursuant to MCR 2.116(C)(8), as there is no actual controversy and no clear legal duty to do what Plaintiffs request.

**CONCLUSION AND RELIEF REQUESTED**

Defendants respectfully request that the Court grant their motion for summary disposition, dismiss the case with prejudice, and grant Defendants such relief as the Court deems just and appropriate.

Respectfully submitted,

*/s/ Heather L. Sneden*
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