Northern Michigan Regional Entity

Board Meeting

February 25, 2026

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 – January 28, 2026	Pages 2 – 15
7.	Correspondence	Pages 16 – 57
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – February 2026	Page 58
	c. Financial Report – December 2025	Pages 59 – 80
	d. Operations Committee Report – February 17, 2026	Pages 81 – 85
	e. NMRE SUD Oversight Board Report – Next Meeting is March 2nd	
11.	New Business	
	a. Nominating Committee	
12.	Old Business	
	a. CMHSP Updates	
	b. Legal Actions Related to PIHP Bid Out	
13.	Presentation	
	NMRE Regional Health Homes	Pages 86 – 101
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – March 25, 2026 at 10:00AM	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – JANUARY 28, 2026
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Dave Freedman, Ed Ginop, Ron Iseler, Dana Labar, Eric Lawson, Michael Newman, Jay O'Farrell, Ruth Pilon, Don Smeltzer, Don Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Karen Goodman**
ABSENT:	**Mary Marois**
NMRE/CMHSP STAFF:	**Bea Arsenov, Carol Balousek, Brady Barnhill, Amy Christie, Lisa Hartley, Chip Johnston, Brooke Kleinert, Eric Kurtz, Brian Martinus, Trish Otremba, Pamela Polom, Nena Sork, Chris VanWagoner, Deanna Yockey, Lynda Zeller**
PUBLIC:	**Erin Barbus, Ann Friend, Genevieve Groover, Sarah Hegg, Terri Henderson, Larry LaCross, Tobias Neal, Rob Palmer, Hilary Rappuhn**

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

ROLL CALL
Let the record show that Mary Marois was excused from the meeting on this date; all other NMRE Board Members were in attendance either in person or virtually.

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 JAY O'FARRELL TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR JANUARY 28, 2026; SUPPORT BY DON SMELTZER. MOTION CARRIED.

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

MOTION BY DAVE FREEDMAN TO APPROVE THE MINUTES OF THE DECEMBER 2, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY RUTH PILON. MOTION CARRIED.

CORRESPONDENCE

1) A press release from the Community Mental Health Association of Michigan (CMHAM) announcing Alan Bolter as its incoming CEO, though Robert Sheehan will also remain as co-CEO until October 31, 2026.
2) Email correspondence from CMHAM CEO, Robert Sheehan, dated January 8, 2026, regarding CMHSP and PIHP Board Member Education.
3) CMHSM document listing Board Member educational opportunities titled, "Guide to Board Members of CMHA Member Organizations to The Offerings at The CMHA Winter 2026 Conference."
4) The statewide Fiscal Year 2025 Quarter 4 Performance Indicator Consultation Draft report.
5) The January 8, 2026, decision from Court of Claims Judge Christopher Yates in the legal cases related to bid out of the Prepaid Inpatient Health Plans (PIHP) initiated by the Michigan Department of Health and Human Services (MDHHS) and the State of Michigan Department of Technology, Management, and Budget (DTMB) (25-000143-MB and 25-000162MB).
6) Email correspondence from CMHAM CEO, Robert Sheehan, dated January 9, 2026 providing an analysis of Judge Yate's opinion regarding the legal issues associated with the PIHP bid out.
7) Correspondence from CMHAM listing "Media Coverage of Judge Yates Opinion on Region 10 Et Al V State Of Michigan."
8) A document from CMHAM titled, "Building a Privatization-Proof Public Mental Health System in Michigan."
9) The Statewide PIHP Eligible Variance Report for the Fiscal YTD Period Ended December 31, 2025.
10) The draft minutes of the January 14, 2026, regional Finance Committee meeting.

Mr. Kurtz highlighted key information from the court opinion and enrollment data trends impacting Medicaid eligibility and CMHSP obligations.

It was noted that the Quarter 4 FY25 Performance Indicator report is the last of its kind as the state is moving toward new quality measures/HEDIS measures beginning in FY26.

ANNOUNCEMENTS

The NMRE received word on December 8, 2025, that Gary Klacking was resigning his position from both the Wellvance Board of Directors and the NMRE Board of Directors. As such, Mr. Tanner was asked to fill in as Board Chair until the election of new officers in April.

NMRE staff announced that the new IRS reimbursable mileage rate as of January 1, 2026, is $0.725 per mile.

PUBLIC COMMENT

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

REPORTS

Executive Committee Report

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

CEO Report
The NMRE CEO Monthly Report for December 2025/January 2026 was included in the materials for the meeting on this date.

On January 16th, Mr. Kurtz and NorthCare Network CEO, Megan Rooney, met with Bob Sheehan and Alan Bolter about the future of CMHAM planning, and future efforts with Bridge Health. The joining of NMRE and NorthCare Network via an Urban Cooperation Agreement has the potential to result in administrative efficiencies and may become a model for the rest of the state to follow. Mr. Bolter agreed to acknowledge NMRE/NorthCare as doing what best for their rural regions and consider that in further messaging.

November 2025 Financial Report
- Net Position showed a net surplus for Medicaid and HMP of $2,611,859. Carry forward was reported as $8,908,717. The total Medicaid and HMP current year surplus was reported as $11,520,576. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $32,110,665.
- Traditional Medicaid showed $38,796,327 in revenue, and $35,670,195 in expenses, resulting in a net surplus of $3,126,132. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $4,476,488 in revenue, and $4,990,761 in expenses, resulting in a net deficit of $514,273. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $8,908,717.
- Health Home showed $557,267 in revenue, and $449,748 in expenses, resulting in a net surplus of $107,519.
- SUD showed all funding source revenue of $3,622,547 and $3,293,226 in expenses, resulting in a net surplus of $329,322. Total PA2 funds were reported as $4,623,649.

PA2/Liquor Tax was summarized as follows:

Projected FY26 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$4,765,231	$1,847,106	$2,377,437	$4,234,900

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$0	$141,582	$4,623,649

Approximately $5M in liquor tax funds were carried over from FY25 into FY26.

FY26 revenue has been lower than projected. Eligibles are declining drastically (5,000 eligibles per month since October), resulting in reduced revenue. Actuaries/Milliman met with CFOs on January 27th. A future rate adjustment has been proposed to account for the minimum wage and DCW increases.

It was noted that the reduction in Medicaid and Healthy Michigan eligibles has led to higher utilization of block grant funding for substance use disorder services.

MOTION BY CHUCK VARNER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2025; SUPPORT BY JAY O'FARRELL. MOTION CARRIED.

Operations Committee Report
The draft minutes from the January 20, 2026, Operations Committee meeting were included in the materials for the meeting on this date. Mr. Kurtz acknowledged that the NMRE has been providing Northern Lakes CMHA with 90% prepayments of the PM/PM. Mr. Kurtz stressed that this is not a payment above the normal PM/PM that they would receive anyway but rather a cash advance/early payment. Ms. Zeller thanked the NMRE for the early payments and shared that Northern Lakes' cash flow is improving.

Mr. Johnston supported the designations used in the Rural Transformation Grants to define frontier, rural, or urban areas. Medicare Advantage Plan protocols are being used in other areas which remove bodies of water from the area calculation.

NMRE SUD Oversight Committee Report
The draft minutes from January 5, 2026, were included in the materials for the meeting on this date. Liquor tax requests will be discussed under "New Business."

NEW BUSINESS
Liquor Tax Requests
The following liquor tax requests were recommended for approval by the NMRE Substance Use Disorder Oversight Committee on November 3, 2025.

	Requesting Entity	Project	County	Amount
1.	Northern Michigan Children's Assessment Center	Advocacy and Educational Support	Multi County	$62,305

Crawford	$	9,329.37
Iosco	$	16,879.68
Ogemaw	$	14,074.90
Oscoda	$	5,559.25
Otsego	$	16,461.07
Total	**$**	**62,304.27**

The request was rounded up to the nearest whole dollar.

MOTION BY CHUCK VARNER TO APPROVE THE REQUEST FROM NORTHERN MICHIGAN CHILDREN'S ASSESSMENT CENTER FOR LIQUOR TAX DOLLARS FROM CRAWFORD, IOSCO, OGEMAW, OSCODA, AND OTSEGO COUNTIES IN THE TOTAL AMOUNT OF SIXTY-TWO THOUSAND THREE HUNDRED FIVE DOLLARS ($62,305.00) FOR ADVOCACY AND EDUCATIONAL SUPPORT; SUPPORT BY ERIC LAWSON.

Discussion: Mr. O'Farrell explained that in 2020, the Northern Michigan Children's Assessment Center (NMCAC) approached Iosco County with a request of $5,000 to support its work with children. In 2026, NMCAC requested $10,000. Because many NMCAC cases involve parental

substance use, Mr. O'Farrell suggested that NMCAC approach the NMRE to request liquor tax funds.

When the request was presented to the NMRE SUD Oversight Committee on January 5, 2026, it included funds from Roscommon County (six counties in total). After consideration, Roscommon County opted to be removed from the request, noting that it supports NMCAC in other ways like providing workspace and technical support.

Wellvance CEO, Trish Otremba, voiced that Wellvance works hand-in-hand with NMCAC and considers it a "very valuable resource."

Mr. Lawson asked to see the full liquor tax applications in future meeting packets.

Roll Call Voting took place on Mr. Varner's motion.

"Yea" Votes: B. Adrian, D. Freedman, E. Ginop, R. Iseler, D. Labar, E. Lawson, M. Newman, J. O'Farrell, R. Pilon, D. Smeltzer, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

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

	Projected FY26 Available Balance	Amount Approved January 5, 2026	Projected Remaining Balance
Crawford	$68,486.06	$9,329.37	$59,156.69
Iosco	$150,966.79	$16,879.68	$134,087.11
Ogemaw	$109,476.60	$14,074.90	$95,401.70
Oscoda	$49,954.93	$5,559.25	$44,395.68
Otsego	$25,698.76	$16,461.07	$9,237.69
Total	**$404,583.14**	**$62,304.27**	**$342,278.87**

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

Election of NMRE Board Officers
The NMRE elects its officers in the month of April. In March, a Nominating Committee will be chosen, and a meeting will be scheduled prior to the April Board meeting. In the interim, the NMRE is currently lacking a Vice-Chair (as former Vice-Chair, Don Tanner, has agreed to assume the position as Board Chair) and Secretary due to recent resignations. Similarly, a member is needed to represent Wellvance on the NMRE Board Executive Committee.

- Appointment of Wellvance Member to the Executive Committee
  Mr. O'Farrell recommended that Chuck Varner be appointed to represent Wellvance on the NMRE Board Executive Committee.

- Vice-Chair
  Mr. Smeltzer nominated Eric Lawson as the NMRE Board Vice-Chair.

- Secretary
  Ms. Pilon volunteered to assume the position of Board Secretary.

Mr. Tanner called three times for any additional nominations; none were brought forward.

MOTION BY DON SMELTZER TO APPROVE THE APPOINTMENT OF CHUCK VARNER TO THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD EXECUTIVE COMMITTEE AND TO APPROVE THE NOMINATIONS OF ERIC LAWSON AND RUTH PILON AS NORTHERN MICHIGAN REGIONAL ENTITY BOARD VICE-CHAIR AND SECRETARY RESPECTFULLY; SUPPORT BY DANA LABAR. MOTION CARRIED.

OLD BUSINESS

CMHSP Updates

Mr. Kurtz explained that "CMHSP Updates" will replace "Northern Lakes Update" on this and future meeting agenda.

- Centra Wellness Network
  Mr. Johnston reported that the financial support being given by Centra Wellness to Northern Lakes CMHS is going well. Mr. Johnston will be giving his "Red Book" training (including Judge Yates' decision) to key Northern Lakes staff in February.

- North Country CMHA
  Ms. Christie reported that North Country CMHA's Executive Team is recreating/revisiting its Strategic Plan. North Country is working to fill some clinical staff vacancies. Work is also being done on performance indicators and beefing up utilization management. North Country has trained 42 staff on the MCG Indicia platform, with good early results.

- Northeast Michigan CMHA
  Ms. Sork reported that Northeast Michigan CMHA is challenged with staffing shortages, though some clinical staff have recently been recruited in addition to an Account Manager. Work is being done on performance indicators. and partnering with Catholic Human Services on a wraparound program. The Behavioral Health Home program is thriving.

- Northern Lakes CMHA
  Ms. Zeller acknowledged that each of her regional CEO colleagues have helped her with something major as have NMRE executive staff. She gave special thanks to Centra Wellness (Donne Nieman) and NorthCare Network (Megan Rooney) for their financial help. Ms. Zeller shared that Northern Lakes still has some big hills to climb. On the positive side, a 2-year downward trend of cash flow has been halted. All investments have been cashed out. General Funds are being closely monitored as they were overspent by $3M in FY25. Utilization management is being reconfigured.

  Mr. Tanner noted that everyone is invested in the success of Northern Lakes.

- Wellvance
  Ms. Otremba reported that Wellvance is doing well. Wellvance is scheduled for Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in late March/early April. Wellvance is building relationships with law enforcement and adding medication assisted treatment (MAT) services to Iosco County jail inmates.

Mr. Tanner suggested that the NMRE revisit the floating financial position that was discussed in May of 2022.

Legal Actions Related to the PIHP Bid Out
In response to the decision by Judge Yates in the Michigan Court of Claims dated January 8, 2026, Mr. Kurtz discussed possible next steps. It was noted that the deadline for the Michigan Department of Health and Human Services (MDHHS) and the State of Michigan Department of Technology, Management, and Budget (DTMB) to appeal the decision is January 29th.

If no appeal is filed, the state may do nothing due to the upcoming change in administration. The timeline is tight if the state chooses to pull back the current RFP and reissue an RFP that meets all the legal requirements. The NMRE is taking a "wait and see" position; however, it is being proactive regarding its collaborative efforts with NorthCare Network.

Ideally, the state will be open to negotiating with the PIHPs that signed redlined versions of the FY25 and FY26 contracts (NorthCare Network, NMRE, Region 10, and CMH Partnership of Southeast Michigan) as the only remaining issue is the risk corridor piece (7.5% internal service fund cap).

Ms. Zeller emphasized that CMHAM is proposing changes in statues; however, nothing needs to change in statute for the UP and tip of mitt to coordinate on physical and behavioral healthcare. She asserted that a "privatization-proof" system is the wrong message as there is much that can be done in the current system, though some consideration for rural exemptions would be beneficial.

PRESENTATION
NMRE FY25 Quality Assessment and Performance Improvement Program (QAPIP) Evaluation and FY26 QAPIP Workplan.

NMRE Chief Clinical Officer, Bransliva Arsenov, reported on the NMRE's FY25 Quality Assessment and Performance Improvement Program (QAPIP) Evaluation and FY26 QAPIP Workplan.

FY25 QAPIP Evaluation

Goal	Outcome
Performance Improvement Projects	
The NMRE will increase the number of individuals enrolled in the Opioid Health Home/SUD Health Home from baseline.	The NMRE was unable to increase enrollment in Health Home programs due to the loss of one SUD Health Home and an increase in individuals losing Medicaid and Healthy Michigan Coverage.
The NMRE will increase the percentage of individuals who are enrolled in the Behavioral Health Home program from 5% to 6%.	Although overall enrollment with CMHSPs decreased likely due to the change in the number of covered beneficiaries (in FY25 61 disenrollments

	were due to no MA) overall enrollment is at 5.92% with the expansion of FQHCs.
The NMRE will increase percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.	In December of 2024, the NMRE set the goal to improve from 67.82%. In Q4 of FY25, the NMRE is scored somewhat higher at 71.74%.
Event Reporting and Notification	
The NMRE will trend, review, and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. The NMRE will work on improving the data quality and timeliness in reporting events.	A 7% increase in the timeliness of critical events reporting was observed from FY24 to FY25. A more uniformed reporting of risk events (RI) is needed, and NMRE will use one reporting document across all five boards to accomplish this in FY26.
Consumer Experience Assessments	
The NMRE will conduct ongoing quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services including long-term supports and services	The number of consumers providing feedback increased in FY25 (942) compared to FY23 (620) and FY24 (921), and so did the percentage of positive feedback.
Provider Network Monitoring	
The NMRE will conduct annual (at minimum) monitoring for all directly contracted providers in the region, and out of region as needed and appropriate, utilizing reciprocity when necessary.	Monitoring was conducted in FY25. For better trending of outcomes and monitoring NMRE will utilize PCE Auditing tools starting FY2026.
The NMRE will perform quarterly audits to verify Medicaid claims/encounters to ensure Medicaid services were furnished to beneficiaries by CMHSPs, SUD providers, providers, and/or subcontractors.	FY25 results showed a 1% increase in validity from FY24.
Behavior Treatment Review	
The NMRE's Regional Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques were approved for use with members and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis.	The NMRE collected data including the number of interventions and length of time the interventions were used with the individual(s). The CMHSPs' BTRCs are tasked with reviewing data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that were approved by the members or their guardians during person-centered planning have been used.
Quality Measures (HEDIS Measures)	
The NMRE will review HEDIS measures tied to the Performance Bonus Incentive Pool (PBIP) to demonstrate and ensure quality care.	The NMRE fell below the standard for Initiation and engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). The NMRE's performance met or exceeded established standards for the other PBIP measures.
Performance Indicators	
The NMRE will monitor the performance indicators for the NMRE CMHSP network as well as individually.	Performance data is reviewed and discussed by QOC on a quarterly basis. The NMRE and its CMHSPs worked toward meeting all MDHHS MMPBIS at a 95% rate or higher for indicators 1, 4a, and 4b.

	Work was done to try and improve indicators 2, 2e, and 3 and move them into at least 50th percentile, increasing to 57%, 68.2%, and 72.9% respectively.
Monitoring and Evaluation	
The NMRE will provide updates to the QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities.	QAPIP activities are continuously reviewed and evaluated by QOC. The QAPIP is reviewed and updated at least annually with the input from CMHSPs, providers, stakeholders, and approved by the Governing Board. QAPIP activities are shared with consumers through the regional Consumer Council (Regional Entity Partners) and other stakeholders through committees, mailers, and posting to the NMRE website.
Practice Guidelines	
The NMRE and its network providers will implement a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and Michigan Department of Health and Human Services (MDHHS).	The NMRE reviews and adopts practice guidelines established by APA and MDHHS annually, every March after they have been reviewed and adopted by the regions' clinical directors. The NMRE disseminates adopted practice guidelines to all affected providers, members, stakeholders, and potential members as needed via the NMRE's website as referenced in the NMRE's annual mailer.
Contracting	
The NMRE will update its Sub-contractual Relationships and Delegation Agreements to include the language: "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later".	The NMRE will update its Sub-contractual Relationships and Delegation Agreements to include the language: "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later".
Credentialing and Recredentialing	
The NMRE and its CMHSPs will adopt the Universal Credentialing CRM as required by MDHHS.	The NMRE's five CMHSPs have all implemented the Universal Credentialing CRM, with the only limitation being the extent that their normal operations have delayed the transition.
Exclusion Checks	
The NMRE will develop standardized utilization management protocols and functions across the region to identify areas of underutilization and overutilization of services.	The NMRE completed MCG Indicia 17 Integration with PCE Systems for all five member CMHSPs in FY25. The NMRE developed reports to monitor, trend, and review SUD admissions and level of care utilization in the NMRE region. FY25 SUD admissions were 15% lower than in FY24 across all levels of care. Additional corrective actions were needed in FY25, resulting in higher enrollment of those receiving qualifying services into 1915(i) SPA. The NMRE continues to monitor Power BI Potential Enrollee Report for discrepancies per board and qualifying service. To ensure appropriate utilization of HSW waiver slots, the NMRE runs a monthly "No-Service" report and shares it with its CMHSPs.

Regional Training	
The NMRE will collect feedback from its member CMHSPs and SUD Providers, as well as record areas of improvement during site visits, and will conduct a series of trainings to aid in process improvement as well as overall compliance.	An IPOS training was completed on October 10th and 11th, 2024 for all five CMHSPs. Adverse Benefit Determination training was completed January 23rd and 24th, 2025. Over 200 staff attended these training sessions.
Maintaining the Handbook	
The NMRE will obtain MDHHS approval, in writing, prior to publishing the original and revised editions of its member handbook.	The NMRE received written approval of its Member Handbook (Guide to Services) from MDHHS. The NMRE uses MDHHS-developed model member handbooks and member notices and ensures that its member handbook and member notices include all MDHHS-developed template language. The NMRE will ensure that all written materials for potential members and members use a font size no smaller than 12pt and are written at or below the 6.9 grade reading level based on the Flesch-Kincaid scale.
Adverse Benefit Determinations	
The NMRE will strengthen compliance with Federal and State laws regarding Adverse Benefit Determinations (ABD) sent to beneficiaries of the NMRE region.	Region-wide training was provided in January 2025, and training was provided to a singular CMHSP in March 2025. Each CMHSP has been compliant with the increased oversight, which has resulted in compliance improvement. Compliance for FY25 Q1 and Q2 focused on the required 6.9 grade level readability, and time frame compliance, of the ABDs. FY25 Q3 (and Q4 when available) will focus on readability, along with proper citation use.
The NMRE will increase compliance with timely authorization decisions for SUD services.	The NMRE developed an internal process for timely authorization denials, as well es exceptions and extensions when appropriate. • FY24 SUD denials made within required decision timeframes: 98.71% • FY25 SUD denials made within required decision timeframes: 100%

FY26 QAPIP Workplan

Goal
Performance Improvement Projects
The NMRE will continue to collect data, conduct ongoing analysis, and coordinate with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program as part of the broader Substance Use Health Home (SUDHH).
The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 6% to 7%,
Performance Indicator 3 (PI 3) improvement goal is to increase the percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.

Event Reporting and Notification
The NMRE provide clear guidance for the reporting and reviewing of critical incidents, sentinel events, risk events, and deaths of beneficiaries. The NMRE will analyze this data quarterly to identify improvement opportunities. The NMRE Quality and Compliance Oversight Committee (QOC) will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm.
Consumer Experience Assessments
The NMRE will conduct ongoing quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services, including long-term supports (LTSS) and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract with the State.
Provider Network Monitoring
The NMRE will conduct site reviews annually for all contracted service providers by September 30, 2026. The NMRE will monitor and follow-up to ensure corrective action plans (CAPs) are being implemented as stated by network providers.
The NMRE will incorporate consumers receiving long-term supports or services (LTSS) into the review and analysis of the information obtained from quantitative and qualitative methods.
The NMRE will perform quarterly audits to verify Medicaid claims/encounters to ensure Medicaid services were furnished to beneficiaries by CMHSPs, SUD providers, providers, and/or subcontractors.
The NMRE and its CMHSPs will monitor Home and Community Based Services (HCBS) under the HCBS Final Rule, the Centers for Medicare and Medicaid (CMS) requirements for both residential and non-residential Home and Community Based Settings.
The Regional Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques were approved for use with members and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Trends and patterns will be reviewed to determine if systems and process improvement initiatives are necessary.
Quality Measures (HEDIS Measures)
The NMRE will review HEDIS Measures related to the Performance Improvement Bonus Pool (PBIP) and Behavioral Health Quality Program Overhaul- Year 1 to demonstrate and ensure quality care. The NMRE will provide and analyze HEDIS measure reports to the NMRE QOC on a quarterly basis.
Performance Indicators
The NMRE will monitor the performance indicator #2 for the NMRE CMHSP network as well as individually with a goal of reaching the 75th percentile (62%).
Monitoring and Evaluation
The NMRE will provide updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities.
Practice Guidelines
The NMRE and its network providers will adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and the Michigan Department of Health and Human Services (MDHHS) annually in March. The NMRE will disseminate adopted practice guidelines to all affected providers, members, stakeholders, and potential members as needed via the NMRE.org website, annual mailer, and/or annual newsletter.
Contracting
The NMRE will ensure that any new Sub-contractual Relationships and Delegation Agreements will to include the language: "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later."
Credentialing and Recredentialing
The NMRE will continue to work with the MDHHS to implement the Universal Credentialing module in their CRM platform, continue to monitor credentialing and recredentialing, and continue with regional educational/training sessions.
Exclusion Checks

The NMRE will continue to monitor its provider network to ensure they are running required monthly excluded provider checks (Office of the Inspector General's (OIG) exclusions database (individual or entity), the System for Award Management (SAM), the State of Michigan Sanctioned Provider List) in accordance with regulatory requirements.
Utilization Management and Authorization of Services
The NMRE will continue to develop standardized utilization management protocols & functions across the region to identify areas of underutilization and overutilization of services. This will ensure access to public behavioral health services in the region is in accordance with the PIHP's contract with MDHHS, relevant Michigan Medicaid Provider Manual (MMPM) sections, and Michigan Mental Health Code (MMHC) requirements.
Regional Training
The NMRE will continue to collect feedback from its member CMHSPs and SUD Providers, as well as record areas of improvement during site visits, and continues to conduct or fund a series of trainings to aid in process improvement as well as overall compliance.
Maintaining the Handbook
The NMRE will obtain written MDHHS approval prior to publishing any revisions of its Member handbook. The NMRE will use MDHHS-developed model member handbooks and member notices and ensure that its member handbook and member notices include all MDHHS-developed template language. The NMRE, and any delegates performing activities on behalf of the NMRE, will ensure that all written materials available for potential members and members use a font size at least 12-point bold font (conspicuously visible), and are written at or below the 6.9 grade reading level based on Flesch-Kincaid score.
Adverse Benefit Determinations
The NMRE will ensure that each ABD notice meets federal and state-specific requirements, as well as content requirement, and is written at or below the 6.9 reading grade level. The NMRE will conduct training and quarterly monitoring of its provider network to measure compliance. Scheduled annual on-site monitoring will continue to include ABD review and monitoring.
Stakeholder Engagement and Input
The NMRE will analyzes feedback received from those who currently receive services, who received services in the past, families and support systems, advocates, contracted providers, community partners, coalitions etc.

MOTION BY BOB ADRIAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY'S FISCAL YEAR 2025 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM EVALUATION AND FISCAL YEAR 2026 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM WORKPLAN; SUPPORT BY ED GINOP. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, R. Iseler, D. Labar, E. Lawson, M. Newman, J. O'Farrell, R. Pilon, D. Smeltzer, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

COMMENTS

Board

Mr. Labar recognized and thanked the CMHSP CEOs and Mr. Kurtz for spearheading the monumental lawsuit against MDHHS and DTMB.

Mr. Freedman announced that a 501(c)(3) that he is involved with is holding a series of non-partisan "meet the candidates" forums related to the November election. He requested permission to share information with the NMRE Board, which was given.

Staff/CMHSP CEOs
Ms. Sork noted that Mental Health of America ranked Michigan #13 for mental health in the United States. She recognized the need to spread the word that the system may need some fixing, but it is not broken.

Mr. Johnston shared that he has attended the Great Lakes Rural Mental Health Association (GLARMA) conference for 5-6 years. This year, all Region 2 CEOs have been invited to attend, further aligning PIHP Regions 1 and 2.

Mr. Kurtz announced that the NMRE will be pursuing full-risk arrangements with the five member CMHSPs so that they in upside and downside risk. An actuarial analysis will be needed prior to moving forward.

Public
Catholic Human Services' Chief Executive Officer, Larry LaCross, spoke about the challenge and uncertainty surrounding the reduction in Medicaid and Health Michigan Plan enrollees and the potential impact on services.

NEXT MEETING DATE
The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on February 25, 2026.

ADJOURN
Let the record show that Mr. Tanner adjourned the meeting at 11:57AM.

Community Mental Health Association of Michigan

Self Determination: Issues to be clarified and resolved

List developed by CMH and PIHP CEOs and knowledgeable staff; November 2022 -January 2023

Aim of this document

Over the past several years, as persons served, families, guardians, and state's CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks have worked to implement self-determination and self-directed budget processes, questions have arisen that, once answered, will strengthen the empowerment and financial infrastructure of the SD system.

One set of those stakeholders, the state's CMHSPs and PIHPs, given their commitment to the aims and sustainability of the self-determination and self-directed philosophy and processes, have identified a number of areas around which clarity and an underscoring of core SD tenets and mechanics are needed.

This document, which contains a set of recommendations relative to the areas needing clarity, is designed to refine Michigan's self-determination/self-directed budget process so as to provide sound guidance to persons served, their families and guardians, and the state's CMHSPs, PIHP, and providers in the CMHSP and PIHP networks.

The clarity outlined by these recommendations would be contained in the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory.

Clarity around these issues and the resolution of unresolved questions will go far in ensuring that these processes support the freedom and autonomy of persons served – aims strongly supported by Michigan's CMHs, PIHPs, and providers – while also complying with Medicaid regulations, and fostering sound fiscal accountability and risk management

Areas in need of clarification and resolution

1. Determining comparative/benchmark services package and its cost: The benchmark service package for use in establishing a self-directed/self-determination (SD) budget to ensure that budget neutrality and equity exist between persons, with similar needs, in SD arrangements and those not in those arrangements.

Clarity and guidance, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory. are needed relative to:

A. Underscore the obligation that the CMHSP and PIHP must use medical necessity criteria to ensure that persons in SD arrangements receive equivalent medically/clinically necessary services and supports as those not in SD arrangement.
B. Underscore that the CMHSP/PIHP, in ensuring cost neutrality between SD and non-SD arrangements, must use, for the SD budget, the unit rate paid by the CMHSP/PIHP for the equivalent services and supports for persons not in SD arrangements, less costs that should be excluded from the SD budget provided to the person served. Examples of such excluded costs include:
    i. The costs of those supervision, compliance, and organizing tasks of the provider organizations when they are not assumed and adequately carried out by the

person served, the family, guardian, or FMS. In these cases, this work must be assumed by the CMHSP, PIHP, or CMH-designated provider organization, with the need for those costs of the CMH or designated provider organization to be reduced from the SD budget provided to the person served.

ii. The costs of the Fiscal Management Services (FMS) are to be removed from the SD budget provided to the person served, given that the costs of similar services, when carried out by the CMHSP/PIHP, are not included in the rate paid to provider organizations for the comparative/benchmark services and supports.

C. Underscore that the CLS rate, paid for CLS the encounters included in a SD budget, includes the dollars to cover time off, training time, and other work, by the CLS staff; workers compensation; supervision; and all indirect costs – as is the case for the CLS rates paid to provider agencies.

D. How the guidance provided during the design of Michigan's SD system, by Michigan's original SD consultants, that a rate 75% of the current/equivalent costs in non-SD arrangements should be used in building the SD budget.

2. When SD-employer cannot find staff at the reasonable/comparative rate determined by CMHSP: When the employer in an SD arrangement (person served, guardian, family) cannot find staff at the reasonable rate as determined by the CMHSP via their equivalent cost analysis (outlined above), it must be clarified, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that the CMHSP/PIHP can provide or designate a provider organization to provide the needed services. If needed, the SD budget will be adjusted to reflect this fact.

Additionally, it must also be clarified, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that if the SD employer cannot find staff to provide CLS or other services in the SD package and does not want to use CMH or CMH-designated provider staff to provide those served, the CMHSP/PIHP can terminate the SD agreement or the relevant sections of the SD agreement.

3. When SD budget is spent at a pace leaving hours or remainder of the year unfunded and uncovered: Two issues within this area are in need of clarification, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory:

A. Hours unfunded and uncovered: If fewer CLS or other service hours are purchased by the person served/guardian at less than the number determined, in the IPOS, to be medically necessary – due to paying higher wages to staff or for other reasons - and the tie to the benchmark service package and its costs are to be retained, it is key that the CMH have the authority to clarity is needed as to the steps that should be taken by the person served, their guardian, or CMH take to ensure that the medically necessary hours are provided while ensuring that the SD budget remains in line with the benchmark service budget.

B Remainder of year unfunded and uncovered: If the SD budget is exhausted before the end of the year, it is key that the CMH have the authority to take the steps needed to ensure that the medically necessary hours are provided while ensuring that the SD budget remains in line with the benchmark service budget. These steps would include meeting with the person served and review data to learn of the reasons causing this spending pattern, and make decisions related to controlling utilization patterns, examining the rates paid to provider staff, paying overtime and,

when needed, and when other approaches have been tried and not been effective, to move to an agency-with-choice SD arrangement, or end the SD arrangement. [i]

Clarity is needed, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, relative to the appropriateness of the rates paid to providers so as to ensure compliance with 2 CFR 200.430, specifically 3b – Reasonableness.

4. When a portion of the SD budget is unspent dollars at year's or month's end: Clarity, in the Medicaid manual and in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, is needed as to how SD budget dollars (as part of the regular budget or budget balances/surpluses) can be used while remaining compliant with Medicaid requirements of medical necessity and reasonableness. Examples of goods and services for which such clarity is needed include:

Good or service used by person served

- Camps
- Massage
- Personal training
- Entertainment (concerts, etc.)
- Vacations
- Music lessons
- Laptops

Goods or services benefitting staff paid by SD budget

- Bonus pay to CLS staff
- Meals, concert tickets, movie tickets, plane tickets, etc. of the staff when providing CLS to a person participating in these events

When and if any of these costs are deemed allowable, clarity is needed, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, as to the method by which reasonableness of these costs are to be determined, with the aim of ensuring compliance with 2 CFR 200.430 (specifically 3b – Reasonableness and 3f – Incentive compensation)

5. Oversight required by CMHSPs/PIHPs: Clarity is needed in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, as to the types of oversight that the CMHSP/PIHP should be carrying out in a SD arrangement.

Over the years, CMHSPs and PIHPs, with the support of MDHHS, have developed sophisticated and proven methods to ensure the accountability of the use of Medicaid funds. Both the freedoms inherent in an SD arrangement and the accountable and appropriate use of Medicaid dollars can be ensured through the design and implementation of sound oversight, of SD arrangements, by the CMHSP/PIHP funding the SD budget.

It is recommended that it be clarified, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that the CMHSP/PIHP, to ensure that the freedoms inherent in an SD arrangement and the accountable and appropriate use of Medicaid dollars, must employ the following processes:

A. Medical necessity determination and authorization: When a person served, with a SD budget, is working with an independent supports coordinator and uses an outside clinician (outside of the CMHSP/PIHP and its provider network) to determine medical/clinical necessity for services in the IPOS, it must be underscored that the CMH nor PIHP retains that requirement to ensure that the services provided are medically necessary. To ensure that the CMH and PIHP can fulfill this responsibility, it is key to underscore that the CMHSP and/or PIHP retains the obligation and responsibility to authorize the payment for these services based on its determination of medical necessity and reasonableness.

It must be clarified, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that the CMHSP/PIHP can require a medical necessity determination be carried out by the CMH or a CMH-designated provider for services in an IPOS in an SD arrangement. Additionally, it is key to underscore that the CMH and/or PIHP retains the obligation and responsibility to authorize the payment for all of the services in an SD arrangement, through the application of medical necessity criteria and the Medicaid standards for covered services and supports.

B. Fiscal accountability and reasonableness: Clarity is needed, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, to underscore that CMHSPs/PIHPs, in an effort to ensure that the funds that they manage are sufficient to meet the needs of all Medicaid beneficiaries to whom they are responsible to provide care, may apply the following language in the Medicaid Provider Manual:

2.5.D. PIHP DECISIONS Using criteria for medical necessity, a PIHP may:

- Deny services:
- that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- that are experimental or investigational in nature; or
- for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

C. Training for staff hired via SD arrangements: Given that the responsibility for health and safety remains with the CMHSP/PIHP as does the mandate to meet their contractual obligations with MDHHS, under SD arrangements, it must be underscored, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that CMHs/PIHPs can require training, of the staff hired by the SD employer, necessary to implement the IPOS specific to the person served/SD employer and training needed to foster the health and safety of the person served. As one example, clarity is needed, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, around whether the Deficit Reduction Act training requirements (compliance, fraud/waste/abuse, etc.) apply to the staff hired by the SD employer.
(https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:4d7d71a0-0e8c-337e-8421-496994e1dc02)

If these training requirements are determined, by MDHHS, to apply in SD arrangements, and the SD employer or FMS provider does not provide this training, it must be clarified, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that the CMHSP or PIHP retains the responsibility to ensure that this training occurs with the funds necessary to provide this training retained by the CMHSP or PIHP, outside of the SD budget to carry out these training functions.

If these training requirements are determined, by MDHHS, to not apply in SD arrangements, it must be stated, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that the CMHSP and/or PIHP is not responsible for the quality of care and the safety of the person served by persons who have not received this training.

D. Required review of documentation: It must be reinforced, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that a CMHSP/PIHP must be allowed to review the service-related, credentialing, and all related documentation generated by the person served, their guardian, the staff hired under SD arrangements, and of the FMS provider. As with all providers of Medicaid services, significant documentation gaps and issues require the recoupment of the Medicaid funds related to these documentation issues.

E. Contract relations of CMHSP/PIHP and FMS provider: It must be reinforced, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that the FMS provider must work with the CMHSP/PIHP to carry out the functions related to a SD arrangement. It must also be reinforced that a CMHSP/PIHP can apply any of its traditional contract management approaches to the relationship between the CMHSP/PIHP and the FMS provider, to ensure a sound SD arrangement, including the suspension or termination of the contract with the FMS provider.

F. Suspension or termination of SD arrangement: It is key to underscore, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that when significant clinical, fiscal, or other documentation issues exist in the implementation of a SD arrangement/budget, the CMHSP/PIHP can take the steps necessary to correct these deficiencies, including the suspension or termination of SD arrangement.

G. Recoupment of inappropriate Medicaid expenditures: In a non-SD agency-provider structure, if the services purchased with Medicaid dollars are found to lack medical necessity, or training, documentation, or other Medicaid standards are not met, the CMHSP/PIHP would recoup those dollars from the provider agency. However, if the services purchased with SD budget dollars are found to be lacking in any of these area, the CMH/PIHP is unlikely to be able to recoup those funds from the providers of SD budget-funded services or from the person served – leaving the CMHSP/PIHP with the need to use scarce state General Fund or local dollars to repay the state for these mis-spent funds.

It is strongly recommended that the CMHSPs/PIHPs be provided with another source from which to recoup Medicaid dollars, inappropriately spent in a SD arrangement, in lieu of the recouping these dollars from the person served, the SD staff, and CMHSP/PIHP.

H. MDHHS guidance: At times, it is unclear to the person in the SD arrangement, their guardian, the CMHSP/PIHP, and/or FMS provider as to the interpretation of the guidance contained in the Michigan Medicaid Provider Manual, Medicaid policy, or the CMHSP or PIHP contract with MDHHS as to a range of SD operational issues including the SD costs that are allowable, as Medicaid expenditures. It is strongly recommended that, when requested by any of these parties, MDHHS provide, in writing, to the person served and/or their guardian, CMHSP/PIHP, and FMS provider, the Department's guidance regarding the Medicaid allowability of a given SD-related expense or practice. This guidance should then be added to both the Self-Directed Services Technical Requirements and the Self-Determination Implementation Technical Advisory,

6. IPOS to stay intact if only unit rates change: The implication, as interpreted by many working in SD arrangements, is that when the budget changes, the IPOS must also change. This implied requirement leads to much unnecessary work with the SD budget changes without any significant changes in the IPOS (such as the recent DCW wage increases that impacted SD budgets).

Needed is the elimination, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, of the requirement to change the IPOS for cases in which the SD budget changes without any significant changes in the IPOS, with the only change in the IPOS necessary when changes in amount, duration, and scope are made to the IPOS.

7. Clarification as to "Responsible relatives" and role of person with Power of Attorney: The Michigan Medicaid Provider Manual indicates that "Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports." (p138 of BH section of manual). Beyond these examples, clarity is needed as to whether a person designated as a "responsible relative" is someone related to and/or lives with the person with the SD budget.

Additionally, clarity is needed, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, as to whether a person who has Power of Attorney, relative to a person served, yet is not the person's guardian, can serve as a paid staff for that person and, if so, for what services.

8. Appeal and grievance: It must be underscored, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that only the formal CMHSP and PIHP grievance and appeals process (including local dispute resolution mediation, Medicaid Fair Hearings), when they apply, are to be used in resolving issues related to SD arrangements. It must also be underscored, in both the Self-Directed Services Technical Requirements and in the Self-Determination Implementation Technical Advisory, that Informal opinions provided by any party, including MDHHS staff, cannot be used to circumvent this formal process.

An alternate approach to the development and management of Self-Directed budgets

Given the complexity of the issues and mechanics central to the design and operation of the state's self-determination/ self-directed budget system and the unintended harm to the relationships that occur – at times - between persons served, their guardians, and families, and local CMHSPs as all of these parties work to balance the freedom of choice/empowerment of the person served with compliance with Medicaid requirements and accountability, it is recommended that MDHHS, persons served, the

state's advocacy groups, CMHA, CMHSPs, and PIHPs jointly examine the potential of MDHHS or a third party taking on the financing and management of SD arrangements.

[i] Given the amount of work necessary for the implementation of SD with fidelity and accountability, the costs, borne by the CMHSPs and PIHPs, in carrying out this work must be reflected in the Medicaid capitation rates paid to the state's PIHPs.

Michigan Department of Health and Human Services
Health Services

MEMORANDUM

To: Chief Executive Officers of the Prepaid Inpatient Health Plans (PIHPs)

From: Kristen Morningstar, Bureau Director
Bureau of Specialty Behavioral Health Services

Date: January 26, 2026

RE: Fiscal Year (FY) 2026 Reference Materials

Below you will find an updated list of FY26 Reference Materials, including excerpts from the FY24 Michigan Department of Health and Human Services (MDHHS)/Prepaid Inpatient Health Plan (PIHP) contract, MDHHS policy, Centers for Medicare & Medicaid Services (CMS) approval notices and Michigan legislative acts. Note that the contents of this FY26 Reference Materials memo must be adhered to, in addition to the contents of the previously issued January 31, 2025, FY24 Reference Materials memo. These materials outline MDHHS expectations on the following subjects:

- 1915(i) State Plan Home and Community-Based Services (HCBS)
- Habilitation Supports Waiver (HSW) Renewal
- Requirements for the Use of the Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener and Comprehensive
- Certified Community Behavioral Health Clinic (CCBHC) Demonstration Responsibility Changes
- Derek Waskul, et al. v. Washtenaw County Community Mental Health, et al. Settlement Agreement
- Michigan Earned Sick Time Act and Minimum Wage Increase
- Home and Community Based Services Final Rule
- 1915(c) Michigan's Children's Waiver Program Waiver Renewal and Amendment Approval
- Occupational Therapy, Speech Therapy, Physical Therapy (OT, ST, PT) for Beneficiaries with Autism Spectrum Disorder (ASD) Clarification
- Intensive Crisis Stabilization Services (ICSS) Updates
- Substance Use Disorder (SUD) Health Home
- MI Coordinated Health (MICH)
- Behavioral Health Home (BHH) Expansion and Authorization of Additional Staff
- Parent Support Partner (PSP) Updates
- Children with Serious Emotional Disturbances (SED) Waiver Renewal
- Electronic Visit Verification (EVV) Updates
- Revisions to Psychiatric Residential Treatment Facility (PRTF) Policy
- Updates to the MDHHS Medicaid Provider Manual; Psychological and Neuro-psychological Evaluation Coverage Responsibility Clarification

- Respite for Children in Foster Care
- Child Caring Institution (CCI) Reimbursement Clarification

These references highlight the responsibility of the PIHPs to continue their ongoing work in these areas under the FY26 contracts as well as the FY24 continuation contracts. As a reminder, the FY26 capitation rates that all 10 PIHPs are currently receiving reflect or will be amended to reflect the policy changes identified above.

In addition to the specific references contained throughout the document, please find the link to the Michigan Medicaid State Plans and Amendments below.

https://www.michigan.gov/mdhhs/inside-mdhhs/budgetfinance/264/state-plan-amendments

The MDHHS/PIHP FY24 and FY26 contracts require compliance with current MDHHS Medicaid policy and publications. Schedule A., Requirements states "Contractor must comply with all provisions of Medicaid policy applicable to Contractors unless provisions of this Contract stipulate otherwise." Furthermore, see Schedule A., F. Covered Services, 1.b.:

> *Contractor must operate consistent with all applicable Medicaid policies and publications for coverages and limitations. If new Medicaid services are added, expanded, eliminated, or otherwise changed, Contractor must implement the changes consistent with State direction and the terms of this Contract.*

Sections of the MDHHS/PIHP FY24 contract specific to requirements herein are also listed below. The table below outlines specific topics relevant to the transition and the role of the PIHPs.

1915(i) State Plan Home and Community-Based Services	**MMP 22-36** *Effective October 1, 2019, behavioral health community-based services that were previously authorized under the Managed Specialty Services & Supports §1915(b1)(b3) waivers moved authorities to the §1915(i) State HCBS as directed by CMS. Effective October 1, 2023, the §1915(i) State Plan Amendment will operate concurrently with the §1115 Behavioral Health Demonstration Waiver which establishes the provision of behavioral health community-based services through Michigan's managed care contract with the regional PIHPs. This bulletin outlines the transition of State Waiver Authority for HCBS into a §1915(i) State Plan benefit. Refer to the Behavioral Health and Intellectual and Developmental Disability (IDD) Supports and Services chapter of the MDHHS Medicaid Provider Manual, General Information section, for an overview of the mental health and developmental disabilities services and supports covered by Medicaid. The MDHHS Medicaid Provider*	Final Bulletin MMP 22-36-BHDDA.pdf

	Manual can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.	
Habilitation Supports Waiver (HSW) Renewal	**1915(c) Renewal Approval Letter** *The CMS approved the state's request to renew Michigan's Habilitation Supports Waiver, MI-0167.R07.00, which serves individuals with developmental disabilities or intellectual disabilities ages 0 or older who meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care.*	1915(c) Renewal Approval Letter [post 11.11.23 w App k provisions]
Requirements for the Use of the Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener and Comprehensive	**MMP 25-36** *The purpose of the bulletin is to establish revisions in Medicaid Policy related to acceptance and use of the MichiCANS Screener and Comprehensive results that are completed by certified raters from MDHHS-designated Michigan child-serving systems. For additional information regarding the use of the MichiCANS tool, refer to the MichiCANS section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the MDHHS Medicaid Provider Manual.*	MMP 25-36
Certified Community Behavioral Health (CCBHC) Demonstration Responsibility Changes	**CCBHC Demonstration Responsibility Changes** *Effective October 1, 2025, oversight of the CCBHC Demonstration has been removed from the PIHP responsibilities. The MDHHS operates the CCBHC Demonstration directly. Further guidance for the PIHPs was included in the "PIHP Responsibilities with FY26 Certified Community Behavioral Health Clinic (CCBHC) Payment Responsibility Changes – Updated" memo. In addition, PIHPs are responsible for paying FY25 Quality Bonus and CCBHC general fund payments to CCBHCs in FY26, as required under the FY24 contract provision obligating PIHPs to make payments to CCBHCs.* **FY24 PIHP Contract, 8. Payment Terms, D. Contractor Performance Bonus, 1. Withhold Arrangements, e. Certified Community Behavioral Health Center (CCBHC) Demonstration Quality Bonus Payment (QBP)** *The State will withhold 5% of the CCBHC benefit plan capitation payments for potential CCBHC QBP award payments for CCBHCs that meet or exceed federally*	

	defined QBP measures and benchmarks. This withhold is outside of the actuarial equivalent PPS-1 rate payment. The methodology for determining QBP payment, including the metrics, specifications, and distribution is cited in the CCBHC Handbook, which can be found at the following website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/ccbhc. The QBP funding awarded to Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.	
Derek Waskul, et al. v. Washtenaw County Community Mental Health, et al. Settlement Agreement	**MMP 25-31** *This bulletin is being issued for settlement-related action items identified in Derek Waskul, et al. v. Washtenaw Community Mental Health, et al. to update policy in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the MDHHS Medicaid Provider Manual, including changes specific to the HSW.* **MMP 25-41** *This bulletin is being issued for settlement-related action items identified in Derek Waskul, et al. v. Washtenaw Community Mental Health, et al. to update policy in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the MDHHS Medicaid Provider Manual, with changes specific to the HSW. The updates include the addition of a new section in the MDHHS Medicaid Provider Manual for establishing self-directed budgeting for Community Living Supports (CLS) for HSW beneficiaries with self-directed service arrangements.*	Final-Bulletin-MMP-25-31-BH.pdf Final-Bulletin-MMP-25-41-BH.pdf
Michigan Earned Sick Time Act and Minimum Wage Increase	**Earned Sick Time Act** *On February 21, 2025, the Michigan Earned Sick Time Act went into effect, establishing changes to the state's earned sick time laws. House Bill 4002 amends the existing Earned Sick Time Act and will expand paid sick leave.* **Minimum Wage Increase** *On February 21, 2025, key changes to Michigan's minimum wage laws went into effect. Senate Bill 8 will incrementally increase the minimum wage to $15 per hour by 2027.*	MCL - Act 338 of 2018 - Michigan Legislature Senate Bill 8 of 2025 (Public Act 1 of 2025) - Michigan Legislature

Home and Community Based Services Final Rule	**MMP 25-53** *On January 16, 2014, CMS released the HCBS Final Rule (CMS 2249-F/2296-F). The HCBS Final Rule specifies requirements for programs offering HCBS under the 1915(c), 1915(i), 1915(k), some 1915(b)(3) and 1115 authorities of the Social Security Act. The HCBS Final Rule is intended to improve the quality of the lives of beneficiaries by providing them with opportunities to live and receive services in the least restrictive setting possible with full integration in the community. This policy identifies specific HCBS requirements for Behavioral Health service providers to ensure compliance. The MDHHS is responsible for ensuring all requirements are met. Further information regarding the HCBS Final Rule can be found in the Home and Community-Based Services chapter of the MDHHS Medicaid Provider Manual.*	Final-Bulletin-MMP-25-53--Final.pdf
1915(c) Michigan's Children's Waiver Program Waiver Renewal and Amendment Approval	**1915(c) Renewal Approval Letter** *The CMS approved the state's request to renew Michigan's Children's Waiver Program, MI.4119.R07.00, which serves individuals with Intellectual Disabilities or Developmental Disabilities or both, that meet an ICF/IID level of care.* **1915(c) Amendment Approval Letter** *The CMS approved the state's request to amend MI.4119.R07.01, Michigan's Children's Waiver Program that serves individuals with autism, developmental disabilities, or intellectual disabilities aged 0-17 years who meet an ICF/IID level of care.* **MMP 25-28** *The purpose of this bulletin is to update policy for Michigan Medicaid coverage of the Children's Waiver Program to align with the provisions of the waiver renewal approved by CMS effective September 1, 2024*	1915(c) Renewal Approval Letter 1915(c) Amendment Approval Letter Final-Bulletin-MMP-25-28-BCCHPS.pdf
OT/ST/PT for Beneficiaries with Autism Spectrum Disorder Clarification	**MMP 25-56** *Medically necessary Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) is covered in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for Medicaid beneficiaries who have been diagnosed with an ASD.*	Final-Bulletin-MMP-25-56-Updates.pdf

	Beneficiaries should be referred to their PIHP for an ASD comprehensive assessment when further evaluation and treatment is determined necessary. Beneficiaries who have been assessed and determined eligible by the PIHP for specialty Behavioral Health Treatment (BHT) services may have related OT, PT, and ST services covered through the PIHP. If the beneficiary was determined ineligible by the PIHP, ASD related OT, PT, and ST may be covered by the Medicaid Health Plan (MHP) or Medicaid Fee-for-Service (FFS) program. Therapy covered by the MHP or FFS MMP 25-56 Page 2 of 2 program must meet the standards of coverage outlined within the Therapy Services chapter of the MDHHS Medicaid Provider Manual. Beneficiaries receiving ASD therapy services through the PIHP may also receive concurrent therapy services through the MHP/FFS program for co-morbid physical health impairments or diagnosis. If therapy is provided under both the physical and behavioral health benefit, the goals and purpose for each must be distinct, and collaboration between therapy providers is required to coordinate therapy and prevent direct duplication of services. Providers should refer to the MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter and the Therapy Services chapter for complete coverage details.	
Intensive Crisis Stabilization Services (ICSS) Updates	**MMP 25-50** *The purpose of this bulletin is to (1) rescind bulletin MMP 25-42 issued on September 30, 2025, and (2) reinstate bulletin MMP 25-20 for Michigan Medicaid coverage of ICSS for children and adults issued on May 30, 2025.* **MMP 25-20** *The purpose of this bulletin is to update policy for Michigan Medicaid coverage ICSS for adults, children, and their families. This policy aligns the crisis continuum of care between adult and children's ICSS, clarifies the target populations for services to include SUD, serious mental illness (SMI), SED, IDD, and mild-to moderate populations, and establishes the use of the Crisis Professional as a provider qualification. This policy supersedes bulletins MSA 14-63, MSA 17-25 and MSA 03-06. Changes to the Medicaid ICSS policy identified within this bulletin are in addition to the ICSS requirements outlined in the*	Final-Bulletin-MMP-25-50-Rescission.pdf Final-Bulletin-MMP-25-20-ICSS.pdf

	Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the MDHHS Medicaid Provider Manual.	
Substance Use Disorder (SUD) Health Home	**MMP 25-49** *Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act/Section 1945 of the Social Security Act, the purpose of this policy is to provide for the coverage and reimbursement of Substance Use Disorder Health Home (SUDHH) services effective for dates of service on and after October 1, 2025. The policy applies to FFS and managed care beneficiaries enrolled in Medicaid, Healthy Michigan Plan, Freedom to Work, Healthy Kids Expansion, or MIChild who meet health home eligibility criteria. In addition, MDHHS will create a companion operations guide for providers, the SUDHH Handbook, which will be maintained on the Substance Use Disorder Health Home website.*	Final-Bulletin-MMP-25-49-SUDHH.pdf
MI Coordinated Health	**MMP 25-47** *The purpose of this policy is to notify providers of the implementation of the MI Coordinated Health (MICH) program and the end of the MI Health Link program. This bulletin includes the addition of a MICH program chapter in the MDHHS Medicaid Provider Manual. The chapter gives providers information on the new MICH program. Effective January 1, 2026, the MI Health Link (MHL) program will transition to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) program called MI Coordinated Health (MICH). A HIDE SNP is a specific type of Medicare Advantage plan that is designed to meet the needs of individuals who are dually eligible for Medicare and Medicaid. The HIDE SNPs will provide aligned coverage of most Medicaid benefits, excluding certain behavioral health services but including long-term services and supports, under a capitated contract that meets the requirements set forth in 42 CFR 422.107. The MICH program operates under concurrent 1915b/c waiver authorities. The HIDE SNP program will be fully operational commencing January 1, 2026, in limited regions of the State of Michigan. The regions of operation are defined in section 1.1. of the MICH MPM chapter. On January 1, 2027, the program is expected to extend to the entire State, contingent upon budget approval.*	Final-Bulletin-MMP-25-47-MICH.pdf

Behavioral Health Home Expansion and Authorization of Additional Staff	**MMP 25-39** *Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act/Section 1945 of the Social Security Act, the purpose of this policy is to provide for the coverage and reimbursement of BHH services. This policy is effective for dates of service on and after October 1, 2025. The policy applies to FFS and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, MIChild, Freedom to Work, or full FFS Healthy Kids – Expansion who meet BHH eligibility criteria. The MDHHS has a companion operational guide for BHH providers called the Behavioral Health Home Handbook.*	Final-Bulletin-MMP-25-39-BHH.pdf
Parent Support Partner (PSP) Updates	**MMP 25-38** *The purpose of this bulletin is to update policy for Michigan Medicaid coverage of PSP as a State Plan service as of October 1, 2024.* **SPA-24-0007** *The CMS reviewed your State Plan Amendment submitted under transmittal number (TN) 24-0007. This State Plan Amendment provides authority to move PSP services to EPSDT from the behavioral health 1915(i). We conducted our review of your submittal according to the statutory requirements at 42 CFR 440.225. We hereby inform you that Medicaid State Plan Amendment 24-0007 is approved effective October 1, 2024. We are enclosing CMS-179 and the amended plan pages.*	Final-Bulletin-MMP-25-38-BCCHPS.pdf SPA-24-0007.pdf
Children with Serious Emotional Disturbances (SED) Waiver Renewal	**1915(c) Renewal Approval** *The CMS is approving the state's request to renew Michigan's Waiver for Children with SED for individuals with SED ages 0-21 years who meet a hospital level of care.* **MMP 25-37** *The purpose of this bulletin is to update policy for Michigan Medicaid coverage of the Waiver for Children with Serious Emotional Disturbance (SEDW) Program in relation to the October 1, 2024, approved waiver renewal by CMS.*	1915(c) Renewal Approval Letter [post 11.11.23 w App k provisions] Final-Bulletin-MMP-25-37-BCCHPS.pdf

Electronic Visit Verification (EVV) Updates	**MMP 25-24** *The purpose of this policy is to clarify time of visit requirements for EVV required Home Health Care Services (HHCS).* **MMP 25-23** *This bulletin provides guidance on logging Home Help services in an EVV system when the services are provided outside the Home Help client's home. The client's home is defined as their permanent, primary address.*	Final-Bulletin-MMP-25-24-Home-Health-Visits.pdf Final-Bulletin-MMP-25-23-EVV.pdf
Revisions to Psychiatric Residential Treatment Facility (PRTF) Policy	**MMP 25-10** *This policy applies to PRTF service providers. According to CMS, a PRTF is any non-hospital facility with a provider agreement with a State Medicaid Agency to provide inpatient psychiatric hospital services for eligible beneficiaries under 21 years old. The PRTFs provide services under the direction of a physician. According to CMS, a PRTF provides comprehensive mental health treatment to children and adolescents (youth) who, due to mental illness, substance abuse, or SED, need treatment that can most effectively be provided in a residential treatment facility. All other ambulatory care resources available in the community must have been identified, and if not accessed, determined not to meet the immediate treatment needs of the youth. PRTF programs are designed to offer a short-term, intense, focused mental health treatment program to promote a successful return of the youth to the community. Specific outcomes of the mental health services include the youth returning to the family/guardian or to another less restrictive community living situation as soon as clinically possible and when treatment in a PRTF is no longer medically necessary. The residential treatment facility is expected to work actively with the family/guardian, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment designed to meet the individual needs of the youth including those identified with emotional and behavioral treatment needs.*	Final-Bulletin-MMP-25-10-PRTF.pdf
Updates to the MDHHS Medicaid Provider Manual; Psychological	**MMP 25-09** *The MDHHS is clarifying coverage responsibility for psychological and neuropsychological evaluations. Psychological and neuropsychological evaluations provided*	Final-bulletin-MMP-25-09.pdf

and Neuro-psychological Evaluation Coverage Responsibility Clarification	*by professionals in the MHP network for mild to moderate conditions remain MHP responsibility. When the assessment is driven by medical need, the MHP is responsible for coverage. The PIHP is responsible for further evaluation when severe concerns are suspected and treatment of the beneficiary is determined eligible for PIHP services or becomes engaged with PIHP services due to identified need.*	
Respite for Children in Foster Care	**L 25-30** *This letter provides an overview of the requirements for coordination of Medicaid-funded respite services with other commercial insurance and government programs. This letter specifically provides clarification on the authorization and delivery of respite services for children and youth placed in foster care.*	Numbered-Letter-L-25-30-BCCHPS.pdf
Child Caring Institution (CCI) Reimbursement Clarification	**L 25-16** *The purpose of this letter is to provide clarification on Medicaid policy related to the reimbursement of services for children with IDD (including children with ASD) who are residing in a Child Caring Institution. The MDHHS is clarifying the use of Medicaid reimbursement for these services to (1) ensure access to appropriate treatment and habilitative services and (2) support transitions of children with IDD to less restrictive settings. This L Letter supersedes the previously issued letter L 23-34.*	Numbered-Letter-L-25-16-IDD.pdf

If you have questions, please email the Contracts and Quality Management Section at MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

cc: Laura Kilfoyle, Manager, Contract Management Section

Email Correspondence

From: Morningstar, Kristen (DHHS)
To: Morningstar, Kristen (DHHS)
Cc: Mills, Michelle (DHHS)
Subject: MDHHS Specialty Behavioral Health Staffing Changes
Date: Wednesday, February 4, 2026 9:44:08 AM

Good morning,

I hope your 2026 is off to a great start. I wanted to make you aware of staffing changes occurring within the Specialty Behavioral Health Bureau at MDHHS, particularly in two key positions.

- Jackie Sproat accepted the role of Senior Behavioral Health Information Technology Advisor. In this position, Jackie will continue reporting to me while focusing on IT systems work and strengthening cross-departmental coordination. She will also assume oversight of the CRM. The Division of Contracts & Quality Management position is currently being updated and will be posted this month. In the interim, if you have questions related to Quality Performance or Payments, please reach out to Kasi Hunziger. If you have questions related to Contracts, please reach out to Laura Kilfoyle.

- Belinda Hawks announced her retirement effective January 5, 2025. Belinda devoted 40 years to Specialty Behavioral Health Services, including 11 years with MDHHS. We will certainly miss her expertise, commitment, and passion for improving lives. The Division Director position is also being updated and will be posted this month. In the interim, if you have questions related to Federal Compliance, please reach out to Lyndia Deromedi. If you have questions related to Community Based Practices, including Peer Supports, please reach out to Brenda Stoneburner.

If you have any questions, don't hesitate to reach out directly to me and/or the managers identified above.

Sincerely,

Kristen Morningstar
Specialty Behavioral Health Services Director
Michigan Department of Health and Human Services
morningstark@michigan.gov
(517) 388-7421

CANCELLATION OF REQUEST FOR PROPOSAL

Notice of Intent to Award Number: 260000000197
for
Request for Proposal (RFP): 250000002670
Cancellation Date: January 29, 2026

The Department of Technology, Management, and Budget, Central Procurement Services has cancelled RFP 250000002670.

Per the RFP Proposal Instructions, Section 11 (b), Reservations, the State has elected to discontinue the RFP process, and no Award will be issued.

If you have any questions, please contact the Solicitation Manager at the contact information below.

Marissa Gove
Govem1@michigan.gov
517-449-8952

Email Correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: CMHA actions - post Yates opinion and RFP withdrawal
Date: Wednesday, February 11, 2026 7:53:37 AM

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: CMHA actions - post Yates opinion and RFP withdrawal

If you were at the recent CMHA Winter 2026 Conference, the CMHA Board of Directors meeting, or the CMHA Directors Forum, you heard Alan and I talk about CMHA's game plan in this post-Yates decision; post RFP withdrawal period. This game plan, with three parallel paths, is summarized below.

A. A pro-active approach at strengthening and advancing improvements to Michigan's public mental health system in statute, policy, and practice

1. CMHA, and its allies – NAMI, Arc, and MAC – are working to refine the **draft set of recommended core components of a redesigned system**. This draft document has been shared with CMHA members several times over the past year. As this document is finalized, it will form the basis of advocacy work of CMHA and these core allies and all of our members.

2. To ensure that this set of recommended core components represents the views of CMHA's diverse membership, CMHA will be calling together a **Guidance Group** made up of representatives of the three types of CMHA members:

- CMHSPs
  - PIHPs
  - Leadership of the CMHA Provider Alliance (representing private providers in the CMHSP and PIHP networks)

This Guidance Group will identify:

- Refinements to be proposed in the Core Components document and related efforts
- Components in the Core Components document which could be pursued without or in advance of statutory changes and those which will require statutory changes

3. In pursuit of the recommendations contained in this document, CMHA, its members, and allies will initiate advocacy around statutory and/or policy changes. s document.

B. Legal action which would required if MDHHS issues a second PIHP RFP

C. Work, in partnership with allies, to halt the implementation of the Mental Health Framework

D. Renewal/continuation of contracts between MDHHS and PIHPs who signed contract negotiated with MDHHS yet not signed by MDHHS

Robert Sheehan

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

MEMORANDUM

To: Executive Officers of the Prepaid Inpatient Health Plans and Community Mental Health Services Program

From: Kristen Morningstar, Director
Bureau of Specialty Behavioral Health Services

Date: February 6, 2026

RE: Revised Clarification of Direct Care Worker Wage Increase

Purpose:

This memorandum provides formal clarification regarding Prepaid Inpatient Health Plans (PIHP) responsibilities for implementing the Direct Care Worker (DCW) Wage Increase under Numbered Letter L-25-78 and outlines how recent minimum wage changes have been incorporated into PIHP managed care capitation rates. This guidance is intended to ensure consistent application across all PIHPs and contracted provider networks.

Statutory and Policy Requirements:

It is the responsibility of PIHPs to implement the wage increases in accordance with L 25-78. For reference please see: Numbered-Letter-L-25-78-DCW.pdf.

The Department continues to receive questions and requests for guidance related to implementation of the Direct Care Worker (DCW) Wage Increase, which are clarified below:

- Consistent with L-25-78, the DCW Wage Increase **cannot** cover costs associated with the minimum wage increase.
- Consistent with L-25-78, the DCW Wage Increase is **in addition to** the minimum wage.
- State minimum wage changes are **separate from** the DCW Wage Increase detailed in L-25-78.
    - DCW Wage Increase is a standardized increase to a worker's hourly wage.
    - State minimum wage changes **do not** result in standardized wage increases.

Incorporation of Minimum Wage Changes Into PIHP Capitation Rates:

SFY 2025 Rate Amendment

- SFY 2025 amended managed care rates support the February 21, 2025, minimum wage increase as related to DCW services.

- Revised PIHP rates were reflected in Gross Adjustments transmitted February 5, 2026.
- As indicated in the SFY 2025 PIHP Rate Certification Amendment (December 26, 2025):
    - Michigan's minimum hourly wage increased to **$12.48** effective February 21, 2025.
    - This adjustment was applied beginning **February 1, 2025,** in recognition of the administrative complexities with implementing mid-month wage increases.
    - The rate adjustment was informed by survey data provided by the Specialty System.
- The Michigan Earned Sick Time Act (effective February 21, 2025) was also incorporated into the rate adjustment with an effective date of February 1, 2025.

SFY 2026 Current PIHP Rates

- SFY 2026 current managed care rates support the **January 1, 2026,** minimum wage increase as related to Direct Care Worker services.
- PIHP Capitation payments effective October 2025 reflect this minimum wage consideration.
- As indicated in the PIHP Rate Certification (September 29, 2025):
    - Michigan's minimum hourly wage increased to **$13.73** effective January 1, 2026.
    - Rates reflect:
        - **$12.48** minimum wage for October 1–December 31, 2025
        - **$13.73** minimum wage for January 1–September 30, 2026
    - The SFY 2026 current rates were informed by survey data provided by the Specialty System.
    - The Michigan Earned Sick Time Act (effective February 21, 2025) was also incorporated into SFY 2026 current rates.

Department Expectations for PIHPs:

As a result of guidance in the form of L-Letters and funding incorporated into PIHP capitation rates as described above, it is MDHHS's reasonable and **firm expectation that all qualifying DCW workers are compensated, prior to overtime consideration, at no less than**:

- **$15.88** per hour ($12.48 + $3.40) for the period **February 1–December 31, 2025**
- **$17.13** per hour ($13.73 + $3.40) beginning **January 1, 2026**

Recordkeeping Requirements:

Additionally, as required under L-25-78:

- DCW agencies that are a network provider under a Medicaid managed care entity and/or their subcontractor must retain documentation demonstrating:
    - Distribution of the DCW Wage Increase to eligible workers.
    - Compliance with all requirements in L-25-78.

- Documentation must be provided upon request by MDHHS or contracted managed care entities.

FY26 Budget Changes- Section 1034:

PIHPs must comply with all requirements under PA 22 of 2025 Sec. 1034. Consider the following when reporting:

  - Neither this guidance nor L 25-78 reflect a requirement for the state minimum wage increase to reflect a uniform contract rate increase.
  - As stated above, state minimum wage changes do not result in standardized wage increases.
  - As such, state minimum wage increases are distinct from program requirements associated with ABA service provision.

Community Mental Health Association of Michigan

Analysis of Medicaid revenue and DCW wage related costs

FY 2026

A. Revenues

1. Revenues projected in Milliman FY 26 Medicaid Rate Certification

Capitated Funding Projected using Actuarial Certification Documents Comparing FY25 to FY26 (Does not include HRA pass through to hospitals)				
Source of Funding:	FY2025	FY2026	Difference	as a %
DAB Capitation Behavioral Health	2,206,700,000	2,115,191,172		
DAB Capitation Substance Use Disorder *	43,100,000	38,465,432		
Total DAB	**2,249,800,000**	**2,153,656,604**	**(96,143,396)**	**-4.3%**
TANF Capitation Behavioral Health	403,900,000	322,536,984		
TANF Capitation Substance Use Disorder*	46,300,000	36,410,191		
Total TANF	**450,200,000**	**358,947,176**	**(91,252,824)**	**-20.3%**
HSW, CWP, & SED Payments **	**709,800,000**	**774,554,090**	**64,754,090**	**9.1%**
HMP Capitation Behavioral Health	335,500,000	297,082,271		
HMP Capitation Substance Use Disorder*	149,100,000	142,758,803		
Total HMP	**484,600,000**	**439,841,074**	**(44,758,926)**	**-9.2%**
Autism all Populations	465,100,000	523,972,354	58,872,354	12.7%
Total:	4,359,500,000	4,250,971,297	(108,528,703)	-2.5%
Total less Autism	**3,894,400,000**	**3,726,998,943**	**(167,401,057)**	**-4.3%**

* *In FY26 the certification document no longer distinguishes or separates Behavioral Health and SUD funding*

*** The projected increase in HSW, CWP, and SED Waiver payments is based on a projected increase of 300 HSW waiver enrollees. The actual enrollment pattern (see enrollment analysis section, below) shows HSW enrollment far below that projection.*

2. Medicaid revenue projected to be received by the PIHPs

Comparison of PIHP Funding Received in September 2025 (FY25) Versus October 2025 (FY26)

	DAB Funding Comparison			TANF Funding Comparison		
	September FY25	October FY26	Difference	September FY25	October FY26	Difference
Totals:	206,218,149	200,369,619	(5,848,531)	54,345,031	47,779,010	(6,566,020)
Difference as a %:			-2.8%			-12.1%

	HMP Funding Comparison			HSW, CWP, & SED Funding Comparison		
	September FY25	October FY26	Difference	September FY25	October FY26	Difference
Totals:	38,084,190	33,988,106	$ (4,096,084)	57,880,479	57,222,638	(657,841)
Difference as a %:			-10.8%			-1.1%

	Total Capitation Funding Comparison			
	September FY25	October FY26	Difference	% Difference
Totals:	356,527,850	339,359,374	(17,168,476)	-4.8%

Annual projection without reflecting enrollment declines **(206,021,718)**

3. Revenue increases tied to DCW wages

The following are excerpts from the Milliman FY 26 Medicaid Rate Certification (https://acrobat.adobe.com/id/urn:aaid:sc:US:272664cb-e6f6-4cb1-9026-05d03303f1d5)

Direct Care Worker (DCW) Wage Adjustment
Effective October 1, 2024, MDHHS increased add-on reimbursement for direct care worker (DCW) services from $3.20 per hour to $3.40 per hour, as directed in Section 231 of SB 747 PA 121 of 2024, with an additional add-on related to **employer related expenses**. MDHHS also continues to allow for funding for all overtime hours. **An assumption of 10% of hours worked qualifying as overtime, resulted in a blended DCW rate of $3.60 per hour.**
MDHHS has indicated that the DCW wage adjustment is incremental to the state minimum wage, which is fully described as a separate program change.

Based on SFY 2024 experience and utilization trend, we determined that the $3.60 per hour adjustment for DCW services would produce approximately a $361.7 million increase in projected revenue for SFY 2026. Figure 3 below documents the time per unit assumptions used in the build-up of this adjustment, which are consistent with those used in the development of the SFY 2025 capitation rates.

Since the base SFY 2024 experience includes approximately $317.6 million related to DCW increases, this amount was deducted from the base experience to avoid duplication.

*(CMHA note: This would mean an increase, in FY 26 rates, of **$44.1 million** related to DCW wage increases and related employer costs and overtime for DCW workers expected to be paid in FY 26.)*

Minimum Wage Increase
Effective February 21, 2025, the State of Michigan increased the minimum hourly wage rate to $12.48. Effective January 1, 2026, the State of Michigan is increasing the minimum hourly wage rate from $12.48 per hour to $13.73. Currently, this adjustment assumes the DCW add-on is additive to the new minimum wage, bringing the effective hourly minimum wage assumptions for direct care workers, before consideration for overtime, to $15.88 and $17.13 for the October 1, 2025 through December 31, 2025 and January 1, 2026 through September 30, 2026 time periods, respectively. The assumptions underlying this adjustment leveraged responses from the SFY 2025 Behavioral Health Provider Staffing and Expense Survey, which were trended by the 4.6% annual unit cost trend assumption and compared to the effective minimum wage across the rating period. **This adjustment increased projected capitation rate funding for SFY 2026 by approximately $23.1 million.**

Earned Sick Time
Effective February 21, 2025, the Michigan Earned Sick Time Act required employers to provide all eligible nonexempt employees with an accrual of one hour of sick time per thirty hours worked up to a specified limit that will roll over to the following year. The adjustments underlying this assumption leveraged SFY 2025 Behavioral Health Provider Staffing and Expense Survey information. **This adjustment increased projected capitation rate funding for SFY 2026 by approximately $12.5 million.**

CMHA note: The increased revenues that the actuaries estimate to be needed to over these three wage increases are:

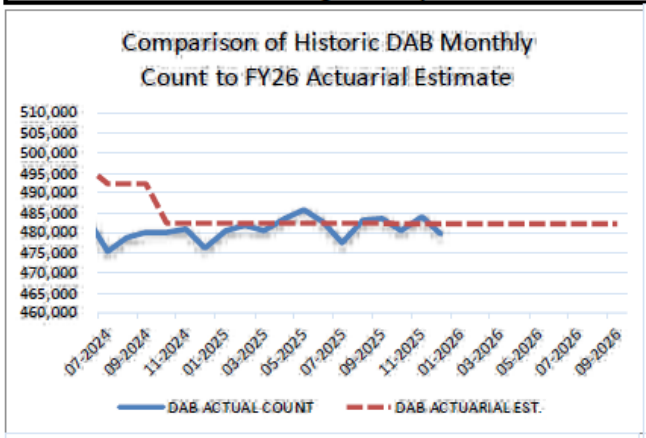
	(In millions)
Reflected in initial FY 26 rates to PIHPs	
FY 26 DCW wage adjustment*	$44.1
FY 26 Earned sick leave	$12.5
Added to FY 26 rates to cover FY 25 DCW-related costs	
To be used to cover Minimum wage increases made in FY 25	$23.1
Total DCW-related revenue reflected in initial FY 26 PIHP rates or added in February 2026	**$79.7**

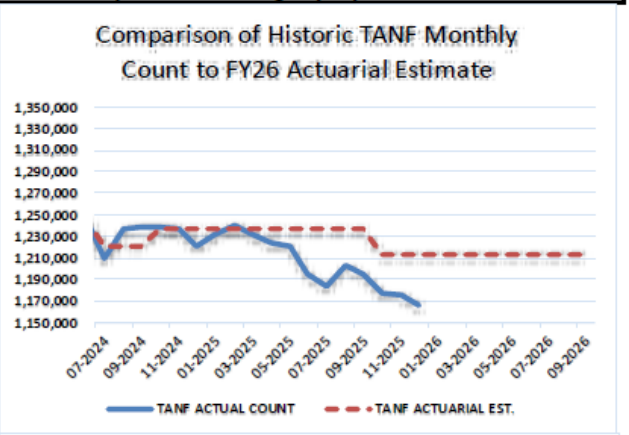
4. Net revenue projection

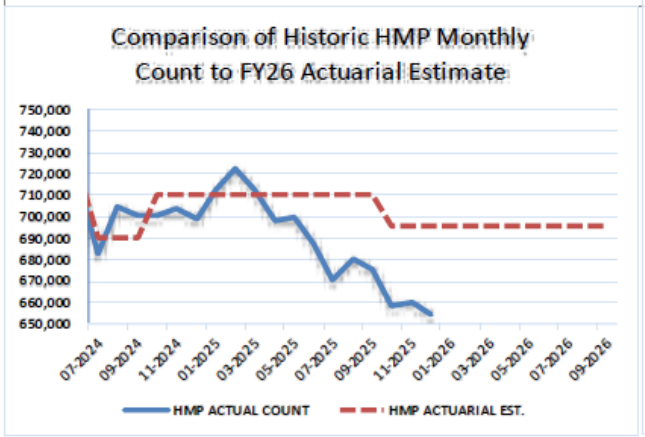
Net revenue position of PIHPs FY 26	
Annual projected change from FY 25 with FY 26 DCW wage adjustment and earned sick leave-related increases already reflected in FY 2026 rates (prior to February 5 rate adjustment)	-$206,021,718
Additional DCW-related increase received in FY 26 (for FY 25 minimum wage payments)	$23,100,000
Net revenue position of PIHPs FY26 compared to FY 25	**-182,921,718**

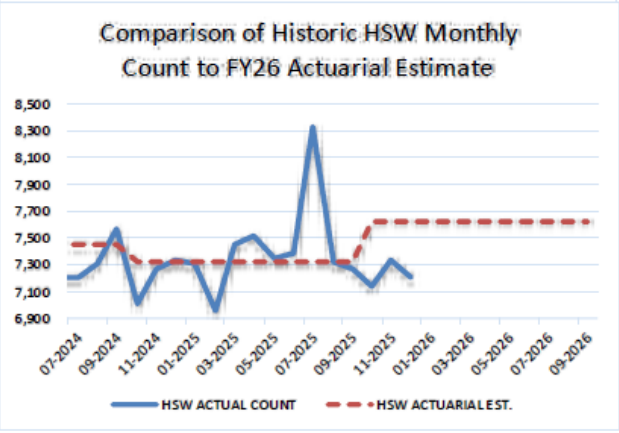
B. FY 2026 Medicaid enrollment declines below those projected by Milliman

Charts begin with July 2024 which is the first month with no public health emergency impact









C. Notes from January 27 meeting of MDHHS Actuarial Office and PIHP CFOs

1. **February 5th, payments totaling about $23.1M did go out to the PIHPs to cover the FY 25 Minimum Wage and ESTA increase.**
2. **MDHHS Actuarial Office is aware that enrollment is down.** They will continue to monitor enrollment trends. If a rate adjustment is needed, to offset this enrollment drop, it is likely to be implemented in the May-June time frame. **Actuarial Office did not commit to making a rate adjustment.**
3. Keith White agreed to follow-up with the group on when HSW will switch from FY 2025 rates to FY 2026 rates.
4. Milliman's FY 26 Medicaid Certification letter states that "based on SFY 2024 experience and utilization trend, we determined that the $3.60 per hour adjustment for DCW services would produce approximately a $361.7 million increase in projected revenue for SFY 2026." It was recognized that this statement, read without the remainder of that section of narrative, has caused confusion in the field as to the dollars available to cover DCW wage costs. That narrative states, ". Since the base SFY 2024 experience includes approximately $317.6 million related to DCW increases, this amount was deducted from the base experience to avoid duplication." **Given this, the FY 26 rates, as initially set, contain approximately $44 million related to DCW wage increases and related employer costs and overtime for DCW workers expected to be incurred in FY 26. The MDHHS Actuarial Office** will work on guidance to send to the providers detailing how the DCW-related revenue increase was developed.
5. MDHHS does an annual survey of providers who do more than $1 million of Medicaid-related business with the state, annually. **The concern that PIHPs raised, as has been raised for the past several years, is that many providers provide less than $1 million in Medicaid business, thus excluding their payrolls from the actuarial analysis.**

Email Correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter
Subject:	Governor"s FY27 Executive Budget Recommendation
Date:	Thursday, February 12, 2026 9:22:25 AM
Attachments:	FY27 Exec Budget Rec.doc

From: Alan Bolter <ABolter@cmham.org>
Sent: Thursday, February 12, 2026, 9:03 AM
To: CMHA Board of Directors, CMH & PIHP Directors, Provider Alliance, Legislation & Policy Committee, SUD Directors, and Public Relations Committee
Subject: Governor's FY27 Executive Budget Recommendation

Yesterday, Governor Gretchen Whitmer's eighth and final executive budget recommendation was presented by State Budget Director Jen Flood. The budget doubles down on the administration's long-term priorities. Amid national economic uncertainty caused by tariffs and deep federal cuts to Medicaid and SNAP, the budget lowers costs, protects access to health care, and makes other key investments to help more families live, work, and play in Michigan.

The proposed FY27 spending plan is $88.1 billion, including a general fund total of $13.6 billion and a school aid budget totaling $21.4 billion. The budget is based on roughly $800 million in tax increases, $630 million in cuts and $400 million from the rainy day fund.

According to the Budget Director, the plan puts a premium on preventing cuts to Medicaid, the health program that roughly 1 in 4 Michiganders count on to cover their care. The One Big Beautiful Bill Act (OBBBA) pushed new eligibility requirements and costs for Medicaid and Supplemental Nutrition Assistance Program (SNAP) recipients onto the states.

According to the Budget Office, Kentucky is proposing a $1 billion rainy-day fund withdrawal to cover the shortfall. Washington is proposing to end corporate tax exemptions and use $1 billion in reserves. Alaska is proposing a new sales tax. Delaware is proposing tax increases. Idaho is looking at a 2% cut to K-12.

Whitmer's plan suggests $804.4 million in tax increases to gaming, tobacco, vaping and digital advertising as a way to make up for the declining federal dollars and new eligibility requirements for Medicaid and food assistance, among other health initiatives.

Despite steep health care increases, Whitmer is also hoping to raise enough money to

get a new psychiatric hospital up and running to care for more people, a raise for health care workers and expanded community violence intervention services.

The DHHS estimates it will cost $97 million to implement the OBBBA. The state is being asked to cover 75% of SNAP benefits as opposed to 50% starting in FY 2027. That's another $97 million. To oversee Medicaid compliance means another 589 assistance payment workers, inspectors, analysts, supervisors and administrative assistants, costing $80.3 million more.

Attached is my document that provides additional budget details – I will continue to update this document over the next several days including adding proposed boilerplate changes. Below is a link to the budget documents:

Executive Budget and Associated Documents

Alan Bolter
Associate Director
Community Mental Health Association of Michigan
507 S. Grand Ave, Lansing MI 48933
(517) 374-6848 Main
(616) 340-7711 Cell

FY27 Executive Budget Proposal

Specific Mental Health/Substance Abuse Services Line items

	FY'25 (Final)	FY'26 (Final)	FY'27 (Exec Rec)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$3,387,066,600	$3,188,847,900	$3,667,513,800
-Medicaid Substance Abuse services	$95,650,100	$96,323,300	$84,902,600
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,626,200	$79,207,900	$79,221,100
-Health Homes Program	$53,418,500	$50,239,800	$50,239,800
-Autism services	$329,620,000	$467,644,200	$560,716,600
-Healthy MI Plan (Behavioral health)	$527,784,600	$438,267,500	$525,256,200
-CCBHC	$525,913,900	$916,062,700	$916,062,700
-Total Local Dollars	$10,190,500	$9,943,600	$9,943,600

Other Highlights of the FY27 Executive Budget:

H.R. 1 Implementation

The Executive Budget includes funding to implement the requirements of H.R. 1. Signed on July 4, 2025, H.R. 1 introduces new eligibility requirements for recipients of Medicaid and the Supplemental Nutrition Assistance Program (SNAP). It also requires additional efforts by state agencies that administer those programs to achieve compliance. Accordingly, the Executive Budget provides new funding to increase capacity within local offices, bolster community engagement and outreach efforts, and enhance information technology capabilities. The intent of these efforts is to (1) help Michigan residents who are eligible to receive public assistance demonstrate compliance and maintain enrollment, and (2) enforce new eligibility requirements.

Proposed investments include:

- $97 million ($154.6 million general fund) to DHHS for H.R. 1 Implementation:

  - $94.3 million (general fund), offset with a like reduction in federal revenue (net zero total) for SNAP administrative costs due to the state's required cost share increasing from 50% to 75% beginning in fiscal year 2027.

  - $80.3 million for additional full-time employees ($54.2 million general fund) to meet workload increases resulting from new requirements within H.R. 1. This investment includes an additional 589.0 FTEs for assistance payment workers, Office of Inspector General agents, departmental analysts, supervisors, and administrative assistants.

  - $16.7 million to expand beneficiary support ($6.1 million general fund) by increasing access to beneficiary help-line services and providing educational support on H.R. 1 changes. This includes a $5 million federal grant from the Centers for Medicare and Medicaid Services (CMS), included in the FY26 supplemental proposal, to support costs related to Medicaid community engagement requirements.

Behavioral Health Facility and Capacity Expansions

The Executive Budget prioritizes needed investments in Michigan's behavioral health system. These investments include supplemental funding for the transition of staff, supplies, and materials to the Southeast Michigan State Psychiatric Hospital (SMSPH), a new facility that is currently under construction and expected to open in October 2026. The Executive Budget includes the following behavioral health facility and capacity expansion investments:

- $7.9 million in supplemental funding and 53.8 FTEs to transfer staff and materials (general fund) from Walter Reuther Hospital to SMSPH. This will allow newly hired staff to shadow and receive necessary training from experienced caregivers transitioning from established facilities to the new hospital.

- $72.2 million and 323.0 FTEs to begin operating SMSPH ($65.8 million general fund), bringing 264 new beds online and increasing total statewide capacity by 54 beds (32 adult beds and 22 pediatric beds). This investment includes operational support and hiring staff to provide services at the facility.

- A net zero transfer of $99.4 million and 584.2 FTEs ($71 million general fund) from Walter Reuther to the SMSPH. This will transfer the entire Walter Reuther appropriation to SMSPH, as Walter Reuther will be closed following the scheduled opening of the new facility in October 2026.

- $7.2 million (general fund) to support the following one-time investments: υ $6 million for upgrades to the psychiatric hospitals' electronic medical and business records system to better manage patient data, ensure appropriate billing, and increase effective use of medication dispensing systems.

- $1.2 million to purchase personal protection devices (PPDs) at Caro Regional Mental Health Center, Center for Forensic Psychiatry, and Kalamazoo Psychiatric Hospital (PPDs have already been purchased for SMSPH). PPDs are wearable, digital panic devices used to reduce violence in health care workplace settings and are expected to significantly increase staff and patient safety across the state hospital system.

- $8.3 million in federal authorization for new psychiatric residential treatment facilities in Grand Rapids, Lansing, and Livonia that together are expected to bring 50 new transitional beds online. Psychiatric residential treatment facilities (PRTFs) provide shortterm, intense, and focused mental health treatment to promote successful integration into the community. PRTFs function as a step-up from the community and as a step-down from state inpatient treatment.

Collectively, these investments intend to expand capacity, address aging infrastructure, and strengthen the state's ability to deliver timely, clinically appropriate care.

Health Care Workforce

The Executive Budget pursues multiple strategies to strengthen Michigan's health care workforce by addressing shortages and enhancing capacity. Direct care worker supports and minimum wage increases seek to improve recruitment and retention efforts by increasing compensation and benefits for frontline caregivers.

- $258.4 million to support 2025 and 2026 direct care worker minimum wage increases ($87.3 million general fund), which preserves $3.40 per hour in increased wages received by workers over the past two years. Currently, federal American Rescue Plan (ARP) funds that expire at the end of FY26 support these increases. This investment backfills the lost ARP funds with general fund to continue drawing down federal Medicaid match dollars.

- $69.5 million to support the 2027 direct care worker minimum wage increase of $1.27 per hour ($23.5 million general fund).

- $24 million to provide sick leave for direct care workers consistent with Public Acts 338 and 369 of 2018 ($8.1 million general fund). Nearly all employers, such as those employing members of the direct care workforce, are required to provide paid sick leave to eligible employees. This investment transitions the cost to general fund and Medicaid matching dollars, as time limited ARP funds currently support this requirement.

- $10 million one-time investment to improve staffing levels in nursing homes (Civil Monetary Penalties). This aims to address chronic workforce shortages that impact the quality of care for residents in long-term care facilities. A recent CMS campaign increased the scope of eligible staffing projects that can be funded with Civil Monetary Penalties.

Medicaid Sustainability

The Executive Budget recognizes the need to bend the curve in Medicaid cost growth, while ensuring access to the necessary and quality care that one in four Michiganders depend on. As health care costs continue to increase at rates exceeding overall inflation, access to affordable care remains a growing concern for families across the nation. Mirroring national trends, Michigan Medicaid has seen significant cost growth in recent years, and it is more important than ever that the state strategically change the trajectory of health care expenditures, pursue new approaches and utilize existing tools to ensure the viability of its Medicaid program for years to come.

Michigan has incorporated a variety of strategies to curb Medicaid cost growth, while ensuring access to necessary and quality care, such as:

- Establishing provider partnerships whereby health care entities such as hospitals, health plans, skilled nursing facilities, and ambulance service providers pay into assessment programs to generate non-federal revenue.

- Implementation of policies, procedures, and technology solutions to increase program efficiencies.

The Governor's budget seeks to use the following funding streams and strategies to support the Michigan Medicaid program in the coming years:

- Tobacco Tax: forecast to generate $232 million in FY27.

- Vape Tax: forecast to generate $95 million in FY27 to be used for cancer prevention, smoking prevention, children's coordinated health care, and for the Medicaid Benefits Trust Fund.

- New internet tax rate on largest casinos: forecast to generate $135.5 million in new tax revenue in FY27, with the majority going directly to the Medicaid Benefits Trust Fund.

- Per-Wager Sports Betting Tax: forecast to generate $38.8 million for the Medicaid Benefits Trust Fund in FY27.

- Elimination of Free Play Deduction: eliminating this deduction is forecast to generate $21.1 million for the Medicaid Benefits Trust Fund in FY27.

- Digital Advertising: the tax is forecast to generate $282 million in FY27.

- **$150 million in efficiency savings identified in collaboration with stakeholders to address costs, accountability and resource effectiveness while maintaining sustainability of services.**

Email Correspondence

From: MDHHS-HLTHSVCS-ACTUARIAL-BUREAU
To: Deanna Yockey (NMRE); Eric Kurtz (NMRE); Carol Balousek (NMRE); Brandon Rhue (NMRE)
Cc: Parker, Christopher (DHHS); White, Keith (DHHS); Williams, Crystal (DHHS); Schneider, Matthew (DHHS); Sproat, Jackie (DHHS); Hunziger, Kasi (DHHS); Stimac, Joseph (DHHS)
Subject: Northern Michigan - PIHP SFY25 - Amendment #5 GA Notification
Date: Tuesday, February 10, 2026 10:40:44 AM

Good morning,

Please see below for a breakdown of your Amendment #5 GA, by Program Code and Fund Source. These funds should have been received on 2/5/26. If you have any questions or needs related to this payment, please let the cc-line know and we will do our best to assist.

Northern Michigan Regional Entity	**$ 1,778,218.29**
0006 - SPMH DAB	$ 937,644.87
0006 - SPMH HK CHIP	$ 11,046.89
0006 - SPMH HK FMAP	$ 792.50
0006 - SPMH Michild	$ 13,272.63
0006 - SPMH TANF	$ 119,959.28
0008 - HMPMH	$ 90,862.53
0045 - HSW-MC	$ 599,197.66
0077 - CWP-MC	$ 2,843.43
0082 - SED - MC	$ 2,598.50

Thank you,
MDHHS Actuarial Team

Bureau of Actuarial Services | Health Services Operations | MDHHS-HLTHSVCS-ACTUARIAL-BUREAU@michigan.gov

If you are not the intended recipient, please contact the sender by reply e-mail and destroy any and all copies of the original message.

Communication with Those Charged with Governance during Planning

February 10, 2026

To the Members of the Board
Northern Michigan Regional Entity
Gaylord, Michigan

We are engaged to audit the financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Northern Michigan Regional Entity (the PIHP) for the year ended September 30, 2025. Professional standards require that we provide you with the following information related to our audit.

We would also like to extend the opportunity for you to share with our firm any concerns you may have regarding the PIHP, whether they be in relation to controls over financial reporting, controls over assets, or issues regarding personnel, as well as an opportunity for you to ask any questions you may have regarding the audit.

Our Responsibilities under U.S. Generally Accepted Auditing Standards, *Government Auditing Standards*, and the Uniform Guidance

As stated in our engagement letter, our responsibility, as described by professional standards, is to express opinions about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

In planning and performing our audit, we will consider the PIHP's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinions on the financial statements and not to provide assurance on the internal control over financial reporting. We will also consider internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with the Uniform Guidance.

As part of obtaining reasonable assurance about whether the PIHP's financial statements are free of material misstatement, we will perform tests of its compliance with certain provisions of laws, regulations, contracts, and grants. However, providing an opinion on compliance with those provisions is not an objective of our audit. Also in accordance with the Uniform Guidance, we will examine, on a test basis, evidence about the PIHP's compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Compliance Supplement applicable to each of its major federal programs for the purpose of expressing an opinion on the PIHP's compliance with those requirements. While our audit will provide a reasonable basis for our opinion, it will not provide a legal determination on the PIHP's compliance with those requirements.

Our responsibility is to plan and perform the audit to obtain reasonable, but not absolute, assurance that the financial statements are free of material misstatement. We are responsible for communicating significant matters related to the audit that are, in our professional judgement, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures specifically to identify such matters.

Planned Scope, Timing of the Audit, Significant Risks, and Other

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of the entity and its environment, including the system of internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent

financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity.

We will generally communicate our significant findings at the conclusion of the audit. However, some matters could be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

During planning for this engagement, we considered the following significant risks of material misstatement. Our auditing procedures have been tailored to help detect these risks should they occur. Should any actual instances of material misstatement be detected during the performance of our engagement, these would be communicated to the Board in the *Communication with Those Charged with Governance at the Conclusion of the Audit*. Those risks considered during planning are:

- Management override of controls
- Improper revenue recognition due to fraud

Again, these are risks that are considered in determining the audit procedures to be applied. While these are risks that are considered during planning, it is not an indication that any such activity has taken place. To address these risks, we incorporate unpredictability into our audit procedures, emphasize the use of professional skepticism, and assign staff to the engagement with industry expertise.

Derek Miller is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it.

This information is intended solely for the use of those charged with governance and management of the PIHP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.
Certified Public Accountants

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – FEBRUARY 11, 2026
VIA TEAMS

ATTENDEES:	**Bea Arsenov, Brian Babbitt, Melissa Bentgen, Connie Cadarette, Ann Friend, Chip Johnston, Nancy Kearly, Eric Kurtz, Allison Nicholson, Donna Nieman, Pamela Polom, Nena Sork, Jennifer Warner, Tricia Wurn, Deanna Yockey, Lynda Zeller, Carol Balousek**

REVIEW AGENDA & ADDITIONS
No additions to the meeting agenda were requested.

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE JANUARY 14, 2026, NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

MONTHLY FINANCIALS
December 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $2,841,802. Carry forward was reported as $8,908,717. The total Medicaid and HMP current year surplus was reported as $11,750,519. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $32,340,608.
- Traditional Medicaid showed $58,028,276 in revenue, and $54,598,291 in expenses, resulting in a net surplus of $3,429,985. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $8,908,717.
- Healthy Michigan Plan showed $6,831,249 in revenue, and $7,419,432 in expenses, resulting in a net deficit of $588,183. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $831,806 in revenue, and $665,135 in expenses, resulting in a net surplus of $166,671.
- SUD showed all funding source revenue of $5,471,776 and $4,871,598 in expenses, resulting in a net surplus of $600,178. Total PA2 funds were reported as $4,879,422.

PA2/Liquor Tax was summarized as follows:

Projected FY26 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$5,142,821	$1,847,106	$2,071,443	$4,918,483

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,142,821	$0	$263,398	$4,879,422

A retroactive adjustment of $1.7M to FY25 revenue will be reported on the FSR. These funds represent a gross adjustment for FY25 to account for minimum wage and ESTA. The $1.7M will be reflected in the FY25 carry forward.

MOTION BY DONNA NIEMAN TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2025; SUPPORT BY ANN FRIEND. MOTION APPROVED.

EDIT UPDATE

The January 15, 2025, EDIT minutes were sent by Donna on January 27th.

- The P3 EQI is due to MDHHS on March 2, 2026.
- MDHHS is no longer pursuing an 1115 Reentry Waiver for incarcerated individuals due to budgetary constraints.
- Effective October 1, 2025, QBHPs can no longer bill for ABA services. LBAs must bill for any assistant behavioral analysts that they supervise (BCaBA, LABA).
- Changes to the Funding Source Code chart have been proposed to separate funding source from authorities.
  - Codes with an authority listed must be under that authority but cad additionally have any of the funding sources listed.
  - Those with Medicaid coverage marked as "yes" must meet all required medical necessity criteria for the listed service.
  - If multiple authorities are listed, individuals need not be enrolled in all, but must be enrolled in at least one.
  - If multiple funding sources are listed, individuals must have at least one of the applicable funding sources.
- MDHHS is considering expanding the available coding for Support Brokers.
- ICSS Code changes include definition of modifiers, H2011-HT, H2011 with ET modifier, H0038 with TS modifier, follow-up and post-stabilization.
- FY26 Q2 updates to the Code Chart and Provider Qualifications Chart include:
  - Removal of Block Grant coverage from H0004 and H0005 MH lines
  - Added CCBHC to Reporting Service flag to T1012
  - Struck out QBHP reference on the provider qualifications tab
  - Struck out QBHP reference on the H0031 tab
  - Specified that H2019 is for adults
  - Removed the word "targeted" from H0036 reporting and costing considerations column
  - Added fencing language to S5165 CWP line reporting and costing considerations column
  - Added not to BCBA and BCaBA qualification
  - Added S9485 note under reporting and costing considerations column to indicated non-Medicaid only

The question was raised regarding whether a priority modifier is needed for instances in which a client receives both a MichiCANS and LOCUS assessment on the same date; no guidance has been provided to date.

Bea shared information from the PIHP Autism Leads Meeting on January 30th during which Mary Luchies (MDHHS) discussed BCaBA guidance that conflicted with what was shared during EDIT. During the Autism Leads meeting, MDHHS indicated that BCaBAs may no longer bill for services citing private insurance standards, though this conflicts with Medicaid Rules and Michigan law allowing supervised practice. Nothing was said about BCaBAs/LABAs providing services under the supervision of LBAs.

EQI UPDATE
Tricia reported that she has received P3 EQIs from North Country, Northeast Michigan, and Wellvance. Donna indicated that Centra Wellness' EQI will be sent to the NMRE later this date.

ELECTRONIC VISIT VERIFICATION (EVV)
Donna reported that an EVV Leads meeting occurred at 9:30 this morning. No update was provided. A regional meeting took place regarding the PCE billing/adjudication piece.

HSW OPEN SLOTS UPDATE
Based on the payment received this morning, the region was paid for 669 HSW enrollees for February. Bea reported that the region currently has 710 of 711 slots filled (shorted 41 slots). Issues in CHAMPS are likely continuing.

Donna asked whether a timeframe has been provided for the recoupment of the October and November overpayment. Deanna responded that she had not heard anything regarding timing.

CHAMPS Fix HSW Update and Verification Research Project
Brandon was not in attendance, but Deanna reported that $136,500 of FY25 waiver payments was received at the end of January. HSW payments (PC5 and PC7) will be sent to the CMHSPs this week. It appears that MDHHS is doing some automated cleanup.

NMRE REVENUE & ELIGIBLES ANALYSIS
The NMRE observed a 5.4% decrease in eligibles between DAB, TANF, and HMP. Milliman is considering a mid-year rate adjustment (possibly in April).

An analysis of October 2023 – January 2026 Revenue and Eligibles was shared with Committee Members.

DAB			
	October 2023	January 2026	% Change
Revenue	$10,003,003	$11,131,548	11.28%
Enrollees	28,444	25,039	-11.97%
Average Payment per Enrollee	$352	$445	26.42%

HMP			
	October 2023	January 2026	% Change
Revenue	$2,369,569	$2,171,980	-8.34%
Enrollees	47,550	27,829	-41.47%
Average Payment per Enrollee	$50	$78	56.62%

TANF			
	October 2023	January 2026	% Change
Revenue	$2,865,200	$2,774,496	-3.17%
Enrollees	66,801	50,558	-24.32%
Average Payment per Enrollee	$43	$55	27.94%

Children's Waiver Program			
	October 2023	January 2026	% Change
Revenue	$36,882	$31,620	-14.27%
Enrollees	11	9	-18.18%
Average Payment per Enrollee	$3,353	$3,513	4.78%

HSW			
	October 2023	January 2026	% Change
Revenue	$4,638,399	$5,662,460	22.08%
Enrollees	650	751	15.54%
Average Payment per Enrollee	$7,136	$7,540	5.66%

SED			
	October 2023	January 2026	% Change
Revenue	$40,846	$30,836	-24.51%
Enrollees	21	42	100%
Average Payment per Enrollee*	$1,945	$734	-62.25%

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

TOTAL			
	October 2023	January 2026	% Change
	$19,953,899	$21,802,941	9.27%

FY25 FSR

After processing the CMHSPs' FSRs, she will email the CFOs regarding any differences. Clarification was made that Health Home deficits will need to be covered with local funds.

NEXT MEETING

The next meeting was scheduled for March 11th at 10:00AM.

Chief Executive Officer Report

February 2026

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.

Jan 23: Attended and participated in statewide CIO Forum.

Jan 24: Presented NMRE regional update to the Wellvance Board.

Feb 5: Attended and participated in NMRE Internal Operations Committee meeting.

Feb 9: Attended Child and Adult Peer Support meeting with MDHHS.

Feb 10: Attended and participated in PIHP CEO Group.

Feb 11: Attended NMRE Regional Finance Committee meeting.

Feb 12: Met with NLCMHA CEO.

Feb 17: Chaired NMRE Operations Committee meeting.

Feb 19: Attended and participated in PIHP/MDHHS Operations meeting.

Feb 19: Presented NMRE regional update to North Country Board.

Northern Michigan Regional Entity

December 2025

Finance Report (revised)

02/19/26

December 2025 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	1,720,599	2,844,054	13,519,285
Healthy Michigan	(643,914)	-	7,070,804
	$ 1,076,685	$ 2,844,054	$ 20,590,089

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	(68,140)	454,681	(2,033,970)	641,227	946,328	795,599	340,960	$ 1,076,685
Carry Forward		-	-	-	-	-	-	2,844,054
Total Med/HMP Current Year Surplus	(68,140)	454,681	(2,033,970)	641,227	946,328	795,599	340,960	$ 3,920,739
Medicaid & HMP Internal Service Fund								20,590,089
Total Medicaid & HMP Net Surplus								$ 24,510,828

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through December 31, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 56,891,864	$ 1,136,414						$ 58,028,278
CMHSP Distributions	(55,723,527)		18,028,384	15,102,822	9,142,885	8,487,116	4,962,320	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	1,168,337	1,136,414	18,028,384	15,102,822	9,142,885	8,487,116	4,962,320	58,028,278
Expense								
PIHP Admin	879,530	13,378						892,908
PIHP SUD Admin		29,019						29,019
SUD Access Center		-						-
Insurance Provider Assessment	467,508	7,280						474,788
Hospital Rate Adjuster	-							-
Services	-	822,688	19,338,445	14,249,170	8,292,983	7,682,779	4,524,899	54,910,964
Total expense	1,347,038	872,365	19,338,445	14,249,170	8,292,983	7,682,779	4,524,899	56,307,679
Net Actual Surplus (Deficit)	$ (178,702)	$ 264,049	$ (1,310,060)	$ 853,652	$ 849,902	$ 804,337	$ 437,421	$ 1,720,599

Notes

Medicaid ISF - $13,519,285 - based on current FSR
Medicaid Savings - $2,844,054

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through December 31, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 4,453,219	$ 2,378,030						$ 6,831,249
CMHSP Distributions	(4,212,144)		1,541,095	1,195,547	540,146	569,169	366,187	0
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	241,075	2,378,030	1,541,095	1,195,547	540,146	569,169	366,187	6,831,249
Expense								
PIHP Admin	83,862	33,544						117,406
PIHP SUD Admin		72,766						72,766
SUD Access Center		-						-
Insurance Provider Assessment	46,651	18,234						64,885
Hospital Rate Adjuster	-							-
Services	-	2,062,854	2,265,005	1,407,972	443,720	577,907	462,648	7,220,106
Total expense	130,513	2,187,398	2,265,005	1,407,972	443,720	577,907	462,648	7,475,163
Net Surplus (Deficit)	$ 110,562	$ 190,632	$ (723,910)	$ (212,425)	$ 96,426	$ (8,738)	$ (96,461)	$ (643,914)

Notes
HMP ISF - $7,070,804 - based on current FSR
HMP Savings - $0

Net Surplus (Deficit) MA/HMP	**$ (68,140)**	**$ 454,681**	**$ (2,033,970)**	**$ 641,227**	**$ 946,328**	**$ 795,599**	**$ 340,960**	**$ 1,076,685**
Medicaid/HMP Carry Forward								**2,844,054**
Total Med/HMP Current Year Surplus								$ 3,920,739
Medicaid & HMP ISF - based on current FSR								**20,590,089**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 24,510,828**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through December 31, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 317,635		95,464	100,026	124,243	61,069	133,369	$ 831,806
CMHSP Distributions	-	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	-
1st/3rd Party receipts	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	-
Net revenue	317,635	-	95,464	100,026	124,243	61,069	133,369	831,806
Expense								
PIHP Admin	10,501	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10,501
BHH Admin	10,334	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10,334
Insurance Provider Assessment	-	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	-
Hospital Rate Adjuster	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Services	131,614		95,464	100,026	124,243	61,069	133,369	645,785
Total expense	152,449	-	95,464	100,026	124,243	61,069	133,369	666,620
Net Surplus (Deficit)	$ 165,186	$ -	$ -	$ -	$ -	$ -	$ -	$ 165,186

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2025 through December 31, 2025

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,136,414	$ 2,378,030	$ 1,042,048	$ 663,147	$ 263,396	$ 5,483,035
Expense						
PIHP Admin						65,212
SUD Admin						199,511
Administration	42,397	106,310	44,393	71,624		264,723
OHH Admin			25,506	-		25,506
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	7,280	18,234	-			25,514
Services:						
Treatment	822,688	2,062,854	861,407	392,284	263,397	4,402,630
Prevention	-	-	-	199,239	-	199,239
Healing and Recovery Grant				-		-
Alcohol Use Disorder Services				-		
ARPA Grant	-	-	-	-	-	-
Total expense	872,365	2,187,398	931,306	663,147	263,397	4,917,612
PA2 Redirect			-	0		0
Net Surplus (Deficit)	$ 264,049	$ 190,632	$ 110,742	$ 0	$ -	$ 565,423

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2025 through December 31, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 56,891,864	$ 1,136,414	$ -	$ 58,028,278
Medicaid Savings	-	-	-	-
Healthy Michigan	4,453,219	2,378,030	-	6,831,249
Healthy Michigan Savings	-	-	-	-
Health Home	831,806	-	-	831,806
Opioid Health Home	-	1,042,048	-	1,042,048
Substance Use Disorder Block Grant	-	663,147	-	663,147
Public Act 2 (Liquor tax)	-	263,396	-	263,396
Affiliate local drawdown	148,704	-	-	148,704
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	-	-	-
Healing & Recovery Revenue	-	-	-	-
Veteran Navigator Grant	34,101	-	-	34,101
SOR Grant Revenue	-	376,991	-	376,991
Gambling Grant Revenue	-	34,030	-	34,030
Other Revenue	70	-	1,023	1,093
Total operating revenue	62,359,764	5,894,056	1,023	68,254,843
Operating expenses				
General Administration	1,039,106	199,511	-	1,238,617
Prevention Administration	-	32,442	-	32,442
OHH Administration	-	25,506	-	25,506
BHH Administration	10,334	-	-	10,334
Insurance Provider Assessment	514,159	25,514	-	539,673
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	54,088,276	822,688	-	54,910,964
Healthy Michigan Services	5,157,252	2,062,854	-	7,220,106
Health Home Services	645,785	-	-	645,785
Opioid Health Home Services	-	861,407	-	861,407
Community Grant	-	392,284	-	392,284
Prevention	-	166,797	-	166,797
State Disability Assistance	-	-	-	-
Alcohol Use Disorder Services	-	-	-	-
ARPA Grant	-	-	-	-
Public Act 2 (Liquor tax)	-	263,398	-	263,398
Local PBIP	-	-	-	-
Local Match Drawdown	148,704	-	-	148,704
Miscellanous Grant	-	-	-	-
Healing & Recovery Grant	-	-	-	-
Veteran Navigator Grant	34,101	-	-	34,101
SOR Grant Expenses	-	376,991	-	376,991
Gambling Grant Expenses	-	34,030	-	34,030
Total operating expenses	61,637,717	5,263,422	-	66,901,139
CY Unspent funds	722,047	630,634	1,023	1,353,704
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	6,886,611	10,929,769	20,586,761	38,403,141
Unspent funds - ending	$ 7,608,658	$ 11,560,403	$ 20,587,784	$ 39,756,845

Northern Michigan Regional Entity

Statement of Net Position

December 31, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 34,680,932	$ 11,118,094	$ 20,587,784	$ 66,386,810
Accounts Receivable	664,733	1,581,857	-	2,246,590
Prepaids	29,988	-	-	29,988
Total current assets	35,375,653	12,699,951	20,587,784	68,663,388
Noncurrent Assets				
Capital assets	361,889	-	-	361,889
Total Assets	35,737,542	12,699,951	20,587,784	69,025,277
Liabilities				
Current liabilities				
Accounts payable	27,796,992	1,139,548	-	28,936,540
Accrued liabilities	331,892	-	-	331,892
Unearned revenue	-	-	-	-
Total current liabilities	28,128,884	1,139,548	-	29,268,432
Unspent funds	$ 7,608,658	$ 11,560,403	$ 20,587,784	$ 39,756,845

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2025 through December 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 46,938,177	$ 56,891,864	$ 9,953,687	21.21%
Carryover	11,400,000	-	-	-	-
Healthy Michigan					
Capitation	19,683,372	4,920,843	4,453,219	(467,624)	(9.50%)
Carryover	5,100,000	-	-	-	0.00%
Health Home	1,451,268	362,817	831,806	468,989	129.26%
Affiliate local drawdown	594,816	148,704	148,704	-	0.00%
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	27,501	34,101	6,600	24.00%
Other Revenue	-	-	70	70	0.00%
Total operating revenue	227,426,695	52,398,042	62,359,764	9,961,722	19.01%
Operating expenses					
General Administration	3,819,287	895,314	1,039,106	(143,792)	(16.06%)
Health Home Administration	-	-	10,334	(10,334)	0.00%
Insurance Provider Assessment	1,897,524	474,381	514,159	(39,778)	(8.39%)
Hospital Rate Adjuster	4,571,328	1,142,832	-	1,142,832	100.00%
Local PBIP	1,737,753	-	-	-	0.00%
Local Match Drawdown	594,816	148,704	148,704	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	22,929	34,101	(11,172)	(48.72%)
Payments to Affiliates:					
Medicaid Services	176,618,616	44,154,654	54,088,276	(9,933,622)	(22.50%)
Healthy Michigan Services	17,639,940	4,409,985	5,157,252	(747,267)	(16.94%)
Health Home Services	1,415,196	353,799	645,785	(291,986)	(82.53%)
Total operating expenses	208,404,464	51,602,598	61,637,717	(10,035,119)	(19.45%)
CY Unspent funds	$ 19,022,231	$ 795,444	722,047	$ (73,397)	
Transfers in			-		
Transfers out			-	61,637,717	
Unspent funds - beginning			6,886,611		
Unspent funds - ending			$ 7,608,658	722,047	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2025 through December 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 1,169,658	$ 1,136,414	$ (33,244)	(2.84%)
Healthy Michigan	11,196,408	2,799,102	2,378,030	(421,072)	(15.04%)
Substance Use Disorder Block Grant	6,467,905	1,616,975	663,147	(953,828)	(58.99%)
Opioid Health Home	3,419,928	854,982	1,042,048	187,066	21.88%
Public Act 2 (Liquor tax)	1,533,979	-	263,396	263,396	0.00%
Miscellanous Grants	4,000	1,000	-	(1,000)	(100.00%)
Healing & Recovery Grant	-	-	-	-	0.00%
SOR Grant	2,043,984	510,996	376,991	(134,005)	(26.22%)
Gambling Prevention Grant	200,000	50,000	34,030	(15,970)	(31.94%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	7,002,713	5,894,056	(1,108,657)	(15.83%)
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,127,295	255,645	199,511	56,134	21.96%
Prevention Administration	131,394	29,607	32,442	(2,835)	(9.58%)
Insurance Provider Assessment	113,604	28,401	25,514	2,887	10.17%
Medicaid Services	3,931,560	982,890	822,688	160,202	16.30%
Healthy Michigan Services	10,226,004	2,556,501	2,062,854	493,647	19.31%
Community Grant	2,074,248	518,562	392,284	126,278	24.35%
Prevention	634,056	158,514	166,797	(8,283)	(5.23%)
State Disability Assistance	95,215	23,809	-	23,809	100.00%
Alcohol Use Disorder Services	-	-	-	-	0.00%
ARPA Grant	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	25,506	(25,506)	0.00%
Opioid Health Home Services	3,165,000	791,250	861,407	(70,157)	(8.87%)
Miscellanous Grants	4,000	1,000	-	1,000	100.00%
Healing & Recovery Grant	-	-	-	-	0.00%
SOR Grant	2,043,984	510,996	376,991	134,005	26.22%
Gambling Prevention	200,000	50,000	34,030	15,970	31.94%
PA2	1,533,978	-	263,398	(263,398)	0.00%
Total operating expenses	25,280,338	5,907,175	5,263,422	643,753	10.90%
CY Unspent funds	$ 4,264,498	$ 1,095,538	630,634	$ (464,904)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			10,929,769		
Unspent funds - ending			$ 11,560,403		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2025 through December 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 2,023,189	$ 480,453	$ 527,792	$ (47,339)	(9.85%)
Fringes	704,786	158,406	167,261	(8,855)	(5.59%)
Contractual	770,808	170,829	282,012	(111,183)	(65.08%)
Board expenses	18,000	4,500	3,334	1,166	25.91%
Day of recovery	14,000	9,000	-	9,000	100.00%
Facilities	152,700	38,175	36,391	1,784	4.67%
Other	135,804	33,951	22,316	11,635	34.27%
Total General Admin	$ 3,819,287	$ 895,314	$ 1,039,106	$ (143,792)	(16.06%)

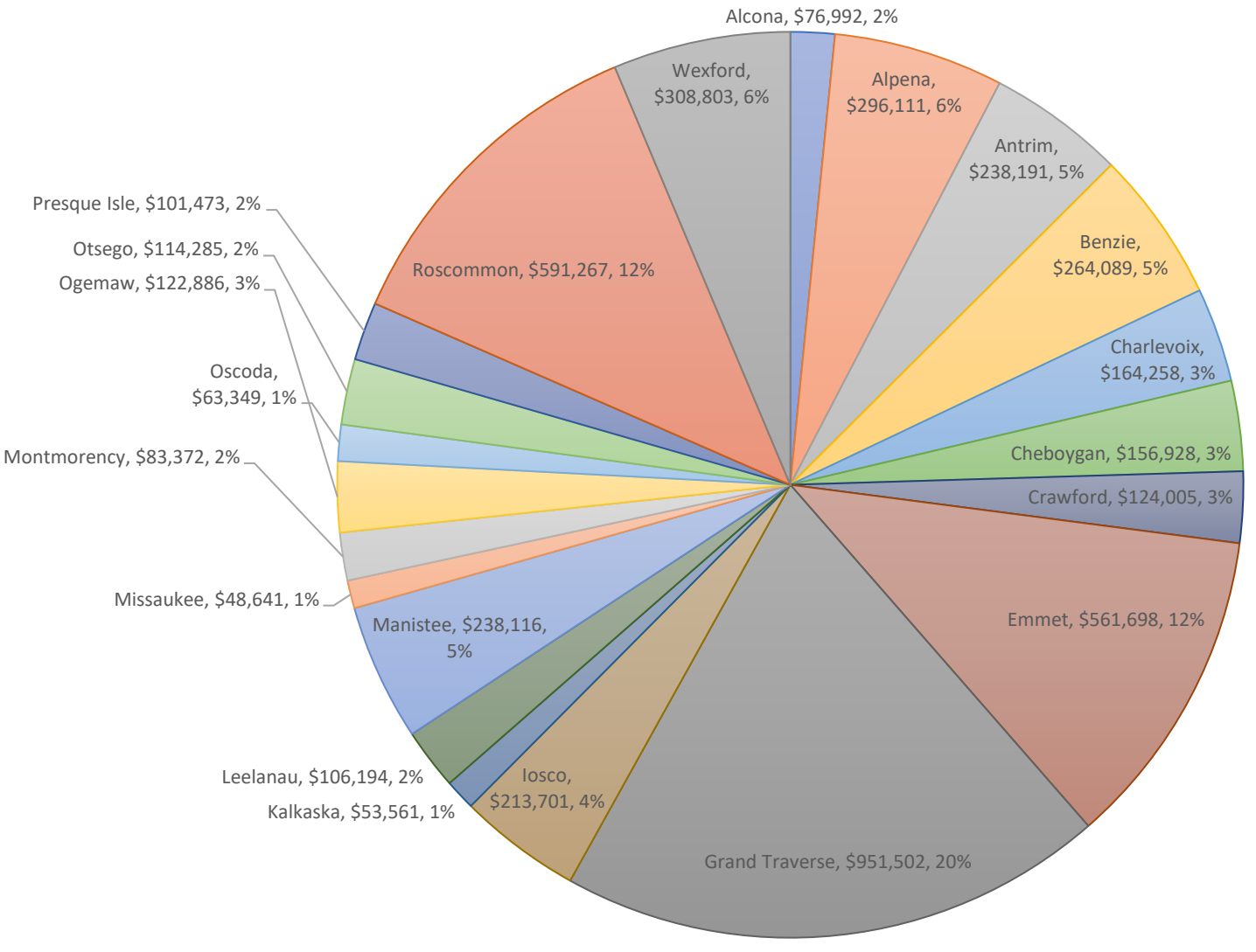
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2025 through December 31, 2025

	Projected FY26 Activity				Actual FY26 Activity			
	Beginning Balance	FY26 Projected Revenue	FY26 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 79,981	$ 23,013	$ 24,001	$ 78,993	$ -	2,988	$ -	$ 76,992
Alpena	315,893	81,249	87,854	309,288	-	19,782	-	296,111
Antrim	248,419	71,430	46,424	273,425	-	10,228	-	238,191
Benzie	276,050	64,021	47,793	292,278	-	11,961	-	264,089
Charlevoix	180,985	106,977	92,341	195,621	-	16,727	-	164,258
Cheboygan	161,840	85,508	81,361	165,987	-	4,912	-	156,928
Crawford	127,739	36,205	33,849	130,095	-	3,733	-	124,005
Emmet	574,150	182,951	332,159	424,942	-	12,452	-	561,698
Grand Traverse	1,037,930	464,163	698,152	803,941	-	86,428	-	951,502
Iosco	217,704	84,319	66,511	235,512	-	4,003	-	213,701
Kalkaska	53,910	41,796	3,936	91,770	-	349	-	53,561
Leelanau	109,318	63,811	44,237	128,892	-	3,124	-	106,194
Manistee	250,862	82,480	40,719	292,623	-	12,747	-	238,116
Missaukee	48,934	22,352	7,175	64,112	-	293	-	48,641
Montmorency	85,825	30,318	14,262	101,881	-	2,453	-	83,372
Ogemaw	123,674	68,787	26,413	166,049	-	789	-	122,886
Oscoda	65,547	21,668	17,149	70,065	-	2,198	-	63,349
Otsego	135,933	105,067	111,286	129,714	-	21,648	-	114,285
Presque Isle	104,871	24,977	20,080	109,768	-	3,398	-	101,473
Roscommon	613,562	87,317	130,060	570,820	-	22,295	-	591,267
Wexford	329,692	98,696	145,681	282,707	-	20,889	-	308,803
	5,142,821	1,847,106	2,071,443	4,918,483	-	263,398	-	4,879,422
PA2 Redirect								-
								4,879,422

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, 2025 through December 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 768,091	$ 180,843	$ 127,907	$ 52,936	29.27%
Fringes	212,604	53,151	41,822	11,329	21.31%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	18,750	20,700	(1,950)	(10.40%)
Board expenses	5,000	1,251	945	306	24.46%
Day of Recover	-	-	-	-	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	1,650	8,137	(6,487)	(393.15%)
Total operating expenses	$ 1,127,295	$ 255,645	$ 199,511	$ 56,134	21.96%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2025 through December 31, 2025

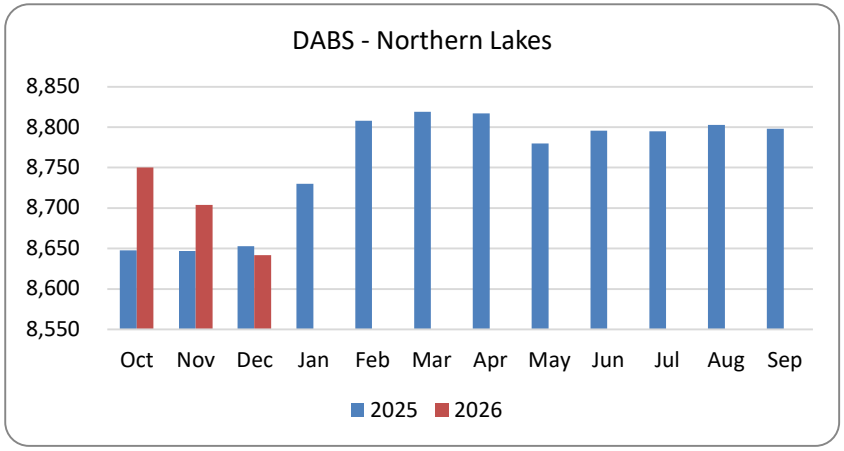
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	1,875	1,023	(852)	(45.44%)
Total operating revenue	7,500	1,875	1,023	(852)	(45.44%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 1,875	1,023	$ (852)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,586,761		
Unspent funds - ending			$ 20,587,784		

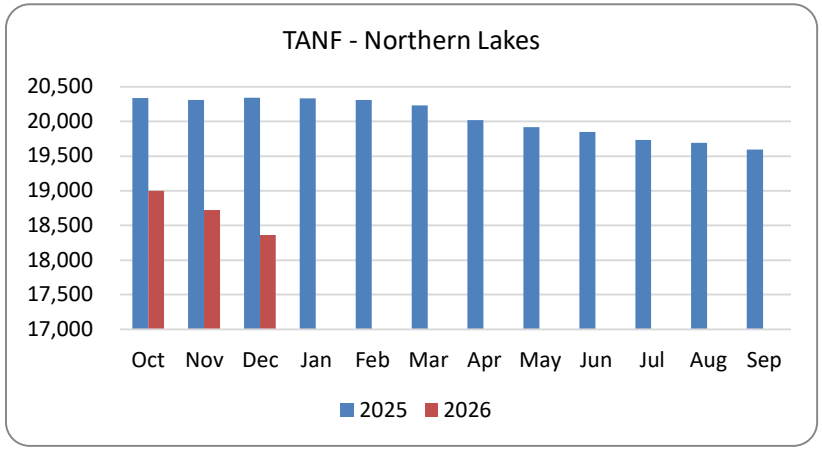
Northern Michigan Regional Entity

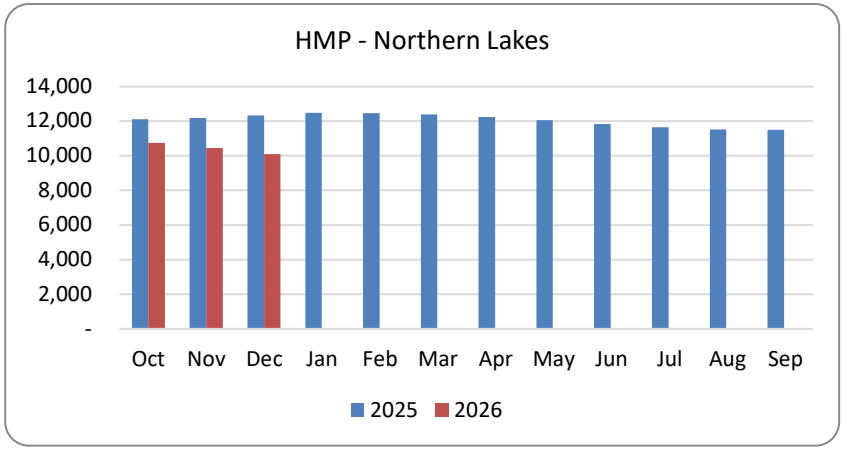
Narrative

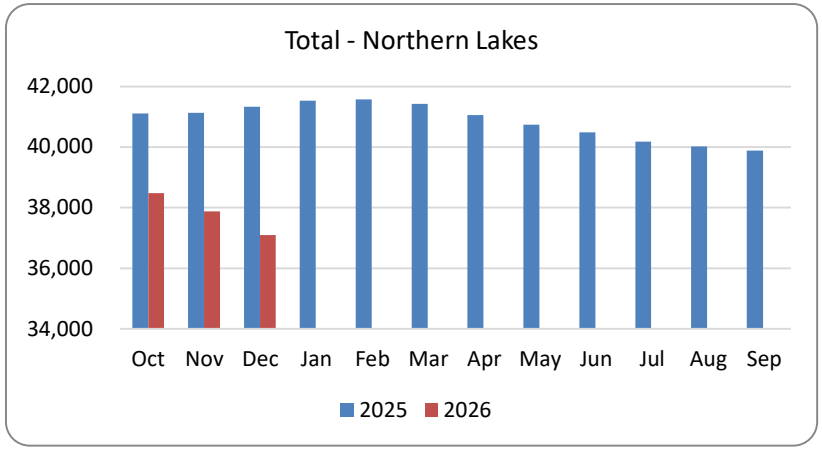
October 1, 2025 through December 31, 2025

Northern Lakes Eligible Members Trending - based on payment files







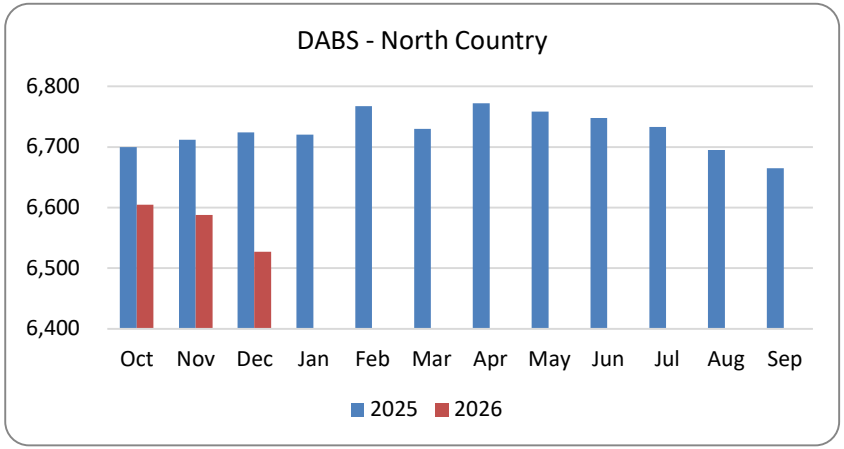


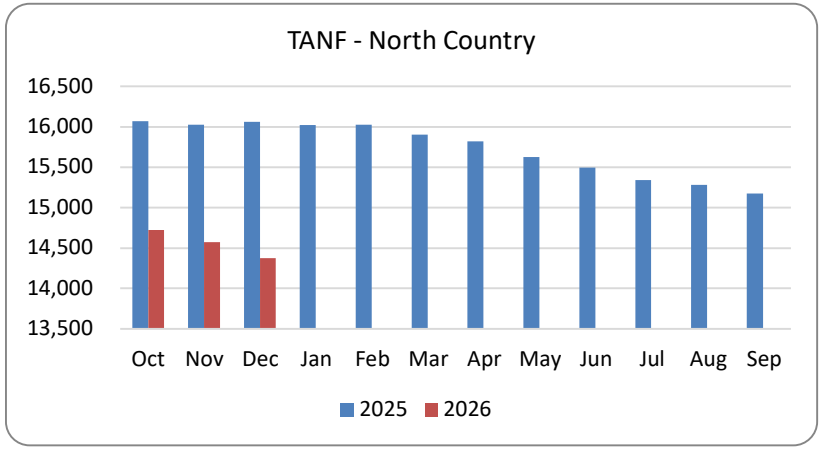
Northern Michigan Regional Entity

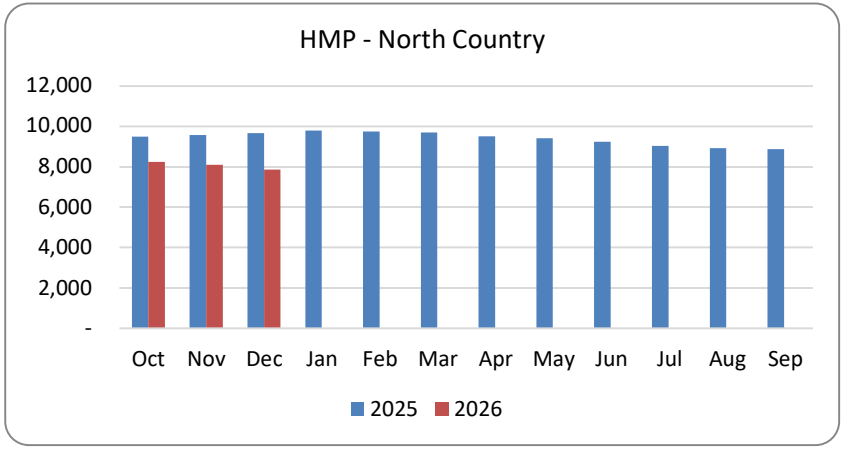
Narrative

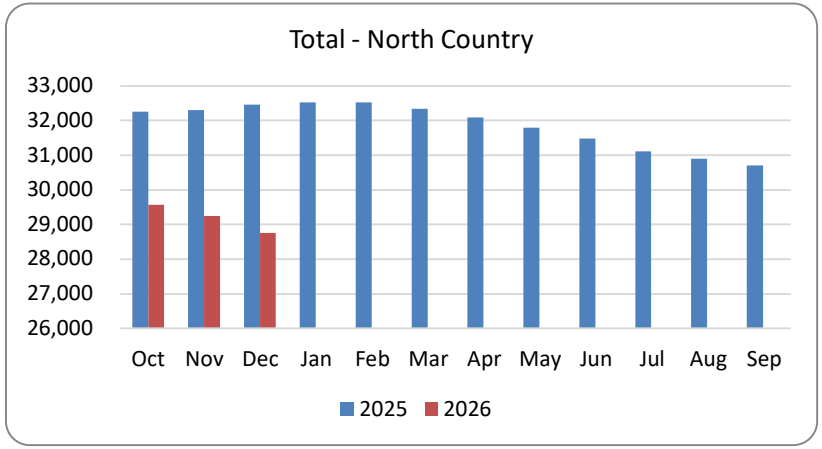
October 1, 2025 through December 31, 2025

North Country Eligible Members Trending - based on payment files







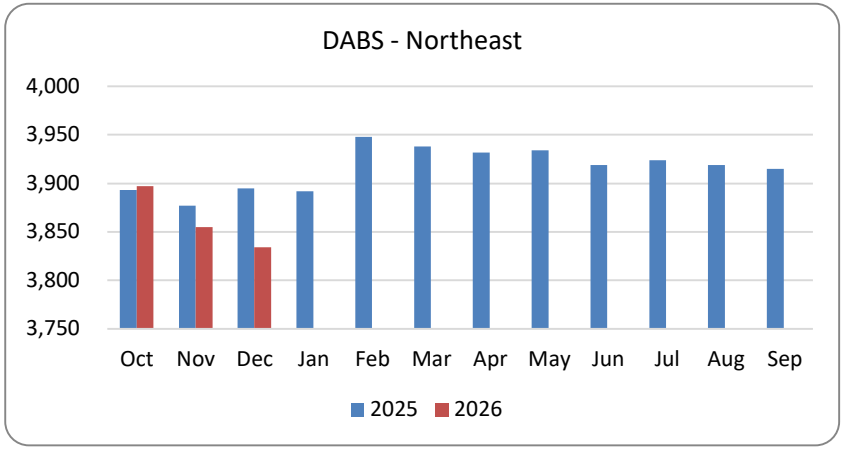


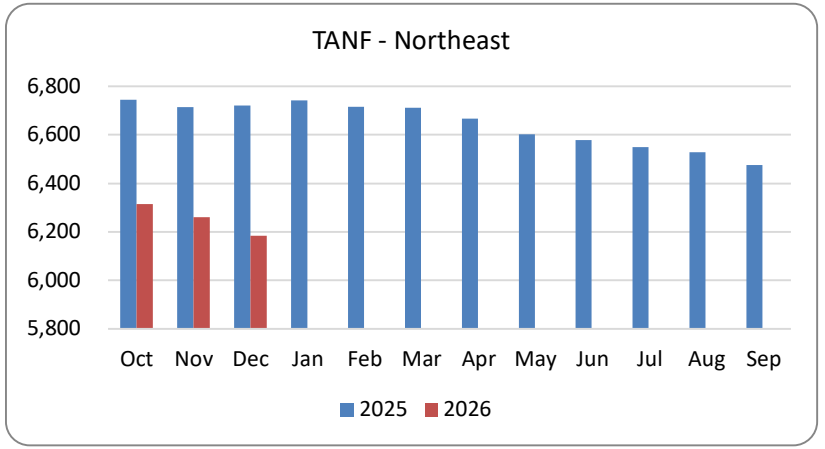
Northern Michigan Regional Entity

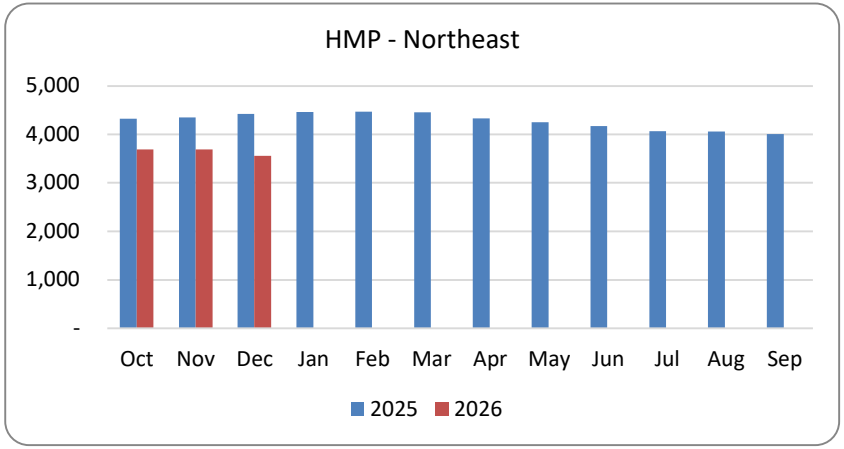
Narrative

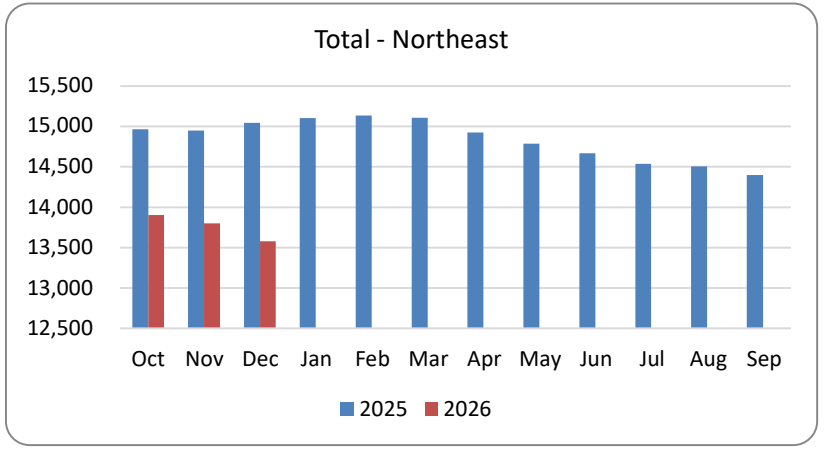
October 1, 2025 through December 31, 2025

Northeast Eligible Members Trending - based on payment files







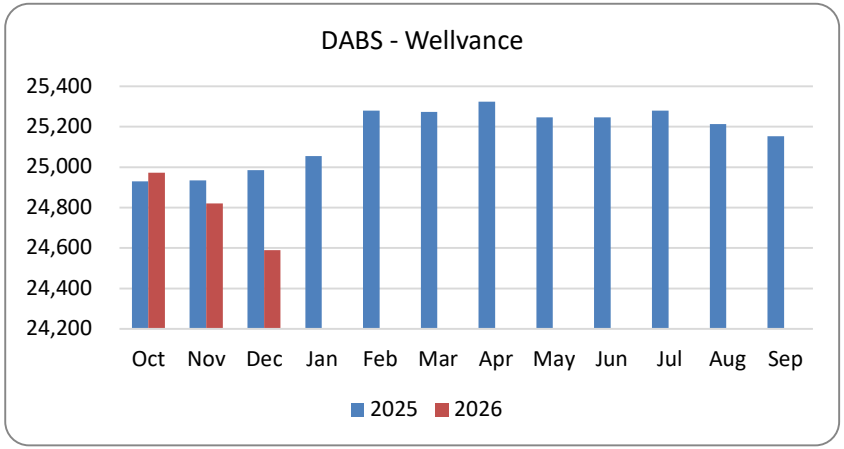


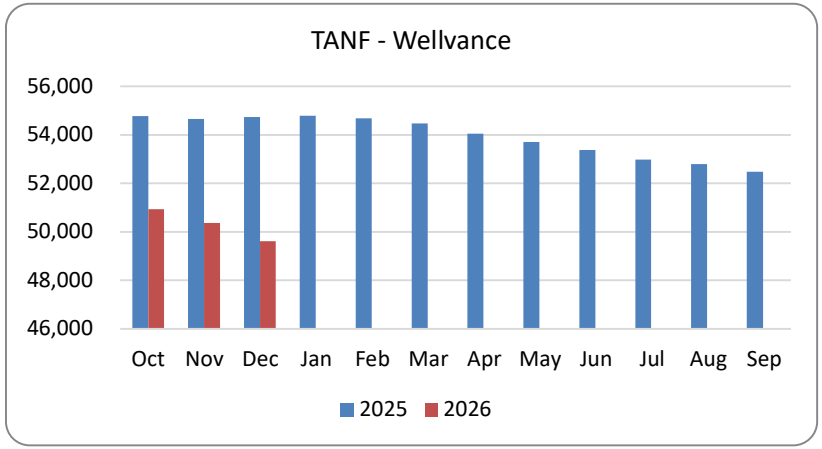
Northern Michigan Regional Entity

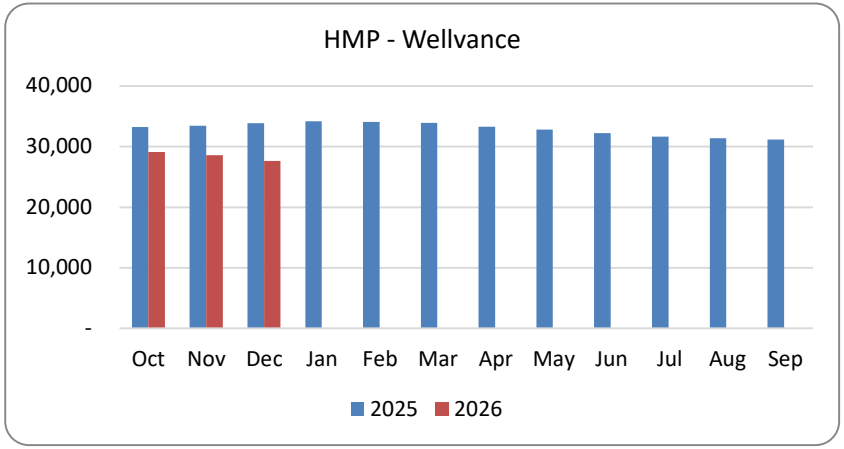
Narrative

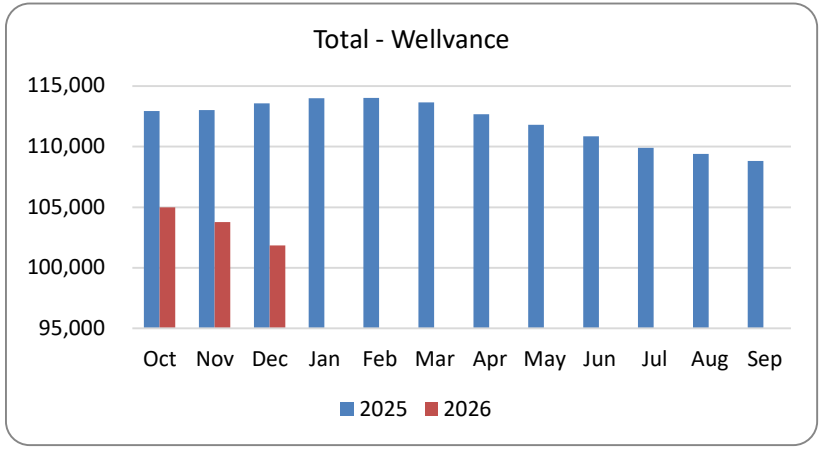
October 1, 2025 through December 31, 2025

Wellvance Eligible Members Trending - based on payment files







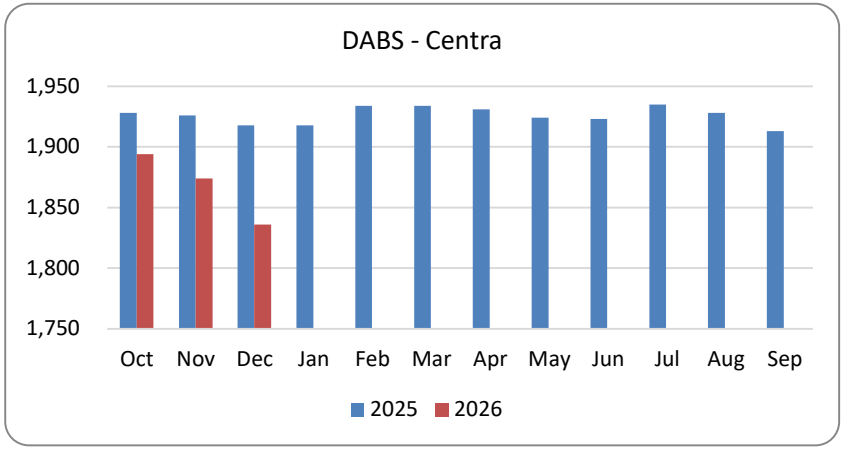


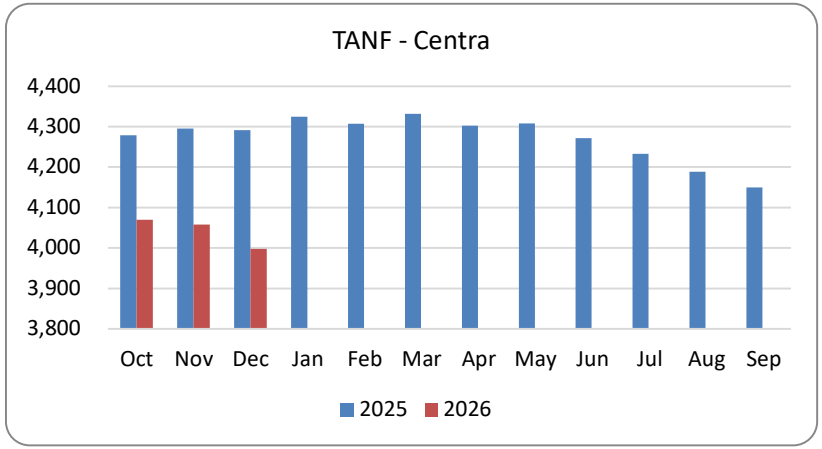
Northern Michigan Regional Entity

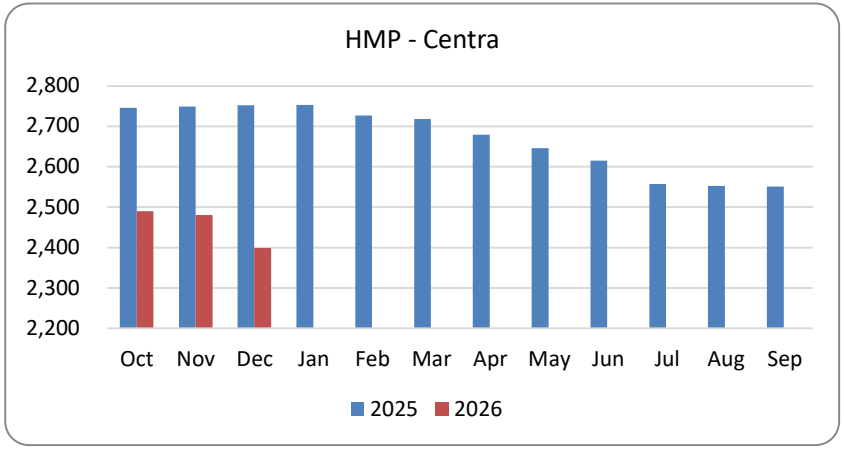
Narrative

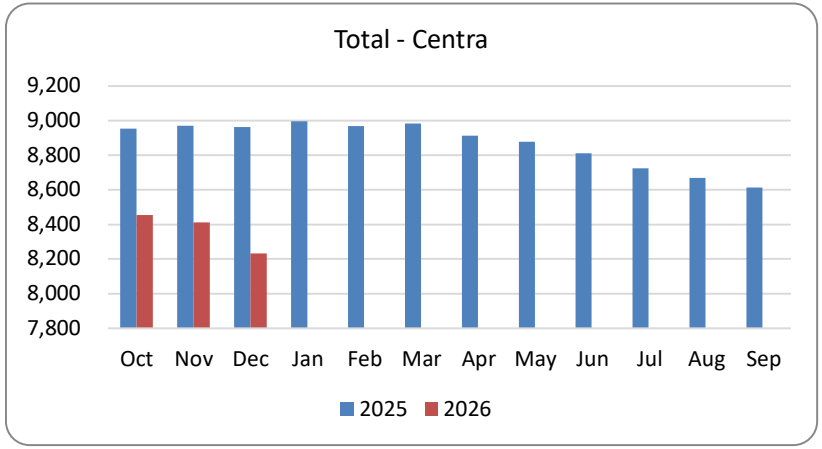
October 1, 2025 through December 31, 2025

Centra Wellness Eligible Members Trending - based on payment files







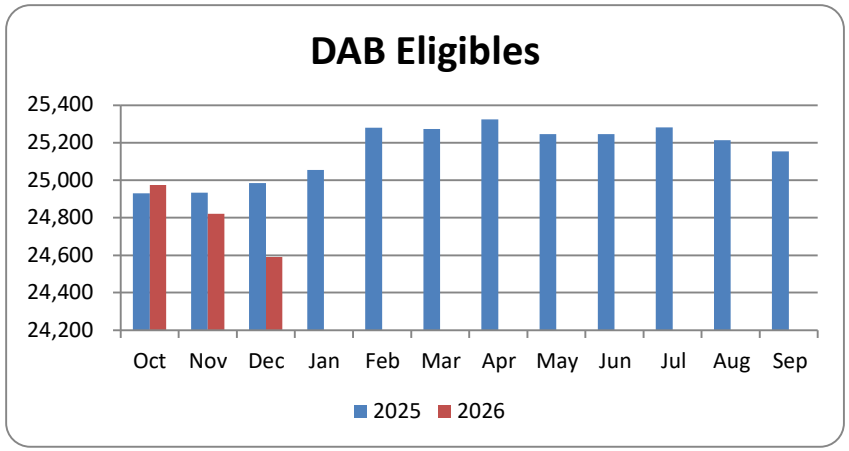


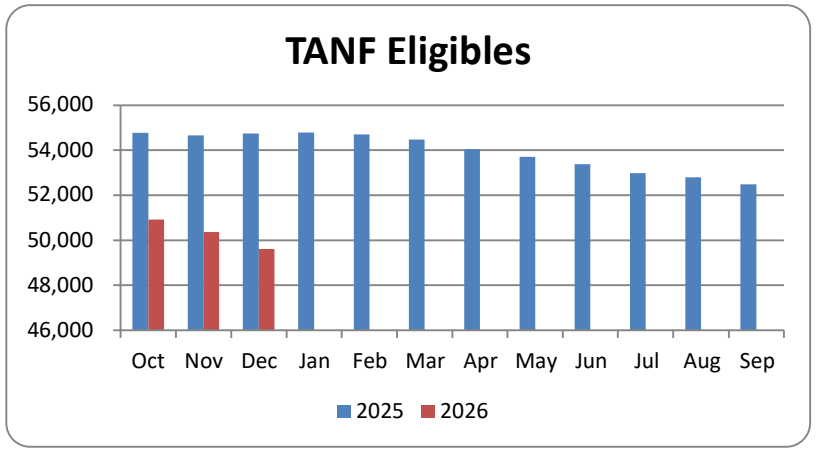
Northern Michigan Regional Entity

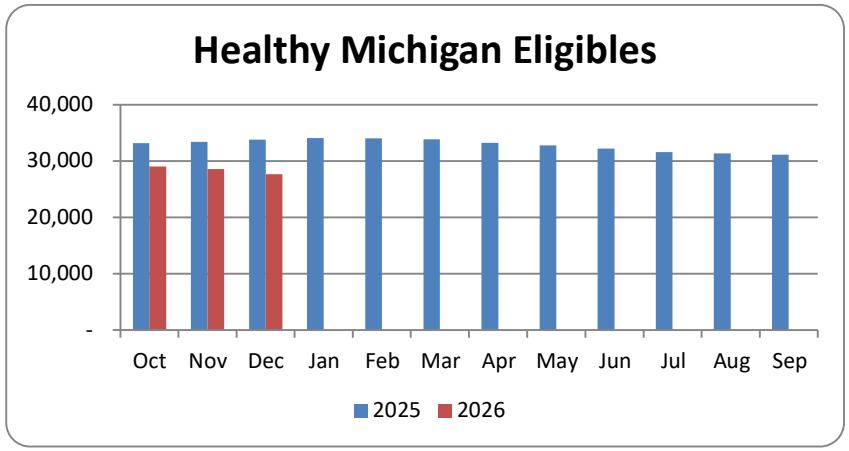
Narrative

October 1, 2025 through December 31, 2025

Regional Eligible Trending





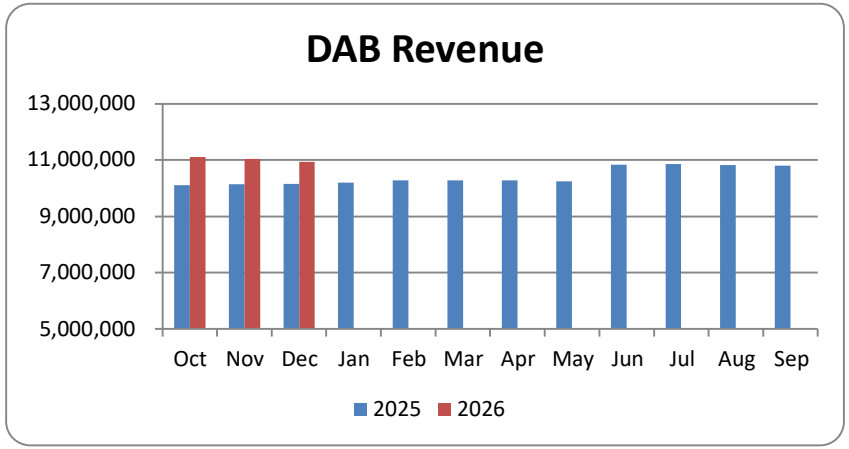


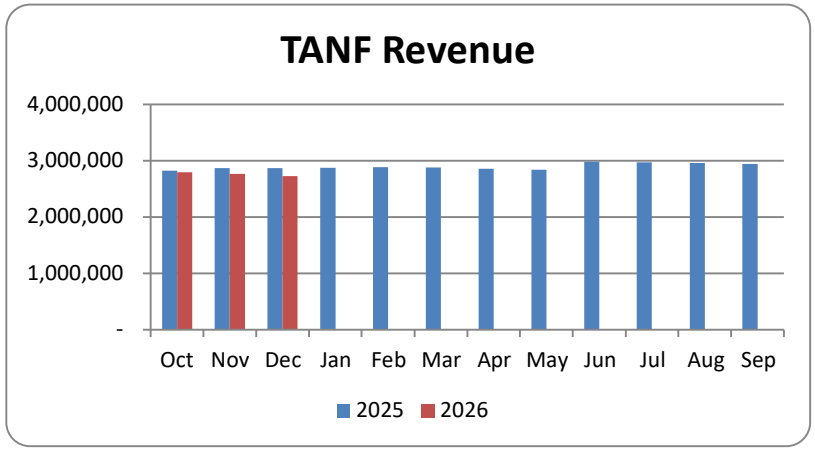
Northern Michigan Regional Entity

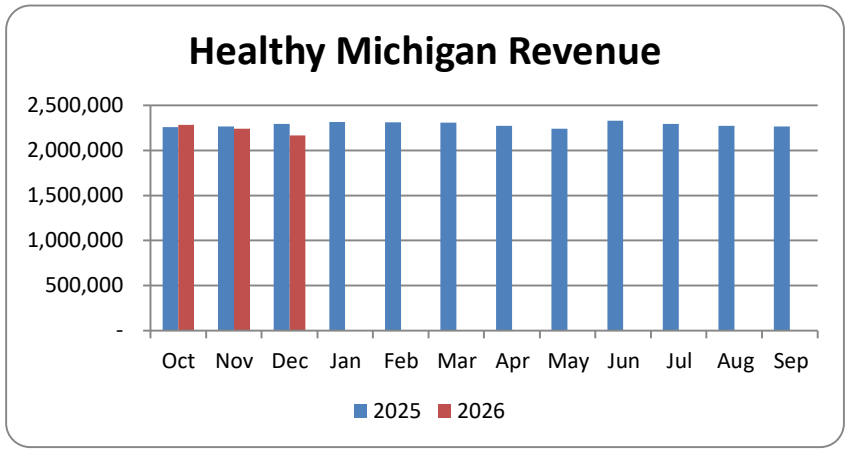
Narrative

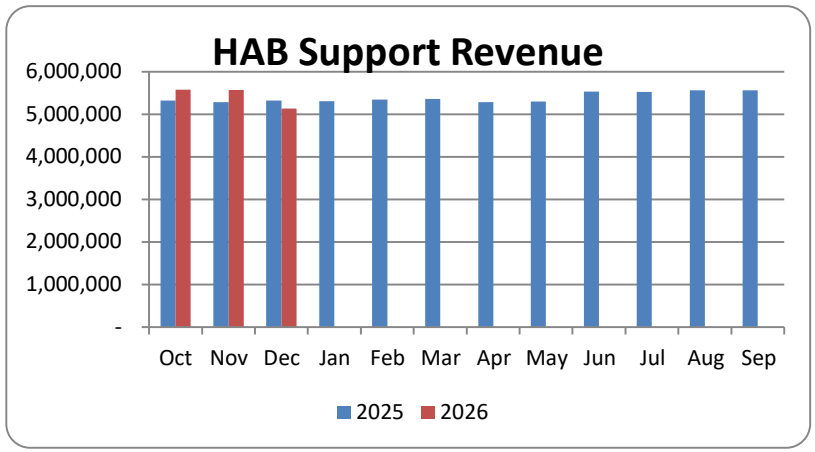
October 1, 2025 through December 31, 2025

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – FEBRUARY 17, 2026
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Brian Babbitt, Chip Johnston, Eric Kurtz, Trish Otremba, Nena Sork, Deanna Yockey, Lynda Zeller, Carol Balousek**

REVIEW OF AGENDA AND ADDITIONS

Mr. Kurtz added Intensive Crisis Stabilization Services (ICSS) Training to the meeting agenda. Mr. Babbitt added DCW and minimum wage increases. Ms. Zeller will provide an update on the status of Northern Lakes' Financial Status Report (FSR) and Encounter Quality Initiative (EQI) reports under the financial discussion.

APPROVAL OF PREVIOUS MINUTES

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

MOTION BY TRISH OTREMBA TO APPROVE THE JANUARY 20, 2026 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY LYNDA ZELLER. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

December 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $2,841,802. Carry forward was reported as $8,908,717. The total Medicaid and HMP current year surplus was reported as $11,750,519. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $32,340,608.
- Traditional Medicaid showed $58,028,276 in revenue, and $54,598,291 in expenses, resulting in a net surplus of $3,429,985. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $8,908,717.
- Healthy Michigan Plan showed $6,831,249 in revenue, and $7,419,432 in expenses, resulting in a net deficit of $588,183. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $831,806 in revenue, and $665,135 in expenses, resulting in a net surplus of $166,671.
- SUD showed all funding source revenue of $5,471,776 and $4,871,598 in expenses, resulting in a net surplus of $600,178. Total PA2 funds were reported as $4,879,422.

PA2/Liquor Tax was summarized as follows:

Projected FY26 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$5,142,821	$1,847,106	$2,071,443	$4,918,483

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,142,821	$0	$263,398	$4,879,422

CMHSP Medicaid and surplus/(deficit) was summarized as follows:

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$437,421	$853,652	$849,902	$388,602	$804,337
HMP	($96,461)	($212,425)	$96,426	($687,554)	($8,738)
Total	$340,960	$641,227	$946,328	($298,952)	$795,599

A retroactive adjustment of $1.7M to FY25 revenue will be reported on the FSR. These funds represent a gross adjustment for FY25 to account for minimum wage and ESTA. The $1.7M will be reflected in the FY25 carry forward. It was noted that no detail was provided other than funding source.

The NMRE has received four of the five CMHSPs' Financial Status Reports (FSR's); an estimate from Northern Lakes is expected. Ms. Zeller reported that Northern Lakes' Interim FSR showed an overspend of $5M between Medicaid and HMP and a General Funds overspent of $3M. Ms. Zeller indicated that actual figures will be closer to $9M overspent on Medicaid and $6M overspent on GF. Mr. Kurtz stated the need to get the actual deficit amounts in front of the Board. Ms. Yockey noted that the Finance report is based on trends from the Interim FSR; she asked whether she should build in the anticipated $9M deficit for Northern Lakes. Ms. Zeller responded that yes, she should.

Ms. Yockey requested a revised estimated FY25 FSR which Ms. Zeller agreed to provide. Ms. Yockey will then revise the December financial report prior to it being sent to the Board. Ms. Yockey requested and estimated EQI in addition to the revised estimated FSR. Ms. Zeller agreed, noting that Northern Lakes received an extension for the Period 3 EQI.

Northern Lakes has faced challenges with the way in which things were costed to GF ($1.9M). Several areas of Northern Lakes' finances still need to be checked. Some individuals have been enrolled in the (i)SPA. There was a question regarding the legitimacy of moving folks to (i)SPA. Mr. Kurtz is waiting for a determination by the state.

Ms. Zeller reported that Northern Lakes is looking at the causes of the overspending, particularly getting aggressive with utilization management. Northern Lakes' biggest cause of overspending is residential services; Northern Lakes needs to redo its residential payment model. Ms. Zeller noted the need to move individuals back to the region. Mr. Babbitt shared that North Country has been trying to move people back to the region since 2017, but it has been extremely difficult.

Ms. Sork referenced the previous Olmstead Committee that was formed in 2014 as part of the Application for Renewal and Recommitment (ARR) which was successful in bringing many individuals back to the region. The CEOs agreed that a regional approach is needed. The possibility of opening a residential home was discussed with the possibility of the NMRE issuing an RFP or RFQ.

Mr. Johnston stated that his Board would appreciate examples of Northern Lakes' cost containment and oversight from NMRE.

MOTION BY BRIAN BABBITT TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2025; SUPPORT BY TRISH OTREMBA. MOTION APPROVED.

Mr. Babbitt requested that the EQI reports be shared regionally, with the possibility of a reciprocal sharing with NorthCare Network's CMHSPs.

PM/PM Revenue Projections
An analysis of October 2023 – January 2026 Revenue and Eligibles was shared with Committee Members.

The NMRE observed a 5.4% decrease in eligibles between DAB, TANF, and HMP. Milliman is considering a mid-year rate adjustment (possibly in April).

CMHAM/MAC OTHER EFFORTS
Mr. Johnston asked Ms. Otremba and Ms. Sork to weigh in on an email received from attorney Chris Cooke on Saturday, February 14th. The Attorney General has asked the plaintiffs to drop the lawsuits related to the PIHP bid out (25-000143-MB and 25-000162MB) as the defendants canceled the RFP. Others do not want it dropped. Responses should convey that any new RFP must account for the fact that CMHSPs want Medicaid funds to go through the Regional Entity of their choice.

Five Michigan Association of Counties (MAC) Executive Committee members have requested that MAC sever its relationship with Rehmann and bow out of any future bids.

RFP RUMORS
Noise emanating from CMHAM is that a new RFP is imminent (possibly March?) Clarification was made that the lawsuits related to the PIHP bid out remain open. Judge Yates gave authority to the Michigan Department of Health and Human Services (MDHHS) and the State of Michigan Department of Technology, Management, and Budget (DTMB) to competitively bid the state's PIHPs so long as they adhere to the mental health code and state law. It was noted that the timing is tight given that a new administration will be elected in November. Mr. Babbitt disagreed with messaging on creating a "privatization-proof" system coming from CMHAM, noting that there is no such thing. The focus must be on improving, and working within, the current system.

MENTAL HEALTH FRAMEWORK

Effective October 1, 2026, Medicaid Health Plans (MHPs) and PIHPs will cover mental health services for enrollees based on the outcomes of provider assessments. When a qualified mental health provider conducts a MichiCANS for a child or a LOCUS for an adult, they will produce a result that will determine whether the MHP or the PIHP is responsible for care.

Recently, however, MDHHS indicated that, because CMHs must do the preadmission screening, CMHSPs will do all mental health framework services/obligations. MHPs will be expected to pay for hospitalizations for the mild/moderate population.

Numerous problems have been identified with the MHF in its current form and the confusing roles of the MHPs and CMHSPs/PIHPs, including violations of the mental health code.

Ms. Zeller asked who is spearheading this initiative at MDHHS. Mr. Kurtz responded that he believes it's Kristen Morningstar.

Ms. Zeller proposed that MHPs pay CMHSPs for the full cost of services if they are unable to provide ongoing services post hospitalization.

Mr. Johnston emphasized that there is no mention of the mental health framework in the PIHP or CMHSP contracts.

HOME-BASED AND CFAP/COI

Pursuant to the conflict-free access and planning (CFA&P) standards in Medicaid home and community-based services (HCBS), if a CMHSP is furnishing HCBS, then CFA&P requirements may be met only if the person-centered planning process is not conducted by CMHSP employees.

In counties defined as "rural," MDHHS allows for "only-willing-and-qualified" providers (OWQP) to provide direct services and perform assessment/plans of services. Fourteen of the NMRE's 21 counties meet the rural criteria (Alcona, Antrim, Cheboygan, Crawford, Iosco, Kalkaska, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, and Roscommon).

Home-based services for children up to age 21 must adhere to the HCBS Final Rule and conflict of interest requirements. Mr. Johnston asserted that Home-based services are all-inclusive and conflict-free.

AUSTISM SERVICES

BcABAs/EDIT

It was stated in the January 15th EDIT meeting that effective October 1, 2025, QBHP's can no longer bill for ABA services. LBAs must bill for any assistant behavioral analysts that they supervise (BCaBA, LABA).

However, during the PIHP Autism Leads Meeting on January 30th, Mary Luchies (MDHHS) discussed BCaBA guidance that conflicted with what was shared during EDIT. During the Autism Leads meeting, MDHHS indicated that BCaBAs may no longer bill for services citing private insurance standards, though this conflicts with Medicaid Rules and Michigan law allowing supervised practice. Nothing was said about BCaBAs/LABAs providing services under the supervision of LBAs.

It was noted that none of the five Member CMHSPs currently have an LBA on staff.

Because there have been no changes to the Medicaid Manual or licensing, Mr. Kurtz advised the CMHSPs to continue doing what they have been doing.

RURAL CAUCUS/RURAL DEFINITIONS

Language is being proposed by Matt Maskart (Pathways Community Mental Health) and Alan Bolter CMHAM) to redefine "rural" using one statewide definition.

INTENSIVE CRISIS STABILIZATION SERVICES (ICSS) TRAINING

An ICSS policy meeting is taking place on Friday, February 20th with Phil Kurdunowicz (MDHHS) to advocate against the model/certification requirement for rural PIHP Regions 1 and 2. Mr. Kurtz asked the CMHSP CEOs to contact him with any issues they would like him to raise during the meeting.

Only one ICSS training had been proposed for northern Michigan (in Traverse City) which was not workable. Subsequently, a training in St. Ignace has been proposed.

DCW

Effective January 1, 2026, the minimum wage in Michigan increased to $13.73/hour. MDHHS also issued a DCW increase of $3.40/hour, making the minimum wage for direct care workers $17.13/hour. Mr. Babbit noted that his contract reflect the hourly rate of $17.13, however, he was unsure what rate to apply to overtime pay as previous guidance is outdated. Mr. Kurtz agreed to seek clarification.

CMHSP UPDATES

North Country CMHA

Mr. Babbitt announced that North Country has received a technology grant from MDHHS. During the Next two years, North Country will develop access points in the community to request telehealth services visits.

Northern Lakes CMHA

The update for Northern Lakes regarding the FSR and EQI submission was addressed under the Financial Report.

NEXT MEETING

The next meeting was scheduled for March 17th at 9:30AM.

NMRE
Health Home Update

Agenda

Health Home History

Who We Serve

Health Home Partners

Enrollment Numbers

Health Home Responsibilities

Partner Initiatives

What's Next

NMRE Health Home History

Who We Serve

- Beneficiaries with qualifying diagnosis
- Enrolled in Medicaid/HMP
- Live within NMRE region
- All Ages

Health Home Partners

- SUD Providers
- CMH Partners
- Federally Qualified Health Centers
- Physician Offices
- Women's Health Clinic
- Health Care Systems

Health Home Services

Care team works with beneficiary to identify their needs and develops a care plan

Assist the beneficiary in meeting their goals and improving health outcomes

Provide care coordination with primary and special medical care, behavioral health services, social, educational, housing and community support services

Assistance in making appointments, coordinating transportation

Provide education, assist patient and family in understanding of health conditions and connect beneficiary to resources

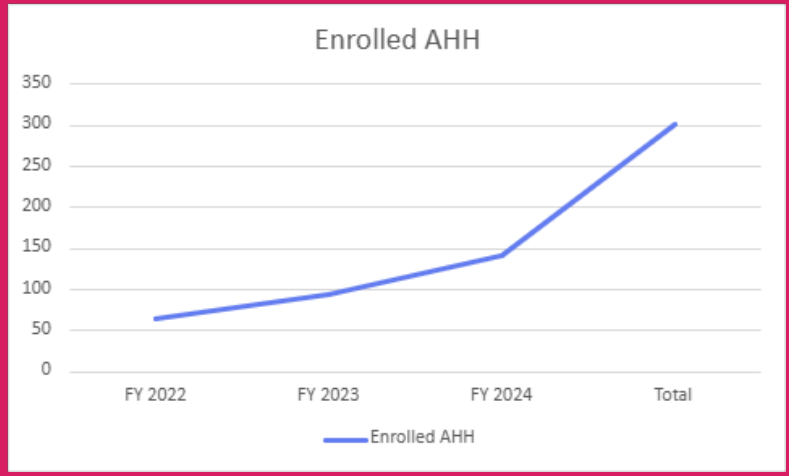
Coordinate with pharmacies, medication reconciliation and compliance

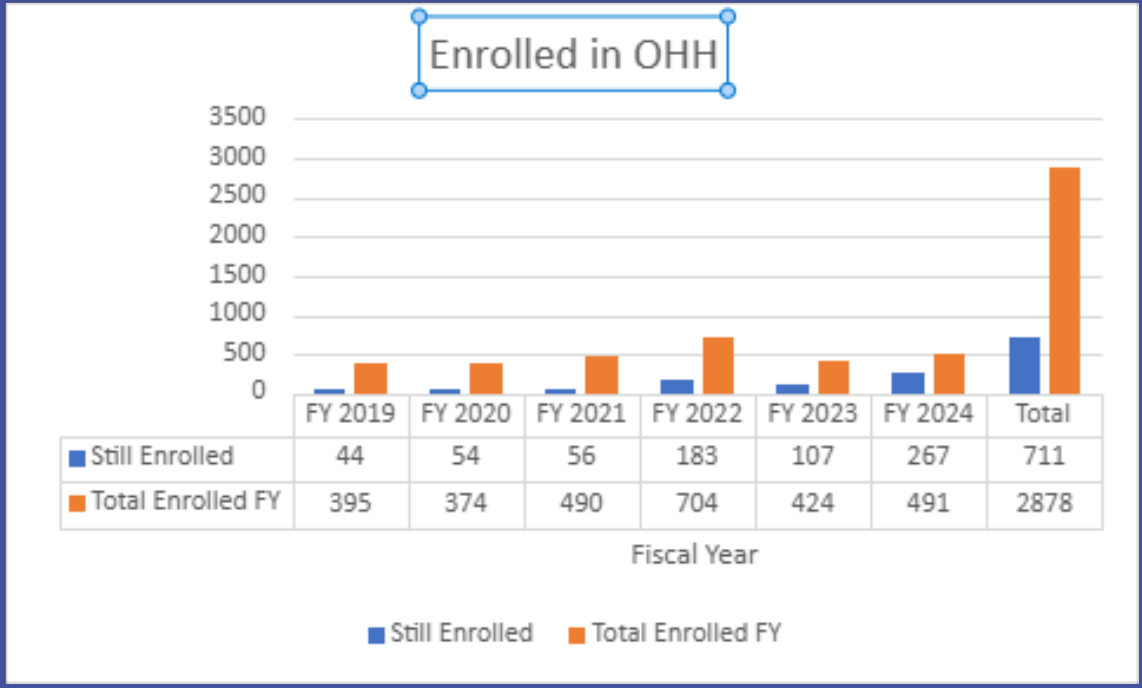
Support beneficiary to obtain services, facilitate transition to high level of care

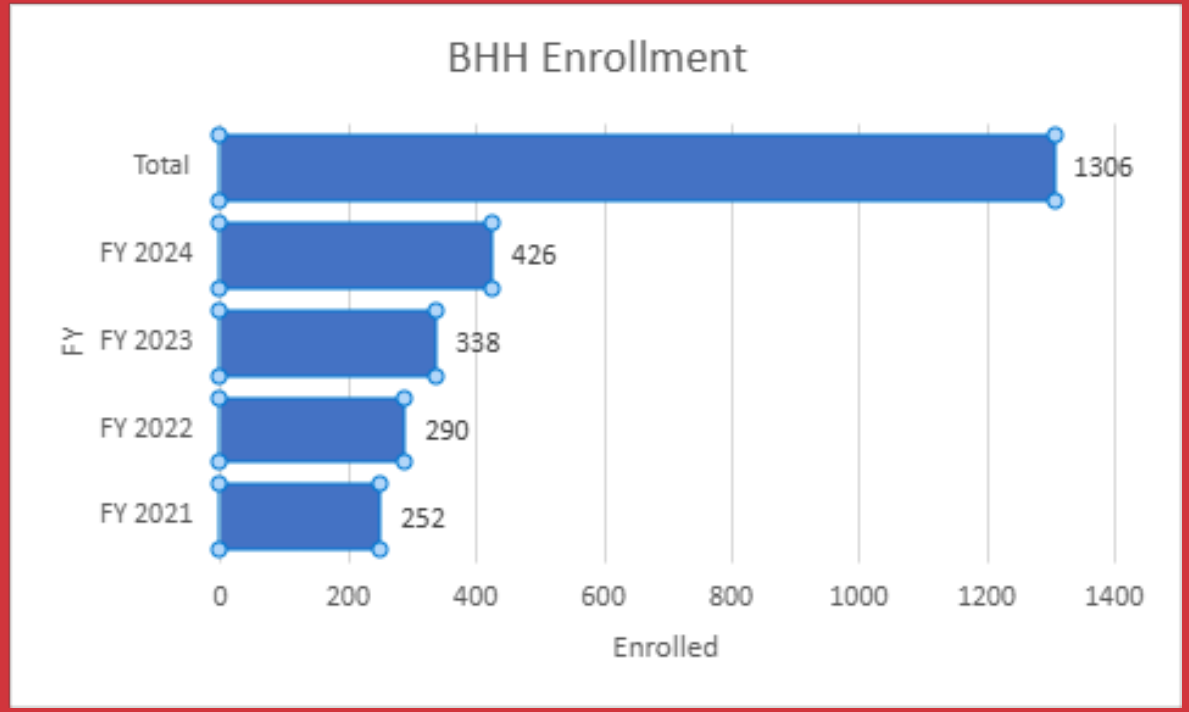
Team huddles

Assist with employment, food insecurity, involved with criminal justice system

Health Home Enrollment



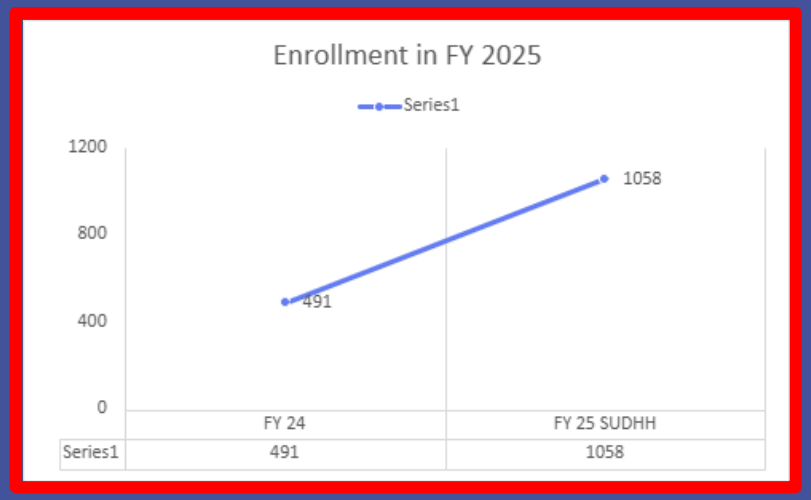




Launch SUDHH in FY 2025

Statewide Expansion serving individuals with

- Alcohol
- Opioid
- Stimulant Use Disorder Diagnosis



Largest annual enrollment increase 115%

Highest enrollment month ever – October 2024

Average enrollment increase at health home partners average of over 200%

First loss of Health Home Partner

Onboard of Munson Behavioral Health

NMRE Responsibilities

Up front monitoring of enrollment/disenrollment

Facilitate monthly meetings with regional HHP's

Communicate and care coordinate with providers when beneficiary status changes

Review health home claims, verify eligibility

Regular one-on-one check in meetings with providers

Monitor report data and communicate results with provider

Provide training for new health home staff and timely response to questions and issues

Advocate with MDHHS for process changes and system updates to create efficiencies for our providers

Provide technical assistance, information and process sharing with other regions

Audit health home partners

Follow up with beneficiaries when disenrolled

Health Home Demographics

Gender	SUDHH	BHH
Female	535	436
Male	471	280
Total	1006	716

Age Category	SUDHH	BHH
Under 12		**21**
Age 12-17		**53**
Age 18-25	50	56
Age 26-39	**488**	151
Age 40-49	**287**	**162**
Age 50-64	174	**223**
Age 65+	7	**50**
Total	1006	716

County	SUDHH	BHH
Alcona	22	7
Alpena	**128**	**84**
Antrim	23	17
Benzie	29	47
Charlevoix	27	11
Cheboygan	58	11
Crawford	22	19
Emmet	60	27
Grand Traverse	**161**	54
Iosco	58	42
Kalkaska	28	8
Leelanau	11	1
Manistee	46	**97**
Missaukee	18	12
Montmorency	23	23
Ogemaw	36	44
Oscoda	14	13
Otsego	65	21
Presque Isle	28	10
Roscommon	**99**	**145**
Wexford	50	23
Total	1006	716

Health Home Funding

NMRE receives funding monthly from MDHHS for beneficiaries enrolled in health home

Health Home Partners are reimbursed for health home services they provide

Pay for Performance (P4P) funding distributed annually by MDHHS when regional performance metrics are achieved

Health Home Partner Initiatives

Centra Wellness Network

- CWN – BHH and SUDHH Partner
- Partner with community agencies and resources
- Provide beneficiaries with food gift cards, hygiene supplies, gas cards and use funds to meet client needs

CHW staff at NCCMH are able to make home deliveries from Bellaire Food Pantry to BHH clients

Health Home Innovative Services and Success Stories

NECMH works with community partners to obtain grants, and donations to help support their health home activities

Mid Michigan Community Health Services

- SUDHH and BHH Partner
- Health Home funding to create a Community Closet providing gently used clothing for all ages, blankets, shoes, toiletries for all patients of Mid Michigan.
- Served 300+ individuals

Mid Michigan Food Pantry

- Roscommon County ranked 6th in state for food insecurity
- Partner with Eastern Michigan Food Bank Opened Pantry in August 2025
- Pantry serves Mid Michigan patients and community members
- In 6 months of operation they have served 740 unduplicated families from 22 counties

What's Happening in FY 2026?

Proposed Rate Increases for BHH and SUDHH

Created regional meeting to connect Peer Support Staff and Community Health Workers (CHW)

Enhancements of
Waiver Support Application (WSA)

Expansion of Partner Locations and Provider Network