Northern Michigan Regional Entity

Board Meeting

February 26, 2025

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – January 22, 2025	Pages 2 – 9
7.	Correspondence	Pages 10 – 42
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – February 2025	Page 43
	c. Financial Report – December 2024	Pages 44 – 64
	d. Operations Committee Report – February 18, 2025	Pages 65 – 69
	e. NMRE SUD Oversight Board Report – Next Meeting March 3rd	
11.	New Business – None	
12.	Old Business	
	a. Northern Lakes Update	
	b. FY25 PIHP Contract Injunction and Complaint - Update	Pages 70 – 92
13.	Presentation	
	Performance Indicators	
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – March 26, 2025 at 10:00AM	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – JANUARY 22, 2025
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Ed Ginop, Gary Klacking, Michael Newman, Gary Nowak, Jay O'Farrell, Ruth Pilon, Karla Sherman, Don Smeltzer, Don Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Mary Marois**
ABSENT:	**Tom Bratton, Eric Lawson, Richard Schmidt,**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Carol Balousek, Eugene Branigan, Lisa Hartley, Chip Johnston, Eric Kurtz, Brian Martinus, Heidi McClenaghan, Brie Molaison, Diane Pelts, Pamela Polom, Brandon Rhue, Nena Sork, Denise Switzer, Chris VanWagoner, Deanna Yockey**
PUBLIC:	**Erin Barbus, Samantha Borowiak, Dave Freedman, Kevin Hartley, Naveed Syed, Kara Steinke**

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

ROLL CALL
Let the record show that Tom Bratton, Eric Lawson, and Richard Schmidt were excused from the meeting on this date. All other NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

APPROVAL OF AGENDA
Let the record show that an NMRE staff cost of living adjustment (COLA) was added to the meeting agenda under "Old Business."

MOTION BY KARLA SHERMAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR JANUARY 22, 2025 AS AMENDED; SUPPORT BY GARY NOWAK. 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 DON TANNER TO APPROVE THE MINUTES OF THE DECEMBER 18, 2024 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY CHUCK VARNER. MOTION CARRIED.

CORRESPONDENCE

1) The minutes of the December 5, 2024 PIHP CEO meeting.
2) The MDHHS Service Delivery Transformation Section Update for November 2024.
3) A memorandum dated January 3rd to PIHP and CMHSP Leadership from Patricia Neitman with MDHHS providing an update on 1915(c) Waiver Programs for Children.
4) A memorandum dated January 16, 2025 to PIHP and CMHSP Executive Directors from Kristen Morningstar providing an update on the 1915(c) Habilitation Supports Waiver.
5) Community Mental Health Association of Michigan (CMHAM) 2024 Lame Durk Tracker.
6) Email correspondence dated January 7, 2025 from CMHAM CEO, Bob Sheehan, proving an update on the Waskul settlement.
7) The Quarter 4 Fiscal Year 2024 Statewide Performance Indicator report.
8) The regional Substance Use Disorder Admissions report through November 30, 2024.
9) The draft minutes of the January 8, 2025 regional Finance Committee meeting.

MDHHS received approval from CMS for the renewal of the Children with Serious Emotional Disturbances Waiver (SEDW) program and Habilitation Supports Waiver (HSW) programs. The waivers were approved for a five-year period with an effective date of October 1, 2024. The renewal applications for both waivers included several programmatic changes, including the Department's approach to meeting the CMS Conflict Free standards (Conflict Free Access and Planning).

Although a settlement has been reached in the Waskul case, there are several conditions that must be satisfied by MDHHS, including a possible amendment to the Medicaid Provider Manual, changes to Administrative Law Judge rules, and Medicaid Fair Hearing rules.

Ms. Pilon noted that the December 5th PIHP CEO minute stated that an amendment to the FY25 PIHP Contract is expected by the end of the week; she inquired about the status of the amendment. Mr. Kurtz responded that it has not yet been issued.

ANNOUNCEMENTS

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

PUBLIC COMMENT

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

REPORTS

Executive Committee Report

The minutes of the January 3rd Executive Committee meeting were included in the materials for the meeting on this date. The meeting was called to review the Rehmann Corporate Investigative Services (CIS) Forensic Accounting Report of Northern Lakes Community Mental Health Authority.

The CIS report focused on three main areas:

1) Overtime/stipend payments

2) Procurement practices
3) Cost Misallocation

Mr. Kurtz explained that the role of the NMRE is to ensure Medicaid funds were used appropriately. Any personnel issues identified in the report should be taken up by the Northern Lakes CMHA Board of Directors.

The Executive Committee recommended that the Rehmann Investigative Review of Northern Lakes CMHA be extended to review cost allocation records for an additional 5-7 fiscal years (FY18 – FY16). There is the potential for Medicaid recoupment and/or movement from Medicaid to a different funding source (local funds) at NLCMHA depending on the results.

MOTION BY KARLA SHERMAN TO AUTHORIZE REHMANN CORPORATE INVESTIGATIVE SERVICES TO GO BACK AS MANY YEARS AS RECORDS ALLOW FOR THE COST ALLOCATION PORTION OF THE FORENSIC INVESTIGATION OF NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY AT A COST NOT TO EXCEED FIFTY THOUSAND DOLLARS ($50,000.00) PER YEAR; SUPPORT BY DON TANNER. MOTON CARRIED.

Discussion: Clarification was made that NMRE has the funds available to pursue the investigation.

ROLL CALL VOTE.

"Yea" Votes:	B. Adrian, E. Ginop, G. Klacking, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, K. Sherman, D. Tanner, C. Varner
"Nay" Votes:	Nil

MOTION CARRIED.

CEO Report
The NMRE CEO Monthly Report for January 2025 was included in the materials for the meeting on this date. Mr. Kurtz spoke highly of a regional Provider Network Training that took place at the NMRE on January 10th and thanked Mr. Johnston for his participation.

November 2024 Financial Report
- Net Position showed net deficit Medicaid and HMP of $721,431. Carry forward was reported as $2,909,566. The total Medicaid and HMP Current Year Surplus was reported as $2,188,135. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $22,764,291.
- Traditional Medicaid showed $33,339,219 in revenue, and $33,746,942 in expenses, resulting in a net deficit of $407,723. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $4,372,373 in revenue, and $4,686,081 in expenses, resulting in a net deficit of $313,708. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $2,909,566.
- Health Home showed $563,897 in revenue, and $455,038 in expenses, resulting in a net surplus of $108,859.
- SUD showed all funding source revenue of $4,638,753 and $3,653,034 in expenses, resulting in a net surplus of $985,719. Total PA2 funds were reported as $4,612,270.

Ms. Yockey explained that both Medicaid and HMP are running at a deficit two months into FY25, which is not sustainable.

A fix for the unpaid HSW slots issue was expected last month; however, the payment received on January 16, 2025, did not show a fix. Approximately $2.7M in missed payments is still expected. NMRE Chief Information Officer, Brandon Rhue, added that the fix in December allowed the state to make manual adjustment payment. This is considered the first step in a multi-step solution. The NMRE will continue to monitor and track what is owed as well as monitor all payment activity to ensure retroactive payments are accurate.

HMP eligibles continue to decline. Ms. Sherman asked whether individuals continue to be placed in lower paying eligibility categories. Mr. Kurtz and Mr. Rhue are meeting with PCE Systems on January 23rd to discuss the statewide migration of individuals from DAB to TANF, HMP, and Plan First. Some preliminary data has been obtained. Mr. Kurtz noted that he received communication from CMHAM CEO, Bob Sheehan, that information on the topic has been shared with former Chief Deputy Director for Health at MDHHS, Farah Hanley, who now works for Health Management Associates.

MOTION BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2024; SUPPORT BY ED GINOP. MOTION CARRIED.

Operations Committee Report
The draft minutes from January 21, 2025 were distributed during the meeting on this date. It was noted that Michigan State University's Institute for Health Policy will be developing the State's Parity Plan.

NMRE SUD Oversight Committee Report
The draft minutes from January 6, 2024 were included in the materials for the meeting on this date.

NEW BUSINESS

Liquor Tax Requests
The following liquor tax requests were recommended for approval by the NMRE Substance Use Disorder Oversight Committee on January 6, 2025.

	Requesting Entity	Project	County	Amount
1.	33rd Circuit Court	Hybrid Drug and DWI Court	Charlevoix	$40,000

MOTION BY CHUCK VARNER TO APPROVE THE LIQUOR TAX REQUEST FROM THE THIRTY-THIRD (33RD) CIRCUIT COURT FOR LIQUOR TAX DOLLARS IN THE AMOUNT OF FORTY THOUSAND DOLLARS ($40,000.00) TO FUND THE HYBRID DRUG AND DRIVING WHILE INTOXICATED (DWI) COURT IN CHARLEVOIX COUNTY; SUPPORT BY JAY O'FARRELL. ROLL CALL VOTE.

"Yea" Votes: B. Adrian, E. Ginop, G. Klacking, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, K. Sherman, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

	Requesting Entity	Project	County	Amount
2.	District Health Department #10	Substance Use Education and Awareness (SEA)	Manistee	$42,090

MOTION BY ED GINOP TO APPROVE THE LIQUOR TAX REQUEST FROM DISTRICT HEALTH DEPARTMENT NUMBER TEN (#10) FOR LIQUOR TAX DOLLARS IN THE AMOUNT OF FORTY-TWO THOUDSAND NINETY DOLLARS ($42,090.00) TO FUND THE SUBSTANCE USE EDUCATION AND AWARENESS PROGRAM IN MANISTEE COUNTY; SUPPORT BY GARY NOWAK. ROLL CALL VOTE.

"Yea" Votes: B. Adrian, E. Ginop, G. Klacking, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, K. Sherman, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

Let the record show that the total liquor tax funding approved during the meeting on this date was **$82,090**.

Business Central Quote Approval
Because Microsoft will end support for Dynamics Great Plains (GP) on September 30, 2029, the NMRE is planning to move to Business Central in FY26. A proposal from the TM Group was included in the meeting materials.

Total Annual Software Investment	$21,912
Total Services Investment	$76,340
Total Investment	**$98,252**

MOTION BY GARY NOWAK TO APPROVE THE PURCHASE OF MICROSOFT DYNAMICS SOFTWARE WITH SUPPORT PROVIDED BY THE TM GROUP, INC. FOR A TOTAL AMOUNT OF NINETY-EIGHT THOUSAND TWO HUNDRED FIFTY-TWO DOLLARS ($98,252.00); SUPPORT BY BOB ADRIAN. ROLL CALL VOTE.

"Yea" Votes: B. Adrian, E. Ginop, G. Klacking, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, K. Sherman, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

New Substance Use Disorder Provider
NMRE Contract and Provider Network Manager, Chris VanWagoner, presented a request to add a new provider to the NMRE Substance Use Disorder Treatment Services Provider Panel.

The NMRE was contacted in October 2024, by Quality Behavioral Health, Inc (QBH), a SUD Treatment provider with a licensed outpatient location in Manistee County. The NMRE provider

panel was closed during this time; however, pursuant to the NMRE Procurement Policy and applicable law, the NMRE may directly purchase services without a competitive procurement process in certain circumstances, including if the services involved are professional and of limited quantity and duration, or if there is a public urgency to obtain the service.

The provider completed and submitted application materials to the NMRE, and primary source verifications were conducted to ensure provider qualifications. An NMRE staff team reviewed this location on November 6, 2024, and confirmed the need and ability to add this location to its network.

There is only one NMRE paneled provider in both Benzie and Wexford, and only one other outpatient SUD location in the county of Manistee (Catholic Human Services). A contract with QBH for outpatient-level SUD Treatment would provide additional service locations, as well as provide clients with the opportunity of a choice of provider.

MOTION BY RUTH PILON TO APPROVE THE ADDITIN OF QUALITY BEHAVIORAL HEALTH TO THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER TREATMENT SERVICES PROVIDER PANEL; SUPPORT BY KARLA SHERMAN. ROLL CALL VOTE.

"Yea" Votes:	B. Adrian, E. Ginop, G. Klacking, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, K. Sherman, D. Tanner, C. Varner
"Nay" Votes:	Nil

MOTION CARRIED.

OLD BUSINESS

Northern Lakes CMHA Update

Ms. Marois shared that the Northern Lakes Board of Directors approved the issuance of a Request for Quotes (RFQ) to solicit a CEO search firm.

Ms. Pilon provided the Northern Lakes Board of Directors with a summary of the Rehmann Corporate Investigative Services (CIS) Forensic Accounting Report during the Board meeting on January 16th. The Northern Lakes Board requested a meeting with Rehmann representatives.

FY25 PIHP Contract Injunction and Complaint Update

The First Amendment to the complaint filed by Taft, Stettinius & Hollister, LLP, on behalf of Northcare Network Mental Health Care Entity, Northern Michigan Regional Entity, Community Mental Health Partnership of Southeast Michigan, and Region 10 PIHP (Plaintiffs) against the State of Michigan, State of Michigan Department of Health and Human Services, a Michigan State Agency, and its Director, Elizabeth Hertel, in her official capacity (Defendants) was included in the meeting materials. The Attorney General's office has until February 7, 2025 to respond.

The complaint was filed in response to the state's failure to accept the modified FY25 PIHP contract language related to the Waskul legal settlement, ISF retention cap of 7.5%, and CCBHC language.

The amended complaint states that on December 16, 2024, MDHHS notified that Plaintiffs that their FY24 Financial Status Reports (FSRs) would not be accepted "if any ISF balance shown therein is greater than 7.5% of the annual operating budget." MDHHS states that rejected submissions would be returned for "corrections" and if not thereafter accepted, would be "considered late for purposes of determining PIHP eligibility for Contractor performance withhold Payments."

NMRE Staff COLA
During the NMRE Board meeting on December 18, 2024, the NMRE Board approved a 3% cost of living adjustment (COLA) for Mr. Kurtz for FY25. This represents the same amount that has been budgeted but not yet issued to NMRE staff. During the December meeting, it was determined that a 3% staff COLA (approximately $78K), which may be made in the form of a salary adjustment or one-time retention payment, will be placed on the Agenda for the January meeting.

MOTION BY DON TANNER TO APPROVE A THREE PERCENT (3%) COST OF LIVING ADJUSTMENT FOR NORTHERN MICHIGAN REGIONAL ENTITY EMPLOYEES FOR FISCAL YEAR 2025; SUPPORT BY CHUCK VARNER. ROLL CALL VOTE.

"Yea" Votes:	B. Adrian, E. Ginop, G. Klacking, M. Newman, G. Nowak, J. O'Farrell, R. Pilon, D. Tanner, C. Varner
"Nay" Votes:	Nil

MOTION CARRIED.

PRESENTATION
NMRE Quality Assessment and Performance Improvement Program FY24 Evaluation and FY25 Workplan
The NMRE's Quality Assessment and Performance Improvement Program (QAPIP) FY24 Evaluation and FY25 Workplan were included in the materials for the meeting; they are due to the State by February 28, 2025. NMRE Quality Manager, Heidi McClenaghan, guided the Board through the documents.

MOTION BY JAY O'FARRELL TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT FISCAL YEAR 2024 EVALUATION; SUPPORT BY GARY NOWAK. MOTION CARRIED.

MOTION BY BOB ADRIAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT FISCAL YEAR 2025 WORKPLAN; SUPPORT BY GARY NOWAK. MOTION CARRIED.

It was noted that although MDHHS initially said that PIHPs with unaccepted FY25 Contracts would not be provided with Medicaid dollars to fund the expansion of the Substance Use Disorder (SUD) Health Home program, that decision has been reversed.

COMMENTS
Staff/CMHSP CEOs
Mr. Johnston clarified that the pronouncement from MDHHS regarding the 7.5% ISF violates the FY24 PIHP Contract because the FY24 Contract does not contain any limitation on the total

amount that the PIHP can maintain in an ISF account. Based on Milliman's FY24 actuarial analysis of the NMRE's ISF, the NMRE's ISF should be funded at approximately 15% of annual revenue.

Public
Catholic Human Services Chief Operating Officer, Kara Steinke, clarified that substance use disorder treatment services are available in person in Cadillac from 8:00AM – 6:30PM four days per week from four clinicians; in Manistee five days per week from one clinician, and in Frankfort one day per week with one clinician with additional access available if there is a need and client community. Virtual access to other clinicians is available five days per week for all locations.

MEETING DATE
The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on February 26, 2025.

ADJOURN
Let the record show that Mr. Klacking adjourned the meeting at 11:18AM.

Introducing CMHA to the Public Facing Children's Specialty Behavioral Health Data Dashboard

MDHHS
Michigan Department of Health & Human Services

Including CMHA in the Development of the Public Facing Children's Specialty Behavioral Health Data Dashboard

- The Children's Specialty Behavioral Health Data Dashboard was introduced to individuals attending the Summer 2024 CMHA Conference, as well as the 2024 Wraparound Conference.

- The public facing data dashboard was presented in greater detail, including purpose, goals, timelines, and screen shots to the attendees of the Fall 2024 CHMA Conference.

- CMHA approached the dashboard development team with a need to better understand:
    - how the data has been collected, organized and vetted
    - the information that will be provided on the dashboard
    - how different audiences may interpret the data contained on the dashboard
    - the approval process for adding data elements as the dashboard evolves.

The need for more information resulted in a meeting that included the DMQI Team, TBD Solutions and CMHA.

MDHHS Michigan Department of Health & Human Services

Discussion Topics/Agenda Provided to CMHA:

- Welcome & Purpose of Meeting
- Background
- Family Driven, Youth Guided
- Dashboard (DRAFT) Review
- Data Review
- Discussion & Next Steps

Goals

INTEGRATION

Develop and execute a plan for a meaningful partnership with those with lived experience to amplify youth and family voice.

DATA & ANALYTICS

Provide quality, trusted information and data about children's public behavioral health services in Michigan.

QUALITY IMPROVEMENT

Empower end users to make informed, data-based decisions and use data to improve quality.

Dashboard 1.0

Title

THE STATE OF MICHIGAN'S

Children's Specialty Behavioral Health Dashboard

Welcome the Michigan Department of Health & Human Service's Data Dashboard for Specialty Behavioral Health.

Here you'll find the latest data on access, timeliness, services offered, and more at the state and county level.

Click the buttons below to either access the dashboard for all behavioral health children's services in Michigan, or the dashboard that specializes in intensive children's services offered in Michigan (*coming soon*).

All Children's Services

DRAFT

Starry Night
By Vincent Van Gogh

Winner of the 2024 Lived Experience Art Contest

Dashboard 1.0

Dashboard 2.0

THE STATE OF MICHIGAN'S

DRAFT

MDHHS | Bureau of Children's Coordinated Health Policy & Supports

Children's Specialty Behavioral Health Dashboard

Welcome to the Michigan Department of Health & Human Service's Data Dashboard for Specialty Behavioral Health.

Here you'll find the latest data on access, timeliness, services offered, and more at the state and county level.

Use the buttons below to learn more. Click the icon on any page to return to this page.

Meeting the Need

The Path to Care

Services by the Numbers

988 Suicide & Crisis Lifeline

Artwork by Youth with Lived Experience

Dashboard 2.0

Children's Specialty Behavioral Health Dashboard

Meeting the **Need**

Use the filters below to update the visuals:

Race	Age Group	Gender
All	All	All

Home

*Research suggests that **8-12%** of children experience high behavioral health needs.*

How many children could benefit from behavioral health services?

143,185

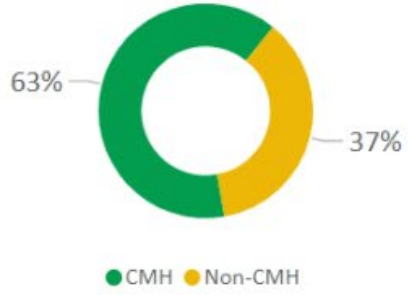
Medicaid-eligible children in Michigan may need behavioral health services... enough to fill

5,727

school classrooms.

Where do children and families get behavioral health support?

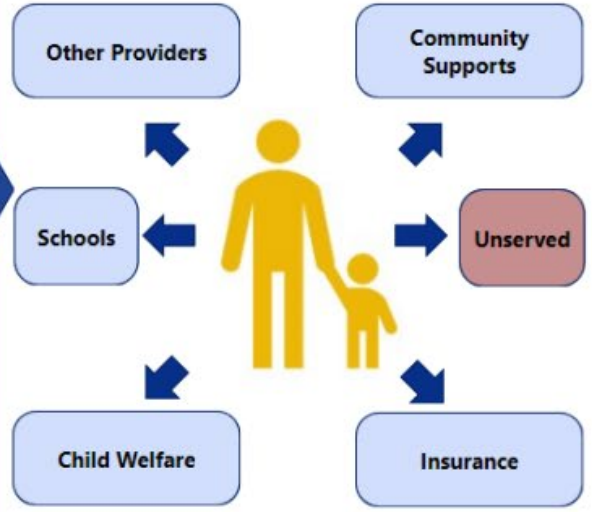
Children and families with the *highest needs* receive services through community mental health (CMH) agencies.



Last year, CMH served ***63%*** of children and their families.

What about the other *37%* ?

Children and families not served at a CMH may have needs met in other ways, including:



MDHHS | Bureau of Children's Coordinated Health Policy & Supports

DRAFT

988 Suicide & Crisis Lifeline

Feedback and Next Steps

- Initial feedback from CMHA was positive, with a desire to continue meeting throughout the development process on a quarterly basis.
- Next meeting is scheduled for March 17, 2025.
- Discussed potentially breaking out into separate groups in the future.
    - Ex: Data/IT group vs. Child serving/clinical focused group.

Current Rural Flexibilities/Guidance:

- Rural/Frontier sites will have until the end of the first demonstration year to comply with all staffing requirements; (Change to 2 years)

- Rural/Frontier sites may develop a DCO agreement with another CCBHC demonstration site to meet CCBHC certification criteria.

- Rural/Frontier sites are encouraged to utilize telehealth/telemedicine services where clinically appropriate and applicable. CCBHCs can establish telehealth-based DCO agreements.

- (Add) Rural behavioral health providers typically have large service areas (CMHSPs responsible for multiple counties, or behavioral health providers with multiple locations in different counties). A needs assessment would focus on one physical service delivery location and a limited, defined service area. MDHHS could support the CCBHC in establishing a different way for costing and reporting for that individual location, which would be required to provide the full array of CCBHC services. Although this would originally establish CCBHC as a "program" rather than an organizational cultural change, this would allow for entry into the demonstration and a slower ramp up period as the CCBHC slowly expands to more rural areas. Lessons learned could be applied as additional service locations are included.

1. Implementation and certification flexibilities

Impact (Federal or State Criteria): Federal and State

Current policy:

Handbook 2.C.2.1	Prior to the demonstration start date, it is the expectation that the site will be able to attest and successfully evidence all components of the CCBHC Model including the required Evidence Based Practices (EBPs). The CCBHC must be in full compliance with the full array of CCBHC services by the first day of the CCBHC Demonstration start date

Proposal: CCBHCs in rural/frontier areas will have additional time to ramp up their services, dependent on their level of readiness and community needs assessments.

Rural CCBHCs receive certification for the first year of the demonstration provided they can meet all certification criteria with the following exceptions:

1. Staffing: CCBHCs will have 1 year to meet staffing requirements. CCBHCs can request an extension year by evidencing efforts to recruit appropriate staff on a case-by-case basis.

2. Crisis Services: As CCBHCs work towards meeting the CCBHC crisis requirements, they are held to the "state-sanctioned" crisis services requirements as outlined in the MI Mental Health Code. CCBHC will meet full crisis requirements by the end of the 3-year certification period.

    a. Crisis Phone Line: A telephone that is answered 24 hours a day for dealing with mental health emergencies. The number for this telephone shall be advertised through the telephone book, public information efforts, and by notifying the appropriate agencies of the telephone number and the services provided.

    b. Operate inpatient screening units following crisis screening standards: Offer emergency intervention services with sufficient capacity to provide clinical evaluation of the problem; to provide appropriate intervention; and to make timely disposition to admit to inpatient care or refer to outpatient services. The organization may use: telephonic crisis intervention counseling, face-to-face crisis assessment, mobile crisis team, and dispatching staff to the emergency room, as appropriate.

    c. Walk in provision of face-to-face services to persons in the areas of crisis evaluation, intervention, and disposition. (CCBHCs can define walk in service hours based on needs identified in the community needs assessment.)

    Notes:
    - Non-CCBHC funding opportunities are available for crisis ramp up (rural mobile crisis funding 4/1/25 – 9/30/25), and crisis HIT changes to setup Air Traffic Control modules in EHRs. Activities can be sustained using CCBHC PPS reimbursement structure.
    - CCBHCs would be required to offer 24/7 community-based mobile crisis response by the end of the 3-year certification period, however CCBHCs can propose alternate models to meet the requirements, including co-response models and virtual options.

3. Evidence Based Practices: CCBHCs are required to implement base evidence-based practices but may request alternate accommodations, including:
    a. Waivers for certain practices provided that they have clinicians trained in the specific area (early childhood = infant mental health, childhood trauma = TFCBT, co-occurring = IDDT) and the CCBHC can justify that the needs identified in their needs assessment are adequately addressed with this alternative. CCBHCs can also establish DCO agreements with other CCBHCs to deliver required EBPs, including CCBHCs with more trained EBP clinicians downstate.

b. Alternate EBPs that respond to the needs of specific populations. Needs assessment must speak to why that EBP is appropriate for their area.

Required Practices	Must implement: • Air Traffic Control • DBT • CBT • MAT – • MI • SBIRT • Zero Suicide (does not have to be fully implemented at time of certification) • Trauma-informed EBP of choice
Waiver Eligible	Required EBPs • Assertive Community Treatment (ACT) – through CPI • Infant Mental Health • Integrated Dual Disorder Treatment (IDDT) • Parent Management Training – Oregon (PMTO) and/or Parenting through Change (PTC) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

2. Financial support

- Provide TA around cost reporting
  - Pulling from mandatory BH bucket
  - Shared risk vs. full risk
  - How to deal with the shift
- Offer 2 years of anticipated costs
- Consider additional QBP associated with non-Medicaid services.

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: CMHA"s federal legislation and policy advocacy plan
Date: Monday, February 10, 2025 12:00:38 PM

To: CEOs of CMHs, PIHPs, and Provider Alliance members; 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's federal legislation and policy advocacy plan

BACKGROUND: As you know, one of the chief purposes of CMHA revolves around identifying, getting ahead of, and responding to both opportunities for and threats against those served by our system and the public system itself.

Over the past several months, a number of you and our partners and allies across the state and the country have expressed the need for CMHA, and groups like ours, to develop and put into place a plan to pre-empt and respond to threats to those whom we serve and the public system that serves them that have already come and are expected to come from the White House and the Congress over the coming months.

To that end, below is a draft CMHA federal advocacy plan around the current and emerging federal proposals.

USE OF PRELIMINARY PLAN, NOW, WITH REFINED PLAN TO COME THROUGH CMHA L&P COMMITTEE: The review and refinement of this draft plan will be on the agenda of the upcoming CMHA Legislation and Policy Committee meeting. While the refined plan will emerge from the discussions of the L&P Committee, given the pace and gravity of the actions and proposals by the White House and the proposals working their way through Congress, CMHA will be implementing this draft plan, in concert with members and partners across Michigan as well as our national association colleagues.

CMHA FEDERAL ADVOCACY PLAN AROUND THE CURRENT AND EMERGING FEDERAL PROPOSALS:

Note, given that contents, pace, impact, and likelihood of being put into place, of the actions and proposals coming from Washington, are in flux, CMHA is outlining, in this plan, only the broad outlines of its federal advocacy efforts. As the dimensions of these actions and proposals become clearer and the resources and partnerships available to respond to them emerge, CMHA will revise and refine this broad outline.

CMHA’s federal advocacy plan centers around several core components:

1. Ensure that CMHA is in coalition with other organizations, in Michigan, representing health and human services systems and those served by those systems. While too numerous to list, some of those organizations, with which CMHA has had longstanding and productive relationships, include: the Michigan Health and Hospital Association, the Michigan Association of Counties, the Michigan Association for Local Public Health, the Michigan Primary Care Association, incompass-Michigan, the Michigan Assisted Living Association, the Michigan League for Public Policy, Arc Michigan, NAMI-Michigan, Mental Health Association in Michigan, Association for Children’s Mental Health, and Disability Rights-Michigan.

2. Work in partnership with MDHHS and other state departments, including the Governor’s Office, in these efforts.

3. Ensure that CMHA is in close and continual communication with both of its national associations, the National Council and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD). Close contact will also be maintained with other national organizations working on these issues.

4. Identify sound sources of information on actions and proposals, from the White House and Congress, of relevance to CMHA members and those whom they serve. Regularly communicate this information to CMHA members.

5. Use any of a range of advocacy tools, drawn from an array of advocacy tools with which CMHA and many of its members and allies have considerable experience, to thwart threats against and pursue opportunities for CMHA members and the persons, families, and communities which they serve.

Note that you may have already received information from CMHA related to advocacy efforts on this front. Again, the pace of this initial wave of White House actions demanded a rapid response, within Michigan and nationwide.

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

email correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter
Subject:	Today February 6: Protecting Medicaid Day of Action
Date:	Thursday, February 6, 2025 9:55:59 AM
Attachments:	image001.png
Importance:	High

To: CEOs of CMHs, PIHPs, and Provider Alliance members; 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: Today February 6: Protecting Medicaid Day of Action
As you may know, the US Congress is working its way through the Budget Reconciliation process. This process will result in the FY 2026 Federal Budget. A range of cuts to the nation's and Michigan's Medicaid program (the program that provides over 90% of the funding to Michigan's public mental health system) have been proposed as part of this budget process. **Some of those proposals would cut $2.3 trillion in Medicaid funding over the next 9 years.** CMHA and a rapidly emerging coalition of other Michigan advocacy organizations are **urging you to join us** and the members of this coalition and others across the country in the **Protect Medicaid Call-in Day of Action on February 6, 2025.** The aim of this nationwide effort is to let your representatives in Congress know of the **strong opposition, by their constituents, to any planned cuts in the nation's and Michigan's Medicaid program.**

PROTECT MEDICAID CALL-IN DAY OF ACTION: A national coalition of the leading health care advocacy organizations has organized the **Protect Medicaid Call-in Day of Action on February 6, 2025.**

We urge you to

1. Take a moment to review the short version of the talking points below (or if you want additional information, take a look at the call script found and other resources found at: 2/6 Protect Medicaid Day of Action Resources
2. **Today, February 6, and/or over the next week**, call your Member of Congress using the **Protect Medicaid Hotline (866-426-2631)** to urge them to **protect**, throughout the budget reconciliation process in which Congress is engaged, Medicaid and other health care programs that keep people healthy. (This is the Protect Medicaid Hotline that will give you a brief pitch on the importance of this work, ask you to enter your zip code, and connect you directly to your congressional representative's office.) This number will stay open until there is a final budget vote!

Short version of talking points for your call:

- 2.5 million Michigan citizens are enrolled in Medicaid, including almost one million children.
- Michigan receives $17.5 billion in federal Medicaid funding and Medicaid is the largest spending category in the state budget.
- Cuts will affect seniors, people with disabilities, pregnant women, children and low-income adults.

Thank you, in advance, for your action on this front. Your voice is key to ensuring that the Medicaid program, upon which hundreds of thousands of Michiganders rely for their mental health services and supports, remains strong and vibrant.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
2nd Floor

email correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter
Subject:	FY26 Executive Budget Proposal
Date:	Thursday, February 6, 2025 1:49:07 PM

From: Alan Bolter <ABolter@cmham.org>
Sent: Thursday, February 6, 2025 1:35 PM
To: CMHA Board of Directors, CMH & PIHP Directors, Provider Alliance, SUD Directors, and Legislation & Policy Committee
Cc: Robert Sheehan <RSheehan@cmham.org>
Subject: FY26 Executive Budget Proposal

All,

Yesterday, Governor Gretchen Whitmer and Michigan State Budget Director Jen Flood and Deputy Director Kyle Guerrant presented Governor Whitmer's Fiscal Year (FY) 2025 - 2026 Executive Budget Recommendations before a joint meeting of the Michigan Senate and House Appropriations Committees. This presentation jumpstarts what is known as budget season in Lansing, where both the House and Senate use the Governor's recommendation as a guide to negotiate their respective budget proposals and ultimately present a unified budget to the Governor before the statutory deadline of July 1st.

It is important to note that this budget recommendation serves as a jumping off point to get the negotiations with the House and Senate started. Many priorities the Governor announced will be replaced with those of legislative leaders. More likely than not, we expect negotiations to continue throughout the summer, past the July 1st statutory deadline into September, with a final FY 26 budget being presented to the Governor days before the October 1st fiscal year start date.

The much-anticipated budget recommendation, which amounts to the largest state budget in Michigan history, was released amidst the January Consensus Revenue Estimating Conference report that indicated the state's general fund was $1.2 billion higher than expected.

This year's presentation offers a $83.5 billion budget recommendation that includes a general fund total of $15.3 billion and a School Aid Fund total of $21.2 billion. The Governor highlighted the following priorities for strategic investment:

Lowering costs for Michiganders

- Creating Jobs
- Getting Smart on Education
- Supporting Seniors
- Protecting and Defending Michiganders
- Making Government Work Better

More specifically, here are the items of significance to the public mental health system (I am in the process of reviewing of boilerplate sections and will send out an updated document once I have completed that review):

Links to budget documents Executive Budget and Associated Documents
Links to budget bill (DHHS begins on page 114): FY26-General-Omnibus.pdf

Specific Mental Health/Substance Abuse Services Line items

	FY'24 (Final)	FY'25 (Final)	FY'26(Exec Rec)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$3,160,958,400	$3,387,066,600	$3,422,415,900
-Medicaid Substance Abuse services	$95,264,000	$95,650,100	$98,752,100
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,599,700	$79,626,200	$80,207,900
-Health Homes	$53,400,100	$53,418,500	$53,239,800

Program			
-Autism services $458,715,500	$279,257,100	$329,620,000	
-Healthy MI Plan (Behavioral health) $535,508,300	$590,860,800	$527,784,600	
-CCBHC $916,062,700	$386,381,700	$525,913,900	
-Total Local Dollars $9,943,600	$10,190,500	$10,190,500	

Other Highlights of the FY26 Executive Budget:

-

Proposed FY26 Investments The FY26 Executive Budget provides $62 million ($15.2 million general fund) in new supports to address the opioid epidemic and provide behavioral health services for those in need. Proposed funding includes:

- $15.2 million to begin operating the new state psychiatric hospital in Northville, bringing 264 new beds online and increasing capacity by 54 beds (32 adult beds and 22 pediatric beds). This investment includes operational support and hiring staff to provide services at the new facility.

- $46.8 million of Michigan Opioid Healing and Recovery Fund dollars for prevention, treatment, harm reduction, recovery, and data collection for those affected by the opioid epidemic. This additional allocation will expand services to reduce the number of opioid users and overdoses.

    - $15 million one-time to invest in new programs to reduce opioid usage and overdoses.
    - $31.8 million ongoing to continue existing, successful programs, including efforts to address the racial disparities in overdose deaths statewide. This brings the total annual ongoing funding to $55 million per year, supported by incoming settlement dollars.
    - The department's three-year plan will drive the use of these resources. The plan represents a comprehensive, multifaceted, data-driven approach

intended to strategically leverage available resources and take full advantage of this generational opportunity in the most impactful yet sustainable way possible. The plan includes:

- Increasing the age of first opioid use though new and expanded programs. The department will partner with nonprofits, youth engagement organizations, and existing partners to expand prevention programing in schools. They will also conduct public awareness campaigns.
- Reducing overdose deaths and addressing racial and geographical disparities. Those disparities are demonstrated in the chart below. DHHS will use resources to award multi-year grants to organizations working in underserved or under resourced communities. DHHS will also provide annual grants or contracts with organizations addressing racial disparities in opioid deaths and continue distributing naloxone in areas that need it most.
- Growing the behavioral health workforce through scholarships to prospective students, paid internships, and loan repayment.
- Prioritizing work to increase recovery beds and access to affordable housing. This will include reimbursing the cost of stay of residents and expansion of recovery housing. It also includes permanent affordable housing and investing in wraparound support programs like transportation and employment that enable people to stay in stable housing.
- Investing in administrative infrastructure to gather data to track success and provide technical assistance to local governments. This ensures these funds are being utilized for maximum impact and allows the department to partner with local governments to collaborate on ways to address opioid usage

- $96.4 million to expand Medicaid eligibility ($33.1 million general fund) with a new income disregard that will allow more people to gain access to coverage.
    - Currently Medicaid requires elderly and disabled enrollees with income above 100% of federal poverty limits (FPL) to spend the majority of their income on health care costs each month – until their remaining income is less than 40% FPL – to access Medicaid. This proposal would shift this level to 100% FPL, broadening access to Medicaid supports and preventing excessive spend down to help keep more seniors in their homes and prevent individuals from spending down into poverty.

- $400,000 to explore the feasibility of expanding Medicaid eligibility for children aged 0 - 6 years ($200,000 general fund).
    - This will allow DHHS to prepare a feasibility study to determine long-term costs, benefits, potential barriers and any associated nuances of implementing continuous eligibility for Medicaid beneficiaries aged 0-6.
- $40 million for the community reentry of incarcerated individuals ($20 million general fund) to provide coverage starting 90 days before an individual's scheduled release.
    - This will allow for health screenings and other services prior to reentry to identify key health needs and social determinants to facilitate a successful transition. Investing in these transition services will help improve health outcomes and access to community services, all of which will reduce recidivism.

- $2.5 million for access to mental health services (general fund, one-time) to support behavioral health resources for first responders and public safety staff.

- $258 million to support the mental and emotional wellbeing of 1.4 million students through continuation of mental health and safety grants to school districts.

- $5 million to support the MiABLE program expansion.

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

2025-2026 HOUSE COMMITTEES

Agriculture	
Neyer (C)	Paiz (MVC)
Wortz (VC)	Dievendorf
Lightner	Rheingans
Alexander	Skaggs
Fox	
Kunse	
Pavlov	

Appropriations			
Bollin (C)	Beson	Farhat (MVC)	McKinney
Maddock (VC)	Borton	O'Neal	Morgan
Green	Roth	Rogers	Price
Jenkins-Arno	Cavitt	Steckloff	Snyder
Markkanen	DeSana	Glanville	Longjohn
Mueller	Kuhn	Edwards	
Slagh	Steele	Martus	
VanWoerkom	Robinson		
Kelly			

Communications & Technology	
Greene (C)	Scott (MVC)
Kunse (VC)	Andrews
Wendzel	Arbit
Schmaltz	Skaggs
Schriver	
Fairbairn	
Linting	

Economic Competitiveness	
Hoadley (C)	Grant (MVC)
Bohnak (VC)	Brixie
Outman	Tate
Harris	Coffia
BeGole	
DeBoyer	
St. Germaine	

Education & Workforce	
DeBoer (C)	Wilson (MVC)
Linting (VC)	Koleszar
Paquette	Weiss
Fox	Byrnes
Kunse	
St. Germaine	
Pavlov	

Election Integrity	
Smit (C)	Wooden (MVC)
Fox (VC)	Koleszar
Outman	Xiong
Alexander	
Hoadley	
Pavlov	

Energy	
Wendzel (C)	Tate (MVC)
Prestin (VC)	Brixie
Martin	Liberati
BeGole	Andrews
DeBoer	Coffia
Schmaltz	Herzberg
Thompson	Myers-Phillips
Fairbairn	
Frisbie	
Linting	

Families & Veterans	
Schmaltz (C)	Young (MVC)
Wozniak (VC)	Byrnes
Fox	Rheingans
Johnsen	Xiong
Thompson	
Pavlov	
Woolford	

Finance	
Tisdel (C)	Hoskins (MVC)
Frisbie (VC)	T. Carter
VanderWall	Neeley
Lightner	Breen
Martin	Young
Posthumus	Paiz
Alexander	
Aragona	
Schuette	

Government Operations	
BeGole (C)	Fitzgerald (MVC)
Harris (VC)	McFall
VanderWall	

Health Policy	
VanderWall (C)	Whitsett (MVC)
Thompson (VC)	B. Carter
Meerman	Witwer
Tisdel	Neeley
Bierlein	Hoskins
DeBoer	Foreman
Prestin	
Schmaltz	
St. Germaine	
Bohnak	
Frisbie	

Insurance	
Harris (C)	B. Carter (MVC)
Tisdel (VC)	Tate
Lightner	Whitsett
Posthumus	Fitzgerald
Aragona	
Neyer	
Schuette	

Joint Committee on Administrative Rules	
Wozniak (C)	Farhat
Johnsen (VC)	B. Carter
Wortz	

Judiciary	
Lightner (C)	T. Carter (MVC)
BeGole (VC)	Hope
Wozniak	Breen
Harris	Scott
DeBoyer	
Johnsen	
Schuette	

Natural Resources & Tourism	
Martin (C)	McFall (MVC)
St. Germaine (VC)	Scott
VanderWall	Weiss
Outman	Arbit
Hoadley	Foreman
Johnsen	Myers-Phillips
Prestin	Wooden
Bohnak	
Fairbairn	
Wortz	

Oversight	
DeBoyer (C)	Miller (MVC)
Bierlein (VC)	Pohutsky
Meerman	Conlin
Paquette	MacDonell
Carra	Mentzer
Bruck	Tsernoglou
Greene	Wegela
Rigas	
Schriver	
Woolford	

Regulatory Reform	
Aragona (C)	Liberati (MVC)
Fairbairn (VC)	T. Carter
Wozniak	Whitsett
Wendzel	Witwer
Tisdel	Neeley
Hoadley	Dievendorf
Neyer	Grant
Rigas	
Thompson	
Linting	

Rules	
Schuette (C)	Witwer (MVC)
Aragona (VC)	Liberati
Wendzel	Herzberg
Martin	
Posthumus	
DeBoer	

Transportation & Infrastructure	
Outman (C)	Herzberg (MVC)
Alexander (VC)	Hope
Carra	Koleszar
Bruck	Andrews
Kunse	Grant
Neyer	Miller
Prestin	Wilson
Bohnak	
Frisbie	
Wortz	

OVERSIGHT SUBCOMMITTEES

Child Welfare System	
Meerman (C)	Conlin (MVC)
Rigas (VC)	MacDonnell
Paquette	

Corporate Subsidies & State Investments	
Carra (C)	Wegela (MVC)
Greene (VC)	Pohutsky
Bierlein	

Homeland Security & Foreign Influence	
Bruck (C)	Mentzer (MVC)
Meerman (VC)	Conlin
Schriver	

Public Health & Food Security	
Bierlein (C)	MacDonnell (MVC)
Paquette (VC)	Tsernoglou
Greene	

State & Local Assistance Programs	
Woolford (C)	Tsernoglou (MVC)
Bruck (VC)	Mentzer
Carra	

Weaponization of State Government	
Rigas (C)	Pohutsky (MVC)
Schriver (VC)	Wegela
Woolford	

APPROPRIATIONS SUBCOMMITTEES

Agriculture and Rural Development & Natural Resources	
Borton (C)	O'Neal (MVC)
Mueller (VC)	McKinney
Green	
Roth	
DeSana	

Corrections & Judiciary	
Slagh (C)	O'Neal (MVC)
Markkanen (VC)	
Beson	
Cavitt	

Higher Education & Community Colleges	
Markkanen (C)	Longjohn (MVC)
Roth (VC)	Rogers
Jenkins-Arno	
Mueller	
Kuhn	

Environment, Great Lakes, and Energy	
Cavitt (C)	Steckloff (MVC)
Borton (VC)	Price
Markkanen	

Human Services	
Roth (C)	Edwards (MVC)
Kelly (VC)	Longjohn
Mueller	
Beson	
DeSana	

General Government	
Kuhn (C)	Snyder (MVC)
VanWoerkom (VC)	
Kelly	
Maddock	

Joint Capital Outlay	
Jenkins-Arno (C)	Steckloff (MVC)
DeSana (VC)	Glanville
Bollin	Farhat
Green	
Slagh	
Steele	

Labor & Economic Opportunity	
Jenkins-Arno (C)	Martus (MVC)
Robinson (VC)	
VanWoerkom	
Cavitt	

Licensing and Regulatory Affairs and Insurance and Financial Services	
Beson (C)	McKinney (MVC)
Steele (VC)	Snyder
VanWoerkom	

Medicaid & Behavioral Health	
VanWoerkom (C)	Rogers (MVC)
Green (VC)	Glanville
Roth	
Kuhn	
Robinson	

Michigan State Police	
Mueller (C)	Snyder (MVC)
Maddock (VC)	Martus
Kelly	

Military & Veterans Affairs	
Robinson (C)	Rogers (MVC)
Cavitt (VC)	Morgan
Maddock	

Public Health	
Green (C)	Price (MVC)
Kuhn (VC)	O'Neal
Maddock	
Slagh	

State & Local Transportation	
Steele (C)	Morgan (MVC)
Slagh (VC)	Edwards
Borton	
DeSana	
Robinson	

School Aid & Dept of Education	
Kelly (C)	Glanville (MVC)
Jenkins-Arno (VC)	Steckloff
Markkanen	
Beson	
Borton	

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

February 20, 2025

Eric Kurtz, CEO
Northern Michigan Regional Entity
1999 Walden Drive
Gaylord, MI 49735

Dear Mr. Kurtz:

The Michigan Department of Health and Human Services (MDHHS) has completed a review of Region 2 – Northern Michigan Regional Entity's (NMRE) FY25 self-reported/unaudited Risk Management Strategy (RMS). The components of NMREs RMS are in compliance with the MDHHS/Prepaid Inpatient Health Plan (PIHP) contract.

Please note that the existing Internal Service Fund (ISF) Technical Requirement document posted online applies only through the end of FY24. The PIHPs should review the FY25 PIHP Contract for any FY25 ISF and FY25 RMS requirements. The ISF Technical Requirement online and in the RMS Technical Advisory letter dated 10/31/2022 are only applicable for FY24 and prior year submissions. Therefore, references to the "ISF Technical Requirement" located within the RMS Technical Advisory letter, dated 10/31/2022, likewise do not apply to the FY25 RMS submissions.

FY25 Projected Medicaid Fund Reported:
Surplus $2,710,000

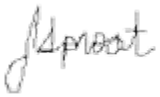
PIHP Response to Deficit:
N/A

Management Decision:
Approved

This approval does not imply MDHHS acceptance of any ISF balances over the contractually limited 7.5%.

If there are any anticipated changes to NMRE FY25 RMS during the fiscal year, please submit a revised plan to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

Sincerely,



Jackie Sproat, Director
Division of Contracts and Quality Management
Bureau of Specialty Behavioral Health Services
Behavioral and Physical Health and Aging Services Administration

c: Laura Kilfoyle, State Administrative Manager
Michael Glud, Departmental Analyst
Deanna Yockey, NMRE

Northern Michigan Regional Entity – Region 2
CONSULTATION DRAFT
FY24 Performance Bonus Incentive Pool (PBIP)
Contractor-only and MHP/Contractor Joint Metrics
Deliverables/Narratives Scoring

This communication serves as the consultation draft review response to your PIHP regarding the FY2024 performance bonus, contract section A.8.D.
Scoring is based on Contractor-only and MHP/Contractor Joint Metrics deliverables.

TOTAL WITHHOLD	TOTAL WITHHOLD UNEARNED
$1,736,971.94	$21,712.15

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

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

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

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

	CY2022		CY2023		Disparity year 1	Disparity year 2	Disparity change
RACE	M rate	W rate	M rate	W rate	Test 1	Test 2	Test 3.3

African American/ Black	30%	32%	39%	28%	No disparity in year 1	No disparity in year 2	No change in disparity from year 1 to year 2
American Indian/ Alaska Native	34%	32%	35%	28%	No disparity in year 1	No disparity in year 2	No change in disparity from year 1 to year 2
Hispanic	17%	32%	31%	28%	Minority rate was significantly lower in year 2	No disparity in year 2	No change in disparity from year 1 to year 2

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

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

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

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

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
CONTRACTOR -only TOTAL	**$1,215,880.36**	**$21,712.15**	**200**	**197**

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

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

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

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

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

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

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

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

	CY2022	CY2023	Disparity year 1	Disparity year 2	Disparity change

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

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

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
MHP/CONTRACTOR JOINT METRICS TOTAL	**$521,091.58**	**$0**	**100**	**100**

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – FEBRUARY 12, 2025
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Connie Cadarette, Ann Friend, Kevin Hartley, Chip Johnston, Nancy Kearly, Eric Kurtz, Allison Nicholson, Diane Pelts, Nena Sork, Erinn Trask, Jennifer Warner, Deanna Yockey, 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 KEVIN HARTLEY TO APPROVE THE MINUTES OF THE JANUARY 8, 2025 NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY ALLISON NICHOLSON. MOTION APPROVED.

MONTHLY FINANCIALS
December 2024

- Net Position showed net surplus Medicaid and HMP of $8,003. Carry forward was reported as $2,909,566. The total Medicaid and HMP Current Year Surplus was reported as $2,917,569. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $23,493,725.
- Traditional Medicaid showed $52,316,661 in revenue, and $51,597,652 in expenses, resulting in a net surplus of $719,009. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $6,554,538 in revenue, and $7,265,544 in expenses, resulting in a net deficit of $711,006. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $2,909,566.
- Health Home showed $850,135 in revenue, and $669,352 in expenses, resulting in a net surplus of $180,783.
- SUD showed all funding source revenue of $7,009,330 and $5,576,966 in expenses, resulting in a net surplus of $1,522,364. Total PA2 funds were reported as $4,574,377.

Deanna noted that the NMRE's ISF is currently funded ($3,141,000) beyond 7.5% of annual revenue per FY24 PIHP contract language. On December 16, 2024, MDHHS notified the NMRE (and other PIHPs) that its FY24 Financial Status Reports (FSRs) would not be accepted "if any ISF balance shown therein is greater than 7.5% of the annual operating budget." MDHHS stated that rejected submissions would be returned for "corrections" and if not thereafter accepted, would be "considered late for purposes of determining PIHP eligibility for Contractor performance withhold Payments." Milliman's 2024 analysis found that the NMRE's ISF should be funded at approximately 15% of annual revenue.

Eric stated that the NMRE will likely "take the hit" and circle back after the legal process plays out.

PA2/Liquor Tax was summarized as follows:

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

Actual FY25 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$92,609	$283,464	$4,574,377

Both Medicaid and HMP are running at a deficit three months into FY25. It was noted that there is not enough carry forward to offset a year-end deficit. The NMRE will need to utilize most of the ISF balance to cost settle with each Board at the current rate of spending.

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$161,104	($536,574)	($80,565)	($1,694,748)	$809,942
HMP	($145,707)	($154,002)	($75,223)	($787,507)	($172,973)
Total	$15,397	($690,576)	($155,788)	($2,482,255)	$636,969

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2024; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

FY24 FINAL FSR
The final FY24 FSR is due to MDHHS on February 28th. Reports have been requested from the CMHSPs by February 14th. The NMRE acknowledged receipt of the report from one of the Boards.

EDIT UPDATE
Neither Donna nor Brandon was available to report on the January EDIT meeting. Donna will report in March.

EQI UPDATE
The full FY24 EQI report is due to MDHHS on February 28th. Reports have been requested from the CMHSPs by February 14th.

Connie asked whether any of the CMHSPs have worked through the financial reconciliation portion of the EQI. Connie noted a possible error with the financial reconciliation tab. A line was added to Northeast Michigan's EQI to state "formula error."

Brian asked if there would be any opposition to sharing the unit costs. Erinn responded that the FY23 EQIs were posted to ShareFile. Deanna agreed to post the FY24 EQIs as well.

ELECTRONIC VISIT VERIFICATION (EVV)
Brandon was not in attendance to provide an update; however, there has been discussion about adding reports to PCE to ensure EVV compliance. A subgroup of the CIO Forum has been created to work through the payment collection process.

HSW OPEN SLOTS UPDATE

The NMRE currently has five open HSW slots; the NMRE needs five more packets to fill the openings.

It was noted that the NMRE is having difficulties with sending in new HSW packets due to BHTEDS coding issues.

NMRE staff discovered a possible interaction that affects the submission of HSW packets. It appears that new HSW packets being submitted after the coding changes get rejected as they don't match the old BHTEDS coding. When the NMRE reached out to MDHHS for assistance, the following reply was received:

> **"A change (correction) record (NOT an update record) needs to be submitted correcting the Living Arrangement and Detailed Living Arrangements fields. If this individual is in Specialized Residential, correct the Living arrangement code to 32-Foster Care and Detailed Living Arrangement to 321-Specialized residential. Set the System Transaction Type to C (change) and submit the record."**

To remedy the issue, The NMRE compiled a list of individuals whose most recent BHTEDS records contain the old coding. These will be uploaded to the CMHSPs' ShareFile folders.

DAB TRANSITION

A meeting took place on February 14th between the PIHPs and PCE; Eric was unable to attend. Evidently, the State has been using Plan First as dumping ground for individuals who didn't meet their spenddowns. The exact financial impact is unknown. Milliman is currently chasing DAB rates as individuals migrate to TANF, HSW, and Plan First. Although Milliman is attempting to increase the DAB rate, it is not enough to counteract the migration to the lower paying benefits.

NMRE REVENUE & ELIGIBLES ANALYSIS

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

Children's Waiver Program			
	November 2023	January 2025	% Change
Revenue	$37,040	$32,754	-11.57%
Enrollees	11	10	-9.09%

DAB			
	November 2023	January 2025	% Change
Revenue	$9,796,214	$9,814,084	0.18%
Enrollees	27,979	25,007	-10.62%
Average Payment per Enrollee	$350.00	$392.00	12.09%

HMP			
	November 2023	January 2025	% Change
Revenue	$2,286,849	$2,222,778	-2.80%
Enrollees	45,924	33,808	-26.38%
Average Payment per Enrollee	$50.00	$66.00	32.03%

HSW			
	November 2023	January 2025	% Change
Revenue	$4,692,308	$5,183,593	10.47%
Enrollees	663	687	3.62%
Average Payment per Enrollee	$7,077.00	$7,545.00	6.61%

SED			
	November 2023	January 2025	% Change*
Revenue	$43,326	$22,080	-49.04%
Enrollees	22	32	45.45%
Average Payment per Enrollee*	$1,969.00	$690.00	-64.96%

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

TANF			
	November 2023	January 2025	% Change
Revenue	$2,763,76	$2,718,299	-1.65%
Enrollees	65,030	54,821	-15.70%
Average Payment per Enrollee	$42.00	$50.00	16.67%

TOTAL			
	November 2023	January 2025	% Change
Monthly Total Revenue	$19,619,501	$19,993,588	1.91%

ALPINE CRISIS RESIDENTIAL UNIT

The CMHSPs general funds usage of the Alpine CRU was included in the meeting materials. The NMRE will continue to pay 50% of operating costs through FY25.

	Units	Total Cost
Centra Wellness	0	—
North Country	17	$15,923.96
Northeast Michigan	36	$33,721.32
Northern Lakes	6	$5,620.22
Wellvance	1	936.70
Total	**60**	**$56,202.20**

Ann asked whether the CMHSPs should be paying the $2.20 direct care worker (DCW) increase for NorthShores/Alpine. Eric responded that the CMHSPs should not be billed for anything through December 2024. Fee for Service Contracts should be in place at the per diem rate of $600 and $350 for respite, effective January 1, 2025.

97153 CODE AND $16.50 PER UNIT

Although it was approved by CMS with an effective date of November 1, 2024, the $16.50 per unit cost for 97153 (15 minutes of adaptive behavior treatment by a technician) has not been rolled out to date. Erinn was told that MDHHS is working on a revenue adjustment to cover it, but nothing has occurred yet. Eric spoke of a possible contract amendment in March. Chip noted that the rate should only be retroactive to providers, if it is paid retroactively to the PIHP/CMHSPs.

OTHER

Chip asked whether anyone has developed an updated funding stream diagram and, if so, could they send it to his attention. He has one from approximately 2017 that does not show the flow of funds with all the new waivers such as 1915(i), etc.

NEXT MEETING

The next meeting was scheduled for March 12th at 10:00AM.

Chief Executive Officer Report

February 2024

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

Jan 29: Attended and participated in CMHAM Directors Forum.

Feb 4 & 5: Attended CMHAM Winter Conference.

Feb 7: Met with NLCMHA Board Chair.

Feb 11: Attended and participated in GTC Crisis Team Meeting.

Feb 11: Attended and participated in PIHP CEO Meeting.

Feb 12: Attended and participated in NMRE Regional Finance Committee Meeting.

Feb 14: Attended NLCMHA Dispute Resolution Committee Meeting.

Feb 18: Chaired NMRE Operations Committee Meeting.

Feb 19: Attended and participated in NMRE Internal Operations Meeting.

December 2024 Finance Report

December 2024 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	719,009	-	13,510,136
Healthy Michigan	(711,006)	2,909,566	7,066,020
	$ 8,003	$ 2,909,566	$ 20,576,156

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	1,301,270	1,382,987	(2,482,255)	(690,576)	(155,788)	636,969	15,396	$ 8,003
Carry Forward		-	-	-	-	-	-	2,909,566
Total Med/HMP Current Year Surplus	1,301,270	1,382,987	(2,482,255)	(690,576)	(155,788)	636,969	15,396	$ 2,917,569
Medicaid & HMP Internal Service Fund								20,576,156
Total Medicaid & HMP Net Surplus								$ 23,493,725

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2024 through December 31, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 50,589,907	$ 1,726,754						$ 52,316,661
CMHSP Distributions	(47,704,975)		15,442,353	12,810,407	8,105,969	6,949,548	4,396,698	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	2,884,932	1,726,754	15,442,353	12,810,407	8,105,969	6,949,548	4,396,698	52,316,661
Expense								
PIHP Admin	772,338	14,759						787,097
PIHP SUD Admin		39,540						39,540
SUD Access Center		-						-
Insurance Provider Assessment	434,339	9,005						443,344
Hospital Rate Adjuster	-							-
Services	344,603	937,252	17,137,101	13,346,981	8,186,534	6,139,606	4,235,594	50,327,671
Total expense	1,551,280	1,000,556	17,137,101	13,346,981	8,186,534	6,139,606	4,235,594	51,597,652
Net Actual Surplus (Deficit)	$ 1,333,653	$ 726,198	$ (1,694,748)	$ (536,574)	$ (80,565)	$ 809,942	$ 161,104	$ 719,009

Notes

Medicaid ISF - $13,510,136 - based on current FSR

Medicaid Savings - $0

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through December 31, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 3,514,991	$ 3,039,547						$ 6,554,538
CMHSP Distributions	(3,433,263)		1,261,612	979,907	443,178	468,167	280,400	(0)
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	81,728	3,039,547	1,261,612	979,907	443,178	468,167	280,400	6,554,538
Expense								
PIHP Admin	74,579	34,930						109,509
PIHP SUD Admin		94,463						94,463
SUD Access Center		-						-
Insurance Provider Assessment	39,531	19,909						59,440
Hospital Rate Adjuster	-							-
Services	-	2,233,456	2,049,119	1,133,909	518,401	641,140	426,107	7,002,132
Total expense	114,110	2,382,758	2,049,119	1,133,909	518,401	641,140	426,107	7,265,544
Net Surplus (Deficit)	$ (32,382)	$ 656,789	$ (787,507)	$ (154,002)	$ (75,223)	$ (172,973)	$ (145,707)	$ (711,006)

Notes
HMP ISF - $7,066,020 - based on current FSR
HMP Savings - $2,909,566

Net Surplus (Deficit) MA/HMP	**$ 1,301,270**	**$ 1,382,987**	**$ (2,482,255)**	**$ (690,576)**	**$ (155,788)**	**$ 636,969**	**$ 15,396**	**$ 8,003**
Medicaid/HMP Carry Forward								**2,909,566**
Total Med/HMP Current Year Surplus								$ 2,917,569
Medicaid & HMP ISF - based on current FSR								**20,576,156**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 23,493,725**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2024 through December 31, 2024

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	AuSable Valley	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 328,593		134,071	90,199	98,623	56,155	142,494	$ 850,135
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	328,593	-	134,071	90,199	98,623	56,155	142,494	850,135
Expense								
PIHP Admin	10,160							10,160
BHH Admin	9,546							9,546
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	128,104		134,071	90,199	98,623	56,155	142,494	649,646
Total expense	147,810	-	134,071	90,199	98,623	56,155	142,494	669,352
Net Surplus (Deficit)	$ 180,783	$ -	$ -	$ -	$ -	$ -	$ -	$ 180,783

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2024 through December 31, 2024

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,726,754	$ 3,039,547	$ 1,054,805	$ 994,763	$ 283,461	$ 7,099,330
Expense						
Administration	54,299	129,393	48,993	44,497		277,182
OHH Admin			20,773	-		20,773
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	9,005	19,909	-			28,914
Services:						
Treatment	937,252	2,233,456	845,661	453,233	283,462	4,753,064
Prevention	-	-	-	221,276	-	221,276
ARPA Grant	-	-	-	275,757	-	275,757
Total expense	1,000,556	2,382,758	915,427	994,763	283,462	5,576,966
PA2 Redirect			-	-		-
Net Surplus (Deficit)	$ 726,198	$ 656,789	$ 139,378	$ 0	$ -	$ 1,522,364

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2024 through December 31, 2024

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 50,589,907	$ 1,726,754	$ -	$ 52,316,661
Medicaid Savings	-	-	-	-
Healthy Michigan	3,514,991	3,039,547	-	6,554,538
Healthy Michigan Savings	-	-	-	-
Health Home	850,135	-	-	850,135
Opioid Health Home	-	1,054,805	-	1,054,805
Substance Use Disorder Block Grant	-	994,763	-	994,763
Public Act 2 (Liquor tax)	-	283,460	-	283,460
Affiliate local drawdown	148,704	-	-	148,704
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	4,000	-	4,000
Veteran Navigator Grant	21,699	-	-	21,699
SOR Grant Revenue	-	370,716	-	370,716
Gambling Grant Revenue	-	51,478	-	51,478
Other Revenue	-	-	814	814
Total operating revenue	55,125,436	7,525,523	814	62,651,773
Operating expenses				
General Administration	934,974	199,285	-	1,134,259
Prevention Administration	-	30,731	-	30,731
OHH Administration	-	20,773	-	20,773
BHH Administration	9,546	-	-	9,546
Insurance Provider Assessment	473,870	28,914	-	502,784
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	49,390,419	937,252	-	50,327,671
Healthy Michigan Services	4,768,676	2,233,456	-	7,002,132
Health Home Services	649,646	-	-	649,646
Opioid Health Home Services	-	845,661	-	845,661
Community Grant	-	453,233	-	453,233
Prevention	-	190,545	-	190,545
State Disability Assistance	-	-	-	-
ARPA Grant	-	275,757	-	275,757
Public Act 2 (Liquor tax)	-	283,462	-	283,462
Local PBIP	-	-	-	-
Local Match Drawdown	148,704	-	-	148,704
Miscellanous Grant	-	4,000	-	4,000
Veteran Navigator Grant	21,699	-	-	21,699
SOR Grant Expenses	-	370,716	-	370,716
Gambling Grant Expenses	-	51,478	-	51,478
Total operating expenses	56,397,534	5,925,263	-	62,322,797
CY Unspent funds	(1,272,098)	1,600,260	814	328,976
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	-	-	-	-
Unspent funds - ending	$ (1,272,098)	$ 1,600,260	$ 814	$ 328,976

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2024 through December 31, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 46,938,177	$ 50,589,907	$ 3,651,730	7.78%
Carryover	11,400,000	-	-	-	-
Healthy Michigan					
Capitation	19,683,372	4,920,843	3,514,991	(1,405,852)	(28.57%)
Carryover	5,100,000	-	-	-	0.00%
Health Home	1,451,268	362,817	850,135	487,318	134.32%
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	21,699	(5,802)	(21.10%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	227,426,695	52,398,042	55,125,436	2,727,394	5.21%
Operating expenses					
General Administration	3,591,836	895,314	934,974	(39,660)	(4.43%)
BHH Administration	-	-	9,546	(9,546)	0.00%
Insurance Provider Assessment	1,897,524	474,381	473,870	511	0.11%
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	21,699	1,230	5.36%
Payments to Affiliates:					
Medicaid Services	176,618,616	44,154,654	49,390,419	(5,235,765)	(11.86%)
Healthy Michigan Services	17,639,940	4,409,985	4,768,676	(358,691)	(8.13%)
Health Home Services	1,415,196	353,799	649,646	(295,847)	(83.62%)
Total operating expenses	208,177,013	51,602,598	56,397,534	(4,794,936)	(9.29%)
CY Unspent funds	$ 19,249,682	$ 795,444	(1,272,098)	$ (2,067,542)	
Transfers in			-		
Transfers out			-	56,397,534	
Unspent funds - beginning			-		
Unspent funds - ending			$ (1,272,098)	(1,272,098)	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2024 through December 31, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 1,169,658	$ 1,726,754	$ 557,096	47.63%
Healthy Michigan	11,196,408	2,799,102	3,039,547	240,445	8.59%
Substance Use Disorder Block Grant	6,467,905	1,616,975	994,763	(622,212)	(38.48%)
Opioid Health Home	3,419,928	854,982	1,054,805	199,823	23.37%
Public Act 2 (Liquor tax)	1,533,979	-	283,460	283,460	0.00%
Miscellanous Grants	4,000	1,000	4,000	3,000	300.00%
SOR Grant	2,043,984	510,996	370,716	(140,280)	(27.45%)
Gambling Prevention Grant	200,000	50,000	51,478	1,478	2.96%
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	7,002,713	7,525,523	522,811	7.47%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	255,645	199,285	56,360	22.05%
Prevention Administration	118,428	29,607	30,731	(1,124)	(3.80%)
Insurance Provider Assessment	113,604	28,401	28,914	(513)	(1.81%)
Medicaid Services	3,931,560	982,890	937,252	45,638	4.64%
Healthy Michigan Services	10,226,004	2,556,501	2,233,456	323,045	12.64%
Community Grant	2,074,248	518,562	453,233	65,329	12.60%
Prevention	634,056	158,514	190,545	(32,031)	(20.21%)
State Disability Assistance	95,215	23,809	-	23,809	100.00%
ARPA Grant	-	-	275,757	(275,757)	0.00%
Opioid Health Home Admin	-	-	20,773	(20,773)	0.00%
Opioid Health Home Services	3,165,000	791,250	845,661	(54,411)	(6.88%)
Miscellanous Grants	4,000	1,000	4,000	(3,000)	(300.00%)
SOR Grant	2,043,984	510,996	370,716	140,280	27.45%
Gambling Prevention	200,000	50,000	51,478	(1,478)	(2.96%)
PA2	1,533,978	-	283,462	(283,462)	0.00%
Total operating expenses	25,222,653	5,907,175	5,925,263	(18,088)	(0.31%)
CY Unspent funds	$ 4,322,183	$ 1,095,538	1,600,260	$ 504,723	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			-		
Unspent funds - ending			$ 1,600,260		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2024 through December 31, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 480,453	$ 498,590	$ (18,137)	(3.77%)
Fringes	666,212	158,406	176,606	(18,200)	(11.49%)
Contractual	683,308	170,829	146,719	24,110	14.11%
Board expenses	18,000	4,500	5,827	(1,327)	(29.49%)
Day of recovery	14,000	9,000	-	9,000	100.00%
Facilities	152,700	38,175	36,971	1,204	3.15%
Other	135,804	33,951	70,261	(36,310)	(106.95%)
Total General Admin	$ 3,591,836	$ 895,314	$ 934,974	$ (39,660)	(4.43%)

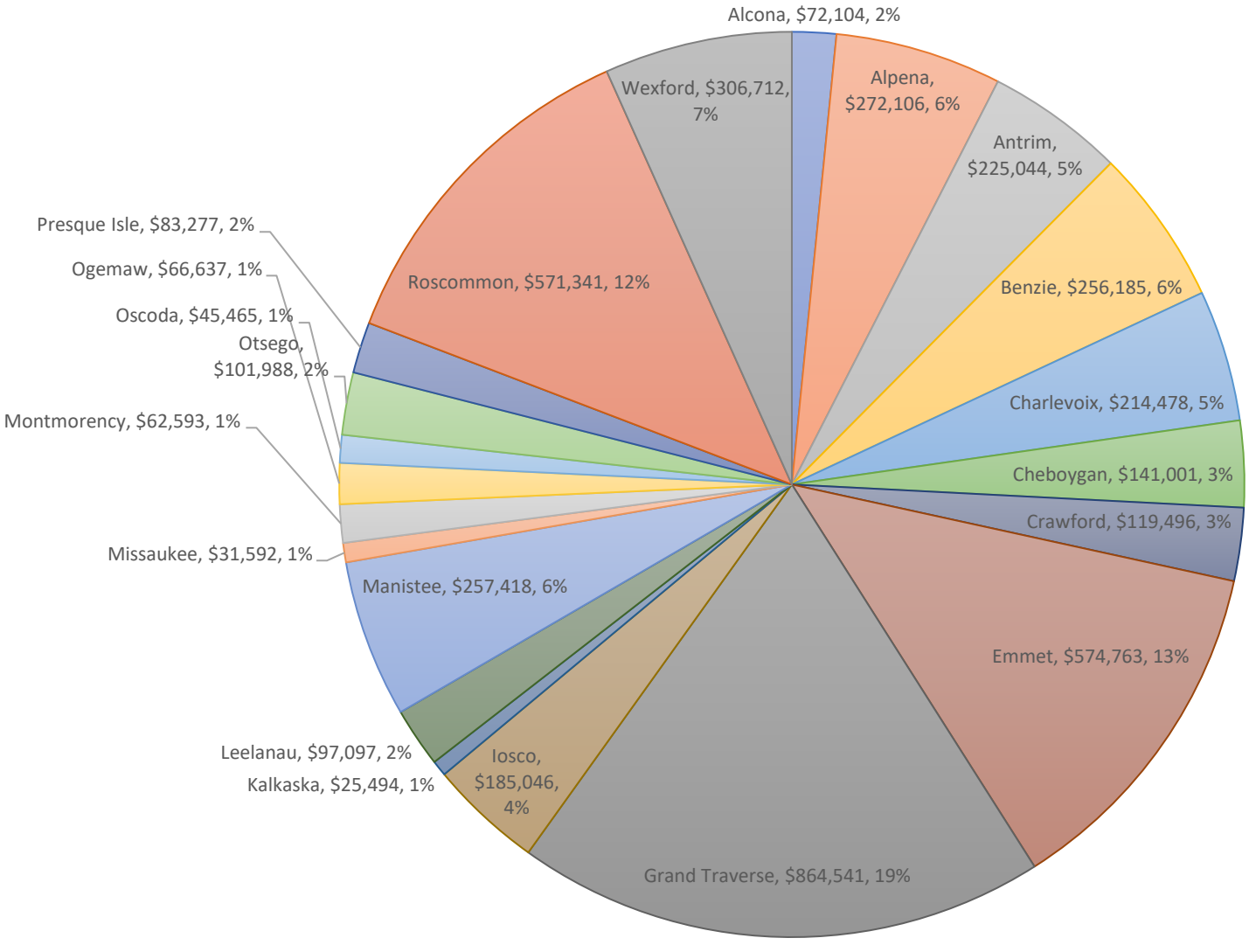
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2024 through December 31, 2024

	Projected FY25 Activity				Actual FY25 Activity			
	Beginning Balance	FY25 Projected Revenue	FY25 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 71,885	$ 23,013	$ 21,562	$ 73,336	$ 1,098	879	$ -	$ 72,104
Alpena	276,605	81,249	115,352	242,502	4,214	8,714	-	272,106
Antrim	225,891	71,430	37,276	260,045	3,747	4,594	-	225,044
Benzie	257,777	64,021	52,479	269,320	3,245	4,838	-	256,185
Charlevoix	240,410	106,977	204,773	142,613	5,172	31,105	-	214,478
Cheboygan	141,238	85,508	65,816	160,930	4,496	4,733	-	141,001
Crawford	126,884	36,205	68,993	94,096	1,986	9,374	-	119,496
Emmet	604,860	182,951	363,695	424,117	9,149	39,246	-	574,763
Grand Traverse	947,150	464,163	558,074	853,238	22,760	105,368	-	864,541
Iosco	186,997	84,319	73,780	197,537	4,287	6,238	-	185,046
Kalkaska	25,843	41,796	2,436	65,203	-	349	-	25,494
Leelanau	97,166	63,811	39,737	121,240	3,101	3,170	-	97,097
Manistee	259,014	82,480	104,210	237,284	4,089	5,685	-	257,418
Missaukee	30,683	22,352	20,908	32,127	1,202	293	-	31,592
Montmorency	59,540	30,318	8,457	81,401	3,518	466	-	62,593
Ogemaw	64,110	68,787	11,101	121,797	3,416	889	-	66,637
Oscoda	44,727	21,668	7,577	58,818	1,156	418	-	45,465
Otsego	112,969	105,067	98,424	119,612	5,328	16,309	-	101,988
Presque Isle	82,660	24,977	11,701	95,936	1,268	651	-	83,277
Roscommon	576,714	87,317	55,007	609,024	4,377	9,750	-	571,341
Wexford	332,107	98,696	229,583	201,220	4,997	30,392	-	306,712
	4,765,231	1,847,106	2,150,940	4,461,397	92,609	283,464	-	4,574,377
PA2 Redirect								-
								4,574,377

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration

October 1, 2024 through December 31, 2024

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 723,372	$ 180,843	$ 104,338	$ 76,505	42.30%
Fringes	212,604	53,151	37,850	15,301	28.79%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	18,750	34,883	(16,133)	(86.04%)
Board expenses	5,000	1,251	1,825	(574)	(45.88%)
Day of Recover	-	-	10,128	(10,128)	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	1,650	10,261	(8,611)	(521.88%)
Total operating expenses	$ 1,082,576	$ 255,645	$ 199,285	$ 56,360	22.05%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2024 through December 31, 2024

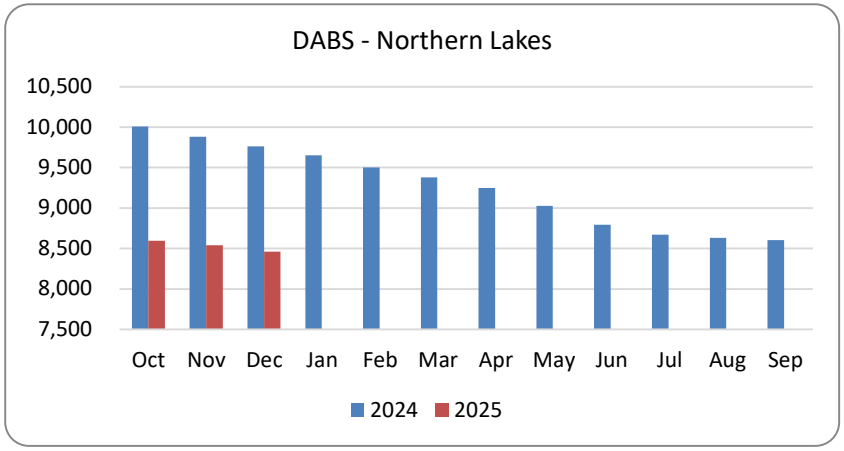
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	1,875	814	(1,061)	(56.59%)
Total operating revenue	7,500	1,875	814	(1,061)	(56.59%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 1,875	814	$ (1,061)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			-		
Unspent funds - ending			$ 814		

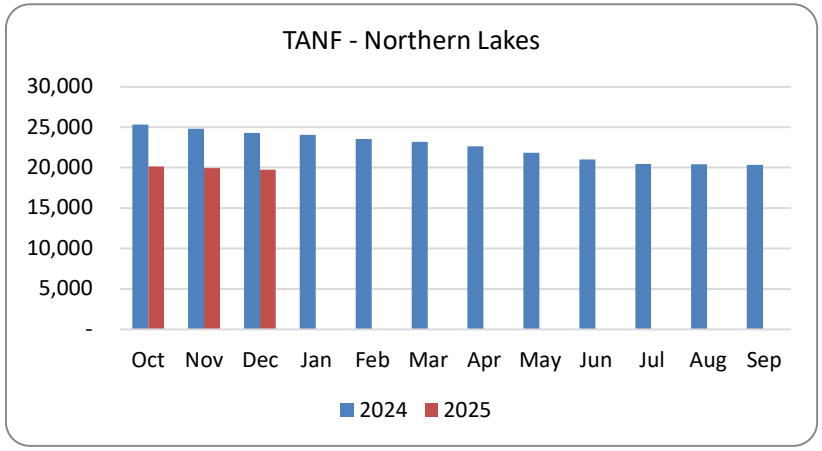
Northern Michigan Regional Entity

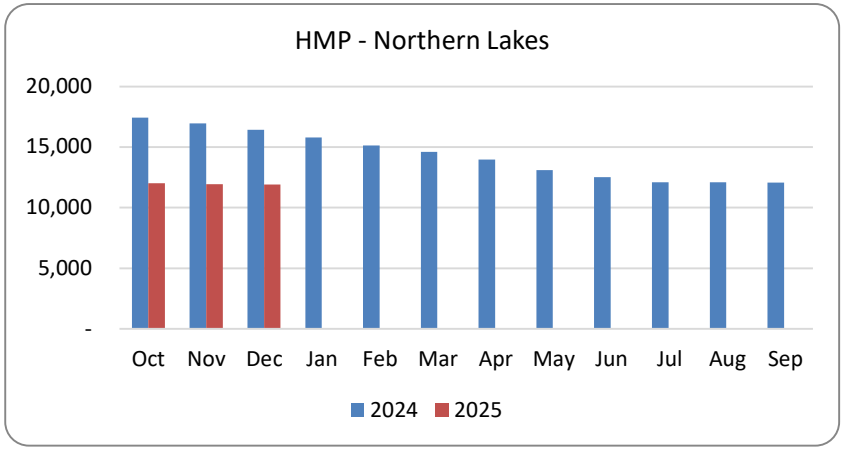
Narrative

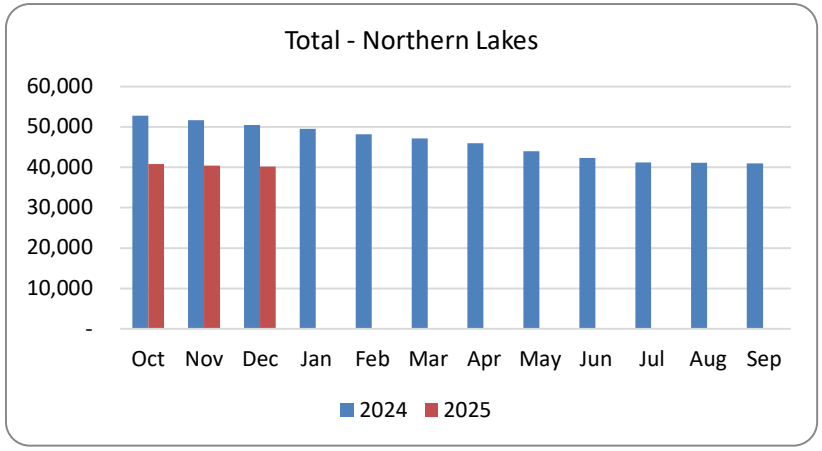
October 1, 2024 through December 31, 2024

Northern Lakes Eligible Members Trending - based on payment files







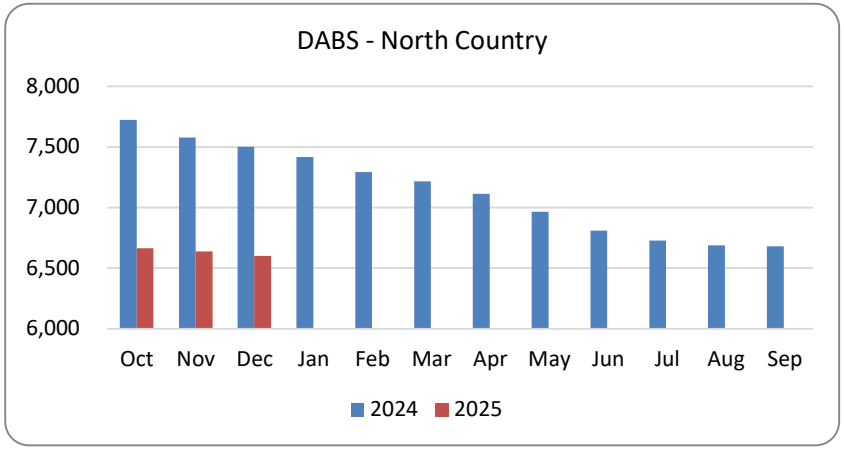


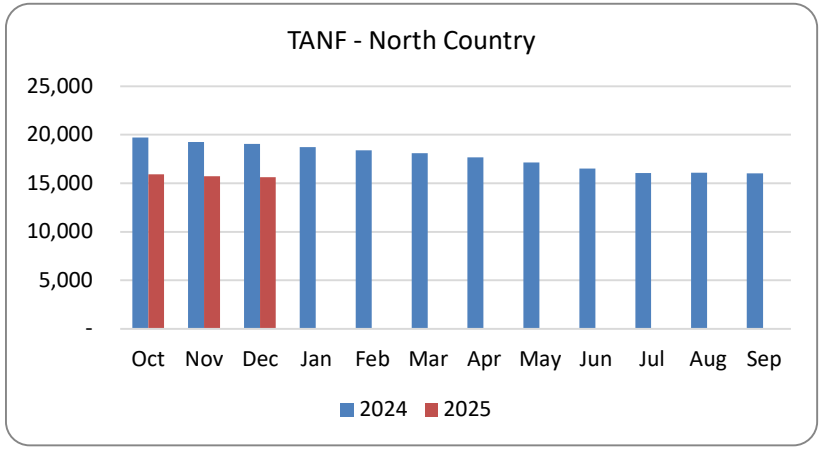
Northern Michigan Regional Entity

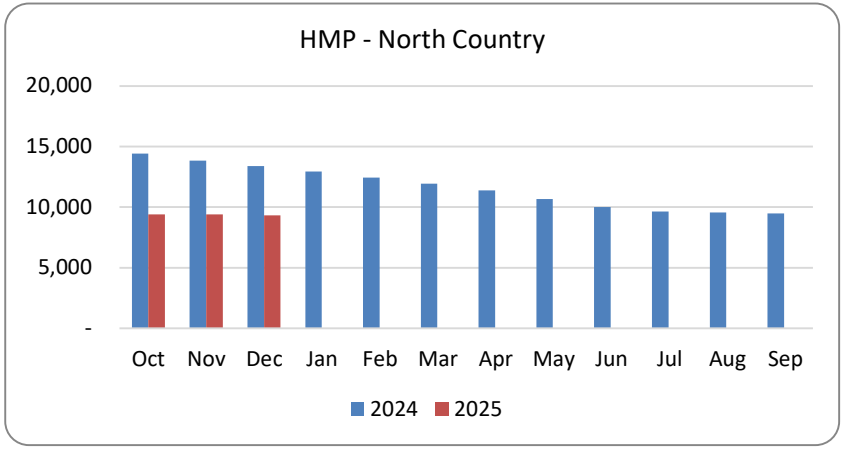
Narrative

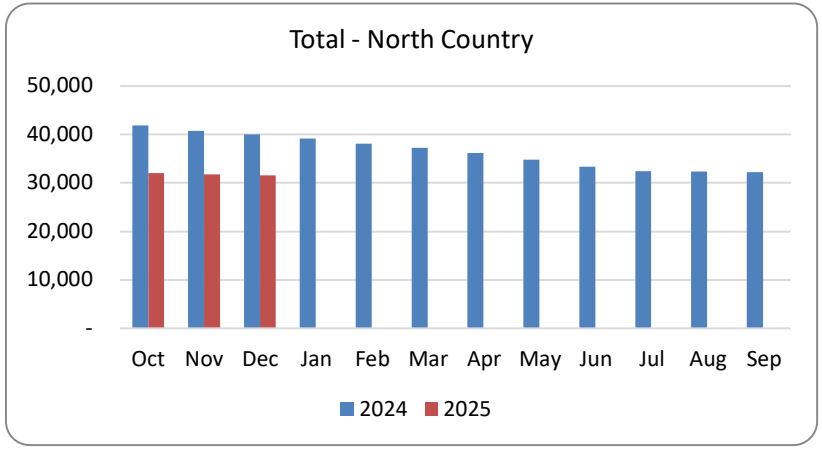
October 1, 2024 through December 31, 2024

North Country Eligible Members Trending - based on payment files







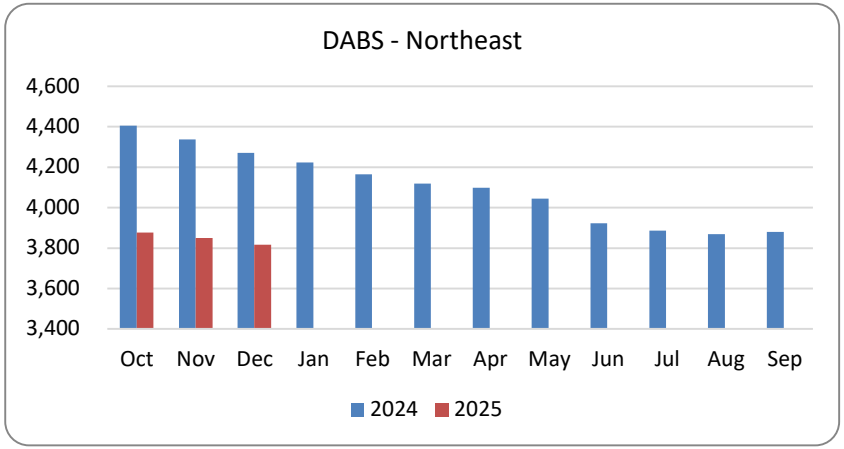


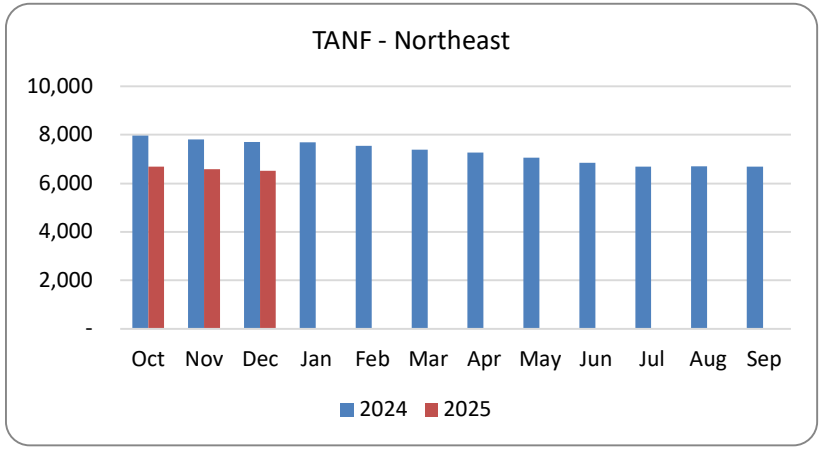
Northern Michigan Regional Entity

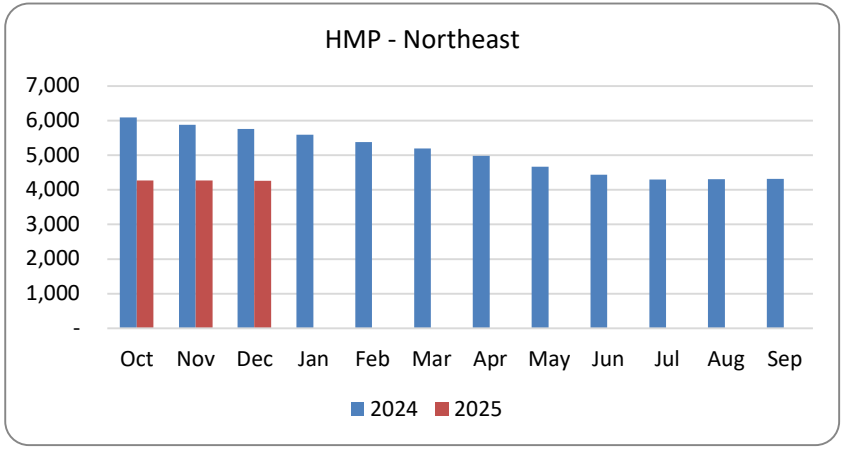
Narrative

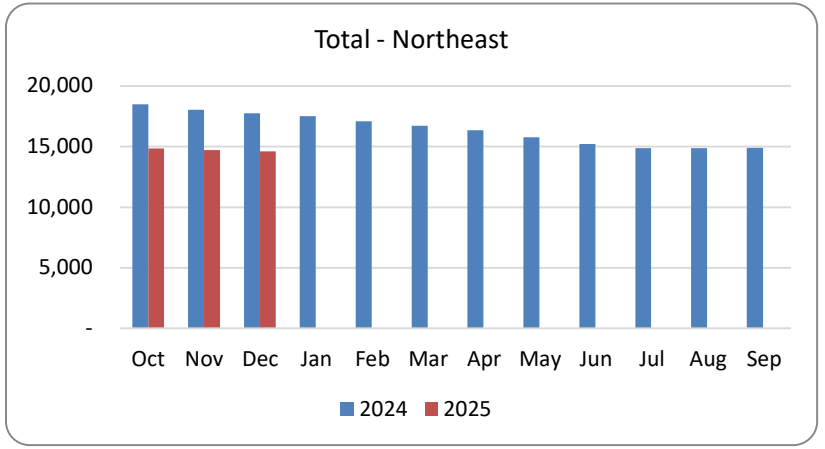
October 1, 2024 through December 31, 2024

Northeast Eligible Members Trending - based on payment files







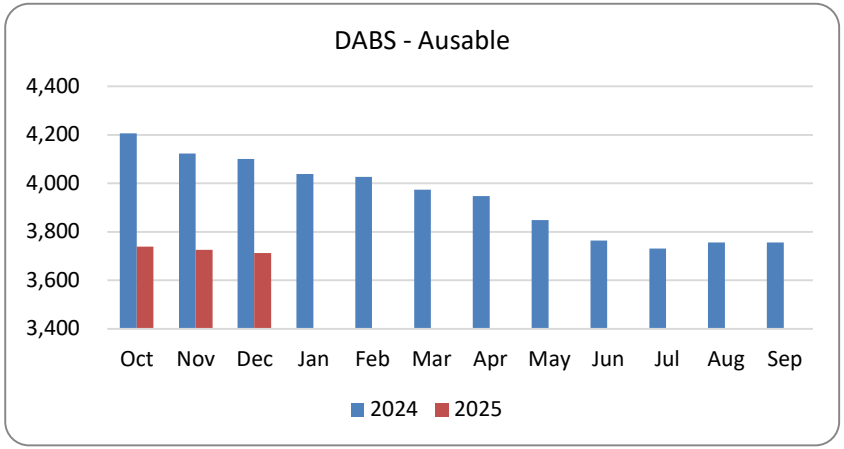


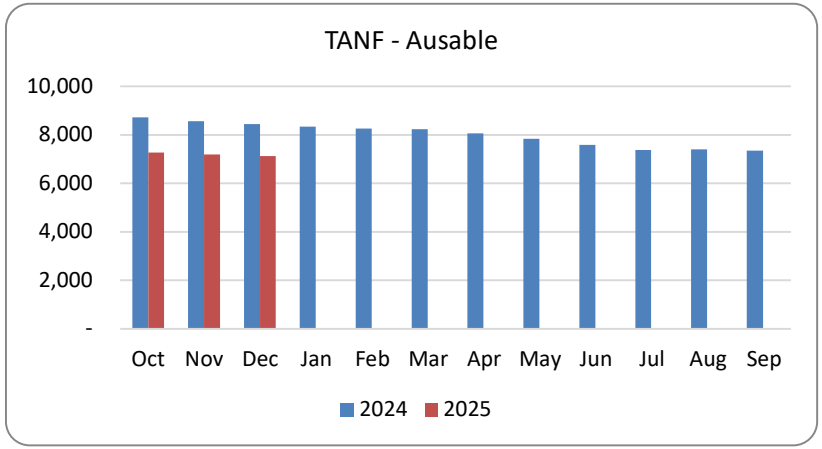
Northern Michigan Regional Entity

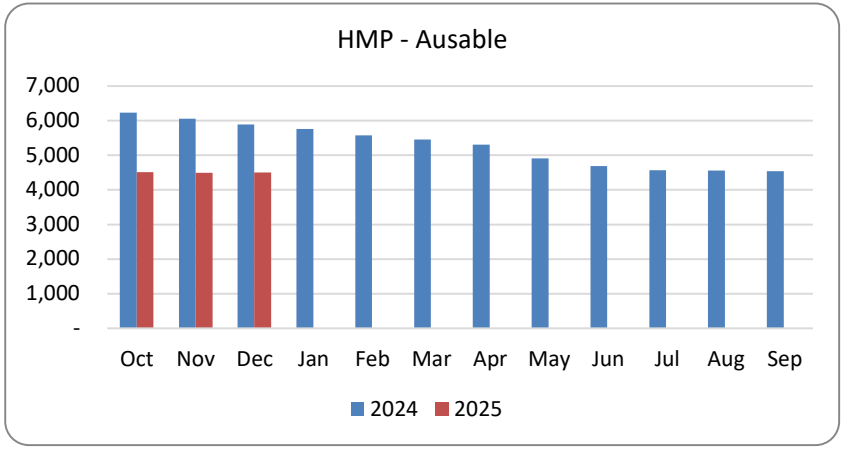
Narrative

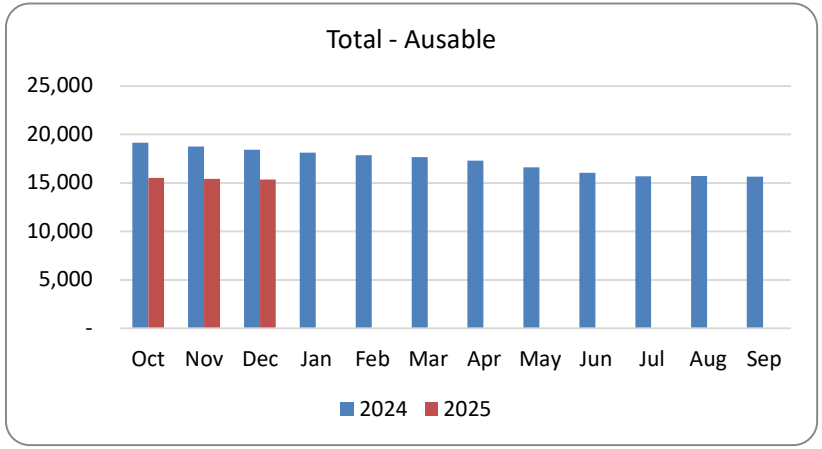
October 1, 2024 through December 31, 2024

AuSable Valley Eligible Members Trending - based on payment files







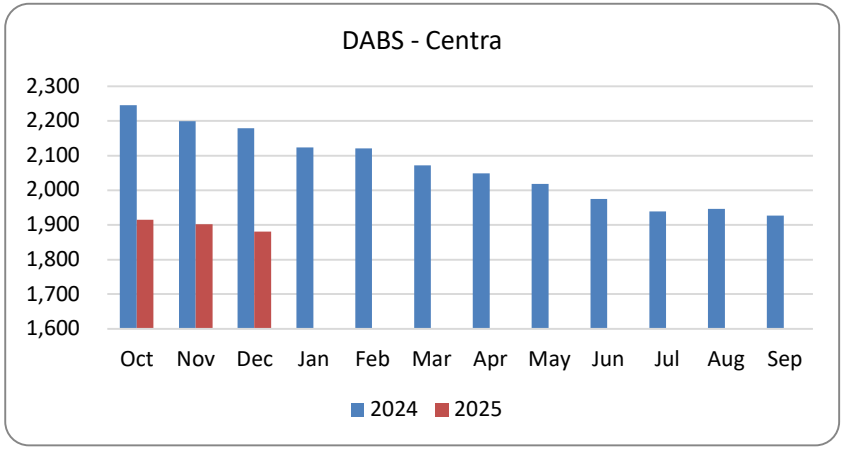


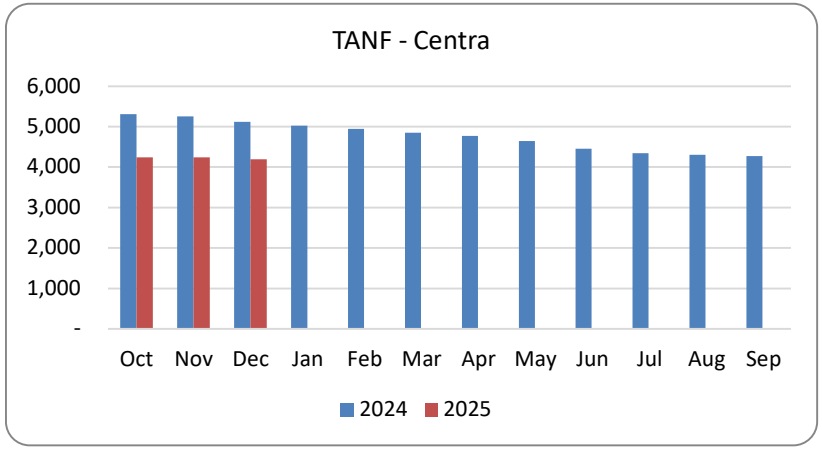
Northern Michigan Regional Entity

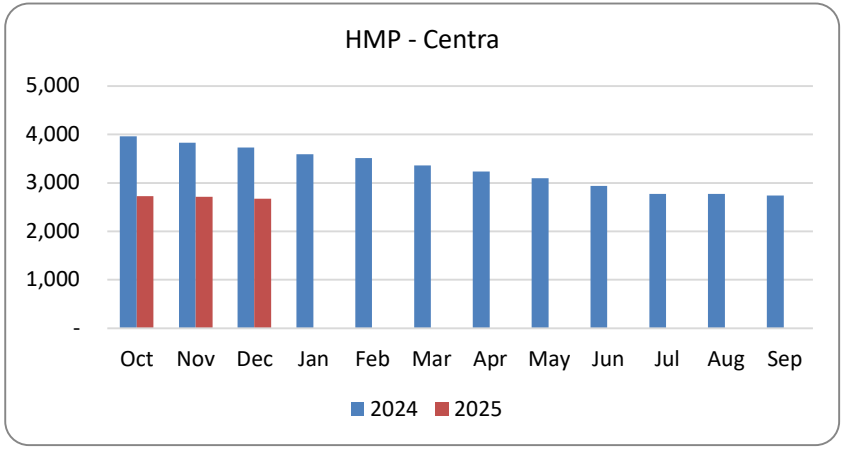
Narrative

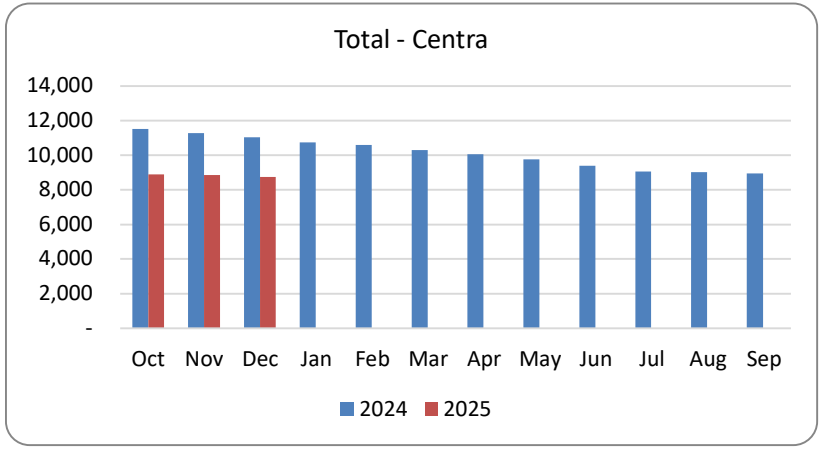
October 1, 2024 through December 31, 2024

Centra Wellness Eligible Members Trending - based on payment files







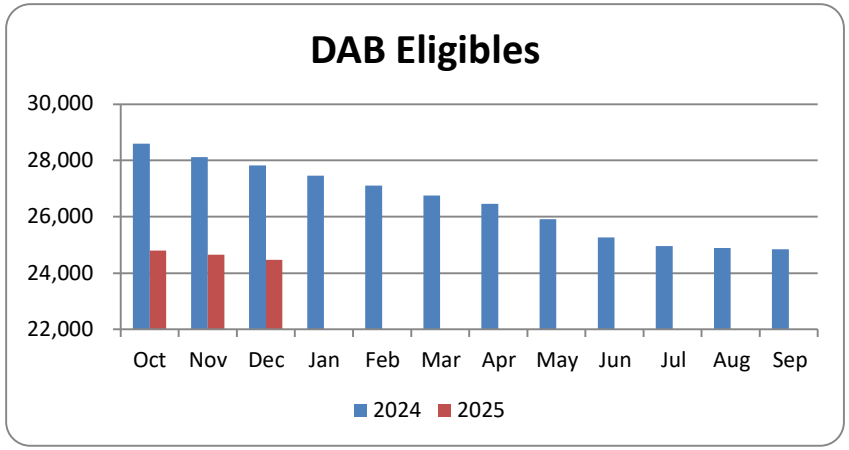


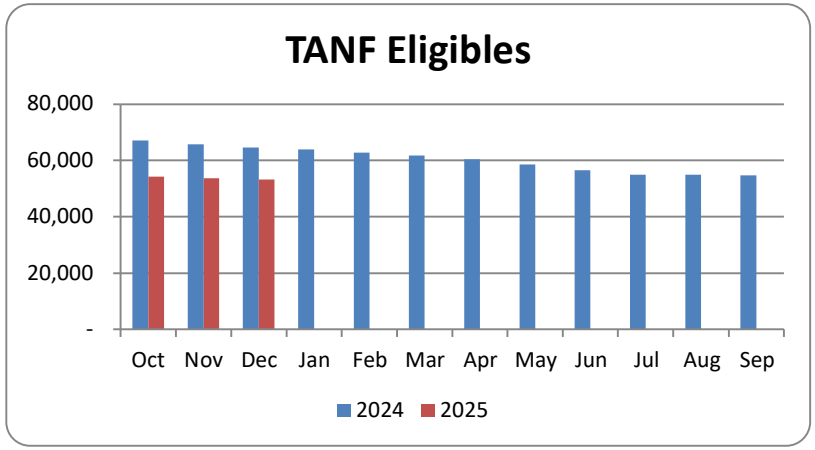
Northern Michigan Regional Entity

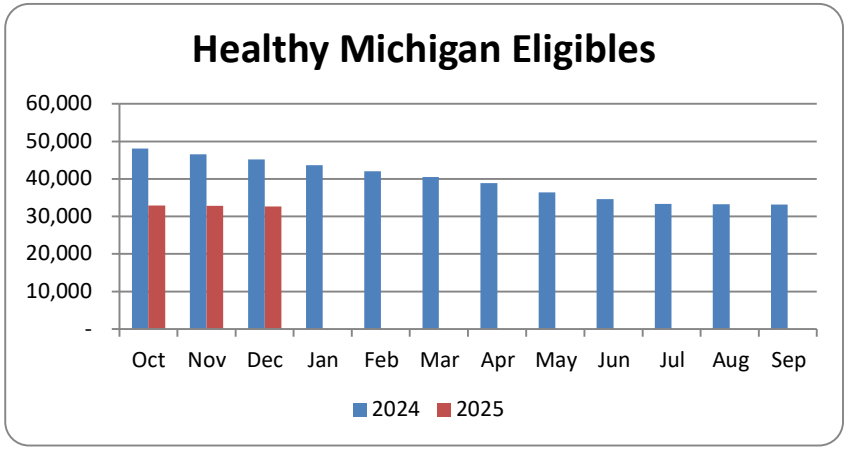
Narrative

October 1, 2024 through December 31, 2024

Regional Eligible Trending





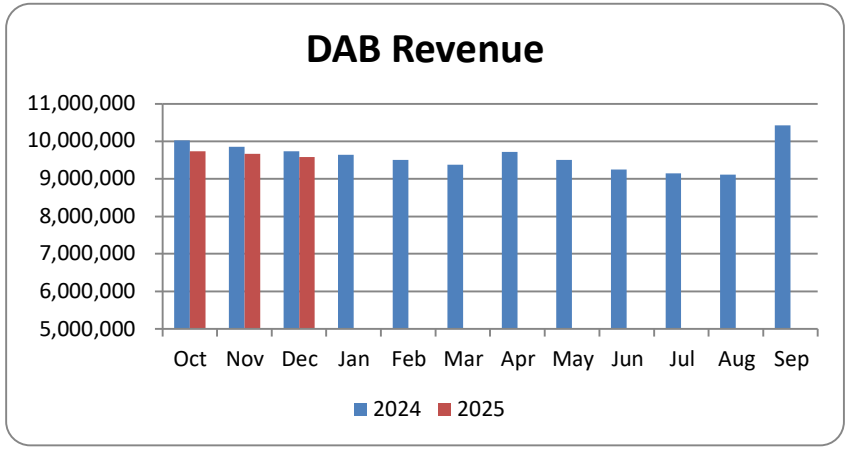


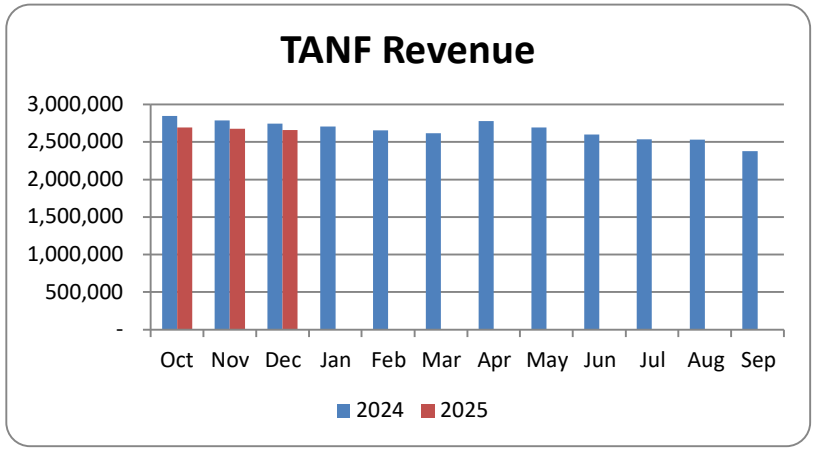
Northern Michigan Regional Entity

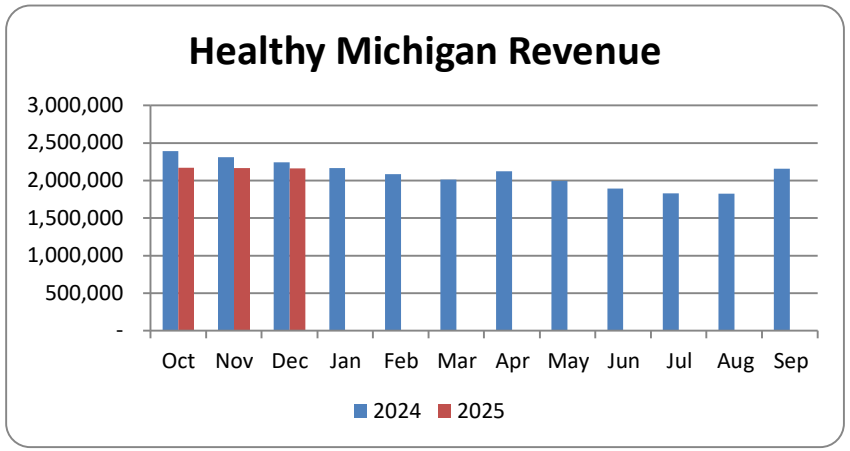
Narrative

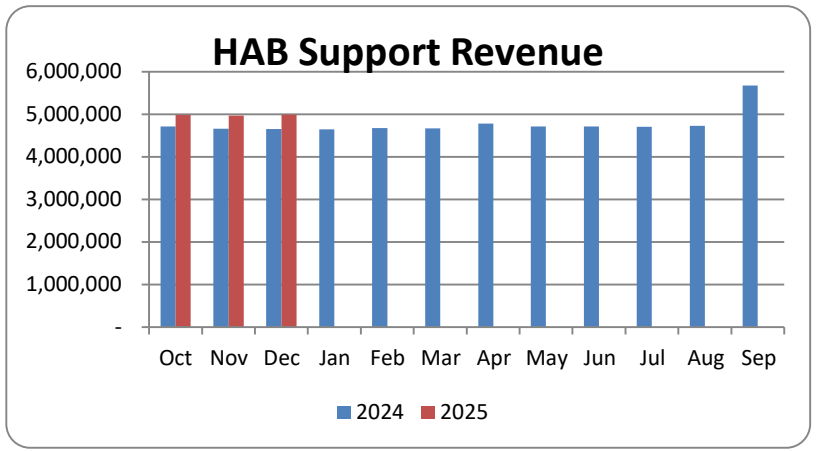
October 1, 2024 through December 31, 2024

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – FEBRUARY 18, 2025
GAYLORD CONFERENCE ROOM

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

REVIEW OF AGENDA AND ADDITIONS
Mr. Johnston asked to add a discussion about a potential CMH legal action.

APPROVAL OF PREVIOUS MINUTES
The minutes from January 21st were included in the meeting materials.

MOTION BY DIANE PELTS TO APPROVE THE JANUARY 21, 2025 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY BRIAN BABBITT. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED
December 2024

- Net Position showed net surplus Medicaid and HMP of $8,003. Carry forward was reported as $2,909,566. The total Medicaid and HMP Current Year Surplus was reported as $2,917,569. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $23,493,725.
- Traditional Medicaid showed $52,316,661 in revenue, and $51,597,652 in expenses, resulting in a net surplus of $719,009. Medicaid ISF was reported as $13,510,136 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $6,554,538 in revenue, and $7,265,544 in expenses, resulting in a net deficit of $711,006. HMP ISF was reported as $7,066,020 based on the current FSR. HMP savings was reported as $2,909,566.
- Health Home showed $850,135 in revenue, and $669,352 in expenses, resulting in a net surplus of $180,783.
- SUD showed all funding source revenue of $7,009,330 and $5,576,966 in expenses, resulting in a net surplus of $1,522,364. Total PA2 funds were reported as $4,574,377.

Both Medicaid and HMP are running at a deficit three months into FY25. It was noted that there is not enough carry forward to offset a year-end deficit. At the current rate of spending, the NMRE will need to utilize most of the ISF balance to cost settle with each Board, unless there is a substantial increase in revenue.

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$161,104	($536,574)	($80,565)	($1,694,748)	$809,942
HMP	($145,707)	($154,002)	($75,223)	($787,507)	($172,973)
Total	$15,397	($690,576)	($155,788)	($2,482,255)	$636,969

MOTION BY BRIAN BABBITT TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2024; SUPPORT BY CHIP JOHNTON. MOTION APPROVED.

FY25 Revenue/Expenditure Outlook
An analysis of November 2023 – January 2025 Revenue and Eligibles was included in meeting materials for informational purposes. Current monthly revenue is 1.91% higher than November 2023.

The NMRE currently has only one open HSW slot. Statewide slot usage for February was presented as:

PIHP	% Filled
Region 1 – NorthCare Network	98.9%
Region 2 – NMRE	99.9%
Region 3 – Lakeshore	98.5%
Region 4 – Southwest	98.9%
Region 5 – MidState	96.8%
Region 6 – Southeast	97.7%
Region 7 – Detroit Wayne	97.0%
Region 8 – Oakland	96.0%
Region 9 – Macomb	98.7%
Region 10	84.2%

NMRE slot allocation per CMHSP was provided as:

CMHSP	Current Number of Filled HSW Slots
Centra Wellness	88
North Country	180
Northeast Michigan	145
Northern Lakes	187
Wellvance	96
Total	**696**

CCBHC RURAL PROPOSAL
The CCBHC Rural Proposal was not included in the meeting materials; however, Mr. Kurtz agreed to send it to the committee.

CONFLICT FREE SEDW AND HSW WAIVERS
The renewal applications for both the Children with Serious Emotional Disturbances Waiver (SEDW) program and the Habilitation Supports Waiver (HSW) program included several programmatic changes, including the Department's approach to meeting the CMS Conflict Free standards (Conflict Free Access and Planning). Mr. Kurtz acknowledged that he is unclear about the expectations of the PIHP, although a plan from the PIHP to the state will be required.

Mr. Babbitt reported that he was on a call with MDHHS during which MDHHS provided zero guidance on how the CMHSPs will be held accountable. Belinda Hawks, Director of the Division of Adult Home and Community Based Services at MDHHS, said that guidance will be issued this month and will be similar to what was shared in April 2024. Full compliance is expected in FY26. Mr. Johnston noted that county designations (micro, urban, rural, etc.) were not consistent with those used by Medicaid Health Plans.

Neil Marchand, the attorney representing Washtenaw County in the Waskul lawsuit, contacted Mr. Johnston suggesting that the Department is diluting the (Medicaid behavioral health) benefit to the extent that it can't be fully achieved. The actions of MDHHS are causing harm to clients. Mr. Johnston asserted that the benefit should be built around core services. He is creating a timeline to show all the add-ons and will share it and the compiled information from Mr. Marchand throughout the state so that CMHSPs can decide whether they want to initiate a lawsuit.

Mr. Kurtz recognized that the state is interpretating the Managed Care Rules so that anywhere that states, "the state shall" is MDHHS' responsibility (vs. the PIHP). The state has added waivers, even though the benefit could be consolidated into a single waiver. An overall lack of understanding about the history of the mental health system and the role/purpose of a CMH at the MDHHS was expressed. Mr. Babbitt stressed that, given reduced funding, the only logical thing to do is go back to basics.

Mr. Babbitt referenced a call with CEOs regarding the states CAP from the CMS site visit for HCBS; CMHSPs are being asked to have policies/procedures to address deficiencies found in other regions.

Mr. Babbitt stressed that CFAP is reducing client choice, not increasing it.

MDHHS SITE REVIEW DRAFT AGENDA

The MDHHS FY25 Site Review draft agenda was included in the meeting materials.

CMHSP	Review Dates
Northern Lakes	April 7th – April 15th
Northeast Michigan	April 16th – April 22nd
North Country	April 23rd – April 29th
Wellvance	April 30th – May 5th
Centra Wellness	May 6th – May 13th

Ms. Pelts noted that Wellvance staff have asked how to respond to standards regarding parity. Mr. Kurtz responded that several years ago, as part of the region's parity plan, the NMRE purchased MCG's managed care guidelines for behavioral health, but MCG is limited in scope. The region can provide comparative data on service ranges, etc. Mr. Kurtz agreed to develop a regional response. Dave Schneider, out of MSU's Institute for Health Policy is leading the development of the state's parity plan.

MCG can be used as a tool to inform authorization decisions. Mr. Johnston agreed to share Wellvance's protocol, which the other CMHSPs may choose to adopt.

Mcg log-in information was provided.

LEGISLATIVE ACTIVITIES

Mr. Johnston reported that Matt Maskart, CEO of Pathways Community Mental, was recently in meeting with Intermediate School Districts in the Upper Peninsula, which was also attended by Lt. Governor Garlin Gilchrist and Rep. John Roth (104th District). The chief complaints from the ISDs were: 1) the inability to secure staff, and 2) the need for a rural approach to behavior health within school systems. Mr. Johnston is also having conversations with Rep. Roth regarding Conflict Free Access and Planning (CFAP) and intends to stress to him, and/or Lt. Governor Gilchrist, the fact that the waivers being submitted by MDHHS have no legislative oversight. There is a strong push to expose the inefficiencies in the current system.

Mr. Johnston is working on an informative packet and infographic to send to Sen. Jon Bumstead (32nd District), however, he is in a minority position in the Senate but wants to be informed. It was suggested Mr. Johnston speak to Rep. Matt Hall (42nd District). Mr. Johnston asserted that the ballooning bureaucracy is at the expense of individuals served. MDHHS is making things unnecessarily difficult.

FY25 PIHP CONTRACT

The Attorney General's response to the complaint filed by Taft, Stettinius & Hollister, LLP, on behalf of Northcare Network Mental Health Care Entity, Northern Michigan Regional Entity, Community Mental Health Partnership of Southeast Michigan, and Region 10 PIHP (Plaintiffs) against the State of Michigan, State of Michigan Department of Health and Human Services, a Michigan State Agency, and its Director, Elizabeth Hertel, in her official capacity (Defendants) was included in the meeting materials. Chris Ryan, attorney with Taft, Stettinius, Hollister, LLP, proposed that a second amended complaint be filed; the document was sent to Mr. Kurtz on this date, which he has not had a chance to review.

REFERENCE DOCUMENT

A memorandum dated January 31, 2025 from Kristen Jordan, State Bureau Administrator, Bureau of Specialty Behavioral Health Services at MDHHS, to PIHP CEOs regarding FY24 Reference Materials was included in the meeting materials.

The document included excerpts from the FY24 MDHHS/PIHP contract, MDHHS policy, Centers for Medicare & Medicaid Services (CMS) approval notices and Michigan legislative acts, which outline MDHHS' expectations on a variety of subjects (DCW increase, autism minimum fee schedule change, private duty nursing rate increase, 1915(c) and 1915(i) changes, adjustments to CCBHC, hospital rate adjuster per diem increase, SUD Health Home and Behavioral Health Home, MichiCANS, and SUD treatment incentives.)

These references highlight the responsibility of the PIHPs to continue their ongoing work in these areas under the FY25 contracts as well as the FY24 continuation contracts. The FY25 capitation rates being paid to all 10 PIHPs reflect, or will be amended to reflect, the policy changes identified.

NLCMHA UPDATE

Mr. Kurtz reported that a Dispute Resolution Committee meeting with the six County Administrators (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford) was scheduled for February 14th; however, there was not a quorum in attendance.

A discussion about overspending followed. The consensus was that Northern Lakes and any other CMH needs to be held accountable and possibly placed under a cost containment plan or put all full risk to ensure regional fiscal solvency.

Along with the deficit is the intermingling of funds with the MI Choice Waiver, which can no longer occur. It was noted that the structural deficit is a separate issue from the Rehmann forensic investigation findings.

Mr. Kurtz agreed to draft a Cost Containment plan/policy to bring to the Operations Committee and be reviewed by the NMRE Board.

CMH LAWSUIT

This topic was discussed under the Conflict Free SEDW and HSW Waivers agenda item.

NEXT MEETING

The next meeting was scheduled for March 18th at 9:30AM.

STATE OF MICHIGAN
COURT OF CLAIMS

NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY, NORTHERN MICHIGAN REGIONAL ENTITY, REGION 10 PIHP, AND COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN,

Plaintiffs,

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, A MICHIGAN STATE AGENCY, AND DIRECTOR, ELIZABETH HERTEL, IN HER OFFICIAL CAPACITY,

Defendants.

COC No. 24-000198-MZ

HON. SIMA G. PATEL

DEFENDANTS' 02/07/2025 MOTION FOR SUMMARY DISPOSITION AND BRIEF IN SUPPORT

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DEFENDANTS' 02/07/2025 MOTION FOR SUMMARY DISPOSITION

ORAL ARGUMENT REQUESTED

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

Pursuant to Court of Claims Local Rule 2.119(A)(2), Defendants requested opposing counsels' concurrence in the relief sought in this motion on February 5, 2025, and opposing counsel did not acquiesce in the relief sought, thereby necessitating this motion.

Respectfully submitted,

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Dated: February 7, 2025

BRIEF IN SUPPORT OF DEFENDANTS' 2/7/2025 MOTION FOR SUMMARY DISPOSITION

INTRODUCTION

Despite attempts to overcomplicate the issues in the case by referencing inapplicable law and mischaracterizing the facts, the issue before the Court is quite simple. The central question is whether Plaintiffs, four entities that formerly contracted with Defendants but elected not to do so for fiscal year 2025 (FY25), may use this Court to force Defendants to modify a proposed contract to adhere to Plaintiffs' preferred terms. The answer, of course, is no. Courts are not arbiters of contract terms when proposed contractors have reservations about signing contracts. Instead, proposed contractors have a remedy, which to not sign a contract that contains terms they find unsatisfactory. That is exactly what occurred here.

The four Plaintiffs, which serve less than one-third of Michigan's PIHP service recipients, are not parties to the FY25 Contract with MDHHS. They declined to sign the FY25 Contract by the required deadline, as they were free to do. But instead of accepting the consequences of their decision, Plaintiffs falsely allege that Defendants terminated the FY25 Contract and ask this Court to force Defendants to change the terms of the proposed FY25 Contract to terms more desirable to Plaintiffs.

But if the Court were to open this door to Plaintiffs, what would stop other prospective State contractors or vendors from doing the same? The answer is that nothing would stop them. *Every* prospective contractor or vendor could and likely would sue MDHHS and potentially many other State agencies in this Court, instead

of engaging in routine contractual negotiations. But State agencies, like any other entity or party, should remain free to negotiate contractual terms without fear of litigation. Particularly here, when the State agency, MDHHS, is tasked with safeguarding the rights of the State's most vulnerable population, Medicaid beneficiaries with limited income, while ensuring that coverage remains affordable and accessible to those who qualify.

All Plaintiffs' FY25 Contract claims fail. Because Plaintiffs are not parties to the FY25 Contract, there is no active case or controversy about its terms, and declaratory relief should be denied. Mandamus is also not appropriate, because Defendants have no clear legal duty to place Plaintiffs' desired terms in the FY25 Contract. Nor are Plaintiffs real parties in interest to, or have standing to challenge, the FY25 Contract. And even if Plaintiffs could overcome these insurmountable hurdles, dismissal would still be appropriate, because their arguments challenging the FY25 Contract are entirely without merit. The same is true for their recently added claims related to the FY24 Contract.

STATEMENT OF FACTS

MDHHS contracts with PIHPs to provide services.

Medicaid, a jointly funded federal-state program, provides reimbursement for covered healthcare services for eligible individuals. 42 USC § 1396, *et seq*.; MCL 400.1, *et seq*. In Michigan, MDHHS is the "single state agency" charged with administering the Medicaid program. 42 USC § 1396a(a)(5). Under approval by the federal Centers for Medicare and Medicaid Services (CMS), MDHHS operates a 1115 Behavioral Health Demonstration Waiver. (Am Compl, Ex F, FY24 Contract,

Schedule A, p 29.) Under this waiver, selected Medicaid State plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been "carved out" from traditional Medicaid physical health care plans and arrangements. (*Id.*) Pursuant to MCL 400.109f, MDHHS selects and contracts with PIHPs to provide these "carved out" specialty services. PIHPs, in turn, contract with local community mental health services programs (CMHs) to deliver services. (Am Compl, ¶¶ 17-38.)

MDHHS provides capitated payments to PIHPs to cover predicted costs.

With this managed care system, MDHHS is a pass-through of Medicaid funds, as it receives federal funds and transmits those funds to the PIHPs. (*Id.*) PIHPs in turn use these payments to fund Medicaid services provided by the CMHs. (*Id.*, ¶ 37.) Under this model, MDHHS provides funds to PIHPs as a capitated payment based upon a per eligible per month methodology. (Am Compl, Ex F, FY24 Contract, p 105.) In essence, this means that MDHHS estimates and prepays the amount PIHPs will need to fund future Medicaid services to beneficiaries within their geographic region. (*Id.* at 101-102.)

The parties failed to reach an agreement on the FY25 Contract terms.

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

¶¶ 46-49.) The period for PIHPs to sign the FY25 Contract closed on October 31, 2024. (*Id.* at ¶ 48.)

Plaintiffs initiate the instant declaratory and mandamus action.

On January 13, 2025, Plaintiffs filed their First Amended Complaint alleging six counts: (1) declaratory relief regarding the ISF limit in the FY24 and FY25 Contracts; (2) declaratory relief regarding the *Waskul* settlement provision in the FY25 Contract; (3) declaratory relief regarding Certified Community Behavioral Health Clinics (CCBHCs) (Plaintiffs CMHPSM and Region 10); (4) violation of the Headlee Amendment and MCL 21.235 regarding CCBHCs (Plaintiffs CMHPSM and Region 10); (5) declaratory relief regarding SUDHH funding; and (6) writ of mandamus regarding funding and provide for a hearing. (Am Compl, ¶¶ 127—164.)

STANDARD OF REVIEW

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

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

ARGUMENT

I. Plaintiffs' FY25 Contract claims should be dismissed.

To be abundantly clear, MDHHS never *terminated* an executed FY25 Contract between the parties. Plaintiffs' allegations instead hinge on failed negotiations between the parties as to the FY25 Contract. Therefore, Plaintiffs have filed suit attempting to compel MDHHS to agree to their preferred contract terms. But because there is no enforceable FY25 Contract between Plaintiffs and Defendants, Plaintiffs' claims fail for three reasons: (1) there is no actual controversy and MDHHS has no obligation to continue to contract with Plaintiffs; (2) Plaintiffs are not the real party in interest; and (3) Plaintiffs lack standing. Summary disposition is proper under MCR 2.116(C)(5) and (8).

A. There is no actual controversy or clear legal duty, and MDHHS is not required to contract with Plaintiffs.

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

Here, Plaintiffs' attempt to have this Court find that three of the FY25 Contract terms proposed by the Defendants are void. But because Plaintiffs never signed the FY25 Contract, there is no contract to enforce between the parties. (Am Compl, Ex A, Unsigned FY25 Contract, p 2.) Consequently, there is no actual

controversy, and MCR 2.605(A)(1) prevents courts from deciding hypothetical issues, as is the case here.

In a last-ditch effort to establish a controversy, Plaintiffs argue MDHHS was required to contract with them pursuant to MCL 400.109f(1) even in the absence of a signed FY25 Contract. (Am Compl, ¶ 161.) But there is no such requirement in MCL 400.109f(1). Indeed, Plaintiffs make no attempt to explain *why* or *how* MCL 400.109f(1) imposes a requirement that MDHHS choose specific PIHPs with which to contract. (See Am Compl.) To the contrary, the statute is clear that MDHHS has discretion to choose which PIHPs it contracts with, stating in relevant part: "Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans *chosen by the department*." MCL 400.109f(1) (emphasis added). The plain language of this statute supports a process wherein MDHHS is required to use PIHPs to manage and deliver services, but MDHHS can *choose* which PIHP to contract with. *Id.* Nothing in MCL 400.109f(1) suggests that MDHHS has *any* obligation to contract with any *specific* PIHP. Because this statutory language is unambiguous, judicial construction is not required or permitted. *Petersen v Magna Corp,* 484 Mich 300, 307 (2009) (citation omitted).

Moreover, the purpose of declaratory relief is to allow "litigants to seek a determination of questions formerly not amenable to judicial determination." *Allstate Ins Co v Hayes*, 442 Mich 56, 64-65 (1993). It has long been held that declaratory judgment is appropriate where it will "serve some practical end in quieting or stabilizing an uncertain or disputed jural relation." *Id.* at 74 (internal

quotation omitted). Here, to declare that the proposed FY25 Contract terms are void will not stave off potential litigation. To the contrary, allowing Plaintiffs to challenge terms of an unsigned contract or require compliance with their preferred language opens the door for *every* possible contractor or vendor to sue any state agency in this Court and coerce them into signing a contract. There is no law or contract provision that requires such an absurd result.

Not only does Plaintiffs' request for declaratory relief fail, but any claim of mandamus also fails. Plaintiffs assert they are entitled to a writ of mandamus because MDHHS has a "non-discretionary" duty to continue funding Plaintiffs even in the absence of a signed FY25 Contract. (Am Compl, ¶¶ 160-162.) However, here, without any legal requirement under MCL 400.109(f)(1) to contract with Plaintiffs, MDHHS has no legal duty to adhere to. See *Jones*, 468 Mich at 658 (where an official has a clear legal duty to act and fails to do so mandamus is appropriate). Thus, mandamus is also not available to require MDHHS to execute the FY25 Contract provisions as proposed by Plaintiffs.

Plaintiffs' claims for declaratory and mandamus relief as to the FY25 Contract (part of Counts I and VI, and all of Counts II, III, IV, V) should therefore be dismissed pursuant to MCR 2.116(C)(8), as there is no actual controversy and no clear legal duty to do what Plaintiffs request.

B. Plaintiffs are not the real party in interest.

In addition to failing to state a claim for declaratory relief and mandamus, Plaintiffs, who never signed the FY25 Contract, are not the real party in interest to assert *any* claims of injury flowing from that unsigned contract. MCR

2.201(B) provides that "[a]n action must be prosecuted in the name of the real party in interest. . . ." The real party in interest is a party who is vested with a right of action in a given claim, although the beneficial interest may be with another. *In re Beatrice Rottenberg Living Trust,* 300 Mich App 339, 356 (2013). Plaintiffs must assert their own legal rights and cannot rest their claims on the rights or interests of third parties. *Barclae v Zarb,* 300 Mich App 455, 483 (2013).

Once again, Plaintiffs never signed the proposed FY25 Contract. Thus, they are not a real party in interest as to that contract. (Am Compl, Ex A, Unsigned FY25 Contract, p 2); *Stillman v Goldfarb*, 172 Mich App 231, 251 (1988) (no real party in interest status when plaintiff had no contract with defendant). Otherwise, *any* person or entity could sue as a third party to a state contract. This Court should decline to interpret the prospective FY25 Contract to impose such an unreasonable condition on MDHHS, which is tasked with negotiating contracts in the best interest of Michigan taxpayers and should not be afraid to advocate for favorable terms that protect Medicaid beneficiaries and the limited funds allotted by the federal government.

Thus, Plaintiffs' claims (part of Counts I and VI, and all of Counts II, III, IV, and V) related to the FY25 Contract should be dismissed pursuant to MCR 2.116(C)(8), as Plaintiffs are not the real party in interest.

C. Plaintiffs lack standing.

In addition, Plaintiffs' FY25 Contract claims should be dismissed pursuant to MCR 2.116(C)(5) as Plaintiffs lack standing and the legal capacity to sue Defendants. The "purpose of the standing doctrine is to assess whether a litigant's

interest in the issue is sufficient to ensure sincere and vigorous advocacy." *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 355 (2010) (citation omitted) (standing "focuses on whether a litigant is a proper party to request adjudication of a particular issue and not whether the issue itself is justiciable[]"). *Id.*[1]

Here, Plaintiffs lack standing to sue Defendants based on a contractual agreement that exists between MDHHS and five *other* PIHPs which did sign the FY25 Contract. (Am Compl, Ex A, Unsigned FY25 Contract, p 2); MCR 2.116(C)(5); *UAW v Cent Michigan Univ Trustees*, 295 Mich App 486, 496 (2012) (no standing to challenge draft procedures as "speculative and hypothetical"); *Mate v Wolverine Mut Ins Co*, 233 Mich App 14, 24 (1999) (third parties lack standing to reform contract).

Thus, Plaintiffs' FY25 Contract claims (part of Counts I and VI, and all of Counts II, III, IV, and V) should also be dismissed for lack of standing, as Plaintiffs are without the legal capacity to sue Defendants. MCR 2.116(C)(5).

II. Even if Plaintiffs could establish a cause of action, the claims raised in the First Amended Complaint should be dismissed under MCR 2.116(C)(8) as Plaintiffs fail to state a claim on the merits.

Even bypassing the issues set forth above, this Court should still dismiss this suit in its entirety. First, Plaintiffs are not entitled to relief on the FY24 Contract claim regarding the Internal Service Fund (ISF), which unambiguously provides for an actuarially sound 7.5% limit to provide for future liabilities in compliance with federal law. The same is true for the ISF limit in the FY25 Contract. Second, the terms of the *Waskul* settlement are valid under state and federal law. Third, the

[1] "[A]lthough the principle of statutory standing overlaps significantly with the real-party-in-interest rule, they are distinct concepts." *Beatrice*, 300 Mich App at 355.

two Plaintiffs bringing a claim regarding the CCBHC program have failed to state a claim that they are receiving inadequate funding for increased responsibilities. Accordingly, all claims raised in Plaintiffs' First Amended Complaint should be dismissed pursuant to MCR 2.116(C)(8).

A. The plain language of the FY24 Contract is unambiguous; it limits the ISF to 7.5% for future liabilities based on sound actuarial principles that comply with federal regulations.

In Count I, Plaintiffs raise three separate challenges to the FY24 Contract, alleging: (1) the contract does not contain a 7.5% limit on the amount that can be present in an ISF account; (2) the ISF limit violates federal law and accounting standards; and (3) the ISF limit can be used for prior deficits. (Am Compl, ¶¶ 60-71, 120-129.) All three fail.

1. The plain language of the FY24 Contract limits the ISF to 7.5%.

In support of their argument that the FY24 Contract does not limit the ISF to 7.5%, Plaintiffs cherry pick two sentences from the contract which read: "Contractor may transfer Medicaid Capitation funds up to 7.5% of the Medicaid/Health Michigan Plan pre-payment authorization to the ISF in any given year. Contractor may not transfer any funds in excess of that percentage to the ISF in any year." (*Id.* at ¶¶ 120-121, 126 (citing Ex F, p 101).) While it is true that this language limits yearly contributions and not the ISF balance at any given time, it is not the end of the analysis. Contrary to well-established legal precedent, Plaintiffs turn a blind eye to the remaining contractual provisions against their position. *Smith v Smith*, 292 Mich App 699, 702 (2011) (internal citation omitted) (contracts must be read and construed as a whole). In fact, Plaintiffs' interpretation directly contravenes the

remaining terms of the FY24 Contract. Such an isolated reading would result in an absurd conclusion that the remainder of the contract would be invalid. See *Hastings Mut Ins Co v Safety King, Inc,* 286 Mich 287, 297 (2009).

Elsewhere in the FY24 Contract, the parties agreed that Plaintiffs "must be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted." (Am Compl, Ex F, p 103.) Additionally, Plaintiffs are "responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted." (*Id*.) The combined effect of these provisions mandates that Plaintiffs, and not the State, are financially responsible for 107.5% of their liabilities (meaning Plaintiffs are responsible for 100% of the liabilities up to the total amount of capitation payments MDHHS made to them during a fiscal year, as well as 7.5% of additional liabilities). Only after Plaintiffs have met this financial responsibility is the State responsible for liabilities under the FY24 Contract beyond what the State already paid in capitation payments. (*Id*.) Thus, the plain language of the FY24 Contract limits the amount to 7.5% that can be *present* in an ISF account, rather than allowing Plaintiffs to build up reserves in their ISF accounts (which could have been spent on providing services to Medicaid beneficiaries) by contributing 7.5% of their annual operating budgets *each year*.

2. The ISF limit complies with federal law and accounting standards.

Second, Plaintiffs contend that the 7.5% ISF limit is not actuarially sound in violation of 42 CFR § 438.6(b)(1), which requires that all risk sharing mechanisms

be developed in accordance with generally accepted actuarial principles. (Am Compl, ¶¶ 57-64, 126.) The only basis Plaintiffs offer in support is 2 CFR Pt. 100, App. V, arguing that this regulation allows for a working capital reserve of 60 calendar days, equal to an ISF limit of 16.4%, which is more than the 7.5% ISF limit provided for in the FY24 Contract. (*Id.* at ¶¶ 65-66.) But this argument entirely misses the point. 2 CFR Pt. 100 has nothing to do with an ISF limit, because the 7.5% ISF limit at issue here is not a "working capital reserve" for Plaintiffs' operation from one billing cycle to the next. Rather, as outlined below, the FY24 Contract ISF is intended to pay for *future* liabilities. Aside from their own reference to 2 CFR Pt. 100, there is simply no indication that this regulation is intended to apply to any provisions in the FY24 Contract.

Moreover, Plaintiffs argue that the 7.5% ISF limit violates GASB Statement No. 10 because the FY24 Contract prohibits Plaintiffs from using ISF funds to pay for services rendered in previous years. (*Id.* at ¶¶ 70-71, 126 (citing GASB Statement No. 10: "Deficits, if any, in the internal service fund…do not need to be charged back to the other funds in any one year, as long as adjustments are made over a reasonable period of time.").) However, Plaintiffs fail to acknowledge that GASB Statement No. 10 does not mandate *how* an ISF is used, rather it provides permissive language that deficits *can* be funded over a reasonable period. Importantly, nothing in GASB Statement No. 10 *prohibits* future use of the ISF funds. Instead, that requirement is dictated by the FY24 Contract, which expressly

requires that the ISF be established for future liabilities. See Section II.A.3; (Am Compl, Ex F, FY24 Contract, Schedule A, p 101).

Plaintiffs' argument that the ISF limit violates 42 CFR § 438.6(c)(1) is similarly flawed. (*Id.* at ¶¶ 67, 73, 126.) Here, Plaintiffs stretch the plain meaning of § 438.6(c)(1) to fit within their desired outcome. That federal regulation provides that the State may not direct contracting PIHP *expenditures*. However, the FY24 Contract, including the ISF limit, does not direct PIHPs *what* to pay for services; rather it sets forth a maximum amount that may be held in the ISF. Nor does the FY24 Contract dictate *which* CMHs the contracting PIHPs use or the providers that offer services. This regulation, therefore, does not render the ISF limit invalid.

Finally, Plaintiffs assert that they are entitled to notice and hearing regarding FY24 bonus payments. (Am Compl, ¶¶ 122-126.) Plaintiffs rely on an email wherein MDHHS notified PIHPs that if their FY24 ISF balances were greater than 7.5% of the annual operating budgets, MDHHS would reject the submissions, and any rejected submission would be considered late for bonus payments. (Am Compl, ¶ 122.) However, Plaintiffs fail to allege any facts or law demonstrating how the failure to pay a *bonus* equates to a sanction which would warrant notice and a hearing. Pursuant to MCL 330.1232b(5), failure to pay a bonus is not a "sanction" which includes "a monetary *penalty* imposed on the administrative and management operation of the specialty prepaid health plan, imposition of temporary state management of a community mental health services program operating as a specialty prepaid health plan. . . ." (emphasis added). And because

any action by MDHHS related to the bonus payment is not associated with any promulgated rule, standard, or federal requirement, Plaintiffs are not entitled to notice and a hearing. See MCL 330.1232b(6). Moreover, this bonus structure is entirely consistent with the language in both the FY24 and FY25 Contracts limiting the ISF to 7.5%. See Section II.A.1.

And from a practical perspective, Plaintiffs' argument further fails because the PIHP contracts must be reviewed and approved by CMS. Here, Plaintiffs cannot and do not challenge the fact that CMS reviewed and approved the FY24 and FY25 Contracts and found that none of their provisions, including the risk corridor provisions, ran afoul of federal law or regulations. Accordingly, the agency that is responsible for creating and administering the regulations Plaintiffs rely on found the FY24 and FY25 Contracts followed relevant federal laws and regulations.

3. The ISF can only be used to finance future liabilities.

Next, Plaintiffs dispute whether the ISF can be used to fund prior deficits. (Am Compl, ¶¶ 119, 126.) However, the plain language of the FY24 Contract provides that contractors are expressly limited to use the ISF for *future* liabilities:

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

(Am Compl, Ex F, FY24 Contract, Schedule A, p 101 (emphasis added).)

The risk corridor section further elucidates this requirement, stating contractors must return unexpended risk corridor related funds over 7.5%. (*Id.* at p 103.) Importantly, like the capitated payments that Plaintiffs receive, Plaintiffs'

potential liabilities are similarly prospective, based on the very nature of the funding methods and risk arrangements under the FY24 Contract. This structure serves as the entire basis of the shared-risk contracts that utilize a risk corridor.

Accordingly, Plaintiffs have failed to state a claim as to the FY24 Contract and ISF limit. See MCR 2.116(C)(8).

B. Defendants agree to SUDHH funding through the transition term outlined in the FY24 Contract, but Plaintiffs fail to state a claim and lack standing as to any further relief.

The parties negotiated and entered an agreement requiring Defendants to provide SUDHH funding and permitting the program to move forward under further order of this Court. (12/23/2024 Stip.) Yet Plaintiffs still seek a declaration that MDHHS must continue to provide funding in the absence of a contract and seek injunctive relief prohibiting Defendants from cutting off funding for the SUDHH program without end. (Am Compl, ¶¶ 154-157.)

Defendants agree that under the FY24 Contract transition provision, the parties are obligated to continue their responsibilities to provide services and funding until of the end of the up-to-two-year transition period. (*Id.* at Ex F, FY24 Contract, p 10.) But upon the expiration of the transition period, neither party has any contractual obligations. As outlined above regarding the FY25 Contract claims, Plaintiffs cannot establish an actual controversy, that they are the real party in interest, or that they have standing. See Section I. Thus, any claims for relief beyond the transition period or related to false allegations of a contract termination should be dismissed pursuant to MCR 2.116(C)(5) and (8).

C. Plaintiffs fail to state a claim that the FY25 Contract provisions are void.

Even if Plaintiffs had signed the FY25 Contract, Plaintiffs fail to state a claim that three of its provisions are invalid.

1. The 7.5% ISF contribution limit is actuarially sound and does not violate federal law.

In Count I, Plaintiffs argue that the FY25 Contract violates federal law and is not actuarially sound. (Am Compl, ¶¶ 60-71, 127-130.) While the FY25 Contract language regarding the ISF was modified from FY24, it also specifically provides for a 7.5% limit. (Am Compl, Ex A, FY25 Contract, pp 112-113 (ISF section), 114-115 (risk corridor section).) And for the same reasons as outlined above, Plaintiffs' allegations regarding the FY25 ISF limit are meritless. See Section II.A. Thus, this claim should be dismissed.

2. Plaintiffs fail to state a claim that the *Waskul* settlement provision is invalid.

Waskul, et al. v Washtenaw Cnty Comm Mental Health, et al., Case No 16-cv-10936, is a federal lawsuit pending in the Eastern District of Michigan. In that case, the plaintiffs are Medicaid beneficiaries who claim four defendants (MDHHS; MDHHS Director, Elizabeth Hertel; Plaintiff in this matter, CMHPSM; and Washtenaw County CMH) violated their rights. On December 1, 2023, MDHHS and Director Hertel executed a Settlement Agreement that requires MDHHS, subject to several contingencies, to make changes to its contract with CMHPSM and to its Medicaid policies. (Am Compl, ¶¶ 79, 83, Ex B, *Waskul* settlement.) CMHPSM and Washtenaw County CMH are not parties to the settlement and objected for various

reasons. Over those objections, the settlement was approved. *Waskul*, ECF No 401. However, when MDHHS offered proposed FY25 Contracts to all PIHPs, approval of the *Waskul* settlement was still pending in federal court. As such, the proposed FY25 Contract included a placeholder, requiring PIHPs to execute contract amendments consistent with *Waskul* settlement, should it be approved. (A m Compl, ¶¶ 83-86 Ex A, Schedule A, p 80.)

Here, in Count II, Plaintiffs challenge that placeholder language for two reasons: (1) none of the Plaintiffs are parties to the *Waskul* settlement and (2) the *Waskul* settlement violates 42 CFR § 438.6 because it improperly directs PIHP expenditures. (Am Compl, ¶¶ 85-93.) Both arguments are without merit.

First, the fact that none of the Plaintiffs are parties to the *Waskul* settlement is irrelevant, because PIHPs have no authority to pick and choose which of MDHHS's Medicaid policy decisions they will follow. As the single state agency in charge of Michigan's Medicaid program, MDHHS is solely responsible for developing Medicaid policy. 42 CFR § 431.10(e). Here, MDHHS has decided to implement the *Waskul* contract amendment provisions statewide. That is the type of policy decision that falls solely to MDHHS, and any recourse by the PIHPs if they do not want to agree to provide services to beneficiaires under said policies is, as Plaintiffs did here, to elect not to sign the next year's contract. It also bears mentioning that Plaintiffs' argument directly contradicts their position that they can pursue any claim at all under the FY25 Contract, which they never signed. But Plaintiffs cannot have it both ways, arguing here that they must be a party to a

settlement to be bound by its terms in a negotiated contract, but alternatively, that the FY25 Contract is void even without signing it.

Second, Plaintiffs' claim that the *Waskul* settlement violates 42 CFR § 438.6 similarly falls flat. Plaintiff CMHPSM made this same argument in objection to the *Waskul* settlement, and the judge approved the settlement over those objections. This is for good reason. Nothing in the *Waskul* settlement directs PIHPs what to pay for *services*; rather it sets forth a statewide minimum rate that must be used in calculating certain self-determination budgets. (Am Compl, Ex B, Settlement Agreement, pp 13-29.) But even if the settlement did implicate 42 CFR § 438.6, the settlement terms are contingent on CMS approval. (*Id.*, pp 30-33.) If CMS found that any provisions run afoul of federal law, then the provisions would not be incorporated into the FY25 Contract. See Section II.C.1.

Therefore, Plaintiffs have failed to state a claim that the terms of the *Waskul* settlement are invalid. See MCR 2.116(C)(8).

3. Plaintiffs CMHPSM and Region 10 fail to state a claim regarding the Headlee Amendment and MCL 21.235.

In Counts III and IV, Plaintiffs CMHPSM and Region 10 claim that the FY25 Contract shifts additional responsibilities onto them for administering the CCBHC program without providing additional funding in violation of the Headlee Amendment and MCL 21.235. (Am Compl, ¶¶ 138-149.) But Plaintiffs consistently mischaracterize the actuarial findings, which directly contradict this assertion.

"Headlee, at its core is intended to prevent attempts by the Legislature to *shift* responsibility for services to the local government . . . in order to save the

money it would have had to use to provide the services itself." *Adair v State*, 470 Mich 105, 112 (2004) (internal quotations omitted) (emphasis added). MCL 21.235 requires the legislature to appropriate enough funds necessary to implement State requirements. But here, any change to the CCBHC administrative duties in the FY25 Contract was simply to *clarify* responsibilities, but did not *shift* or require *additional* responsibilities of the participating PIHPs. This is directly confirmed by Milliman's actuarial report, which provides, "[m]any of the PIHP responsibilities for the CCBHC Demonstration are currently being performed as part of the existing program. . . . [W]e have reviewed the historical administrative expenditures reported in the EQI reports and *have not included any increase* to the variable administrative percentages *based on this data*." (Am Compl, Ex D, p 46 (emphasis added).) Therefore, Plaintiffs CMHPSM and Region 10 fail to state a claim.[2]

CONCLUSION AND RELIEF REQUESTED

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

Respectfully submitted,

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