Northern Michigan Regional Entity

Board Meeting

March 25, 2026

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – February 25, 2025	Pages 2 – 7
7.	Correspondence	Pages 8 – 39
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – March 2026	Page 40
	c. Financial Report – January 2026	Pages 41 – 62
	d. Operations Committee Report – March 17, 2026	Pages 63 – 67
	e. NMRE SUD Oversight Board Report – Next Meeting is May 4th	
11.	New Business	
	a. Nominating Committee Report/Election of Officers	Pages 68 – 69
12.	Old Business	
	a. CMHSP Updates	
	b. Legal Actions Related to PIHP Bid Out	
13.	Presentation	
	New Horizons Learning Credit Request and Usage Report	Pages 70 – 73
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – April 22, 2026 at 10:00AM	
16.	Adjourn	

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – FEBRUARY 25, 2026
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Dave Freedman, Ed Ginop, Ron Iseler, Michael Newman, Ruth Pilon, Don Smeltzer, Don Tanner**
VIRTUAL ATTENDEES:	**Dana Labar, Eric Lawson**
ABSENT:	**Karen Goodman, Mary Marois, Jay O'Farrell, Chuck Varner**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Jodie Balhorn, Carol Balousek, Brady Barnhill, Eugene Branigan, Amy Christie, Gail Grangood-Griffin, Lisa Hartley, Chip Johnston, Brooke Kleinert, Eric Kurtz, Brian Martinus, Heidi McClenaghan, Trish Otremba, Pamela Polom, Brandon Rhue, Sonya Russell, Nena Sork, Denise Switzer, Deanna Yockey, Lynda Zeller**
PUBLIC:	**Anonymous (2), Ann Friend, Genevieve Groover, Sarah Hegg, Terri Henderson, Larry LaCross, Tobias Neal, Rob Palmer, Kim Rappleyea, Justin Reed**

CALL TO ORDER
Let the record show that Board Vice-Chairman, Don Tanner, called the meeting to order at 10:15AM as no quorum was present until that time.

ROLL CALL
Let the record show that Karen Goodman, Mary Marois Jay O'Farrell, and Chuck Varner were excused from the meeting on this date; all other NMRE Board Members were in attendance either in person or virtually.

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

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

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

MOTION BY DAVE FREEDMAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR FEBRUARY 25, 2026; SUPPORT BY RUTH PILON. MOTION CARRIED.

DRAFT

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

MOTION BY BOB ADRIAN TO APPROVE THE MINUTES OF THE JANUARY 28, 2026 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY DAVE FREEDMAN. MOTION CARRIED.

CORRESPONDENCE
1) Document from the Community Mental Health Association of Michigan (CMHAM) titled, "Self Determination: Issues to be clarified and resolved," dated November 2022 – January 2023.
2) A memorandum dated January 26, 2026, from Kristin Morningstar (MDHHS) to PIHP Chief Executive Officers containing "Fiscal Year 2026 Reference Materials."
3) Email correspondence from Kristen Morningstar (MDHHS) dated February 2, 2026, announcing MDHHS Specialty Behavioral Health Staffing Changes.
4) Notification from the Department of Technology, Management, and Budget, Central Procurement Services dated January 29, 2026, canceling the Request for Proposal (250000002670) to procure Michigan's Prepaid Inpatient Health Plans.
5) Email correspondence from Robert Sheehan and Alan Bolter (CMHSM) dated February 11, 2026, outlining "CMHA Actions - Post Yates Opinion and RFP Withdrawal."
6) A memorandum from Kristen Morningstar (DHHS) dated February 6, 2026, to CMHSP and PIHP CEOs providing "Revised Clarification of Direct Care Worker Wage Increase."
7) Analysis from CMHAM providing an "Analysis of FY 2026 Medicaid Revenue and DCW Wage Related Costs."
8) Email correspondence from Alan Bolter (CMHSM) dated February 13, 2026, regarding "Governor's FY27 Executive Budget Recommendation."
9) Michigan's FY27 Executive Budget Proposal supplied by CMHAM.
10) Email correspondence dated February 10, 2026, from the MDHHS Actuarial Team providing notification to the NMRE of a FY25 gross adjustment in the amount of $1,778,218.29.
11) Communication dated February 10, 2026 from NMRE financial auditors, Roslund, Prestage, and Co. to the NMRE Board of Directors extending Board Members the "opportunity to share any concerns they have regarding the NMRE, whether they be in relation to controls over financial reporting, controls over assets, or issues regarding personnel, as well as affording an opportunity for Board Members to ask any questions they have regarding the audit."
12) The draft minutes of the February 11, 2026, regional Finance Committee meeting.

Mr. Kurtz highlighted the Self-Determination document from CMHAM. Recommendations were provided to provide sound guidance to individuals served, their families and guardians, and the state's CMHSPs, PIHP, and providers in the wake of Waskul[1] settlement.

Mr. Kurtz next highlighted the cancellation of the RFP to procure the state's PIHPs by the MDHHS and DTMB. It is unknown whether a new RFP will be issued or the state will negotiate with PIHPs regarding contract disputes. The NMRE will continue business as usual and foster its growing relationship with NorthCare Network/Region 1 PIHP.

[1]*Waskul v. Michigan Department of Health and Human Services* (2016) is a landmark case significantly impacting Michigan disability services. Approved in early 2025, it establishes a $31/hour rate for caregivers (HSW SD CLS), enhances self-determination rights, and improves budgetary transparency.

The analysis of Medicaid review and DCW wage related costs by CMHAM shows a decline in revenue for all funding buckets. There is the possibility of a rate adjustment in May/June to account for declining enrollment. FY26 rates include funding for the direct care wage (DCW) increase, but not for the increase in minimum wage.

Mr. Lawson asked about the potential impact of the state's transition to a direct payment model for the state's Certified Community Behavioral Health Clinics (CCBHS). Mr. Kurtz responded that as of October 1, 2025, PIHPs no longer receive capitation payments for CCBHC services. Although two years remain on the CCBHC Demonstration; new programs are not being enrolled at present.

ANNOUNCEMENTS

Let the record show that Mark Surbrook, has been named as a new Board Member representing Wellvance.

Former NMRE Board Chair, Gary Klacking, has agreed to attend the March meeting to accept a Certificate of Appreciation from the Board.

PUBLIC COMMENT

Justin Reed shared that Traverse House Clubhouse will be celebrating 30 years with an upcoming celebration. The specific date will be shared when known and Board members were invited to attend.

REPORTS

Executive Committee Report

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

CEO Report

The NMRE CEO Monthly Report for February 2026 was included in the materials for the meeting on this date. Mr. Kurtz highlighted his participation in North Country CMHA's Board Planning Session on February 19th and thanked Mr. Babbitt and Mr. Ginop for the invitation.

December 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $1,076,685. Carry forward was reported as $2,844,054. The total Medicaid and HMP current year surplus was reported as $3,920,739. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $24,510,828.
- Traditional Medicaid showed $58,028,278 in revenue, and $56,307,679 in expenses, resulting in a net surplus of $1,720,599. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $2,844,054.
- Healthy Michigan Plan showed $6,831,249 in revenue, and $7,475,163 in expenses, resulting in a net deficit of $643,914. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $831,806 in revenue, and $666,620 in expenses, resulting in a net surplus of $165,186.
- SUD showed all funding source revenue of $5,483,035 and $4,917,612 in expenses, resulting in a net surplus of $565,. Total PA2 funds were reported as $4,879,422.

DRAFT

PA2/Liquor Tax was summarized as follows:

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

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

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

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$437,421	$853,652	$849,902	($1,310,060)	$804,337
HMP	($96,461)	($212,425)	$96,426	($723,920)	($8,738)
Total	$340,960	$641,227	$946,328	($2,033,970)	$795,599

The NMRE's FY25 Financial Status Report (FSR) is due to MDHHS on March 2nd. Reports have been received by four of the CMHSPs with an estimate provided by Northern Lakes which reduced the carry forward to $2.8M.

No PA2 payments have been received to date for Quarter 1 of FY26.

A letter dated February 23, 2026, was distributed to the Board from Northern Lakes' CEO, Lynda Zeller, in which a financial and operations update was provided.

Northern Lakes is in the process of correcting issues related to its financial accounts and reporting systems. In preparing the Final FSR, issues were identified that created a variance when compared to the Interim FSR, which have all been corrected. FY25 expenses are estimated to exceed revenue by $12 million instead of the $5.9 million initially reported in November.

Cost containment efforts will potentially amount to a $5.3 million dollar savings for FY26. It was noted that the cost containment efforts implemented in July 2025 ($3M) were not reflected in FY25 finances but are being realized in FY26.

Northern Lakes is strengthening its utilization management (UM) processes and tools to ensure that individuals are getting the right service, at the right time, with "discharge planning" beginning at admission.

MOTION BY DAVE FREEDMAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR DECEMBER 2025; SUPPORT BY ED GINOP. MOTION CARRIED.

Operations Committee Report
The draft minutes from the February 17, 2026, Operations Committee meeting were included in the materials for the meeting on this date. Topics discussed included those already addressed under the Financial Report.

DRAFT

NMRE SUD Oversight Committee Report
Let the record show that the next meeting of the NMRE Substance Use Disorder Oversight Committee is March 2, 2026, at 10:00AM.

NEW BUSINESS
Nominating Committee
Mr. Tanner appointed the following members to the Board Nominating Committee:
Don appointed the following members:

- Centra Wellness – Don Smeltzer
- North Country – Michael Newman
- Northeast Michigan – Bob Adrian
- Northern Lakes – Dave Freedman
- Wellvance – Jay O'Farrell

A meeting will occur prior to the March 25th Board Meeting. It was noted that Wellvance still has 1½ years remaining on its Chairmanship term; the Chair will then rotate to North Country CMHA.

OLD BUSINESS
CMHSP Updates
North Country CMHA's Chief Clinical Officer, Amy Christie, announced that North Country has received a technology grant from MDHHS. During the next two years, North Country will develop access points (kiosks) in the community where individuals can request telehealth services visits.

Legal Actions Related to the PIHP Bid Out
Since MDHHS and DTMB have cancelled the RFP, the Attorney General's office has submitted a motion to dismiss the associated lawsuits (25-000143-MB and 25-000162MB). A decision is expected on April 13th.

Regarding the lawsuit related to FY25 PIHP Contract language (24-000198-MZ), the only issue that remains is the 7.5% cap on the Internal Service Fund. Ideally, the state will be open to negotiations.

PRESENTATION
NMRE Regional Health Homes
NMRE Quality Manager, Heidi McClenaghan, reported on the NMRE's Health Homes. (get updated presentation from Heidi)

Health Home programs provide coordinated, patient-centered care for Medicaid beneficiaries with serious mental illnesses (BHH) or specific substance use disorders (SUDHH), aiming to integrate physical and behavioral health, manage chronic conditions, and improve outcomes.

2014	2018	2020	2022	2025
Behavioral Health Home (BHH) begins in NMRE region	NMRE selected by MDHHS as pilot for Opioid Health Home (OHH)	BHH expanded to all five CMHSPs in the NMRE region	NMRE begins an Alcohol Health Home (AHH)	OHH expands to SUDHH to include alcohol and stimulant use disorders

Individuals (adults and children) with qualifying diagnoses, who are enrolled in Medicaid/HMP, and live within the NMRE region are eligible to participate in health home programs.

The NMRE's "Health Home Partners" include SUD Providers, CMHSPs, Federally Qualified Health Centers (FQHC), physicians' offices, Women's Health Clinics, and Health Care Systems.

Current enrollment shows 720 individuals enrolled in BHH and 990 enrolled in SUDHH.

COMMENTS

Board

Mr. Freedman thanked the NMRE and CMHSPs for their support, understanding, and patience as Northern Lakes restructures its finances.

Staff/CMHSP CEOs

Ms. Sork thanked Ms. Zeller for her detailed cost containment report.

Public

Larry LaCross, CEO of Catholic Human Services, thanked the NMRE for the collaborative, and supportive relationship between the two entities. CHS is working through state implemented guidance related to the Mental Health Framework.

NEXT MEETING DATE

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

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:38AM.

DRAFT

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

February 2, 2026

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) FY26 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 – ISF Requirements pertaining to FY26 are addressed in the FY26 PIHP Contract, effective October 1, 2025. The PIHPs should review the FY26 PIHP Contract for any FY26 ISF and FY26 RMS requirements.

FY26 Projected Medicaid Fund Reported:
DEFICIT $2,059,818

PIHP Response to Deficit:
"FY25 Carry Forward to cover over expenditures in FY26."
"The NMRE estimates FY26 revenue and FY25 savings will be sufficient to cover FY26 expenses."

Management Decision:
Approved

It has been noted by MDHHS that #3B: "Projection of Medicaid/HMP waiver expenditures for PIHP and affiliates in total" should have been inputted as a negative amount, to derive correct Deficit amount.

The MDHHS acceptance of this RMS submission does not imply MDHHS acceptance of, or approval of, any ISF balances stated therein that are greater than the contractually limited 7.5% of PIHP's most-recent year's annual operating budget.
If there are any anticipated changes to the FY26 RMS during the fiscal year, please submit a revised plan to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

Sincerely,

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

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

Community Mental Health Association of Michigan

Comments regarding Michigan’s 2026 HSW Amendment

Below are the comments of the Community Mental Health Association of Michigan (CMHA) relative to the Habilitative Supports Waiver amendment proposed by MDHHS in February 2026. **These comments focus, in the main, on Section D-1: Service Plan Development.**

Summary of comments

While CMHA and its members strongly support the aim of the CMS rule, the Community Mental Health Association of Michigan (CMHA), its members, and the persons served who participated in the 2022 MDHHS Listening Sessions have concerns regarding the approach outlined in Michigan’s 2026 HSW amendment, designed to achieve this aim. These concerns center around the **threat that these options hold for persons served and to the integrity of Michigan’s public mental health system**.

In the comments below, CMHA outlines these concerns and proposes a comprehensive alternative to the approach outlined in Michigan’s HSW waiver amendment. This alternative provides for conflict mitigation while also ensuring a sound HCBS system, complying with federal and state law and Michigan’s Medicaid waivers, and ensuring ease of access for Michiganders to mental health services.

Support for the intent of CMS rule and for freedom of choice for persons served

CMHA and its members strongly support the aim of the CMS rule - to ensure that conflicts of interest in the provision and financing of services are mitigated.

Additionally, **CMHA and its members strongly support the foundational principle that persons served be empowered by exercising their rights to make choices regarding the services and supports** that they receive. These rights include:

- the right to select an independent facilitator of their person-centered planning (PCP) (not employed by or affiliated with the CMHSP/PIHP) to facilitate the PCP process.
- the right to lead the person-centered planning (PCP) process with the involvement of allies chosen by the person served.
- the right to be provided with full information regarding the array of services and supports available, the choice of providers, and access to self-determination arrangements.
- The right to choose their case manager/supports coordinator – from those employed by the CMHSP, the CMHSP contractor, or to choose an independent supports coordinator ((not employed directly by a CMHSP or by a current CMH contracted provider)
- The right to use the CMHSP Recipient Rights System and Grievance/Appeal process. These processes are independent of the clinical reporting line from PCP development, service authorization, and HCBS services and are subject to MDHHS oversight.

Concerns around approach outlined in proposed HSW amendment

1. This structural separation of access, planning, and case management from service delivery, proposed by in the 2026 HSW amendment, **makes an already complex system more complex for persons** served and creates an artificial access barrier to persons seeking services and weakens continuity and coordination/integration of care.

In fact, same day service (what is often termed "treat first") would be impossible under the separation of functions that MDHHS is proposing.

Additionally, outreach to persons in need of services would be seriously hindered by prohibiting the services provider from assessing and building a treatment/services plan with the person in need.

The comments of persons served**, obtained during the MDHHS listening sessions held in 2022 underscore the concerns of persons served** around the complexity, loss of access, and continuity of care that will occur as a result of the Department's proposed system restructuring. These comments are provided below:

- "I think [Separating access/planning from direct service] could be problematic due to a person having to repeat providing their info…"
- "Having to go from here, to here, to here to do it when being in a place where I need help would be a lot. It's a lot to ask one person to go through."
- "The concern is the challenge is managing [different organizations] that need to be in alignment with one another. The management now is already a concern. Does this make it worse.
- "…if no communication or miscommunication this will be hard because it will be left to person with disabilities to relay info."
- "[I have] mixed feelings. [It is] Protecting people getting these services, but I can get frantic going places to places."
- "Between the point of access and referral, things get dropped and lost."
- "It feels like the game it goes through several people and it is not the same in the end after it has moved through all the steps."

2. The CMS rules were intended to prevent inappropriate financial gain/inappropriate profit taking by providers.

CMHSPs are governmental bodies funded via Medicaid capitation payments, with not incentive or legal basis for profit-taking. Because Michigan's CMHSPs, unlike nearly every other state in the country, are financed via a prepaid capitated basis, the state's CMHSPs:

As **public/governmental organizations** (not profit taking) have **no legal basis nor incentive for under-authorizing services** contained in the person-centered plan as would be true or a for-profit provider

As **organizations whose HCBS services are funded via a capitated funding** , have **no incentive for over-authorizing services** contained in the person-centered plan as would be true in a private or fee-for-service financing model.

3.The approach outlined in the 2026 HSW amendment dismantles and is in conflict with:

- The **statutorily required core functions of Michigan's CMHSPs** – access and assessment, clinical plan development, and provision of services directly or through a directly managed provider network.

- The **federally required core functions of Michigan's Certified Community Behavioral Health Clinics (CCBHC) and Behavioral Health Homes (BHH)** – the functions of access and assessment, clinical plan (individual plan of service) development, and provision of services directly and through a directly managed provider network.

4. MDHHS has the approval of CMS of the innovative set of sound conflict-mitigation design elements and <u>can apply the CMS-outlined exception to the CMS rule</u>. These approaches reflect the unique nature of Michigan's system and are included in Michigan's HCBS plan amendment and again in the proposed 2026 HSW amendment.

These conflict mitigation approaches include:

- The person facilitating the Person Centered Planning process are not providers of any Home and Community Based Services (HCBS) for that individual and are not the same persons responsible for the independent HCBS needs assessment.
- The person facilitating the PCP process does not authorize the services contained in the plan
- The development of the IPOS through the person-centered planning (PCP) process is led by the person served with the involvement of allies chosen by the person served to ensure that the service plan development is conducted in the best interests of the beneficiary.
- The person served can choose an independent facilitator (not employed by or affiliated with the CMHSP/PIHP) to facilitate the PCP process.
- The CMHSPs are required to provide full information regarding the array of services and supports available, the choice of providers, and access to self-determination arrangements.
- The person served can choose their case manager/supports coordinator employed by a CMHSP or PIHP contractor or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network)
- The persons served has the right to use the CMHSP Recipient Rights System and Grievance/Appeal process. These processes are independent of the clinical reporting line from PCP development, service authorization, and HCBS services and are subject to MDHHS oversight.

The public structure of and the state statutes that guide Michigan's CMH system **provides Michigan with the ability to apply the exception to the CMS rule which would allow the use of these conflict mitigation approaches**. The basis for such an exception is contained on page 6 of the legal opinion of the firm of Feldesman Tucker (one of the nation's leading Medicaid managed care law firms).

5. Rather than harm access and cause unnecessary system complexity, what is needed are efforts to ensure that these conflict mitigation approaches are widely known and used by persons served. If these options are not often requested by persons served, what is needed is a strengthened effort to ensure that all persons served are informed of and supported in pursuing these options with the vigor that is found in the system's work to ensure that persons served are aware of their Recipient Rights.

Recommendation: Comprehensive conflict mitigation approach to Home and Community Based Services in Michigan

As Michigan works to ensure compliance with the CMS rule, the intent of which is strongly supported by the Community Mental Health Association of Michigan (CMHA), **CMHA and its members have proposed, below, an alternative conflict mitigation approach to those proposed by MDHHS.**

This alternative approach:

- Is founded on state and federal law and Medicaid waivers
- Provides strong safeguards against conflict of interest
- Prevents the addition of unnecessary and access-hindering complexity to the service access and delivery system
- Ensures the comprehensive organized system of care provided by Michigan's public mental health system and its ability to fulfill its statutory obligations.
- Can obtain CMS approval based on the points contained in this paper

Proposed approach to HCBS conflict mitigation

The alternative approach, outlined below, builds upon and strengthens the wide range of conflict mitigation processes and tools currently existing in Michigan's system and described in Michigan's HCBS plan amendment .

The efforts proposed below need to be **designed and implemented with the vigor, breadth, and depth found in the state's mental health Recipient Rights system**. This effort would significantly bolster the state's work in ensuring HCBS conflicts are mitigated and that all persons served are informed of and supported in the exercise of the rights outlined in state's HCBS plan and the Michigan Mental Health Code.

The recommended HCBS conflict mitigation approach consists of the following components:

A. Designation of all of Michigan's CMHSPs as OWSPs: It is strongly recommended that the HSW amendment indicate that the specifications developed by MDHHS for OWQP (as cited in Appendix D-1) must comply with Michigan law and the unique inherently conflict-mitigating nature of Michigan's CMHSP system.

The CMS rules were intended to prevent inappropriate financial gain/inappropriate profit taking by providers. CMHSPs are governmental bodies, prohibited from profit-taking. Because Michigan's CMHSPs, unlike nearly every other state in the country, are public/governmental bodies financed via prepaid capitated basis, the state's CMHSPs:

- As public/governmental organizations (not profit taking) have no motivation for under-authorizing services contained in the person-centered plan as would be true or a for-profit provider

- As organizations whose HCBS services are funded via a capitated funding there is no motivation for over-authorizing services contained in the person-centered plan as would be true in a private or fee-for-service financing model.

B. Ensuring a robust monitoring and contract compliance processes to ensure that:

- The person facilitating the PCP process is **not a provider** of Home and Community Based services **nor the person authorizing** the services contained in the plan,
- The development of the IPOS through the person-centered planning (PCP) process is **led by the person served with the involvement of allies chosen by the person served** to ensure that the service plan development is conducted in the best interests of the beneficiary,
- The person served has (and is informed that they have**) the right to choose an independent facilitator** (not employed by or affiliated with the CMHSP/PIHP) to facilitate the PCP process,
- The person served can (and is informed that they can) **choose their case manager/supports coordinator** employed by a CMHSP or PIHP contractor or can choose an independent case manager/supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network),
- The person served was made **aware of all of the forms of grievance and appeals** to which they have a right and supported in pursuing those grievances and appeals if they choose to do so.
- The **selection of the HCBS providers**, by the person served, their family, and/or guardian, follows the process outlined above.
- Neither the persons facilitating the Person-Centered Planning process nor the providers of any Home and Community Based Services (HCBS) can be the person responsible for the **independent HCBS eligibility determination**. This latter role is held by MDHHS.

C. Employing a comprehensive communication and information sharing system:

1. **Accessible, frequent, and readily available information** to persons served regarding the rights outlined above – through the use of:
    - A uniform set of hard-copy handouts and electronic messages
    - Notices on the websites of the state's CMHSPs, PIHPs, providers, and MDHHS
    - Social media posts

2. **Continual education, training, supervision, and coaching of CMHSP, PIHP, and provider staff** around these rights – efforts led by MDHHS, the state's major advocacy organizations, and CMHA

3. The **use of contractual powers, corrective action plans, and sanctions**, when needed, to ensure that these rights are afforded persons served – via the MDHHS/PIHP contract, the MDHHS/CMHSP contract, and the PIHP/CMHSP contract.

Email Correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter; David Lowe; Sarah Botruff
Subject:	Requesting your participation in a 2026 Special Assessment
Date:	Friday, March 6, 2026 10:24:06 AM

To: CEOs of CMHs and PIHPs
Cc: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: SPECIAL ASSESSMENT: Strengthening CMHA's advocacy efforts in the face of privatization threat: Special Assessment of CMH and PIHP members of CMHA

CONTEXT TO THIS REQUEST: MOST RECENT DIALOGUE WITH MDHHS UNDERSCORING CONTINUED PRIVATIZATION THREAT: While many of us predicted that MDHHS is likely to issue a new RFP of the state's PIHP contract, in the aftermath of the Judge Yates opinion and the Department's withdrawal of the initial RFP, this week's Listening Sessions with MDHHS (one involving CMHSPS; one involving PIHPs) reinforced that view.

The tone of those meetings was relatively cordial, although MDHHS declined to outline its next steps, if any, in its system redesign and/or RFP efforts. The questions asked by MDHHS, in both sessions were centered around refining the Department's flawed initial RFP in what appeared, to many of us, as part of the preparation for another RFP.

These two Listening Sessions have reinforced the view, by CMHA and many of its members, outlined below, that we must be ready – in our resolve, commitment, and financially - for the legal, political, and media related action needed to thwart what looks to be another RFP-centered privatization threat to our system.

BACKGROUND: As you know, in 2025, with your support, CMHA issued a very successful Special Assessment of its members. **The revenues generated by this Special Assessment were key to the legal and media advocacy efforts, of CMHA and the plaintiffs in the lawsuit, which successfully thwarted the privatization threat posed by the PIHP Request for Proposal (RFP) issued by MDHHS.**

We want to applaud, again, the participation of our members in this Special Assessment effort.

For context, the legal costs related to this suit exceeded $1.2 million. These costs were covered by: $100,000 drawn from the balance of the Special Assessment fund built, several years ago, to fight the privatization threat posed by Senator Shirkey's proposed legislation; $500,000 from the 2025 Special Assessment; and $600,000 contributed by CMHA, by drawing down its fund balance.

COMING THREAT: Even prior to the Listening Sessions, discussed above, while the initial RFP has been withdrawn, many of us are aware that a number of MDHHS staff are nonetheless working on a second RFP of the PIHP contracts. As we noted above, the Listening Sessions only reinforced our view of the likelihood of another RFP.

While CMHA, our members, and our allies see that it is unlikely that this new RFP will comply with state law, given the depth of the violations of state law found by Judge Yates in the original RFP, some MDHHS staff are convinced of the need to pursue this wrong-headed approach to system improvement.

If the Department does issue a new RFP, the plaintiffs in the original suit (the Region 10 v MDHHS suit) or other plaintiffs will need to have legal counsel review this new RFP to determine how it conflicts with state law. If conflicts with state law are found in this new RFP, legal counsel will need to, once again, file suit with the Michigan Court of

Claims to halt the issuance of this RFP. Whether Judge Yates or another judge is selected as the presiding judge on this new case, the legal proceedings involve hearings and extensive legal review and motions by legal counsel. If Judge Yates is not selected as the presiding judge, the legal proceedings could be as in-depth and extensive as those related to the original case. **The legal costs related to defending our system against another illegal RFP will be substantial – as they were with the most recent legal battle.**

REQUESTING YOUR SUPPORT FOR A 2026 SPECIAL ASSESSMENT OF CMHA MEMBERS: Given these factors, above, we are asking for your participation in a 2026 Special Assessment

PURPOSE OF VOLUNTARY SPECIAL ASSESSMENT: The purpose of this special assessment **(Note: in recognition of the variation in the fiscal condition of CMHA members, participation in this assessment is voluntary on the part of each CMH and PIHP)** is to provide a significantly increased level of funding for CMHA's advocacy work, including legal, media, and legislative advocacy – an increase designed to match the level of threats and opportunities faced by the state's CMHs and PIHPs and those whom we serve – in the face of the current threat posed by what we predict to be a new RFP for the state's PIHP contracts.

These increased dollars would be used, as your dues and fees to CMHA are currently used, to fund the advocacy, government affairs, media/public relations work, and legal work of CMHA around the current privatization threat posed by the - **but with greater intensity and reach**.

TREAT SPECIAL ASSESSMENT AS ANY DUES OR FEES PAID TO CMHA: The legal and accounting bases for your supporting this special assessment are no different than those for the dues and fees that you have traditionally paid to CMHA- thus allowing the use of any funding source (Medicaid, GF, local, earned revenue, etc.) to be used to pay this special assessment.

A fuller discussion of the basis of this determination is included in the **attached Q&A document.** This document provides answers to a number of questions raised by CMHA members during past special assessment processes.

SIZE OF SPECIAL ASSESSMENT: To build this fund in a way that is roughly proportional to the size of the budgets of CMHA member organizations, CMHA is suggesting (not requiring) that the voluntary special assessment be at the level of the annual CMHA dues and fees paid by the state's CMHSPs and PIHPs. Those FY 2026 dues and fee levels are **attached.** However, each CMHSP and PIHP determines the level to contribute – by completing the questions below.

ACTION REQUESTD BY YOU: Because of the voluntary nature of this special assessment, the mechanics differ from the traditional dues and fees invoicing process. The process that is being used for this special assessment is outlined below:

1. Please indicate, below, the level of special assessment that your organization will contribute:
Same as our organization's current CMHA dues
Other $___________
Our organization will not be contributing

After you have indicated your answer to question 1, above, send this email with your response, above, reflected in your return email (not via respond to all) to Bob Sheehan (rsheehan@cmham.org) **as soon as possible.**

2. Based on your response, above, CMHA will send your organization an invoice in the amount that you have indicated in this survey.

3. Your organization pays the invoice.

4. CMHA implements the expansion of its public education, media relations, and legal work related to the most serious threats and opportunities facing CMHA members and those whom we serve.

Thank you, in advance, for your participation in this effort – an effort key to our advocacy efforts in opposition to the privatization of our system.

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

CMHAM Dues for FY24/25

Boards	CMHAM Total Dues FY25/26 (12 months)	MDHHS Authorization FY22/23	CMHAM Dues FY25/26 - 2.5% Increase in Variable Base	Variable Base FY25/26	Total Dues-Variable Base FY25/26-Amount	
Band 7 - Boards with more than $140 million - 24% of dues / 7 boards						
Detroit-Wayne	$ 31,798	$ 1,139,994,795	-	$ 26,029	$ 182,203	23.87%
Oakland	$ 31,798	$ 489,916,787				
Macomb	$ 31,798	$ 346,092,898				
Network180(Kent)	$ 31,798	$ 222,253,322				
Clinton Eaton Ingham	$ 31,798	$ 189,583,074				
Genesee	$ 31,798	$ 163,642,706				
CMH for Central MI	$ 31,798	$ 157,659,731				
Sub Total	**$ 222,586**	**$ 2,709,143,313**				
Band 6 - Boards with more more than $100 - $140 million - 12% of dues / 4 boards						
Saginaw	$ 28,564	$ 123,607,766	-	$ 23,002	$ 92,008	12.05%
Kalamazoo	$ 28,315	$ 118,073,251				
Washtenaw	$ 28,223	$ 116,015,500				
LifeWays	$ 28,208	$ 115,687,332				
Sub Total	**$ 113,310**	**$ 473,383,849**				
Band 5 - Boards with more than $80 - $100 million - 8% of dues / 3 boards						
St. Clair	$ 27,730	$ 105,059,405	-	$ 19,934	$ 59,802	7.83%
Muskegon	$ 24,274	$ 96,449,771				
Northern Lakes	$ 23,801	$ 85,923,161				
Sub Total	**$ 75,804**	**$ 287,432,337**				
Band 4 - Boards with more than $50 - $80 million - 16% of dues / 7 boards						
Summit Pointe	$ 20,136	$ 72,677,393	-	$ 16,866	$ 118,062	15.47%
Bay Arenac	$ 20,012	$ 69,910,768				
Berrien	$ 19,796	$ 65,102,391				
North Country	$ 19,716	$ 63,341,628				
Ottawa	$ 19,663	$ 62,150,261				
Pathways	$ 19,299	$ 54,062,140				
Monroe	$ 19,165	$ 51,097,204				
Sub-total	**$ 137,787**	**$ 438,341,785**				
Band 3 - Boards with more than $25 - $50 million - 25% of dues / 14 boards						
Livingston	$ 15,960	$ 47,978,153	-	$ 13,801	$ 193,214	25.31%
Allegan	$ 15,652	$ 41,143,879				
Northeast Michigan	$ 15,616	$ 40,323,424				
Van Buren	$ 15,410	$ 35,766,467				
West Michigan	$ 15,399	$ 35,504,753				
Lapeer	$ 15,220	$ 31,538,258				
Montcalm	$ 15,178	$ 30,602,313				
Shiawassee	$ 15,175	$ 30,526,821				
St. Joseph	$ 15,150	$ 29,973,828				
AuSable Valley	$ 15,131	$ 29,555,216				
Lenawee	$ 15,053	$ 27,811,559				
Sanilac	$ 14,988	$ 26,387,626				
Ionia	$ 14,983	$ 26,267,704				
Tuscola	$ 14,971	$ 25,999,212				
Sub-total	**$ 213,886**	**$ 459,379,213**				
Band 2 - Boards with more than $10 - $25 million - 15% of dues / 11 boards						
Northpointe	$ 11,848	$ 24,725,336	-	$ 10,735	$ 118,085	15.47%
Gratiot	$ 11,792	$ 23,495,091				
Woodlands	$ 11,745	$ 22,444,849				
Newaygo	$ 11,718	$ 21,838,014				
Copper Country	$ 11,715	$ 21,785,275				
Centra Wellness NW (Mans B)	$ 11,700	$ 21,441,418				
Hiawatha	$ 11,662	$ 20,601,361				
Pines	$ 11,616	$ 19,583,264				
Barry	$ 11,476	$ 16,464,197				
Huron	$ 11,444	$ 15,753,335				
Gogebic	$ 11,250	$ 11,446,927				
Sub-total	**$ 127,966**	**$ 219,579,067**				
Band 1 - Boards with less than $10 million - 0% of dues / 0 board						
			-	$ 7,668	$ -	0.00%
Sub-total	**$ -**	**$ -**				
Grand Total	**$ 891,340**	**$ 4,587,259,564**			**$763,374**	**100.00%**

CMHAM Formula Calculations for Member Dues for Fiscal Year 2025-26

A	B	C	D	E	F	G	H	I
CMHSP	Total Revenue/Cost FY22	Total Revenue/Cost FY23	Variable Base (All Dues Capped at $26,029)	Remaining Spread (cost /1000*.045)	Proposed FY26 Dues based on FY23 Allocations (All Dues Capped at $31,798)	FY25 Assessed Dues based on FY22 Allocations	Change in Dues Amount from FY25 to FY26	%age change from FY25 to FY26
Allegan	38,871,333	41,143,879	13,801	1,851	15,652	15,213	439	2.89%
AuSable Valley	26,325,823	29,555,216	13,801	1,330	15,131	14,649	482	3.29%
Barry	14,748,251	16,464,197	10,735	741	11,476	11,137	339	3.05%
Bay-Arenac	63,882,950	69,910,768	16,866	3,146	20,012	19,330	682	3.53%
Berrien	56,755,316	65,102,391	16,866	2,930	19,796	19,009	787	4.14%
Centra Wellness NW (Mans B)	19,578,885	21,441,418	10,735	965	11,700	11,354	346	3.05%
Clinton Eaton Ingham	170,933,582	189,583,074	26,029	8,531	31,798	31,022	776	2.50%
CMH for Central MI	139,409,301	157,659,731	26,029	7,095	31,798	28,714	3,084	10.74%
Copper Country	22,024,070	21,785,275	10,735	980	11,715	11,464	251	2.19%
Detroit-Wayne	1,054,197,848	1,139,994,795	26,029	51,300	31,798	31,022	776	2.50%
Genesee	150,450,284	163,642,706	26,029	7,364	31,798	31,022	776	2.50%
Gogebic	11,345,969	11,446,927	10,735	515	11,250	10,984	267	2.43%
Gratiot	20,348,247	23,495,091	10,735	1,057	11,792	11,389	404	3.54%
Hiawatha	19,390,268	20,601,361	10,735	927	11,662	11,346	316	2.79%
Huron	14,215,211	15,753,335	10,735	709	11,444	11,113	331	2.98%
Ionia- The Right Door for Hope	22,996,159	26,267,704	13,801	1,182	14,983	11,508	3,475	30.20%
Kalamazoo	110,356,986	118,073,251	23,002	5,313	28,315	27,407	908	3.31%
Lapeer	26,971,064	31,538,258	13,801	1,419	15,220	14,678	543	3.70%
Lenawee	25,940,139	27,811,559	13,801	1,252	15,053	14,631	421	2.88%
LifeWays	103,239,769	115,687,332	23,002	5,206	28,208	27,087	1,121	4.14%
Livingston	44,446,099	47,978,153	13,801	2,159	15,960	15,464	496	3.21%
Macomb	331,944,442	346,092,898	26,029	15,574	31,798	31,022	776	2.50%
Monroe	45,022,112	51,097,204	16,866	2,299	19,165	15,490	3,675	23.73%
Montcalm	26,617,713	30,602,313	13,801	1,377	15,178	14,662	516	3.52%
Muskegon- HW	86,995,023	96,449,771	19,934	4,340	24,274	23,363	911	3.90%
Network180 (Kent)	202,218,891	222,253,322	26,029	10,001	31,798	31,022	776	2.50%
Newaygo	20,153,753	21,838,014	10,735	983	11,718	11,380	338	2.97%
North Country	60,063,756	63,341,628	16,866	2,850	19,716	19,158	559	2.92%
Northeast Michigan	37,873,886	40,323,424	13,801	1,815	15,616	15,168	447	2.95%
Northern Lakes	85,923,161	85,923,161	19,934	3,867	23,801	23,315	486	2.08%
Northpointe	23,777,225	24,725,336	10,735	1,113	11,848	11,543	305	2.64%
Oakland	440,656,765	489,916,787	26,029	22,046	31,798	31,022	776	2.50%
Ottawa	55,090,552	62,150,261	16,866	2,797	19,663	18,934	729	3.85%
Pathways	51,166,842	54,062,140	16,866	2,433	19,299	18,758	541	2.89%
Pines	17,594,381	19,583,264	10,735	881	11,616	11,265	351	3.12%
Saginaw	98,171,352	123,607,766	23,002	5,562	28,564	23,866	4,699	19.69%
Sanilac	23,861,749	26,387,626	13,801	1,187	14,988	11,547	3,442	29.81%
Shiawassee	30,346,393	30,526,821	13,801	1,374	15,175	14,830	345	2.33%
St. Clair	94,933,089	105,059,405	23,002	4,728	27,730	23,720	4,010	16.90%
St. Joseph	24,130,209	29,973,828	13,801	1,349	15,150	11,559	3,591	31.07%
Summit Pointe	65,809,654	72,677,393	16,866	3,270	20,136	19,416	720	3.71%
Tuscola	25,050,840	25,999,212	13,801	1,170	14,971	14,591	380	2.60%
Van Buren	31,603,439	35,766,467	13,801	1,609	15,410	14,886	524	3.52%
Washtenaw	110,535,972	116,015,500	23,002	5,221	28,223	27,415	808	2.95%
West Michigan	34,305,234	35,504,753	13,801	1,598	15,399	15,008	391	2.61%
Woodlands	16,804,412	22,444,849	10,735	1,010	11,745	11,229	516	4.59%
Totals:	**4,197,078,399**	**4,587,259,564**	**766,442**	**206,427**	**891,340**	**843,708**	**47,632**	
PIHP'S- 10					57,330	55,930	1,400	

CMHA Special Assessment 2026: Q&A

March 2026

In the past, CMHA members have asked for responses to several questions related to the payment of the special assessments. These questions and their answers, relevant to the 2025 special assessment, are provided below.

1. Can Medicaid funds make up part or all of the payment, by a CMH or PIHP, of this special assessment and any other dues payment to CMHA, if those funds fuel advocacy work?
2. Does the federal Hatch Act prohibit a CMH or PIHP from making this special assessment payment if those funds fuel advocacy work?
3: Can a voluntary/discretionary expenditure, such as the Special Assessment, by a reasonable and necessary cost as required by Medicaid?

CMHA used the guidance of legal counsel – the firm of Feldesman, Tucker (a nationally recognized law firm that provides legal counsel to the National Council for Mental Wellbeing and many National Council members, including CMHA) and the firm of Cohl, Stoker, and Toskey (a firm recognized across the state and providing legal counsel for decades to CMHA and many CMHA members and partners) – on these two issues.

The legal opinions on the first two questions cited above, one by the Feldesman firm and one by the Cohl firm, are provided below:

Question 1: Can Medicaid funds make up part or all of the payment, by a CMH or PIHP, of this special assessment and any other dues payment to CMHA, if those funds fuel advocacy work?

Legal opinion of Feldesman, Tucker, Liefer, and Fidell:

You had asked for my legal opinion as to whether your members (CMHs and their regional PIHPs), both of which are subject to Part 200 cost principles, may charge membership dues in CMHA to Medicaid when part of those membership dues are to be used for the purpose of advocacy activities.

The cost principles under Part 200 dictate to what extent certain administrative costs are allowable and can be charged to Medicaid by an organization. Specifically, 2 CFR § 200.454 governs the allowability of memberships, subscriptions, and professional activity costs. That provision states that:

(a) Costs of the non-Federal entity's membership in business, technical, and professional organizations are allowable.
(b) Costs of the non-Federal entity's subscriptions to business, professional, and technical periodicals are allowable.
(c) Costs of membership in any civic or community organization are allowable with prior approval by the Federal awarding agency or pass-through entity.
(d) Costs of membership in any country club or social or dining club or organization are unallowable.
(e) Costs of membership in organizations whose primary purpose is lobbying are unallowable. See also § 200.450.

Accordingly, membership dues in a business and professional organization are allowable costs under Part 200, provided that the primary purpose of the organization is not lobbying.

If CMHA's financial records demonstrate that lobbying activities comprise less than 51% of its expenditures in any given year, then your members should be able to charge CMHA membership dues to Medicaid.

Adam Falcone he/him/his
Partner
Feldesman Tucker Leifer Fidell LLP
1129 20th Street, NW, Suite 400
Washington, DC 20036
T. 202.466.8960
F. 202.293.8103
www.ftlf.com

Answer 1: Determination as to whether lobbying is the primary purpose of CMHA, **in light of Adam Falcone's counsel, above**: The lobbying costs of CMHA total $300,000 per year (reflecting staff time spent in lobbying, contracts with multi-client lobbying firms, and corporate contributions to the corporate/issue advocacy/officeholder accounts of elected officials; note that these are not and cannot be campaign contributions). If the lobbying component of the Special Assessment is $100,000, the total lobbying expenditures would be $400,000. **So, at its peak, the lobbying expenditures of CMHA would be 2.5% of the association's annual budget of $15,513,000 (FY 2025) – far below the 51% threshold that is the standard measure for determining if lobbying is the primary purpose of an organization.**

Thus, Medicaid dollars can be used, by CMH and PIHP members of CMHA can use Medicaid funds to pay dues and fees, including special assessments, to CMHA.

Question 2. Does the federal Hatch Act prohibit a CMH or PIHP from making this special assessment payment if those funds fuel advocacy work?

Legal Opinion of Cohl, Stoker, and Toskey (examining both the federal Hatch Act and the segments of the MDHHS contracts with the state's CMHs and PIHPs that cite the Hatch Act):

> The Hatch Act, 5 USC §1501 *et seq*., generally prohibits Federal employees, or State or local officers or employees whose positions are funded in whole or in part by Federal funds, from (1) using their position to interfere with or affect the result of an election or nomination for office; (2) coercing, commanding or advising a State or local officer or employee to pay, lend, or contribute anything of value to a party, committee, organization, agency, or person for political purposes; or (3) being a candidate for elective office. 5 USC §1502(a).
>
> Thus, the Act applies to individual employed by a State or local agency, such as a CMHSP, whose principal employment is in connection with an activity which is financed in whole or in part by loans or grants made by the United States or a Federal agency, but does not apply to an individual who exercises no functions in connection with that activity. 5 USC §1501(4)(A).
>
> There are exceptions to the prohibition on candidacy for (1) persons holding elective office, and (2) to allow for an employee to be a candidate for non-partisan elective office. 5 USC §§1502(c)(4), 1503.
>
> Individuals subject to the Act retain the right to vote as they choose and to express opinions on political subjects and candidates. 5 USC §1502(b).
>
> Sec. 15.6 of the Michigan Managed Mental Health Supports and Services FY21 Contract states:
> "15.6 Hatch Political Activity Act and Inter-governmental Personnel Act. The CMHSP will comply with the Hatch Political Activity Act, 5 USC 1501-1508, and the Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs."
>
> Timothy M. Perrone
> Cohl, Stoker & Toskey, P.C.
> (517) 372-9000
> tperrone@cstmlaw.com

Answer 2: Based on legal opinion above, determination if the lobbying done by CMHA is in violation of Hatch Act: CMHs and PIHPs who, as members of CMHA, pay dues and fees for such membership are not (1) using their position to interfere with or affect the result of an election or nomination for office; (2) coercing, commanding or advising a State or local officer or employee to pay, lend, or contribute anything of value to a party, committee, organization, agency, or person for political purposes; or (3) being a candidate for elective office.

Thus, CMHs and PIHPs who, as members of CMHA, pay dues and fees, including the current Special Assessment, for such membership are not in violation of the Hatch Act.

Question 3: Can a voluntary/discretionary expenditure, such as the Special Assessment, by a reasonable and necessary cost as required by Medicaid?

Answer 3: The voluntary nature of the Special Assessment has caused some of you to be concerned as to whether Medicaid can be used to make a voluntary expenditure, given that all charges to Medicaid must be reasonable and necessary.

In responding to this question, it is key to see that many, if not all, of the costs paid by a PIHP, CMH, or provider, using Medicaid dollars, have a voluntary/discretionary component to them, yet they do not lose their reasonable nor necessary quality. Some examples include:

- Staff: while staff are necessary for operations, the number of staff hired and the pay and benefits level provided them are determined, voluntarily, by the management of the PIHP or CMH (at times, in negotiations with their labor representatives) and yet are seen as reasonable and necessary
- Office space: A voluntary, discretionary expenditure (with the widespread use of virtual connections and work-from-home arrangements), however, the owning or leasing of office space, the amount of space, and the price paid for it are determined by management and, as with staff costs, are seen as reasonable and necessary
- Medications prescribed by a CMH physician and clinical services provided: again, while psychiatric medications and services and supports are reasonable and necessary, the use of them, the type, the dosage, frequency, duration, and intensity are determined by the person centered plan and the clinician, using his/her discretion, yet do not lose their reasonable and necessary character.

There are, of course, many other examples, both administrative and clinical, that have the same voluntary/discretionary traits yet retain their reasonable and necessary qualities.

In these examples, above, and for nearly every other expenditure, the reasonableness and necessity of the expenditure are determined by management or clinicians.

Given the discussion, above, the payment of a special assessment, even a voluntary special assessment, by an association to which the CMHSP or PIHP belongs, is a reasonable and necessary cost as required by Medicaid. Thus, Medicaid funds can be used to make this payment.

Email Correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter; David Lowe
Subject: Impressive
Date: Thursday, March 5, 2026 3:27:09 PM

To: CEOs of CMHs and PIHPs
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Impressive

The statements made by the CMHSP and PIHP leaders in attendance at this week's Listening Session with MDHHS were right on point. Your messages were clear, concise, firm, sound, and compelling from a legal, policy, service delivery, client- and community-centered, and ethical/moral framework.

We were impressed with the clarity, power, and relevance of the statements made by the CMHSP and PIHP CEOs and the fact that we were in solidarity around the key points. MDHHS staff could clearly see that we were organized, unified, and had thought through these core issues. That says a lot to MDHHS, giving them pause as they think about going forward in pursuit of the bid-out approach to system change.

This meeting underscored: our willingness to work as partners to strengthen and improve the system, our deep understanding of the system and its unique role in the health and human services ecology, our unity, and our unwillingness to back-down in the face of this recently passed threat and any coming threats.

Many of you expressed, during the sessions, and to Alan and I, off-line during the sessions, and soon afterwards, your concerns relative to the potential that MDHHS is working on another RFP. Alan and I join you in that concern. So much so that CMHA will be issuing a Special Assessment request to our members, later this week, to ensure that we have the financial fire power needed to fuel legal action to protect the system, if and when a new RFP is issued.

As always, we will continue to keep our eyes open relative to threats and opportunities that may arise in the future.

Below is a very rough summary of the contents of this week's CMHSP CEO and PIHP CEO Listening Session with MDHHS.

____

MDHHS indicated that they will not be sharing notes nor video recording with this group. MDHHS will not be able to answer any questions, given that they are still involved in litigation.

The Department asked for how CMHSPs and PIHPs see the RFP's contents, around several issues, would impact their operations:

Conflict of interest: MDHHS focused, in this issue, around board composition and conflict-free access and planning. CMHSPs underscored: no conflict in CMHSP role as provider and purchaser; if PIHP board structure we are open to dialogue; regional entities were developed in alignment with state law and MDHHS guidance; conflict-free access and planning is not an issue for CMHSPs given that they have no interest in under-authorizing (in that they cannot keep the savings) and no interest in over-authorizing given that CMHSPs, because they are do not bring in additional dollars when more services are authorized.

Access to services: This issue was not addressed during the CMHSP session. During the PIHP session, the lack of providers in the rural communities, including CCIs and children's residential was raised. While sufficient rates are important in recruitment and retention of providers, the administrative burden, paperwork demands, and audits imposed on providers drive providers away and draw their time away from serving clients.

SUD services: Added to the agenda. MDHHS was seeking guidance on how the RFP's view of SUD services and network management. CMHSPs reiterated that the Poleski language gave CMHSPs or a CMHSP entity that role and only those bodies. The PIHPs underscored that the RFP did not clearly outline the mechanics of SUD system management.

Roles and responsibilities of PIHP v CMHSP: Was not addressed in the CMHSP session. The PIHPs underscored that the code-defined roles of the state's CMHSPs must be distinguished from the PIHP Medicaid managed care functions.

Recipient Rights: Added to the agenda. CMHSPs underscores the uniquely strong Recipient Rights system in Michigan and its direct link to the CMHSPs holding the contract with the provider network is key to making the RR system work.

Provider Network and Contracting: CMHSPs underscored that the network/contract management by CMHSPs is key to ensuring a strong system, with CMHSPs as the necessary hub/glue/support structure to hold the local service delivery system together.

Medicaid cuts: CMHSPs underscored the need for MDHHS and the CMHSPs to work closely together to respond to and address the impact of the federal Medicaid cuts.

Additional comments: CMHSPs and PIHPs indicated that they hope that these sessions are only the beginning of a longer and more in-depth discussion around system strengthening and improvement. CMHSPs and PIHPs underscored that a regular and collaborative problem-solving dialogue, between MDHHS and the state's CMHSPs and PIHPs, is a far more effective approach to system improvement than one-time discussions and bid out approach. These dialogues could also be used to focus the joint work of MDHHS, PIHPs, and CMHSPs upon a few key system improvements, rather than a large number of uncoordinated and, at times, contradictory, new initiatives.

PIHPs indicated that the public nature of the state's PIHPs and CMHSPs is a benefit to collaboratively building a stronger system

CMHSPs asked for the plans, by MDHHS, in the near and longer term. MDHHS told the CMHSPs that they could not share this information and that their future plans are still being developed. PIHPs underscored that the lack of certainty around the Department's next steps makes planning, by the PIHP system, nearly impossible.

Comments by Elizabeth Hertel: Director Hertel, at the CMHSP session: She appreciated the comments of the CMHSPs on the call. She indicated that she heard that many think that MDHHS has not partnered with the CMHSPs and PIHPs. However, she indicated that she thinks that a partnership exists and that MDHHS is always willing to hear from the state's CMHSPs and PIHPs. Director Hertel did not make a closing comment in the PIHP meeting.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan

Protecting Rural Access to Behavioral Health Services
Proposed FY27 Budget Boilerplate

The Rural and Frontier Caucus of the Community Mental Health Association of Michigan (CMHA) is proposing the attached boilerplate language for the FY27 budget. This proposal ensures that rural communities are defined consistently across all programs administered and/or funded (either directly or via a pass through/fiduciary arrangement) by the Michigan Department of Health and Human Services (MDHHS), recognizes the unique challenges faced by frontier areas, and establishes a structured process for rural consultation on policies that affect access to care.

The Challenge:

- Rural communities are often defined inconsistently, which can affect eligibility for funding, grants, and program participation.
- Rural communities are often consulted late or not at all, limiting opportunities to address unintended impacts on rural service delivery.
- Rural and frontier communities face structural barriers such as workforce shortages, long travel distances, and limited provider networks that must be recognized in program design.

What the Proposed Boilerplate Language Does:

1. **Protect Access to Behavioral Health Services in Rural and Frontier Communities**
    - Rural and frontier counties face persistent barriers to behavioral health access, including limited workforce availability, long travel distances, and transportation challenges.
    - CMHSPs and other rural providers must organize services around these realities. When definitions of “rural” change across programs, it disrupts planning and can affect access to funding and program eligibility.
    - Stable policy definitions and predictable program rules are necessary to support workforce recruitment, service placement, and transportation solutions.

2. **Establish a Clear and Consistent Definition of Rural**
    - MDHHS programs currently rely on multiple and sometimes conflicting definitions of “rural,” creating uncertainty for counties and providers trying to plan services and access funding opportunities.
    - The proposed boilerplate establishes a single statewide framework for defining rural, partially rural, and frontier areas, based on the U.S. Department of Agriculture’s Frontier and Remote Area (FAR) methodology.
    - A consistent definition promotes fairness, transparency, and predictable policy implementation across department programs

3. **Ensure Rural Communities Have a Voice in State Policy Decisions**
    - State policy changes related to Medicaid, behavioral health delivery, and program funding can have unintended consequences for rural communities.
    - The proposed language establishes a Rural Consultation Caucus to ensure that rural counties, providers, and residents have a formal opportunity to provide input before major policy decisions are finalized.
    - Early consultation improves policy outcomes and helps the department identify rural implementation challenges before policies are adopted.

Why It Matters:

Consistent definitions and meaningful consultation help ensure that rural communities are treated fairly across state programs and that policies affecting access to care reflect the realities of rural service delivery.

Proposed FY 2027 MDHHS Budget Boilerplate
Standard Definition of Rural

Sec. XXXX. To assist in providing policy-relevant information about conditions in sparsely-settled, remote areas of the Michigan, the following has been established to use a single definition of rural, partial rural, and frontier that is applied consistently across all department programs for the purposes of administering and implementing department programs, services, grants, and policies.

(1) For purposes of this section, the department's standard definition of rural and frontier shall be based upon the U.S. Department of Agriculture's Economic Research Service Frontier and Remote Area Codes.

(2) The department may designate counties as rural, partially rural, or frontier counties for purposes of program eligibility, service delivery, funding flexibility, or policy implementation based on the following criterial in (3), (4), or (5).

(3) The department shall designate counties that meet the criteria described in this section as rural counties for department programming purposes if the county meets one or more of the following criteria:

- **(a)** Frontier and Remote Area (FAR) Level One - consist of rural areas up to 50,000 people that are 60 minutes or more driving time from an urban area of 50,000 or more people.
- **(b)** Frontier and Remote Area (FAR) Level Two - consist of rural areas up to 25,000 people that are 45 minutes or more driving time from an urban area of 25,000-49,999 people and 60 minutes or more from an urban area of 50,000 or more people.

(4) The department may designate counties as partially rural if those counties include census tracts meeting the following criteria:

- **(a)** Census tracts located within metropolitan counties that are designated with Rural-Urban Commuting Area (RUCA) codes 4 through 10.
- **(b)** Census tracts located within metropolitan counties that are at least 400 square miles in area, have a population density of 35 or fewer persons per square mile, and are designated with RUCA codes 2 or 3.
- **(c)** Census tracts located within metropolitan counties that are designated as Rural-Rural Strong (RRS) level 5, have RUCA codes 2 or 3, and are at least 20 square miles in area.

(5) The department shall designate counties that meet the criteria described in this section as frontier counties for department programming purposes if the county meets one or more of the following criteria:

- **(a)** Frontier and Remote Area (FAR) Level Three - consist of rural areas and urban areas up to 10,000 people that are: 30 minutes or more from an urban area of 10,000-24,999; 45 minutes or more from an urban area of 25,000-49,999 people; and 60 minutes or more from an urban area of 50,000 or more people.
- **(b)** Frontier and Remote Area (FAR) Level Four - consist of rural areas that are: 15 minutes or more from an urban area of 2,500-9,999 people; 30 minutes or more from an urban area of 10,000-24,999 people; 45 minutes or more from an urban area of 25,000-49,999 people; and 60 minutes or more from an urban area of 50,000 or more people.

(6) The department shall apply the standard definition established under this section consistently across department programs to the extent practicable, except where a different definition of rural is required by federal law or regulation.

(7) To ensure meaningful and ongoing consultation with rural communities regarding Medicaid and other department programs, the department shall establish a Rural Consultation Caucus.

(8) The Rural Consultation Caucus shall include:

- **(a)** One representative appointed by each county designated as rural.
- **(b)** A proportional number of representatives from partially rural and frontier counties.
- **(c)** Representatives of rural health providers, rural community mental health authorities, and other rural-serving organizations identified by the department.
- **(d)** Up to four at-large members representing rural consumers, families, or caregivers.
- **(e)** Legislators representing rural districts may participate in an advisory capacity.

(9) The department shall engage in consultation with the Rural Consultation Caucus before proposing, adopting, amending, or implementing any policy, state plan amendment, waiver, operational change, funding methodology, or administrative action that has a substantial effect on rural access, service availability, financing, or delivery.

(10) Consultation under this section shall include:

- **(a)** Written notice of the proposed action provided at least 60 days before finalizing or submitting the proposal, including a summary of the proposed action and its expected impact on rural communities.
- **(b)** A minimum of one scheduled consultation meeting, virtual or in person, at which department officials with decision-making authority are present.
- **(c)** Opportunities for written and verbal comment from caucus members.
- **(d)** A written departmental response summarizing rural input and explaining how such input was incorporated or the reasons for declining specific recommendations.

(11) When federal requirements or urgent circumstances do not permit a 60-day notice period, the department may initiate an expedited consultation process, with consultation occurring within 21 days of notice.

(12) The department shall maintain written records of all consultation activities conducted under this section, including notices, meeting summaries, written comments, and the department’s responses.

(13) The department shall report to the senate and house appropriations subcommittees on health and human services no later than March 1, 2027, on the implementation of the standard rural definition, including a list of counties designated as rural, partially rural, or frontier.

HOUSE BILL NO. 4536

June 03, 2025, Introduced by Reps. Rheingans, Coffia, Price, Byrnes, Mortan, Eegela, Tsernoglou, Breen, Young, Wilson, and MacDonnell and referred to Committee on Communications and Technology.

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
(MCL 500.100 to 500.8302) by adding section 3406ss.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 **Sec. 3406ss. An insurer that delivers, issues for delivery, or**
2 **renews in this state a health insurance policy shall not deny,**
3 **modify, or delay a claim based on a review using artificial**
4 **intelligence.**

FINAL PAGE

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Bulletin Number: MMP 26-01

Distribution: All Providers, Medicaid Health Plans, Prepaid Inpatient Health Plans, Community Mental Health Services Programs

Issued: March 18, 2026

Subject: Medicaid Health Plan (MHP) Provider Mental Health Assessment Requirements for Comprehensive Health Care Program (CHCP) Enrollees

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

This policy establishes standardized mental health assessment requirements for mental health providers who serve beneficiaries enrolled in a MHP. Standardizing and strengthening these requirements will support an ongoing transition to a more transparent, consistent, and person-centered mental health coverage for MHP enrollees as part of the Michigan Department of Health and Human Services (MDHHS) Mental Health Framework Initiative. The information in this bulletin is effective for dates of services on and after October 1, 2025.

I. General Information

Providers who serve MHP enrollees and whose scope of practice includes assessment of mental health need are to begin incorporating the required standardized assessments into their practice as of October 1, 2025. These standardized assessment tools, the Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener or Level of Care Utilization System (LOCUS), will help determine the MHP enrollee's level of mental health need. In the future, information obtained from the assessments will more clearly determine which payer (i.e., the enrollee's MHP or Prepaid Inpatient Health Plan [PIHP]) is responsible for their mental health coverage and related services. In support of these new requirements, MDHHS has issued a corresponding Standardized Mental Health Assessment Guide that describes expectations around timeliness of assessment, reassessment, and documentation. A copy of the guide is available on the MDHHS website at www.michigan.gov/mdhhs/mihealthylife >> Mental Health Framework.

Providers are not required to complete a standardized assessment before delivering mental health treatment services to an enrollee. In many cases, treatment services may be rendered concurrently with conducting a standardized assessment of mental health needs. Enrollees newly seeking mental health services should be assessed using the MichiCANS

Screener or LOCUS when initially presenting for mental health services. Assessments should not be completed during a crisis.

Standardized assessments alone cannot be used to determine, limit, or restrict the amount, scope, or duration of services. Providers must continue to follow the requirements for services as outlined in the MDHHS Medicaid Provider Manual.

II. Assessment Tools

The following assessment tools must be incorporated into the assessment and reassessment process for all enrollees who are seeking mental health supports and services from a qualified provider. These assessments will be conducted upon initial mental health service use, with reassessment required every 12 months or more frequently upon change in condition (e.g., due to a significant change in life circumstances, a behavioral health event, and/or a change in the level of behavioral health care needed according to the beneficiary's provider). Providers should use clinical judgment to determine when a reassessment is necessary to ensure care remains appropriate and responsive to evolving needs. Assessments should not be completed during a crisis.

A. Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener

The MichiCANS Screener is the standardized mental health assessment tool for all infants, toddlers, children, youth, and young adults ages birth to 18. The MichiCANS Screener is a Michigan-specific version of the Child and Adolescent Needs and Strengths (CANS) tool, a comprehensive information integration tool for use with infants, toddlers, children, youth and young adults, designed to summarize and organize information gathered from assessments and other sources. Additional information about the MichiCANS Screener, including training resources and reference guides, can be found on the MDHHS website at www.michigan.gov/mdhhs/mihealthylife >> Mental Health Framework.

B. Level of Care Utilization System (LOCUS)

LOCUS is the state-designated tool required for assessing the level of mental health need for enrollees aged 18 and older. LOCUS is a multi-dimensional assessment instrument used to determine the appropriate level of care for adults with mental health needs or co-occurring mental health and substance use disorder-related needs. More information on LOCUS can be found in the Standardized Mental Health Assessment Guide available at www.michigan.gov/mdhhs/mihealthylife >> Mental Health Framework.

III. Allowable Providers

A. Enrollable Providers

LOCUS and MichiCANS Screener assessments must be completed by a Medicaid-enrolled Qualified Mental Health Professional (QMHP), Child Mental Health

Professional (CMHP), or Qualified Intellectual Disability Professional (QIDP) whose scope of practice includes assessment of mental health need. QMHPs are individuals who have specialized training or one year of experience in treating or working with a person who has mental illness. CMHPs are individuals who are trained and have one year of experience in the examination, evaluation, and treatment of minors and their families. QIDPs are individuals who have specialized training or one year of experience in treating or working with a person who has an intellectual disability. Allowable QMHPs, CMHPs, and QIDPs include the following licensed practitioners:

- Physician
- Psychiatrist
- Nurse Practitioner
- Physician's Assistant
- Licensed or Limited Licensed Psychologist/Clinical Psychologist
- Licensed or Limited Licensed Master's Level Social Worker
- Licensed or Limited Licensed Professional Counselor
- Licensed or Limited Licensed Marriage and Family Therapist

Evidence of specialized training would include fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience. The time spent in fieldwork or internship can be counted toward the one-year experience requirement and must be documented by the student's supervisor or the program's coordinator for fieldwork/internships.

Limited licensed providers may only perform assessment services under the supervision of a fully licensed provider of the same profession. Supervision for limited licensed providers is defined by Section 333.16109 of the Public Health Code when required. Master's Level Limited Licensed Psychologists are excluded from supervision requirements when employed by certain organizations as specified within Section 333.18223 of the Public Health Code (Act 368 of 1978). MHP network limited licensed providers performing assessments are required to be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) on the date of service reported on the claim but are not eligible to be directly reimbursed. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter; Non-Physician Behavioral Health Appendix of the MDHHS Medicaid Provider Manual for complete billing information.)

All services performed by an assessment provider must be in compliance with the provider enrollment agreement, MHP contracts, Medicaid policies, and all applicable county, state, and federal laws and regulations governing the delivery of health care services.

B. Bachelor's Level Providers

For mental health assessments paid for by MHPs for Medicaid enrollees, non-licensed bachelor's level providers may assist in conducting assessments if they meet the following conditions:

- The assistance must occur under the licensure and supervision of an allowable MHP provider (see section III. Allowable Providers) as defined in this Bulletin.
- Both the bachelor's level provider and the supervising provider have completed the required MichiCANS Screener or LOCUS standardized mental health assessment training and passed the corresponding certification exams.
- The MichiCANS Screener and LOCUS assessments will be entered and billed to the MHP under the supervising provider. The supervising provider's National Provider Identifier (NPI) must be listed as the rendering/attending (based on the billing format) provider on the claim.
- The supervising provider must be the one to request access to the CareConnect360 (MichiCANS Screener) platform and the webpage housing the LOCUS tool.

C. PIHP Providers

If a PIHP is paying for the mental health assessment for Medicaid enrollees seeking specialty behavioral health services (including those enrolled in a MHP), the current PIHP requirements (i.e. allowable provider types, Medicaid enrollment requirements, assessment requirements, and billing instructions) remain unchanged. PIHP network providers serving a MHP enrollee, including non-licensed bachelor's level providers who qualify as a QMHP, CMHP, or QIDP as defined in this Bulletin, should continue their current assessment processes. Providers should refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the MDHHS Medicaid Provider Manual and the Behavioral Health Code charts and Provider Qualifications document located on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Behavioral Health/Substance Abuse for additional information.

IV. Training

Prior to performing and billing for LOCUS and MichiCANS Screener assessments, QMHPs, CMHPs, and QIDPs must complete an MDHHS training program and pass the associated certification tests. (Refer to the Standardized Mental Health Assessment Guide available at www.michigan.gov/mdhhs/mihealthylife >> Mental Health Framework for complete training details.)

Organizations have discretion to determine which individual providers should complete the MichiCANS Screener or LOCUS trainings. Enrollees seeking mental health services from the organization will receive a standardized assessment from a trained provider upon initial mental health service use (if the enrollee does not already have a valid assessment on file

in the Community Health Automated Medicaid Processing System [CHAMPS]), and every 12 months thereafter or upon change in condition. MDHHS encourages all practices to maximize the number of providers trained in order to minimize enrollee disruption and ensure that assessments are conducted by providers who know and consistently work with an enrollee.

V. Billing Guidelines and Reimbursement Considerations

A. MHP Enrollees

MHPs or PIHPs will reimburse enrolled eligible providers for LOCUS and MichiCANS Screener assessments provided to MHP enrollees. Assessment services for MHP enrollees should be reported with the following Healthcare Common Procedure Coding System (HCPCS) codes and modifiers:

Assessment Type	Procedure Code	Modifier
MichiCANS Screener	H0002	7Y
LOCUS	H0031	WX

The MHP is responsible for outpatient mental health services provided in other office or clinic-based settings to enrollees with mild to moderate mental illness or whose severity has not yet been determined. These services include necessary screening. Refer to Beneficiary Eligibility subsection (General Information section) in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the MDHHS Medicaid Provider Manual for additional information regarding billing responsibility.

These procedure code and modifier combinations were established by Medicaid to represent the LOCUS/MichiCANS Screener completion. All qualified provider types should report these HCPCS codes regardless of the procedure code's national description. Clinical evaluation or other services provided to the enrollee in addition to the LOCUS/MichiCANS Screener completion may be reported and reimbursed separately. Services may be provided and reimbursed regardless of whether an assessment has been completed.

MHP-contracted providers will be reimbursed for services according to their MHP contract specified rates. MHPs will reimburse out-of-network providers at their usual and customary charges.

MHP providers should refer to the Standardized Mental Health Assessment Guide available at www.michigan.gov/mdhhs/mihealthylife >> Mental Health Framework for additional billing and reimbursement information.

B. Medicaid FFS Program Beneficiaries

MHP QMHPs, CMHPs, and QIDPs who provide mental health care services for Medicaid FFS beneficiaries are not required to perform LOCUS and MichiCANS Screener assessments for FFS beneficiaries; however, providers may choose to perform these assessments for FFS beneficiaries.

All mental health assessment services, including LOCUS and MichiCANS Screener completion, should be billed to Medicaid FFS using a psychiatric diagnostic evaluation or other applicable behavioral screening and testing procedure code represented by an American Medical Association (AMA) HCPCS Level I code. Modifiers WX or 7Y should not be reported. Providers will be reimbursed according to the practitioner or non-physician behavioral health provider (as applicable) Michigan Medicaid fee schedule published at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information.

C. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tribal Health Center (THC) and Tribal FQHC Providers

QMHPs, CMHPs, and QIDPs providing services within a FQHC, RHC, THC, or Tribal FQHC must complete the LOCUS or MichiCANS Screener assessments for MHP beneficiaries who are seeking or receiving mental health supports and services from a qualifying provider. These assessments are considered a qualifying visit and will be reimbursed according to the Prospective Payment System (PPS) methodology or All-Inclusive Rate (AIR) methodology.

LOCUS/MichiCANS Screener assessment services billed by clinics should be billed on the institutional claim form using the Group/Organizational - Type 2 clinic specialty enrolled NPI. The Attending Provider field line should include an eligible Individual – Type 1 provider who is responsible for the overall care of the beneficiary at the clinic. The NPI of the provider performing the assessment at the clinic should be listed in the Other/Rendering field line (referring/rendering/ordering). (Refer to the various clinic chapters within the MDHHS Medicaid Provider Manual for complete billing instructions.)

Manual Maintenance

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

Questions

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

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

Approved

Meghan E. Groen, Chief Deputy Director
Health Services

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

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

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

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

MOTION BY DONNA NIEMAN TO APPROVE THE MINUTES OF THE FEBRUARY 11, 2026, NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

MONTHLY FINANCIALS
January 2026 Financial Report[1]

- Net Position showed a net surplus for Medicaid and HMP of $2,898,539. Carry forward was reported as $2,844,054. The total Medicaid and HMP current year surplus was reported as $5,833,593. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $26,423,682.
- Traditional Medicaid showed $77,578,883 in revenue, and $73,899,837 in expenses, resulting in a net surplus of $3,679,046. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $2,844,054.
- Healthy Michigan Plan showed $9,003,229 in revenue, and $9,692,736 in expenses, resulting in a net deficit of $689,507. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $1,113,754 in revenue, and $869,057 in expenses, resulting in a net surplus of $244,697.
- SUD showed all funding source revenue of $7,321,002 and $6,438,200 in expenses, resulting in a net surplus of $882,802. Total PA2 funds were reported as $4,766,844.

PA2/Liquor Tax was summarized as follows:

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

[1] During the meeting, Melissa indicated that expenses for Northern Lakes were overstated. A revised report was sent following the meeting. The numbers reflected in the meeting minutes are the revised figures.

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,142,821	$0	$375,976	$4,766,844

The ISF is currently funded $1.1M beyond 7.5% of the total Medicaid capitation.

It was noted that SUD revenue has declined 22.9% from the same time in FY25.

A $23.43 rate increase for BHH is expected, which will be retroactive to October 1, 2025. The rate increase will be passed onto the CMHSPs; however, the NMRE retains 10% of BHH payments for administrative overhead.

No PA2 payments have been received thus far for FY26. The Quarter 1 payments were used by the Michigan Department of Treasury to pay on debt. Quarter 2 payments are expected at the end of April. The projected PA2 revenue for FY26 of $1,847,106 will likely be reduced by at least $50K.

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE REVISED NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JANUARY 2026; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

EDIT UPDATE

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

EQI UPDATE

The NMRE received an extension from MDHHS for the FY25 EQI submission. The report is now due April 1, 2026. Discussion will occur during the April meeting. The CMHSPs' EQIs will be posted to ShareFile.

ELECTRONIC VISIT VERIFICATION (EVV)

An EVV Leads meeting is scheduled for this date. Compliance rates are being monitored and will be reviewed beginning April 1st. Adjudication is not currently tied to the HHAeX system. The state is pushing to monitor account utilization in the EVV tool (all users). A state-level workgroup has been formed to conduct field work and review potential changes to EVV processes. Bea agreed to attempt to obtain the document listing the proposed changes.

HSW OPEN SLOTS UPDATE

For March, payment was received for 673 slots which represents a slight improvement. Currently 4 of the region's 711 slots open with packets in the queue, representing 99.6% utilization (the highest in the state). The March payment included one payment/recoupment for FY25. The recoup/repay for October and November at the higher rate has not yet occurred. There has been talk of a mid-year (April) rate adjustment, but nothing official has been announced.

CHAMPS Fix HSW Update & Verification Research Project

The NMRE continues to track lost payments. Last week, the NMRE IT Department pushed out a test report in a shared Power BI environment with CMHSP representatives that have Power BI licenses. Testing will begin with North Country CMHA. Once security has been verified, the

report will be extended to the rest of the CMHSPs so long as they have Power BI viewers' licenses in Office 365.

The last report showed 7 missed payments, after the six-month window.

NMRE REVENUE & ELIGIBLES ANALYSIS

The NMRE observed a 4.7% decrease in eligibles between DAB, TANF, and HMP. The FY26 budget was prepared using September eligibles and FY26 rates, trending flat. Deanna recommended that the CMHSPs follow their PM/PM and budget accordingly. Overall, February revenue (all funding sources) was $460K lower than September 2025.

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

DAB			
	October 2023	February 2026	% Change
Revenue	$10,003,003	$11,132,438	11.29%
Enrollees	28,444	25,097	-11.77%
Average Payment per Enrollee	$352	$444	26.13%

HMP			
	October 2023	February 2026	% Change
Revenue	$2,369,569	$2,224,704	-6.11%
Enrollees	47,550	28,441	-40.19%
Average Payment per Enrollee	$50	$78	56.97%

TANF			
	October 2023	February 2026	% Change
Revenue	$2,865,200	$2,784,283	-2.82%
Enrollees	66,801	50,723	-24.07%
Average Payment per Enrollee	$43	$55	27.98

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

HSW			
	October 2023	February 2026	% Change
Revenue	$4,638,399	$4,965,922	7.06%
Enrollees	650	688	5.85%
Average Payment per Enrollee	$7,136	$7,218	1.15%

DRAFT

SED			
	October 2023	February 2026	% Change
Revenue	$40,846	$28,787	-29.52%
Enrollees	21	39	85.71%
Average Payment per Enrollee*	$1,945	$738	-62.05%

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

TOTAL			
	October 2023	February 2026	% Change
	$19,953,899	$21,167,753	6.08%

Clarification was made that the November HSW payment included prior year retroactivity totaling $616K and the January HSW payment included prior year retroactivity totaling $136K.

FY25 FSR
The FY25 FSR was submitted by the March 2nd due date. A revised Final Report will be submitted once a final report is received from Northern Lakes. Currently, the region has a $2.8M surplus from FY25. Lynda thanked Deanna and Donna for working with Northern Lakes and supporting its cleanup efforts.

REGIONAL TRAINING
The NMRE has purchased training credits to be used by staff from the NMRE and its five Member CMHSPs for the past several years. Current training funds are low. New Horizons offers a 100% match so long as the purchase price is larger than the previous amount. The NMRE is requesting training credits totaling $30,000 for a total of $60,000 training credits to be used regionwide. Brian requested a utilization report for North Country. Brandon agreed to send the utilization report to all five CMHSPs.

MOTION BY CONNIE CADARETTE TO RECOMMEND APPROVAL OF THE PURCHASE OF NEW HORIZONS TRAINING CREDITS IN THE AMOUNT OF THIRTY THOUSAND DOLLARS ($30,000.00); SUPPORT BY DONNA NIEMAN. MOTION CARRIED.

REGIONAL POWER BI
This topic was discussed under HSW Update.

NEXT MEETING
The next meeting was scheduled for April 15th at 10:00AM.

Because the May 13th meeting takes place during the Improving Outcomes Conference, the start time was moved to 9:00AM.

DRAFT

Chief Executive Officer Report

March 2026

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

Feb 20: Met with MDHHS Children's Division about Intensive Crisis Services.

Feb 23: Met with CMHAM and legal regarding potential next steps if RFP is issued.

March 3: Attended and participated in PIHP CEO Group.

March 5: Attended and participated in NMRE Internal Operations Committee Meeting.

March 10: Attended and participated in CMHAM System Guidance Group.

March 11: Attended NMRE Regional Finance Committee Meeting.

March 12: Met with legal regarding Region 10 et a.l regarding lawsuit.

March 17: Chaired NMRE Regional Operations Meeting.

March 18: Attended and participated in CMHAM System Guidance Group.

March 19: Attended and participated in NMRE Operations Meeting.

January 2026

Finance Report v2

January 2026 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	3,679,046	2,844,054	13,519,285
Healthy Michigan	(689,507)	-	7,070,804
	$ 2,989,539	$ 2,844,054	$ 20,590,089

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	(39,521)	703,422	(1,531,804)	933,836	1,357,466	1,106,090	460,051	$ 2,989,539
Carry Forward		-	-	-	-	-	-	2,844,054
Total Med/HMP Current Year Surplus	(39,521)	703,422	(1,531,804)	933,836	1,357,466	1,106,090	460,051	$ 5,833,593
Medicaid & HMP Internal Service Fund								20,590,089
Total Medicaid & HMP Net Surplus								$ 26,423,682

Northern Michigan Regional Entity

Funding Source Report - PIHP
Mental Health
October 1, 2025 through January 31, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 76,064,849	$ 1,514,034						$ 77,578,883
CMHSP Distributions	(74,603,847)		24,046,381	20,247,850	12,318,901	11,410,959	6,579,756	(0)
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	1,461,002	1,514,034	24,046,381	20,247,850	12,318,901	11,410,959	6,579,756	77,578,883
Expense								
PIHP Admin	1,143,670	16,927						1,160,598
PIHP SUD Admin		39,031						39,031
SUD Access Center		-						-
Insurance Provider Assessment	467,508	7,280						474,788
Hospital Rate Adjuster	-							-
Services	-	1,053,410	24,711,000	19,147,600	11,076,686	10,208,747	6,027,978	72,225,421
Total expense	1,611,178	1,116,648	24,711,000	19,147,600	11,076,686	10,208,747	6,027,978	73,899,837
Net Actual Surplus (Deficit)	$ (150,176)	$ 397,386	$ (664,619)	$ 1,100,250	$ 1,242,215	$ 1,202,212	$ 551,778	$ 3,679,046

Notes

Medicaid ISF - $13,519,285 - based on current FSR

Medicaid Savings - $2,844,054

Northern Michigan Regional Entity

Funding Source Report - PIHP
Mental Health
October 1, 2025 through January 31, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 5,852,302	$ 3,150,927						$ 9,003,229
CMHSP Distributions	(5,587,435)		2,039,991	1,587,666	719,625	754,423	485,731	-
1st/3rd Party receipts				-	-	-	-	-
Net revenue	264,867	3,150,927	2,039,991	1,587,666	719,625	754,423	485,731	9,003,229
Expense								
PIHP Admin	107,561	43,131						150,691
PIHP SUD Admin		99,449						99,449
SUD Access Center		-						-
Insurance Provider Assessment	46,651	18,234						64,885
Hospital Rate Adjuster	-							-
Services	-	2,684,077	2,907,176	1,754,080	604,374	850,545	577,458	9,377,710
Total expense	154,212	2,844,891	2,907,176	1,754,080	604,374	850,545	577,458	9,692,736
Net Surplus (Deficit)	$ 110,655	$ 306,036	$ (867,185)	$ (166,414)	$ 115,251	$ (96,122)	$ (91,727)	$ (689,507)

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

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	$ (39,521)	$ 703,422	$ (1,531,804)	$ 933,836	$ 1,357,466	$ 1,106,090	$ 460,051	$ 2,989,539
Medicaid/HMP Carry Forward								2,844,054
Total Med/HMP Current Year Surplus								$ 5,833,593
Medicaid & HMP ISF - based on current FSR								20,590,089
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								$ 26,423,682

Northern Michigan Regional Entity

Funding Source Report - PIHP
Mental Health
October 1, 2025 through January 31, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 451,122		125,296	132,316	166,711	61,069	177,240	$ 1,113,754
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	451,122	-	125,296	132,316	166,711	61,069	177,240	1,113,754
Expense								
PIHP Admin	13,507							13,507
BHH Admin	14,977							14,977
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	177,941		125,296	132,316	166,711	61,069	177,240	840,573
Total expense	206,425	-	125,296	132,316	166,711	61,069	177,240	869,057
Net Surplus (Deficit)	$ 244,697	$ -	$ -	$ -	$ -	$ -	$ -	$ 244,697

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2025 through January 31, 2026

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,514,034	$ 3,150,927	$ 1,416,369	$ 863,697	$ 375,975	$ 7,321,002
Expense						
PIHP Admin						84,475
SUD Admin						270,305
Administration	55,958	142,580	60,744	95,498		354,780
OHH Admin			32,733	-		32,733
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	7,280	18,234	-			25,514
Services:						
Treatment	1,053,410	2,684,077	1,143,513	508,186	375,975	5,765,161
Prevention	-	-	-	260,012	-	260,012
Healing and Recovery Grant				-		-
Alcohol Use Disorder Services				-		
ARPA Grant	-	-	-	-	-	-
Total expense	1,116,648	2,844,891	1,236,990	863,697	375,975	6,438,200
PA2 Redirect			-	-		-
Net Surplus (Deficit)	$ 397,386	$ 306,036	$ 179,379	$ -	$ -	$ 882,802

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of
Revenues, Expenses, and Unspent Funds
October 1, 2025 through January 31, 2026

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 76,064,849	$ 1,514,034	$ -	$ 77,578,883
Medicaid Savings	-	-	-	-
Healthy Michigan	5,852,302	3,150,927	-	9,003,229
Healthy Michigan Savings	-	-	-	-
Health Home	1,113,754	-	-	1,113,754
Opioid Health Home	-	1,416,369	-	1,416,369
Substance Use Disorder Block Grant	-	863,697	-	863,697
Public Act 2 (Liquor tax)	-	375,975	-	375,975
Affiliate local drawdown	148,704	-	-	148,704
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	-	-	-
Healing & Recovery Revenue	-	-	-	-
Veteran Navigator Grant	45,307	-	-	45,307
SOR Grant Revenue	-	506,226	-	506,226
Gambling Grant Revenue	-	54,471	-	54,471
Other Revenue	70	-	1,356	1,426
Total operating revenue	83,224,986	7,881,699	1,356	91,108,041
Operating expenses				
General Administration	1,349,213	270,305	-	1,619,518
Prevention Administration	-	42,791	-	42,791
OHH Administration	-	32,733	-	32,733
BHH Administration	14,977	-	-	14,977
Insurance Provider Assessment	514,159	25,514	-	539,673
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	71,172,011	1,053,410	-	72,225,421
Healthy Michigan Services	6,693,633	2,684,077	-	9,377,710
Health Home Services	840,573	-	-	840,573
Opioid Health Home Services	-	1,143,513	-	1,143,513
Community Grant	-	508,186	-	508,186
Prevention	-	217,221	-	217,221
State Disability Assistance	-	-	-	-
Alcohol Use Disorder Services	-	-	-	-
ARPA Grant	-	-	-	-
Public Act 2 (Liquor tax)	-	375,976	-	375,976
Local PBIP	-	-	-	-
Local Match Drawdown	148,704	-	-	148,704
Miscellanous Grant	-	-	-	-
Healing & Recovery Grant	-	-	-	-
Veteran Navigator Grant	45,307	-	-	45,307
SOR Grant Expenses	-	506,226	-	506,226
Gambling Grant Expenses	-	54,471	-	54,471
Total operating expenses	80,778,577	6,914,423	-	87,693,000
CY Unspent funds	2,446,409	967,276	1,356	3,415,041
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	10,733,799	10,929,769	20,586,761	42,250,329
Unspent funds - ending	$ 13,180,208	$ 11,897,045	$ 20,588,117	$ 45,665,370

Northern Michigan Regional Entity

Statement of Net Position

January 31, 2026

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 45,086,502	$ 10,954,472	$ 20,588,117	$ 76,629,091
Accounts Receivable	3,746,997	2,150,018	-	5,897,015
Prepaids	29,988	-	-	29,988
Total current assets	48,863,487	13,104,490	20,588,117	82,556,094
Noncurrent Assets				
Capital assets	377,692	-	-	377,692
Total Assets	49,241,179	13,104,490	20,588,117	82,933,786
Liabilities				
Current liabilities				
Accounts payable	35,831,284	1,207,445	-	37,038,729
Accrued liabilities	229,687	-	-	229,687
Unearned revenue	-	-	-	-
Total current liabilities	36,060,971	1,207,445	-	37,268,416
Unspent funds	$ 13,180,208	$ 11,897,045	$ 20,588,117	$ 45,665,370

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2025 through January 31, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 229,702,368	$ 76,567,456	$ 76,064,849	$ (502,607)	(0.66%)
Carryover	4,449,500	1,483,167	-	(1,483,167)	(1)
Healthy Michigan					
Capitation	17,969,268	5,989,756	5,852,302	(137,454)	(2.29%)
Carryover	-	-	-	-	0.00%
Health Home	2,844,551	948,184	1,113,754	165,570	17.46%
Affiliate local drawdown	594,816	148,704	148,704	-	0.00%
Performance Bonus Incentive	2,184,505	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	36,668	45,307	8,639	23.56%
Other Revenue	-	-	70	70	0.00%
Total operating revenue	257,855,008	85,173,934	83,224,986	(1,948,948)	(2.29%)
Operating expenses					
General Administration	4,481,376	1,429,141	1,349,213	79,928	5.59%
Health Home Administration	-	-	14,977	(14,977)	0.00%
Insurance Provider Assessment	2,038,488	679,496	514,159	165,337	24.33%
Hospital Rate Adjuster	7,687,213	2,562,404	-	2,562,404	100.00%
Local PBIP	2,184,505	-	-	-	0.00%
Local Match Drawdown	594,816	148,704	148,704	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	135,336	37,740	45,307	(7,567)	(20.05%)
Payments to Affiliates:					
Medicaid Services	218,897,134	72,965,711	71,172,011	1,793,700	2.46%
Healthy Michigan Services	15,738,212	5,246,071	6,693,633	(1,447,562)	(27.59%)
Health Home Services	2,844,551	948,184	840,573	107,611	11.35%
Total operating expenses	254,601,631	84,017,451	80,778,577	3,238,874	3.86%
CY Unspent funds	$ 3,253,377	$ 1,156,483	2,446,409	$ 1,289,926	
Transfers in			-		
Transfers out			-	80,778,577	
Unspent funds - beginning			10,733,799		
Unspent funds - ending			$ 13,180,208	2,446,409	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2025 through January 31, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 7,015,245	$ 2,338,415	$ 1,514,034	$ (824,381)	(35.25%)
Healthy Michigan	12,312,158	4,104,053	3,150,927	(953,126)	(23.22%)
Substance Use Disorder Block Grant	3,525,032	1,067,415	863,697	(203,718)	(19.09%)
Opioid Health Home	3,556,831	1,185,610	1,416,369	230,759	19.46%
Public Act 2 (Liquor tax)	1,794,486	-	375,975	375,975	0.00%
Miscellanous Grants	4,000	1,333	-	(1,333)	(100.00%)
Alcohol Disorder Grant	285,600	95,200	-	(95,200)	(100.00%)
Healing & Recovery Grant	150,000	50,000	-	(50,000)	(100.00%)
SOR Grant	1,546,979	515,660	506,226	(9,434)	(1.83%)
Gambling Prevention Grant	200,000	66,667	54,471	(12,196)	(18.29%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	30,390,331	9,424,353	7,881,699	(1,542,654)	(16.37%)
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,025,044	299,577	270,305	29,272	9.77%
Prevention Administration	143,928	47,976	42,791	5,185	10.81%
Insurance Provider Assessment	120,208	40,069	25,514	14,555	36.33%
Medicaid Services	3,700,000	1,233,333	1,053,410	179,923	14.59%
Healthy Michigan Services	8,634,200	2,878,067	2,684,077	193,990	6.74%
Community Grant	2,130,419	710,140	508,186	201,954	28.44%
Prevention	838,096	171,770	217,221	(45,451)	(26.46%)
State Disability Assistance	93,043	31,014	-	31,014	100.00%
Alcohol Use Disorder Services	285,600	95,200	-	95,200	100.00%
ARPA Grant	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	32,733	(32,733)	0.00%
Opioid Health Home Services	3,556,813	1,185,604	1,143,513	42,091	3.55%
Miscellanous Grants	4,000	1,333	-	1,333	100.00%
Healing & Recovery Grant	150,000	50,000	-	50,000	100.00%
SOR Grant	1,546,979	515,660	506,226	9,434	1.83%
Gambling Prevention	200,000	66,667	54,471	12,196	18.29%
PA2	1,794,492	-	375,976	(375,976)	0.00%
Total operating expenses	24,222,822	7,326,410	6,914,423	411,987	5.62%
CY Unspent funds	$ 6,167,509	$ 2,097,942	967,276	$ (1,130,666)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			10,929,769		
Unspent funds - ending			$ 11,897,045		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

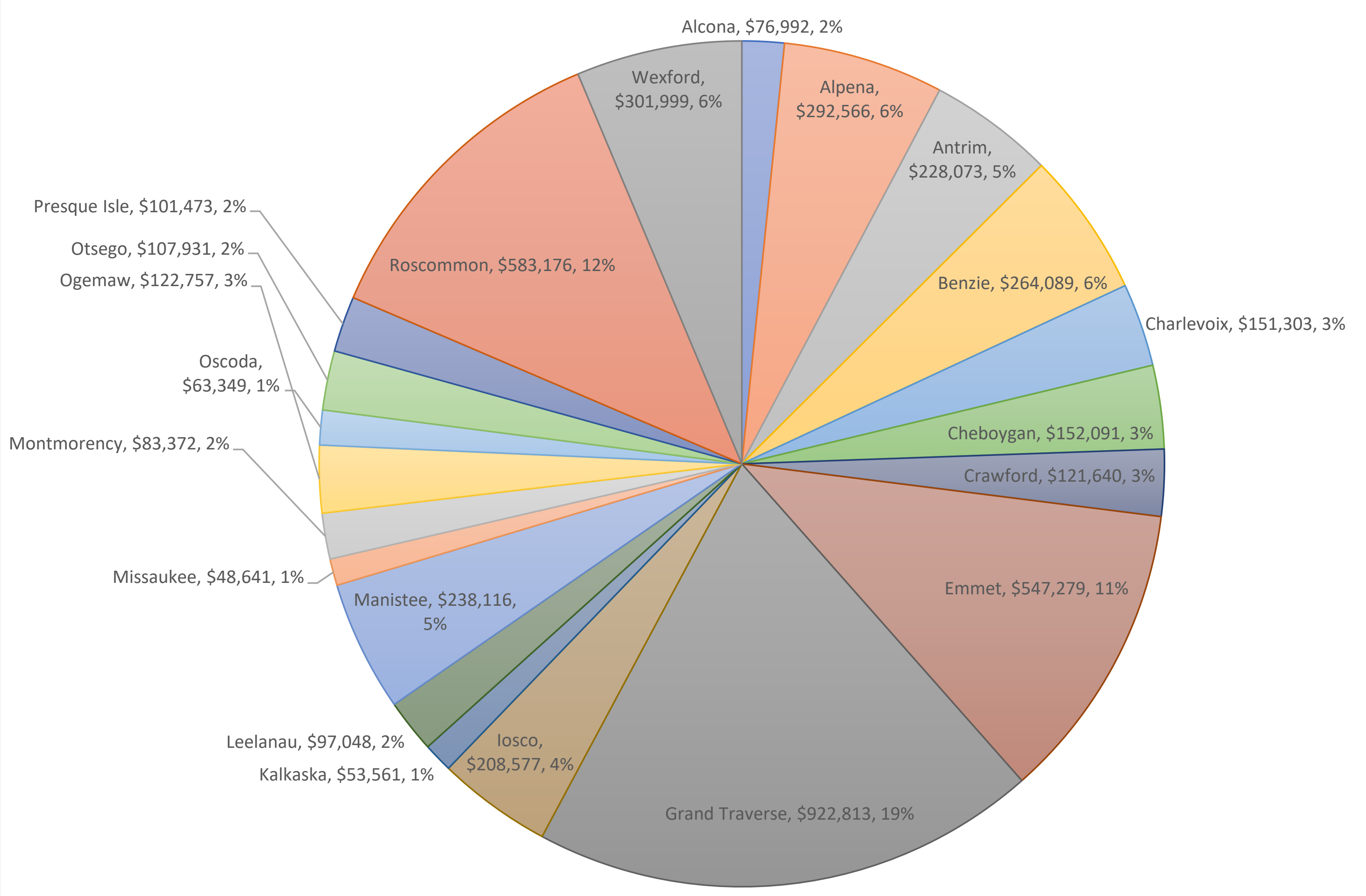
Budget to Actual - Mental Health Administration
October 1, 2025 through January 31, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 2,442,372	$ 814,124	$ 701,428	$ 112,696	13.84%
Fringes	768,300	251,116	223,879	27,237	10.85%
Contractual	952,800	257,935	343,015	(85,080)	(32.99%)
Board expenses	13,500	4,500	5,003	(503)	(11.18%)
Day of recovery	14,000	4,667	-	4,667	100.00%
Facilities	133,000	44,332	49,357	(5,025)	(11.33%)
Other	157,404	52,468	26,531	25,937	49.43%
Total General Admin	$ 4,481,376	$ 1,429,141	$ 1,349,213	$ 79,928	5.59%

Northern Michigan Regional Entity

Schedule of PA2 by County
October 1, 2025 through January 31, 2026

	Projected FY26 Activity				Actual FY26 Activity			
	Beginning Balance	FY26 Projected Revenue	FY26 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects (Actual Expenditures by County)	Region Wide Projects by Population (Actual Expenditures by County)	Ending Balance
County								
Alcona	$ 79,981	$ 23,013	$ 24,001	$ 78,993	$ -	2,988	$ -	$ 76,992
Alpena	315,893	81,249	87,854	309,288	-	23,327	-	292,566
Antrim	248,419	71,430	46,424	273,425	-	20,346	-	228,073
Benzie	276,050	64,021	47,793	292,278	-	11,961	-	264,089
Charlevoix	180,985	106,977	92,341	195,621	-	29,682	-	151,303
Cheboygan	161,840	85,508	81,361	165,987	-	9,749	-	152,091
Crawford	127,739	36,205	33,849	130,095	-	6,099	-	121,640
Emmet	574,150	182,951	332,159	424,942	-	26,871	-	547,279
Grand Traverse	1,037,930	464,163	698,152	803,941	-	115,117	-	922,813
Iosco	217,704	84,319	66,511	235,512	-	9,127	-	208,577
Kalkaska	53,910	41,796	3,936	91,770	-	349	-	53,561
Leelanau	109,318	63,811	44,237	128,892	-	12,270	-	97,048
Manistee	250,862	82,480	40,719	292,623	-	12,747	-	238,116
Missaukee	48,934	22,352	7,175	64,112	-	293	-	48,641
Montmorency	85,825	30,318	14,262	101,881	-	2,453	-	83,372
Ogemaw	123,674	68,787	26,413	166,049	-	917	-	122,757
Oscoda	65,547	21,668	17,149	70,065	-	2,198	-	63,349
Otsego	135,933	105,067	111,286	129,714	-	28,002	-	107,931
Presque Isle	104,871	24,977	20,080	109,768	-	3,398	-	101,473
Roscommon	613,562	87,317	130,060	570,820	-	30,387	-	583,176
Wexford	329,692	98,696	145,681	282,707	-	27,693	-	301,999
	5,142,821	1,847,106	2,071,443	4,918,483	-	375,976	-	4,766,844
PA2 Redirect								-
								4,766,844


PA2 FUND BALANCES BY COUNTY
Alcona, $76,992, 2%
Alpena, $292,566, 6%
Antrim, $228,073, 5%
Benzie, $264,089, 6%
Charlevoix, $151,303, 3%
Cheboygan, $152,091, 3%
Crawford, $121,640, 3%
Emmet, $547,279, 11%
Grand Traverse, $922,813, 19%
Iosco, $208,577, 4%
Kalkaska, $53,561, 1%
Leelanau, $97,048, 2%
Manistee, $238,116, 5%
Missaukee, $48,641, 1%
Montmorency, $83,372, 2%
Oscoda, $63,349, 1%
Ogemaw, $122,757, 3%
Otsego, $107,931, 2%
Presque Isle, $101,473, 2%
Roscommon, $583,176, 12%
Wexford, $301,999, 6%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2025 through January 31, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 646,392	$ 215,464	$ 170,663	$ 44,801	20.79%
Fringes	227,940	75,980	56,937	19,043	25.06%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	114,000	-	32,800	(32,800)	0.00%
Board expenses	5,000	1,667	1,530	137	8.20%
Day of Recover	9,000	3,000	-	3,000	100.00%
Facilities	-	-	-	-	0.00%
Other	22,712	3,467	8,375	(4,908)	(141.59%)
Total operating expenses	$ 1,025,044	$ 299,577	$ 270,305	$ 29,272	9.77%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2025 through January 31, 2026

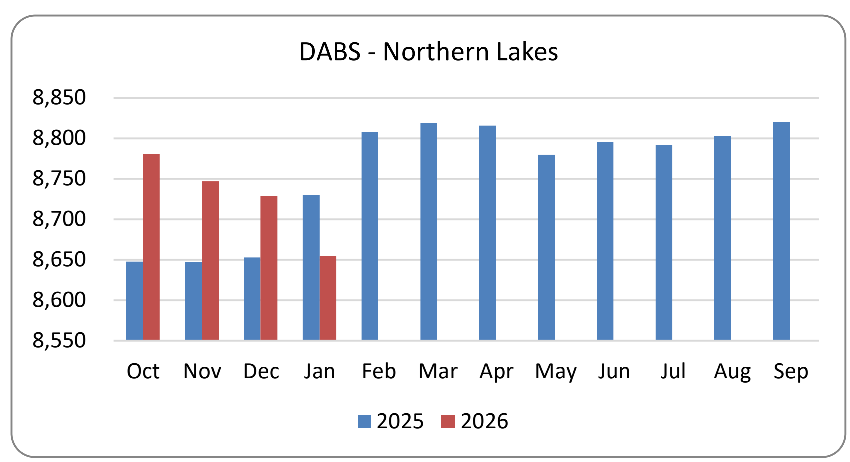
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	3,500	1,167	1,356	189	16.23%
Total operating revenue	3,500	1,167	1,356	189	16.23%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 3,500	$ 1,167	1,356	$ 189	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,586,761		
Unspent funds - ending			$ 20,588,117		

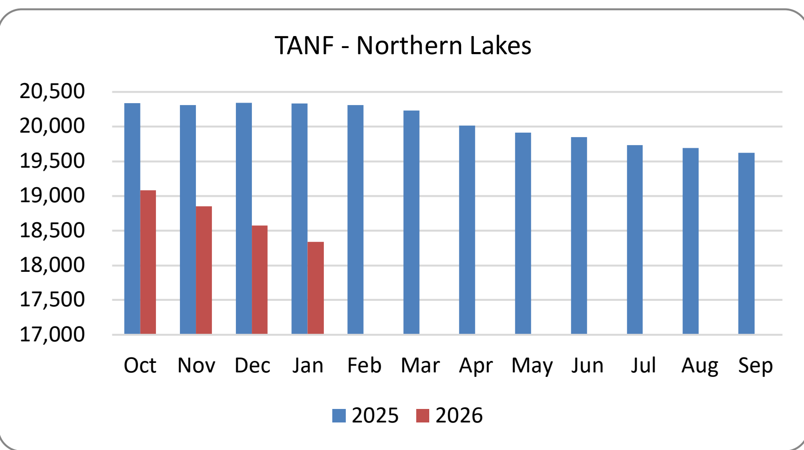
Northern Michigan Regional Entity

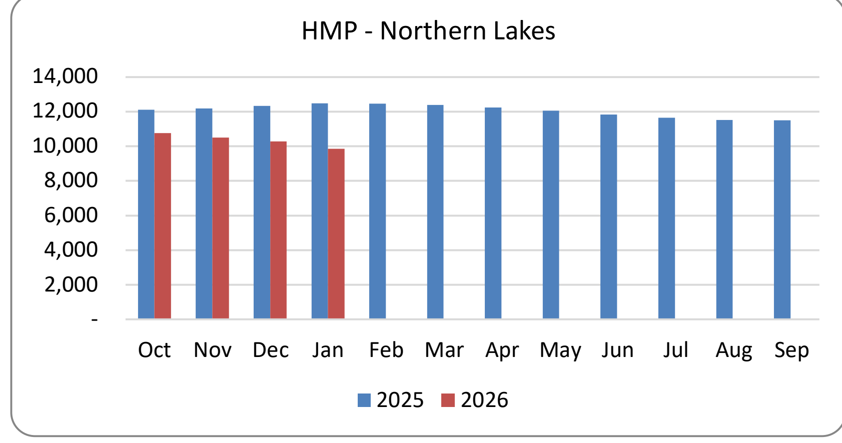
Narrative

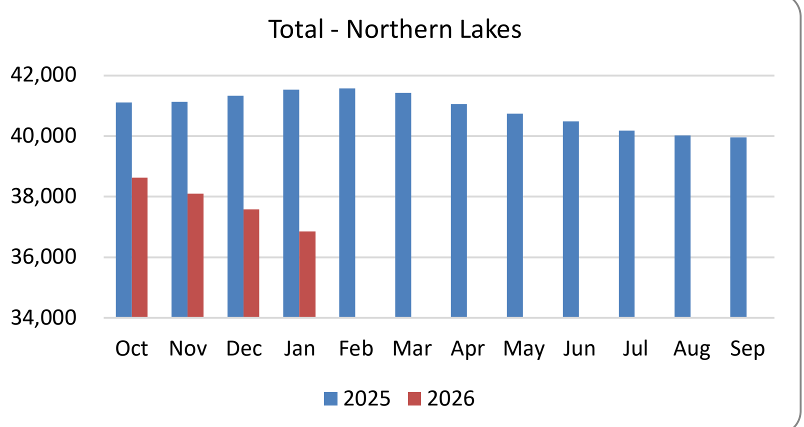
October 1, 2025 through January 31, 2026

Northern Lakes Eligible Members Trending - based on payment files







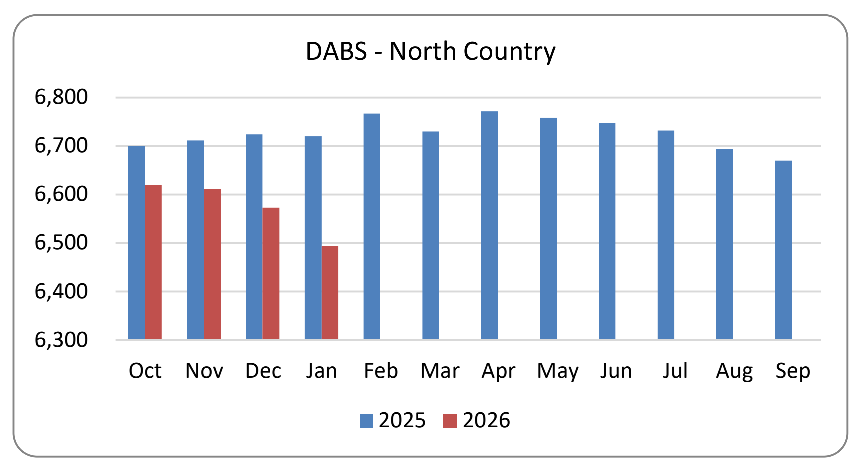


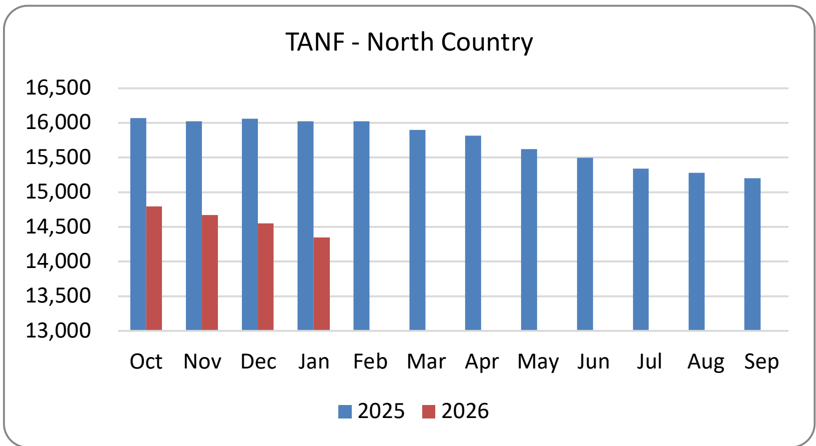
Northern Michigan Regional Entity

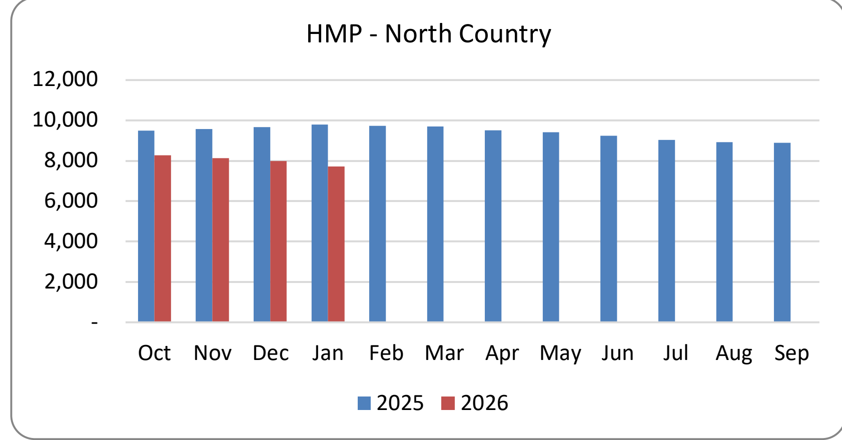
Narrative

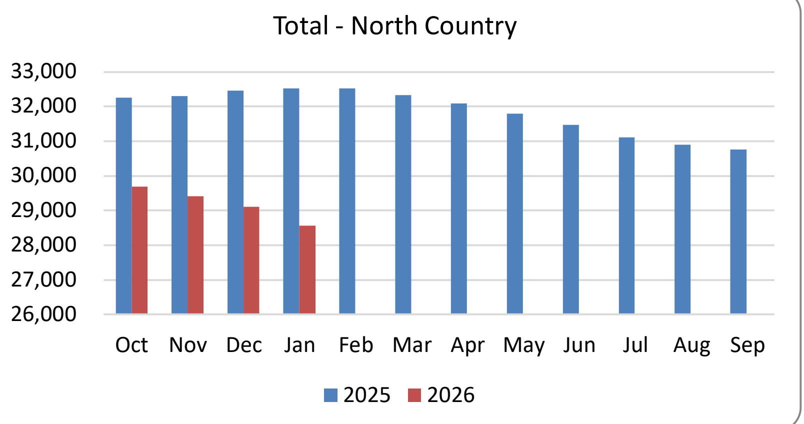
October 1, 2025 through January 31, 2026

North Country Eligible Members Trending - based on payment files







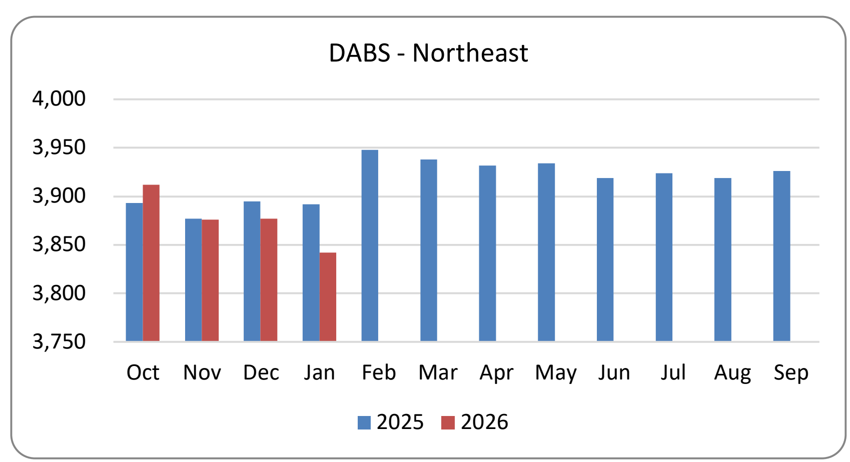


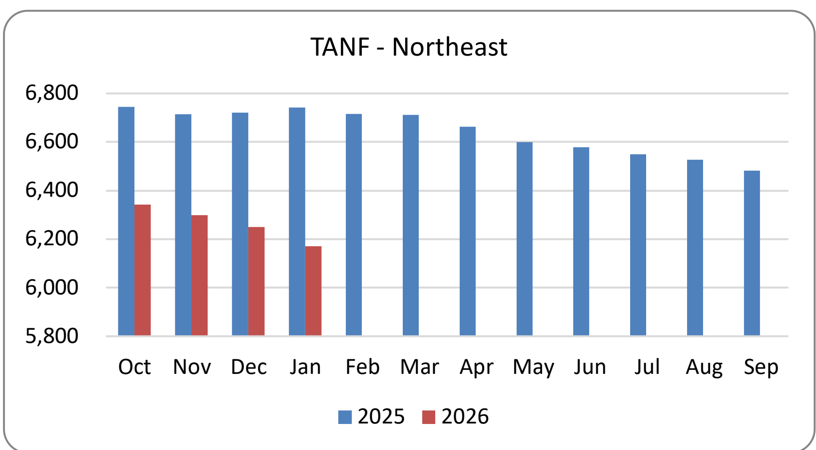
Northern Michigan Regional Entity

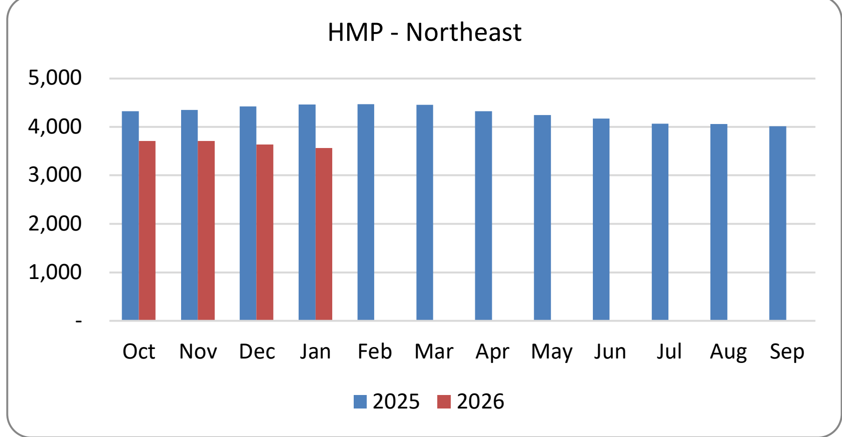
Narrative

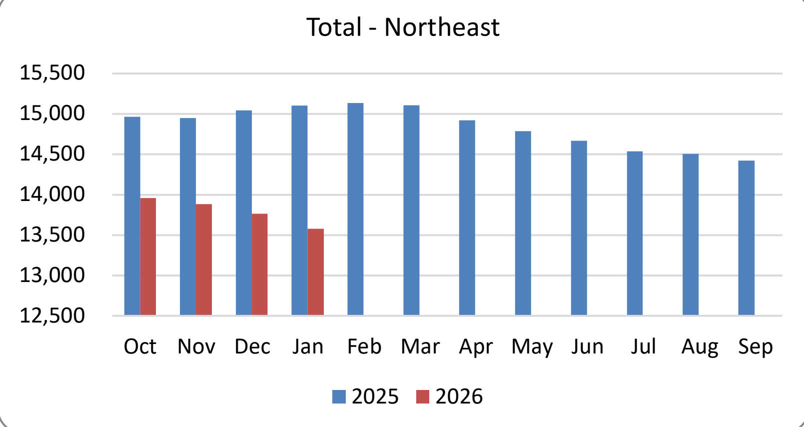
October 1, 2025 through January 31, 2026

Northeast Eligible Members Trending - based on payment files





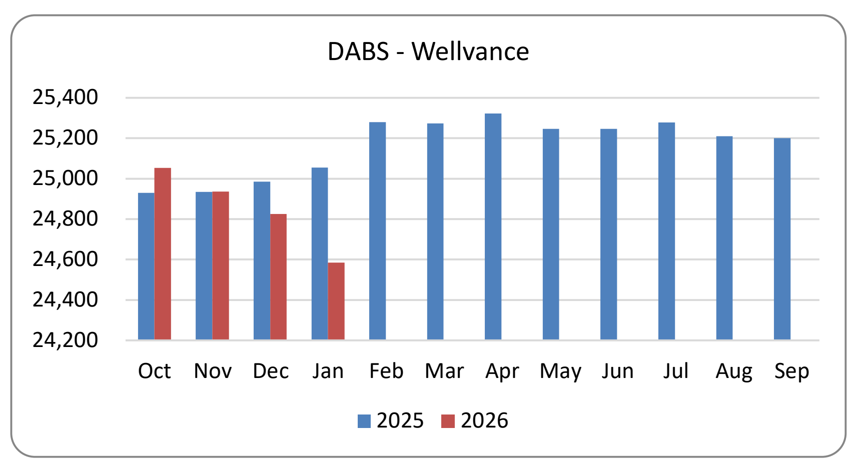


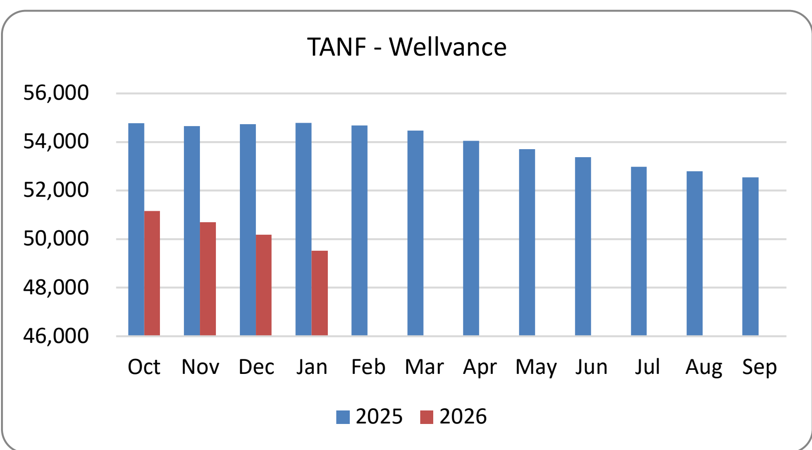


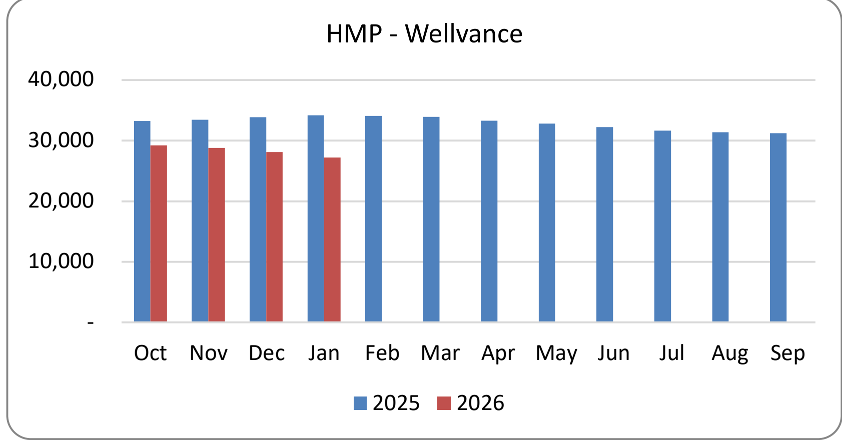
Northern Michigan Regional Entity

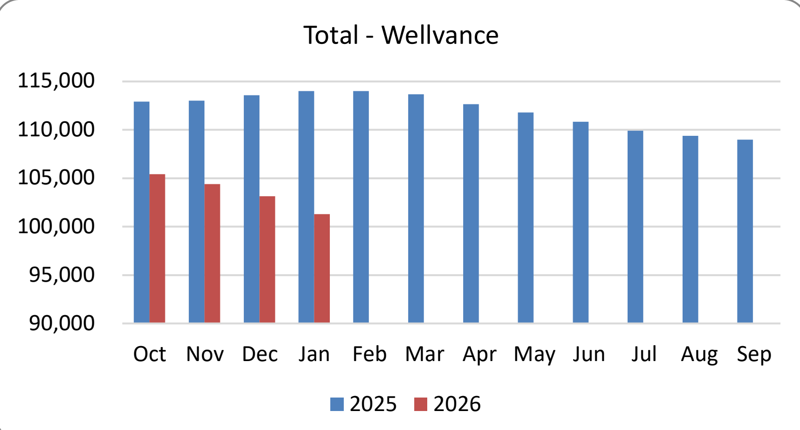
Narrative
October 1, 2025 through January 31, 2026

Wellvance Eligible Members Trending - based on payment files





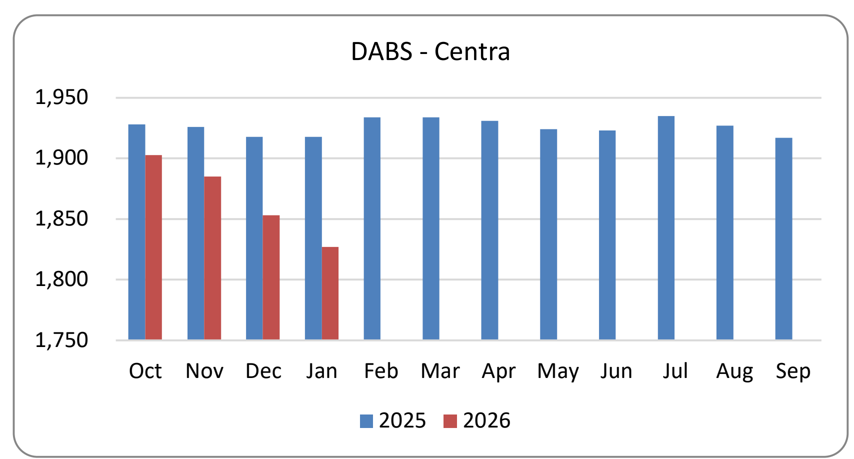


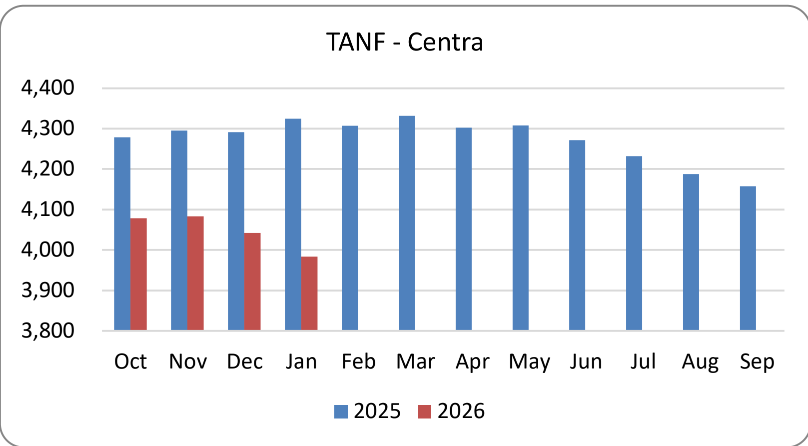


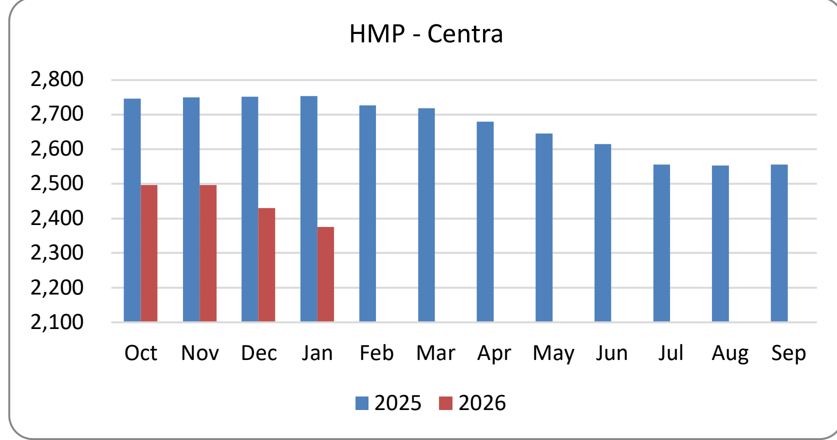
Northern Michigan Regional Entity

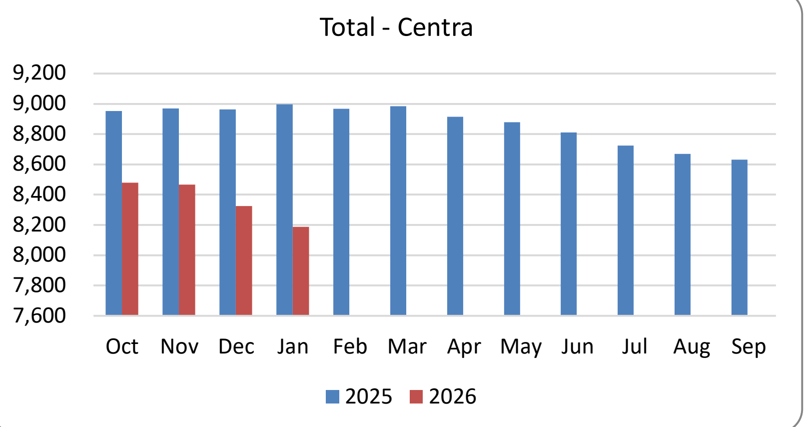
Narrative
October 1, 2025 through January 31, 2026

Centra Wellness Eligible Members Trending - based on payment files







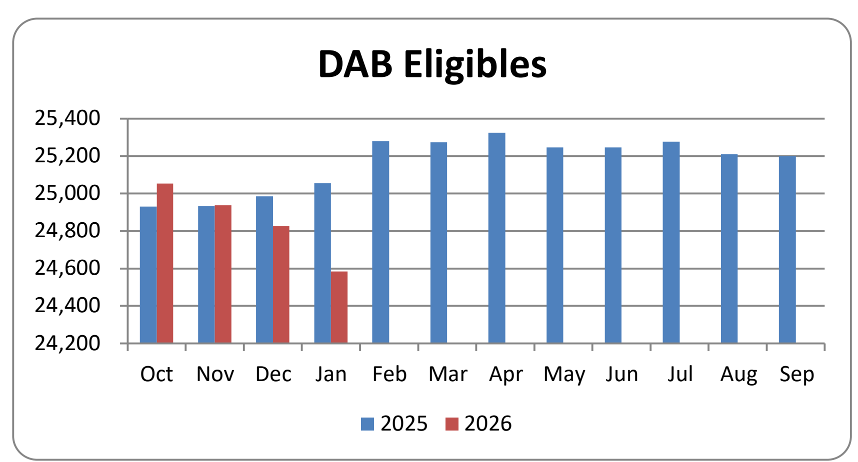


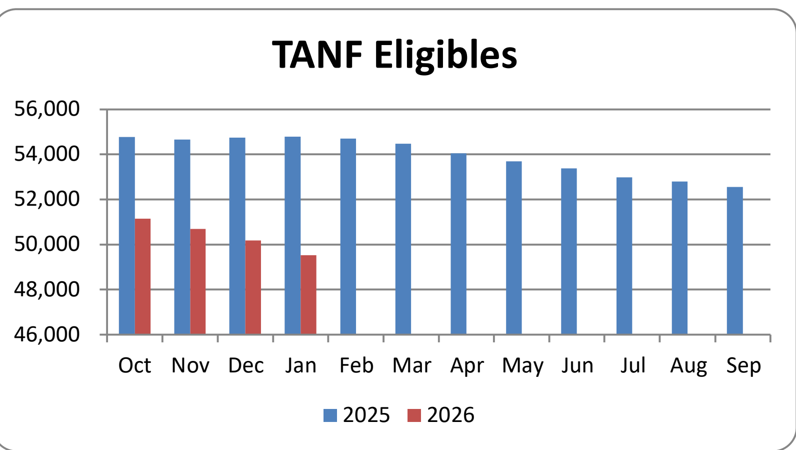
Northern Michigan Regional Entity

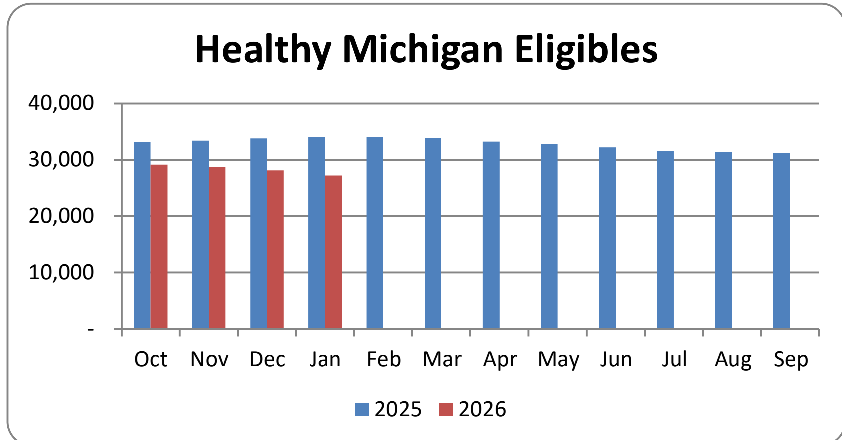
Narrative

October 1, 2025 through January 31, 2026

Regional Eligible Trending





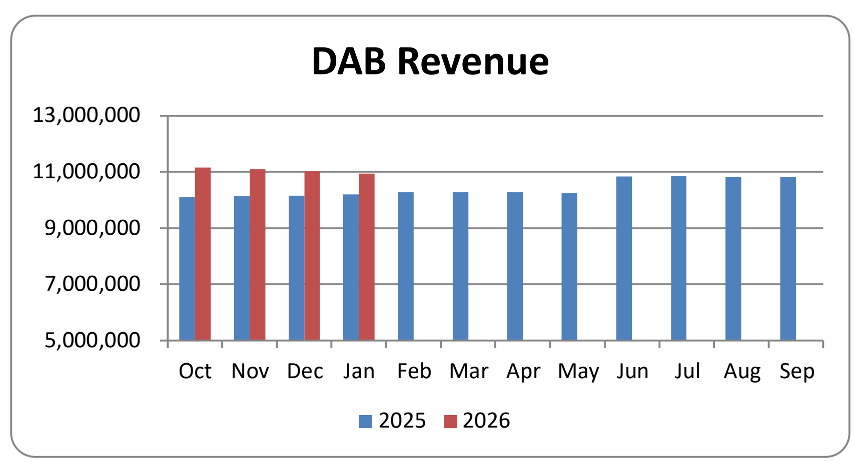


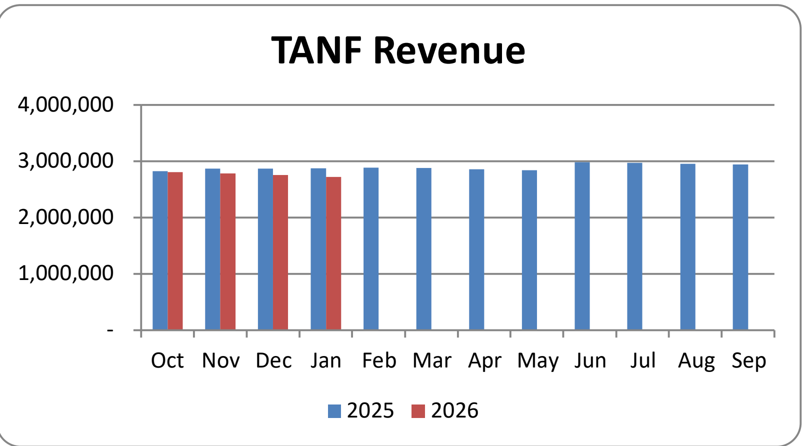
Northern Michigan Regional Entity

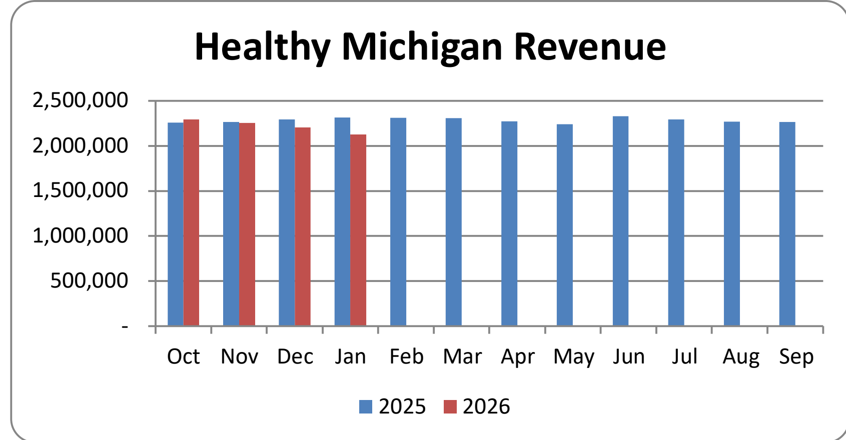
Narrative

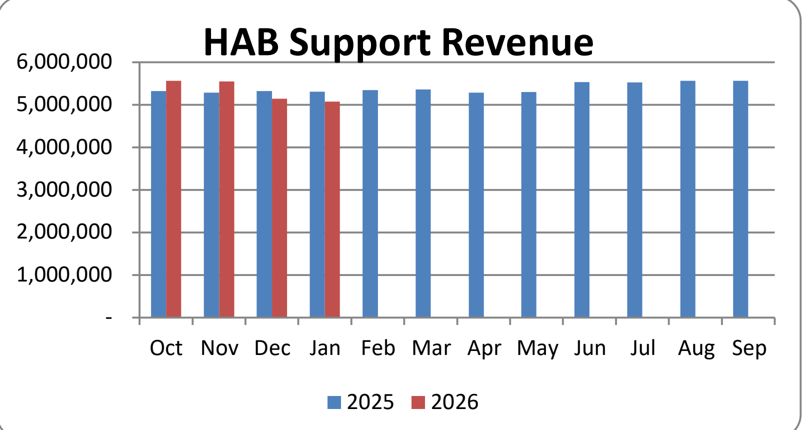
October 1, 2025 through January 31, 2026

Regional Revenue Trending









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

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

REVIEW OF AGENDA AND ADDITIONS
Ms. Zeller requested that a discussion of COFRs be added to the meeting agenda.

APPROVAL OF PREVIOUS MINUTES
The minutes from February 17th were included in the meeting materials.

MOTION BY TRISH OTREMBA TO APPROVE THE FEBRUARY 17, 2026 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY LYNDA ZELLER. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED
January 2026 Financial Report
- Net Position showed a net surplus for Medicaid and HMP of $2,898,539. Carry forward was reported as $2,844,054. The total Medicaid and HMP current year surplus was reported as $5,833,593. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $26,423,682.
- Traditional Medicaid showed $77,578,883 in revenue, and $73,899,837 in expenses, resulting in a net surplus of $3,679,046. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $2,844,054.
- Healthy Michigan Plan showed $9,003,229 in revenue, and $9,692,736 in expenses, resulting in a net deficit of $689,507. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $1,113,754 in revenue, and $869,057 in expenses, resulting in a net surplus of $244,697.
- SUD showed all funding source revenue of $7,321,002 and $6,438,200 in expenses, resulting in a net surplus of $882,802. Total PA2 funds were reported as $4,766,844.

PA2/Liquor Tax was summarized as follows:

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

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,142,821	$0	$375,976	$4,766,844

DRAFT

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

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$551,778	$1,100,250	$1,242,215	($664,619)	$1,202,212
HMP	($91,727)	($166,414)	$115,251	($867,185)	($96,122)
Total	$460,051	$933,836	$1,357,466	($1,531,804)	$1,106.090

The ISF is currently funded $1.1M beyond 7.5% of the total Medicaid capitation.

PIHPs were urged by MDHHS to make sure they are being paid for Health Homes in accordance with the six-month lookback. Ms. Yockey will be working with the NMRE IT Department on this.

No PA2 payments have been received thus far for FY26. The Quarter 1 payments were used by the Michigan Department of Treasury to pay on debt. Quarter 2 payments are expected at the end of April. The projected PA2 revenue for FY26 of $1,847,106 will likely be reduced by at least $50K.

Ms. Zeller asked whether the $7M being held in escrow for fiscal years 2023 and 2024 cost settlement (as approved by the NMRE Board on October 22, 2025) is included in the 26M surplus. Ms. Yockey replied that it is not.

Regarding Northern Lakes, clarification was made that fiscal years 2023 and 2024 are not in dispute. More discussion is needed regarding fiscal years 2020, 2021, and 2022.

MOTION BY BRIAN BABBITT TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JANUARY 2026; SUPPORT BY TRISH OTREMBA. MOTION APPROVED.

PM/PM Revenue Projections

An analysis of October 2023 – February 2026 Revenue and Eligibles was shared with Committee Members. October 2025 through January 2026 revenue looks similar to September 2025, on which the FY26 budget was based. Overall, February revenue (all funding sources) was $460K lower than September 2025. There is talk about a mid-year rate adjustment (possibly in April). There is no indication that eligibles will increase.

October – February Revenue FY25	October – February Revenue FY26	FY26 October – February Projected Revenue Based on September 2025
$97,413,552	$107,913,888	$108,142,255

Mr. Babbitt noted that North Country was paid for fewer HSW slots than usual. Ms. Yockey asked him to send the details to NMRE's Chief Information Officer and Operations Manager, Brandon Rhue, as IT is tracking missed HSW payments.

DRAFT

Ms. Yockey offered to create a 6-month PM/PM analysis by CMHSP. The NMRE observed a 4.7% decrease in eligibles between DAB, TANF, and HMP (statewide trend). Mr. Babbitt questioned the fluctuations in the DAB category as this benefit should remain relatively consistent.

The rate for HSW was lowered in December; a recoupment for the difference between the higher and lower rate will occur for October and November. Ms. Yockey encouraged the CMHSPs to take their HSW revenue and pair it with expenditures and see where they land.

Ms. Yockey mentioned that a statewide workgroup has been formed to identify PIHP responsibilities under the federal regulations and develop a standardized budget template and instructions for the entire state to use for Self Determination in the wake of the Waskul settlement.

Regional Training Request

The NMRE has purchased training credits to be used by staff from the NMRE and its five Member CMHSPs for the past several years. Current training funds are low. New Horizons offers a 100% match so long as the purchase price is larger than the previous amount. The NMRE is requesting training credits totaling $30,000 for a total of $60,000 training credits to be used regionwide. A utilization report was shared with the CMHSPs.

MOTION BY BRIAN BABBITT TO RECOMMEND APPROVAL OF THE PURCHASE OF NEW HORIZONS TRAINING CREDITS IN THE AMOUNT OF THIRTY THOUSAND DOLLARS ($30,000.00); SUPPORT BY TRISH OTREMBA. MOTION CARRIED.

BCCHPS AND ICSS MEETING

A meeting took place on February 20th with Mr. Kurtz, Megan Rooney (NorthCare Network CEO), and Patty Neitman and Phil Kurdunowicz from the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS), a division of MDHHS, to discuss matters related to Intensive Crisis Stabilization Services (ICSS) requirements in rural northern Michigan. The training, originally scheduled to take place in Traverse City, was moved to St. Ignace. Discussion then turned to the KB lawsuit, the ICSS program itself. Mr. Kurtz referred to it as a "good meeting." Ms. Rooney is drafting notes from the meeting which will be shared with the CEOs. A discrepancy between the importance of the children's and adult's ICSS was recognized. Ms. Neitman and Mr. Kurdunowicz would like to attend a future meeting of the Rural Caucus (or at least with PIHP Regions 1 and 2).

CMHAM GUIDANCE GROUP DRAFT

A document from CMHAM titled, "Recommended Core Components of a Strengthened and Improved Public Mental Health System in Michigan" dated March 12, 2026, was included in the meeting materials in draft form. The document was "designed to provide a preliminary structure around which a more robust and system redesign effort would be built, collectively by representatives from MDHHS, NAMI-Michigan, Arc-Michigan, persons served, the Michigan Association of Counties (MAC), and the Community Mental Health Association of Michigan (CMHA)" in response to the ruling from Judge Yates on the lawsuits related to the RFP to

procure the state's PIHPs. Mr. Kurtz, Mr. Johnston, and Mr. Babbitt were part of the workgroup that authored the document.

The document addresses the following areas:
A) Defining nature and roles of Michigan's Medicaid behavioral health plans and CMHSPs
B) Aligning governance with three distinct sets of stakeholders
C) Financing model, risk sharing, and ability build risk reserves
D) Uniformity when uniformity improves care and fosters administrative efficiency and retains local control and community- and person- specific variance
E) Partnership relationship between Medicaid behavioral health plans, CMHSP, and providers in the networks of the health plans and CMHSPs

MENTAL HEALTH FRAMEWORK
MDHHS has apparently contracted with Manatt (out of California) to do the policy work for the Mental Health Framework. This group was also used in the development of Conflict-Free Access and Planning (CFAP) protocols.

EVIDENCE-BASED PRACTICES
The five CMHSP CEOs held a retreat on March 5th and 6th, with Mr. Kurtz joining on day two. Ms. Sork stated that this is the last year for the Last year for Behavioral Health Endowment grants. Concept papers are due March 30th. Grant applications are due June 1st.

Northeast Michigan staff have begun collecting a list of colleges and universities in the state that have MSW programs to reach out regarding internships and employment opportunities.

Ms. Sork asked whether there are any regional initiatives that could be funded with the grant. Ms. Zeller suggested looking at the Behavioral Health Home model versus the Certified Behavioral Health Clinics (CCBH) or mobile intensive services models versus Assertive Community Treatment (ACT). The CMHSPs and the NMRE supported the use of grant funds to look at the benefits of BHH over CCHBC. Mr. Kurtz suggested also including SUD Health Homes. Ms. Zeller suggested the following language: "PIHP leadership will work with its providers and nonprofits to build a case for SUD as well." The determination was made for Northeast Michigan to complete the application with the support and involvement of the NMRE and the other regional CMHSPs. Ms. Sork will reach out to the CMHSPs for input when she is drafting the concept paper.

BRIDGE HEALTH
Mr. Kurtz had a conversation with attorney Chris Ryan (Taft, Stettinius & Hollister) regarding the strategy of the Plaintiffs moving forward with the lawsuit against the State of Michigan, MDHHS, and Elizabeth Hertel (Case #24-000198-MZ) related to the FY25 contract as some of the issues have been partially resolved (Waskul, CCBHCs).

There have been many failed attempts to bring MDHHS and the Attorney General's office together to discuss the 7.5% ISF cap. Mr. Kurtz will consult with Ms. Rooney and share any communication with the CEOs for input prior to sending it to MDHHS.

DRAFT

RURAL CAUCUS/RURAL DEFINITIONS
Language is being proposed by Matt Maskart (Pathways Community Mental Health) and Alan Bolter CMHAM) to redefine "rural" using one statewide definition. Mr. Kurtz acknowledged that the timing is not great.

COFRs
While assisting Northern Lakes CMHA with its financial accounts, Centra Wellness' CFO, Donna Nieman, discovered that Northern Lakes approaches in-region COFR arrangements differently than Centra Wellness. Since the NMRE cost-settles with the CMHSPs, for Medicaid, an in-region CMHSP provides and pays for services for individuals whose county of financial responsibility is in another in-region CMHSPs service area without a COFR agreement (with the exception of inpatient hospitalizations). Ms. Otremba noted that problems arise because the CMHSPs all have different rates. Mr. Babbitt added that, if external contractors are involved, they are typically paid by the CMHSP, which is the county of responsibility. Ms. Otremba offered to revisit Wellvance's financial arrangements with the other CMHSPs.

CMHSP UPDATES
North Country has hired a traditional recruiter to search for a Licensed Behavioral Analyst (LBA).

Wellvance's CARF accreditation has been delayed until May/June due to auditors' schedules. Wellvance is also in discussions with the Iosco County Jail about a grant opportunity for treatment services.

OTHER
Ms. Otremba announced that she will be on vacation until March 30th.

Mr. Johnston announced his retirement effective October 1st.

Mr. Babbitt noted that he registered for the rural health conference at the end of April.

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

DRAFT

NMRE BOARD OFFICERS

May 26, 2021 Election of Officers
Chair – Don Tanner
Vice-Chair – Ed Ginop
Secretary – Nina Zamora
Executive Committee – Gary Nowak, Joe Stone

August 25, 2021
Secretary – Gary Nowak
Executive Committee – Mary Marois (to replace Nina Zamora)

April 27, 2022 Election of Officers
Chair – Don Tanner
Vice-Chair – Ed Ginop
Secretary – Gary Nowak
Executive Committee – Mary Marois, Joe Stone

September 28, 2022
Executive Committee – Jay O'Farrell (to replace Joe Stone)

May 24, 2023 Election of Officers
Chair – Don Tanner
Vice-Chair – Ed Ginop
Secretary – Gary Nowak
Executive Committee – Jay O'Farrell and Ruth Pilon

April 24, 2024 Election of Officers
Chair – Gary Klacking
Vice-Chair – Don Tanner
Secretary – Karla Sherman
Executive Committee – Eric Lawson and Ruth Pilon

April 23, 2025 Election of Officers
Chair – Gary Klacking
Vice-Chair – Don Tanner
Secretary – Karla Sherman
Executive Committee – Eric Lawson and Ruth Pilon

Gary Klacking resigned from the Board on January 5, 2026 at which time, Don Tanner assumed the role of Chair. Karla Sherman retired from the Board on August 12, 2025. Ruth Pilon was elected as Secretary on January 28, 2026. Eric Lawson was named Vice-Chair on January 28, 2026. Chuck Varner was named to the Executive Committee on January 28, 2026.

March 25, 2026 Election of Officers

NMRE Bylaws, Article VI – Officers of the Governing Board, Section 6.5, Term of Office

Each officer shall hold office for a term of one (1) year. Officers may serve a maximum of three (3) consecutive years. Upon the completion of his/her tennis the Chair's replacement shall be appointed from another Member's appointee to the Governing Board, to allow for an equitable rotation of the Chair positions amongst the Members.

Former Board Chairs

Joe Stone (AV): April 2013 – April 2016
Dennis Priess (NC): April 2016 – April 2017
Randy Kamps (NL): April 2017 – May 2020
Gary Nowak (NEM): May 2020 – May 2021
Don Tanner (CWN): May 2021 – April 2024
Gary Klacking (AV): April 2024 – January 2026

Karen Forester | Enterprise Account Manager | karen.forester@educate360.com
March 11, 2026

Brandon Rhue | Chief Information Officer & Operations Director
Northern Michigan Regional Entity

This Order Agreement ("Agreement") is between New Horizons Learning, LLC, and its subsidiaries ("New Horizons"), a Delaware limited liability company and Northern Michigan Regional Entity ("Purchaser") (together, the "Parties").
Thank you for your partnership with New Horizons. We appreciate the opportunity to support your organization's training and development needs. This pricing is valid until March 31, 2026.

Program Details

A more agile, skilled, and future-ready organization starts with the right training, when and where you need it. With New Horizons' Learning Credit Program, you can secure your training budget upfront and allocate it throughout the year based on employee needs, new business priorities, or strategic integrations. Our flexible credit system gives you access to training across project management, leadership, and technology- the three pillars of long-term success.

Learning Credits can be used to meet the needs of each learner on your team. Whether enrolling into one of the hundreds of classes on our public schedule; to purchase an e-learning library or to fund a dedicated team training event, you are in control of how your credits are used.

Learning Credit Investment and Subsidy Information

Number of Learning Credits Purchased	30,000
Subsidy %	100
Number of Subsidy Credits Provided	30,000
Total Number of Learning Credits on Account	60,000
Total Invoice Amount	$30,000

Comments

Policies

New Horizons Purchase Policies ("Policies"), as revised or amended from time-to-time, are incorporated into this Order Agreement and any other purchase documents. The Policies are located at https://educate360.com/policies/ and Customer acknowledges receipt, review and acceptance of all Policies.

- All sales are final.
- Invoices are sent at the time of signature of this agreement and payment terms are Net-30.
- Sales tax will be added to the invoice, where required by law.
- All Learning Credits expire one year from the date of the invoice.
- All delivery must be completed by the expiration date.
- For every one dollar invested by the customer, the customer purchases one Learning Credit.
- Each subsidy Learning Credit provided is also worth one Learning Credit.
- Customer Learning Credits will be utilized prior to utilizing any Subsidy Credits.
- All solutions are deducted from Learning Credits at retail rates for all eligible classes and products.
- Learning Credits can be used for enrollments into our public course schedule, dedicated delivery of our courses, and consulting services. A complete list of eligible products can be found on our website at www.educate360.com/eligible.
- Products found on our website, but not listed as eligible, can also be funded with Learning Credits. These products will be deducted at retail, plus an amount equal to the percentage of the subsidy. (Ex. e-learning libraries, practice exams, assessments, and exam vouchers.)
- All exam vouchers must be requested by the expiration date.
- This agreement confirms that the signer has read and agrees to comply with the policies and terms information located on all pages of this document, is authorized to sign on behalf of the Customer and that no other terms written or verbal are valid.

Customer to complete the billing information below:

Accounts Payable Contact

Company Name	Billing Contact Name	Billing Email Address
Northern Michigan Regional Entity	Brandon Rhue	brhue@nmre.org
Billing Phone Number	**Billing Address**	**Billing City, State Zip Code**
231-383-6557	1999 Walden Dr	Gaylord, MI 49735
Additional Billing Notes (if applicable)		

Method of Payment

☐	**Credit Card**	The payment link will be sent with the invoice.
☐	**Purchase Order**	Please include a copy of the Purchase Order.
☐	**ACH or Wire**	Banking Information can be requested from your Account Executive.
☐	**Invoice**	Invoice sent via email. Net-30 Payment Terms from the date of invoice.

Please send purchase documentation and signed agreement to Educate 360 representative's email address listed on cover page.

Customer Acceptance and Approval to Invoice

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

Acceptance and Approval

Approval:	[signature]	**Date:**	03/11/2-26

General Terms and Conditions

1. **Scope.** These Terms apply to your purchase and use of New Horizons Learning, LLC ("New Horizons") training products and services ("Licensed Materials"). They are part of any order, proposal, or other ordering document ("Agreement") you sign with New Horizons.
2. **License & Term.** New Horizons gives you a limited, non-transferable license to use the Licensed Materials for your organization's internal training during the period stated in your order. A "User" is anyone you've paid for and authorized to access the Licensed Materials.
3. **Fees & Payment.**
   a. You must pay all fees listed in your Agreement before using the Licensed Materials unless stated otherwise.
   b. These do not include taxes. You are responsible for those.
   c. Fees are non-refundable unless stated otherwise.
   d. If you fail to pay, New Horizons may suspend your access to Licensed Materials.
4. **Customer Responsibilities**.
   You must not:
   a. Sell, share, or transfer the Licensed Materials without permission.
   b. Copy, alter, or use them to compete with New Horizons.
   c. Use them for illegal, harmful, or offensive purposes.
   d. Interfere with or hack New Horizons' systems or introduce viruses.
   You are responsible for:
   e. Ensuring your Users employ and use the Licensed Materials in conformity with the Agreement and these terms.
   f. Protecting and keeping passwords secure.

   g. Ensuring your systems are safe and compatible with Licensed Materials.
   h. Compliance with all applicable laws.
5. **E360's Responsibilities**. New Horizons will provide access to the Licensed Materials as stated in your ordering document.
6. **Ownership**. Unless otherwise stated in the ordering document, the Licensed Materials remain the property of New Horizons. You may not copy, reverse-engineer, or share them with third parties. When your license ends, you must stop using the Licensed Materials and delete all copies.
7. **Changes to Licensed Materials**. Without reducing overall quality, New Horizons may update, modify, or discontinue some Licensed Materials at any time without liability.
8. **No Warranties**. The Licensed Materials are provided "as-is." New Horizons does not guarantee the Licensed Materials will always work without error.
9. **Limitation of Liability**. New Horizons' total liability is capped at the fees you paid in the three months prior to the event giving rise to your claim.
10. **Indemnification**. You agree to indemnify New Horizons from all claims, damages, or costs (including reasonable attorneys' fees) arising from the breach of the Agreement and these terms, or the unauthorized use of the License Materials.
11. **Confidential Information**. Both parties must use reasonable care to protect the other's confidential information and only share it when legally required or after obtaining written permission from the other party. Confidential information includes, but is not limited to, proprietary materials, technology, customer information, product information, and other information of a proprietary nature.
12. **Non-Solicitation**. You may not hire or try to hire employees or contractors of New Horizons during the term of your Agreement and for 12 months after your Agreement ends unless you obtain prior written permission from New Horizons.
13. **Termination**. The parties may terminate the Agreement for convenience upon 30 days' written notice. Either side may terminate after 7 days' written notice of a breach the Agreement or these terms that remains uncured. Upon termination, you must return or delete all Licensed Materials and pay all outstanding invoices and costs associated with the termination.
14. **General Provisions**. You cannot transfer the Agreement without New Horizons' written consent. New Horizons may freely assign the Agreement. The Agreement and these terms are governed by the laws of Delaware and the parties consent to the exclusive jurisdiction of the state and federal courts of Delaware for any dispute arising from or relating to the Agreement or these terms. Legal notices must be in writing delivered by hand, certified mail, overnight-courier, or verifiable email. New Horizons is not responsible for delays or failures caused by events beyond its control (e.g., natural disasters, strikes, pandemics cyber-attacks, or power outages). The ordering document and these terms are the entire Agreement. Any changes must be in writing and signed. Failure to enforce a right is not a waiver. If one part of the Agreement is invalid, the other parts still apply. Payment, indemnification, and confidentiality obligations survive termination.