Northern Michigan Regional Entity

Board Meeting

August 27, 2025

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – July 23, 2025	Pages 2 – 10
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9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – August 13, 2024	Pages 62 – 64
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	c. Financial Report – June 2025	Pages 66 – 87
	d. Operations Committee Report – August 19, 2025	Pages 88 – 92
	e. NMRE SUD Oversight Board Report – Next Meeting September 8th	
11.	New Business	
	a. CMHM Special Assessment Request	Pages 93 – 99
	b. Legal Budget	
	c. UCA	Pages 100 – 109
	d. Northern Lakes Lookback	Pages 110 – 120
12.	Old Business	
	a. Northern Lakes Update	
	b. FY25 PIHP Contract Injunction and Complaint - Update	
13.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
14.	Next Meeting Date – September 24, 2025 at 10:00AM	
15.	Adjourn	

Join Microsoft Teams Meeting

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – JULY 23, 2025
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Dave Freedman, Ed Ginop, Gary Klacking, Dana Labar, Eric Lawson, Mary Marois, Michael Newman, Jay O'Farrell, Ruth Pilon, Karla Sherman, Don Smeltzer, Don Tanner**
VIRTUAL ATTENDEES:	**Karen Goodman**
ABSENT:	**Chuck Varner**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Jodie Balhorn, Carol Balousek, Brady Barnhill, Eugene Branigan, Curt Cummins, Lisa Hartley, Chip Johnston, Eric Kurtz, Brian Martinus, Brie Molaison, Diane Pelts, Nena Sork, Denise Switzer, Tricia Wurn, Deanna Yockey**
PUBLIC:	**Nate Alger, Anonymous (2), Kari Barker, Carrie Borowiak, Hannah Driver, Tiffany Fewins, Nichole Flickema, Ann Friend, Kevin Hartley, Nicole Hutchinson, Sophorn Klingelsmith, Erica Longstreet, Stacy Maiville, Greg McMorrow, Travis Merz, Susan Pulaski, Justin Reed, Abby Schonfeld, Melanie Schopieray, Lori Stendel, Sharon Vreeland, Jessica Williams**

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

ROLL CALL
Let the record show that Chuck Varner was excused from the meeting on this date. All other NMRE Board Members were in attendance either virtually or in Gaylord.

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

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

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

MOTION BY KARLA SHERMAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR JULY 23, 2025; SUPPORT BY DON SMELTZER. MOTION CARRIED.

APPROVAL OF PAST MINUTES

Let the record show that the June minutes of the NMRE Governing Board were included in the materials for the meeting on this date. Ms. Marois requested that clarification be made that her comment regarding the previous Interim CEO of Northern Lakes CMHA was her opinion alone and not that of the Northern Lakes Board.

MOTION BY ERIC LAWSON TO APPROVE THE MINUTES OF THE JUNE 25, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS AS AMENDED; SUPPORT BY DON TANNER. MOTION CARRIED WITH ONE ABSTENTION RECORDED FROM MR. FREEDMAN.

CORRESPONDENCE

1) An article by Peter Kobs from the Traverse City Record Eagle dated July 12, 2025 titled, "Milestone for Community: Mental Health Crisis Center Now Open 24/7."
2) An article by Mark Sanches from Crain's Grand Rapids Business dated July 9. 2025 titled, "Michigan Hospitals Brace for $6B in Medicaid Funding Cuts."
3) Email correspondence from Community Mental Health Association of Michigan (CMHA) CEO, Robert Sheehan, dated July 14, 2025 regarding a recent FOIA response that confirms that there is no CMS prohibition on current MDHHS sole-source contract with public PIHPs.
4) Email correspondence from CMHA CEO, Robert Sheehan, dated July 17, 2025 regarding survey responses provided in response to CMHA's FOIA request.
5) Infographic provided by CMHA titled, "What Happens If the State Privatizes Mental Health?"
6) The draft minutes of the July 9, 2025, regional Finance Committee meeting.

Mr. Kurtz drew attention to the response to CMHA's FOIA inquiry. The communication from MDHHS states, "To the best of the Department's knowledge, information, and belief, this Department does not possess or maintain records under the description you provided or by other names reasonably known to the Department**.** CMS has not required that we change or halt our sole source process."

ANNOUNCEMENTS

Let the record show that new Board Member, Dave Freedman, representing Northern Lakes CMHA was introduced. Acknowledgement was given to Diane Pelts on her last NMRE Board meeting as she will be retiring on August 1st.

PUBLIC COMMENT

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

REPORTS

Executive Committee Report

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

CEO Report

The NMRE CEO Monthly Report for June 2025 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to a meeting that occurred on July 17th with Elizabeth Hertel, Meghan Groen, and Kristen Morningstar to discuss rural issues related to the PIHP bid out. A document titled, "NorthCare and Northern Michigan Regional Entity's Follow Up Regarding

MDHHS's PIHP Proposed Bid Out," which formally requests a rural exemption for PIHP Regions 1 and 2, was distributed during the meeting.

May 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $1,866,598. Carry forward was reported as $736,656. The total Medicaid and HMP current year surplus was reported as $2,603,254. FY24 HSW revenue was reported as $1,137,411. The total Medicaid and HMP adjusted current year surplus was reported as $1,465,843. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $23,179,410.
- Traditional Medicaid showed $145,510,866 in revenue, and $141,600,288 in expenses, resulting in a net surplus of $3,910,578. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $19,385,187 in revenue, and $21,429,166 in expenses, resulting in a net deficit of $2,043,979. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $2,150,637 in revenue, and $1,722,783 in expenses, resulting in a net surplus of $377,854.
- SUD showed all funding source revenue of $18,962,214 and $14,823,574 in expenses, resulting in a net surplus of $4,138,640. Total PA2 funds were reported as $4,646,549.

PA2/Liquor Tax was summarized as follows:

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

Actual FY25 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$835,755	$954,437	$4,646,549

Pursuant to Amendment No. 3 to the PIHP Contract, MDHHS intends on recouping all payments for FY25 and repaying them at a higher rate ($161.4M statewide). This may allow the NMRE to preserve some of its ISF this year. Ms. Yockey confirmed that the higher rate was used in calculating the July payment.

It was noted that last year, the NMRE's block grant funding was overspent by $310K which had to be supplemented with liquor tax funds. This year looks much better and the NMRE is working to redirect PA2 funds to block grant funding, where it can.

MOTION BY DON TANNER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MAY 2025; SUPPORT BY JAY O'FARRELL. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

Operations Committee Report
The draft minutes from July 15, 2025 were included in the materials for the meeting on this date. The meeting focused on items related to the proposed PIHP bid out. Attorney Chris Cooke (Secrest Wardle) was invited to join the meeting to review legal options. Ms. Sherman referred to the proposed PIHP bid out as a "desperate situation for individuals served, families, and northern Michigan communities."

NMRE SUD Oversight Committee Report
The draft minutes from July 7, 2025 were included in the materials for the meeting on this date. Liquor tax requests will be discussed under "New Business."

NEW BUSINESS
FY25 Liquor Tax Requests
The following liquor tax requests were recommended for approval by the NMRE Substance Use Disorder Oversight Committee on July 7, 2025.

	Requesting Entity	Project	County	Amount
1.	Centra Wellness Network	Benzie Area Youth (BAY) Initiative	Benzie	$10,068
2.	217 Recovery	Recovery Engagement Advocate	Grand Traverse	$29,760
3.	217 Recovery	Recovery Stories: Message of Hope Part VI	Grand Traverse	$4,700

MOTION BY JAY O'FARRELL TO APPROVE THE FISCAL YEAR 2025 LIQUOR TAX REQUESTS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE ON JULY 7, 2025 IN THE TOTAL AMOUNT OF FORTY-FOUR THOUSAND FIVE HUNDRED TWENTY-EIGHT DOLLARS ($44,528.00); SUPPORT BY DAVE FREEDMAN.

Discussion: Clarification was made that the Recovery Stories: Message of Hope Part VI is intended to support healing by creating a safe, supportive space where individuals can connect, feel seen, and share their stories. These events foster trust, reduce isolation, and empower people in recovery by promoting healthy relationships, emotional safety, and a strong sense of community, which are all essential for long-term healing and recovery. Over 150 individuals participated in Recovery Stories: Message of Hope Part V, including families and children. Ms. Marois asked that reports be provided showing the effectiveness of projects for which continuation funding is requested. Ms. Arsenov responded that internal staff review progress reports and outcomes of liquor tax projects on a quarterly basis.

ROLL CALL VOTING TOOK PLACE ON MR. O'FARRELL'S MOTION.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

FY25 County Overviews
The impact of the liquor tax requests approved on this date on county fund balances was reported as:

	Projected FY25 Available Balance	Amount Approved July 7, 2025	Projected Remaining Balance
Benzie	$193,744.70	$10,068.00	$183,676.70
Grand Traverse	$383,275.88	$34,460.00	$348,815.88
Total		**$44,528.00**	

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

FY26 Liquor Tax Requests
The following liquor tax requests were recommended for approval by the NMRE Substance Use Disorder Oversight Committee on July 7, 2025.

	Requesting Entity	Project	County	Amount
1.	57th Circuit Court	Emmet County Recovery Program (ECRP)	Emmet	$267,037
2.	Catholic Human Services	Alcona County Students Leading Students (SLS)	Alcona	$9,900
3.	Catholic Human Services	Alpena Prevention Students Leading Students (SLS)	Alpena	$51,687
4.	33rd Circuit Court	Charlevoix County Hybrid Drug Court	Charlevoix	$17,480
5.	Catholic Human Services	Crawford Partnership to End Substance Misuse	Crawford	$22,621
6.	Catholic Human Services	Generations Ahead Substance Use Prevention with Teen Parents	Grand Traverse	$79,329
7.	Catholic Human Services	Grand Traverse Addiction and Recovery Council	Grand Traverse	$76,665
8.	Catholic Human Services	Grand Traverse Jail-Based Substance Use Disorder Program	Grand Traverse	$53,438
9.	Health Department of Northwest Michigan	SAFE in Northern Michigan	Antrim, Charlevoix, Emmet	$132,000
10.	Catholic Human Services	Iosco Substance Free Coalition	Iosco	$46,162
11.	Catholic Human Services	Leelanau County Coordinated Youth SUD Prevention	Leelanau	$36,740
12.	Catholic Human Services	Ogemaw County Drug Free Coalition	Ogemaw	$9.450
13.	Catholic Human Services	Pulling Together: Cheboygan County Drug Free Coalition	Cheboygan	$73,360

14.	Catholic Human Services	Substance Free Coalition of Northern Michigan Opioid Use Prevention and Medication Safety Campaign	Grand Traverse	$155,000
15.	Health Department of Northwest Michigan	RISE Otsego Substance Free Coalition	Otsego	$86,932
16.	Catholic Human Services	Roscommon Jail-Based Substance Use Disorder Program	Roscommon	$53,438
17.	Catholic Human Services	Wexford Substance Use Disorder Program	Wexford	$107,194

MOTION BY MARY MAROIS TO APPROVE THE FISCAL YEAR 2026 LIQUOR TAX REQUESTS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE ON JULY 7, 2025 IN THE TOTAL AMOUNT OF ONE MILLION TWO HUNDRED SEVENTY-EIGHT THOUSAND FOUR HUNDRED THIRTY-THREE DOLLARS ($1,278,433.00); SUPPORT BY DANA LABAR. MOTION CARRIED. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

FY26 County Overviews

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

	Projected FY26 Available Balance	Amount Approved July 7, 2025	Projected Remaining Balance
Alcona	$71,518.76	$9,900.00	$61,618.76
Alpena	$244,953.50	$51,687.00	$193,266.50
Antrim	$253,333.30	$37,211.27	$216,122.03
Charlevoix	$121,585.71	$59,239.63	$62,346.08
Cheboygan	$162,226.55	$73,360.00	$88,866.55
Crawford	$92,752.89	$22,621.00	$70,131.89
Emmet	$320,158.73	$320,066.10	$92.63
Grand Traverse	$800,645.87	$364,432.00	$436,213.87
Iosco	$200,106.61	$46,162.00	$153,944.61
Leelanau	$103,348.17	$36,740.00	$66,608.17
Ogemaw	$121,409.61	$9,450.00	$111,959.61
Otsego	$120,034.73	$86,932.00	$33,102.73
Roscommon	$608,965.37	$53,438.00	$555,527.37
Wexford	$197,283.85	$107,194.00	$90,089.85
Total	**$3,418,323.65**	**$1,278,433.00**	**$2,139,890.65**

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

Prevention Services Request for Proposals (RFP)
The NMRE conducted a Request for Proposals (RFP) from May 12, 2025 – June 6, 2025 to select providers of prevention services for 7 of the region's 21 counties. Based on the submissions received, prevention contracts were awarded as follows:

NMRE County Recommendations for Contract Award	Provider	Amount Requested of NMRE Estimated Allocation ($)
Benzie	*No proposals received*	
Grand Traverse	Catholic Human Services	$96,641.00
Kalkaska	Catholic Human Services	$16,357.00
Leelanau	Catholic Human Services	$20,906.00
Manistee	District Health Department 10	$23,742.00
Missaukee	District Health Department 10	$13,379.00
Wexford	District Health Department 10	$32,715.00
	Total	**$203,740.00**

MOTION BY JAY O'FARRELL TO AWARD PREVENTION SERVICES CONTRACTS TO CATHOLIC HUMAN SERVICES FOR GRAND TRAVERSE, KALKASKA, AND LEELANAU COUNTIES IN THE AMOUNT OF ONE HUNDRED THIRTY-THREE THOUSAND NINE HUNDRED FOUR DOLLARS ($133,904.00) AND DISTRICT HEALTH DEPARTMENT TEN FOR MANISTEE, MISSAUKEE, AND WEXFORD COUNTIES IN THE AMOUNT OF SIXTY-NINE THOUSAND EIGHT HUNDRED THIRTY-SIX DOLLARS ($69,836.00); SUPPORT BY DANA LABAR. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

NMRE Financial Auditing Firm Selection
An RFP was conducted from May 15th – June 27th to collect bids to secure a financial auditing firm(s) for fiscal years 2025, 2026, and 2027 for the NMRE, Centra Wellness, North Country, Northern Lakes and Wellvance. Northeast Michigan already approved the auding firm of Straley Lamp & Kraenzlein.

NMRE staff met on June 2nd to review and score the bids that were received from Roslund, Prestage, & Company (RPC) and Yeo and Yeo. Based on the submissions, NMRE staff recommended that RPC be awarded the audit contract for the NMRE based on cost and experience. This recommendation was supported by the regional Finance and Operations Committees.

MOTION BY DON TANNER TO APPROVE THE SELECTION OF ROSLUND, PRESTAGE, AND COMPANY, PC AS THE NORTHERN MICHIGAN REGIONAL ENTITY'S FINANCIAL AUDITING FIRM FOR THE FISCAL YEARS ENDING SEPTEMBER 20, 2025, SEPTEMBER 30, 2026, AND SEPTEMBER 30, 2027 AT A COST NOT TO EXCEED FOUR HUNDRED

TWENTY-TWO THOUSAND SEVEN HUNDRED DOLLARS ($422,700.00); SUPPORT BY MARY MAROIS. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, K. Sherman, D. Smeltzer, D. Tanner

"Nay" Votes: Nil

MOTION CARRIED.

OLD BUSINESS

Northern Lakes CMHA Update

Mr. Kurtz announced that Northern Lakes CMHA's Medical Director, Dr. Curt Cummins, was appointed Interim CEO. The search for a permanent CEO is ongoing.

Mr. Freedman shared that the Northern Lakes Board also selected RPC for Northern Lakes' auditing firm for fiscal years 2025, 2026, and 2027. Financial audits for fiscal years 2023 and 2024 have closed.

Mr. Lawson asked whether Northern Lakes has made any progress to get spending in line with Per Member/Per Month revenue. Dr. Cummins reported that additional information was presented to the Northern Lakes Board on June 27th, which enabled them to approve a reduction of 27 positions. Additional funding cuts that do not affect mandated services will be pursued.

FY25 PIHP Contract Injunction and Complaint Update

The complaint filed by Taft, Stettinius & Hollister, LLP, on behalf of Northcare Network Mental Health Care Entity, Northern Michigan Regional Entity, Community Mental Health Partnership of Southeast Michigan, and Region 10 PIHP (Plaintiffs) against the State of Michigan, State of Michigan Department of Health and Human Services, a Michigan State Agency, and its Director, Elizabeth Hertel, in her official capacity (Defendants) is currently in a waiting period pending the appointed judge's decision.

PRESENTATION

FY25 Member Satisfaction Survey Results

Brie Molaison, the NMRE's Compliance and Customer Services Officer, was in attendance to report the results of the 2025 Member Satisfaction Survey for Mental Health Services.

Total responses to the survey were 960, which represents a 10% participation rate.

The survey results found that:

- 87.5% of beneficiaries are comfortable asking questions about their services or requesting new services.
- 99.25% of beneficiaries said staff treat them with dignity and respect.
- 94% of beneficiaries said they are involved in the development of their treatment plan.
- 92% of beneficiaries are aware they can file an appeal if they disagree with a change in services.
- 98.5% of beneficiaries are overall satisfied with the services they receive.
- 34.5% of beneficiaries stated that they did not receive an Adverse Benefit Determination from their CMHSP when their services were denied, reduced, suspended, or terminated.

Ms. Molaison clarified that all questions included a response of "This does not apply to me" so that Individuals did not respond "No" to a question that was not applicable to their circumstances or the services they receive.

COMMENTS

Board

Ms. Sherman asked how the NMRE is planning for "bad news" (related to the PIHP bid out). Mr. Kurtz responded that the NMRE (along with NorthCare Network) is being proactive where it can be. The three-pronged approach includes working with MDHHS, creating an arrangement that allows NMRE and Northcare Network to bid (rural exemption), and, if necessary, pursuing other legal options.

Mr. Adrian stressed the need for a unified message to the media in the event the PIHP bid out moves forward. Mr. Kurtz agreed. It was noted that the SUD Oversight Committee must remain in existence per Public Act 500 of 2012 (which hasn't been addressed in state's bid out plan.) Mr. Adrian drew attention to the low administrative cost percentage of the NMRE (<3%) versus. for profit insurance providers.

Staff/CMHSP CEOs

Ms. Pelts shared that it has been her honor and privilege to be part of the region and lead Welvance. She has valued the friendships of her colleagues and Board Members.

Public

Justin Reed reported that Roslund, Prestage, and Company concluded Northern Lakes CMHA's financial audits for fiscal years 2023 and 2024. He is hopeful that cost-settlement funds will be paid to Northern Lakes by the NMRE.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on August 27, 2025.

ADJOURN

Let the record show that Mr. Klacking adjourned the meeting at 11:27AM.

From: Info CMHAM
To: Carol Balousek (NMRE)
Subject: ACTION ALERT Tell Your Legislator to Express Concern Over MDHHS PIHP Procurement Proposal
Date: Monday, July 28, 2025 10:11:47 AM

Community Mental Health Association of Michigan

On May 23, the Michigan Department of Health and Human Services announced that they do in fact plan to move forward with a competitive procurement process for the state's Pre-Paid Inpatient Health Plan (PIHP) contracts. MDHHS plans to issue a request for proposals (RFP) for Pre-Paid Inpatient Health Plans (PIHPs) the summer of 2025 with the goal of a service start date Oct. 1, 2026.

The Community Mental Health Association of Michigan (CMHA) and our members remain deeply committed to improving Michigan's public behavioral health system. While we support meaningful reforms that enhance access and quality of care, we have serious concerns about the Michigan Department of Health and Human Services' (MDHHS) announcement regarding a new procurement process for Pre-Paid Inpatient Health Plans (PIHPs).

Although MDHHS states this initiative will increase access, choice, and preserve current Community Mental Health (CMH) providers, the reality of the proposed plan tells a different story.

Privatization Threatens Local Control and Accountability

The proposed competitive procurement process appears structured to favor large, private non-profit health plans—while excluding the very public PIHPs that have successfully managed Michigan's specialty behavioral health services for decades. These PIHPs, governed locally and accountable to

county-elected officials, will be barred from applying in their current form. This marks a major shift away from local governance, transparency, and public accountability.

A Misguided Approach to System Challenges

This proposal does not address the root causes of access and timeliness challenges in the system—namely, workforce shortages and chronic underfunding. Instead, it risks diverting hundreds of millions of dollars away from direct care and into administrative overhead. Private plans often operate with 15% overhead costs, compared to the 2% of current PIHPs. This could result in $300–$500 million in funds no longer reaching those who need services most.

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

REQUEST FOR ACTION: We are asking you to reach out to your House and Senate members and express your concerns with the department's competitive procurement process for the state's PIHP contracts. This proposal appears to be an attempt to privatize the public mental health system and why are we doing it at a time of such uncertainty? Let them know you support meaningful reforms that enhance access and quality of care, but this procurement process is not the way to address them.

Please feel free to customize your response as you see fit

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

ACTION ALERT Tell Your Legislator to Express Concern Over MDHHS PIHP Procurement Proposal

email correspondence

Subject: FW: FOR IMMEDIATE RELEASE: MDHHS seeking proposals to improve specialty behavioral health care for Medicaid beneficiaries
Date: Tuesday, August 5, 2025 12:38:02 PM

From: Michigan Department of Health and Human Services <MDHHS@govsubscriptions.michigan.gov>
Sent: Tuesday, August 5, 2025 12:02 PM
To: Eric Kurtz (NMRE) <ekurtz@nmre.org>
Subject: FOR IMMEDIATE RELEASE: MDHHS seeking proposals to improve specialty behavioral health care for Medicaid beneficiaries

Press Release

FOR IMMEDIATE RELEASE: Aug. 5, 2025

CONTACT: Lynn Sutfin, 517-241-2112, SutfinL1@michigan.gov

MDHHS seeking proposals to improve specialty behavioral health care for Medicaid beneficiaries

Deadline for proposals is September 29

LANSING, Mich. – The Michigan Department of Health and Human Services (MDHHS) is seeking proposals from entities to serve as the state's Prepaid Inpatient Health Plans (PIHP) to ensure Medicaid beneficiaries receive behavioral health care services and support.

Michigan's specialty behavioral health care system provides health care coverage to approximately 300,000 Michiganders, including adults with serious mental illness, children with serious emotional disturbance, individuals with substance use disorder and individuals with intellectual and developmental disabilities. MDHHS contracts with regional PIHPs to manage and deliver these Medicaid-covered services in conjunction with the Community Mental Health Service providers embedded in the communities across the state.

"Michigan Medicaid beneficiaries deserve access to behavioral health care services when and where they need them," said Elizabeth Hertel, MDHHS director. "A competitive procurement process for the state's Prepaid Inpatient Health Plan contracts will help create a more accessible and person-centered system of care dedicated to ensuring Michigan residents a healthier future."

PIHPs are responsible for making sure people receive the behavioral health care services and support they need and managing the network of behavioral health care providers including Community Mental Health Service Providers (CMHSPs). They play a vital role in helping the department achieve its mission to improve the health, safety and prosperity of residents.

Through a competitive procurement process, MDHHS will select PIHPs to contract with the state to provide managed care functions for the specialty behavioral health care services. The PIHP must contract with CMHSPs to provide a comprehensive array of mental health services as required by the Mental Health Code.

Feedback MDHHS received from Medicaid beneficiaries and their families, advocacy groups, community-based organizations, federally recognized tribal governments, health care providers and others via an online survey helped inform the request for proposal (RFP). MDHHS received more than 2,600 responses representing a variety of individuals and partners across Michigan.

MDHHS remains committed to transparency and preserving the public foundation that has long anchored behavioral health care in the state. As such:

- PIHPs will be required to adhere to the standards set forth in the Open Meetings Act and the Freedom of Information Act.
- The RFP is limited to nonprofit organizations and additional consideration will be provided to public entities to support public value and encourage collaborative governance.
- A minimum of one-third of the PIHP's governing body must be individuals with lived experience in Michigan's specialty behavioral health system elevating the voice of individuals and families served.

The Michigan Department of Technology, Management & Budget (DTMB) is managing the RFP process on behalf of MDHHS. The PIHP RFP is posted on SIGMA Vendor-Self Service system online. To bid on proposals, all vendors must first be registered with SIGMA Vendor Self-Service. Registration is free, and information on how to register and obtain an account to bid on open solicitations is available online: DTMB – How to Register as a Vendor.

Interested bidders are encouraged to refer to the proposal instructions for additional information regarding questions, submittal and deadlines. Responses from bidders are due Monday, Sept. 29. Bidders may submit written questions by emailing the solicitation manager Wednesday, Aug. 20. DTMB will post answers to bidder questions on the SIGMA system by Friday, Aug. 29.

Additional information about Michigan's Specialty Behavioral Health Services can be found at Michigan.gov/BehavioralHealth.

# # #

- PIHP RFP NR.pdf

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: CMHA being approached by private health plans
Date: Thursday, August 7, 2025 2:24:45 PM
Attachments: image001.png

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: RFP: CMHA being approached by private health plans

You may know that every time that a privatization threat or health plan rebid appears in our environment, private health plans reach out to our association as they do to many of our members. The aim of the outreach is to explore the development, by the plan, of a partnership with CMHA or its members.

The current PIHP RFP privatization threat is no different.

Since the preliminary announcement of the PIHP RFP in May, CMHA has been approached by health plans and health plan consultants regarding potential partnerships. CMHA, given its commitment to the survival and strengthening of the public system, engages in these discussions, seeking avenues that may prove worthwhile in ensuring a sound public system and preventing future threats of privatization. As you may remember, these discussions were founded on a public private partnership model that many of us saw as a sound model for achieving these aims.

Our recent discussion with one of these plans looks to be more promising than those that we have seen the in past. While our discussions with this plan are at a very preliminary stage, they seem to hold some promise relative to a partnership (with CMHA or a group of its members who would seek such a partnership). This potential promise comes from discussions of partnership components, outlined by the health plan, that will ensure a strong public system, ensure high quality of care to persons served and their communities, and work to thwart future privatization threats.

If CMHA and this plan continue discussions and begin to put thoughts on paper, we will come to the CMHA Officers,, and then, with their guidance, the full Board for consideration of a partnership with this plan, in the development of an alternative to the current RFP or, if our efforts to halt the RFP fail, to the submission of a bid in response to the RFP.

As these discussions progress, we will keep you informed and, as noted above, involved in reviewing and, if you think it wise, supporting such a partnership.

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

email correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Underscoring foundations and pillars of CMHA advocacy strategy
Date: Friday, August 8, 2025 12:37:06 PM
Attachments: image001.png

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

As you have heard us say, since the PIHP RFP was issued, earlier this week, **the issuing of this RFP does not change the multi-pronged strategy that we have pursued for the past several month**s. The gravity and complexity of the threats and opportunities present in this current environment demands a strategy with sophistication, determination, creativity, and financial muscle to thwart the threat and capture the opportunities.

Given this, we wanted to ensure that you were aware of the need that we see to reinforce the foundations to our strategy and the next steps in CMHA's pursuit of its multi-component strategy. Both are outlined below.

CORE FOUNDATIONS UNDERGIRDING CMHA STRATEGY AROUND CURRENT PRIVATIZATION THREAT – THE PIHP RFP: The CMHA strategy, as it has been for years, centers around fostering system-strengthening change and thwarting the privatization threat and is founded on several themes:

1. As voiced and defended y CMHA members and allies, the system **must remain publicly managed at the state and local level** with policies and financing supporting not hampering this public management.

2. Many of us – CMHA member organizations, advocacy organizations, state legislators, MDHHS leadership - for the past several years, have seen the **need to rethink the design of Michigan's public mental health system**. That redesign has a number of aims, as voiced by many of you, including: **ensuring local autonomy while fostering some level of uniformity across the state; fostering the long term fiscal, clinical, political, operational health of the system; reduction in administrative demands and complexity; developing a structure that prevents the continual emergence of privatization threats.**

3. The **political and fiscal environment** in which our system operates is, at times, **favorable to the aims noted above and, at times, hostile to them.**

CENTRAL TENET OF CMHA'S STRATEGY: These themes have led to the view, in the face of the current PIHP RFP, to the central tenet of CMHA's strategy:

> **System redesign is an aim desired by many, via a robust co-design process involving MDHHS, the leaders of the system, persons served, and other key stakeholders to the system. However, the RFP, because it holds the real threat of privatization, deep harm to persons served and the public system that serves them, is not the way to enact that system change.**

Over the past several weeks, with increased frequency over the past week, it has become clear that **large**

health plans, with federal non-profit 501 status, are developing applications in response to the RFP.

Parallel to this, **some plans have reached out to CMHA members, with the view that partnering with our system, rather than competing, is a better option**.

These two parallel currents underscore the mix of real threat and real opportunity for our system.

CMHA ACTIONS IN PURSUIT OF MULTI-COMPONENT STRATEGY:

1. Strategy component: Continue strong advocacy effort in opposition to the RFP being pursued (including political and media efforts) **recognizing that the RFP can be withdrawn by MDHHS at any time**.

- **CMHA is assembling the group (and growing) of organizations and statewide leaders** who oppose the privatization of the system, next week, to increase the intensity of the already robust political, media, and public sentiment advocacy pursued by CMHA, all of you, and our allies. Look for these actions, by CMHA, and for calls to action of you and our allies.

- **CMHA continues to urge its members and allies** to be strongly opposed to this procurement process.

2. Strategy component: Legal action to halt or alter the RFP to ensure that Michigan's public system retains the sole or lion's share of the management of the state's mental health system.

- CMHA is working with its legal counsel to **develop and take pre-bid and post-bid legal action**. As part of this effort, CMHA and our legal counsel will be reaching out to several CMHA members, requesting that they agree to be plaintiffs in this legal action.

- CMHA is also **urging CMHA members organizations**, especially those who have contemplated legal action related to the procurement, to consult with their legal counsel relative to legal action spurred by the release of the RFP.

- CMHA will be issuing a **special assessment of its CMHSP and PIHP members (to build an advocacy war chest)** for use in covering the related legal costs incurred by CMHA and the CMHA members who agree to be plaintiffs in this case as well as other advocacy-related costs. **CMHA will also be contributing $100,000** from its fund balance to this war chest. **CMH and PIHP CEOs will see a special assessment request in the coming days.**

3. Strategy component: Development of innovative structural and financing models that retain the strength of the public system.

- CMHA will continue to urge its members, now with greater focus, to develop structural redesigns that can form the basis for a **in lieu of the RFP process, a robust system co-design effort by MDHHS, the leaders of the system, persons served, and other key stakeholders to the system** or, if the political, media, and legal advocacy outlined above is not successful in halting the RFP process, as **public-system centered bids in response to this RFP.**

Robert Sheehan
Community Mental Health Association of Michigan Chief Executive Officer

Concerns Regarding MDHHS PIHP Contract Procurement Proposal

BACKGROUND: Earlier this year, the Michigan Department of Health and Human Services (MDHHS) recently issued a press release and posted on its Specialty Behavioral Services webpage information regarding the Department's proposal to bid out the contracts of Michigan's public Prepaid Inpatient Health Plans (PIHP).

CONCERNS: This plan:

1. Does not eliminate an administrative layer in Michigan's public mental health system. Instead, it replaces a public managed care system, that is transparent and low cost (2% overhead) with a **private managed care system that is not transparent, has a failed track record of managing Medicaid behavioral health in Michigan, is far more costly (15% overhead resulting in $500 million in additional overhead costs**, coming out of dollars currently available for services), and is the model that, in the states in which such privatization has been implemented, has harmed persons served and the provider networks that have long served them. See below for more on the flaws in the MDHHS proposal.

2. Is not required by the federal Centers for Medicare and Medicaid Services (CMS). MDHHS leadership has repeatedly indicated that the Department was pursuing the bid-out of those contracts in compliance with a requirement by the federal Centers for Medicare and Medicaid Services (CMS) to halt its 27-year long sole source arrangement with these PIHPs and to reprocure those contracts including private health plans as bidders. In a recent response to a FOIA request, MDHHS indicated that "**CMS has not required that we change or halt our sole source process**."

3. Will dramatically reduce access to and quality of behavioral healthcare for hundreds of thousands of Michiganders depend upon **by cutting $500 million out of the system –** the result of the administrative overhead of private plans health plans, at 15%, compared with the 2% overhead of the state's PIHPs. This cut will only compound those proposed by the Trump administration and the US House.

4. Moves the management of the entire Medicaid behavioral health system, serving persons with complex and serious mental health needs **to private plans who have proven unable to adequately manage the behavioral health benefit for those Michiganders with far milder mental health needs.**

5. Mirrors failed privatization efforts of other states. Studies conducted in 2016a ,2016b, 2022 found that behavioral health system privatization led to service fragmentation, reduced access, and diminished provider networks.

6. Eliminates the public behavioral health safety net role of the state's CMHSPs by ignoring the statutorily defined role of the CMHs as the state-designated community-based behavioral health provider and purchaser of care, relegating them to being one of a number of fee-for-service providers in the new managed care organization's network.

7. Eliminates the transparency currently guaranteed by law. Current public entities are subject to the **Michigan Open Meetings Act** and **Freedom of Information Act**, ensuring a high degree of transparency. Private health plans are not bound by these requirements, leaving critical decisions about public funds and services outside the public eye

8. Fails to address the root causes of existing access issues: behavioral health workforce shortages, chronic underfunding, crisis and inpatient capacity needs, and MDHHS-imposed unnecessary administrative burdens. The analysis of the responses of the 2,600 respondents to the MDHHS on system strengths and needed improvement – designed to guide the Department's efforts to advance the system - found that **none of the themes most frequently contained in the survey responses call for the contract bid-out approach proposed by MDHHS** nor for for the management of the state's Medicaid behavioral healthcare system/benefit by private non-profit health plans.

9. Prohibits the state's current PIHPs from bidding while prioritizing bids from private non-profit health plans/health insurance companies. Some of Michigan's largest private health plans/health insurance companies are private non-profit organizations: Blue Cross/Blue Shield, Priority Health, McLaren Health Plan, and HAP.

10. Is strongly opposed by Michiganders. A study of Michiganders, conducted by EPIC-MRA, found strong public opposition to the privatization of the state's public mental health system.

Community Mental Health Association of Michigan

Core concepts for use in guiding the development of alternatives to privatization-focused PIHP contract procurement proposal

August 2025

CMHA CONTINUES TO OPPOSE MDHHS PROPOSAL TO BID OUT PIHP CONTRCTS

As CMHA members and allies know, CMHA is **strongly opposed to the MDHHS proposal to competitively procure the contracts currently held by the state's public PIHPs**. CMHA's critique of the MDHHS procurement proposal can be found here.

CMHA, its members, and allies have been and will continue to advocate for system refinement as the most effective approach to improving access to and the quality of mental health services to Michiganders. Those efforts have focused and will continue to focus on the need for improved financing, reduction in administrative burden, and closing the behavioral health workforce shortage, among other issues.

BOLD ALTERNATIVE NECESSARY

While CMHA remains deeply opposed to the MDHHS PIHP contract procurement proposal, in light of the threat of the potential privatization that is the aim of the Department's current PIHP contract procurement proposal, **CMHA members and allies have asked CMHA to develop and distribute a set of concepts** that will guide the development of alternative system structures – alternatives to the privatization-focused procurement process that MDHHS is proposing. Below are those concepts.

CORE CONCEPTS RECOMMENDED FOR INCLUSION IN ALTERNATIVE PROPOSAL

Over the past several years, with increased clarity over the past several months, a number of themes have emerged, from stakeholders to Michigan's public mental health system, around the system design elements sought by them. **Some of these concepts have garnered significant agreement**, albeit not unanimous agreement, among a diverse set of stakeholders – persons served and their families, the state's leading advocacy groups, a significant number of CMHSPs and PIHPs, private providers in the public mental health system, state legislators, and MDHHS (the latter as noted in the rudiments of the PIHP contract procurement RFP published by MDHHS and in discussions with MDHHS leadership).

The concepts that represent those that have garnered general acceptance by a diverse set of stakeholders (forming a "center of gravity" of concepts) around system redesign are provided below.

In CMHA's view and that of many observers, **system redesign proposals that reflect these concepts will have a greater chance of acceptance and support by a range of stakeholders than those that do not reflect them.**

1. A sound system redesign calls for the replacement of the current PIHPs with a small number of (or single statewide) public bodies, with:
    a. The members of the board of directors of these public bodies appointed by county commissions, with some, potentially, appointed by state level elected officials
    b. Seats on the board of directors of these public bodies guaranteed for persons served and family members of persons served.
    c. CMHSP staff, CMHSP board members, staff and board members of mental health provider organizations prohibited from serving as board members of these public bodies.

2. If a public-private partnership is created to serve in this role:
    a. The public members of the board of directors of these bodies would hold the majority of Board seats.
    b. The appointment and financial/logistical support of the public members of the board of directors would comply with the standards listed above.
    c. The partnership would be structured in a way that the private partner bears its share of the fiscal risk borne by the partnership.
    d. A range of protections to ensure that this partnership does not become a path to privatization, including those that prohibit the private partner from selling or conveying its interest to another party.

3. These public bodies or public-private partnerships would develop, in concert with the CMHSPs in their region and the providers in their network, standard private provider contract language and performance standards. The use of these standard contract and performance standards would be required to be used by these public bodies and the CMHSPs in contracts with the providers in their provider networks.

4. These public bodies or public-private partnerships would ensure relative uniformity of access and intensity of services across the state supported by funding reflecting each community's diverse needs. Local variance from uniform access and intensity would be expected due to variations in: prevalence of needs and service demand; levels of community financing, resources, services, and supports; workforce capacity and gaps; population density; appropriateness of clinical models for rural versus urban communities, among other factors.

5. The payments made to the state's CMHSPs and, where possible, to private providers, would reflect alternative payment systems, such as the subcapitated financing used for the past several decades to fund the state's CMHSPs.

6. To aid in understanding, by a broad range of stakeholders, of the fiscal conditions tied to service access, intensity of services, and contract rates, the public body would ensure continual transparency and education around the financial condition of these public bodies or public-private partnerships.

7. To aid in the understanding of the factors that guide the use of Medicaid dollars in providing mental health services, continual transparency and education around the authorization standards and processes used by these public bodies or public-private partnerships and the CMHSPs in their region.

8. The requirement that when these public bodies or public-private partnerships receive directed Medicaid payments or targeted General Fund appropriations, designed to address financing needs of the providers in the system, those funds be provided to the providers in the CMHSP provider networks and the SUD provider network to the extent that they are received by the public bodies, public-private partnerships, and CMHSPs

    If the funding provided, through directed Medicaid payments or targeted General Fund appropriations to these public bodies, public-private partnerships, or the CMHSPs in their region are insufficient to fully fulfill the aim of the directed payments or appropriations, these public bodies, public-private partnerships and the CMHSPs in the region would ensure that this fact and the related fiscal analysis is provided to providers in their networks. If other factors hinder the full payment of these directed funds to providers, information related to those factors would also be shared with network providers.

email correspondence

From: Monique Francis <MFrancis@cmham.org>
Sent: Wednesday, August 20, 2025 9:19 AM
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Two sessions, aimed at public, to be held by MDHHS to explain the MDHHS' Plan to Competitively Procure PIHPs

Follow Up Flag: Follow up
Flag Status: Flagged

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Two sessions, aimed at public, to be held by MDHHS to explain the MDHHS' Plan to Competitively Procure PIHPs

While you may have already received the notice below, we did want you to be aware of these two presentations being provided, to the public, by MDHHS regarding the PIHP contract bid out.

These are being offered, by MDHHS, in light of the growing opposition to the Department's PIHP bid out plan. The content is expected to contain the same explanations that have been shared, by MDHHS, with many of you and our allies when the Department is questioned about the wisdom, aim, and legality of the PIHP bid out.

We are sharing this information with you, not that we think that these sessions will provide any information that you do not already have nor even to encourage your attendance. We simply want you to be aware of these events, as context to our collective work to thwart this threat.

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Mental Health Association in Michigan

August 25 | Webinar: MDHHS' Plan to Competitively Procure PIHPs Explained

Date: Monday, August 25 | Time: 3:00 - 5:00pm

The Mental Health Association in Michigan and **The Arc Michigan** have teamed up to bring you a presentation by the **Michigan Department of Health and Human Services (MDHHS)** as they are seeking proposals from entities to

serve as the state's Prepaid Inpatient Health Plans (PIHP) to ensure Medicaid beneficiaries receive behavioral health care services and support.

Through a competitive procurement process, MDHHS will select PIHPs to contract with the state to provide managed care functions for the specialty behavioral health care services. The PIHP must contract with CMHSPs to provide a comprehensive array of mental health services as required by the Mental Health Code. This presentation will explain the process and what to expect.

Registration required.

Presenter:

Kristen Morningstar

Director of Specialty Behavioral Health Services

MDHHS

Registration:

Complimentary

Register for 8/25 MDHHS Webinar

September 3 | MDHHS' Plan to Competitively Procure PIHPs Explained Held at Heritage Hall in Lansing

Date: Wednesday, September 3 | Time: 2:00 - 4:30pm

Presenter:

Kristen Morningstar

Director of Specialty Behavioral Health Services

MDHHS

Location:

Heritage Hall

North Room

323 Ottawa St.

Lansing, MI 48933

Parking:

Street parking and local parking structures.

Registration:

Complimentary

Register for 9/3 MDHHS In-person Event

Michigan Health Association in Michigan

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MDHHS
Michigan Department of Health & Human Services

Behavioral Health Home
Annual Report

FY 2024: Oct. 1, 2023 to Sept. 30, 2024

Behavioral Health Home Annual Report
FY2024 October 1, 2023 – September 30, 2024

Contents

Overview of Michigan's Behavioral Health Home

Michigan's Behavioral Health Home (BHH) is an optional State Plan benefit authorized under Section 1945 of the US Social Security Act. BHH started as a county framework model and was rolled out in 2014 within 3 Michigan counties. BHH was revamped to the current regional model in 2020 and has expanded multiple times. In FY24, 6 out of 10 Prepaid Inpatient Health Plan (PIHP) regions were authorized by Michigan's State Plan Amendment (SPA) to deliver services. BHH provides comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness or serious emotional disturbance. Behavioral Health Home Partners (HHPs) are required to deliver the following 6 core services:

1. Care Management
2. Care Coordination
3. Health Promotion
4. Individual and Family Supports
5. Referral to Community and Supports Services
6. Comprehensive Transitional Care

HHPs utilize a "whole person" approach to integrate and coordinate all primary, acute, behavioral health, and long-term services[1]. To that end, HHPs are required to utilize a multidisciplinary care team comprised of the following staff per 100 enrollees to treat the whole person. This required staffing structure includes the following:

- Behavioral Health Specialist (.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Peer Support Specialist, Youth Peer Support Specialist, Community Health Worker, Medical Assistant (3.00-4.00 FTE)
- Psychiatric Consultant (.10 FT)

[1] Health Homes | Medicaid

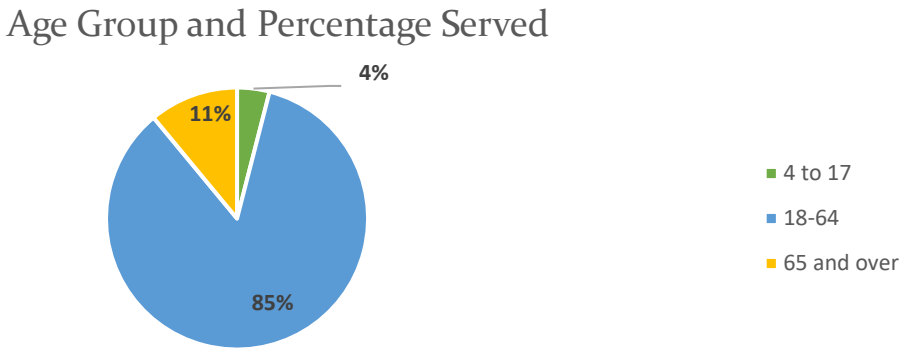
- Medical Consultant (.10 FTE)

Eligible HHP organizations include Community Mental Health Services Programs, Federally Qualified Health Centers, Rural Health Clinics, and Tribal and Health Centers. There are 41 HHPs across the state.

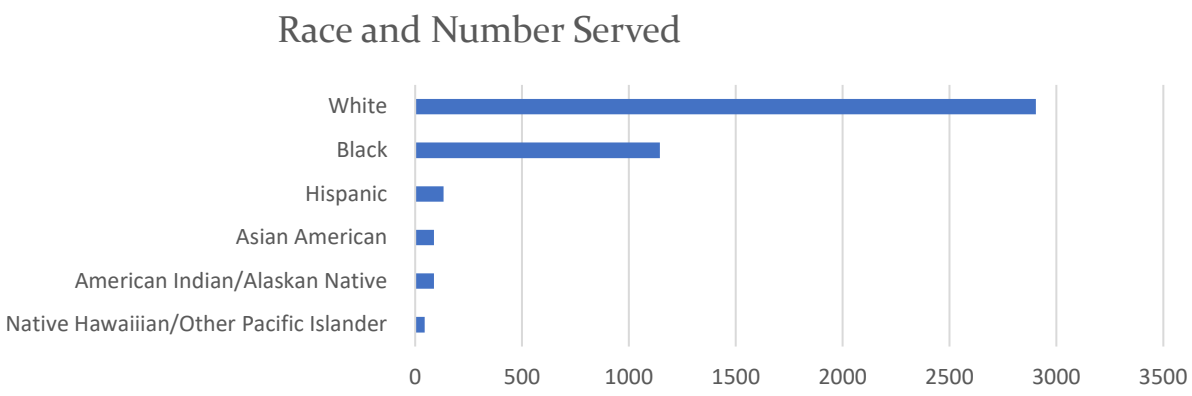
This report provides an analysis of the populations served, prevalent diagnoses, services provided, quality performance, and future outlook for BHH. Data sources used include service encounter data[2], and beneficiary information stored in the MDHHS Data Warehouse

1. Persons Served

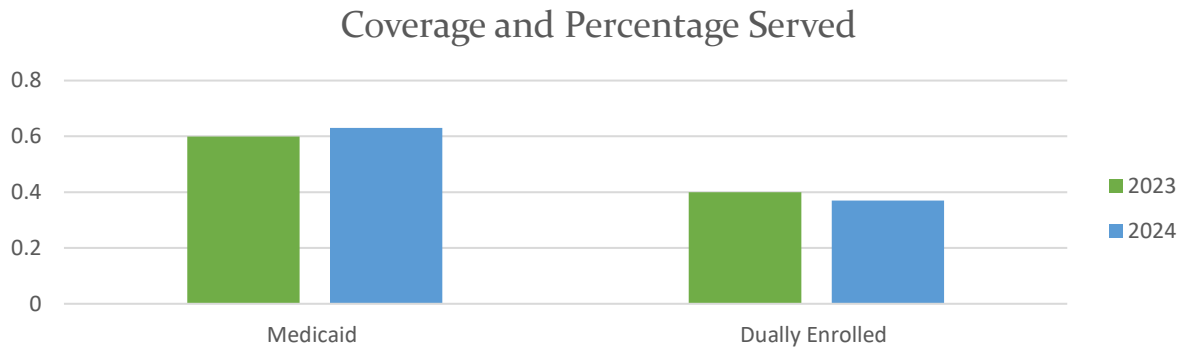
In FY24, a total of 4,399 beneficiaries received Behavioral Health Home (BHH) services, marking a significant increase of 30 percent compared to FY23, with 3,389 beneficiaries served. The age range of beneficiaries served was 4 -86 years old, with 4 percent of beneficiaries being children/youth under the age of 17 and 11 percent being 65 and over. The demographic profile of beneficiaries served was 66 percent White, 26 percent Black, 3 percent Hispanic, 2 percent Asian American, 2 percent American Indian/Alaskan Native, and less than 1 percent Native Hawaiian and Pacific Islander. When comparing the demographic profile of BHH to that of Michigan[3], Blacks have the highest penetration rate as evidenced by the percentage of Blacks enrolled in BHH compared to the percentage of Blacks living in Michigan, and the number of PIHP regions in the state authorized to deliver BHH services. Enrollment disparities among other racial groups may be influenced by a combination of cultural factors, socio-economic challenges, historical inequities in access to healthcare, and systemic issues within the healthcare system.



[2] Encounter data available in MDHHS Data Warehouse as of December 2024 (program counts).
[3] US Census Bureau. *Population Estimates, July 1, 2024,* Quick Facts.
Retrieved December 19, 2024, from U.S. Census Bureau QuickFacts: Michigan



In FY23, 40 percent of beneficiaries were dually enrolled in both Medicaid and Medicare, and in FY24 the percentage of dually enrolled beneficiaries decreased to 37 percent. While overall enrollment in BHH services rose, the decline in dually enrolled beneficiaries raises important considerations. The increase in total enrollment can be attributed to several key factors, including expanded access to care, enhanced outreach efforts to inform communities about available services, and a heightened focus on integrated, holistic care models such as BHH. The decrease in enrollment among the dually enrolled population may be influenced by the availability of benefit plans like MI HealthLink, which offer targeted services specifically for this demographic. Since MI HealthLink is not a coexisting benefit plan with BHH, beneficiaries who enroll in MI HealthLink are ineligible for BHH services. Additionally, a lack of awareness regarding the specific benefits of BHH for dually enrolled individuals could also contribute to this decline.



2. Diagnoses

Knowledge of prevalent diagnoses within BHH is critical as it enables HHPs to tailor interventions, including evidence-based practices, to improve health and wellness outcomes. Additionally, it assists HHPs to allocate resource efficiently and deliver effective education, empowering beneficiaries and families to take an active role in care planning and care management. The top 5 most common diagnoses for beneficiaries enrolled in BHH across the state were the same in FY23 And FY24:

1. Post-Traumatic Stress Disorder
2. Generalized Anxiety Disorder
3. Schizoaffective Disorder
4. Major Depressive Disorder, Recurrent, and Moderate
5. Major Depressive Disorder, Recurrent, and Severe

Z Codes, which are part of the ICD-10 coding system, identify factors that influence a beneficiaries health status and contact with the healthcare system. Z codes are used to help identify services that address the Social Determinants of Health needs for individuals seeking and/or receiving medical, behavioral, and social services. The top 5 Z Codes submitted with BHH encounters in 2024 include:

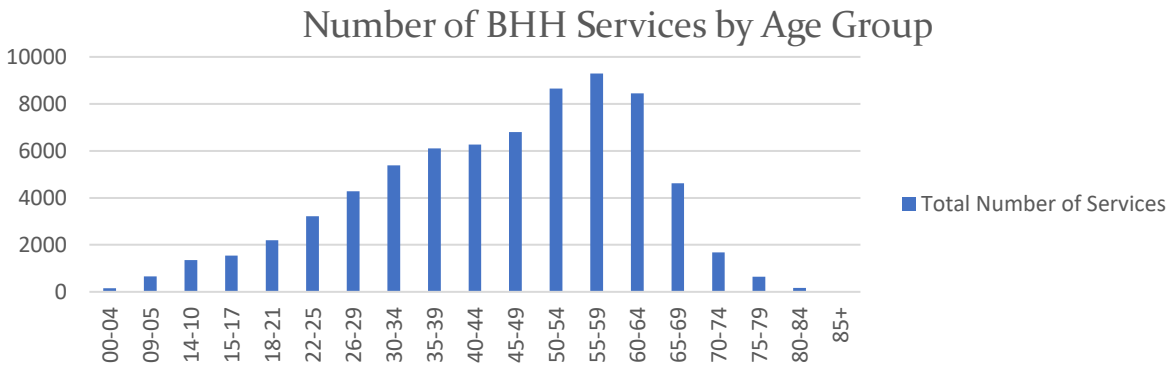
1. Unspecified problems related to employment
2. Problem related to housing and economic circumstances, unspecified
3. Problem related to social environment, unspecified
4. Low income
5. Problems of adjustment to life-cycle transitions

3. Services Delivered

In 2024, 48,790 BHH service encounters were submitted. The highest number of service encounters submitted per beneficiary was 198, the lowest was 1, and the average number of services was 11.

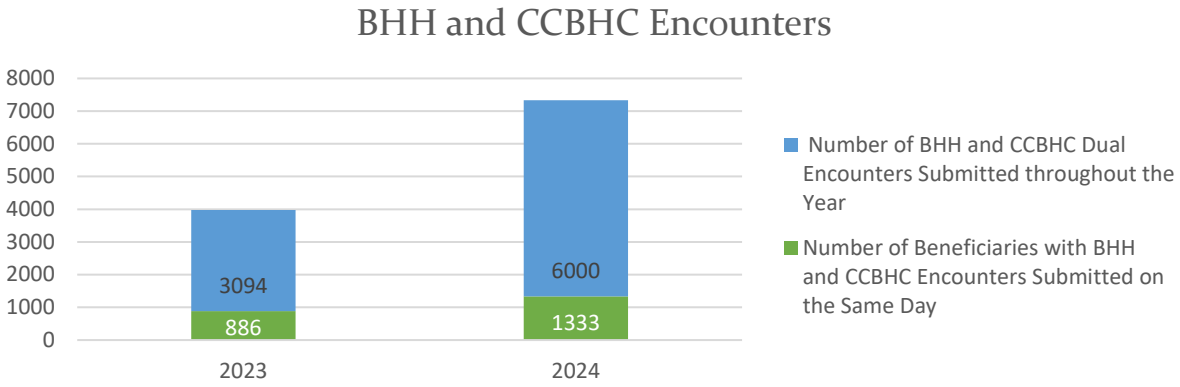
Age

In FY24, 6 percent of all BHH services provided in Michigan were to children/youth under the age of 17. The highest proportion of services were delivered to beneficiaries between the ages of 55-59, accounting for 12 percent of total services. Beneficiaries 85 and older received the fewest services.



BHH and CCBHC

BHH and Certified Community Behavioral Health Clinics (CCBHC) are both innovative models focused on integrating and coordinating behavioral health and primary care services. BHH and CCBHC were developed to be complementary in Michigan and the synergistic relationship between these models is aimed at improving access to care, enhancing care coordination, and promoting a "whole person" holistic approach to health. BHH provides care coordination and care management services and CCBHCs provide outpatient mental health and substance use disorder services. In FY24, 30 percent of BHH beneficiaries had a BHH and CCBHC service encounter submitted on the same day. This marks a 4 percent increase over dual encounters submitted in FY23. The maximum number of dual encounters submitted per beneficiary in FY24 was 40, the minimum was 1, and the average was 5. Overall, a total of 6,000 dual encounters were submitted in FY24.



BHH Service Success Story

The following BHH success story highlights the transformative power of Behavioral Health Home services. This account not only underscores the effectiveness of tailored interventions and coordinated care but illustrates how these services empower beneficiaries to overcome challenges, achieve their personal goals, and ultimately lead healthier, more fulfilling lives. This story displays the profound benefits of BHH services and their critical role in redefining the landscape of behavioral health care.

A Male in his 50s with a history of psychiatric hospitalizations, IV drug use (remission), legal issues and incarceration, and significant trauma, was referred by his Primary Care Physician (PCP) for BHH services. When the beneficiary began receiving BHH services in 2023 he was isolating and experiencing severe anxiety, homicidal thoughts, insomnia, COPD, poorly controlled diabetes, and severe neuropathy with recommendation for amputation of both feet. The beneficiary had forged a good relationship with his PCP, but was hesitant to engage in BHH services. Beneficiary was not open to taking medication(s), but did want to learn alternative methods for managing trauma, stressors, and emotional wellbeing. The beneficiary also wanted to learn about his health conditions and managing diabetes—including lowering his A1C. The BHH nurse met the beneficiary where he was at and supported members desire to avoid pharmaceutical/western medicine interventions. BHH staff began meeting the beneficiary in his home and attending appointments with him. BHH staff helped the beneficiary find shoes specific for people with diabetic neuropathy so he could start walking and referred him to the Food is Medicine program. Within 1 year in BHH the beneficiary has lost 36 lbs., A1C went from 8.4 to 4.8, PHQ9 score significantly improved, CPAP utilization significantly increased, complete blood count and metabolic panel testing is within normal range, beneficiary is no longer experiencing homicidal ideation, neuropathy symptoms have significantly improved, and amputation is no longer a recommendation.

4. Quality Performance

Both the Centers for Medicare & Medicaid Services (CMS) and Michigan Department of Health and Human Services (MDHHS) have quality monitoring and evaluation requirements for the Behavioral Health Home program. CMS has two broad sets of reporting requirements, including core utilization and core quality measures. HHPs must share all BHH clinical and cost data with MDHHS and the data is analyzed and reported annually by MDHHS to CMS. The specific Core Measures and other federal requirements can be found on this page: CMS Health Homes Quality Reporting.

In addition to federal Health Home reporting requirements, CMS requires that states develop a distinct quality monitoring plan tailored to the specific population(s) targeted by their Health Home program(s). BHH has developed a value-based Pay for Performance (P4P) structure where HHPs receive funding for meeting quality improvement benchmarks identified by the state. In FY24 the following measures were selected as P4P measures:

- Controlling High Blood Pressure (CBP-HH)
- Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)
- Access to Preventive/Ambulatory Health Services (AAP)

FY24 BHH Measurement Rates

The rates below reflect the most recent FY24 BHH data available in MDHHS's data warehouse[4]. In FY24, MDHHS added BHH measures into Care Connect360, a statewide care management web portal, to allow providers to access quality measures throughout the fiscal year.
BHH is exceeding the state's performance in 9 of the 11 measures listed below. The data indicates that the BHH program is highly effective in improving access to preventive services and follow-up care for beneficiaries with behavioral health needs. The significant disparity between state rates and BHH rates across most measures highlights the program's efficacy in improving health outcomes for beneficiaries. However, the lower rates in substance use treatment initiation and engagement suggest areas for improvement. Continued focus on these metrics will be essential for ensuring integrated care across the state.

Measure	Description	State Rate	BHH Rate
Adult Access to Preventative/Ambulatory Health Services (AAP)	Patient(s) 20 years and older that had a preventive or ambulatory care visit during the last 12 months of the report period	78.31	98.01
Controlling High Blood Pressure (CBP-AD)	Patients 18-85 years with hypertension with the most recent documented blood pressure less than 140/90mm Hg	38.77	43.40
Colorectal Cancer Screening (COL)	Patient(s) 50 - 75 years that had appropriate screening for colorectal cancer.	42.48	59.30
Follow-up after ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA-7)	Follow-up after ED Visit for Alcohol and Other Drug Abuse or Dependence	23.77	45.10

[4] Measurement data available in Care Connect 360 as of December 2024. Measure date June 30, 2024

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-30)	Patients 13 years and older with an ED visit for alcohol and other drug abuse or dependence that had a follow-up visit within 30 days	36.29	74.51
Mental Illness, Follow-Up After Hospitalization (National Standard) (FUH-7)	Patients 18-64 years hospitalized for mental illness or intentional self-harm that had a follow-up encounter with a mental health practitioner within 7 days after discharge	44.35	53.66
Mental Illness, Follow-Up After Hospitalization (National Standard) (FUH-30) a mental health practitioner within 30 days after discharge.	Patients 18-64 years hospitalized for mental illness or intentional self-harm that had a follow-up encounter with a mental health practitioner within 30 days after discharge	66.30	87.80
Follow-Up After Emergency Department Visit for Mental Illness (FUM-7)	Patients 6 years of age or older with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 7 days	44.85	66.96
Follow-Up After Emergency Department Visit for Mental Illness (FUM-30)	Patients 6 years of age or older with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 30 days	59.74	85.71
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-14)	Patients aged 18 years or older with a new episode of alcohol or drug (AOD) abuse or dependence who initiated treatment within 14 days of the diagnosis	37.16	35.71

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-34 AD)	Patients aged 18 years or older with a new episode of alcohol or drug (AOD) abuse or dependence who initiated treatment and engaged in ongoing treatment within 34 days of the initiation visit	10.76	4.46

5. Next Steps and Future Outlook

The outlook for BHH in Michigan is promising, with key developments in FY25 aimed at enhancing service access and improving outcomes. MDHHS submitted a FY25 SPA amendment to expand BHH to three additional PIHP regions, include new eligible children's diagnoses, and integrate Youth Peer Support Specialists into the Health Home staffing structure. This amendment was approved and took effect on October 1, 2024. Moreover, MDHHS is in the process of developing a two-tiered Health Home model to offer customized services based on individual needs, ensuring that those requiring intensive support receive comprehensive care, while others can access more streamlined services—enhancing overall efficiency. With these strategic enhancements, the BHH program will be well-positioned to improve access and outcomes for diverse populations, fostering a holistic and inclusive approach to behavioral health care.

This year, we have witnessed encouraging results from the Behavioral Health Home program. By fostering collaboration and breaking down barriers, we are enabling individuals to take control of their health journeys. Michigan is committed to integrated behavioral health, understanding that mental health is vital to overall wellness. We strive to ensure everyone has access to necessary resources. Looking ahead, we remain dedicated to delivering equitable, accessible, and high-quality care for all, continuously innovating to meet the changing needs of our diverse communities.

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

	Percentage	Number of Emergency Referrals for Children	Number Completed in Three Hours for Children
Detroit Wayne Mental Health Authority	99.12	680	674
Lakeshore Regional Entity	98.94	377	373
Macomb Co CMH Services	97.27	220	214
Mid-State Health Network	98.91	822	813
NorthCare Network	100.00	51	51
Northern MI Regional Entity	99.26	135	134
Oakland Co CMH Authority	100.00	276	276
Region 10	99.16	239	237
CMH Partnership of Southeast MI	99.38	160	159
Southwest MI Behavioral Health	100.00	212	212
Statewide Total		**3,172**	**3,143**

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

	Percentage	Number of Emergency Referrals for Adults	Number Completed in Three Hours for Adults
Detroit Wayne Mental Health Authority	95.13	2,525	2,402
Lakeshore Regional Entity	98.81	1,509	1,491
Macomb Co CMH Services	91.84	968	889
Mid-State Health Network	99.41	3,222	3,203
NorthCare Network	100.00	275	275
Northern MI Regional Entity	98.34	604	594
Oakland Co CMH Authority	97.81	1,278	1,250
Region 10	96.59	850	821
CMH Partnership of Southeast MI	99.48	582	579
Southwest MI Behavioral Health	98.85	783	774
Statewide Total		**12,596**	**12,278**

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

	Percentage	# of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	53.37	3,352	1,789
Lakeshore Regional Entity	73.48	1,444	1,061
Macomb Co CMH Services	56.77	953	541
Mid-State Health Network	59.01	4,213	2,486
NorthCare Network	60.18	555	334
Northern MI Regional Entity	62.02	982	609
Oakland Co CMH Authority	54.05	1,036	560
Region 10	55.13	2,222	1,225
CMH Partnership of Southeast MI	44.31	1,160	514
Southwest MI Behavioral Health	73.48	2,447	1,798
Statewide Total		**18,364**	**10,917**

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

	Percentage	# MI Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	62.10	781	485
Lakeshore Regional Entity	72.62	599	435
Macomb Co CMH Services	46.58	219	102
Mid-State Health Network	59.19	1,404	831
NorthCare Network	59.81	209	125
Northern MI Regional Entity	64.71	306	198
Oakland Co CMH Authority	50.13	375	188
Region 10	47.89	641	307
CMH Partnership of Southeast MI	46.29	283	131
Southwest MI Behavioral Health	73.29	689	505
Statewide Total		**5,506**	**3,307**

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

	Percentage	# MI Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.97	1,736	989
Lakeshore Regional Entity	73.27	591	433
Macomb Co CMH Services	62.18	550	342
Mid-State Health Network	61.14	2,357	1,441
NorthCare Network	58.75	303	178
Northern MI Regional Entity	58.53	545	319
Oakland Co CMH Authority	62.28	570	355
Region 10	60.84	1,259	766
CMH Partnership of Southeast MI	41.64	706	294
Southwest MI Behavioral Health	73.14	1,571	1,149
Statewide Total		**10,188**	**6,266**

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

	Percentage	# DD Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	34.14	700	239
Lakeshore Regional Entity	79.62	157	125
Macomb Co CMH Services	53.62	138	74
Mid-State Health Network	44.38	338	150
NorthCare Network	68.18	22	15
Northern MI Regional Entity	73.00	100	73
Oakland Co CMH Authority	11.11	45	5
Region 10	44.05	252	111
CMH Partnership of Southeast MI	53.79	132	71
Southwest MI Behavioral Health	79.58	142	113
Statewide Total		**2,026**	**976**

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

	Percentage	# DD Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.30	135	76
Lakeshore Regional Entity	70.10	97	68
Macomb Co CMH Services	50.00	46	23
Mid-State Health Network	56.14	114	64
NorthCare Network	76.19	21	16
Northern MI Regional Entity	61.29	31	19
Oakland Co CMH Authority	26.09	46	12
Region 10	58.57	70	41
CMH Partnership of Southeast MI	46.15	39	18
Southwest MI Behavioral Health	68.89	45	31
Statewide Total		**644**	**368**

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

		Admissions			
	Percentage	# of Non-Urgent Admissions to a Licensed SUD Treatment Facility as reported in BH TEDS	# of Expired Requests Reported by the PIHP	Total	# of Persons Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request
Detroit Wayne Mental Health Authority	70.07	3,474	940	4,414	3,093
Lakeshore Regional Entity	66.76	1,458	245	1,703	1,137
Macomb Co CMH Services	71.39	1,222	365	1,587	1,133
Mid-State Health Network	78.93	2,423	201	2,624	2,071
NorthCare Network	54.57	422	212	634	346
Northern MI Regional Entity	71.71	953	210	1,163	834
Oakland Co CMH Authority	84.41	826	104	930	785
Region 10	80.83	1,674	256	1,930	1,560
CMH Partnership of Southeast MI	59.75	867	236	1,103	659
Southwest MI Behavioral Health	68.20	999	218	1,217	830
Statewide Total		**14,318**	**2,987**	**17,305**	**12,448**

Indicator 3: Percentage of New Persons During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# of Persons Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	94.86	2,512	2,383
Lakeshore Regional Entity	63.78	1,317	840
Macomb Co CMH Services	59.54	692	412
Mid-State Health Network	66.62	3,146	2,096
NorthCare Network	69.38	418	290
Northern MI Regional Entity	68.43	681	466
Oakland Co CMH Authority	99.31	721	716
Region 10	78.65	1,560	1,227
CMH Partnership of Southeast MI	73.04	738	539
Southwest MI Behavioral Health	72.87	1,957	1,426
Statewide Total		**13,742**	**10,395**

Indicator 3a: The Percentage of New Children with Emotional Disturbance During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	96.21	607	584
Lakeshore Regional Entity	55.73	558	311
Macomb Co CMH Services	37.42	155	58
Mid-State Health Network	58.27	1,040	606
NorthCare Network	72.05	161	116
Northern MI Regional Entity	68.64	220	151
Oakland Co CMH Authority	98.53	273	269
Region 10	77.57	428	332
CMH Partnership of Southeast MI	76.60	188	144
Southwest MI Behavioral Health	70.30	542	381
Statewide Total		**4,172**	**2,952**

Indicator 3b: The Percentage of New Adults with Mental Illness During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# MI Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	93.39	1,285	1,200
Lakeshore Regional Entity	70.21	527	370
Macomb Co CMH Services	58.84	396	233
Mid-State Health Network	68.68	1,705	1,171
NorthCare Network	70.64	218	154
Northern MI Regional Entity	65.23	348	227
Oakland Co CMH Authority	99.73	371	370
Region 10	77.47	901	698
CMH Partnership of Southeast MI	68.17	421	287
Southwest MI Behavioral Health	73.47	1,244	914
Statewide Total		**7,416**	**5,624**

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

	Percentage	# DD Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	97.86	515	504
Lakeshore Regional Entity	65.73	143	94
Macomb Co CMH Services	87.85	107	94
Mid-State Health Network	83.28	299	249
NorthCare Network	47.62	21	10
Northern MI Regional Entity	72.94	85	62
Oakland Co CMH Authority	100.00	29	29
Region 10	86.29	175	151
CMH Partnership of Southeast MI	84.54	97	82
Southwest MI Behavioral Health	73.28	131	96
Statewide Total		**1,602**	**1,371**

Indicator 3d: The Percentage of New Adults with Developmental Disabilities During the Quarter Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Non-Emergent Biopsychosocial Assessment

	Percentage	# DD Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	90.48	105	95
Lakeshore Regional Entity	73.03	89	65
Macomb Co CMH Services	79.41	34	27
Mid-State Health Network	68.63	102	70
NorthCare Network	55.56	18	10
Northern MI Regional Entity	92.86	28	26
Oakland Co CMH Authority	100.00	48	48
Region 10	82.14	56	46
CMH Partnership of Southeast MI	81.25	32	26
Southwest MI Behavioral Health	87.50	40	35
Statewide Total		**552**	**448**

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

	Percentage	# Children Discharged from Psychiatric Inpatient Unit	# Children Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	98.21	56	55
Lakeshore Regional Entity	97.70	87	85
Macomb Co CMH Services	89.09	55	49
Mid-State Health Network	98.11	159	156
NorthCare Network	95.00	20	19
Northern MI Regional Entity	97.87	47	46
Oakland Co CMH Authority	90.48	42	38
Region 10	97.26	73	71
CMH Partnership of Southeast MI	96.00	50	48
Southwest MI Behavioral Health	94.52	73	69
Statewide Total		**662**	**636**

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

	Percentage	# Adults Discharged from Psychiatric Inpatient Unit	# Adults Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	96.76	680	658
Lakeshore Regional Entity	96.73	306	296
Macomb Co CMH Services	79.31	261	207
Mid-State Health Network	95.81	597	572
NorthCare Network	96.43	84	81
Northern MI Regional Entity	95.80	119	114
Oakland Co CMH Authority	95.02	261	248
Region 10	98.23	282	277
CMH Partnership of Southeast MI	84.34	198	167
Southwest MI Behavioral Health	96.41	306	295
Statewide Total		**3,094**	**2,915**

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

	Percentage	# SA Discharged from Substance Abuse Detox Unit	# SA Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	96.77	526	509
Lakeshore Regional Entity	96.94	98	95
Macomb Co CMH Services	100.00	237	237
Mid-State Health Network	91.53	177	162
NorthCare Network	100.00	36	36
Northern MI Regional Entity	93.71	143	134
Oakland Co CMH Authority	97.84	139	136
Region 10	79.63	54	43
CMH Partnership of Southeast MI	96.25	80	77
Southwest MI Behavioral Health	100.00	159	159
Statewide Total		**1,649**	**1,588**

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

	Percentage	Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients
Detroit Wayne Mental Health Authority	6.85	47,262	689,677
Lakeshore Regional Entity	6.68	18,255	273,267
Macomb Co CMH Services	5.45	12,037	220,895
Mid-State Health Network	8.55	34,030	398,161
NorthCare Network	8.47	5,423	64,032
Northern MI Regional Entity	8.17	9,508	116,339
Oakland Co CMH Authority	8.92	17,152	192,194
Region 10	8.85	17,739	200,369
CMH Partnership of Southeast MI	7.67	9,780	127,488
Southwest MI Behavioral Health	8.88	18,658	210,065
Statewide Total		**189,844**	**2,492,487**

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

	Percentage	# of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	Total Number of HSW Enrollees
Detroit Wayne Mental Health Authority	96.17	1,005	1,045
Lakeshore Regional Entity	95.71	624	652
Macomb Co CMH Services	92.94	421	453
Mid-State Health Network	96.70	1,437	1,486
NorthCare Network	98.64	363	368
Northern MI Regional Entity	91.55	607	663
Oakland Co CMH Authority	96.63	775	802
Region 10	98.44	505	513
CMH Partnership of Southeast MI	95.51	659	690
Southwest MI Behavioral Health	97.41	676	694
Statewide Total		**7,072**	**7,366**

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

	Percentage	Number of Children Discharged from Inpatient Care	# Children Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	11.11	207	23
Lakeshore Regional Entity	11.50	113	13
Macomb Co CMH Services	11.69	77	9
Mid-State Health Network	12.05	249	30
NorthCare Network	9.52	21	2
Northern MI Regional Entity	6.67	60	4
Oakland Co CMH Authority	5.36	56	3
Region 10	4.95	101	5
CMH Partnership of Southeast MI	12.07	58	7
Southwest MI Behavioral Health	11.88	101	12
Statewide Total		**1,043**	**108**

Indicator 10b (old #12b): The Percentage of Adults Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit -- 15% or Less Standard

	Percentage	Number of Adults Discharged from Inpatient Care	# Adults Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	15.57	1,567	244
Lakeshore Regional Entity	13.79	515	71
Macomb Co CMH Services	16.56	483	80
Mid-State Health Network	12.92	1,060	137
NorthCare Network	15.45	110	17
Northern MI Regional Entity	11.22	196	22
Oakland Co CMH Authority	10.65	479	51
Region 10	15.75	508	80
CMH Partnership of Southeast MI	12.63	285	36
Southwest MI Behavioral Health	15.82	512	81
Statewide Total		**5,715**	**819**

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – AUGUST 13, 2025
VIA TEAMS

ATTENDEES:	**Brian Babbitt, Connie Cadarette, Ann Friend, Kevin Hartley, Chip Johnston, Nancy Kearly, Eric Kurtz, Allison Nicholson, Brandon Rhue, Nena Sork, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

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

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE JULY 9, 2025, NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY KEVIN HARTLEY. MOTION APPROVED.

MONTHLY FINANCIALS
June 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $2,540,625. Carry forward was reported as $736,656. The total Medicaid and HMP current year surplus was reported as $3,277,281. FY24 HSW revenue was reported as $1,289,241. The total Medicaid and HMP adjusted current year surplus was reported as $1,988,040. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $23,853,437.
- Traditional Medicaid showed $164,525,484 in revenue, and $159,902,729 in expenses, resulting in a net surplus of $4,622,755. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $21,732,996 in revenue, and $23,815,126 in expenses, resulting in a net deficit of $2,082,130. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $2,371,360 in revenue, and $1,973,305 in expenses, resulting in a net surplus of $398,055.
- SUD showed all funding source revenue of $21,616,899 and $16,921,089 in expenses, resulting in a net surplus of $4,695,811. Total PA2 funds were reported as $4,349,717.

PA2/Liquor Tax was summarized as follows:

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

Actual FY25 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$835,755	$1,251,270	$4,349,717

The financial outlook is much improved with the new rates. CMHSP expenditures through June have stabilized for Medicaid; HMP continues to be overspent.

It was noted that the NMRE is working to redirect PA2 funds to block grant funding, where it can.

MOTION BY KEVIN HARTLEY TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JUNE 2025; SUPPORT BY ALLISON NICHOLSON. MOTION APPROVED.

EDIT UPDATE

The minutes from July 17th were included in the meeting materials. Donna was not in attendance to expand on the minutes.

- ASAM patient placement criteria was updated to a 4th edition and MCHHS is in the process of revising policy to align with the update. Providers will have until October 1, 2026 to get the changes in place. The ASAM continuum is expected to be released to PIHPs for implementation in the system beginning January 1, 2026.
- The definition of a Qualified Intellectual Disability Professional (QIDP) has been updated to read, "Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons with intellectual or developmental disabilities as part of that experience) OR one year of experience in treating or working with a person who has an intellectual disability (*prior to or post degree acquisition*); AND is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, dietician, therapeutic recreation specialist, a licensed/limited-licensed professional counselor, OR a human services professional with at least a bachelor's degree in a human services field."
- Language was updated for several codes to align with the 1915(i) HAB Waiver renewals.
- The 8Y modifier has been added to the MichiCANS comprehensive assessment to allow for data analysis, effective October 1, 2025.
- A Certified Peer Support Specialist (CPSS) designation can only be used for H0038 when it is referenced in the IPOS and is part of a bundled service.
- The June 30th updates to the Code Chart and Provider Qualifications Chart may be found by visiting: Reporting Requirements.

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

EQI UPDATE

Tricia is waiting for information from the state before she establishes the due dates for Period 2 from the CMHSPs. Period 2 is due from the NMRE to MDHHS on September 30th. Tricia is currently resolving the variance report for Period 1. Because the health home programs are paid, fee-for-service, they are appearing on the EQI as contracted services.

The Period 1 variance report will be shared with the CMHSPs. A pull date of September 3rd was set for Period 2.

ELECTRONIC VISIT VERIFICATION (EVV)
Portal utilization continues to be monitored.

HSW OPEN SLOTS UPDATE
The region currently has 4 (of 697) open waiver slots with 14 packets in the queue.

CHAMPS Fix Update/Verification
The payment file for HSW was received earlier on this date. It looks as though the fix put in place has not been effective. The August initial payment was for 657 of the 694 filled slots. Brandon noted that a separate eligibility issue (not related to HSW) is also occurring in CHAMPS. In situations where two primary care physicians are listed for one individual, the mental health coverage code is prevented from being populated in CHAMPS, so it appears there is no mental health coverage. MDHHS has identified the problem and is working on correcting the issue. A fix is expected in December. Until then, daily manual fixes are occurring.

NMRE REVENUE & ELIGIBLES ANALYSIS
An analysis of October 2023 – July 2025 Revenue and Eligibles was emailed to the committee during the meeting.

Children's Waiver Program			
	October 2023	July 2025	% Change
Revenue	$36,882	$36,896	0.04%
Enrollees	11	9	-18.18%
Average Payment per Enrollee	$3,353	$4,100	22.27%

DAB			
	October 2023	July 2025	% Change
Revenue	$10,003,003	$12,423,006	24.19%
Enrollees	28,444	24,993	-12.13%
Average Payment per Enrollee	$352	$497	41.34%

HMP			
	October 2023	July 2025	% Change
Revenue	$2,369,569	$2,645,927	11.66%
Enrollees	47,550	31,157	-34.48%
Average Payment per Enrollee	$50	$85	70.41%

HSW			
	October 2023	July 2025	% Change
Revenue	$4,638,399	$7,077,834	52.59%
Enrollees	650	720	10.77%
Average Payment per Enrollee	$7,136	$9,830	37.76%

SED			
	October 2023	July 2025	% Change**
Revenue	$40,846	$31,915	-21.87
Enrollees	21	39	85.71
Average Payment per Enrollee*	$1,945	$818	-57.93

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

TANF			
	October 2023	July 2025	% Change
Revenue	$2,865,200	$3,524,131	23.00%
Enrollees	66,801	52,034	-22.11%
Average Payment per Enrollee	$43	$68	57.90%

TOTAL			
	October 2023	July 2025***	% Change
	$19,953,899	25,739,709	29.00%

***The April payment included retro HSW.

FY25 year-to-date revenue was compared by funding source to FY24 July year-to-date revenue.

	DAB	HMP	HSW	TANF	Total
YTD July 2024	$95,867,636	$20,947,286	$46,822,406	$26,903,730	$190,541,057
YTD July 2025	$100,678,809	$22,676,184	$54,222,898	$28,465,861	$206,043,752
Increase	$4,811,173	$1,728,899	$7,400,493	$1,562,131	**$15,502,695**

Ann noted that, according to the payment file, North Country enrollees decreased by 510 in Medicaid and 538 in HMP. Regionally, enrollees fell between June and July by 446 for DAB, 1,629 for HMP, and 1,249 for TANF, totaling 3,324. Brandon responded that the NMRE IT Department is monitoring the drop off as it may be related to the enrollment issue in CHAMPS. The enrollment drop off issue will be presented to the CIO Forum on August 29th.

AUDIT FY25 – FY26 RFP AWARD LETTERS

North Country, Northern Lakes, Wellvance, and the NMRE have all approved Roslund, Prestage, and Company, PC. as their audit firm for fiscal years 2025, 2026, and 2027. A recommendation will go before Centra Wellness' board on August 14th. Once all five Boards have approved RPC, an award letter will be sent from the NMRE. A letter to the Yeo & Yeo will also be sent.

FY25 RATE AMENDMENT SCHEDULE

On August 7th, the recoup/repay was sent for November and December 2024 for $1.4M. The next payment is scheduled for August 17th for June recoup/repay for BHMA, MHMA-MHP, BHHMP, and MHHMP-MC. Deanna will continue to update CFOs as payments roll in.

Deanna noted that administration was deducted from the July 24th payment and from the July 31st recoup/repay. To correct this, the August payment will not include an admin deduction.

OTHER

Connie asked how Boards are handing Earned Sick Time Act (ESTA) requirement for staff hired by individuals in self-determined arrangements. Since each individual person in an SD arrangement is their own employer, staff would essentially accrue sick time from each client, even if they work for several. The accrual is one hour for every 30 hours worked, and the accrual is capped at 40 hours per year. Staff can use 40 hours per year of paid sick leave and 32 hours per year of unpaid sick leave. The sick leave can only be used to replace scheduled shifts it is not to be vacation time.

The accrual can be front loaded; however, the full amount would then be available to be used immediately. If front loaded any left at year end does not have to be carried over.

The accrual can be accumulated at 1 hour for every 30 hours worked and the employee can only use paid sick leave for time accumulated and unpaid sick time (up to 32 hours) for time not yet accumulated. If done this way the accrual DOES carry over from year to year.

NEXT MEETING

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

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD EXECUTIVE COMMITTEE MEETING
3:00PM – AUGUST 13, 2025
GAYLORD BOARDROOM

ATTENDEES:	**Don Tanner, Ruth Pilon, Gary Klacking**
VIRTUAL ATTENDEES:	**Eric Lawson**
NMRE STAFF	**Eric Kurtz, Deanna Yockey, Carol Balousek**

LEGAL ACTION

On August 8th, the four PIHPs in the current lawsuit (NorthCare Network, NMRE, CMH Partnership of Southeast Michigan, and Region 10) met at the request of attorney Chris Ryan (Taft, Stettinius & Hollister, LLP) upon the issuance of the RFP to procure the state's PIHPs on August 4th. The four PIHPs previously identified were asked to get authority from their Boards of Directors to pursue legal action. Mr. Ryan will likely select one of the four PIHPs to file the injunction (Region 10) and enjoin the others as the process moves forward.

MOTION BY DON TANNER TO GRANT THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUTIVE OFFICER THE AUTHORITY TO EITHER FILE OR ENJOIN A FUTURE LAWSUIT AGAINST THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES REGARDING THE PROCUREMENT PROCESS FOR MICHIGAN'S PREPAID INPAITENT HEALTH PLANS, IF REQUESTED; SUPPORT BY RUTH PILON. MOTION CARRIED.

The NMRE will continue exploring legal action against MDHHS regarding the procurement process on behalf of the CMHSPs. On August 19th, a meeting is scheduled with Mr. Kurtz, attorney Chris Cooke (Secrest Wardle), NorthCare Network CEO, Megan Rooney, and the 10 CMHSP CEOs from PIHP Regions 1 and 2. The PIHP procurement, as written in the RFP, is very detrimental to the CMHSPs. CMHSPs will be stripped of some of their authority, while administration of the CMHSP network and management will be given to the three new PIHPs. CMHSPs will conduct preadmission screenings, crisis services, and direct run services, basically rendering them clinical services providers, paid with the Medicaid portion of services on a fee-for-service basis. CMHSPs would not have the ability to manage any subcontractors or pay claims. Under the current Mental Health Code, they are allowed to perform those functions as comprehensive services providers. It was noted that there have not been any changes to the Mental Health Code to disallow these functions. Mr. Cooke is advising the CMHSPs to pursue legal action.

The NMRE has a current agreement/contract with attorney Chris Cooke (Secrest Wardle) and $2,000 left in his $10,000 retainer. Mr. Kurtz requested permission from the Executive Committee to increase the funding for legal services so that the region can pursue all legal channels against the RFP/PIHP procurement process. It was noted that before the RFP was issued, Mr. Kurtz requested a rural exemption to the RFP for Regions 1 and 2 based on a lack of providers. The due date to respond to the RFP is 11:50AM on September 29, 2025.

MOTION BY DON TANNER TO AUTHORIZE AN INCREASE TO THE NORTHERN MICHIGAN REGIONAL ENTITY'S FISCAL YEAR 2025 BUDGET LINE ITEM FOR LEGAL EXPENSES BY FIFTY THOUSAND DOLLARS ($50,000.00), IF NEEDED; SUPPORT BY RUTH PILON. ROLL CALL VOTE.

"Yea" Votes: Gary Klacking, Eric Lawson, Ruth Pilon, Don Tanner

"Nay" Votes: Nil

MOTION CARRIED.

DRAFT URBAN COOPERATION ACT AGREEMENT

A draft Urban Cooperation Act Agreement (UCA) was included in the meeting materials. Because the MDHHS current RFP to procure the state's PIHPs does not allow NorthCare Network or Northern Michigan Regional Entity to bid, the two PIHPs representing the 36 counties of northern Michigan would like to form a separate legal entity to be known as Bridge Health. The UCA will be filed in Marquette and Otsego Counties and a federal ID# will be acquired.

The Board of Directors for Bridge Health will be consistent with the provisions afforded in the RFP. Ideally, an equal number of Members will be appointed by the Upper Peninsula and Northern Lower Peninsula.

Mr. Kurtz acknowledged that the current draft UCA needs some revising based on the RFP.

MOTION BY DON TANNER TO GRANT THE AUTHORITY TO THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUTIVE OFFICER TO FINALIZE AND FILE THE INTERLOCAL AGREEMENT WITH NORTHCARE NETWORK; SUPPORT BY RUTH PILON. ROLL CALL VOTE.

"Yea" Votes: Gary Klacking, Eric Lawson, Ruth Pilon, Don Tanner

"Nay" Votes: Nil

MOTION CARRIED.

NORTHERN LAKES MISALLOCATION LOOKBACK

Mr. Kurtz has discussed the findings of the Rehmann lookback and the FY23 and FY24 cost settlement with Northern Lakes' Board Chair Greg McMorrow, Interim Chief Executive Officer Curt Cummins, and Chief Financial Officer, Kevin Hartley.

Funds due to Northern Lakes for the cost settlement of fiscal years 2023 and 2024 are offset by what is owed to NMRE based on the Cost Misallocation Lookback conducted by Rehmann.

Cost Misallocation Summary

	Due to NMRE
FY18	$2,004,763
FY19	$2,134,376
FY20	$1,677,753
FY21	$3,336,632
FY22	$2,010,778
Total	**$11,164.302**

It was noted that, because information was not provided by Northern Lakes for fiscal years 2019 and 2019, the weighted average percent of the questioned costs for fiscal years 2020 – 2022 of 3.76% was applied to the reported expenditures in fiscal years 2018 and 2019.

Cost Settlement Summary

	Due to NLCMHA
FY23	$1,466,073
FY24	$8,599,401
Total	**$10,065,474**

The net difference between the cost misallocation and cost settlement **$1,098,828** owed to NMRE from Northern Lakes. No funds for FY23 and FY24 are due to Northern Lakes from the NMRE.

These findings will be presented to the full NMRE board on August 27th.

Mr. Klacking adjourned the meeting at 3:56PM.

Chief Executive Officer Report

August 2025

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

July 29: Participated in NEMCMHA CMHA CARF Survey.

July 30: Met with NLCMHA Board Chair and staff regarding lookback.

July 31: Attended and participated in CMHAM RFP strategy session.

Aug 4: Met with NLCMHA and NMRE staff regarding NLCMHA restructuring.

Aug 7: Attended and participated in CMHAM RFP discussion.

Aug 7: Attended and participated in NMRE Internal Operations Committee meeting.

Aug 11: Attended and participated in PIHP Rate Setting Conference.

Aug 11: Attended and participated in PIHP RFP Bidders Conference.

Aug 12: Chaired ad hoc NMRE Operations Committee regarding RFP.

Aug 13: Attended and participated in NMRE Finance Committee meeting.

Aug 13: Attended and participated in NMRE Executive Committee meeting.

Aug 14: Attended CMHAM briefing on legal strategy.

Aug 15: Attended participated in RFP prep meeting with Region 1.

Aug 19: Chaired and participated in NMRE regional Operations Committee meeting.

Aug 21: Attended and participated in NMRE Internal Operations Committee meeting.

Northern Michigan Regional Entity

June 2025 Finance Report

June 2025 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	4,622,755	-	13,514,675
Healthy Michigan	(2,082,130)	736,656	7,068,394
	$ 2,540,625	$ 736,656	$ 20,583,069

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	2,247,095	4,387,178	(5,412,287)	(31,302)	304,540	823,785	221,615	$ 2,540,625
Carry Forward		-	-	-	-	-	-	736,656
Total Med/HMP Current Year Surplus	2,247,095	4,387,178	(5,412,287)	(31,302)	304,540	823,785	221,615	$ 3,277,281
FY24 Hab Support Waiver Revenue								$ (1,289,241)
Total Med/HMP Current Year Surplus Adjusted								$ 1,988,040
Medicaid & HMP Internal Service Fund								20,576,156
Total Medicaid & HMP Net Surplus								$ 23,853,437

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through June 30, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 159,291,714	$ 5,233,770						$ 164,525,484
CMHSP Distributions	(150,436,779)		48,477,111	**41,083,296**	25,334,890	21,833,268	13,708,214	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	8,854,935	5,233,770	48,477,111	41,083,296	25,334,890	21,833,268	13,708,214	164,525,484
Expense								
PIHP Admin	2,287,889	42,033						2,329,922
PIHP SUD Admin		105,733						105,733
SUD Access Center		-						-
Insurance Provider Assessment	1,361,695	26,865						1,388,560
Hospital Rate Adjuster	2,263,034							2,263,034
Services	590,748	2,774,882	51,355,576	40,814,500	24,850,422	20,592,947	12,836,405	153,815,480
Total expense	6,503,366	2,949,513	51,355,576	40,814,500	24,850,422	20,592,947	12,836,405	159,902,729
Net Actual Surplus (Deficit)	$ 2,351,569	$ 2,284,257	$ (2,878,465)	$ 268,796	$ 484,468	$ 1,240,321	$ 871,809	$ 4,622,755

Notes

Medicaid ISF - $13,514,675 - based on current FSR
Medicaid Savings - $0

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through June 30, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 12,490,541	$ 9,242,455						$ 21,732,996
CMHSP Distributions	(10,540,190)		3,876,922	3,012,196	1,365,055	1,432,007	854,009	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	1,950,351	9,242,455	3,876,922	3,012,196	1,365,055	1,432,007	854,009	21,732,996
Expense								
PIHP Admin	221,468	101,773						323,241
PIHP SUD Admin		256,012						256,012
SUD Access Center		-						-
Insurance Provider Assessment	130,618	62,954						193,572
Hospital Rate Adjuster	1,702,739							1,702,739
Services	-	6,718,795	6,410,743	3,312,294	1,544,984	1,848,543	1,504,203	21,339,562
Total expense	2,054,825	7,139,534	6,410,743	3,312,294	1,544,984	1,848,543	1,504,203	23,815,126
Net Surplus (Deficit)	$ (104,474)	$ 2,102,921	$ (2,533,821)	$ (300,098)	$ (179,929)	$ (416,536)	$ (650,194)	$ (2,082,130)

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

Net Surplus (Deficit) MA/HMP	**$ 2,247,095**	**$ 4,387,178**	**$ (5,412,287)**	**$ (31,302)**	**$ 304,540**	**$ 823,785**	**$ 221,615**	**$ 2,540,625**
Medicaid/HMP Carry Forward								**736,656**
Total Med/HMP Current Year Surplus								$ 3,277,281
Medicaid & HMP ISF - based on current FSR								**20,576,156**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 23,853,437**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through June 30, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 833,760		386,418	274,108	316,926	144,600	415,548	$ 2,371,360
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	833,760	-	386,418	274,108	316,926	144,600	415,548	2,371,360
Expense								
PIHP Admin	29,000							29,000
BHH Admin	29,786							29,786
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	376,919		386,418	274,108	316,926	144,600	415,548	1,914,519
Total expense	435,705	-	386,418	274,108	316,926	144,600	415,548	1,973,305
Net Surplus (Deficit)	$ 398,055	$ -	$ -	$ -	$ -	$ -	$ -	$ 398,055

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2024 through June 30, 2025

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 5,233,770	$ 9,242,455	$ 3,055,297	$ 2,834,110	$ 1,251,267	$ 21,616,899
Expense						
Administration	147,766	357,785	135,954	134,525		776,031
OHH Admin			57,653	-		57,653
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	26,865	62,954	-			89,819
Services:						
Treatment	2,774,882	6,718,795	2,553,057	1,285,526	1,251,267	14,583,527
Prevention	-	-	-	724,272	-	724,272
Healing and Recovery Grant				149,034		149,034
ARPA Grant	-	-	-	540,753	-	540,753
Total expense	2,949,513	7,139,534	2,746,664	2,834,110	1,251,267	16,921,089
PA2 Redirect			-	0		0
Net Surplus (Deficit)	$ 2,284,257	$ 2,102,921	$ 308,633	$ 0	$ -	$ 4,695,811

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2024 through June 30, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 159,291,714	$ 5,233,770	$ -	$ 164,525,484
Medicaid Savings	-	-	-	-
Healthy Michigan	12,490,541	9,242,455	-	21,732,996
Healthy Michigan Savings	736,656	-	-	736,656
Health Home	2,371,360	-	-	2,371,360
Opioid Health Home	-	3,055,297	-	3,055,297
Substance Use Disorder Block Grant	-	2,834,110	-	2,834,110
Public Act 2 (Liquor tax)	-	1,251,267	-	1,251,267
Affiliate local drawdown	446,112	-	-	446,112
Performance Incentive Bonus	1,653,705	-	-	1,653,705
Miscellanous Grant Revenue	-	4,000	-	4,000
Healing & Recovery Revenue	-	-	-	-
Veteran Navigator Grant	66,418	-	-	66,418
SOR Grant Revenue	-	1,147,319	-	1,147,319
Gambling Grant Revenue	-	159,827	-	159,827
Other Revenue	59	-	2,669	2,728
Total operating revenue	177,056,565	22,928,045	2,669	199,987,279
Operating expenses				
General Administration	2,739,789	574,599	-	3,314,388
Prevention Administration	-	92,022	-	92,022
OHH Administration	-	57,653	-	57,653
BHH Administration	29,786	-	-	29,786
Insurance Provider Assessment	1,492,313	89,819	-	1,582,132
Hospital Rate Adjuster	3,965,773	-	-	3,965,773
Payments to Affiliates:				
Medicaid Services	151,040,598	2,774,882	-	153,815,480
Healthy Michigan Services	14,620,767	6,718,795	-	21,339,562
Health Home Services	1,914,519	-	-	1,914,519
Opioid Health Home Services	-	2,553,057	-	2,553,057
Community Grant	-	1,285,526	-	1,285,526
Prevention	-	632,250	-	632,250
State Disability Assistance	-	-	-	-
ARPA Grant	-	540,753	-	540,753
Public Act 2 (Liquor tax)	-	1,251,267	-	1,251,267
Local PBIP	1,579,647	-	-	1,579,647
Local Match Drawdown	446,112	-	-	446,112
Miscellanous Grant	-	4,000	-	4,000
Healing & Recovery Grant	-	149,034	-	149,034
Veteran Navigator Grant	66,418	-	-	66,418
SOR Grant Expenses	-	1,147,319	-	1,147,319
Gambling Grant Expenses	-	159,827	-	159,827
Total operating expenses	177,895,722	18,030,803	-	195,926,525
CY Unspent funds	(839,157)	4,897,242	2,669	4,060,754
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	3,466,474	4,765,230	20,583,069	28,814,773
Unspent funds - ending	$ 2,627,317	$ 9,662,472	$ 20,585,738	$ 32,875,527

Northern Michigan Regional Entity

Statement of Net Position

June 30, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 56,026,276	$ 8,040,719	$ 20,585,738	$ 84,652,733
Accounts Receivable	2,399,424	2,747,088	-	5,146,512
Prepaids	84,521	-	-	84,521
Total current assets	58,510,221	10,787,807	20,585,738	89,883,766
Noncurrent Assets				
Capital assets	479,259	-	-	479,259
Total Assets	58,989,480	10,787,807	20,585,738	90,363,025
Liabilities				
Current liabilities				
Accounts payable	56,059,247	1,125,335	-	57,184,582
Accrued liabilities	302,916	-	-	302,916
Unearned revenue	-	-	-	-
Total current liabilities	56,362,163	1,125,335	-	57,487,498
Unspent funds	$ 2,627,317	$ 9,662,472	$ 20,585,738	$ 32,875,527

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2024 through June 30, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 140,814,531	$ 159,291,714	$ 18,477,183	13.12%
Carryover	11,400,000	-	-	-	-
Healthy Michigan					
Capitation	19,683,372	14,762,529	12,490,541	(2,271,988)	(15.39%)
Carryover	5,100,000	-	736,656	736,656	0.00%
Health Home	1,451,268	1,088,451	2,371,360	1,282,909	117.87%
Affiliate local drawdown	594,816	446,112	446,112	-	0.00%
Performance Bonus Incentive	1,334,531	1,334,531	1,653,705	319,174	23.92%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	82,503	66,418	(16,085)	(19.50%)
Other Revenue	-	-	59	59	0.00%
Total operating revenue	227,426,695	158,528,657	177,056,565	18,527,908	11.69%
Operating expenses					
General Administration	3,591,836	2,672,942	2,739,789	(66,847)	(2.50%)
Health Home Administration	-	-	29,786	(29,786)	0.00%
Insurance Provider Assessment	1,897,524	1,423,143	1,492,313	(69,170)	(4.86%)
Hospital Rate Adjuster	4,571,328	3,428,496	3,965,773	(537,277)	(15.67%)
Local PBIP	1,737,753	-	1,579,647	(1,579,647)	0.00%
Local Match Drawdown	594,816	446,112	446,112	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	68,787	66,418	2,369	3.44%
Payments to Affiliates:					
Medicaid Services	176,618,616	132,463,962	151,040,598	(18,576,636)	(14.02%)
Healthy Michigan Services	17,639,940	13,229,955	14,620,767	(1,390,812)	(10.51%)
Health Home Services	1,415,196	1,061,397	1,914,519	(853,122)	(80.38%)
Total operating expenses	208,177,013	154,794,794	177,895,722	(23,100,928)	(14.92%)
CY Unspent funds	$ 19,249,682	$ 3,733,863	(839,157)	$ (4,573,020)	
Transfers in			-		
Transfers out			-	177,895,722	
Unspent funds - beginning			3,466,474		
Unspent funds - ending			$ 2,627,317	(839,157)	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2024 through June 30, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 3,508,974	$ 5,233,770	$ 1,724,796	49.15%
Healthy Michigan	11,196,408	8,397,306	9,242,455	845,149	10.06%
Substance Use Disorder Block Grant	6,467,905	4,850,928	2,834,110	(2,016,818)	(41.58%)
Opioid Health Home	3,419,928	2,564,946	3,055,297	490,351	19.12%
Public Act 2 (Liquor tax)	1,533,979	511,326	1,251,267	739,941	144.71%
Miscellanous Grants	4,000	3,000	4,000	1,000	33.33%
Healing & Recovery Grant	-	-	-	-	0.00%
SOR Grant	2,043,984	1,532,988	1,147,319	(385,669)	(25.16%)
Gambling Prevention Grant	200,000	150,000	159,827	9,827	6.55%
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	21,519,468	22,928,045	1,408,577	6.55%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,082,576	766,935	574,599	192,336	25.08%
Prevention Administration	118,428	88,821	92,022	(3,201)	(3.60%)
Insurance Provider Assessment	113,604	85,203	89,819	(4,616)	(5.42%)
Medicaid Services	3,931,560	2,948,670	2,774,882	173,788	5.89%
Healthy Michigan Services	10,226,004	7,669,503	6,718,795	950,708	12.40%
Community Grant	2,074,248	1,555,686	1,285,526	270,160	17.37%
Prevention	634,056	475,542	632,250	(156,708)	(32.95%)
State Disability Assistance	95,215	71,413	-	71,413	100.00%
ARPA Grant	-	-	540,753	(540,753)	0.00%
Opioid Health Home Admin	-	-	57,653	(57,653)	0.00%
Opioid Health Home Services	3,165,000	2,373,750	2,553,057	(179,307)	(7.55%)
Miscellanous Grants	4,000	3,000	4,000	(1,000)	(33.33%)
Healing & Recovery Grant	-	-	149,034	(149,034)	0.00%
SOR Grant	2,043,984	1,532,988	1,147,319	385,669	25.16%
Gambling Prevention	200,000	150,000	159,827	(9,827)	(6.55%)
PA2	1,533,978	511,326	1,251,267	(739,941)	(144.71%)
Total operating expenses	25,222,653	18,232,837	18,030,803	202,034	1.11%
CY Unspent funds	$ 4,322,183	$ 3,286,631	4,897,242	$ 1,610,611	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			4,765,230		
Unspent funds - ending			$ 9,662,472		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2024 through June 30, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 1,921,812	$ 1,441,359	$ 1,505,833	$ (64,474)	(4.47%)
Fringes	666,212	475,218	472,357	2,861	0.60%
Contractual	683,308	512,487	520,376	(7,889)	(1.54%)
Board expenses	18,000	13,500	16,924	(3,424)	(25.36%)
Day of recovery	14,000	14,000	8,968	5,032	35.94%
Facilities	152,700	114,525	97,433	17,092	14.92%
Other	135,804	101,853	117,898	(16,045)	(15.75%)
Total General Admin	$ 3,591,836	$ 2,672,942	$ 2,739,789	$ (66,847)	(2.50%)

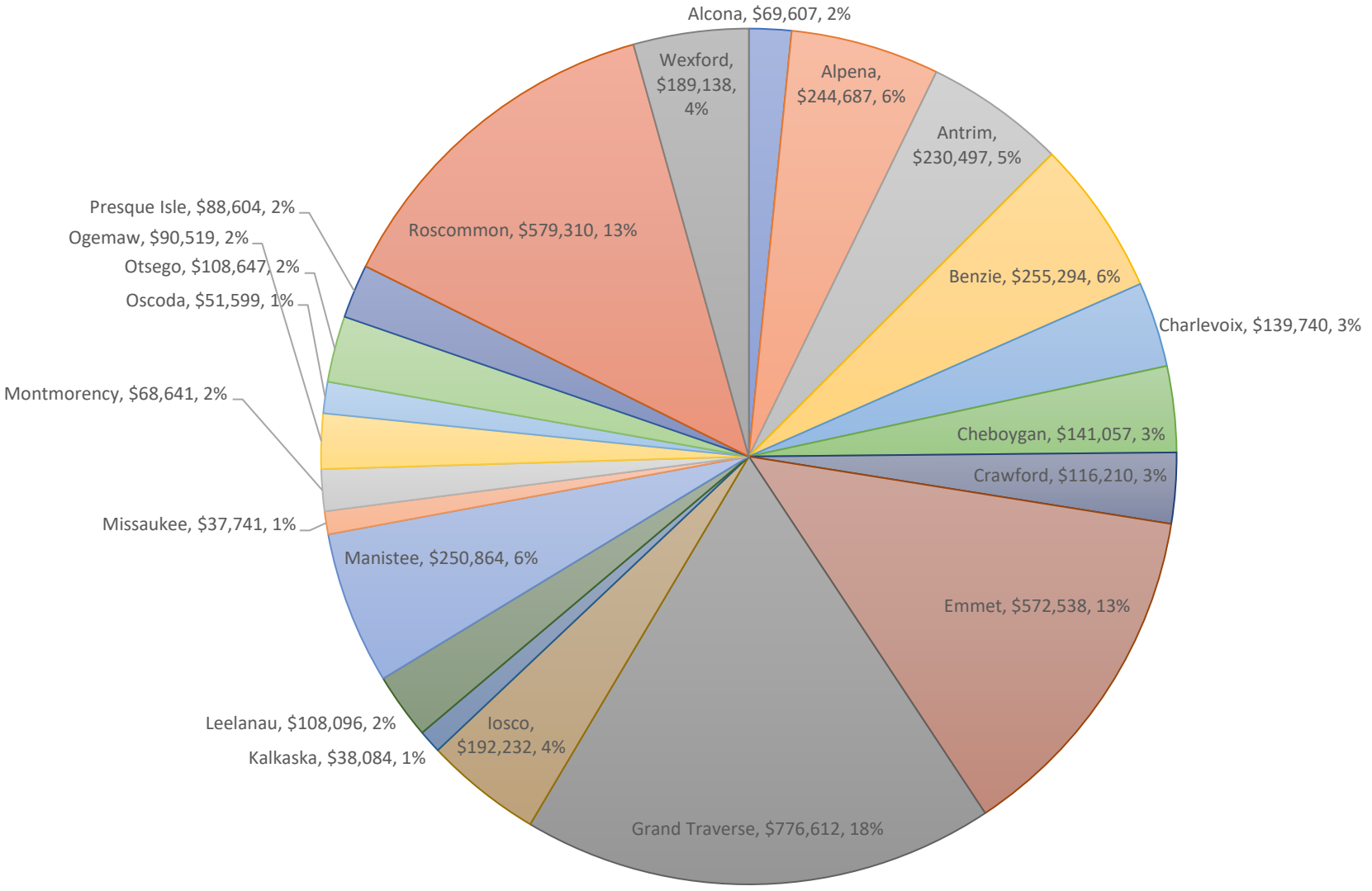
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2024 through June 30, 2025

	Projected FY25 Activity				Actual FY25 Activity			
	Beginning Balance	FY25 Projected Revenue	FY25 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 71,885	$ 23,013	$ 21,562	$ 73,336	$ 9,914	12,191	$ -	$ 69,607
Alpena	276,605	81,249	115,352	242,502	38,033	69,951	-	244,687
Antrim	225,891	71,430	37,276	260,045	33,812	29,205	-	230,497
Benzie	257,777	64,021	52,479	269,320	29,286	31,769	-	255,294
Charlevoix	240,410	106,977	204,773	142,613	46,677	147,347	-	139,740
Cheboygan	141,238	85,508	65,816	160,930	40,575	40,756	-	141,057
Crawford	126,884	36,205	68,993	94,096	17,924	28,598	-	116,210
Emmet	604,860	182,951	363,695	424,117	82,567	114,890	-	572,538
Grand Traverse	947,150	464,163	558,074	853,238	205,396	375,934	-	776,612
Iosco	186,997	84,319	73,780	197,537	38,690	33,455	-	192,232
Kalkaska	25,843	41,796	2,436	65,203	18,678	6,437	-	38,084
Leelanau	97,166	63,811	39,737	121,240	27,988	17,059	-	108,096
Manistee	259,014	82,480	104,210	237,284	36,904	45,053	-	250,864
Missaukee	30,683	22,352	20,908	32,127	10,850	3,793	-	37,741
Montmorency	59,540	30,318	8,457	81,401	13,074	3,973	-	68,641
Ogemaw	64,110	68,787	11,101	121,797	30,828	4,419	-	90,519
Oscoda	44,727	21,668	7,577	58,818	10,432	3,560	-	51,599
Otsego	112,969	105,067	98,424	119,612	48,085	52,408	-	108,647
Presque Isle	82,660	24,977	11,701	95,936	11,445	5,501	-	88,604
Roscommon	576,714	87,317	55,007	609,024	39,501	36,905	-	579,310
Wexford	332,107	98,696	229,583	201,220	45,098	188,067	-	189,138
	4,765,231	1,847,106	2,150,940	4,461,397	835,755	1,251,270	-	4,349,717
PA2 Redirect								-
								4,349,717

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2024 through June 30, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 723,372	$ 542,529	$ 339,371	$ 203,158	37.45%
Fringes	212,604	159,453	114,793	44,660	28.01%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	56,250	84,157	(27,907)	(49.61%)
Board expenses	5,000	3,753	3,500	253	6.74%
Day of Recover	-	-	13,971	(13,971)	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	4,950	18,807	(13,857)	(279.94%)
Total operating expenses	$ 1,082,576	$ 766,935	$ 574,599	$ 192,336	25.08%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2024 through June 30, 2025

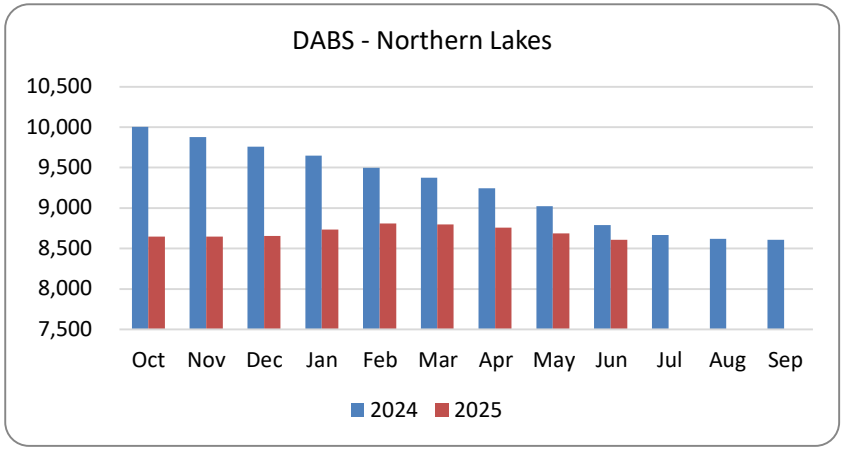
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	5,625	2,669	(2,956)	(52.55%)
Total operating revenue	7,500	5,625	2,669	(2,956)	(52.55%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 5,625	2,669	$ (2,956)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,583,069		
Unspent funds - ending			$ 20,585,738		

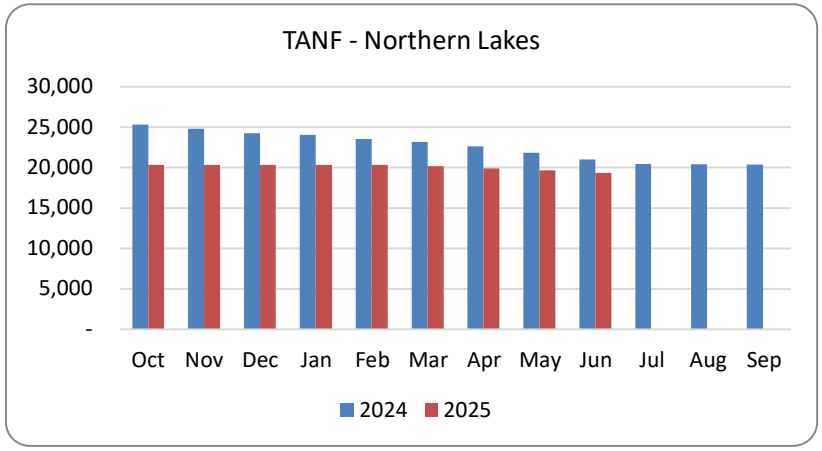
Northern Michigan Regional Entity

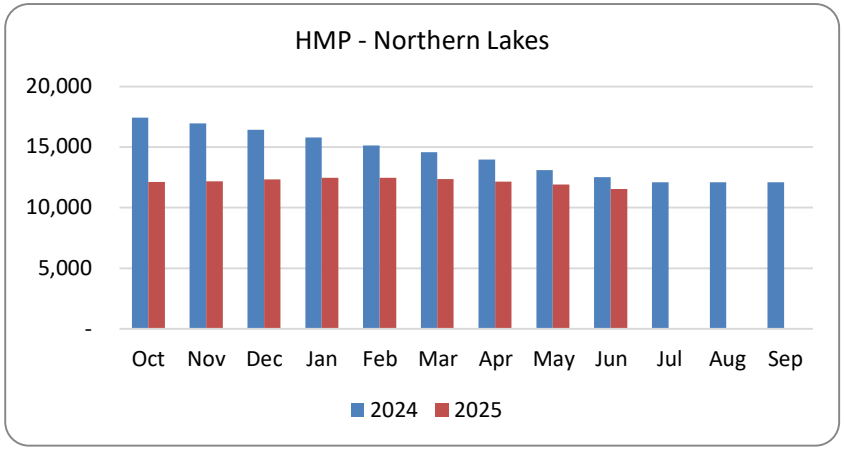
Narrative

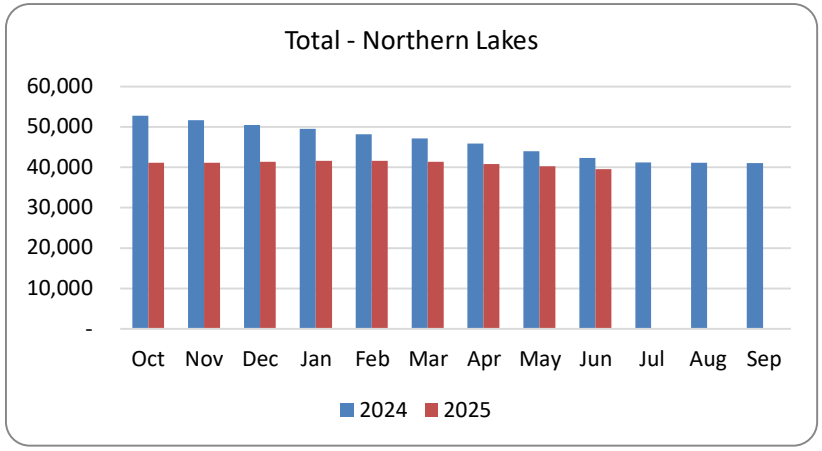
October 1, 2024 through June 30, 2025

Northern Lakes Eligible Members Trending - based on payment files







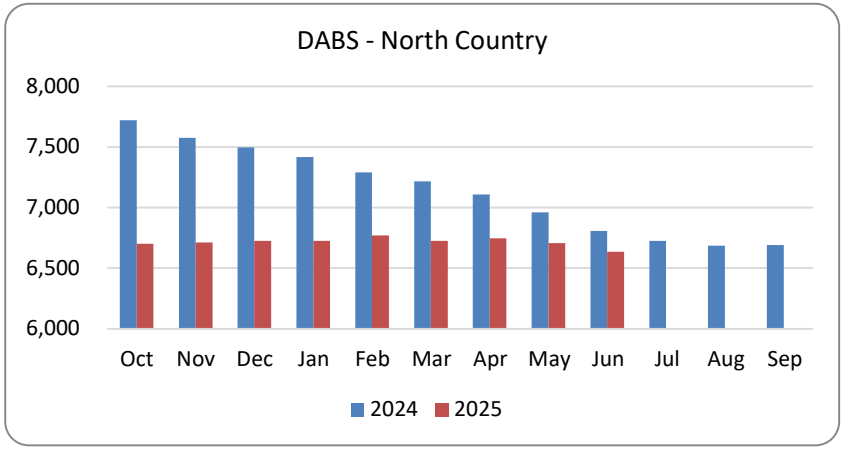


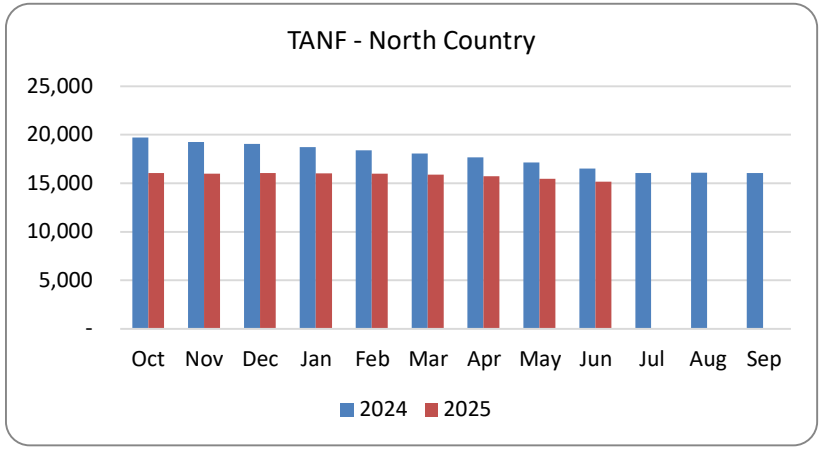
Northern Michigan Regional Entity

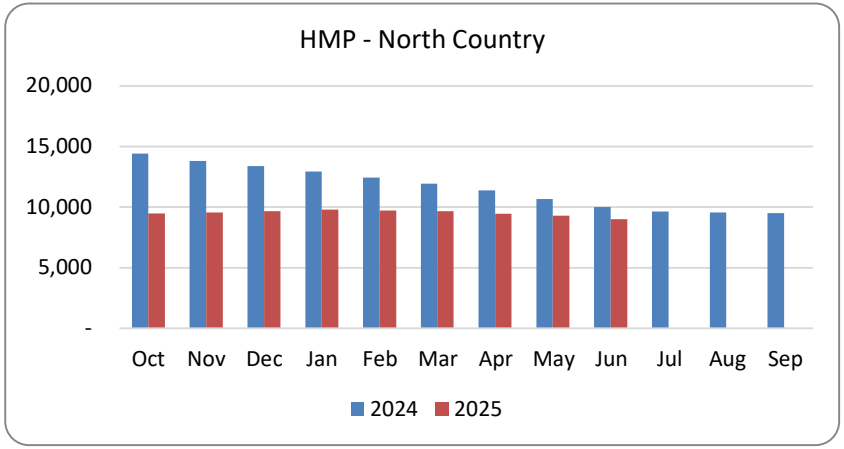
Narrative

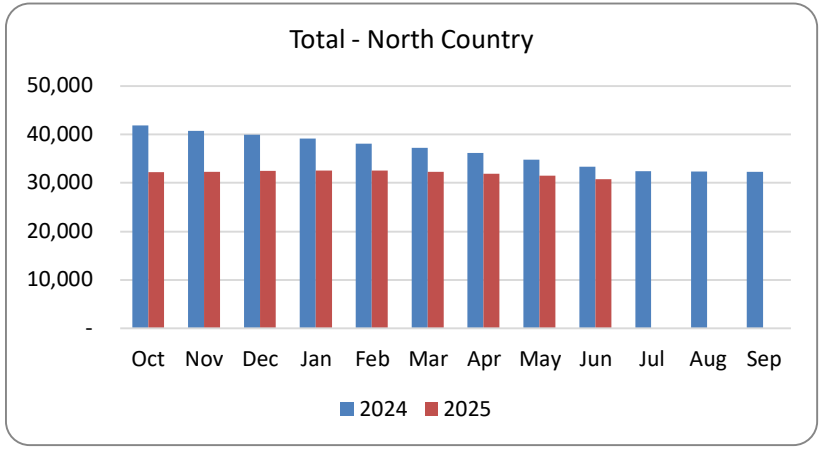
October 1, 2024 through June 30, 2025

North Country Eligible Members Trending - based on payment files







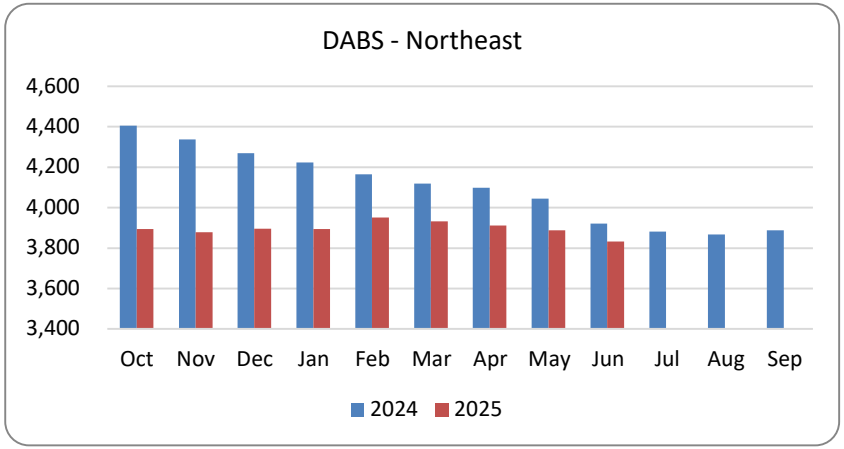


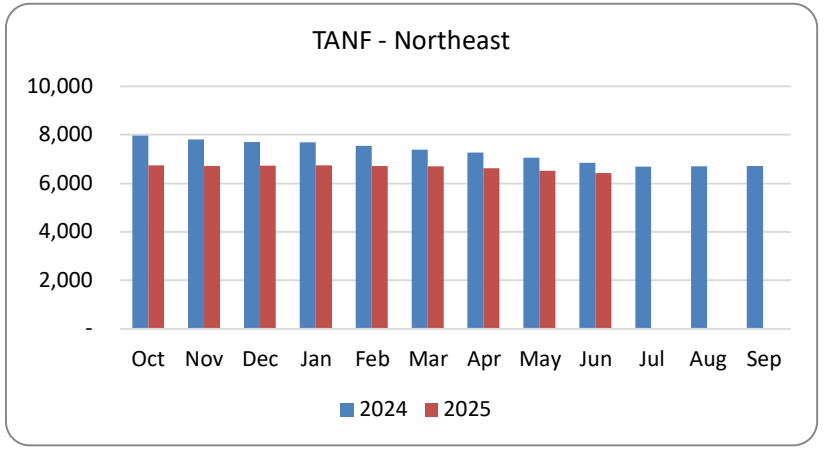
Northern Michigan Regional Entity

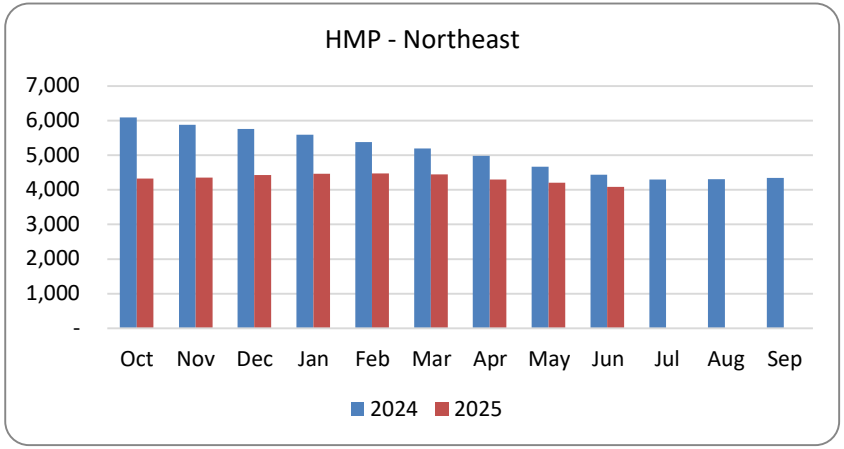
Narrative

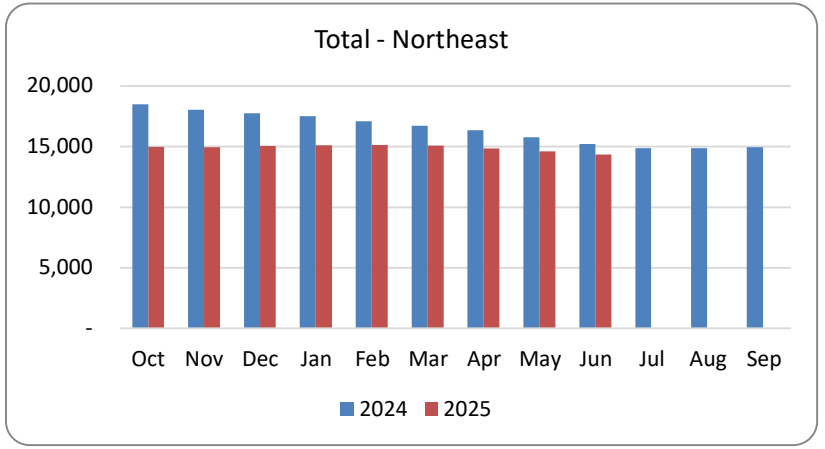
October 1, 2024 through June 30, 2025

Northeast Eligible Members Trending - based on payment files







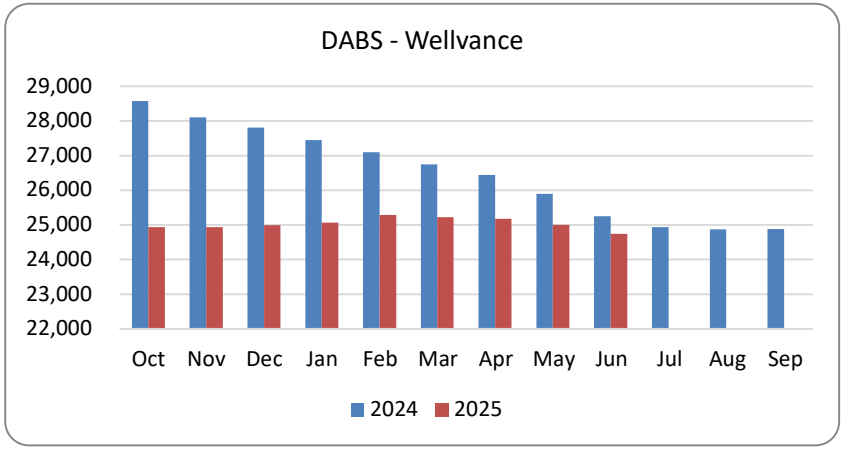


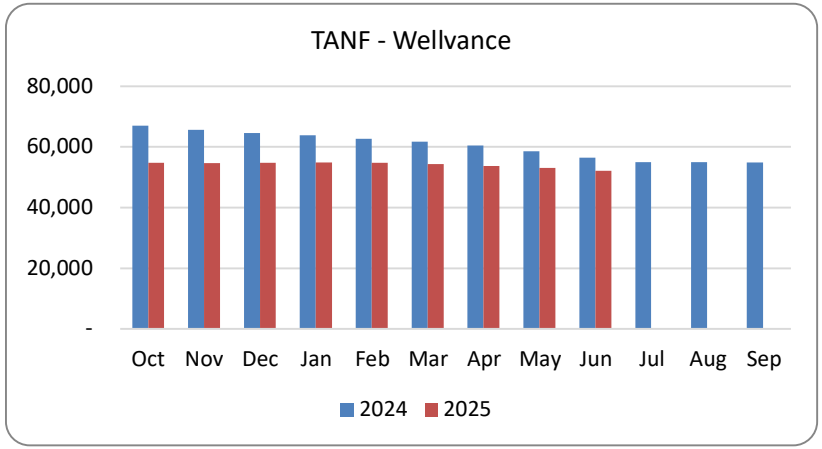
Northern Michigan Regional Entity

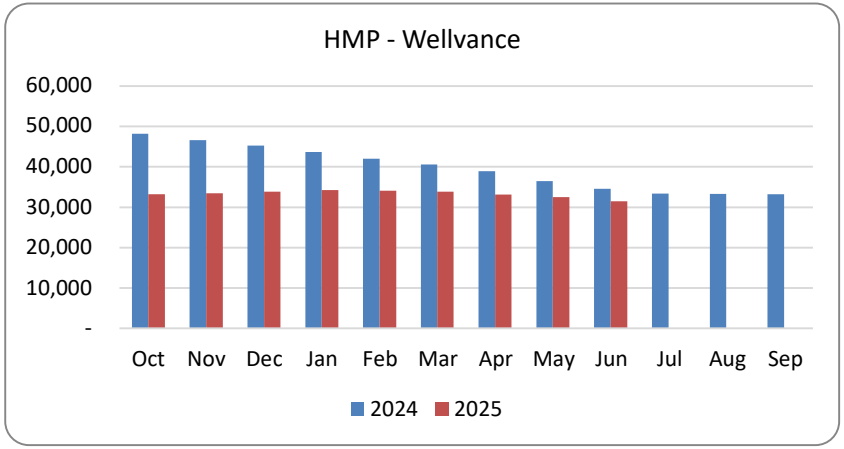
Narrative

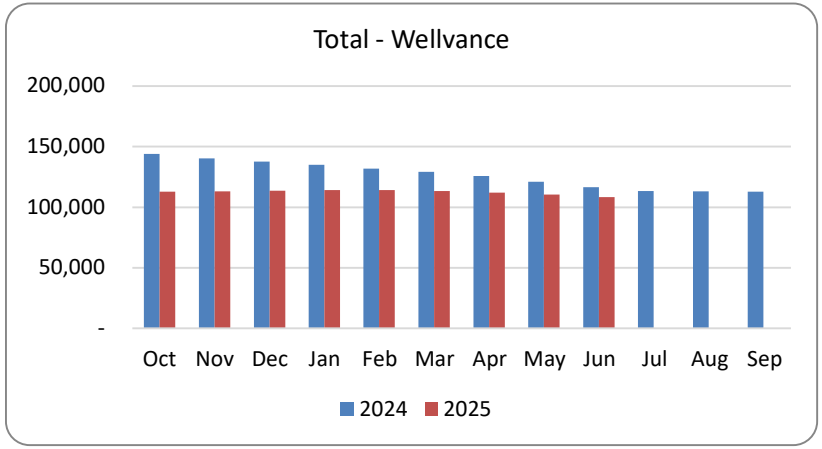
October 1, 2024 through June 30, 2025

Wellvance Eligible Members Trending - based on payment files







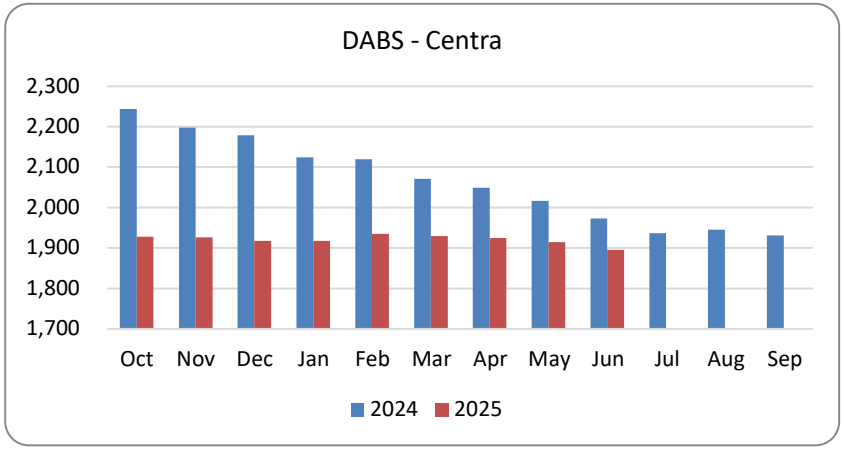


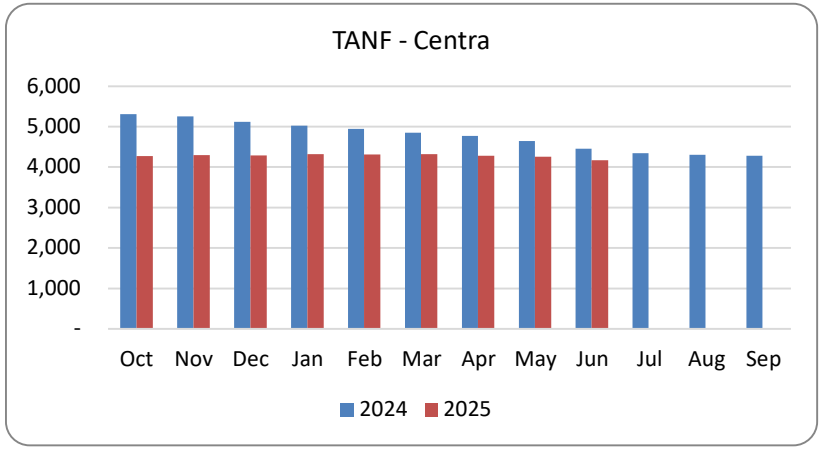
Northern Michigan Regional Entity

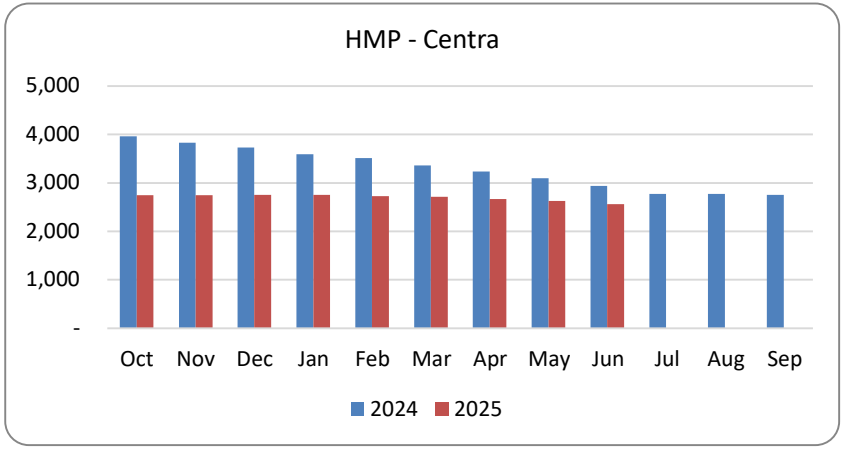
Narrative

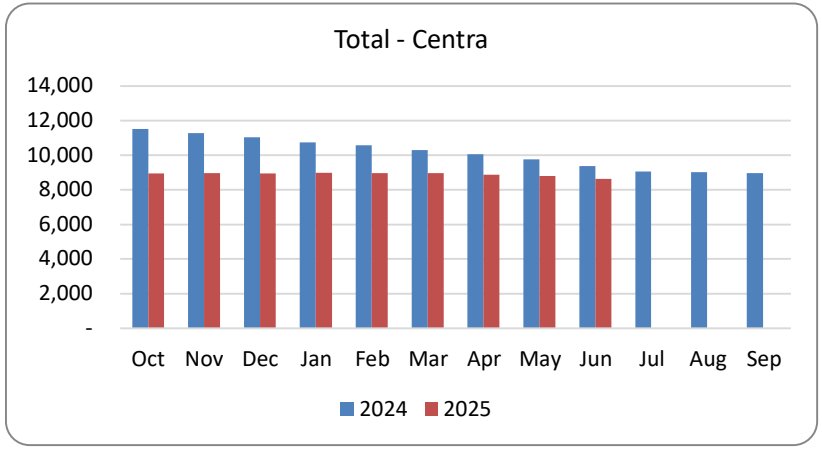
October 1, 2024 through June 30, 2025

Centra Wellness Eligible Members Trending - based on payment files







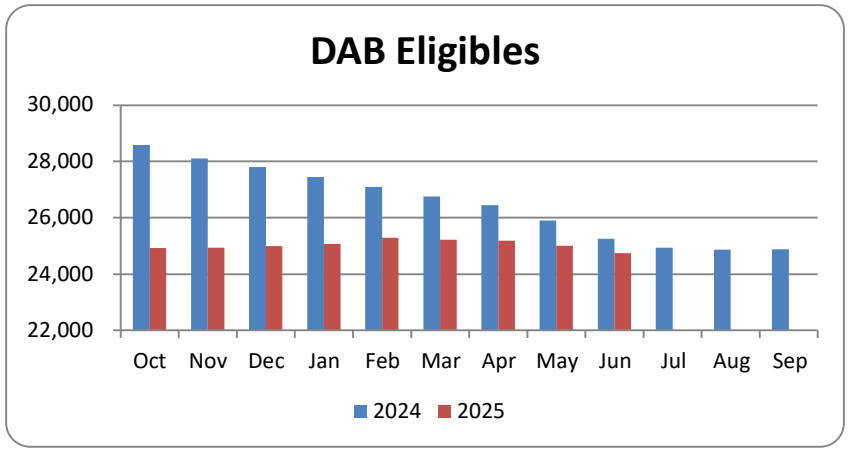


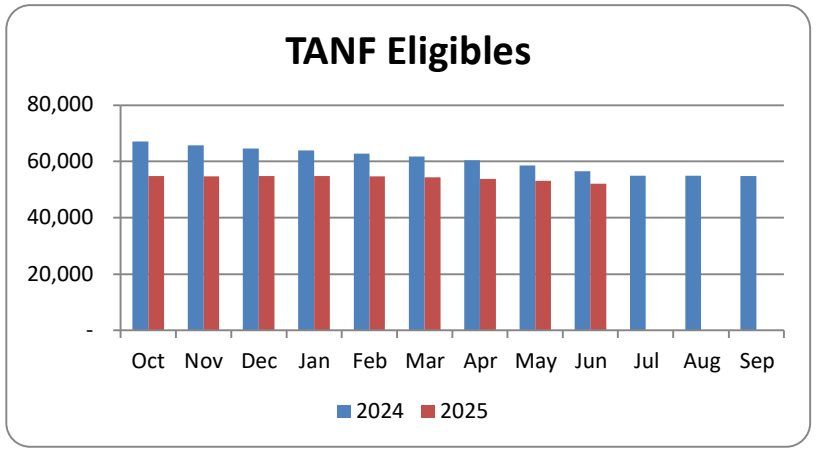
Northern Michigan Regional Entity

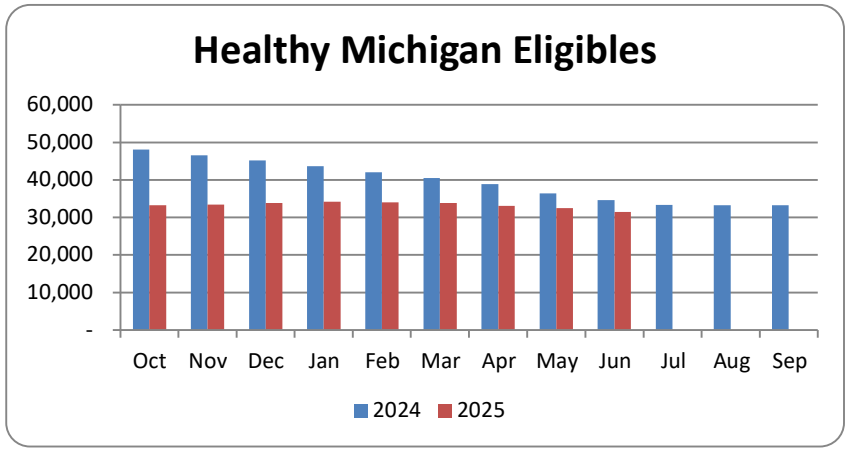
Narrative

October 1, 2024 through June 30, 2025

Regional Eligible Trending





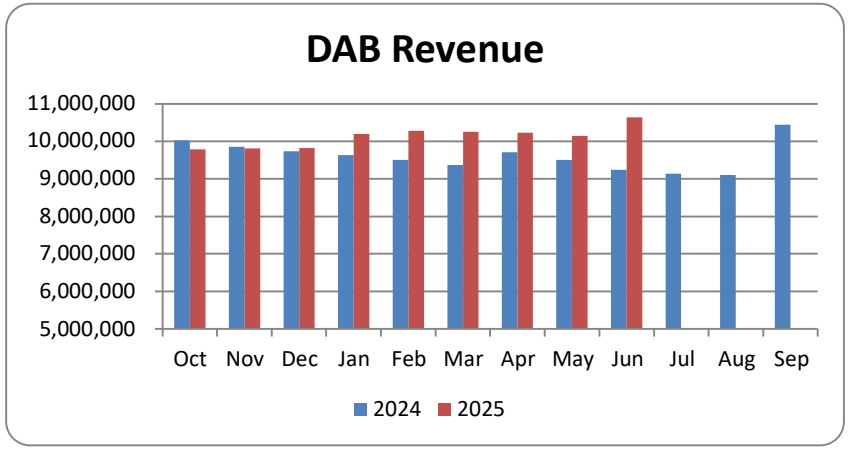


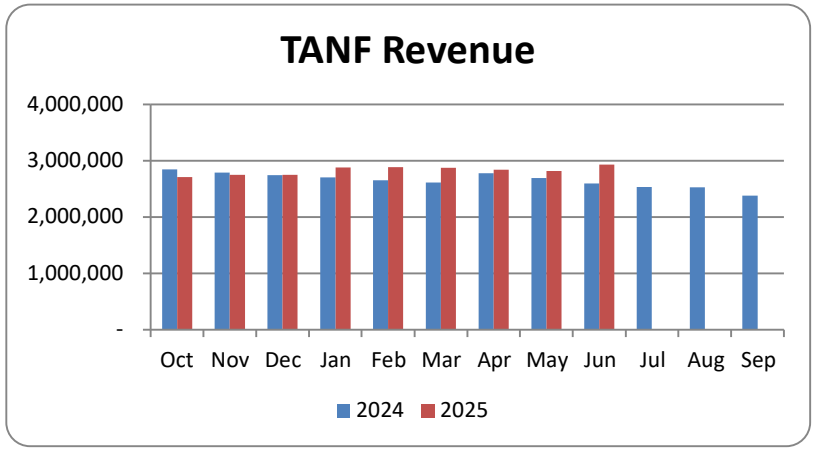
Northern Michigan Regional Entity

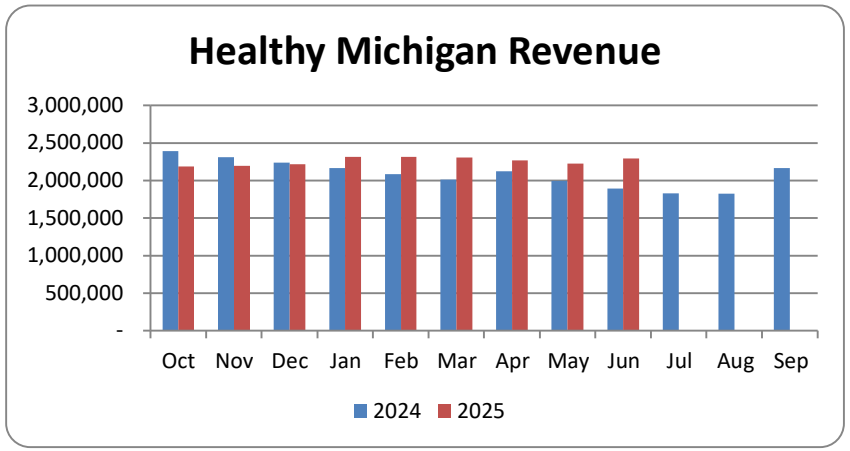
Narrative

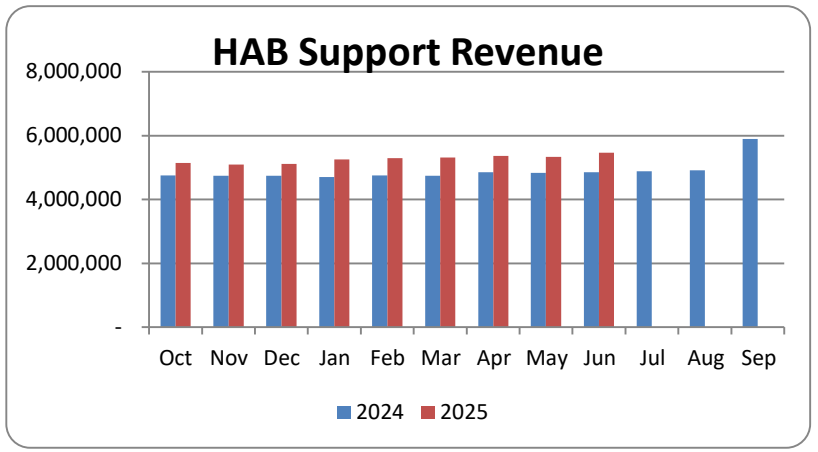
October 1, 2024 through June 30, 2025

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – AUGUST 19, 2025
GAYLORD CONFERENCE ROOM

ATTENDEES:	**Brian Babbitt, Curt Cummins, Chip Johnston, Eric Kurtz, Trish Otremba, Nena Sork, Carol Balousek**
GUESTS:	**Mike Bach, Chris Cooke, Tess Greenough, Lisa Harris (for Dan McKinney), Matt Maskart, Steven Meerschaert, Mandy Padget. Megan Rooney**

REVIEW OF AGENDA AND ADDITIONS

Mr. Babbit requested that an update on the waiver request for LBA requirement and budget approach for FY26 be added to the meeting agenda.

APPROVAL OF PREVIOUS MINUTES

The minutes from July 15th were included in the meeting materials.

MOTION BY NENA SORK TO APPROVE THE JULY 15, 2025 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY BRIAN BABBITT. MOTION CARRIED.

LEGAL DISCUSSION WITH REGIONS 1 AND 2

At 10:00AM, the CMH CEOs from Region 1 joined the meeting, along with NorthCare Network CEO, Megan Rooney, attorney Chris Cooke, and law clerk Steven Meerschaert (Secrest Wardle).

Mr. Cooke is keeping in touch with Mr. Ryan regarding their respective actions. injunctions and tactics.

FINANCE COMMITTEE AND RELATED

June 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $2,540,625. Carry forward was reported as $736,656. The total Medicaid and HMP current year surplus was reported as $3,277,281. FY24 HSW revenue was reported as $1,289,241. The total Medicaid and HMP adjusted current year surplus was reported as $1,988,040. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $23,853,437.
- Traditional Medicaid showed $164,525,484 in revenue, and $159,902,729 in expenses, resulting in a net surplus of $4,622,755. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $21,732,996 in revenue, and $23,815,126 in expenses, resulting in a net deficit of $2,082,130. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.

- Health Home showed $2,371,360 in revenue, and $1,973,305 in expenses, resulting in a net surplus of $398,055.
- SUD showed all funding source revenue of $21,616,899 and $16,921,089 in expenses, resulting in a net surplus of $4,695,811. Total PA2 funds were reported as $4,349,717.

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$871,809	$268,796	$484,468	($2,878,465)	$1,240,321
HMP	($650,194)	($300,098)	($179,929)	($2,533,821)	($416,536)
Total	$221,615	($31,302)	$304,540	($5,412,287)	$823,785

The financial outlook is much improved with the new rates; approximately $5M has been rolled out. June – September revenue is anticipated to be $1M higher than what was predicted before the rate adjustment. FY26 revenue will likely stay consistent with the adjusted rates. The CMHSPs' expenditures through June have stabilized for Medicaid; HMP continues to be overspent. Ms. Yockey intends to trend revenue flat when budgeting for FY26.

MOTION BY BRIAN BABBITT TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JUNE 2025; SUPPORT BY NENA SORK. MOTION APPROVED.

NLCMHA Lookback

Mr. Kurtz has discussed the findings of the Rehmann lookback and the FY23 and FY24 cost settlement with Northern Lakes' Board Chair Greg McMorrow, Interim Chief Executive Officer Curt Cummins, and Chief Financial Officer, Kevin Hartley.

Funds due to Northern Lakes for the cost settlement of fiscal years 2023 and 2024 are offset by what is owed to NMRE based on the Cost Misallocation Lookback conducted by Rehmann. The net difference between the cost misallocation ($11,164,302 owed to NMRE) and cost settlement ($10,065,474 owed to Northern Lakes) is **$1,098,828** owed to NMRE from Northern Lakes. No funds for FY23 and FY24 are due to Northern Lakes from the NMRE. The NMRE has cost settled with the Department through fiscal year 2020.

Legal Fund

On August 13th, the NMRE Board Executive Committee authorized an increase of up to $50,000 to the legal expenses line item in the FY25 budget.

ALPINE CRISIS RESIDENTIAL

Dr. Ibrahim reached out to Mr. Kurtz indicating that the Alpine Crisis Residential facility is not sustainable unless the current funding arrangement (the NMRE pays 50% of the facility's costs) continues. Occupancy is currently around 50%. The goal had been to pay the facility fee-for-service by October 2025 or January of 2026. Mr. Babbitt requested the FY26 fee-for-service rate, which Mr. Kurtz agreed to provide.

UCA

A draft Urban Cooperation Act Agreement (UCA) was included in the meeting materials. Because the RFP to procure the state's PIHPs does not allow NorthCare Network or Northern Michigan Regional Entity to bid, the two PIHPs representing the 36 counties of northern Michigan would like to enter into a UCA to form a legal entity to be known as Bridge Health. The UCA will be filed in Marquette and Otsego Counties and a federal ID# will be acquired.

It was noted that the UCA was drafted prior to the release of the RFP and requires some modification.

During the NMRE Board Executive Committee meeting on August 13th, authority was given to Mr. Kurtz to finalize and file the interlocal agreement with NorthCare Network.

CMHAM LEGAL ISSUES REGARDING BID OUT

This topic was discussed previously. Clarification was made that none of the CMHSPs nor the NMRE is planning to pay the special assessment requested by the Community Mental Health Association of Michigan (CMHA) but it will be presented to the NMRE Board and CMHSP Boards respectively.

NLCMHA UPDATE

The Cost Misallocation Lookback was discussed previously during the meeting. Dr. Cummins reported that additional staffing changes went into effect on August 18th. Northern Lakes' Leadership Team has been reduced to 6 members. A CEO Search Committee meeting took place on August 14th, during which candidate applications were reviewed. Two candidates will be brought to the region in mid-September. Northern Lakes continues to work on cost containment measures. Committee Members offered their support to Dr. Cummins.

HOSPITAL RATE REQUESTS

NMRE Provider Network Manager, Chris VanWagoner, included the following hospital rate requests for FY26.

BCA StoneCrest

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$808.55	$825.00	2%
Enhanced Rate 1:1 Staffing	$1071.20	$1,093.00	2%

Bronson Behavioral Health

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	1,090.00	$1,123.00	3%

Harbor Oaks

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$824.00	$849.00	3%
Specialized Pediatric Unit (0100)	$1,400.00	$1,442.00	3%

Havenwyck

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult/Adolescent Psychiatric Inpatient (0100)	$999.01	$1,029.00	3%
Partial Hospitalization (0912)	$439.81	$453	

* Single Case Agreements (SCAs) may be used for Enhanced Staffing at a rate of $1,149.01.

Henry Ford Kingswood

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	—	$1,123.00	NA
Specialized Inpatient Pediatric Unit	—	$1,442.00	NA
ECT (0901)	—	$1,350.00	NA

McLaren Healthcare

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,037.21	$1,068.00	3%
Partial Hospitalization (0912)	$519.12	$535.00	3%

Munson Medical Center

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,175.86	$1,193.50	1.2%
Partial Hospitalization (0912)	$471.19	$487.28	3.4%
ECT (0901)	$799.28	$811.27	1.5%

HealthSource Saginaw

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,081.50	$1,103.13	2%
Adolescent Psychiatric Inpatient (0100)	—	$1,113.95	NA
Geriatric Psychiatric Inpatient (0100)	—	$1,113.95	NA

* SCAs may be used for Enhanced Staffing at a rate of $1,500.00.

In July, the committee gave approval for all FY26 rate requests ≤ 3%; therefore, no action was required.

UPDATE ON THE WAIVER REQUEST FOR LBA REQUIREMENT

MDHHS has issued a directive that Behavior Treatment plans be written by Licensed Behavioral Analysts (LBA) or a psychologist under the supervision of LBA, effective October 1st. None of the five CMHSPs have an LBA on staff and will not prior to October 1st. During the July meeting, Mr. Babbitt questioned the possibility of a waiver. Mr. Kurtz agreed to send a a response to MDHHS requesting a waiver for Region 2.

BUDGET APPROACH FOR FY26

As stated previously, revenue for FY26 will likely be consistent with what is being received following the FY25 revenue adjustment.

NEXT MEETING

The next meeting was scheduled for September 16th at 9:30AM

email correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter
Subject:	Strengthening CMHA's advocacy efforts in the face of privatization threat: Special Assessment of CMH and PIHP members of CMHA
Date:	Monday, August 11, 2025 11:01:38 AM
Attachments:	image004.png image005.png CMHSP & PIHP FY 2025 dues & fees.pdf Q&A CMHA 2025 Special Assessment.pdf
Importance:	High

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: Strengthening CMHA's advocacy efforts in the face of privatization threat: Special Assessment of CMH and PIHP members of CMHA

HISTORY: You may remember that several years ago, when faced with the privatization threat posed by bills sponsored by Senator Shirkey, CMHA levied a Special Assessment of its CMHSP and PIHP members. That Special Assessment provided a significantly increased level of funding for CMHA's advocacy work – an increase designed to match the level of threats and opportunities faced, at that time, by the state's CMHSPs and PIHPs and those whom we serve. The funds raised by this Special Assessment were key to the success of our collective efforts in thwarting that threat. Only $15,093 remains in the CMHA Advocacy and Education Fund – the fund created with the revenues collected through that previous Special Assessment.

CURRENT REQUEST: As you know, CMHA, its members, and allies are, once again, battling a privatization threat to Michigan's public mental health system.

During several discussions with the CEOs of the CMHSP and PIHP members of CMHA, the proposal was made, by the majority of those present, that CMHA, once again, issue a Special Assessment of its CMHSP and PIHP members. The CMHA Executive Committee (its officers) have approved of this Special Assessment. As a result, CMHA is issuing, via this email, a special assessment. The details of this assessment are provided below, including a Q&A section based on the questions raised during the previous Special Assessment.

PURPOSE OF VOLUNTARY SPECIAL ASSESSMENT: The purpose of this special assessment (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 – 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 the recently issued 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**.

CMHA TO CONTRIBUTE: The funds raised by this Special Assessment will be added to the balance remaining in the CMHA Education and Advocacy Fund, from the previous Special Assessment. Additionally, **CMHA will draw $100,000 from its fund balance and contribute those dollars to this fund.**

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: **CMHA is working to draw together, through this special assessment, a public education and media relations fund of size – a size to compete in the public arena with those promoting this latest privatization effort.**

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 2025 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 (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

CMHA Member Dues and Fees Fiscal Year 2025

CMHSP dues to CMHA	FY 2025
CMHSP	
Allegan	15,213
AuSable Valley	14,649
Barry	11,137
Bay-Arenac	19,330
Berrien	19,009
Centra Wellness NW (Mans B)	11,354
Clinton Eaton Ingham	31,022
CMH for Central MI	28,714
Copper Country	11,464
Detroit-Wayne	31,022
Genesee	31,022
Gogebic	10,984
Gratiot	11,389
Hiawatha	11,346
Huron	11,113
Ionia- The Right Door for Hope	11,508
Kalamazoo	27,407
Lapeer	14,678
Lenawee	14,631
LifeWays	27,087
Livingston	15,464
Macomb	31,022
Monroe	15,490
Montcalm	14,662
Muskegon- HW	23,363
Network180 (Kent)	31,022
Newaygo	11,380
North Country	19,158
Northeast Michigan	15,168
Northern Lakes	23,315
Northpointe	11,543
Oakland	31,022
Ottawa	18,934
Pathways	18,758
Pines	11,265
Saginaw	23,866
Sanilac	11,547
Shiawassee	14,830
St. Clair	23,720
St. Joseph	11,559
Summit Pointe	19,416
Tuscola	14,591
Van Buren	14,886
Washtenaw	27,415
West Michigan	15,008
Woodlands	11,229

PIHP Fees to CMHA	FY 2025
All 10 PIHPs	53,780

Community Mental Health Association of Michigan

CMHA Special Assessment: Q&A

August 2025

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.

AGREEMENT FOR THE BRIDGE HEALTH ORGANIZATION

THIS AGREEMENT made and entered into this ____ day of _____, A.D., ___, by and between the Regional Boards of NorthCare Network Regional Entity (NorthCare) of the 15 Counties located in Michigan's Upper Peninsula and The Northern Michigan Regional Entity (NMRE) located in the 21 Counties of Northern Lower Michigan (hereinafter collectively referred to as "Entity" or "Entities").

WITNESSETH:

WHEREAS, the Michigan Mental Health Code Act 258 of Public Acts of 1974, as amended, of the State of Michigan provides that the 36 counties have established various Community Mental Health Programs (hereinafter referred to as "CMHSP") by a majority vote of each Counties Board of Commissioners; and

WHEREAS, Section 1204b of the Michigan Mental Health Code Act 258 of Public Acts of 1974, as amended, requires an agreement of said CMHSP to establish and determine procedures and regulations for the NorthCare and NMRE Regional Entities; and

WHEREAS, Article 7, Section 28 of the Michigan Constitution of 1963 and Act 7 of the Public Acts of 1967, as amended, MCL 124.501 et seq., permits public entities to, by agreement, perform functions that could be performed by individual public entities; and

WHEREAS, the Entities desire to enter into an agreement to establish and create a board known as the Bridge Health Organization (hereinafter sometimes referred to as BHO), and to specify the powers and duties under which it will operate pursuant to the above cited authority;

THEREFORE, for and in consideration of the mutual covenants hereinafter contained, IT IS HEREBY AGREED as follows:

I.

Establishment

Pursuant to the Mental Health Code, 1974 PA 258, MCL 330.1200, et seq., as amended, Social Welfare Act PA 280 of 1930, MCL 400.109 (f) et seq., as amended, and pursuant to the Michigan Constitution of 1963, Article 7, Section 28, and 1967 PA 7, as amended, MCL 124.501, et seq., the duly appointed members of the Regional Entities of NorthCare Network and the Northern Michigan Regional Entity, hereby establish a board to be known as the Bridge Health Organization.

II.

Definitions

The following terms for this Agreement shall have the meanings attached to them:

"Board" means the Bridge Health Organization Board for Upper Peninsula and Northern Lower Michigan.

"Executive Director" means the director of the BHO.

"Service" means a mental health or Substance Use service.

“Service Area” means area or span of control afforded by MCL §330.1204b to the Entities

"Department" means the Department of Health and Humans Services of the State of Michigan.

"Director" means· the director of the Department of Health and Human Services of the State of Michigan.

III.

Purpose of the Board

The purpose of the Bridge Health Organization Board is to provide administrative management of services and funding for a range of mental health and substance use services for people located within the thirty-six counties as required by and permitted under The Mental Health Code 1974 PA 258, as amended.

The Board shall advocate and promote behavioral health services that are appropriate for rural communities that are resource poor. To address needs in the most efficacious and effective manner possible, maximizing behavioral health care delivery.

The Board shall carry out the applicable provisions of the Mental Health Code, Social Welfare Act, and shall, subject to the rules designated by the Michigan Department of Health and Human Services, provide administrative management and payment for services in at least one of the following mental health areas:

Mental Illness, Intellectual and developmental disabilities, organic brain and other neurological impairment or disease, and substance use.

A service provided pursuant to this Agreement is any of the following:

a) Prevention, consultation, collaboration, education or information service;
b) Diagnostic service;
c) Emergency service;
d) In-patient service;
e) Out-patient service;
f) Partial hospitalization service;
g) Residential, sheltered or protective care service;
h) Habilitation or rehabilitation service;
i) Any other service approved by the State Department of Health and Human Services.

IV.

Area Served

The Board shall provide the funding of services set forth herein to people who are located within the 36 counties of Michigan's Upper Peninsula which contains Copper Community Mental Health Authority, Gogebic Community Mental Health Authority, Hiawatha Community Mental Health Authority, Northpointe Community Mental Health Authority, and Pathways Community Mental Health Authority and Lower Northern Michigan which contains AuSable Community Mental Health Authority d/b/a Wellvance, Manistee-Benzie Community Mental Health Organization d/b/a Centra Wellness Network, North Country Community Mental Health Authority, Northeast Community Mental Health Authority, and Northern Lakes Community Mental Health Authority.

V.

Establishment of the Board

The Entities hereby establish an Organization consisting of Eleven-(11) members to serve for the term and upon the conditions. set forth in Article VI. Initially each Board of Member shall, by a majority vote, be appointed by the Board members from the Entities. Five (5) Board members will be appointed from the counties of Michigan's Upper Peninsula, five (5) Board members will be appointed from the counties of Northern Lower Michigan, and one member shall be from a Michigan approved Medicaid health plan operating within the catchment areas of the Upper Peninsula or the Northern Lower Peninsula of Michigan as agreed to by the Entities. These Eleven (11) members shall not be a current member of the Entity nor a current member of a CMHSP with the TEN (10) appointed from dispersed geographic locations across the Upper Peninsula and Northern Lower Michigan.

SUD Oversight Policy Board: Contractor must establish a SUD Oversight Policy Board or Boards pursuant to Section 330.1287 of PA 258 of 1974, as amended in the Mental Health Code.

VI.

Term of Board Membership, Vacancies, Removal from Office

Recommended new appointments to the Board shall be made annually following the expiration of a term, the vacancy of a member, or a resignation. Appointments will be made and approved by the Entities.

The term of office of a Board member shall be three (3) years from January 1 of the year of appointment, except that of the members first appointed, four shall be appointed for a term of one year, four for two years and three for three years. The makeup of the Board shall be maintained as having 50% from the Upper Peninsula, Five (5) and 50% from the Northern Lower Peninsula of Michigan, Five (5), with one from a Medicaid Health Plan in the service area. Vacancies shall be filled with unexpired terms in the same manner as original appointments. A Board member may be removed from office by the Board Chair for either neglect of official duty or misconduct in office (to be defined in the BHOs Bylaws) after being given a written statement of reasons and an opportunity to be heard thereon.

VII.

Qualifications for Board Members

The composition of the Bridge Health Organization shall be representative of all providers of mental health and substance abuse services, recipients or consumers of services, agencies and occupations having a working involvement with services, and the general public, although such representation need not be in any fixed proportion.

A minimum of one-third (1/3) of its Governing Body must be individuals with lived experience in Michigan's specialty behavioral health system. One of the individuals must include a family member of a youth receiving services through Michigan's public specialty behavioral health system. At least two members with "lived" experiences or are Immediate family members including but not limited to Substance Use, Mental Health, Autism, and Intellectual Development Disabilities with at least one from NorthCare and one from the NRME service area and one at large representing a family member of a youth receiving services through Michigan's public specialty behavioral health system.

Network Providers may hold no more than one-third (1/3) of the seats of the governing body, and board must:

1. Exclude any Network Providers that have ownership in the Contractor entity.
2. Ensure members do not have any control, influence, or decision-making authority in establishment of the regional PIHP Provider Networks.

No more than half of the total Board members may be state, or local public officials. For purposes of this section, public officials are defined as people serving in an elected or appointed public office or employed more than twenty (20) hours per week by an agency of federal, state, city or local government.

The Board shall have no more than one representative from the Michigan Medicaid Health Plans.

A Board member shall have his/her place of residence in communities of the Upper Peninsula or Northern Lower Michigan he/she represents. An employee of the Department, an employee of CMHSP, or an employee or representative of an agency having a direct contractual relationship with CMHSP or an Entity may not be appointed to serve on the Board.

VIII.

Compensation and Expenses for Board Members

A Board member shall be paid per diem for meetings attended in an amount authorized pursuant to the Mental Health Code, as amended, 1974 PA 258, as amended, Section 224. Board members shall receive a mileage reimbursement at a rate not more than the rate determined by the State Officers' Compensation Commission. A Board member shall not receive more than one per diem payment per day, regardless of the number of meetings attended related to CMHSP business.

The Board members shall be eligible for necessary other expenses and reimbursements as are permitted by the Board with respect to conferences, seminars and other Organizational related activities. The BHO shall seek reimbursement from the Department subject to its rules and regulations for per diem payments made to the Mental Health Boards under Section 224 of The Mental Health Code, Act 258 of Public Acts. of 1974, as amended.

Governing Body Conflict of Interest:

1. Members of the governing body must be selected in a way that minimizes any potential or perceived conflicts of interest.
2. Governance for the payor entity must be fully independent of and distinct from any providers with which they contract for Medicaid-covered services, as well as from any owners holding direct or indirect interests in those providers.
3. Board members must not be compensated officers, key personnel, or employees employed by or responsible for the conduct of the Contractor.
4. Board members must not be members of multiple PIHP boards.

IX.

Board Duties

The Board shall:

a) Annually examine and evaluate the mental health and substance use needs of the service area and the public and non-public services necessary to meet those needs.
b) The governing body must meet at least quarterly and must keep a timely permanent and public record of all proceedings available to MDHHS and/or CMS upon request.
c) Take action to secure private, federal and other public funds to help support its program(s).
d) Approve and authorize all contracts for the providing of services.
e) Review and evaluate the quality, effectiveness, and efficiency of services being provided by its program.
f) Appoint an executive director who shall meet standards of training and experience established by the Department.
g) Establish general policy guidelines within which the executive director shall execute the BHO program.
h) State and local contributions and all other funds received shall be handled and banked directly by the BHO, which has the duty to ensure that the funds are banked and accounted for consistently with requirements of law for local governmental units.
i) Governing Body Procedures: Contractor must have written and publicly posted policies and procedures for the governing body detailing, at a minimum, the following:
    a. Board accountability statement.
    b. Board goals and priorities.
    c. Conflict of interest and independence requirements for board membership.
    d. The length of the term for board members.
    e. Filling of vacancies.
    f. Information accessibility.
j) Governing Board Notifications: Contractor must provide timely notification to MDHHS, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

X.

Powers of the Board

The Board shall have all the rights, powers, duties and obligations set forth in the Mental Health Code, 1974 PA 258, as amended, MCL 330.1204b, as amended, and shall have the

following powers and duties in addition to the other powers and duties stated under this agreement:

a) To enter contracts, including contracts for the purchase of mental health services with private people and/or entities or public agencies. The contracts may be entered into with any facility or entity of the State Department of Health and Human Services.

b) To acquire ownership, custody, operation, maintenance, lease or sale of real or personal property, subject to any limitation on the payment or funding therefore now or subsequently imposed by the Mental Health Code, 1974 PA 258, as amended.

c) To dispose of, divide, and distribute property.

d) To accept gifts, grants, assistance, funds or bequests.

e) To make claims for federal or state aid payable to the participants in the programs of the Board.

f) To incur debts, liabilities or obligations which do not constitute the debts, liabilities or obligations of any of the parties to this agreement, subject to any limitations thereon which are now or hereafter imposed by the Mental Health Code, 1974 PA 258, as amended.

g) To, in its own name, employ, contract and/or lease employees and agents, which employees or agents shall be considered employees or agents on the Board. The Board shall have the power, duties and responsibility for establishing policies, guidelines and procedures for employees and shall have the power, duty and responsibility to establish wages and fringe benefits such as, but not limited to, sick leave, vacation, health insurance, pension and life insurance; to provide for worker's compensation and for any and all other terms and conditions of employment of an employee of the Board unless contracted or leased. However, pursuant to the Mental Health Code, as amended, MCL §330.1204a (3) et seq., any Entity employees who were initially transferred to the BHO by either of the Entities shall continue to have all benefits, obligations and status with respect to pay, seniority credits, and sick leave, vacation, insurance and pension credits that the individual held as an Entity employee. The above-stated conditions and limitations upon the transfer of Entity employees shall not serve to limit the right of the BHO to hire Entity employees voluntarily seeking a job change upon such terms and conditions as the BHO and the individual may agree upon.

h) To fix and collect charges, rates, rents or fees where appropriate and to promulgate rules and regulations related thereto.

XI.

Director

The executive director shall function as the chief executive and administrative officer of the BHO and shall execute and administer the BHO in accordance with the approved plan and budget, the general policy guidelines established by the Board, the applicable procedures and regulations, and the provisions of state statute. The terms and conditions of the executive director's employment, including tenure of service, shall be as mutually agreed to by the Board and the executive director and shall be specified in writing.

XII.

Funding

Cost sharing for BHO shall be based upon the foundations of equal protection found in Article 14 of the United States Constitution and in Article 1, Section 2 of the Michigan Constitution. Medicaid member/beneficiary enrollment population distribution as displayed in the most recent Department of Health and Human Services data. Nothing contained herein shall prevent any Entities from allocating available funds more than minimum obligations pursuant to this contract and the Mental Health Code, PA 258 of 1974, as amended, upon such terms as the Entities determine.

XIII.

Information

The Board and Director seek to provide Counties and Entities separately and/or jointly, as requested, all information related to the operations of the Board on a timely basis.

XIV.

Duration of This Agreement
and Rights Upon Termination

1. The duration of this agreement shall be perpetual. However, either of the Entities participating pursuant to this agreement may accomplish a termination by official notice from the Entities' Board to the Secretary of State and the Department of Health and Human Services and the other Entities' Board. The date of termination shall be two (2) years following the receipt of such notification, unless the Director of the Department of Health and Human Services consents to an earlier

termination. In the interim between notification and official termination, the Entities' participation in the program pursuant to this agreement shall be maintained. Upon the termination of participation by either Entities, the BHO shall be dissolved on the effective date of termination.

2. Upon the termination of the BHO, each Entity shall receive from the Board, in proportion to its total economic contribution for the existence of the Board, such real and personal property as is then held by the Board after the payment by the Board of all outstanding debts and obligations, including the return to the State or other entity such real and/ or personal property as that entity has a legitimate legal claim to receive.

Nothing contained herein shall preclude the two Entities from jointly agreeing in writing to any distribution of real and personal property among themselves as they deem proper.

XV.

Status of the Board

The Board established pursuant to this agreement shall be a separate legal governmental entity with the power to sue and be sued.

XVI.

Amendment Procedures

This agreement may.be amended only by the mutual agreement of the contracting Entities pursuant to resolution authorized by both Entities Boards and entered into writing.

XVII.

Conflict of Provisions

If there is any conflict between this agreement and the Mental Health Code, as amended, as existing or as subsequently amended, the Mental Health Code shall prevail, and those provisions of this agreement inconsistent therewith shall be deemed of no effect.

XVIII.

Effectuation of Agreement

This agreement shall be filed with the clerk of each county in which participating the participating Entities are located and with the secretary of state.

The business address of the Bridge Health Organization _____. Any subsequent change thereof by the Board shall be reported in writing to the formal Entity.

The individuals' signing this agreement hereby verify by their signature that they are authorized to execute this agreement pursuant to the appropriate Entities Board.

IN THE PRESENCE OF: NORTHCARE REGIONAL ENTITY

IN THE PRESENCE OF: NORTHERN MICHIGAN REGIONAL ENTITY

PREPARED BY:

Joseph Johnston, and

Steve Burnham

Northern Lakes Community Mental Health (NLCMH) Assessment for the Northern Michigan Regional Entity (NMRE) Steps and Notes FY 20 – FY 22

SCOPE LIMITATION

The original agreement was intended to include assessments of all years 2018-2022. Due to transitions to a new general ledger system in 2019, the data necessary for the 2018 and 2019 assessment was not readily available. Based on discussion with NMRE leadership, we will calculate the average adjustments for 2020-2022 and estimate the impact related to 2018-2019.

STANDARDS

SCA transition/implementation began in FY 22. FY 20 and FY 21 were prepared using 2 CFR 200 standards which are less strict but still provide requirements and limitations on how costs must be grouped and accounted for during an allocation process. Of particular note, as it is the primary finding of this assessment, how costs are allocated:

a. 2 CFR 200.403 ***Factors affecting allowability of costs***. item (c) Be consistent with policies and procedures that **apply uniformly [Emphasis Added]** to both federally financed and other activities of the recipient or subrecipient.
b. 200.405 Allocable Costs, item (b) ***Allocation of indirect costs.*** **All activities** which benefit from the recipient's or subrecipient's indirect cost, including unallowable activities and donated services by the recipient or subrecipient or third parties, **will receive an appropriate allocation of indirect costs**.
c. 200.405, item (c) ***Limitation on charging certain allocable costs to other Federal awards.*** A cost allocable to a particular Federal award may not be charged to other Federal awards (for example, to overcome fund deficiencies or to avoid restrictions imposed by Federal statutes, regulations, or the terms and conditions of the Federal awards). However, this prohibition would not preclude the recipient or subrecipient from shifting costs that are allowable under two or more Federal awards in accordance with existing Federal statutes, regulations, or the terms and conditions of the Federal awards.

TRIAL BALANCE AND COST ACCUMULATION VALIDATION PROCEDURES

1. **TB reconciliation to the Audited Financials**
    1. Compared TB received to Financial Audit Report and determined agreement.
        a. Confirmed initial alignment of the totals by financial statement line item indicating that the financial records are materially consistent with the audit findings.
            - *Reconciliation support is included in the "Trial Balance – Financials Statements" workbook for each respective year.*
            - *Noted the due to NMRE does not balance to the newly calculated cost settlement figure. Client GL appears to have some receivables and payables net that are not matching the expected totals. Amounts will be forced to balance in the current term after settlement figures are agreed upon.*
2. **Chart of Accounts / Cost Center Review**
    1. Reviewed the basis used for capturing costs especially shared costs benefiting multiple fund sources including:
        a. Direct Run Services
        b. Contracted Provider Network
        c. Grants and Other Contracted Programs
        d. MiChoice Waiver
        e. Administrative Costs
        f. Managed Care Costs
    2. Our review highlighted that the number of cost centers in place was minimal for FY 20 and FY 21. FY 22 set up was based upon standard cost allocation requirements.

       While this approach is not specifically prohibited, it demonstrated that the trial balance detail was not used to support the client prepared costing calculations.
        a. Internal and External services were comingled. To establish the proper costing bases, the direct internal service expenses were separated from the NOLA claims transactions.
            - To verify AP claims reconciled to the general ledger, the amounts were separated, and any remaining expenses were moved to an internal cost center.
        b. Grant activity was comingled in direct run cost centers most often without grant dimensions. Additionally, grant revenue was captured in one admin cost center. To establish the proper costing bases, all

grant activity was reclassified into a unique cost center containing revenue and expenses for each grant award.

c. Only three costs centers were found to be in use for capturing administrative and managed care costs. To establish the proper costing bases, reclassifications were made using the client-prepared calculation to separate MCO delegated expenses from MCO administrative (retained) expenses. MCO administrative expenses are part of the administrative overhead required to be applied to internal service activity as well as grants and other program activities like the MiChoice Waiver program.
d. Most non-payroll transactions were allocated during the accounts payable process. These allocations appeared to be based on the number of full-time equivalents (FTEs) assigned to each cost center, serving as the basis for distributing shared expenses that were deemed to directly benefit the respective cost centers. While we did not specifically assess these allocations, we did not observe any expenses that appeared unreasonable.
e. Journal Entry Adjustments for Costing Base: The primary objective of the costing review was to assess the accuracy account balances impacting the accuracy of fund source assignments, not to validate or correct the underlying cost center data. While individual cost center balances may contain inaccuracies, the aggregated totals within the broader costing categories (or "costing buckets") were reviewed and deemed to be materially accurate for the purposes of this analysis.

3. **Grant TB reconciliation to the SEFA**
    1. Compared grant activity to Schedule of Federal Awards (SEFA) and final Federal Financial Report (FSR) to confirm the revenue and expenses matched the audited balances. Adjustments were made as necessary to the account balances as some activity was comingled with internal service departments or the activity was missing grant dimension designations.
        a. Internal NFT grant reported on the FSR did not match the SEFA for FY 20.
4. **General Fund Detail**
    1. The client's FSR calculations did not include specific details outlining the components of amounts assigned to the fund using. Using the EQI, a summary of the General Fund categories was prepared to highlight any differences in how the fund sources were assigned.

5. **FTE Review**
    1. A budgeted staff listing was obtained to estimate full-time equivalents (FTEs) and to identify the appropriate cost centers associated with staff expenses. This review also assessed the reasonableness of cost center assignments based on staff roles and responsibilities.
        a. Our review focused on how administrative and managed care staff were captured in the trial balance as the improper allocations to these two costing buckets impact the accuracy of expenses by fund source. As previously stated, adjustments were made to separate MCO delegated expenses from general MCO administrative expenses.
        b. Many internal staff were noted to be in incorrect cost centers, however only those staff having an impact on the fund source assignment were adjusted.
        c. *Reconciliation support is included in the "Personnel Budget" workbook for each respective year. Amounts were also compared to GL details for reasonableness and matched the total GL.*
6. **Delegated vs. Retained Costs**
    1. **Delegated costs**: Reviewed the client assigned percentages and percentages were deemed reasonable based on managed care activity definitions. AJE's were made to reclass the costs to support the costing calculations.
        a. *Reclass support is included in the MCO Reclass Support workpaper for FY 20 and FY 21 prepared using CFR 200 versus Standard Cost Allocation rules.*
    2. **Retained costs**: Our review of retained costs revealed that the amounts should have been part of the admin cost pool as they represented to portion of costs such as the CEO and finance department that were not deemed to be delegated from the PIHP and benefited programs in addition to Medicaid and General Fund.
        a. *Reclass support is included in the MCO Reclass Support workpaper for FY 20 and FY 21 prepared using CFR 200 versus Standard Cost Allocation rules.*
7. **PCE EQI Fund Source Assignment**
    1. Upon review, we noted a significant number of transactions coded to NMRE BHH fund source that were not related to BHH CPT Code S0280. Per Rob Palmer, a PCE coding error in the assignment of Original SAL/AP Fund Source existed that was subsequently corrected.
        a. Adjustments were made to the Original SA: AP Fund source to match the consumer's eligibility. We don't expect this to be a difference from the clients methodology.

8. **Internal Costing Methodology Used (FY 20 & FY 21):** Our review of client prepared Cost Finding Outline procedure indicates service unit costs were developed using the average of individual service provider costs. Service information extracted from the Electronic Health Record by the client included Provider ID Number, minutes of effort of the activity being measured, quantity of the services, type of activity, service funding source, and population served.

   The procedure document describes that costs not allocated to grants or other operations are used in the rate setting process which seems to mean the Medicaid/GF costing. Such costs are either direct service costs or administration costs.

   A rate setting calculation was located. No comparison was performed between the calculated rates and the amounts entered into the PCE system as the focus of this assessment is FSR costing procedures.

   Our review of the client's Excel-based FSR calculations confirmed that the process involved removing expenses related to grants and non-Medicaid/General fund programs from the total general ledger expense total. Administrative cost centers were then isolated, and their amounts were allocated back to direct service activities. This allocation was based first on the internal vs. external service delivery percentages, and then further distributed according to the proportion of each fund source.

   We were unable to verify or recalculate the client's direct service and administrative cost allocations due to the absence of traceable source data. Most figures within the Excel workbook were manually entered without references or documentation indicating their origin. Additionally, we noted that the initial administrative/managed care allocation was based on a different total expense figure than the final amount reported in the FSR, further limiting the ability to confirm the accuracy of the allocations.

9. **Admin Allocated Method Standard Expected:** No specific costing methodologies more strict that 2 CFR 200 were in place during fiscal years 2020 or 2021 that required a specific treatment of cost pools. In contrast, we noted that for fiscal year 2022, the client modified the chart of accounts to match the Standard Cost Allocation methodology introduced by Milliman.

   2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards requirement for all three years include the following general requirements:

1. **Allowability**: Administrative costs must be necessary, reasonable, and allocable to the federal award under the principles outlined in Subpart E (§§ 200.400–200.476)
2. **Consistency**: Costs must be treated consistently across all programs. For example, a cost that is treated as indirect for one program must not be treated as direct for another (§ 200.412).
3. **Allocability**: Costs must be allocated in proportion to the relative benefits received by each program or cost objective (§ 200.405).
4. **Documentation**: Adequate documentation must support the allocation method used, including time and effort reporting for personnel costs (§ 200.430).
5. **All activities** which benefit from the recipient's or subrecipient's indirect cost, including unallowable activities and donated services by the recipient or subrecipient or third parties, **will receive an appropriate allocation of indirect costs**.
6. A cost allocable to a particular Federal award may not be charged to other Federal awards (for example, to overcome fund deficiencies or to avoid restrictions imposed by Federal statutes, regulations, or the terms and conditions of the Federal awards).

FINANCIAL REPORTING AND ALLOCATION ACCURACY FINDINGS

Our review found that fund source allocations were based on percentages derived from consumer eligibility for services, rather than being directly linked to the actual fund source associated with each specific service. This approach prohibits comparing the output with an actual calculation by CPT service level. Applying a uniform percentage to the entire cost pool does not account for the variability in service-level funding and as a result, reconciling each dollar difference between the client's calculated fund sources and actual service-level funding will be impractical.

Our procedures included confirming our understanding of the details related to all non-Medicaid fund source allocations, such as grants, programs, and the General Fund. Accordingly, the remaining cost pool was attributed to Medicaid transactions. For the purposes of our analysis, we combined all Medicaid and Healthy Michigan amounts into a single "Medicaid" Fund Source, which was sufficient for evaluating total Medicaid Program expenses and potential financial impact to the NMRE.

Key Findings from Analysis of Client's Calculation Method

Our review identified several areas where fund source allocations and administrative cost methodologies did not align with federal cost principles or lacked sufficient documentation. These issues span multiple fiscal years and impact the accuracy and appropriateness of reported expenses across various programs.

1. **Fund Source Allocation Methodology (FY20–FY21)**
2. Fund source allocations were applied using a general eligibility percentage rather than being directly tied to the actual cost and fund source associated with each specific service. This approach does not account for service-level funding variability, making it impractical to reconcile dollar-level differences. Additionally, it remains unclear how spend-down was incorporated into the methodology.
3. **MiChoice Waiver Administrative Costs (FY20–FY22)**
4. Administrative costs allocated to the MiChoice Waiver Program were based on a fixed percentage (8.5%) without supporting documentation of how the amount was derived. We observed a variety of calculations and understand a board policy existed related to the admin portion of expenses. However, this method does not comply with federal cost principles, which require consistent allocation across programs.
5. **Grant-Funded Program Understatement (FY20–FY22)**
6. Administrative cost calculations for grant-funded programs were not located. An amount was reported in the EQI under the General Fund; however, detail of the calculation was not identified. Indirect costs were not included in the general mental health block grant budgets, implying that all administrative expenses should have been covered by the General Fund. The client does not have a federal indirect cost rate and the 10% de minimus could apply.
7. **Room and Board Misclassification (FY20–FY22)**
8. Room and board expenses were reported under Medicaid in the FSR and offset by consumer remittances. However, total expenses exceeded consumer collections, resulting in charges to Medicaid that should be covered by the State General Fund contract.
9. **OBRA Department Overages (FY20–FY22)**
10. OBRA department expenses exceeded the approved grant budget, with the excess costs improperly included in the Medicaid cost pool. OBRA staff did not perform Medicaid services as evidenced in the Service Activity Report.

11. **Integrated Health Clinic (IHC) Loss Misallocation (FY20–FY22)** IHC losses were covered by the General Fund and administrative costs were applied using a fixed percentage, which does not follow allocation consistency requirements as previously described. The IHC provides physical health services not covered under the CMHSP contract and should have been funded through billings and local sources.
12. **Offsetting Revenues (FY20–FY22)**
13. Revenues such as medical record fees were not used to offset expenses allocated to Medicaid, leading to an overstatement of Medicaid expenses.
14. **Behavioral Health Home (FY20–FY22)**
15. There was no evidence of administrative cost allocation, as the fixed percentage method used does not follow allocation consistency standards. In FY22, a significant portion of payroll-related expenses was covered by a grant, while staff were simultaneously billing for fee-for-service activities. No evidence of procedures was available to identify potential instances of double dipping, where services charged to the Behavioral Health Home (BHH) fund source may have been supported by costs reimbursed through grant or other Medicaid revenue.
16. **Grant / Medicaid Comingling for Direct Services (FY 22)**

In FY 22, a significant amount of payroll related expenses was covered by a grant at the same time staff were billing fee for service. Staff members submitted Medicaid encounters for the transactions. This treatment does not affect the Medicaid program cost settlement; however, the cost of services reported within the EQI would be understated by the amount of the grant funding.

FSR Comparison Differences

We conducted a detailed comparison between the client's original calculations and our independent recalculations for amounts reported in the Financial Status Report (FSR). While total expenses agreed, there were significant discrepancies in the assignment of expenses across key fund sources**,** specifically Local/Other, General Fund, Mi Choice Waiver, and Medicaid**.**

Amounts listed below represent specific amounts that were able to be compared and do not total to the amount due to NMRE which includes variances from the percentage of fund source allocation that cannot be specifically identified.

Note: The item in following schedules titled service costing and allocation of service administration, represents the difference between the cost of service being reported originally vs the cost of service as they should have been costed along with the allocation of administration that would need to be included in that service cost. We were unable to find documentation of how service cost was being calculated. It appears that service cost estimates (the posted rates in the electronic medical record system) were used instead of costing services based on actual expenditures.

Non-Compliance Observations FY 20	Client Assigned Fund Source	Expected Fund Source	FY 20 Variance
Grant Administrative Costs	Medicaid	General Fund	$ 130,270
PA 423 Allocation (Medicaid)	Medicaid	General Fund	280,136
Mi Choice Admin Costs	Medicaid	Mi Choice Waiver	165,984
Room & Board	Medicaid	General Fund	40,013
Local Only Expenses	Medicaid	Local	4,391
Offsetting Revenues	Medicaid	Local/Other	53,872
Service Costing and allocation of service administration	Medicaid	Other	1,003,087
Total Questioned Costs			**$ 1,677,753**

These questioned costs represent 2.91% of the total Medicaid and Healthy Michigan expenditures reported on the Financial Status Report submitted to the NMRE.

Non-Compliance Observations FY 21	Client Assigned Fund Source	Expected Fund Source	FY 21 Variance
Grant Administrative Costs	Medicaid	General Fund	$ 278,283
PA 423 Allocation (Medicaid)	Medicaid	General Fund	255,592
Mi Choice Admin Costs	Medicaid	Mi Choice Waiver	840,741
Room & Board	Medicaid	General Fund	24,090
Local Only Expenses	Medicaid	Local	74,783
Offsetting Revenues	Medicaid	Other	33,204
Behavioral Health Home	Medicaid	Local	78,273
Service Costing and allocation of service administration	Medicaid	Other	1,751,666
Total Questioned Costs			**$ 3,336,632**

These questioned costs represent 5.28% of the total Medicaid and Healthy Michigan expenditures reported on the Financial Status Report submitted to the NMRE.

Non-Compliance Observations FY 22	Client Assigned Fund Source	Expected Fund Source	FY 22 Variance
Grant Administrative Costs	Medicaid	General Fund	$ 404,817
PA 423 Allocation (Medicaid)	Medicaid	General Fund	316,782
Mi Choice Admin Costs	Medicaid	Mi Choice Waiver	134,797
Room & Board	Medicaid	General Fund	228,361
Local Only Expenses	Medicaid	Local	5,617
Offsetting Revenues	Medicaid	Other	48,815
Behavioral Health Home	Medicaid	Local	(6,780)
Service Costing and allocation of service administration	Medicaid	Other	878,369
Total Questioned Costs			**$ 2,010,778**

These questioned costs represent 3.07% of the total Medicaid and Healthy Michigan expenditures reported on the Financial Status Report submitted to the NMRE.

The weighted average percent of the questioned costs for FY2020-2022 is 3.76% If this was applied to the reported expenditures in FY2018 of $53,318,165 and FY2019 of $56,765,325 it would result in additional questioned costs of **$2,004,763** and **$2,134,376**, respectively.

Northern Lakes Medicaid/HMP

FY18		(2,004,763)	(Due to the NMRE)
FY19		(2,134,376)	(Due to the NMRE)
FY20		(1,677,753)	(Due to the NMRE)
FY21		(3,336,632)	(Due to the NMRE)
FY22		(2,010,778)	(Due to the NMRE)
Lookback Total	$	(11,164,302)	
FY23		1,466,073	Due from the NMRE
FY24		8,599,401	Due from the NMRE
	$	10,065,474	
	$	(1,098,828)	(Due to the NMRE)