Northern Michigan Regional Entity

Board Meeting

January 28, 2026

1999 Walden Drive, Gaylord

10:00AM

Agenda

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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 – December 2, 2025	Pages 2 – 8
7.	Correspondence	Pages 9 – 71
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – December 2025/January 2026	Page 72
	c. Financial Report – November 2025	Pages 73 – 94
	d. Operations Committee Report – January 20, 2026	Pages 95 – 101
	e. NMRE SUD Oversight Board Report – January 5, 2025	Pages 102 – 106
11.	New Business	
	a. Liquor Tax Requests (1)	Page 109
	County Overviews	Pages 110 – 114
	b. Election of Officers	
12.	Old Business	
	a. CMHSP Updates	
	b. Legal Actions Related to PIHP Bid Out	Pages 34 – 52
13.	Presentation	
	FY25 Quality Assessment and Performance Improvement Program Evaluation (QAPIP) and FY26 QAPIP Workplan	Pages 115 - 171
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
14.	Next Meeting Date – February 25, 2026 at 10:00AM	
15.	Adjourn	

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Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – DECEMBER 3, 2025
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Dave Freedman, Ed Ginop, Ron Iseler, Mary Marois, Michael Newman, Ruth Pilon, Don Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Karen Goodman**
ABSENT:	**Gary Klacking, Dana Labar, Eric Lawson, Jay O'Farrell, Don Smeltzer**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Carol Balousek, Brady Barnhill, Gail Grangood-Griffin, Lisa Hartley, Chip Johnston, Brooke Kleinert, Eric Kurtz, Brian Martinus, Trish Otremba, Pamela Polom, Nena Sork, Denise Switzer, Deanna Yockey, Lynda Zeller**
PUBLIC:	**Anonymous (2), Sarah Garthe, Genevieve Groover, Terri Henderson, Larry LaCross, Rob Palmer, Diane Pelts, Kim Rappleyea**

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

ROLL CALL
Let the record show that Gary Klacking, Dana Labar, Eric Lawson, Jay O'Farrell, and Don Smeltzer were excused from the meeting on this date; all other NMRE Board Members were in attendance either in person or virtually.

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

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

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

MOTION BY MARY MAROIS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR DECEMBER 3, 2025; SUPPORT BY CHUCK VARNER. MOTION CARRIED.

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

MOTION BY CHUCK VARNER TO APPROVE THE MINUTES OF THE OCTOBER 22, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY DAVE FREEDMAN. MOTION CARRIED.

CORRESPONDENCE

1) Notice from the Community Mental Health Association of Michigan (CMHAM) announcing incoming Chief Executive Officer, Alan Bolter, effective November 1, 2025. Previous CEO, Robert Sheenan, will continue serving as CEO through October 31, 2026.
2) Michigan Department of Health and Human Services (MDHHS) Schedule G – Local Funding Obligation Schedule Pursuant to PA22 of 2025.
3) A letter from Angie Cline, Conference Coordinator for Great Lakes Rural Mental Health Association (GLRMHA) thanking Mr. Kurtz for attending GLRMHA's 32nd Annual Fall Conference and inviting the NMRE and its member CMHSPs to attend the 2026 conference.
4) Email correspondence dated October 23, 2025, from CMHAM CEO, Robert Sheehan, supplying sound bites in opposition to the PIHP bid out.
5) An Action Alert from CMHAM urging the public to contact legislators, the Governor, and the Lieutenant Governor to express concern about MDHHS's RFP process.
6) A document from CMHAM titled, "Recommended Components of a Redesigned Public Mental Health System in Michigan."
7) Email correspondence from CMHAM announcing the upcoming hearing dates of December 8th (Lansing) and December 9th (Grand Rapids) in the litigation related to the PIHP bid out.
8) A letter from the Centra Wellness Board of Directors dated November 4, 2025, to Mr. Kurtz and Mr. Klacking expressing concern with budgetary issues, including accountability of the region's CMHSPs to remain with PM/PM, the need to implement full risk contracting for the region's CMHSPs, and the lack of a mechanism to prevent a CMHSP from attacking the risk corridor at a level higher than it contributes without proper safeguards.
9) The draft minutes of the November 10, 2025, regional Finance Committee meeting.

Mr. Kurtz drew attention to the letter received from Great Lakes Rural Mental Health Association (GLRMHA) and the correspondence from CMHAM regarding the hearings scheduled for December 8th and 9th.

The letter from the Centra Wellness Network Board of Directors will be discussed in further detail under the PM/PM History Review portion of the agenda.

ANNOUNCEMENTS

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

PUBLIC COMMENT

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

REPORTS

Executive Committee Report

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

CEO Report

The NMRE CEO Monthly Report for November 2025 was included in the materials for the meeting on this date. Mr. Kurtz highlighted his participation in a Commission on Accreditation of Rehabilitation Facilities (CARF) interview for North Country CMHA.

Draft September 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $7,354,182. Carry forward was reported as $447,383. The total Medicaid and HMP current year surplus was reported as $7,801,565. FY24 HSW revenue was reported as $1,289,241. The total Medicaid and HMP adjusted current year surplus was reported as $6,512,324. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $28,377,721.
- Traditional Medicaid showed $229,155,265 in revenue, and $218,601,787 in expenses, resulting in a net surplus of $10,553,478. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $ 30,031,322 in revenue, and $33,230,618 in expenses, resulting in a net deficit of $3,199,296. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $3,193,959 in revenue, and $2,726,906 in expenses, resulting in a net surplus of $467,053.
- SUD showed all funding source revenue of $28,898,004 and $24,160,950 in expenses, resulting in a net surplus of $4,737,054. Total PA2 funds were reported as $4,669,035.

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	$2,377,437	$4,234,900

Actual FY25 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$1,780,037	$1,876,232	$4,669,035

It was noted that although the Quarter 3 Liquor Tax payments were not sent as the funds were directed to debt services, the overall annual impact to liquor tax was only $67,069 less than projected.

Roughly $616K in SUD Block Grant Funding will be used to fund projects originally approved for liquor tax funds, where applicable.

The numbers reflected in the year-end report were submitted to MDHHS for the Interim FSR due November 10th, though it was noted that numbers will change between now and February 28th as additional claims come in.

October and November revenue was much lower than anticipated (approximately $200K per month). Eligibles dropped significantly between September and October. This is a statewide trend. There has been no word of a rate adjustment. Individuals are being abruptly dropped from

Medicaid and HMP. Between September and October, DAB, HMP, and TANF (combined) eligibles dropped by 4,551. The NMRE will continue to monitor revenue and eligibles closely.

Mr. Kurtz acknowledged that the CMHSPs may have to look at adjustments to their FY26 budgets.

MOTION BY DAVE FREEDMAN TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR SEPTEMBER 2025; SUPPORT BY MARY MAROIS. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, R. Iseler, M. Marois, M. Newman, R. Pilon, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

Operations Committee Report
The draft minutes from December 2, 2025, were distributed during the meeting on this date. The FY26 revenue and the drop in eligibles were reviewed. Legal action against the PIHP bid out and PM/PM History Review were the primary topics of discussion, both of which are upcoming agenda items for the meeting on this date.

NMRE SUD Oversight Committee Report
The draft minutes from November 3, 2025, were included in the materials for the meeting on this date. Liquor tax requests will be discussed under "New Business."

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

	Requesting Entity	Project	County	Amount
1.	217 Recovery	Recover Center and Peer Services	Grand Traverse	$100,000
2.	Catholic Human Services	Grand Traverse County Jail SUD Medication	Grand Traverse	$200,000
3.	Centra Wellness Network	Safenet Prevention Program	Benzie, Manistee	$64,304
4.	District Health Department #10	Deterra Disposal and Medication Lockbox Project	Missaukee, Wexford	$10,000
5.	Health Department of Northwest MI	Michigan Profile for Healthy Youth (MIPHY) Incentive Program	Benzie, Missaukee, Wexford	$12,000

Ms. Marois asked whether prior performance is considered when projects are requesting continuation funding. Ms. Arsenov responded that all grants and PA2 projects have reporting goals and benchmarks that need to be achieved. Status update meetings are held monthly at the NMRE. Ms. Marois requested a summary of project activities and objectives for accountability which Ms. Arsenov agreed to provide.

MOTION BY DAVE FREEDMAN TO APPROVE THE LIQUOR TAX REQUESTS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE ON NOVEMBER 3, 2025, IN THE TOTAL AMOUNT OF THREE HUNDRED EIGHTY-SIX THOUSAND TWO HUNDRED FOUR DOLLARS ($386,204.00); SUPPORT BY CHUCK VARNER.

Discussion: Regarding the request for Jail SUD medication, clarification was made that the program was originally funded through other grants. Liquor tax funds would be used only to purchase the medications, with no staffing or administrative charges applied.

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

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, R. Iseler. M. Marois, M. Newman, R. Pilon, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

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

	Projected FY26 Available Balance	Amount Approved November 3, 2025	Projected Remaining Balance
Benzie	$233,454.16	$29,863.26	$203,590.90
Grand Traverse	$404,348.90	$300,000.00	$104,348.90
Manistee	$215,833.04	$37,340.74	$178,492.30
Missaukee	$48,748.14	$5,106.85	$43,641.29
Wexford	$66,151.78	$13,893.15	$52,258.63
Total	**$968,536.02**	**$386,204.00**	**$582,332.02**

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

OLD BUSINESS

Northern Lakes Lookback and Update
On Nov. 25th, Mr. Kurtz and Ms. Yockey met with Lynda Zeller, Northern Lakes CMHA's Interim CFO, Melissa Bentgen, and representatives of Roslund, Prestage, and Company (RPC) and Rehmann. Regarding the cost misallocation lookback, the decision was made that Centra Wellness CFO, Donna Nieman, and NorthCare Network CEO, Megan Rooney, will work with Ms. Zeller and her staff to redo the Financial Status Reports (FSR) for fiscal years 2020, 2021, and 2022, with input from the Rehmann lookback, which will be reviewed by RPC for compliance. A dialogue between RPC and Rehmann will follow. No lookback of fiscal years 2018 and 2019 will occur until this has been completed.

All parties agreed that it is best to resolve this matter quickly. No engagement letters have been signed to date.

Mr. Freedman expressed appreciation for the support received from Ms. Nieman, Ms. Rooney, and others.

Legal Actions Related to the PIHP Bid Out
Lawsuits filed by Region 10 PIHP, Southwest Michigan Behavioral Health, Mid-State Health Network, St. Clair County Community Mental Health Authority, Integrated Services of Kalamazoo, And Saginaw County Community Mental Health Authority (Case # 25-000148-MB) and Centra Wellness Network, Northeast Michigan CMHA, Wellvance, Gogebic CMHA, North Country CMHA, and Manistee County (Case #25-000162-MB) against State of Michigan, State of Michigan Department of Health And Human Services, a Michigan State Agency, and State of Michigan Department of Technology, Management & Budget, a Michigan State Agency have been enjoined. A hearing is scheduled to take place on December 8th and 9th. A large turnout is expected.

PM/PM HISTORY REVIEW
In a letter dated November 4, 2025, to NMRE CEO, Eric Kurtz, and Board Chair, Gary Klacking, the Centra Wellness Board of Directors expressed concern with the following budgetary issues:

- Accountability of all CMH's to remain within their PM/PM
- Need to implement the NMRE Board's directive to move to full risk contracting for the CMH's within the NMRE
- Lack of mechanism to prevent a CMH from attacking the risk corridor at a level higher than they contribute without proper safeguards

A summary of the CMHSPs' spending (over)/under the PM/PM was distributed to Board Members. It was noted that FY25 numbers are based on the Interim FSR.

	FY17	FY18	FY19	FY20	FY21
CWN	59,097	(1,012)	(303,596)	1,551,273	2,528,263
NC	(1,055,044)	708,073	(1,730,469)	3.565,072	6,784,896
NEM	(578,436)	(202,753)	84,616	2,104,085	2,060,469
NL	(1,943,167)	(2,696,180)	(4,960,531)	3,155,724	8,087,605
Wellvance	(83,098)	309,646	(899,838)	2,522,126	5,959,278
Total	**(3,600,649)**	**(1,882,225)**	**(7,809,818)**	**12,898,280**	**25,420,510**

	FY22	FY23	FY24	FY25	TOTAL
CWN	1,101,736	(1,022,066)	(683,029)	1,196,096	4,426,762
NC	2,982,251	(1,537,373)	(2,246,875)	2,246,875	8,347,201
NEM	281,993	(2,748,143)	(1,376,478)	470,200	95,551
NL	4,823,169	(1,466,073)	(8,599,401)	(5,964,071)	(9,562,924)
Wellvance	4,419,718	2,078,439	1,119,784	1,493,736	16,919,791
Total	**13,608,967**	**(4,695,216)**	**(13,156,204)**	**(557,164)**	**20,226,381**

Mr. Kurtz noted that the numbers for Fiscal years 2020, 2021, and 2022 are deceptive due to the COVID pandemic and frankly should not be considered in the analysis due to the pause in Medicaid redeterminations which kept Medicaid flowing at an artificially high level. Excess funding for those years was lapsed back to the State.

It was noted that the region intentionally spent $4.6M beyond the PM/PM in FY23 (budget stabilization spending). These were intended to be one-time expenses though some have continued.

Mr. Kurtz explained that PIHPs are under a net cost settlement arrangement with the state. PIHPs can fund CMHSPs' Medicaid overages on legitimate Medicaid expenses. Because the state does not give PIHP's any leverage to hold CMHSPs' accountable for overspending, the question was raised regarding putting the CMHSPs at full risk. Other PIHP regions are interested in adopting the same approach. Depending on the outcome of the PIHP bid-out, CMHSPs may be under full risk, fee-for-service payment model anyway.

An actuarial analysis is being considered, as a first step toward this process. It was noted that this analysis will be costly.

Mr. Tanner voiced appreciation for the report.

COMMENTS

Board

Mr. Tanner commented that Michigan Association of Counties' (MAC) Board of Directors decided to submit bids (with Rehmann) on the three PIHP regions (via the creation of the MAC Behavioral Network, a separate 501(c)(3)) to offer a collaborative option based on local control and maintain as much of the current system as possible. Mr. Tanner questioned whether the move was vetted by County Commissioners as many oppose privatization. It was noted that CMHAM has asked to know the names of the bidders under the Freedom of Information Act. Mr. Freedman asserted that the names of bidders should be public information. Publicly, MAC still opposes the direction the department has taken in putting the system out to bid and has asked for the RFP to be pulled back.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on January 28, 2026.

ADJOURN

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

FOR IMMEDIATE RELEASE

COMMUNITY MENTAL HEALTH ASSOCIATION ANNOUNCES NEW CHIEF EXECUTIVE OFFICER

LANSING, MICH. — November 3, 2025 — The Community Mental Health Association of Michigan (CMHA) Board of Directors today announced the appointment of Alan Bolter as the organization's incoming Chief Executive Officer, effective November 1, 2025. Bolter will succeed Robert Sheehan, who has successfully led CMHA for the past decade. Sheehan will continue serving as CEO through October 31, 2026, to ensure a seamless transition in leadership.

"We feel fortunate to have selected Alan as the next CEO of CMHA, given his caliber and proven track record," said Craig Reiter, President of the CMHA Board of Directors. "Alan has spent the last 25 years dedicated to public policy and governmental affairs—14 of those years advocating on behalf of CMHA. We are confident he will continue to strengthen our mission of informing, educating, and advocating for mental health across Michigan."

A distinguished and highly respected lobbyist, Bolter joined the Community Mental Health Association of Michigan in 2009 and has since been recognized multiple times among Michigan's most effective association lobbyists by the MIRS/EPIC-MRA Michigan Insider's Survey in 2019, 2021, 2023, and again in 2025. His work has been instrumental in advancing the expansion of CCBHC sites statewide, securing increased wages for direct care workers, and championing key state appropriations that have expanded access to essential behavioral health services throughout Michigan.

Prior to joining CMHA, Bolter spent 12 years in Michigan state government, including roles in the Lieutenant Governor's office and as Chief of Staff in both chambers of the Legislature.

"Stepping into this new role is a tremendous honor," said Alan Bolter. "I deeply believe in the mission of the Community Mental Health Association and feel privileged to work alongside so many dedicated professionals who share our commitment to ensuring consistent, reliable, and affordable healthcare for all Michiganders."

The Community Mental Health Association of Michigan (CMHA) is a trade association representing Michigan's public mental health system, which delivers mental health, substance use disorder, and developmental disability services in every community across the state.

# # #

Email Correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: CMHA"s strengthened board member education approach
Date: Thursday, January 8, 2026 3:47:18 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: CMHA's strengthened board member education approach

Over the past year, you may have noticed a number of changes to the methods used by CMHA to provide education resources to the board members of CMHA member organizations.

Those changes, with more to come in the coming months, include:

1. **All of the CMHA Boardworks sessions are posted on the CMHA website** for use by the board members of CMHA member organizations at any time of the day. (The Boardworks sessions have been the core component of CMHA's education and training efforts designed to support the work of the board members of CMHA's member organizations.) By providing these Boardworks sessions online, CMHA member organizations no longer have to purchase the DVD recordings of these sessions.

2. **Use of recorded Boardworks sessions by CMHA member organizations to expand board member educational opportunities:** Many of the boards of directors of the CMHA member organizations use the recorded Boardworks sessions, found on the CMHA website, in one of two ways:
    a. **Group learning sessions**, where a local board, as a group, views and discusses the contents of a Boardworks session, often in tandem with a meeting of that local board.
    b. **Encouraging their board members to view the online Boardworks series at times convenient for them** outside of the meetings of the local board.

3. **Cross-organization board sharing and learning workshops to be offered at 3 annual CMHA conferences:** Posting the Boardworks sessions online allows CMHA to replace the Boardworks sessions, traditionally offered at the three annual CMHA conferences, often with low participation rates (note this means that Boardworks sessions will no longer be offered as workshops at CMHA conferences) with other sessions designed to supplement the Boardworks series.

    These live sessions will be offered as workshops at CMHA's three annual conferences and are designed provide board members with structured opportunities for cross-organization sharing of information and approaches while allowing for learning opportunities directly related to board governance knowledge and skills.

    Some of these sessions will be "Board Member Cracker Barrels" – informal, dialogue-rich sessions to allow the Board members of any CMHA member organization to learn from each other and identify areas of common interest.

Other board-member-focused sessions will be topic specific and led by a subject matter expert around topics identified by the Member Services Committee. Topics may include Roberts Rules of Order, Michigan's Open Meetings Act, Michigan's Freedom of Information Act, strategic planning, forms of board governance and structure, and CEO evaluation, among others.

4. **Workshops of interest to board members to be listed in conference programs**: CMHA will be providing, in its upcoming annual conferences, a set of recommendations as to the workshops that best meet the needs of board members in guiding their organizations. These recommendations – a curated list of recommended workshops - would be designed to ensure that local board members gained an understanding of the clinical, collaborative, legal and regulatory, technological, and financial dimensions of the environment in which their organizations work.

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Community Mental Health Association of Michigan

Guide to Board members of CMHA member organizations to the offerings at the CMHA Winter 2026 Conference

CMHA, with the guidance of its Member Services Committee, has recently redesigned its approach to providing sound and valuable education and training resources to the members of the Boards of Directors of CMHA member organizations. This aim of the redesigned approach is to ensure that CMHA's **Board member education program has greater depth and breadth than past efforts and one that fosters cross-board and cross-organization exchange.**

As part of CMHA's revamped and strengthened Board member education and training system, below is a list of those workshops, offered during the CMHA Winter 2026 Conference, which will provide the members of the Boards of Directors of CMHA member organizations with the knowledge needed to be effective members of those boards.

While all of the workshops offered at this conference would benefit Board members, **those noted below (in addition all of the Keynote presentations), are seen as especially relevant to the work of the Board members of CMHA member organizations. These workshops provide Board members with insight into the day-to-day work of the organizations which they govern, into innovations in that work, and into the environment, opportunities, and threats with which their organizations deal every day.**

Note that there is no one Board member track of workshops. Rather, this listing provides a guide to a diverse set of offerings relevant to the work of Board members.

Date	**Time**	**Workshop Title**
Tuesday, February 3, 2026	10:00am - 11:30am	2. What's New in Lansing
Tuesday, February 3, 2026	10:00am - 11:30am	3. Live One, Do One, Teach One: Peer Professional Workforce Development and Evaluation
Tuesday, February 3, 2026	10:00am - 11:30am	5. Life Is Not Over At Disability
Tuesday, February 3, 2026	1:30pm - 3:30pm	7. Opioid Crisis in Michigan: Responding with Naloxone
Tuesday, February 3, 2026	1:30pm - 3:30pm	8. Trauma-Informed Justice Reform: Practical Tools for Professionals
Tuesday, February 3, 2026	1:30pm - 3:30pm	10. Compassion without Collapse: Sustaining Yourself in Clinical Practice
Tuesday, February 3, 2026	3:30pm - 5:00pm	11. Improving Outcomes with AOT

Tuesday, February 3, 2026	3:30pm - 5:00pm	15. Open Forum/"Cracker Barrel" Dialogue: Exclusively for Board Members of CMHA's CMHSP, PIHP, and Provider Alliance Members
Wednesday, February 4, 2026	10:30am - Noon	16. Strengthening the Social Work Workforce: Evidence-Based Training for Substance Use Practice Patients in the Community – Challenges and Changes
Wednesday, February 4, 2026	10:30am - Noon	17. From Data to Decisions: Deploying an Evidence-Based AI Risk Model in CMH
Wednesday, February 4, 2026	10:30am - Noon	19. Advancing Technology First: Transforming Support for People with IDD in Michigan

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	99.00	599	593
Lakeshore Regional Entity	98.69	383	378
Macomb Co CMH Services	100.00	227	227
Mid-State Health Network	99.76	831	829
NorthCare Network	100.00	60	60
Northern MI Regional Entity	96.03	151	145
Oakland Co CMH Authority	99.60	251	250
Region 10	98.42	253	249
CMH Partnership of Southeast MI	100.00	148	148
Southwest MI Behavioral Health	98.92	185	183
Statewide Total		**3,088**	**3,062**

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

	Percentage	Number of Emergency Referrals for Adults	Number Completed in Three Hours for Adults
Detroit Wayne Mental Health Authority	97.57	2,341	2,284
Lakeshore Regional Entity	98.72	1,714	1,692
Macomb Co CMH Services	99.73	1,107	1,104
Mid-State Health Network	99.36	2,645	2,628
NorthCare Network	99.60	252	251
Northern MI Regional Entity	98.29	700	688
Oakland Co CMH Authority	93.04	1,623	1,510
Region 10	98.17	927	910
CMH Partnership of Southeast MI	99.70	660	658
Southwest MI Behavioral Health	98.90	821	812
Statewide Total		**12,790**	**12,537**

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	53.71	3,154	1,694
Lakeshore Regional Entity	78.62	1,319	1,037
Macomb Co CMH Services	61.08	830	507
Mid-State Health Network	66.74	3,978	2,655
NorthCare Network	63.35	502	318
Northern MI Regional Entity	64.55	914	590
Oakland Co CMH Authority	46.78	622	291
Region 10	62.10	2,095	1,301
CMH Partnership of Southeast MI	47.91	1,127	540
Southwest MI Behavioral Health	75.61	2,538	1,919
Statewide Total		**17,079**	**10,852**

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	55.59	626	348
Lakeshore Regional Entity	78.79	528	416
Macomb Co CMH Services	48.33	209	101
Mid-State Health Network	67.24	1,212	815
NorthCare Network	61.76	170	105
Northern MI Regional Entity	68.48	276	189
Oakland Co CMH Authority	39.90	193	77
Region 10	62.41	572	357
CMH Partnership of Southeast MI	48.11	264	127
Southwest MI Behavioral Health	76.75	684	525
Statewide Total		**4,734**	**3,060**

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	58.75	1,738	1,021
Lakeshore Regional Entity	77.59	598	464
Macomb Co CMH Services	71.08	498	354
Mid-State Health Network	69.25	2,299	1,592
NorthCare Network	64.06	281	180
Northern MI Regional Entity	59.38	517	307
Oakland Co CMH Authority	55.21	355	196
Region 10	65.03	1,161	755
CMH Partnership of Southeast MI	46.18	706	326
Southwest MI Behavioral Health	74.04	1,672	1,238
Statewide Total		**9,825**	**6,433**

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	34.79	664	231
Lakeshore Regional Entity	81.36	118	96
Macomb Co CMH Services	38.20	89	34
Mid-State Health Network	48.88	358	175
NorthCare Network	66.67	30	20
Northern MI Regional Entity	83.13	83	69
Oakland Co CMH Authority	17.78	45	8
Region 10	51.19	293	150
CMH Partnership of Southeast MI	54.39	114	62
Southwest MI Behavioral Health	87.07	147	128
Statewide Total		**1,941**	**973**

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	74.60	126	94
Lakeshore Regional Entity	81.33	75	61
Macomb Co CMH Services	52.94	34	18
Mid-State Health Network	66.97	109	73
NorthCare Network	61.90	21	13
Northern MI Regional Entity	65.79	38	25
Oakland Co CMH Authority	34.48	29	10
Region 10	56.52	69	39
CMH Partnership of Southeast MI	58.14	43	25
Southwest MI Behavioral Health	80.00	35	28
Statewide Total		**579**	**386**

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	67.81	3,386	1,094	4,480	3,038
Lakeshore Regional Entity	77.87	1,551	184	1,735	1,351
Macomb Co CMH Services	72.29	1,268	345	1,613	1,166
Mid-State Health Network	82.12	2,427	190	2,617	2,149
NorthCare Network	72.26	400	101	501	362
Northern MI Regional Entity	62.64	899	335	1,234	773
Oakland Co CMH Authority	80.34	800	146	946	760
Region 10	75.88	1,560	335	1,895	1,438
CMH Partnership of Southeast MI	60.03	882	264	1,146	688
Southwest MI Behavioral Health	69.29	1,080	239	1,319	914
Statewide Total		**14,253**	**3,233**	**17,486**	**12,639**

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	92.32	2,410	2,225
Lakeshore Regional Entity	63.59	1,214	772
Macomb Co CMH Services	77.86	664	517
Mid-State Health Network	69.34	3,160	2,191
NorthCare Network	67.88	386	262
Northern MI Regional Entity	71.74	637	457
Oakland Co CMH Authority	98.09	366	359
Region 10	80.70	1,523	1,229
CMH Partnership of Southeast MI	65.13	760	495
Southwest MI Behavioral Health	69.50	2,095	1,456
Statewide Total		**13,215**	**9,963**

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	90.99	466	424
Lakeshore Regional Entity	54.75	495	271
Macomb Co CMH Services	66.20	142	94
Mid-State Health Network	66.77	930	621
NorthCare Network	63.49	126	80
Northern MI Regional Entity	70.62	194	137
Oakland Co CMH Authority	96.40	139	134
Region 10	79.64	442	352
CMH Partnership of Southeast MI	67.63	173	117
Southwest MI Behavioral Health	71.40	556	397
Statewide Total		**3,663**	**2,627**

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	91.77	1,313	1,205
Lakeshore Regional Entity	66.67	534	356
Macomb Co CMH Services	83.29	383	319
Mid-State Health Network	68.53	1,773	1,215
NorthCare Network	68.61	223	153
Northern MI Regional Entity	70.03	337	236
Oakland Co CMH Authority	98.98	196	194
Region 10	78.31	830	650
CMH Partnership of Southeast MI	60.43	465	281
Southwest MI Behavioral Health	68.59	1,369	939
Statewide Total		**7,423**	**5,548**

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	94.59	518	490
Lakeshore Regional Entity	83.76	117	98
Macomb Co CMH Services	71.15	104	74
Mid-State Health Network	80.74	353	285
NorthCare Network	77.27	22	17
Northern MI Regional Entity	75.00	76	57
Oakland Co CMH Authority	100.00	16	16
Region 10	89.80	196	176
CMH Partnership of Southeast MI	77.78	90	70
Southwest MI Behavioral Health	66.43	140	93
Statewide Total		**1,632**	**1,376**

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	93.81	113	106
Lakeshore Regional Entity	69.12	68	47
Macomb Co CMH Services	85.71	35	30
Mid-State Health Network	67.31	104	70
NorthCare Network	80.00	15	12
Northern MI Regional Entity	90.00	30	27
Oakland Co CMH Authority	100.00	15	15
Region 10	92.73	55	51
CMH Partnership of Southeast MI	84.38	32	27
Southwest MI Behavioral Health	90.00	30	27
Statewide Total		**497**	**412**

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	98.81	84	83
Lakeshore Regional Entity	100.00	92	92
Macomb Co CMH Services	77.59	58	45
Mid-State Health Network	96.48	142	137
NorthCare Network	100.00	25	25
Northern MI Regional Entity	95.12	41	39
Oakland Co CMH Authority	95.45	44	42
Region 10	98.57	70	69
CMH Partnership of Southeast MI	78.13	32	25
Southwest MI Behavioral Health	94.64	56	53
Statewide Total		**644**	**610**

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	95.63	756	723
Lakeshore Regional Entity	97.73	353	345
Macomb Co CMH Services	79.75	321	256
Mid-State Health Network	96.21	634	610
NorthCare Network	100.00	74	74
Northern MI Regional Entity	86.40	125	108
Oakland Co CMH Authority	90.28	319	288
Region 10	95.86	290	278
CMH Partnership of Southeast MI	90.50	179	162
Southwest MI Behavioral Health	95.16	289	275
Statewide Total		**3,340**	**3,119**

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	98.28	464	456
Lakeshore Regional Entity	100.00	97	97
Macomb Co CMH Services	100.00	238	238
Mid-State Health Network	93.45	168	157
NorthCare Network	100.00	33	33
Northern MI Regional Entity	83.55	152	127
Oakland Co CMH Authority	99.11	112	111
Region 10	96.77	62	60
CMH Partnership of Southeast MI	100.00	84	84
Southwest MI Behavioral Health	100.00	153	153
Statewide Total		**1,563**	**1,516**

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	6.93	47,688	688,543
Lakeshore Regional Entity	6.89	18,584	269,904
Macomb Co CMH Services	5.06	11,075	218,665
Mid-State Health Network	8.69	34,141	392,818
NorthCare Network	8.52	5,337	62,606
Northern MI Regional Entity	8.62	9,833	114,134
Oakland Co CMH Authority	9.02	17,071	189,241
Region 10	9.13	18,066	197,894
CMH Partnership of Southeast MI	8.01	10,175	127,004
Southwest MI Behavioral Health	9.14	19,011	208,076
Statewide Total		**190,981**	**2,468,885**

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	93.37	986	1,056
Lakeshore Regional Entity	93.96	622	662
Macomb Co CMH Services	94.05	427	454
Mid-State Health Network	97.78	1,456	1,489
NorthCare Network	98.07	356	363
Northern MI Regional Entity	96.76	658	680
Oakland Co CMH Authority	93.60	746	797
Region 10	97.84	498	509
CMH Partnership of Southeast MI	96.34	684	710
Southwest MI Behavioral Health	97.86	687	702
Statewide Total		**7,120**	**7,422**

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	13.99	243	34
Lakeshore Regional Entity	9.23	130	12
Macomb Co CMH Services	6.25	96	6
Mid-State Health Network	8.18	220	18
NorthCare Network	16.67	30	5
Northern MI Regional Entity	15.56	45	7
Oakland Co CMH Authority	8.33	60	5
Region 10	14.42	104	15
CMH Partnership of Southeast MI	9.30	43	4
Southwest MI Behavioral Health	17.86	84	15
Statewide Total		**1,055**	**121**

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	14.98	1,636	245
Lakeshore Regional Entity	11.81	576	68
Macomb Co CMH Services	18.21	626	114
Mid-State Health Network	10.40	1,164	121
NorthCare Network	17.02	94	16
Northern MI Regional Entity	13.78	225	31
Oakland Co CMH Authority	10.28	535	55
Region 10	13.72	503	69
CMH Partnership of Southeast MI	10.10	287	29
Southwest MI Behavioral Health	15.78	526	83
Statewide Total		**6,172**	**831**

STATE OF MICHIGAN

COURT OF CLAIMS

REGION 10 PIHP, SOUTHWEST MICHIGAN BEHAVIORAL HEALTH, MID-STATE HEALTH NETWORK, ST. CLAIR COUNTY CMHA, INTEGRATED SERVICES OF KALAMAZOO AND SAGINAW COUNTY CMHA,

Plaintiffs,

v

Consolidated Case Nos. 25-000143-MB and 25-000162-MB

Hon. Christopher P. Yates

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, and STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY, MANAGEMENT, AND BUDGET,

Defendants.
_____/

CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY, and MANISTEE COUNTY,

Plaintiffs,

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, and STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY, MANAGEMENT, AND BUDGET,

Defendants.
_____/

OPINION AND ORDER DENYING DEFENDANTS' MOTION FOR SUMMARY DISPOSITION UNDER MCR 2.116(C)(10) AND GRANTING, IN PART, PLAINTIFFS' REQUEST FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(I)(2)

On October 14, 2025, this Court issued an opinion and order granting, in part, defendants' summary disposition motion, ruling that Michigan law allows defendant, the Michigan Department of Health and Human Services (MDHHS), to transition from a single-source procurement system to a competitive procurement system. The Court further determined that the MDHHS may reduce the number of prepaid inpatient health plan (PIHP) regions from ten to three. But the Court denied defendants summary disposition on the question of the legality of the terms in the 2025 request for proposal (RFP) that the Michigan Department of Technology, Management, and Budget (DTMB) issued on behalf of the MDHHS to effectuate that transition because the record was insufficient to decide whether the RFP conflicts with Michigan law and impairs the ability of community mental health service programs (CMHSPs) to carry out their statutorily-mandated duties. To address that question, the parties conducted discovery on an expedited basis, and they were joined by additional plaintiff-CMHSPs, which sued the same defendants in a separate complaint filed in case number 25-000162-MB.[1] The parties presented arguments and evidence at a three-day hearing that began on December 8, 2025.[2]

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[1] The plaintiffs in case number 25-000162-MB include Manistee County and numerous CMHSPs, including: Manistee-Benzie Community Mental Health d/b/a Centra-Wellness Network; AuSable Valley Community Mental Health Authority d/b/a Wellvance; Gogebic Community Mental Health Authority; Northeast Michigan Community Mental Health Authority; North Country Community Mental Health Authority. They filed their lawsuit against the State of Michigan, the MDHHS and the DTMB. The two cases were consolidated through a stipulated order of consolidation entered on November 26, 2025.

[2] The Court permitted the parties to present testimony as well as other evidence and oral argument because plaintiffs had requested a preliminary injunction in addition to declaratory relief regarding the actions of the MDHHS.

Based on the record developed by the parties, the Court shall deny summary disposition to defendants and grant plaintiffs partial summary disposition coupled with a declaration that the RFP violates Michigan law by inhibiting the CMHSPs from fulfilling numerous statutory mandates set forth in the Michigan Mental Health Code, MCL 330.1011 *et seq*. But the Court shall decline, at this time, to issue an injunction barring the MDHHS and the DTMB from selecting PIHPs through a competitive-bidding process or requiring specific action with respect to the 2025 RFP. The RFP must be brought into compliance with Michigan law, which requires, at a minimum, that sufficient Medicaid funds must be allocated to CMHSPs to allow them to perform their statutorily-mandated obligations through financial contracts with other providers. Whether compliance with Michigan law should be achieved through a notice of deficiency, an amended RFP, or a pull-back of the RFP is a matter that the Court must leave to defendants.

I. FACTUAL BACKGROUND

The underlying facts are set forth in the October 14, 2025 opinion and order.[3] The primary issue requiring further consideration is the relationship among the MDHHS, the CMHSPs, and the PIHPs in the provision of mental-health services to Medicaid and non-Medicaid beneficiaries.

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[3] After the Court issued its October 14, 2025 opinion and order, the parties submitted briefing prior to the hearing on December 8, 2025. Defendants cited the doctrines of ripeness and standing as defenses to plaintiffs' claims. Those defenses challenge the justiciability of plaintiffs' claims, but both lack merit. Specifically, ripeness attacks justiciability based on timing because "[a] claim is not ripe if it rests upon contingent future events that may not occur as anticipated, or may not occur at all." *Citizens Protecting Mich's Constitution v Secretary of State*, 280 Mich App 273, 282; 761 NW2d 210 (2008), aff'd in part, appeal denied in part, 482 Mich 960 (2008). In contrast, "the standing inquiry focuses on whether a litigant is a proper party to request adjudication of a particular issue[.]" *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 355; 792 NW2d 686 (2010) (quotation marks and citations omitted). Plaintiffs were under contract with either a PIHP or the MDHHS to offer services that are the subject of the 2025 RFP, and their claims are based on an actual or alleged inability to continue doing so under the 2025 RFP. The instant case is not

Both the MDHHS and the CMHSPs play leading roles in providing mental health services in Michigan. As explained in the opinion and order, the MDHHS is responsible for "support[ing] the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries" that "shall be managed and delivered by specialty prepaid health plans chosen by [the MDHHS]." MCL 400.109f. The MDHHS must "continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state." MCL 330.1116(1). To this end, the MDHHS "shall" "[d]irect services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance," prioritizing those who have the "most severe forms of mental illness, serious emotional disturbance, or developmental disability" and who "are in urgent or emergency situations." MCL 330.1116(2)(a). The MDHHS must carry out that duty by including promotion and maintenance of "an adequate and appropriate system of [CMHSPs] throughout the state." MCL 330.1116(2)(b). "[I]t shall be the objective of the [MDHHS] to shift primary responsibility for the direct delivery of public mental health services from the state to a [CMHSP] whenever the [CMHSP] has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for . . . that service area." MCL 330.1116(2)(b).

CMHSPs play a crucial role not only as a direct provider of mental health services, but also in management or coordination of such care. Created pursuant to the Mental Health Code, MCL

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like *UAW v Central Mich Univ*, 295 Mich App 486; 815 NW2d 132 (2012), in which the plaintiff was found to lack standing to challenge procedures that existed solely in draft form. The 2025 RFP at issue in this case is final, bids were submitted months ago, and the results of the 2025 RFP will be contracts that significantly alter funding and services that the plaintiffs are authorized to provide to Medicaid beneficiaries in their geographic regions. Thus, plaintiffs' claims are ripe for review, and the CMHSPs have a sufficient interest in their claims to provide standing.

330.1204, CMHSPs are governmental entities, formed by one or more counties, with policies and procedures set by the CMHSP's board or the board of commissioners in the CMHSP's counties. MCL 330.1204(1), (2); MCL 330.1204a; MCL 330.1205. Each CMHSP receives an annual, direct appropriation through a general fund contract with the MDHHS, which each CMHSP can use for services for Medicaid or non-Medicaid beneficiaries. General fund allocations account for only a small portion of the budget through which CMHSPs provide services in their geographic regions, which include both Medicaid and non-Medicaid-eligible consumers.

A CMHSP is required by Michigan law "to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay." MCL 330.1206(1). Such services "shall include, at a minimum, all of the following":

> (a) Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to a person experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.
>
> (b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.
>
> (c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.
>
> (d) Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.
>
> (e) Recipient rights services.
>
> (f) Mental health advocacy.
>
> (g) Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.
>
> (h) Any other service approved by the [MDHHS]. [MCL 330.1206(1).]

CMHSPs must fulfill that obligation for both Medicaid and non-Medicaid recipients. In fact, CMHSPs are prohibited from denying services because a person is financially unable to pay. MCL 330.1208(4). And CMHSPs are statutorily authorized to bill Medicaid or other appropriate payers for the services. MCL 330.1202(2). Indeed, CMHSPs do not often know whether a person in need of services is covered by any third-party payor, including Medicaid.

The Mental Health Code recognizes that CMHSPs may contract with service providers for the services described above. This is evident in Section 206a, which requires that recipients must be afforded an opportunity to request mediation "to resolve a dispute between the recipient . . . and the [CMHSP] or *other service provider under contract with the* [*CMHSP*] related to planning and providing services or supports to the recipient." MCL 330.1206a(1) (emphasis added). There is good reason to believe that that applies to Medicaid recipients because that same section provides that the right to mediation does not preclude a recipient from pursuing other forms of alternative resolution, including "the state Medicaid fair hearing[.]" See MCL 330.1206a(6).

Further support for the right of CMHSPs to contract with service providers can be gleaned from the CMHSPs' duty to furnish at least a plan for services to individuals prior to their release to an appropriate community placement. Section 209a of the Mental Health Code makes clear that that CMHSPs, "with the assistance of the state facility or licensed hospital under contract with" a CMHSP, "shall develop an individualized prerelease plan for appropriate community placement and a prerelease plan for aftercare services appropriate for each resident" unless a state facility fulfills that duty. MCL 330.1209a(1). CMHSPs may contract with a service provider to carry out that duty, including a "licensed hospital under contract with a [CMHSP] or state facility," and the CMHSP must offer prerelease planning services and "develop a release plan in cooperation with

the individual unless the individual refuses this option." MCL 330.1209a(2), (3). The plan has to be prepared "within 10 days after release." MCL 330.1209a(4). The directors of CMHSPs find it impractical, if not impossible, to fulfill that duty without the ability to negotiate a financial contract with other providers that applies to services afforded to Medicaid recipients. Payment of funds is the consideration promised in exchange for ensuring each provider's cooperation with CMHSPs.

The Mental Health Code also requires CMHSPs to have "a written interagency agreement in place for a collaborative program to provide mental health treatment and assistance" to "persons with serious mental illness" who are involved in the criminal justice system. MCL 330.1207a(1). A CMHSP, rather than the MDHHS or a PIHP, is a required party to each interagency agreement, and the mandatory components of an interagency agreement include "(a) Guidelines for program eligibility, . . . (c) Day-to-day program administration, . . . (g) Resource sharing between the parties to the interagency agreement, (h) Screening and assessment procedures, (i) Guidelines for case management, . . . [and] (m) Procedures for first response to potential cases, including response to crises." MCL 330.1207a(3). Counties are not required to provide funds for the program except to the extent appropriated annually by the Legislature. MCL 330.1207a(7). The statute provides no release of this obligation for people within the CMHSP's duties who are recipients of Medicaid.

A similar situation exists with respect to the CMHSPs' duties for preadmission screening. The Mental Health Code permits CMHSPs to enter into contracts with hospitals and other agencies qualified to serve those needing urgent and emergent care. It also requires CMHSPs to coordinate with providers both before and after the provision of services. CMHSPs must "establish 1 or more preadmission screening units with 24-hour availability to provide assessment and screening for individuals being considered for admission into hospitals, assisted outpatient treatment programs,

or crisis services on a voluntary basis." MCL 330.1409(1). CMHSPs may satisfy that requirement by employing mental health service professionals or contracting with another agency with similar qualifications. MCL 330.1409(1). The duties extend beyond screening to mandate coordination with the various entities involved in the person's care. To address the needs of the individual being screened, the CMHSP "shall assess an individual being considered for admission into a hospital operated by [the MDHHS] or under contract with" the CMHSP. And if the individual is clinically suitable for hospitalization, the "preadmission screening unit shall authorize voluntary admission to the hospital." MCL 330.1409(3). A hospital that receives a person taken into protective custody who has been referred by a CMHSP's preadmission screening unit "shall notify the unit of the results of an examination of that individual conducted by the hospital." MCL 330.1427(3).

When an individual does not meet the requirements for hospitalization, the "preadmission screening unit shall ensure provisions of follow-up counseling and diagnostic and referral services if needed." MCL 330.1427(1). The preadmission screening unit is also responsible for providing "information regarding alternative services and the availability of those services" and "making appropriate referrals" to individuals who are found not clinically suitable for hospitalization. MCL 330.1409(5). A CMHSP's preadmission screening unit may also operate a crisis stabilization unit pursuant to MCL 330.1971 *et seq.*, followed by the "clinically appropriate level of care" including referrals to outpatient services, a partial hospitalization program, a residential treatment center, an inpatient bed, or an order for involuntary treatment. MCL 330.1409(7).

Even in the case of voluntary admissions, the CMHSP's preadmission screening unit must authorize admission to a hospital or an outpatient treatment program. Specifically, MCL 330.1410 states that "an individual who requests, applies for, or assents to either informal or formal voluntary

admission to a hospital or outpatient treatment program operated by [MDHHS] or a hospital or outpatient treatment program under contract with a [CMHSP] may be considered for admission by the hospital or outpatient treatment program only after authorization by a [CMHSP] preadmission screening unit." MCL 330.1410.

Ensuring that people receive the benefit of the recipient rights legislation is also within the purview of the CMHSPs. Chapter 7 of the Mental Health Code, MCL 330.1700 *et seq.*, identifies numerous rights that must be afforded to the recipients of mental health services. A CMHSP must "establish an office of recipient rights," MCL 330.1755, which shall have "unimpeded access" to programs and services offered by the CMHSP or licensed hospitals, staff employed under contract with the entities, and evidence needed to "conduct a thorough investigation or fulfill its monitoring function." MCL 330.1755(2)(a), (d)(*i*)-(*iii*). In addition, "[e]ach contract between the [CMHSP] or licensed hospital and a provider" must ensure each provider and its employees receive recipient rights training and that recipients are "protected from rights violations while they are receiving services under the contract." MCL 330.1755(2)(f). The office of recipient rights must "[p]rovide or coordinate the protection of recipient rights for all directly operated or contracted services" and ensure that recipients have access to summaries of such rights and that records are maintained of "reports of apparent or suspected violations of rights within the [CMHSP] system or the licensed hospital system." MCL 330.1755(5). CMHSPs are responsible for site visits and ensuring that people within the CMHSP, "contract agency, or licensed hospital" are trained on recipient rights protection. MCL 330.1755(5)(f). The board of the CMHSP is responsible for reviewing an annual report on the status of recipient rights within its community. MCL 330.1755(6).

CMHSPs are obligated to furnish all recipients with a "choice of physician or other mental health professional" in accordance with the policies of the CMHSP, licensed hospital, or "service provider under contract with the [CMHSP]." MCL 330.1713. Also, CMHSPs must "ensure that appropriate disciplinary action is taken against" entities or individuals who "have engaged in abuse or neglect" of recipients of mental health services. MCL 330.1722. Under that statute, CMHSPs are regarded as akin to the MDHHS, licensed hospitals, and service providers under contract with the MDHHS or the CMHSP. MCL 330.1722(2).

Defendants issued the challenged RFP on August 4, 2025, proposals had to be submitted by October 6, 2025, and contracted services are scheduled to begin on October 1, 2026. During the hearing, MDHHS representatives testified that the operational aspects of the RFP have not yet been worked out. By its terms, the RFP requires that bidders must be either a nonprofit, a public body or governmental entity, or a public university, and its proposal must provide services to one of three regions of the state, "not by individual counties." According to the RFP, "[b]idders must demonstrate the ability to be fully operational across the entire geographic area of the region for which they are submitting a proposal. Bidders that cannot provide services throughout the entire region will not be considered." Further, defendants have the right to discontinue the RFP process "at any time for any or no reason," or to "[a]ward multiple, optional-use contracts, or award by Contract Activity." The RFP affects between $5 and $6 billion in state-administered funding.

The successful bidder for each of the three regions is to serve as the PIHP with the sole and nondelegable right to provide managed care functions to Medicaid beneficiaries, except CMHSPs may authorize inpatient admissions through preadmission screenings. As Section 1.1 of the RFP explains:

> Contractors are expected to provide managed care functions to beneficiaries. Those functions cannot be delegated to contracted network providers with the exception of Preadmission screening for emergency intervention services per Mental Health Code MCL 330.1409 which shall be performed by the CMHSP with Contractor authorization of inpatient admissions as indicated by the preadmission screening unit. Managed care functions include, but are not limited to, eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities. . . . Contractor may not directly provide or deliver health care services beyond these managed care functions.

The contractor is responsible for managing the Specialty Behavior Health Services population in one of three regions and serving beneficiaries eligible for Medicaid Specialty Behavioral Services in the service area identified in the contract. The contractor must ensure that "the residential (adult foster care, specialized residential, providers owned/controlled) and non-residential services (skills building, community living supports, and out of home non-vocational)" furnished to individuals supported by several federal and state programs "maintain a home and community character setting as required by federal regulation and outlined in the HCBS Section of the Medicaid Provider Manual."

The RFP places responsibility on each contractor to pay service providers and to establish, maintain, and evaluate an effective provider network. But the "Contractor remains the accountable party for the Medicaid beneficiaries in its service area." According to the RFP, the contractor is "responsible for development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract." When subcontractors are employed to do the work, the contractor must adhere to applicable provisions of the federal procurement requirements.

The contractor is responsible for "medically necessary community-based SUD treatment services for individuals under the supervision of the [Michigan Department of Corrections]" who

are "typically under parole or probation orders." Those "referred by court and services through local community corrections (PA 511) systems must not be excluded from these Medicaid/Healthy Michigan program funded medically necessary community-based behavioral health and SUD treatment services." With respect to those services, the contractor is "solely responsible for the composition, compensation, and performance of its contracted provider network." The contractor is also required to "develop and implement a transition of care policy," as well as the provision of "certain enhanced community support services for those beneficiaries in the service area who are enrolled in one of three Michigan's 1915(c) HCBS Waivers."

The RFP also requires the contractor to provide substance abuse home health services and behavioral health services that consist of "comprehensive care management and coordination" to Medicaid beneficiaries with serious mental illness or substance use disorders. The substance use and behavioral health services are the "central point of contact for directing patient-centered care across the broader health care systems." Additionally, the RFP requires the contractor to "restrict the entity (CMHSP or contracted provider) that develops the person-centered service plan from providing services without the direct approval of the state."

The Court heard testimony during the hearing from executive directors of CMHSPs, who stated that up to 95% of the CMHSPs' budgets were paid through Medicaid's capitated payment system, and performing the duties assigned to CMHSPs under the Mental Health Code necessarily required CHMSPs to perform some of the functions designated as "managed care functions" in the RFP. CMHSPs serve as more than just providers. Rather, they coordinate with a local provider network through contracts with the providers that involve not only payment, but also an agreement that the provider will allow an investigation into noncompliance that includes, without limitation,

the failure to provide beneficiaries with the rights required as recipient rights under Chapter 7 of the Mental Health Code, MCL 330.1700 *et seq*. Additional contract functions mandate the right to mediation, person-centered planning, pre-release plans, and the CMHSP's right to ensure that disciplinary action is taken against those who violate beneficiaries' rights under MCL 330.1722(1).

Providers entering into these contracts include more than just hospitals, but may include providers of rehabilitation services, members of law enforcement, and other individuals or entities that interact with those who face mental health crises in the CMHSP's geographic area. Provider contracts accounted for approximately $9 million of the $21 million budget for Centra Wellness Network, a CMHSP serving Manistee and Benzie counties. Those funds are essential for meeting the CMHSP's statutory duties, especially in situations requiring crisis intervention. The CMHSP directors testified that the contracts were necessary for them to perform the functions mandated by Michigan law. This is especially significant in the context of the CMHSP's responsibility under MCL 330.1438 to those who present with an emergency. Multiple contracts are necessary because recipients must be given a choice of physician or mental health professional "in accordance with the policies of the [CMHSPs]." MCL 330.1713.

Medicaid funds are necessary to enable CMHSPs to furnish the administrative, assessment, and service-identification functions mandated by MCL 330.1226(1)(a). Some of those costs are required by statute. For example, CMHSPs must "select a physician, a registered nurse with a specialty certification issued under [MCL 333.17210], or a licensed psychologist to advise the [CMHSP] on treatment issues." MCL 330.1226(1)(m). With respect to the spreading of this cost, Michigan law permits CMHSPs to "[s]hare the costs or risks, or both, of managing and providing publicly funded mental health services with other [CMHSPs] through participation in risk pooling

arrangements, reinsurance agreements, and other joint or cooperative arrangements as permitted by law." MCL 330.1226(2)(e). In addition, the Mental Health Code allows CMHSPs to "[e]nter into agreements with other providers or managers of health care or rehabilitative services to foster interagency communication, cooperation, coordination, and consultation." MCL 330.1226(2)(f).

This prominently plays out in the situation when a person presents at a community mental health facility with the need for inpatient psychiatric treatment. Preadmission screening remains a responsibility of the CMHSPs even under the RFP, but CMHSPs cannot carry out that function unless they are allowed to provide the managed care functions designated exclusively to the PIHPs in the RFP. Without the ability to enter into contracts incentivized through payments to hospitals and other providers of services to people who present for involuntary or voluntary admission, the CMHSP cannot adequately serve those people. In emergent situations, neither the CMHSP nor the provider knows whether the individual is covered by Medicaid at the time of the screening, so the ability of the CMHSP to guarantee payment at the time of admission is crucial. Moreover, if the individual is a child, the CMHSP must undertake a search for the child's parent or guardian prior to admission, and the source of funding is unclear in that situation.

Wrap-around services are another area that CMHSP directors described as a crucial part of their work in serving their communities, and something that requires them to serve in a managed-care capacity, rather than as a provider. To be sure, CMHSPs have sources of funding other than Medicaid, such as commercial insurance, Medicare, general funds, or various grants. But CMHSP directors explained that they do not always know whether a person who presents for care qualifies for funding from any of those sources.

Marissa Grove, who serves as a solicitation manager at DTMB, explained the process for issuing an RFP. She explained that DTMB has three options for revising an issued RFP. It can issue a notice of deficiency, it can issue an amendment to the RFP, or it can pull back the RFP if major problems exist. Here, five amendments have already been made to the RFP. The RFP sets the terms of the contract, and both the contract terms and the RFP are subject to change after the bid is accepted, even if there is a change that cancels the RFP.

Raymie Postema, the MDHHS Director of the State Office of Recipient Rights, testified that she had concerns about the RFP and its potential negative impact on the protection of recipient rights throughout the state. CMHSPs are statutorily required to train and enforce recipient rights, so transferring that responsibility to the successful bidders for PIHP roles impedes that process.

Aneza Smith-Butterwick, the MDHHS's subject-matter expert for substance use disorder (SUD) in the context of the RFP, explained that SUD services are governed by the Mental Health Code, and they must be provided by a CMHSP or a regional entity. The RFP allows for more than one entity in a single geographic region if the entities bid together, but a public university cannot receive block-grant funds for SUD services.

Kristen Morningstar, the MDHHS Bureau Administrator, who served as program manager for procurement at the MDHHS, stated that managed-care functions are a core feature of the RFP, and those functions cannot be delegated, so CMHSPs cannot contract with a provider for managed-care services. Morningstar was unsure how CMHSPs could fulfill their statutory duties under MCL 330.1309 and MCL 330.1422. Several others with authority at the MDHHS, including Postema, raised concerns about the RFP and compliance with Michigan law. Postema commented that SUD services cannot be managed under the RFP if a PIHP is not a regional entity or a CMHSP.

Leslie Asman from the Bureau of Legal Affairs offered reasons for the RFP. Specifically, she mentioned introducing competitive procurement, the possibility of the federal government not renewing a waiver for the Medicaid program, and concerns about administrative duplication. At present, seven of the ten existing PIHPs delegate functions to CMHSPs. Asman testified that the RFP resolves conflicts of interest because it places the payor role solely in the hands of the PIHPs, not the CMHSPs, which act as providers of some services. She also described the operation of the PIHPs and the system established by the RFP. How this will take place in terms of operations has yet to be determined, but because the MDHHS has experience in carrying out operations without details set in advance, Asman had no concerns about that matter. Therefore, defendants asked the Court to place its imprimatur on the existing RFP by awarding them summary disposition.

II. LEGAL ANALYSIS

Defendants sought summary disposition under MCR 2.116(C)(8) and (10), and plaintiffs responded by asking for similar relief under MCR 2.116(I)(2). What remains unresolved after the Court's October 14, 2025 opinion and order is a single issue under MCR 2.116(C)(10) and MCR 2.116(I)(2). A motion requesting summary disposition under MCR 2.116(C)(10) "tests the *factual sufficiency* of a claim." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159-160; 934 NW2d 665 (2019). Summary disposition under MCR 2.116(C)(10) may be awarded only if "there is no genuine issue of material fact." *Id.* Such a genuine issue of material fact exists "when the record leaves open an issue upon which reasonable minds might differ." *Id.* The remaining issue here is whether the RFP conflicts with the Mental Health Code, and particularly MCL 330.1206(1), which assigns certain functions to CMHSPs, rather than PIHPs. Several significant conflicts exist.

The RFP does not obligate the PIHPs selected through the bidding process to give priority to CMHSPs for the "comprehensive array of mental health services appropriate to conditions of

individuals who are located within its geographic service area," except pre-admission screening for inpatient hospital services, which the CMHSPs are statutorily mandated to provide "regardless of an individual's ability to pay." MCL 330.1206(1). More importantly, the RFP bars successful bidders for PIHP roles from paying CMHSPs for services provided through contracts with service providers. This conflicts with numerous provisions of the Mental Health Code, which recognizes that CMHSPs must provide certain services and ensure recipients of those services receive various rights either directly from the CMHSPs or through contracts with other service providers.

Indeed, each of the mental health services that CMHSPs are required, "at a minimum," to provide pursuant to MCL 330.1206 requires CMHSPs to develop a network of providers (through contractual relationships) to furnish services to Medicaid beneficiaries, to carry out eligibility and coverage verification for Medicaid beneficiaries, and to engage in activities to improve health care quality. Crisis stabilization and response, for example, requires CMHSPs to maintain a network of providers to react with flexibility and in a short timeframe. See MCL 330.1206(1)(a). Recipient rights services are incentivized through financial contracts that give CMHSPs authority to conduct the necessary investigations into beneficiaries' complaints. See MCL 330.1206(e). And mental-health advocacy and prevention activities that inform and educate with the "intent of reducing the risk of severe recipient dysfunction" are closely related, if not identical, to activities that improve health-care quality. See MCL 330.1206(g). Those duties are imposed on the CMHSPs regardless of whether or not the recipients are Medicaid beneficiaries and, in fact, directors of the CMHSPs commented that they often do not know whether those seeking services are eligible for Medicaid. Medicaid funding is such a significant portion of the budgets of CMHSPs that it is impractical, if not impossible, for CMHSPs to differentiate Medicaid beneficiaries from others to whom they are statutorily obligated to provide mental-health services. CMHSPs must provide services regardless

of an individual's ability to pay, MCL 330.1208(4), and CMHSPs are statutorily authorized to bill Medicaid or other appropriate payers for the services. MCL 330.1202(2).

That obligation extends far beyond the duties identified in MCL 330.1206. The CMHSPs' statutory duty to provide preadmission screening requires the CMHSPs to have flexibility to enter into financial contracts with service providers above and beyond inpatient hospital admissions to address the complex needs of individuals to whom they provide services. Their contracts must be negotiated in advance because preadmission screening must be available seven days a week, 24 hours a day. MCL 330.1409(1). Moreover, the duties following the screening require coordination with other entities involved in each person's care. MCL 330.1409(5), (7). Services following pre-admission screening may include hospitalization, or if the person does not meet the requirements for hospitalization, the CMHSP instead must "ensure the provisions of follow-up counseling and diagnostic and referral services if needed." MCL 330.1427. Individuals determined not clinically appropriate for inpatient placement must be directed to clinically appropriate levels of care that may include outpatient services or a residential treatment center. MCL 330.1409(7). Medicaid funding is crucial to the CMHSPs' ability to carry out those statutory mandates because it depends on the maintenance of a provider network.

Numerous provisions of the Mental Health Code require CMHSPs to contract with service providers. Those provisions include recipients' rights to request mediation and receive individual prerelease plans for appropriate community placement as well as plans for aftercare services. MCL 330.1206a; MCL 330.1209a(1), (2), (3). Also, CMHSPs must enter into interagency agreements for a collaborative program to provide mental-health treatment and assistance to qualifying people involved in the criminal justice system. MCL 330.1207a(3).

Finally, CMHSPs' contracts with providers ordinarily include a provision authorizing the CMHSPs to carry out investigations and take disciplinary actions to ensure that the recipient rights provisions in Chapter 7 of the Mental Health Code are carried out. The RFP's prohibition of PIHPs delegating that function to CMHSPs through financial contracts conflicts with Michigan law.

III. CONCLUSION

For the reasons explained above, defendants' motion for summary disposition beyond the award in the Court's October 14, 2025 opinion and order is denied, and the Court hereby issues a declaratory pronouncement that the RFP, as drafted, impermissibly conflicts with Michigan law in numerous respects, especially insofar as the RFP restricts CMHSPs from entering into financial contracts for the purpose of funding CMHSPs' managed-care functions. However, the Court will not yet issue injunctive relief that directs defendants to amend or pull back the RFP.[4] Defendants must decide, in the first instance, how to address the conflicts between Michigan law and the RFP that the Court has identified.

IT IS SO ORDERED.

This is not a final order. It does not resolve the last pending claim or close the case.

Date: January 8, 2026

Court of Claims State of Michigan

Hon. Christopher P. Yates (P41017)
Judge, Michigan Court of Claims

[4] Michigan law disfavors injunctive relief against state agencies and officials except in cases where declaratory relief has failed. See *Davis v Detroit Fin Review Team*, 296 Mich App 568, 614; 821 NW2d 896 (2012). Consequently, the Court will stay its hand unless and until defendants prove unable or unwilling to fulfill their obligations under this Court's declaratory pronouncement.

Email Correspondence

From: Monique Francis
To: Monique Francis
Cc: Robert Sheehan; Alan Bolter
Subject: Judge Yates" opinion and order: appreciation. applause, and short analysis
Date: Friday, January 9, 2026 8:00:11 AM

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Judge Yates' opinion and order: appreciation. applause, and short analysis

The recent decision, by Judge Yates (attached in original and highlighted version), represents a powerful win for Michigan's public mental health system and the individuals, families, and communities served by this system.

This email contains several messages.

APPRECIATION AND APPLAUSE: First, to applaud you, CMHA members, for your support and solidarity in this effort – a truly sophisticated collective effort on political and legal fronts - to fight back against this latest privatization threat to our system. Your engagement in fighting this threat was key to the success of this effort.

Beyond your support for the legal fight, your work in the political and media relations components of this advocacy effort, your willingness to share your knowledge and views, in word, in action, in solidarity around this cause, were vital. The fact that so many of us in this fight were united on the principle of the value of public system was essential to this successful effort to turn back this most recent privatization-centered threat to our system.

On behalf of the Association, Alan and I want to applaud you for your courage, commitment, brains, brawn, and backbone in this fight. Bravo.

SHORT ANALYSIS OF OPINION AND ORDER: Secondly, we want to provide a very short analysis of Judge Yates' opinion and order. While much can be written about this document, and our members can (and are encouraged to) read and construct their own analysis of the full opinion and order document, we want to highlight only a few points. To aid in the analysis of the judge's opinion and order, we have provided, as attachments to this email, the original document, issued by the judge, and a version in which the most salient points (from CMHA's perspective) are highlighted.

The judge's conclusion, at the end of the document, provides the most succinct summation of his analysis and opinion. The key excerpts of that opinion are provided below:

> *"… the Court hereby issues a declaratory pronouncement that the RFP, as drafted, impermissibly conflicts with Michigan law in numerous respects, especially insofar as the RFP restricts CMHSPs from entering into financial contracts for the purpose of funding CMHSPs' managed-care functions. However, the Court will not yet issue injunctive relief that directs defendants to amend or pull back the RFP. Defendants must decide, in the first instance, how to address the conflicts between Michigan law and the RFP that the Court has identified."*

As a review of the highlighted sections of the opinion and order indicates, the violation of law, represented by the RFP, center around the Mental Health Code's: dictate that the state's CMHSP have been delegated the responsibility to fulfill the State's obligation to provide mental health care to its residents; requirement that CMHSPs carry out

inpatient pre-admission screening and authorization; requirements that CMHSPs provide, directly or via contract with other providers, a comprehensive set of mental health services to Michiganders; requirements that the CMHSPs fulfill functions that the RFP prohibited from being delegated to or performed by them; and linking of recipient rights protections, by the state's CMHSPs and the MDHHS Office of Recipient Rights, only to the persons served by the state's CMHSPs or the providers on contract with the state's CMHSPs.

The opinion and order put the ball in the court of MDHHS and DTMB (the defendants in this case), with the onus on these state departments to resolve the conflict between the RFP and state law. We will all await the actions and decisions by these departments. However, we will not sit by and await the actions by these departments, hence the next theme, below, in this communication.

COLLECTIVE NEXT STEPS IN SYSTEM REDESIGN: Finally, as we have said many times over the past decade, and more frequently during the past year, our work to halt the privatization threats faced by our system is founded on two beliefs. First, that the privatization of the management of this system is wrong-headed and harmful to Michiganders in need of mental health care and to the public system upon which they rely (as it has been in states across the country). Secondly, that the current structure of our system is politically unsustainable, leaving it open to continual privatization threats. Judge Yates' opinion gives all of us an opening to **build a system that is privatization-proof,** supported by our members, our advocacy allies, and our legislative allies. We cannot return to the status quo, simply awaiting the next privatization threat.

In this vein, CMHA will be working with you and our key allies in efforts to close out this chapter and prevent all subsequent chapters in our system's longstanding fight against privatization

Again, thank you and bravo to you for your work in this collective effort.

Robert Sheehan
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Media coverage of Judge Yates opinion on Region 10 et al v State of Michigan

Detroit News – January 9, 2026
Judge finds illegal language in MDHHS proposal to restructure state mental health services (Kara Berg)

A Michigan Court of Claims judge has found that the language in the state health department's attempt to possibly privatize community health agencies violates Michigan's mental health code.

Two lawsuits were filed in August by three regional entities that manage mental health, substance abuse and disability care — called Prepaid Inpatient Health Plans, or PIHPs — along with seven Community Mental Health agencies over a plan to possibly privatize some community mental health services. The lawsuits were filed after the Michigan Department of Health and Human Services issued a request for proposals seeking bids from both private and public entities to apply to take over handling of the state's PIHPs and mental health services.

But Judge Christopher Yates wrote in an opinion issued Thursday that the language in the request for proposals the state issued violates Michigan law because it prevents Community Mental Health agencies from fulfilling their statutory requirements to use Medicaid funds to provide services to people who could not otherwise pay for them by having financial contracts with providers.

But Yates said MDHHS's plan to select PIHPs through a competitive bidding process is legal and can continue, once MDHHS brings the request for proposals into compliance with Michigan law.
MDHHS spokesperson Lynn Sutfin said the state is reviewing Yates' decision to determine next steps.

Community Mental Health CEO Robert Sheehan and incoming CEO Alan Bolter said in a joint statement that they were pleased with Yates' decision and are ready to work with MDHHS and mental health stakeholders to design and implement "bold system improvements and reforms" to strengthen the system.

“We appreciate the Court’s careful review and its acknowledgment that the bid out requirements raised serious legal and operational violations of the Michigan Mental Health Code — particularly those which would have prohibited the state’s public Community Mental Health centers from carrying out their statutory responsibilities, from providing a comprehensive set of services, from ensuring the rights of persons served, and the administration of essential mental health and substance use disorder services," Sheehan and Bolter said in the statement.

Community Mental Health agencies fear allowing for private PIHPs will severely restrict their ability to function, but MDHHS says it could boost efficiencies.

Christopher Cooke, one of the attorneys for four community mental health agencies, said if a bid is granted to privatize some of these services, it will "essentially destroy" the ability of community mental health agencies to comply with statutory requirements in the mental health code.

"The lack of Medicaid funding will decimate our organizations," Cooke said. "Even if it is allowed to survive, it will be a very minimalist organization that won't be able to comply with the statute."

Since 2014, the state has had 10 regional entities that manage mental health, substance abuse and disability care, or Prepaid Inpatient Health Plans, divided up by regions of the state, to distribute millions of dollars in Medicaid funds. They offer a range of services for everything from those battling substance abuse disorders to those with developmental disabilities.

But state officials say expanding these regional care plan providers to include outside private providers to deliver care could improve services. Officials said whichever organizations end up as PIHPs must contract with Community Mental Health agencies to provide specialty services and support.

"The state's intent here was to strengthen (Community Mental Health Service Programs') statutory functions," said Assistant Attorney General Stephanie Service, who is representing MDHHS, during a hearing before Yates in December. "(The issues) are all hypothetical at this point. We don't know who will win the bids."

Yates, who heard three days of attorney arguments and witness testimony in December, said during the December hearing he doesn't run MDHHS but called the plan to accept public and private bids to run these plans and agencies "crazy from a policy standpoint."

But "I am not here to determine what good policy is," Yates said. "All I have to do is determine if the (request for proposals) is in violation of state law."

State Affairs (Gongwer) - January 10, 2026:
Judge says DHHS request for rebid conflicts with state law, but declines to issue injunction

The request for proposals issued by the Department of Health and Human Services in 2025 to rebid public coverage of behavioral and mental health services is in conflict with the law, a Court of Claims judge wrote Thursday, but the department must rectify the situation itself.

Judge Christopher Yates issued an opinion in which he declined to grant injunctive relief to the plaintiffs in *Region 10 PIHP v. Michigan* (COC Docket No. 25-000143), who had sought to block the department's rebid of prepaid inpatient health plans. Plaintiffs argued the rebid essentially privatized the system of coverage by writing the RPF to exclude existing PIHPs.

Although Yates did not issue a declaratory ruling or injunction and the case remains open, he opined that the drafted RFP is in conflict with the law, particularly in how it would restrict community mental health service providers from entering into managed-care contracts.

"The court hereby issues a declaratory pronouncement that the RFP, as drafted, impermissibly conflicts with Michigan law in numerous respects, especially insofar as the RFP restricts CMHSPs from entering into financial contracts for the purpose of funding CMHSPs' managed-care functions," Yates wrote. "However, the court will not yet issue injunctive relief that directs defendants to amend or pull back the RFP. Defendants must decide, in the first instance, how to address the conflicts between Michigan law and the RFP that the court has identified."
Community mental health providers celebrated the opinion from Yates on Friday and said they hope to collaborate with the department to ensure changes to the PIHP system comply with state law.
Community Mental Health Association of Michigan CEO Robert Sheehan and the organization's incoming CEO Alan Bolter issued a statement Friday saying their members "stand ready to work with the department" and are pleased with Yates's consideration of their case.

"We are pleased that the court recognized fundamental inconsistencies between the state's attempt to bid out the management of Michigan's public mental health system and Michigan law. Judge Yates' questions and observations in the opinion underscored his substantial concerns relative to how the RFP violates the Mental Health Code and the statutory framework governing Michigan's public behavioral health system," Sheehan and Bolter said. "We appreciate the court's careful review and its acknowledgment that the bid out requirements raised serious legal and operational violations of the (code) – particularly those which would have prohibited the state's public CMH centers from carrying out their statutory responsibilities, from providing a comprehensive set of services, from ensuring the rights of persons served and the administration of essential mental health and substance use disorder services."

An initial ruling from Yates at the end of last year dismissed much of the plaintiffs' case, granting DHHS the ability to competitively rebid for a reduction in regional PIHPs. Still, the injunction request was allowed to go forward and Yates said he will consider it alongside DHHS's response to his declaratory pronouncement.

The Michigan Association of Health Plans, which welcomed the RFP when it was issued last year, expressed disappointment with the court's decision on Friday.

"Michigan's Court of Claims just put thousands of Michiganders who desperately desire an improved public mental health system in limbo. The fact that the court believes that state law may restrict MDHHS's ability to seek better alternatives and choices for improved services through a simple RFP for our most vulnerable population is a travesty," MAHP Executive Director Dominick Pallone said in a statement. "It is a sad day when our state laws are interpreted to block a pathway for improved competition, choice and access to mental health services."

A spokesperson for DHHS said department officials are reviewing the opinion and did not provide further comment on any change in timeline for the rebid given the court's decision. The initial RFP had set a goal of fall 2026 for implementation of a new coverage system.

Bridge - January 9, 2026:
Judge: Michigan bid to rebuild mental health care has 'significant conflicts'

Michigan wants to restructure how the state administers Medicaid funds for mental health care, but its planned overhaul of the system hit a legal hurdle this week.

The state has offered organizations a chance to submit proposals to manage the money, but a judge says the bid-out process violates state law.

The decision adds a wrinkle to enacting the state's new vision for how regional health agencies facilitate programs that cover over 300,000 Michiganders.

Several of the regional agencies filed suit in August after the Michigan Department of Health and Human Services unveiled proposals for a "competitive procurement process" to contract out the administration of $4.9 billion in behavioral health programs.

MDHHS says the reforms are necessary to improve access and introduce consumer choice. Critics say the state's efforts are tantamount to privatization that would water down local oversight and expertise.

Judge Christopher Yates of the Michigan Court of Claims determined last year that MDHHS had the authority to restructure its systems, but deferred judgment on the legality of its bid process.

On Thursday, Yates ruled the state's request for proposals "impermissibly conflicts with Michigan law in numerous respects," but stopped short of forcing the health department to withdraw the bid. He said any modifications of the plan would need to ensure Medicaid-funded Community Mental Health Service Programs receive enough funding to perform their legally required obligations as they contract with providers.

Officials with MDHHS told Bridge Michigan the agency is reviewing the decision.
Those representing plaintiffs in the case say Judge Yates' decision was correct in noting the legal flaws in the state's proposal and forcing the health department to redress those deficiencies.

"We're really very pleased with the judge's opinion," said Robert Sheehan, chief executive officer of the Community Mental Health Association of Michigan. "That bid-out is not the way to build something collaboratively."

Sheehan said that as a result of the ruling, more applicants should be eligible to bid.

The MI Care Council, a coalition of behavioral health and substance-use treatment providers across the state, also welcomed the court's decision, saying the reorganization of mental health care in Michigan is a "necessary step toward simplifying oversight" and creating a more efficient structure.

"We believe this decision will help create a clearer pathway for providers to deliver consistent, high quality care and strengthen a system that too often leaves people waiting for services," said MI Care Council executive director Daniel Cherrin in an email. "As the process continues, we remain committed to working with the state to ensure that the transition improves access, protects community based providers, and keeps the focus on the people we serve."

A 'damaging shift' or necessary reform?
Ten Prepaid Inpatient Health Plans, or PIHPs, operate regionally to manage the state's Medicaid funding for individuals with intellectual and developmental disabilities, substance use disorder and those experiencing other serious mental illness or emotional disturbances. Each agency oversees a network of mental health service providers that work directly with Michigan's patient population.

Under MDHHS's new initiative, the number of PIHPs would be reduced to three. New organizations that contract with the state would need to be a nonprofit, governmental entity or a public university, and be subject to the Open Meetings Act and the Freedom of Information Act. The changes are slated to take effect in October.
In his ruling, Judge Yates said the state's proposal contained "several significant conflicts" with the Mental Health Code. He said the state's request for proposals is structured in a way that unlawfully limits how regional health entities pay Community Mental Health Service Programs.

Community Mental Health Service Programs are the local groups that coordinate care with providers.
"Medicaid funding is such a significant portion of the budgets of CMHSPs that it is impractical, if not impossible, for CMHSPs to differentiate Medicaid beneficiaries from others to whom they are statutorily obligated to provide mental-health services," Yates wrote in his decision. "Medicaid funding is crucial to the CMHSPs' ability to carry out those statutory mandates because it depends on the maintenance of a provider network."

A coalition of leaders representing mental health service providers and their related advocacy groups signed on to decry the disputed MDHHS proposal. In an open letter released in September, the coalition called the plan a "damaging shift" in the way behavioral health services are structured and delivered in Michigan — taking management out of the hands of agencies that are held accountable by locally elected officials.

"This bid-out process seeks to move this management role to other organizations – through a bid process that heavily favors private health insurance companies," the letter reads.

The Community Mental Health Association of Michigan estimates higher overhead costs associated with the state's new plan will result in an immediate loss of $500 million in mental health services.

Those representing many of Michigan's health insurance companies say Judge Yates' decision jeopardizes the state's mental health system. Michigan Association of Health Plans Executive Director Dominick Pallone called it a "travesty" that blocks choice and competition.

"Michigan's Court of Claims just put thousands of Michiganders who desperately desire an improved public mental health system in limbo," Pallone said in a statement.

How it started
Michigan's managed care model has been in place since the 1990s, when state officials opted to "carve out" Medicaid dollars for behavioral health care.

The PIHPs were first downsized to 10 from 18 in 2014 under the Snyder administration.

Critics of that restructuring believe it created a conflict of interest within the regional groups, allowing them to both manage federal dollars and act as a direct provider of Medicaid-funded services. The community mental health groups argue the concern is misdirected, as they exist as governmental entities with proper safeguards in place.

Gov. Gretchen Whitmer has seen other managed care system reforms floated in her term. Plans to eliminate the PIHP system set forth by former Senate Majority Leader Mike Shirkey and another Republican state lawmaker failed to materialize.

Michigan Advance - January 9, 2026
Change isn't the problem—Profitizing Michigan's mental health system is

Editorial of Tom Watkins, former DWIHN CEO

Change is inevitable, progress should not be optional.

This old saying comes to mind as the State of Michigan, now going back decades, has threatened to privatize or what I call the "profitization" of public community-based behavioral health, better known to many as mental health and addiction services.

These vital community resources have been provided at the local level going back to President John F. Kennedy's administration and are desperately needed to bring a semblance of help and human decency to

individuals and their families who are combating serious mental illness, intellectual and developmental disabilities and substance use disorders.

Using the euphemism of "bidding out or redesigning the system of care" the state under the direction of the Department of Health and Human Services, going back to Governor Engler's administration, have attempted to give the insurance companies control of billions of our tax dollars to "manage" these services.

The courts slowed down the state's action and a recent court pronouncement resulted in a "kissing your sister ruling," as a long-time watcher said, not fully satisfying either the department or advocates fighting the state move.

The ball appears to be back in Governor Whitmer and State Department of Health and Human Services Director Hertel's hands on how they wish to proceed.

They should follow the railway warning: Stop, look and listen.

Those advocating for the "redesign" believe it will modernize the system of care and provide better outcomes than the current system. Those advocating for the change provide no evidence or data that the changes will add any additional value or make a difference to persons in need and their families' lives.
To the contrary these proposed changes would result in a loss of local control, increase administrative costs, replace a publicly managed care system that has a 2% overhead with a privately managed profit care system that has up to a 20% overhead.

In a strongly worded open letter to Michigan's Governor and the State Legislature, the National Alliance of Mental Illness (NAMI-MI) made it abundantly clear they oppose the "redesign" process saying: "The RFP/bid out process represents a significant and damaging shift in the structure and delivery of behavioral health services in our state with far-reaching harm to the ability of Michiganders to receive needed mental health care and to the locally driven system upon which 300,000 Michiganders (and the 1 million family members) have come to rely."

The Community Mental Health Association of Michigan which is opposed to the redesign process says it provides, "serious risks without addressing the system's core challenges." The organization goes on to say, "Other states that have pursued similar restructuring have experienced higher costs, workforce losses, fragmented services and diminished access for those most in need. Michigan must not repeat those mistakes."

Debbie Stabenow, who has spent her professional career of over a half century serving as a county commissioner, state Representative, state Senator, U.S. House member and U.S. senator, has been a staunch advocate and supporter of a strong community based public mental health system. She has been a vocal critic of the Michigan Department of Health and Human Services plan to privatize the state's public mental health system.

Stabenow retired from the U.S. Senate in January 2025 but has continued to voice her opposition against the Whitmer's administration's effort to the state's proposal since it was introduced in 2024.

Tenacious Debbie has ferociously argued that the state's privatization proposal would be detrimental to patients and the public system as a whole by increasing costs, decreasing access, reduce transparency and accountability and concluded saying that Michigan's mental health system is in need of greater public investment — not being put up for private management.

The former senator has earned the respect and admiration of behavioral health consumers, their families and community based providers across Michigan and deserves to be listened to, and more importantly, followed.

Wishful thinking by state government is neither a strategy nor a plan. Consumers and their families fear these changes and don't believe the state with their mantra, "We are from the government and we are here to help you."

In her final year in office Gov. Gretchen Whitmer and the Legislature must pull together to enhance and improve public mental health access and integration of care in the new year. "Profitizing" it by turning it over to profit-driven insurance companies is not the answer.

Period- full stop!

This is not a side issue that impacts "those people." Mental health and substance use disorders impact every ZIP code and one in four people across this great nation of ours. Dr. Vivek Murthy, former U.S. Surgeon General, says the mental health crisis is the biggest health concern facing the country because it impacts so many people and different facets of life.

This fact was recently bought home by the death of the iconic actor and film producer, Rob Reiner, and his wife Michelle, by their son Nick Reiner, who has been charged with their murders. Nick has struggled with mental health and addiction issues since his adolescence.

We need to listen to those most directly impacted by these threatened changes. There is a palpable fear among parents, consumers and advocates that the public mental health safety net will be ripped to shreds. Family members worry about losing long-term relationships with trusted providers and new rules that limit service. Given the struggles to get what they have, their worries are not without merit.

The voices of county sheriffs, boards of county commissioners, police officer associations, local hospitals, the Community Mental Health Association of Michigan, National Alliance of Mental Illness, Michigan Mental Health Association and other advocacy organizations are opposing this false promise that would place profits before people.
The so called "redesign" is not truly about solutions to the real issues facing a system of care that does need additional support and sensible consumer-focused reforms. We must do better by serving not profiting from persons with behavioral health needs.

Here's how we continue the pursuit of an integrated health care system that maximizes public resources, is consumer and community-focused and is data-driven and evidence-based:

- Eliminate the separation of physical health care services from behavioral health care. Integrate care at the consumer level where no person is turned away. Treat the whole person; the mind is connected to the body;
- Shut down services that continually abuse taxpayers' resources while enriching themselves at the expense of those most vulnerable;
- Create crisis intervention teams for law enforcement agencies throughout the state. Such partnerships between law enforcement and behavioral health care providers considerably improve care while reducing police officer injuries and costs when responding to mental health crisis calls. Sadly, our jails and prisons have become 21st-century psychiatric holding cells;
- Significantly step up audits on Medicare/Medicaid providers to identify and prevent fraud and abuse;

- Pay livable wages to direct-care staff. Stop the rhetoric about "supporting 'essential' workers" while paying invaluable staffers a pittance, often with no benefits.
- Fund advocacy organizations adequately to enable them to hold the system accountable. Without their watchdog eyes and ears the system will slip off track with devastating consequences to people's lives;
- End the stigma of mental illness. Channel funds toward researching the causes of serious mental illness and developing responses to these disorders;
- Utilize digital technologies and artificial intelligence which have the potential to profoundly impact behavioral health services. We need to use predictive analytics to design programs that help people engage with behavioral health services. Smart analytics could help educate people about behavioral health services;
- Continue insurance reimbursement for virtual mental health services after the COVID-19 crisis subsides. It works;
- Address shortages of certain specialty providers, including psychiatrists as well as eating disorder and autism specialists;
- Fund local community mental health agencies to work with schools to address psychosocial issues students face that were exacerbated by the pandemic;
- Create partnerships between behavioral health services and employers to boost awareness, acceptance, prevention and recovery within the workplace;
- Move nonviolent persons with serious mental health issues currently in our prison system to appropriate behavioral health programs;
- Hold hospitals accountable for serving people with serious mental illness. Michigan needs to get serious about using all the tools at its disposal, including certificates of need, licensing and tax policy forcing hospitals to accept public money to serve patients. Finding a psychiatric bed for someone with serious mental illness can often feel like their name is Mary or Joseph and it is Dec. 24 in Bethlehem. It is unconscionable that people with mental illness in need of hospital settings are denied service.

Decisions that benefit consumers and taxpayers instead of the "system" will lead us to a path that adds value and makes a difference. Without a shift in emphasis from profit to quality care, future policymakers will be confronted with an unfathomable mess to clean up.
Let's work together to enhance care, support and opportunities for strangers, friends and family members with an illness or disability. A friend with cerebral palsy once called me a TAB: temporarily able-bodied. He explained that we are all one life-changing event away from needing some level of assistance. There, but for the grace of God, go I.

Everything we do should create a life of dignity and self-determination for our fellow citizens. We ought to proceed as though our actions will impact someone's mother, father, sister, brother or son or daughter – because ultimately it will.

Let's move forward, getting past the turf protection and place our focus on integrating care for our families and neighbors in need of quality mental health and substance use services.
People over profits.

Immediate action to develop a privatization -proof system

With the favorable opinion of Judge Yates centered around the most recent attack on the state's public mental health system, the MDHHS PIHP RFP, the time is right for the implementation of the next phase in the advocacy plan of CMHA, its members and allies. This phase, kicking off now and lasting, perhaps, into the next legislative session in 2027, involves taking aggressive and coalition-based steps to make our system **privatization-proof**.

System is vulnerable to another privatization attack – basis for advocacy plan

The need to take substantial privatization-proof redesign steps is based on the fact that **our system continues to be vulnerable to another privatization effort** – as it has been since 1998, when the state moved its Medicaid system to one based upon a managed care approach. Those privatization efforts have increased, in frequency and intensity, over the last ten years, with five attempts in that period.

Given this threat:

1. Michigan's public mental health system must be redesigned to be privatization-proof
2. The system cannot stand pat, with the system structured as it is, leaving it vulnerable to another privatization attack
3. The privatization-proof redesign, to be implemented in statute and via administrative action, will require the support of and involvement of our allies. Those allies, who, in the face of considerable pressure, remained committed to Michigan's mental health system remaining public and strong, include:
    - National Alliance for Mental Illness (NAMI)-Michigan
    - Arc-Michigan
    - Michigan Association of Counties (MAC)
    - Private provider organizations in the networks of the state's CMHSPs and PIHPs who have advocated to retain a public system
    - Other longtime allies who were key to the political advocacy against the PIHP RFP

Core anti-privatization components

The following components, identified as important to the allies who were key to our collective efforts to thwart current and the past privatization threats, are fundamental to the design of a privatization-proof system.

Identity of Medicaid behavioral health plan or plans[1]

The state's Medicaid behavioral health plans must be public bodies formed via collaboration of the counties and the state of Michigan. These public plans can be formed via any of a number of mechanisms: multi-county authority, Urban Cooperation Act, Regional Entity. These public bodies will be tied to and not circumvent the authority of the counties forming these bodies.

The **number of public Medicaid behavioral health plans** should be structured to ensure effective management capacity, low administrative costs, and uniformity of key variables within regions.

Governing board of public Medicaid behavioral health plan

The **Appointment of governing board members** will be done by county commissions with recommendations from knowledgeable parties

[1] In federal terms, a Medicaid Behavioral Health Prepaid Inpatient Health Plan (PIHP)

The **membership of governing board** will include persons served and/or families (1/3 of the boards of these plans; ½ of this 1/3 will be persons served) and members representing one or more of major statewide advocacy groups. Remainder of board appointed to **ensure that the interests of the counties served by this body are pursued and protected.**

Bearing financial risk

These plans will be in a **meaningful shared risk arrangement** in which the public Medicaid behavioral health plans and the State of Michigan share financial risk. This shared risk arrangement will be one based on a joint and collaborative arrangement between these plans and the State of Michigan - unlike the current shared risk arrangement in which the State of Michigan has rarely shared in the risk borne by the system.

This public Medicaid behavioral health plan is **sufficiently funded and has the ability to hold an actuarially sound risk reserve** that would allow the newly formed public body to retain its fiscal stability in this shared risk arrangement.

Funding methodology of Community Mental Health Services Programs (CMHSPs)

Givens:

- As per the Michigan Mental Health Code (and reinforced by Judge Yates' opinion), the CMHSPs, as the mental health/intellectual and developmental disability services hubs in each community, are the organizations with whom the public Medicaid behavioral health plan will contract and finance for the provision of mental health and intellectual/developmental disability services.

- CMHSPs can provide these services directly or through a contract with other providers. As per the Code, the public Medicaid behavioral health plan can fund other provider organizations to provide substance use disorder services.

The CMHSPs will be funded by the public plan via a **shared risk capitation** financing design – ensuring that the public plan and the CMHSPs in its region share both the savings and losses.

Any **savings, accrued by the CMHSPs** must be spent on services to persons with mental health needs, to ensure fiscal stability, and other statutorily mandated functions of the state's CMHSPs.

Under-funding of any given CMHSP is addressed jointly by the public Medicaid behavioral health plan and the State of Michigan.

Financial and operational transparency

The public Medicaid behavioral health plan would be **required to provide the public and stakeholders with regular picture of financing status, service authorization standards and processes, services demand patterns, and other operational information.**

Role of public Medicaid behavioral health plans and CMHSPs in carrying out oversight and administrative functions

The management of funds to the CMHSPs; system performance and compliance with federal and state statutes, regulations, and Medicaid waivers will be the **joint responsibility of the State of Michigan and the Public Medicaid behavioral health plan**

Provider network management (except for substance use disorder services) is the responsibility of the CMHSPs, including the development of the network, holding contracts with providers, ensuring quality of care provided by providers and provider compliance with statutes, regulations, and Medicaid waivers, payment of claims, and other network management functions).

The public Medicaid behavioral health plan hold the **network management functions for substance use disorder services** or delegate that responsibility to the CMHSPs in the region.

The **authorization of services and utilization management (except for substance use disorders) will be the responsibility of the public CMHSPs**.

The CMHSPs must ensure that **no conflict of interest exists that would foster over-authorization (provision of clinically unnecessary services) nor under-authorization (failure to provide clinically necessary services).**

Uniformity of Medicaid service array statewide

The public health plans and the State of Michigan will ensure that the **array of Medicaid services and the processes for authorizing those services are as uniform across the state as possible**. Variances from this uniformity, when they occur, must be tied to differences in community needs and resources or differences in the needs and choices of persons served and their families.

Uniformity of provider contracts, contractual requirements, compliance/performance standards

The public health plans will **ensure the uniformity, to the greatest extent possible, of the contracts as well as the compliance, and performance standards and measurement methods applied to CMHSPs and providers in the system.**

Statewide PIHP's
Eligble Variance Report
For the Fiscal YTD Period Ended 12/31/2025

	Average Actual October 2025-December 2025		
Region 1 - Northcare			
Population	Appendix 4	Actual	Difference
DAB	13,828.00	14,017.33	1.37%
HMP	18,459.00	17,037.00	-7.70%
TANF	29,488.00	28,317.33	-3.97%
Region 2 - NMRE			
Population	Appendix 4	Actual	Difference
DAB	25,266.00	25,051.00	-0.85%
HMP	33,084.00	28,617.00	-13.50%
TANF	53,867.00	51,001.00	-5.32%
Region 3 - LRE			
Population	Appendix 4	Actual	Difference
DAB	50,455.67	49,903.67	-1.09%
HMP	67,012.33	63,574.33	-5.13%
TANF	143,535.33	136,151.00	-5.14%
Region 4 - SWMBH			
Population	Appendix 4	Actual	Difference
DAB	41,885.67	41,875.33	-0.02%
HMP	53,559.50	49,821.33	-6.98%
TANF	105,382.50	101,298.67	-3.88%
Region 5 Midstate			
Population	Appendix 4	Actual	Difference
DAB	81,743.33	82,153.33	0.50%
HMP	108,623.42	101,263.33	-6.78%
TANF	192,397.58	187,089.00	-2.76%
Region 6 - Southeast			
Population	Appendix 4	Actual	Difference
DAB	23,514.00	23,567.00	0.23%
HMP	38,733.00	37,642.00	-2.82%
TANF	59,312.00	57,732.00	-2.66%
Region 7 - Detroit Wayne			
Population	Appendix 4	Actual	Difference
DAB	127,928.25	130,589.67	2.08%
HMP	196,043.42	189,609.00	-3.28%
TANF	342,860.83	348,444.33	1.63%
Region 8 - Oakland			
Population	Appendix 4	Actual	Difference
DAB	39,063.58	38,385.33	-1.74%
HMP	57,097.08	53,614.67	-6.10%
TANF	84,800.42	80,256.00	-5.36%
Region 9 - Macomb			
Population	Appendix 4	Actual	Difference
DAB	41,216.92	40,657.33	-1.36%
HMP	66,239.83	62,444.33	-5.73%
TANF	103,410.17	98,697.00	-4.56%
Region 10 - R10			
Population	Appendix 4	Actual	Difference
DAB	37,497.92	37,058.67	-1.17%
HMP	56,854.08	52,989.33	-6.80%
TANF	98,026.42	93,618.67	-4.50%
Statewide			
DAB	**482,399.33**	**483,258.67**	**0.18%**
HMP	**695,705.67**	**656,612.33**	**-5.62%**
TANF	**1,213,080.25**	**1,182,605.00**	**-2.51%**

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – JANUARY 14, 2026
VIA TEAMS

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

REVIEW AGENDA & ADDITIONS
Donna asked to add BHH Cost Settlement to the meeting agenda.

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE DECEMBER 10, 2025, NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY CHIP JOHNSTON. MOTION APPROVED.

MONTHLY FINANCIALS
November 2025 Financial Report

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

A drop in the HSW rate was noted. Deanna drew attention to the (statewide) drop in eligibles. Northern Lakes' information was trended from FY25 as Northern Lakes is in the process of verifying its data.

How much surplus the region retains in carry forward and how much is put into the ISF is yet to be determined. It was noted that the NMRE retained the $1.6M additional earned in PBIP, some of which was used for legal expenses.

PA2/Liquor Tax was summarized as follows:

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

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

For FY25, $761K was moved from PA2 to SUD block grant funding.

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2025 ; SUPPORT BY CONNIE CADARETTE. MOTION APPROVED.

A significant decline in eligibility was observed. A potential rate adjustment is being discussed. Erinn referenced the minimum wage ($13.73) and DCW ($3.40) increases, noting that providers are concerned about wage compression.

EDIT UPDATE
The next EDIT meeting is scheduled for January 15, 2026 at 10:00AM. The agenda includes an EQI update, ABA provider code update, tweaks to the code chart to specify funding source, ICCS, and December 22nd code chart updates.

EQI UPDATE
The due date for the CMHSPs to get their FY25 EQI and FSR reports to the NMRE is February 9th. The due date to the state is now March 2nd (due to Feb. 28th being a Saturday).

ELECTRONIC VISIT VERIFICATION (EVV)
A January 13, 2026 email from Meghan Groen, intended to provide an update on the state-sponsored EVV system as it relates to self-directed arrangements involving agencies and FI/FMS entities, was shared in the meeting chat.

MDHHS and HHAeXchange (HHAX) have identified a solution to fully support EVV reporting for the stated population. HHAX is currently completing the required system changes, and MDHHS is targeting March 2026 for implementation.

A Welcome Letter from MDHHS is scheduled to be sent to providers in early January and will include more details about next steps, including training timelines.

Per MDHHS, individuals who need to use the state-sponsored system for EVV related to self-directed arrangements will not be penalized for EVV non-compliance while the system is being developed and onboarding/training is in process.

HSW OPEN SLOTS UPDATE
January 2026 data included 672 paid slots, which is typical. Currently, 705 of the region's 711 HSW slots are filled; the remaining six slots are expected to be filled by the end of January. It was noted that the rate for December and January was substantially lower than anticipated and the region was paid for 26 fewer recipients in December than in October 2025.

CHAMPS Fix Update & Verification Research Project
Brandon was not in attendance to provide a report, but the NMRE is fairly caught up on back billing with just a small amount left outstanding.

Payment Changes in December
Decreased FY26 rates were implemented in December. There will likely be a recoupment for October and November. Deanna agreed to follow-up with MDHHS.

Eric asked the CMHSPs how often their rates are updated for the EQI. Centra Wellness and North Country responded that their rates are updated annually. Ann acknowledged that North Country was behind, but rates were updated in April 2025, and will be annually ongoing. Melissa added that Northern Lakes was also behind but updated rates in July 2025.

The NMRE is monitoring services to ensure HSW enrolled individuals are receiving a qualified service monthly.

Ann requested the FY26 Milliman rates for HSW, which Donna agreed to send. Tricia noted that the Milliman rates are not what is currently being paid.

Residential Living Arrangement	Old Rate	New Rate
RLA 2	$5,206.05	$4,751.59
RLA 3	$12,096.14	$11,040.23
RLA 6	$8,113.58	$7,405.32

Tricia agreed to post each CMHSPs HSW payments to ShareFile.

Eric requested the impact of the new/lower rates on the CMHSPs so that he can bring the matter to the attention of Keith White at MDHHS.

Clarification was made that 100% of the HSW payment is paid out to the CMHSPs; the insurance provider assessment (IPA) is sent to the NMRE separately.

In an email to the Finance Committee dated January 16th, Eric clarified:

> "It seems the difference between the SFY 2026 Capitation Rates, and the amount being paid is the deduction of the PBIP."
>
> "As for the overall rate reduction, and apparent when looking at it further, our Base Benefit Expense is lower than the Composite Population Rate, which means they use our Base Benefit Expense in the rate development as opposed to Composite Population Rate. It basically means we need to look at our rates and update them regularly, as well as the overall service utilization provided to our HSW enrollees."

<u>NMRE REVENUE & ELIGIBLES ANALYSIS</u>
An analysis of October 2023 – December 2025 Revenue and Eligibles was shared with Committee Members.

DAB			
	October 2023	December 2025	% Change
Revenue	$10,003,003	$11,067,559	10.64%
Enrollees	28,444	24,907	-12.43%
Average Payment per Enrollee	$352	$444	26.35%

HMP			
	October 2023	December 2025	% Change
Revenue	$2,369,569	$2,200,188	-7.15%
Enrollees	47,550	28,219	-40.65%
Average Payment per Enrollee	$50	$78	56.46%

TANF			
	October 2023	December 2025	% Change
Revenue	$2,865,200	$2,777,086	-3.08%
Enrollees	66,801	50,707	-24.09%
Average Payment per Enrollee	$43	$55	27.69%

Children's Waiver Program,			
	October 2023	December 2025	% Change
Revenue	$36,882	$31,620	-14.27%
Enrollees	11	9	-18.18%
Average Payment per Enrollee	$3,353	$3,513	4.78%

HSW			
	October 2023	December 2025	% Change
Revenue	$4,638,399	$4,959,756	6.93%
Enrollees	650	673	3.54%
Average Payment per Enrollee	$7,136	$7,370	3.29%

SED			
	October 2023	December 2025	% Change
Revenue	$40,846	$24,101	-40.00%
Enrollees	21	33	57.14%
Average Payment per Enrollee*	$1,945	$730	-62.45%

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

TOTAL			
	October 2023	December 2025	% Change
	$19,953,899	$21,060,309	5.54%

Revenue projections were much higher based on Milliman rates vs. actual payments. This topic will be discussed from a statewide perspective during CFI on January 15th at 10:00AM.
The change in revenue and enrollment for FY26 was presented as:

	DAB, HMP, TANF	Waivers	Total
Change in Revenue from September 2025 to December 2025	($31,155)	($536,987)	($568,142)
Change in Eligibles from September 2025 to December 2025	(5,526)	(16)	(5,542)

BHH COST SETTLEMENT

Donna requested the BHH Cost settlement as she needs to confirm revenue numbers for the FY25 financial audit.

Clarification was made that over-expenditures for BHH should be covered with the CMHSPs' local funds. The NMRE is not permitted to cost-settle with the CMHSPs as it is unable to cost settle with FQHCs.

The NMRE ended FY25 with a surplus for both BHH and SUDHH. Although the NMRE will not be rolling out the surplus in the form of cost-settlement, other things can be done with the funds. The NMRE also retains 10% of health home funding pay staff at NMRE, not all of which is spent.

NEXT MEETING

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

Chief Executive Officer Report

January 2026

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

Nov 24: Attended and participated in coast allocation lookback review with Rehmann, Rosland and NL.

Dec 2: Chaired NMRE Operations Committee Meeting.

Dec. 2: Attended and participated in PIHP CEO Group .

Dec 8, 9, 10: Attended COC hearing.

Dec 11: Attended and participated in NMRE Internal Operations Committee Meeting.

Dec 12: Attended and participated in NMRE Holiday Trainings.

Dec 19: Attended and participated in SUD Oversight Committee Meeting.

Jan 5: Attended NMRE Regional Finance Committee Meeting.

Jan 6: Attended and participated in PIHP CEO Group.

Jan 8: Attended and participated in NMRE Internal Operations Committee Meeting.

Jan 14: Attended and participated in NMRE Regional Finance Committee Meeting.

Jan 15: Attended and participated in MDHHS PIHP Operations Committee Meeting.

Jan 16: Attended and participated in CMHAM call regarding Regions 1 and 2.

Jan 20: Chaired NMRE Operations Committee Meeting.

Jan 22: Attended and participated in NMRE Internal Operations Committee Meeting.

Northern Michigan Regional Entity

November 2025 Finance Report

November 2025 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	3,126,132	-	13,519,285
Healthy Michigan	(514,273)	8,908,717	7,070,804
	$ 2,611,859	$ 8,908,717	$ 20,590,089

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	(386,623)	257,826	(140,211)	662,006	816,354	1,055,256	347,251	$ 2,611,859
Carry Forward		-	-	-	-	-	-	8,908,717
Total Med/HMP Current Year Surplus	(386,623)	257,826	(140,211)	662,006	816,354	1,055,256	347,251	$ 11,520,576
Medicaid & HMP Internal Service Fund								20,590,089
Total Medicaid & HMP Net Surplus								$ 32,110,665

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through November 30, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 38,036,334	$ 759,993						$ 38,796,327
CMHSP Distributions	(37,611,334)		12,069,914	10,216,696	6,227,544	5,743,394	3,353,786	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	425,000	759,993	12,069,914	10,216,696	6,227,544	5,743,394	3,353,786	38,796,327
Expense								
PIHP Admin	507,752	8,448						516,200
PIHP SUD Admin		19,573						19,573
SUD Access Center		-						-
Insurance Provider Assessment	289,559	6,004						295,563
Hospital Rate Adjuster	-							-
Services	-	570,131	11,759,855	9,389,292	5,462,011	4,730,178	2,927,392	34,838,859
Total expense	797,311	604,156	11,759,855	9,389,292	5,462,011	4,730,178	2,927,392	35,670,195
Net Actual Surplus (Deficit)	$ (372,311)	$ 155,837	$ 310,059	$ 827,404	$ 765,533	$ 1,013,216	$ 426,394	$ 3,126,132

Notes

Medicaid ISF - $13,519,285 - based on current FSR
Medicaid Savings - $0

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through November 30, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 2,880,325	$ 1,596,163						$ 4,476,488
CMHSP Distributions	(2,817,615)		1,035,496	795,979	360,169	381,208	244,763	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	62,710	1,596,163	1,035,496	795,979	360,169	381,208	244,763	4,476,488
Expense								
PIHP Admin	50,667	20,914						71,581
PIHP SUD Admin		48,459						48,459
SUD Access Center		-						-
Insurance Provider Assessment	26,354	13,272						39,626
Hospital Rate Adjuster	-							-
Services	-	1,411,529	1,485,766	961,377	309,348	339,169	323,906	4,831,095
Total expense	77,021	1,494,174	1,485,766	961,377	309,348	339,169	323,906	4,990,761
Net Surplus (Deficit)	$ (14,311)	$ 101,989	$ (450,270)	$ (165,398)	$ 50,821	$ 42,039	$ (79,143)	$ (514,273)

Notes
HMP ISF - $7,070,804 - based on current FSR
HMP Savings - $8,908,717

Net Surplus (Deficit) MA/HMP	**$ (386,623)**	**$ 257,826**	**$ (140,211)**	**$ 662,006**	**$ 816,354**	**$ 1,055,256**	**$ 347,251**	**$ 2,611,859**
Medicaid/HMP Carry Forward								**8,908,717**
Total Med/HMP Current Year Surplus								$ 11,520,576
Medicaid & HMP ISF - based on current FSR								**20,590,089**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 32,110,665**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through November 30, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 205,244		60,367	66,684	83,180	49,487	92,305	$ 557,267
CMHSP Distributions	-	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	-
1st/3rd Party receipts	[redacted]							-
Net revenue	205,244	-	60,367	66,684	83,180	49,487	92,305	557,267
Expense								
PIHP Admin	6,474	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6,474
BHH Admin	6,316							6,316
Insurance Provider Assessment	-							-
Hospital Rate Adjuster	[redacted]							[redacted]
Services	84,935		60,367	66,684	83,180	49,487	92,305	436,958
Total expense	97,725	-	60,367	66,684	83,180	49,487	92,305	449,748
Net Surplus (Deficit)	$ 107,519	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,519

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2025 through November 30, 2025

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 759,993	$ 1,596,163	$ 693,605	$ 431,204	$ 141,582	$ 3,622,547
Expense						
PIHP Admin						39,985
SUD Admin						133,436
Administration	28,021	69,373	28,278	47,749		173,421
OHH Admin			18,467	-		18,467
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	6,004	13,272	-			19,276
Services:						
Treatment	570,131	1,411,529	575,365	248,836	141,582	2,947,443
Prevention	-	-	-	134,619	-	134,619
Healing and Recovery Grant				-		-
Alcohol Use Disorder Services				-		
ARPA Grant	-	-	-	-	-	-
Total expense	604,156	1,494,174	622,110	431,204	141,582	3,293,226
PA2 Redirect			-	0		0
Net Surplus (Deficit)	$ 155,837	$ 101,989	$ 71,495	$ 0	$ -	$ 329,322

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2025 through November 30, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 38,036,334	$ 759,993	$ -	$ 38,796,327
Medicaid Savings	-	-	-	-
Healthy Michigan	2,880,325	1,596,163	-	4,476,488
Healthy Michigan Savings	-	-	-	-
Health Home	557,267	-	-	557,267
Opioid Health Home	-	693,605	-	693,605
Substance Use Disorder Block Grant	-	431,204	-	431,204
Public Act 2 (Liquor tax)	-	141,582	-	141,582
Affiliate local drawdown	148,704	-	-	148,704
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	-	-	-
Healing & Recovery Revenue	-	-	-	-
Veteran Navigator Grant	22,138	-	-	22,138
SOR Grant Revenue	-	248,182	-	248,182
Gambling Grant Revenue	-	17,562	-	17,562
Other Revenue	70	-	656	726
Total operating revenue	41,644,838	3,888,291	656	45,533,785
Operating expenses				
General Administration	604,878	133,436	-	738,314
Prevention Administration	-	20,766	-	20,766
OHH Administration	-	18,467	-	18,467
BHH Administration	6,316	-	-	6,316
Insurance Provider Assessment	315,913	19,276	-	335,189
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	34,268,728	570,131	-	34,838,859
Healthy Michigan Services	3,419,566	1,411,529	-	4,831,095
Health Home Services	436,958	-	-	436,958
Opioid Health Home Services	-	575,365	-	575,365
Community Grant	-	248,836	-	248,836
Prevention	-	113,853	-	113,853
State Disability Assistance	-	-	-	-
Alcohol Use Disorder Services	-	-	-	-
ARPA Grant	-	-	-	-
Public Act 2 (Liquor tax)	-	141,582	-	141,582
Local PBIP	-	-	-	-
Local Match Drawdown	148,704	-	-	148,704
Miscellanous Grant	-	-	-	-
Healing & Recovery Grant	-	-	-	-
Veteran Navigator Grant	22,138	-	-	22,138
SOR Grant Expenses	-	248,182	-	248,182
Gambling Grant Expenses	-	17,562	-	17,562
Total operating expenses	39,223,201	3,518,985	-	42,742,186
CY Unspent funds	2,421,637	369,306	656	2,791,599
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	6,806,600	10,990,375	20,586,761	38,383,736
Unspent funds - ending	$ 9,228,237	$ 11,359,681	$ 20,587,417	$ 41,175,335

Northern Michigan Regional Entity

Statement of Net Position

November 30, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 49,754,606	$ 8,224,766	$ 20,587,417	$ 78,566,789
Accounts Receivable	(752)	5,445,774	-	5,445,022
Prepaids	84,521	-	-	84,521
Total current assets	49,838,375	13,670,540	20,587,417	84,096,332
Noncurrent Assets				
Capital assets	479,259	-	-	479,259
Total Assets	50,317,634	13,670,540	20,587,417	84,575,591
Liabilities				
Current liabilities				
Accounts payable	40,795,702	1,398,622	-	42,194,324
Accrued liabilities	293,695	-	-	293,695
Unearned revenue	-	-	-	-
Total current liabilities	41,089,397	1,398,622	-	42,488,019
Unspent funds	$ 9,228,237	$ 12,271,918	$ 20,587,417	$ 42,087,572

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 31,292,118	$ 38,036,334	$ 6,744,216	21.55%
Carryover	11,400,000	-	-	-	-
Healthy Michigan					
Capitation	19,683,372	3,280,562	2,880,325	(400,237)	(12.20%)
Carryover	5,100,000	-	-	-	0.00%
Health Home	1,451,268	241,878	557,267	315,389	130.39%
Affiliate local drawdown	594,816	148,704	148,704	-	0.00%
Performance Bonus Incentive	1,334,531	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	18,334	22,138	3,804	20.75%
Other Revenue	-	-	70	70	0.00%
Total operating revenue	227,426,695	34,981,596	41,644,838	6,663,242	19.05%
Operating expenses					
General Administration	3,819,287	599,876	604,878	(5,002)	(0.83%)
Health Home Administration	-	-	6,316	(6,316)	0.00%
Insurance Provider Assessment	1,897,524	316,254	315,913	341	0.11%
Hospital Rate Adjuster	4,571,328	761,888	-	761,888	100.00%
Local PBIP	1,737,753	-	-	-	0.00%
Local Match Drawdown	594,816	148,704	148,704	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	15,286	22,138	(6,852)	(44.83%)
Payments to Affiliates:					
Medicaid Services	176,618,616	29,436,436	34,268,728	(4,832,292)	(16.42%)
Healthy Michigan Services	17,639,940	2,939,990	3,419,566	(479,576)	(16.31%)
Health Home Services	1,415,196	235,866	436,958	(201,092)	(85.26%)
Total operating expenses	208,404,464	34,454,300	39,223,201	(4,768,901)	(13.84%)
CY Unspent funds	$ 19,022,231	$ 527,296	2,421,637	$ 1,894,341	
Transfers in			-		
Transfers out			-	39,223,201	
Unspent funds - beginning			6,806,600		
Unspent funds - ending			$ 9,228,237	2,421,637	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 779,772	$ 759,993	$ (19,779)	(2.54%)
Healthy Michigan	11,196,408	1,866,068	1,596,163	(269,905)	(14.46%)
Substance Use Disorder Block Grant	6,467,905	1,077,983	431,204	(646,779)	(60.00%)
Opioid Health Home	3,419,928	569,988	693,605	123,617	21.69%
Public Act 2 (Liquor tax)	1,533,979	-	141,582	141,582	0.00%
Miscellanous Grants	4,000	667	-	(667)	(100.00%)
Healing & Recovery Grant	-	-	-	-	0.00%
SOR Grant	2,043,984	340,664	248,182	(92,482)	(27.15%)
Gambling Prevention Grant	200,000	33,333	17,562	(15,771)	(47.31%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	4,668,475	3,888,291	(780,184)	(16.71%)
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,127,295	170,430	133,436	36,994	21.71%
Prevention Administration	131,394	19,738	20,766	(1,028)	(5.21%)
Insurance Provider Assessment	113,604	18,934	19,276	(342)	(1.81%)
Medicaid Services	3,931,560	655,260	570,131	85,129	12.99%
Healthy Michigan Services	10,226,004	1,704,334	1,411,529	292,805	17.18%
Community Grant	2,074,248	345,708	248,836	96,872	28.02%
Prevention	634,056	105,676	113,853	(8,177)	(7.74%)
State Disability Assistance	95,215	15,875	-	15,875	100.00%
Alcohol Use Disorder Services	-	-	-	-	0.00%
ARPA Grant	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	18,467	(18,467)	0.00%
Opioid Health Home Services	3,165,000	527,500	575,365	(47,865)	(9.07%)
Miscellanous Grants	4,000	667	-	667	100.00%
Healing & Recovery Grant	-	-	-	-	0.00%
SOR Grant	2,043,984	340,664	248,182	92,482	27.15%
Gambling Prevention	200,000	33,333	17,562	15,771	47.31%
PA2	1,533,978	-	141,582	(141,582)	0.00%
Total operating expenses	25,280,338	3,938,119	3,518,985	419,134	10.64%
CY Unspent funds	$ 4,264,498	$ 730,356	369,306	$ (361,050)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			10,990,375		
Unspent funds - ending			$ 11,359,681		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 2,023,189	$ 320,302	$ 351,486	$ (31,184)	(9.74%)
Fringes	704,786	105,604	110,931	(5,327)	(5.04%)
Contractual	770,808	113,886	98,539	15,347	13.48%
Board expenses	18,000	3,000	2,063	937	31.23%
Day of recovery	14,000	9,000	-	9,000	100.00%
Facilities	152,700	25,450	24,368	1,082	4.25%
Other	135,804	22,634	17,491	5,143	22.72%
Total General Admin	$ 3,819,287	$ 599,876	$ 604,878	$ (5,002)	(0.83%)

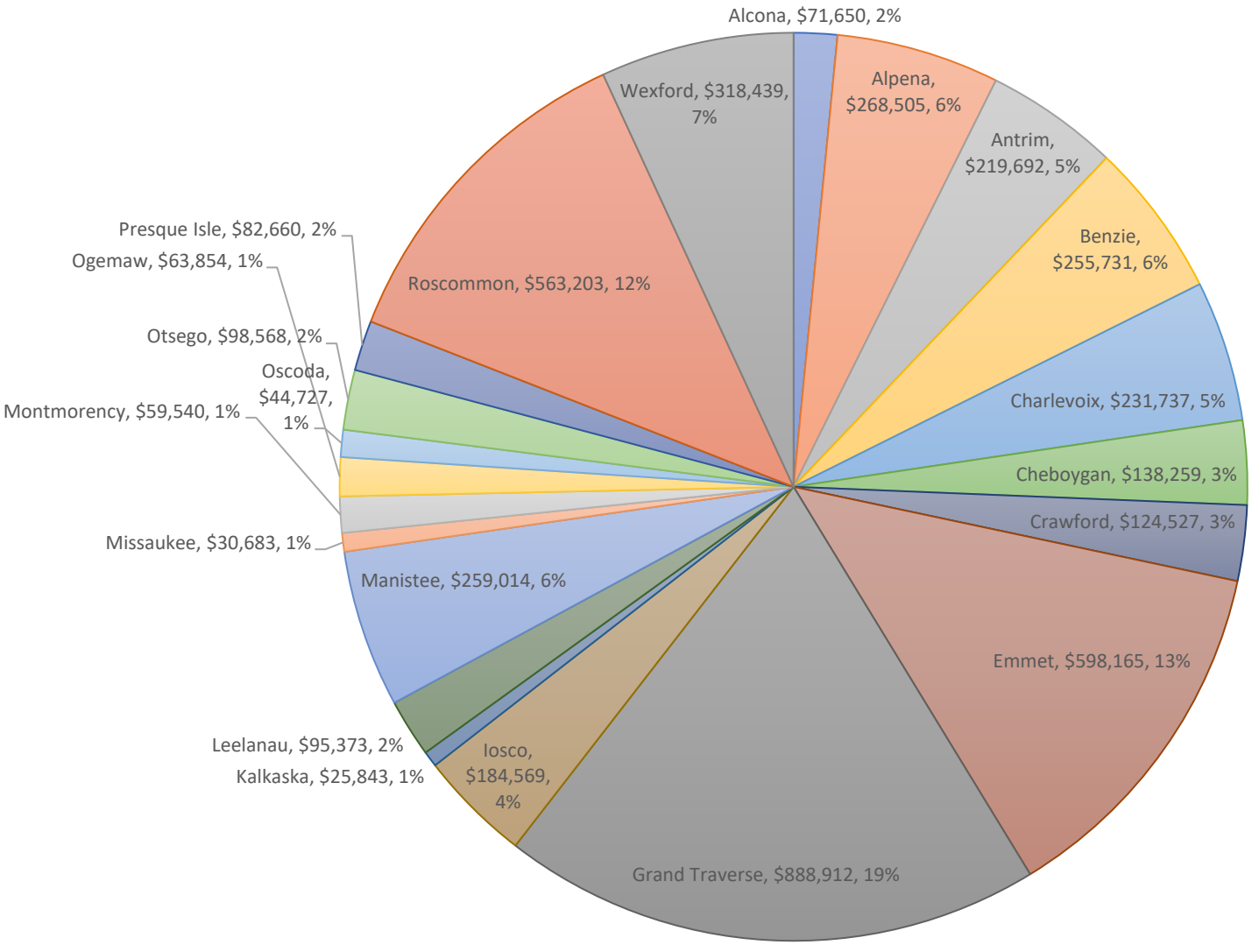
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2025 through November 30, 2025

	Projected FY26 Activity				Actual FY26 Activity			
	Beginning Balance	FY26 Projected Revenue	FY26 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 71,885	$ 23,013	$ 21,562	$ 73,336	$ -	235	$ -	$ 71,650
Alpena	276,605	81,249	115,352	242,502	-	8,100	-	268,505
Antrim	225,891	71,430	52,590	244,731	-	6,198	-	219,692
Benzie	257,777	64,021	74,100	247,698	-	2,046	-	255,731
Charlevoix	240,410	106,977	224,833	122,553	-	8,673	-	231,737
Cheboygan	141,238	85,508	65,816	160,930	-	2,979	-	138,259
Crawford	126,884	36,205	68,993	94,096	-	2,358	-	124,527
Emmet	604,860	182,951	467,204	320,608	-	6,695	-	598,165
Grand Traverse	947,150	464,163	598,334	812,978	-	58,238	-	888,912
Iosco	186,997	84,319	73,780	197,537	-	2,429	-	184,569
Kalkaska	25,843	41,796	14,030	53,610	-	-	-	25,843
Leelanau	97,166	63,811	53,976	107,001	-	1,793	-	95,373
Manistee	259,014	82,480	120,153	221,341	-	-	-	259,014
Missaukee	30,683	22,352	4,864	48,171	-	-	-	30,683
Montmorency	59,540	30,318	8,457	81,401	-	-	-	59,540
Ogemaw	64,110	68,787	11,101	121,797	-	256	-	63,854
Oscoda	44,727	21,668	7,577	58,818	-	-	-	44,727
Otsego	112,969	105,067	98,424	119,612	-	14,402	-	98,568
Presque Isle	82,660	24,977	11,701	95,936	-	-	-	82,660
Roscommon	576,714	87,317	55,007	609,024	-	13,511	-	563,203
Wexford	332,107	98,696	229,583	201,220	-	13,669	-	318,439
	4,765,231	1,847,106	2,377,437	4,234,900	-	141,582	-	4,623,649
PA2 Redirect								-
								4,623,649

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 768,091	$ 120,562	$ 82,413	$ 38,149	31.64%
Fringes	212,604	35,434	27,050	8,384	23.66%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	12,500	16,400	(3,900)	(31.20%)
Board expenses	5,000	834	945	(111)	(13.31%)
Day of Recover	-	-	-	-	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	1,100	6,628	(5,528)	(502.55%)
Total operating expenses	$ 1,127,295	$ 170,430	$ 133,436	$ 36,994	21.71%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2025 through November 30, 2025

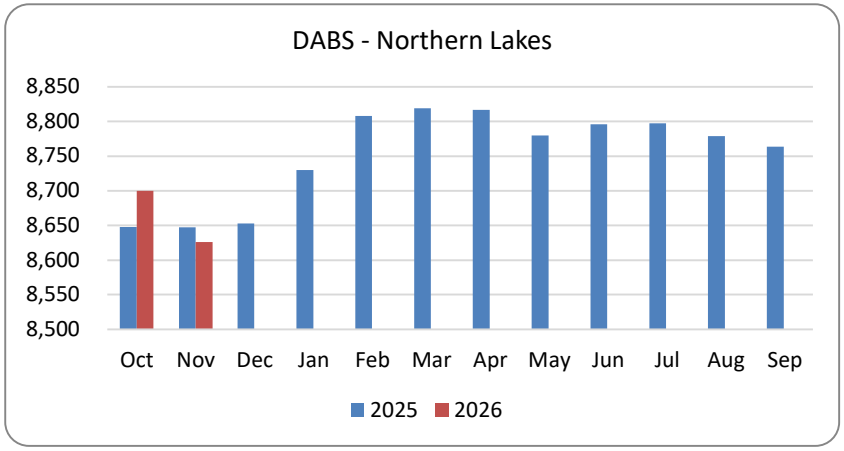
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	1,250	656	(594)	(47.52%)
Total operating revenue	7,500	1,250	656	(594)	(47.52%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 1,250	656	$ (594)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,586,761		
Unspent funds - ending			$ 20,587,417		

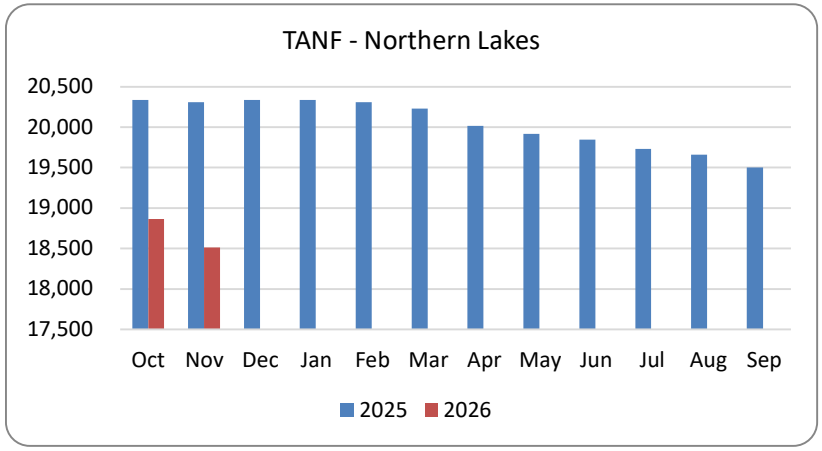
Northern Michigan Regional Entity

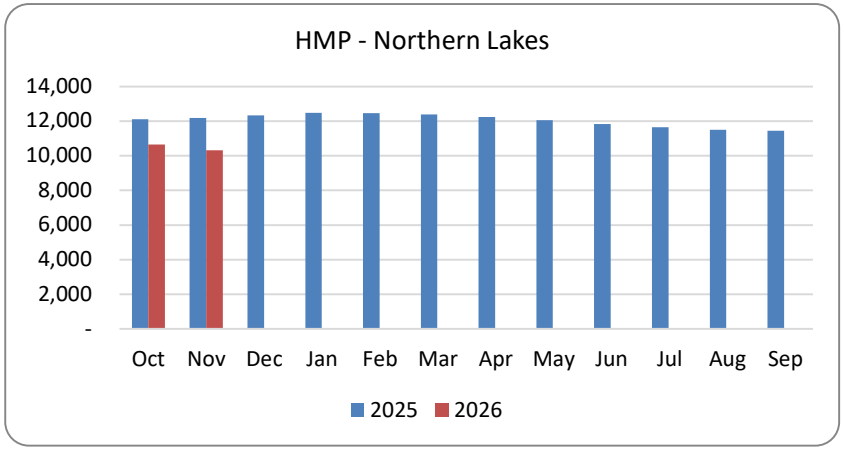
Narrative

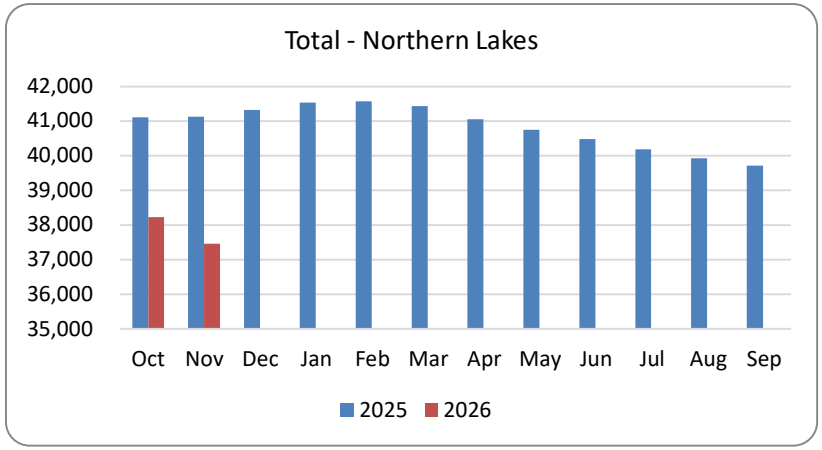
October 1, 2025 through November 30, 2025

Northern Lakes Eligible Members Trending - based on payment files







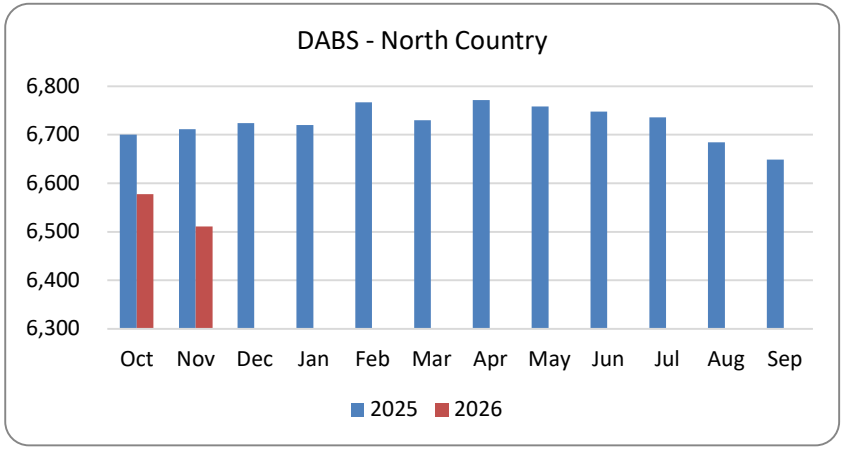


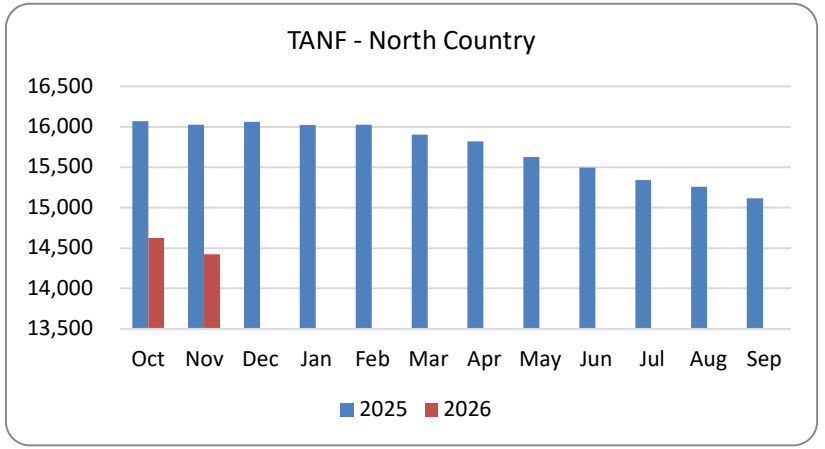
Northern Michigan Regional Entity

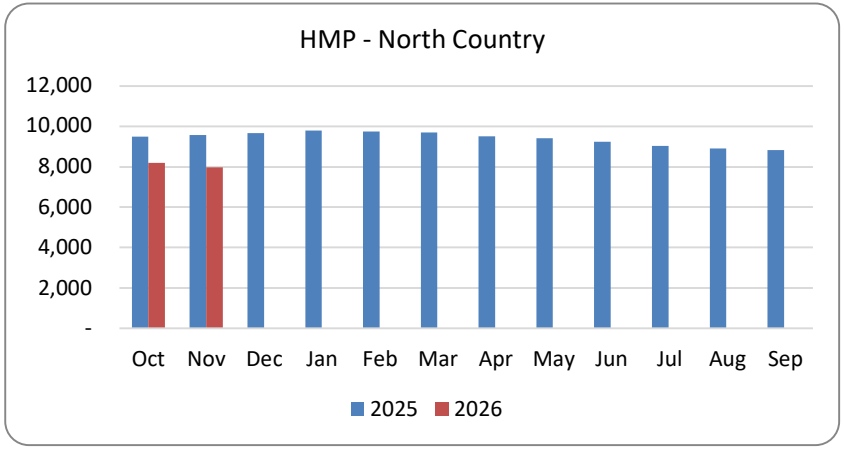
Narrative

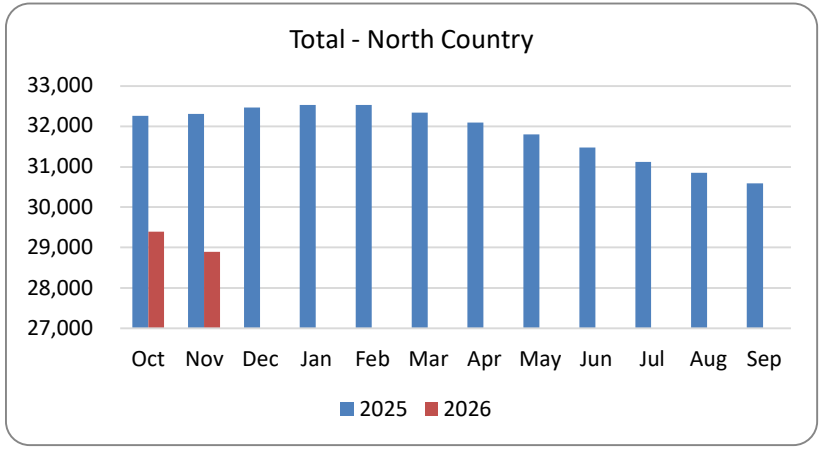
October 1, 2025 through November 30, 2025

North Country Eligible Members Trending - based on payment files







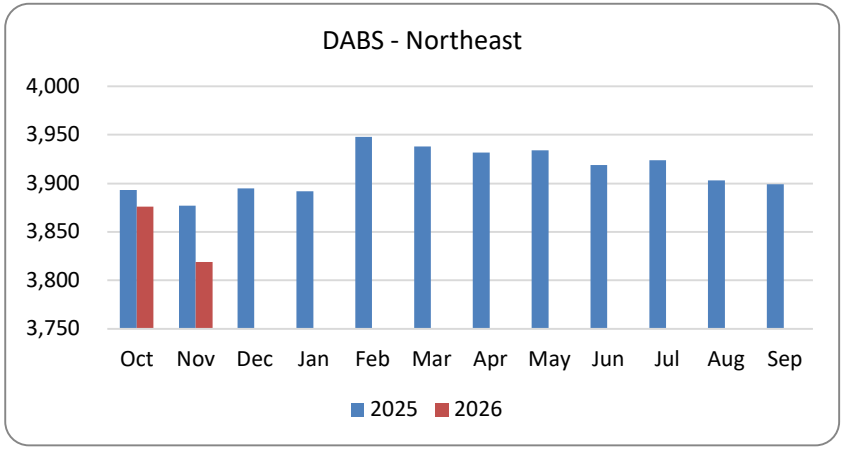


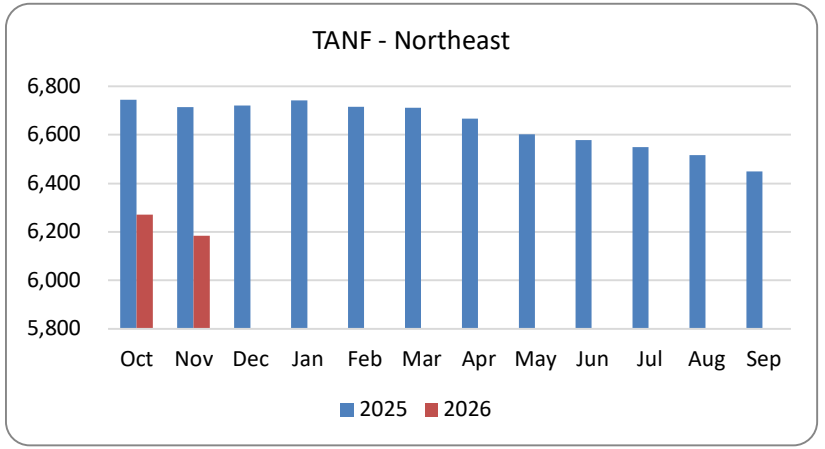
Northern Michigan Regional Entity

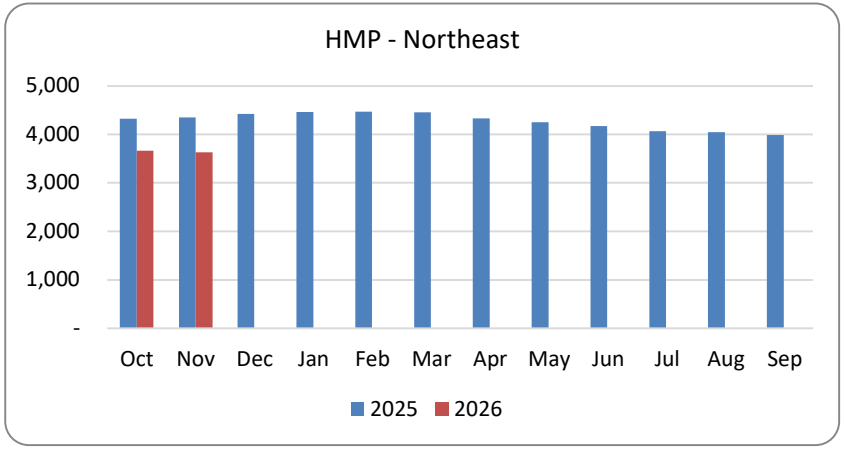
Narrative

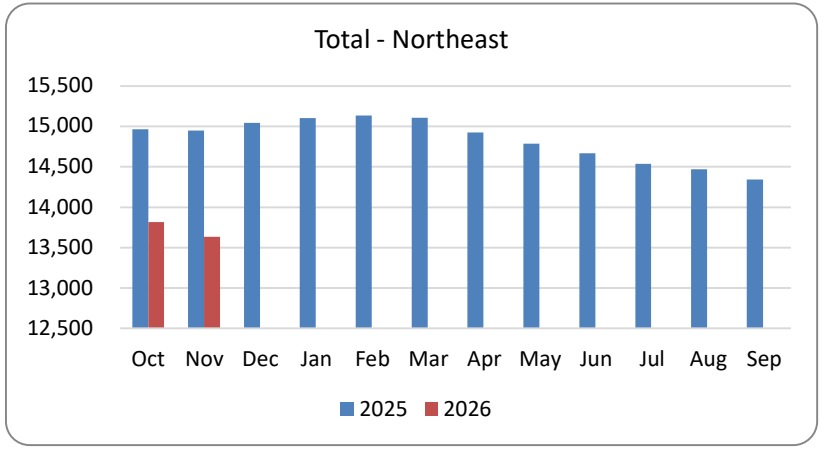
October 1, 2025 through November 30, 2025

Northeast Eligible Members Trending - based on payment files







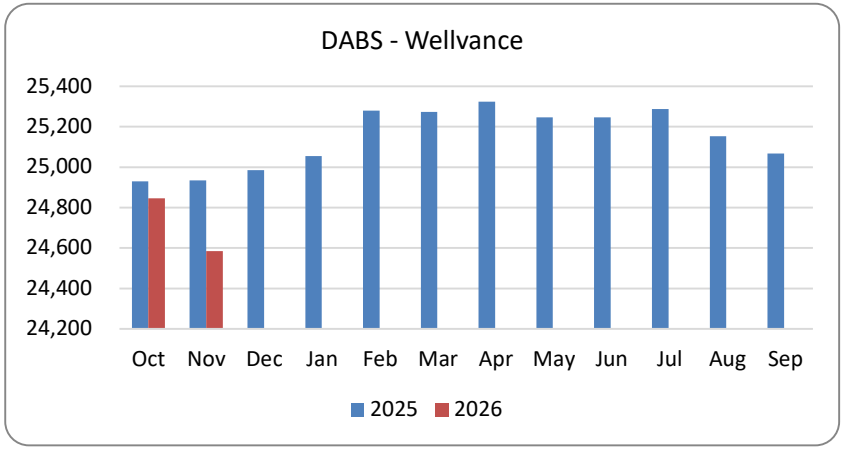


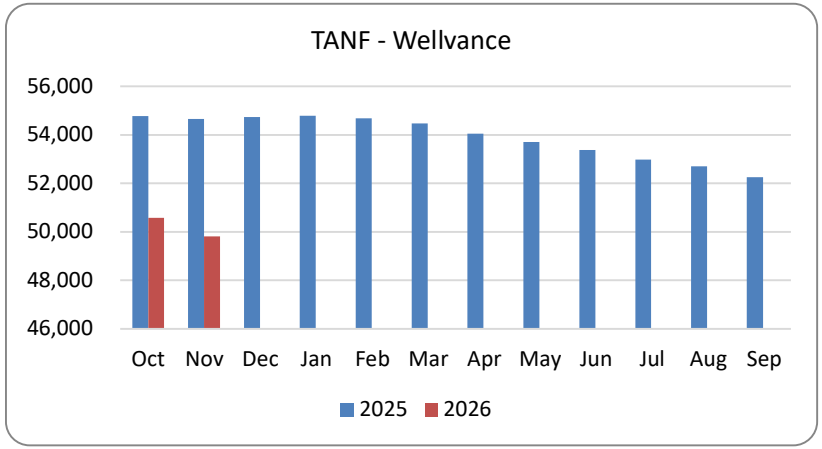
Northern Michigan Regional Entity

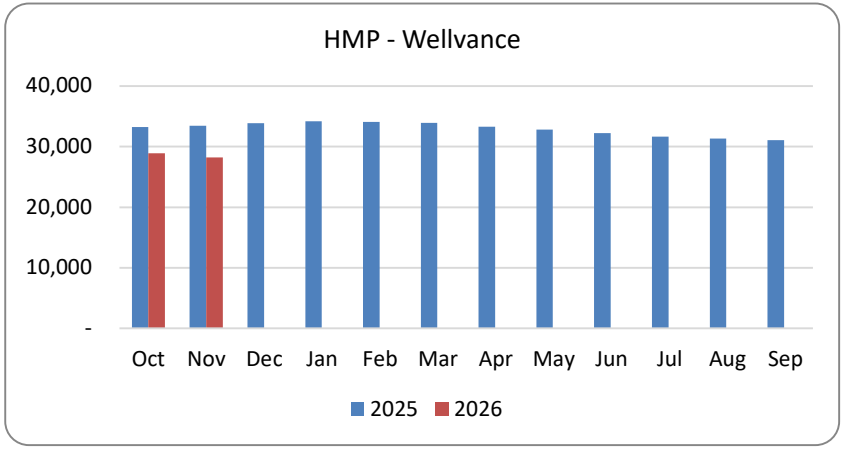
Narrative

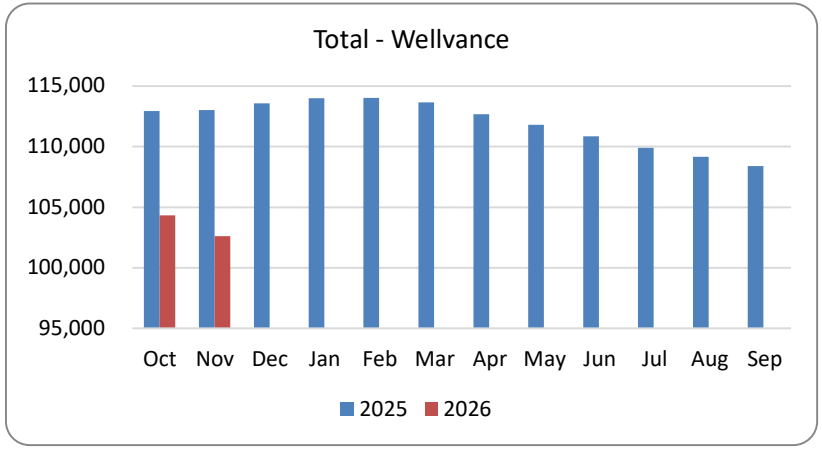
October 1, 2025 through November 30, 2025

Wellvance Eligible Members Trending - based on payment files







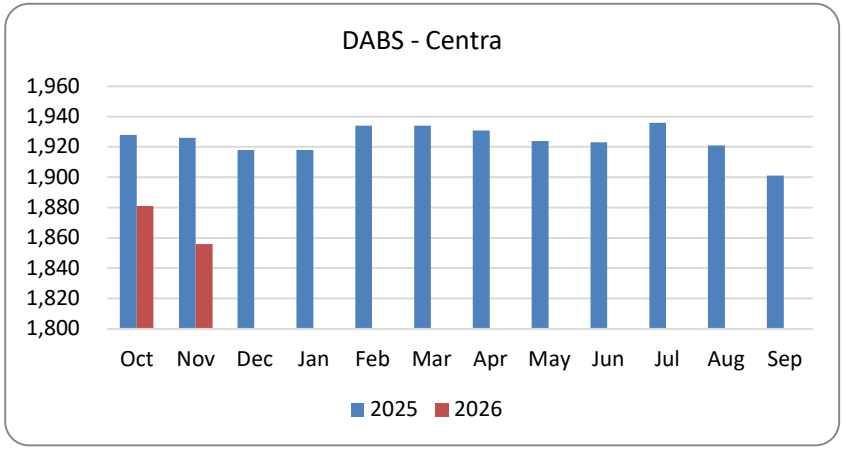


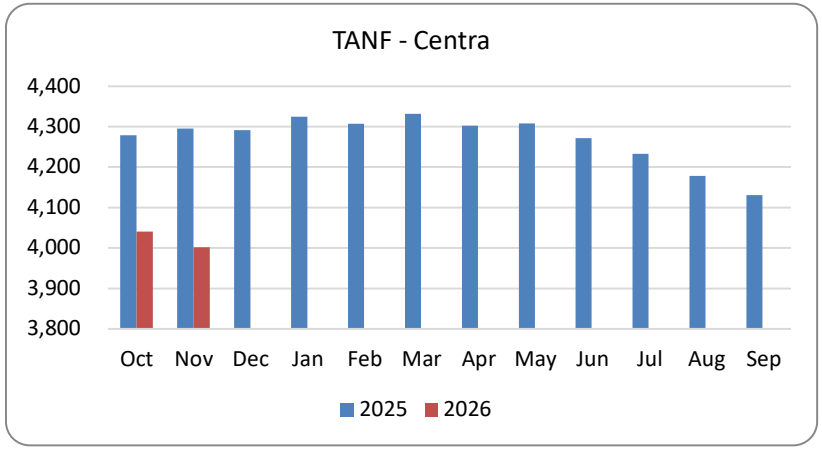
Northern Michigan Regional Entity

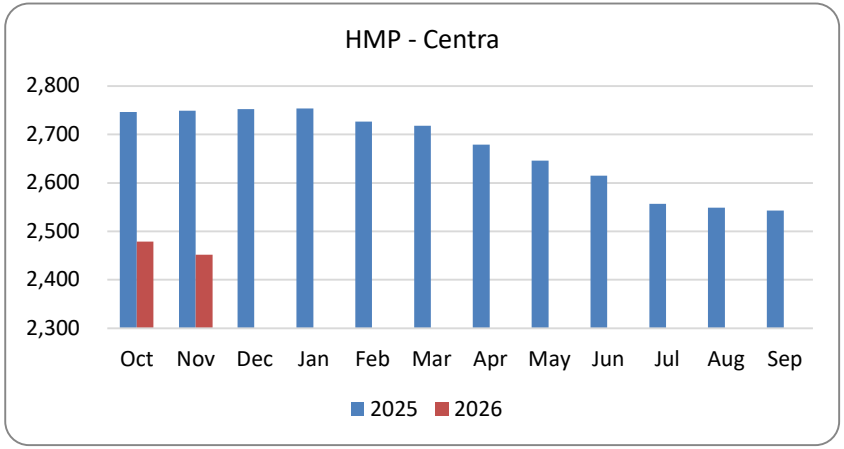
Narrative

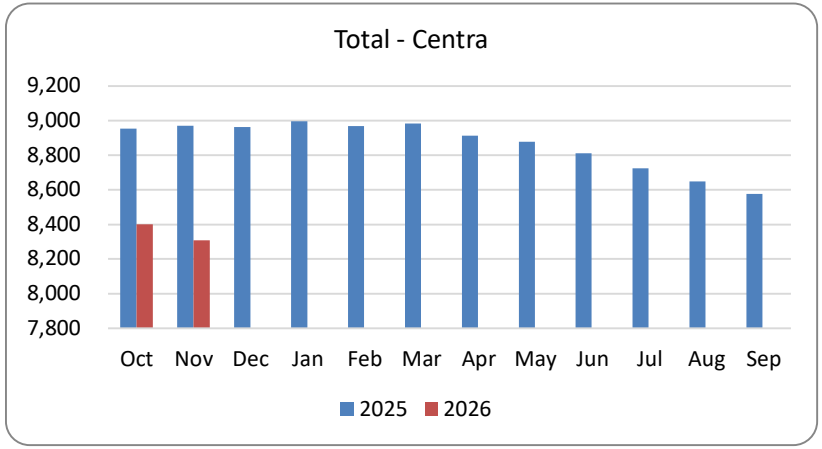
October 1, 2025 through November 30, 2025

Centra Wellness Eligible Members Trending - based on payment files







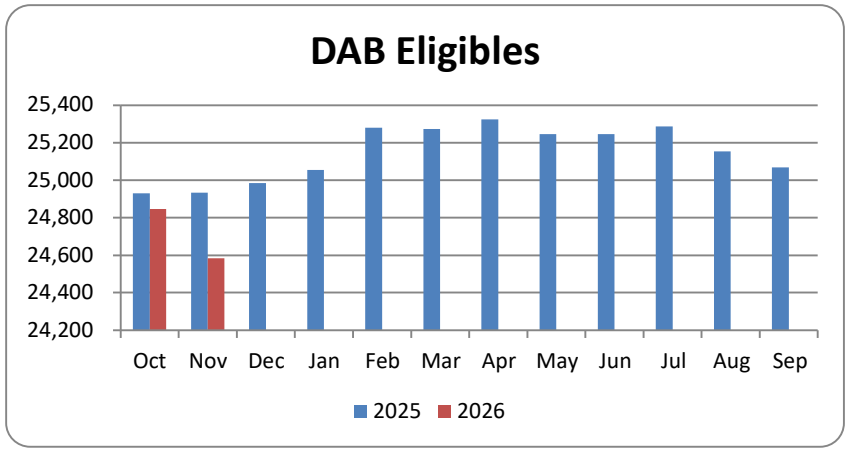


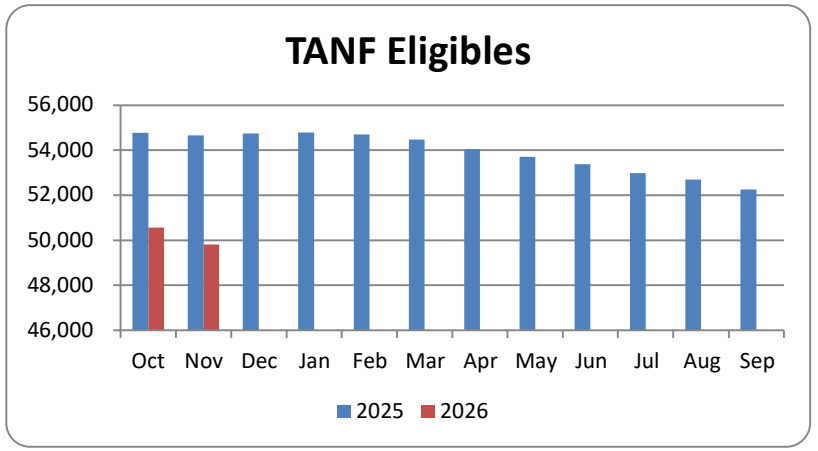
Northern Michigan Regional Entity

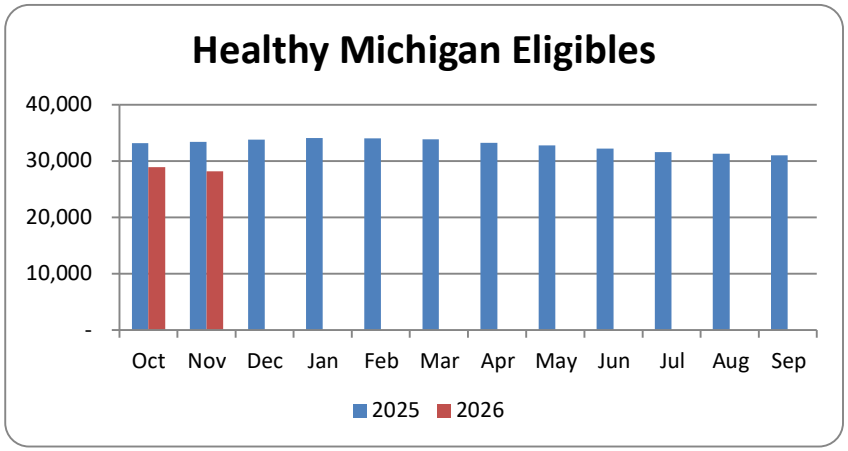
Narrative

October 1, 2025 through November 30, 2025

Regional Eligible Trending





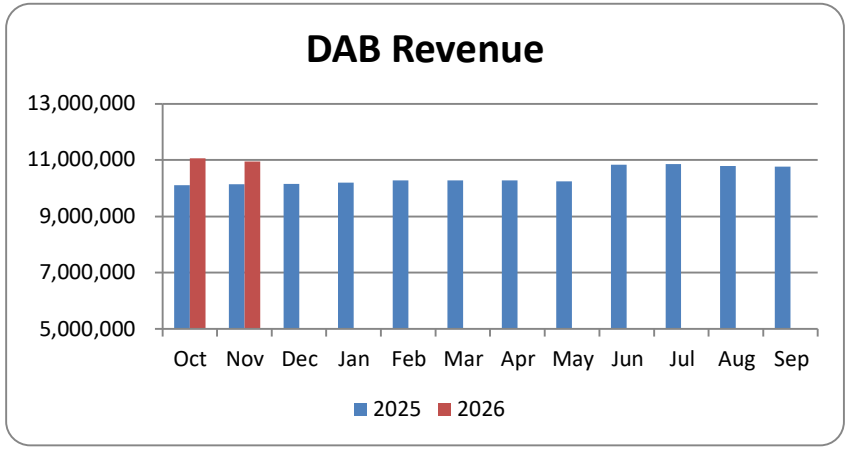


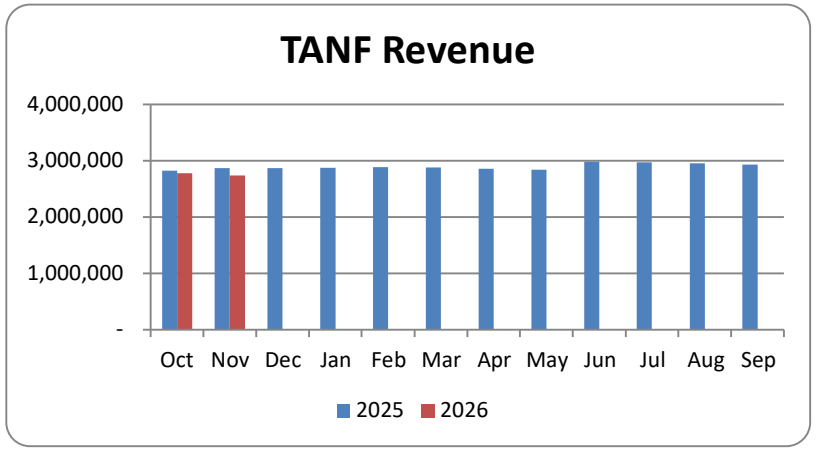
Northern Michigan Regional Entity

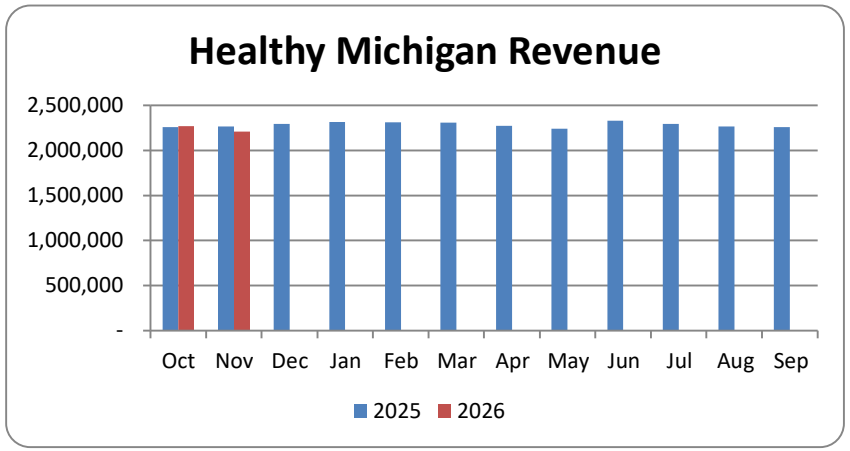
Narrative

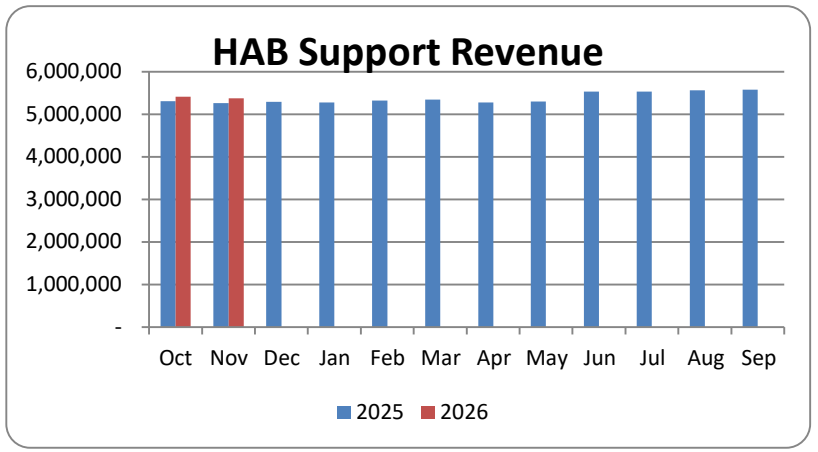
October 1, 2025 through November 30, 2025

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – JANUARY 20, 2026
GAYLORD CONFERENCE ROOM

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

REVIEW OF AGENDA AND ADDITIONS
Intensive Crisis Stabilization Services (ICSS) Certification was added to the meeting agenda.

APPROVAL OF PREVIOUS MINUTES
The minutes from December 2nd were included in the meeting materials.

MOTION BY TRISH OTREMBA TO APPROVE THE DECEMBER 2, 2025 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY NENA SORK. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED
November 2025 Financial Report

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

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

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

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

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$426,394	$827,404	$765,533	$310,059	$1,013,216
HMP	($79,143)	($165,398)	$50,821	($450,270)	$42,039
Total	$347,251	$662,006	$662,006	($140,211)	$1,055,256

A possible typo in North Country numbers was pointed out during the regional Finance Committee meeting on January 14th ($665K rather than $662K) which will be corrected before the November Financial Report goes to the Board on January 28th.

MOTION BY BRIAN BABBITT TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR NOVEMBER 2025; SUPPORT BY LYNDA ZELLER. MOTION APPROVED.

Decreased FY26 rates were implemented in December for HSW. There will likely be a recoupment for October and November.

Eligibles declined sharply from September to October. Mr. Babbitt noted that the fluctuations in DAB don't make sense; this benefit level should be consistent not "off and on". Current revenue is $700K-$800/month lower than projections.

Actuaries/Milliman are meeting with CFOs later in the month. Keith White (MDHHS) has asked for a list of questions.

A possible rate adjustment has been proposed to account for the minimum wage and DCW increases.

Mr. Babbitt reported that North Country was paid for 15 additional HSW enrollees in December but the payment was $500K lower than expected. Ms. Yockey agreed to investigate the issue.

The January capitation payment will come out on the 29th. The Revenue and Enrollee Data Analysis spreadsheet will be updated after that and will be shared with the CMHSPs for further discussion.

Ms. Zeller said that Northern Lakes will need 90% of its capitation payment early this month (as was done in December) though the shortage is less. The PM/PM payments will be sent to the CMHSPs on Feb. 3rd, but 90% can be sent to Northern Lakes on January 22nd. Ms. Zeller shared that Northern Lakes is reengineering its Utilization Management and Access systems, which will likely take six months.

PM/PM Revenue Projections
The Statewide PIHP's Eligible Variance Report for the Fiscal YTD Period Ended 12/31/2025 was included in the meeting materials.

The NMRE's numbers were presented as:

	Appendix 4 of FY26 Milliman Rates	Actual Payments	Difference
DAB	$25,266.00	$25,051.00	-0.85%
HMP	$33,084.00	$28,617.00	-13.50%
TANF	$53,867.00	$51,001.00	-5.32%

Although all ten regions are declining in eligibles, it was noted that the 13.5% decline in HMP was the largest in the state. The Department did not offer any action during the January 15th PIHP Operations meeting. Keith White agreed to relay the issue to Milliman.

The change in revenue and enrollment for FY26 was presented as:

	DAB, HMP, TANF	Waivers	Total
Change in Revenue from September 2025 to December 2025	($31,155)	($536,987)	($568,142)
Change in Eligibles from September 2025 to December 2025	(5,526)	(16)	(5,542)

The NMRE will continue to monitor revenue and eligibles closely.

HSW
The decline in HSW revenue was discussed during the regional Finance Committee on January 14th.

In discussions with NorthCare Network CEO, Megan Rooney, Mr. Kurtz determined that if the region's "base benefit rate" (from the EQI) is less than the "statewide composite rate", the "base benefit rate" is used resulting in lower revenue. The NMRE will run service utilization numbers to determine whether the highest cost individuals are being enrolled in the waiver. Mr. Kurtz encouraged the CMHSPs to update their rates regularly and monitor the overall service utilization provided to HSW enrollees.

<u>COC DISCUSSION</u>
Judge Yates' decision on the lawsuits related to the PIHP bid out was released on January 8th. Judge Yates' decision stated, in part:

> "… defendants' motion for summary disposition beyond the award in the Court's October 14, 2025 opinion and order is denied, and the Court hereby issues a declaratory pronouncement that the RFP, as drafted, impermissibly conflicts with Michigan law in numerous respects, especially insofar as the RFP restricts CMHSPs from entering into financial contracts for the purpose of

> funding CMHSPs' managed-care functions. However, the Court will not yet issue injunctive relief that directs defendants to amend or pull back the RFP. Defendants must decide, in the first instance, how to address the conflicts between Michigan law and the RFP that the Court has identified."

No timeline was identified for MDHHS' next steps.

No movement has been made on the on FY25 Contract lawsuit. Mr. Kurtz suggested that MDHHS negotiate with the PIHPs involved in the lawsuit (NorthCare Network, NMRE, Region 10, and CMH Partnership of Southeast Michigan) instead of going to court. The only issue remaining is the risk corridor piece (7.5% ISF cap).

Attorney Chris Cooke will stay involved if Department makes any changes to the RFP.

It was noted that Judge Yates' decision was primarily based on the CMH (Centra Wellness Network, Northeast Michigan CMHA, Wellvance, Gogebic CMHA, North Country CMHA, and Manistee County) lawsuit.

CMHAM/MAC NEXT STEPS

On January 16th, Mr. Kurtz and NorthCare Network CEO, Megan Rooney, met with Bob Sheehan and Alan Bolter about the future of CMHAM planning, and future efforts Bridge Health. The joining of NMRE and NorthCare Network via an Urban Cooperation Agreement has the potential to result in administrative efficiencies and may become a model for the rest of the state to follow. Medicaid Health Plans (MHPs) and hospitals could be brought in to create a rural health system. Mr. Johnston raised the possibility of NMRE and NorthCare Network creating a 36-county Regional Entity, but the UCA, if used, would be much preferred. Mr. Bolter agreed to acknowledge NMRE/NorthCare as doing what best for their rural regions and consider that in further messaging.

A draft letter written by Mr. Babbitt to Bob Sheehan and Alan Bolter expressing the member CMHSPs' "support for efforts to improve systems in ways that meaningfully address the real issues facing the public mental health system and the people served" was included in the meeting materials. The letter will be finalized, signed by the five CEOs and Mr. Kurtz and sent to Mr. Sheehan and Mr. Bolter.

ICSS CERTIFICATION

MDHHS is requiring all PIHPs ICSS programs to be certified. Programs will be certified every three years, with the capacity to recertify as needed. There may be some elements of certification that will be phased in and developed over time. The process requires:

- CMHSPs to track program certification information and prepare for submission for both directly and contractually provided services.
- PIHPs to review program certification and approve submission
- to MDHHS.

- MDHHS to review and send back any required changes to both the PIHP and CMHSP with the expectation that the PIHP will review all changes prior to resubmission to MDHHS.

The CMHSPs in the NMRE region have been given a Priority 1 designation, meaning that CMHSPs must submit evidence outlined in the certification rubric to be submitted by the NMRE by January 19, 2026. The NMRE must submit applications with their approval to MDHHS by February 4th. MDHHS will review applications and ask for additional information if needed from February 4th through April 1st.

ICSS providers meeting all requirements will receive full ICSS certification. ICSS providers not meeting all requirements may receive provisional certification. If provisionally certified, ICSS providers will develop and submit time-limited (up to six months) corrective action plans with MDHHS feedback and approval.

Mr. Johnston asserted that ICSS certification is not a mental health mandate. The MDHHS cannot tie funding to the certification requirement. Mr. Kurtz acknowledged that ICSS is both unfeasible and unfundable in the current environment. Mr. Kurtz advised the CMHSPs to keep doing what they're doing as they pretty much meet the requirements already.

MENTAL HEALTH FRAMEWORK

Beginning in October 2026, Medicaid Health Plans are responsible for most mental health services for Medicaid beneficiaries with lower levels of mental health need (including inpatient psychiatric care, crisis residential services, partial hospitalization services, and targeted case management).

An email from Audra Parsons dated January 5th regarding Mental Health Framework (MHF) Resources: Standardized Assessment & Standardized Referrals Guides was included in the meeting materials.

The first MHF-related changes, Standardized Assessment and Standardized Referrals, began on October 1, 2025.

As of January 16th, (Behavioral Health 1915(i)SPA Leads Meeting) MDHHS indicated that, because CMHs must do the preadmission screening, CMHSPs will do all mental health framework services/obligations. The state will force MHPs to pay for hospitalizations for the mild/moderate population.

It was noted that numerous problems have been identified with the MHF in its current form and the confusing roles of the MHPs and CMHSPs/PIHPs.

DCW

Effective January 1, 2026 the minimum wage increased to $13.73/hour. MDHHS also issued a DCW increase of $3.40/hour. Mr. Babbitt asked how the CMHSPs are calculating the aggregate increase. $13.40 Minimum wage + $3.40 DCW = $17.13/hour. Mr. Johnston noted that

previous DCW increases were supported by legislative action, this one was not. It was noted that the $3.40 additional DCW was supported in the budget as shared below.

Mr. Johnston attached an excerpt from PA 22 of 2025 (FY25 State budget) to the meeting chat:

> Sec. 231. (1) The department shall not expend the funds appropriated in part 1 to enter into any contract with a Medicaid managed care organization of MI Choice Waiver, MI Health Link, MI Coordinated Health, or behavioral health unless the Medicaid managed care organization agrees to do all the following:
>
> (1) Continue the direct care wage increase funded at $3.40 per hour for the services noted in the department's Medicaid provider letter L 21-76 under the Medicaid managed care organization's relevant program.
> (2) Ensure, to the greatest extent possible, that the full amount of funds appropriated for direct care worker wages, except for costs incurred by the employer, including payroll taxes, is provided to direct care workers through maintained increased wages.
> (3) Permit a direct care worker to elect, in writing or electronically, to not receive the wage increase provided in this section.

A link to the full Act was provided as: 2025-PA-0022.pdf

RURAL TRANSFORMATION GRANT

Mr. Johnston explained that organizations interested in discontinuing subcontracts with the state are pursuing a grant through the rural transformation fund. Mr. Johnston asked whether the CMHSPs are interested in doing something like what is being done in Benzie County. In Benzie County, the rural transformation grant is paying for a for deputy in the Sheriff's office. The Benzie County Sherrif has already spoken with the Grand Traverse County Sheriff. Mr. Johnston clarified that the model began with health fund dollars in Manistee (Michigan Health Endowment Fund). Mr. Johnston and Ms. Zeller agreed to have a private conversation to discuss the matter further.

CMHSP UPDATES

Northern Lakes CMHA

Ms. Zeller reported that Northern Lakes is revamping its Utilization Management. Clinical staff from the other CMHSPs have been very helpful. Mr. Kurtz noted that the NMRE is looking at penetration rates, costs, and service utilization.

Ms. Zeller continues to meet with County Administrators and Boards of Commissioners.

North Country CMHA

Mr. Babbitt reported that he has received positive feedback on the MCG Indicia platform. Indicia can be used to inform authorization decisions but is not a replacement for clinical judgement.

North County is losing staff that author Behavior Treatment Plans (BTPs). Active recruitment is being done, and preference will be given to LBAs. Ms. Otremba noted that Sarah Bannon reached out to her regarding openings, including psychologists.

OTHER

Ms. Sork stated that funding has ceased for HFA workers.

Mr. Johnston referred back to the next steps for Bridge Health. Mr. Babbitt shared an MDHHS memo regarding a tribal health consultation policy. Mr. Babbitt redlined and updated the policy and suggested that it be sent to Bob Sheehan, Alan Bolter, Rob Kennedy (Capitol Affairs) and Gabe Schneider (Munson). Mr. Babbitt asked Mr. Kurtz to beef up the portions related to the spending authority which he agreed to do.

NEXT MEETING

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

RTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING
10:00AM – JANUARY 5, 2026
GAYLORD CONFERENCE ROOM & MICROSOFT TEAMS

Alcona	☒ Carolyn Brummund	**Kalkaska**	☐ David Comai
Alpena	☐ Lucille Bray	**Leelanau**	☐ Vacant
Antrim	☒ Pam Singer	**Manistee**	☐ Vacant
Benzie	☒ Tim Markey	**Missaukee**	☐ Dean Smallegan
Charlevoix	☒ Annemarie Conway	**Montmorency**	☐ Michelle Hamlin
Cheboygan	☒ John Wallace	**Ogemaw**	☐ Ron Quackenbush
Crawford	☐ Matthew Moeller	**Oscoda**	☒ Chuck Varner
Emmet	☒ Terry Newton	**Otsego**	☒ Doug Johnson
Grand Traverse	☒ Dave Freedman	**Presque Isle**	☒ Dana Labar
Iosco	☒ Jay O'Farrell	**Roscommon**	☒ Darlene Sensor
		Wexford	☒ Gary Taylor

Staff:	☒ Bea Arsenov	Chief Clinical Officer
	☒ Jodie Balhorn	Prevention Coordinator
	☒ Carol Balousek	Executive Administrator
	☐ Brady Barnhill	IT Specialist
	☒ Lisa Hartley	Claims Assistant
	☒ Eric Kurtz	Chief Executive Officer
	☒ Heidi McClenaghan	Quality Manager
	☒ Pamela Polom	Finance Specialist
	☐ Brandon Rhue	Chief Information Officer/Operations Director
	☒ Denise Switzer	Grant and Treatment Manager
	☐ Chris VanWagoner	Contract and Provider Network Manager
	☒ Deanna Yockey	Chief Financial Officer
Public:	Nichole Flickema, Donna Hardies, Sarah Hegg, Taylor Ignaczak, Chip Johnston, Vicki Konczak, Larry LaCross, Susan Pulaski, Rhonda Reynolds, Ellen Templeton, Kayla Thomas, Lynda Zeller	

CALL TO ORDER
Let the record show that acting Chair, Jay O'Farrel, called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that Lucille Bray, David Comai, Michelle Hamlin, Matt Moeller, Ron Quackenbush, and Dean Smallegan, were absent for the meeting on this date; all other SUD Oversight Committee Members were in attendance either in Gaylord or virtually.

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

APPROVAL OF PAST MINUTES
The November minutes were included in the materials for the meeting on this date.

MOTION BY CHUCK VARNER TO APPROVE THE MINUTES OF THE NOVEMBER 3, 2025 NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING; SUPPORT BY DOUG JOHNSON. MOTION CARRIED.

APPROVAL OF AGENDA
Let the record show that no additions or revisions to the meeting Agenda were proposed.

MOTION BY GARY TAYLOR TO APPROVE THE AGENDA FOR THE JANUARY 5, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE; SUPPORT BY ANNE MARIE CONWAY. MOTION CARRIED.

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

Mr. Kurtz wished attends a Happy New Year and reported that there has been no decision from Judge Yates in the lawsuits (25-000143-MB and 25-000162MB) related to the PIHP bid out.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST
Let the record show that Mr. O'Farrell called for any conflicts of interest to any of the meeting agenda items; none were declared.

INFORMATIONAL REPORTS
Regional Admissions Report
The admissions report through November 30, 2025, was included in the materials for the meeting on this date. Admissions were down 8.35% from the same period in FY25. It was noted that the number of covered lives in the region has also declined. The data showed that outpatient was the highest level of treatment admissions at 38%; residential withdrawal management was the second highest level of treatment at 30%. Alcohol was the most prevalent primary substance at 63%, all opiates (including heroin) were the second most prevalent primary substance at 16%, and methamphetamine was the third most prevalent primary substance at 15%.

County-specific reports were posted to the NMRE website at County Admission Reports | NMRE. The county-specific reports are intended to be shared with Boards of Commissioners and other community stakeholders.

Financial Report
At the end of FY25 (September 30, 2025) SUD showed all funding source revenue of $28,898,004 and $24,160,950 in expenses, resulting in a net surplus of $4,737,054. Total PA2 funds were reported as $4,669,035.

For FY25, $761K was moved from PA2 to SUD block grant funding.

LIQUOR TAX PARAMETERS
The Liquor Tax funds parameters approved by the NMRE Board of Directors on April 24, 2024 were included in the meeting materials to inform the SUD Oversight Committee's decision whether to recommend approval of the liquor tax requests brought before the Committee on this date.

FY26 Liquor Tax Requests

1.	Northern Michigan Children's Assessment Center	Advocacy and Educational Support	Multi County	$78,334	New

Meets PA2 Parameters? ☒ Yes ☐ No

Crawford	$	9,329.37
Iosco	$	16,879.68
Ogemaw	$	14,074.90
Oscoda	$	5,559.25
Otsego	$	16,461.07
Roscommon	$	16,029.72
Total	**$**	**78,334.00**

Discussion:
In an email dated January 3, 2026, Ms. Sensor expressed concerns with the request. First, as the Roscommon County representative on the NMRE Substance Use Disorder Oversight Committee, she had no prior knowledge of the request which is in violation of current practices. Second, Roscommon County already provides various substance use services targeting youth. Ms. Sensor requested that this matter be tabled (at least for Roscommon County's participation) until the meeting on March 2, 2026, to allow her to gather additional information and speak with the Roscommon County Administrator and Board of Commissioners (Ms. Sensor is the Chair of the BOC).

Mr. Kurtz agreed that liquor tax requests are intended to be brought to the representatives on the SUD Oversight Committee for which liquor tax funds are being requested prior to being presented to the NMRE and the SUD Oversight Committee.

Mr. O'Farrell noted that counties provide funding to Northern Michigan Children's Assessment Center (NMCAC) from their general funds. Granting this PA2 request would save counties' local dollars.

Taylor Ignaczak from NMCAC was in attendance. Ms. Ignaczak stressed that funds will be used for education, advocacy, and prevention efforts (not billable services) as well as salary and benefits for an Outreach Coordinator.

Mr. O'Farrell requested that Ms. Spencer get approval for Roscommon County prior to the NMRE Board meeting on January 28th, if possible, which she agreed to do.

MOTION BY CHUCK VARNER TO APPROVE THE REQUEST FROM NORTHERN MICHIGAN CHILDREN'S ASSESSMENT CENTER FOR LIQUOR TAX DOLLARS FROM CRAWFORD, IOSCO, OGEMAW, OSCODA, OTSEGO, AND ROSCOMMON COUNTIES IN THE TOTAL AMOUNT OF SEVENTY-EIGHT THOUSAND THREE HUNDRED THIRTY-FOUR DOLLARS ($78,334.00) FOR ADVOCACY AND EDUCATIONAL SUPPORT PENDING APPROVAL FROM ROSCOMMON COUNTY; SUPPORT BY TERRY

NEWTON. MOTION CARRIED WITH ONE NAY VOTE RECORDED FROM MS. SENSOR.

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

	Projected FY26 Available Balance	Amount Approved January 5, 2026	Projected Remaining Balance
Crawford	$68,486.06	$9,329.37	$59,156.69
Iosco	$150,966.79	$16,879.68	$134,087.11
Ogemaw	$109,476.60	$14,074.90	$95,401.70
Oscoda	$49,954.93	$5,559.25	$44,395.68
Otsego	$25,698.76	$16,461.07	$9,237.69
Roscommon	*$479,362.50*	*$16,029.72*	*$463,332.78*
Total	**$883,945.64**	**$78,334.00**	**$805,611.65**

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

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

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

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

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

Current enrollment shows 693 individuals enrolled in BHH and 1,010 enrolled in SUDHH.

RISE Otsego Substance Free Coalition and SAFE in Northern Michigan
Ellen Templeton, Project Coordinator for the RISE Otsego Substance Free Coalition, and Susan Pulaski, Project Director, and Nichole Flickema, Project Coordinator, of SAFE in Northern Michigan were in attendance to give updates on their coalitions.

- SAFE in Northern Michigan was organized in 2007 in Antrim, Charlevoix, and Emmet Counties as a community response after local students ranked youth substance use as a top priority for action.

- RISE Otsego Substance Free Coalition was established in 2018 in Otsego County as a substance-free coalition aimed at preventing youth substance use, increasing community awareness, and creating change through collaboration, education, and prevention initiatives.

- In 2025, SAFE in Northern Michigan's media campaigns delivered over 5 million prevention messages on alcohol, marijuana, vaping, and youth assets to support healthier, drug-free youth.
- In 2025 Rise media campaigns delivered over 2 million impressions on substance use prevention, seatbelt use, and distracted driving awareness.

PUBLIC COMMENT
Both Ms. Singer and Mr. Newton thanked the presenters for their reports and good work.

NEXT MEETING
The next meeting was scheduled for March 2, 2026 at 10:00AM.

ADJOURNMENT
MOTION BY PAM SINGER TO ADJOURN THE MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING FOR JANUARY 5, 2026; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

Let the record show that Mr. O'Farrell adjourned the meeting at 11:22 AM.

PA2/Liquor Tax Criteria for Review/Adoption

- The NMRE will update projected end balances for each county for the current fiscal year monthly. New applications will be compared to projected end balances to ensure that there is adequate funding in the county to financially support the request.
- If possible, depending on SUD Block Grant usage, a balance equivalent to one year's revenue will remain as a fund balance for each county.
- Project requests for services that can be covered by routine funding from other sources (Medicaid, Healthy Michigan) will not be considered.
- Applications that include any purchase of or renovations to buildings, automobiles, or other capital investments* will not be considered.
- To be considered, applications must be for substance use disorder prevention, treatment, or recovery services or supports.
- Region-wide (21 county) requests should be limited to media requests; other region-wide requests will be evaluated on a case-by-case basis.
- Multi-county requests (2 or more) must include detailed information on the provision of services and/or project activities for each county from which funds are requested.
- Staff who receive staffing grants via liquor tax approvals will not be eligible to bill services to the NMRE.
- Budget Requirements:
  - Budgets must include information in all required fields.
  - Fringe benefit budget requests that exceed 30% should be broken out by Health, Dental, Vision, Retirement, taxes, etc. totals and be subject to NMRE staff and Board approval.
  - Indirect costs, when applicable, should **not** exceed 10% of the requested budget total.
  - Liquor tax funds may be used to cover up to one FTE (across all projects) per person.

- The amount requested for salaries should be based on the staff person's actual salary and not the billable rate.
- All staff participating in PA2 funded activities are to be listed under budget FTEs (not under indirect cost).

- Requests for liquor tax funds should be coordinated with area stakeholders (CMHSPs, SUD Oversight Committee Members, County Commissioners, courts, law enforcement, SUD services providers) whenever possible.
  - Requestor should inform the county of the request submission at the same time submission to NMRE is completed.

* "Capital.investment‹ .refers.to.funds.invested.in.a.company.or.enterprise.to.further.its.business objectives¡.Capital.investments.are.often.used.to.acquire.or.upgrade.physical.assets.such.as property?buildings?or.equipment.to.expand.or.improve.long_term.productivity.or.efficiency¡ (Source¿Nasdaq)

If at the end of the NMRE's fiscal year there is excess SUD Block Grant funding available, it will be used to offset liquor tax expenses as opposed to lapsing SUD Block Grant funding. In reverse, if SUD Block Grant funding runs a deficit, PA2 funding is used for treatment deficits. Normally for under or uninsured clients.

PREVENTION, ADVOCACY & EDUCATIONAL SUPPORT - NEW

Organization/Fiduciary:	**Northern Michigan Children's Assessment Center**
County:	**Multi County**
Project Total:	**$ 62,305**

DESCRIPTION:

The prevention, advocacy, and educational support project will address the need for trauma-focused services in the five counties served by Northern Michigan Children's Assessment Center (NMCAC). Services provided include trauma-focused prevention, education, and advocacy. NMCAC's outreach coordinator will work closely with community partners and NMCAC's therapist as necessary, to provide information on youth substance abuse. Community programs and education will focus on providing youth with normative education to increase youth's accurate understanding of the prevalence of substance abuse. Advocacy services will target substance abuse with selective prevention and information dissemination.

This project will identify the need for prevention, advocacy, and educational interventions for children influenced or affected by substance abuse. Through this project the increased need for early intervention and advocacy surrounding substance use will be addressed. Services will focus on educating clients on the risk associated with substance use and educating on healthy coping skills.

Recommendation: Approve

County	Project	Requested Budget
Crawford	Prevention, Advocacy & Educational Support	$9,329.37
Iosco	Prevention, Advocacy & Educational Support	$16,879.68
Ogemaw	Prevention, Advocacy & Educational Support	$14,074.90
Oscoda	Prevention, Advocacy & Educational Support	$5,559.25
Otsego	Prevention, Advocacy & Educational Support	$16,461.07

CRAWFORD COUNTY OVERVIEW

Projected FY26 Balance	**$68,486.06**

Project	Requested Budget	Remaining County Running Balance
Prevention, Advocacy & Educational Support	$9,329.37	$59,156.69

County	One Year Fund Balance (withheld)	Projected FY26 Available Balance	Sum of Requested Project Amounts	Projected Remaining Balance
Crawford	**$35,114.80**	**$68,486.06**	**$9,329.37**	**$59,156.69**

IOSCO COUNTY OVERVIEW

Projected FY26 Balance	**$150,966.79**

Project	Requested Budget	Remaining County Running Balance
Prevention, Advocacy & Educational Support	$16,879.68	$134,087.11

County	One Year Fund Balance (withheld)	Projected FY26 Available Balance	Sum of Requested Project Amounts	Projected Remaining Balance
Iosco	**$87,380.80**	**$150,966.79**	**$16,879.68**	**$134,087.11**

OGEMAW COUNTY OVERVIEW

Projected FY26 Balance	**$109,476.60**

Project	Requested Budget	Remaining County Running Balance
Prevention, Advocacy & Educational Support	$14,074.90	$95,401.70

County	One Year Fund Balance (withheld)	Projected FY26 Available Balance	Sum of Requested Project Amounts	Projected Remaining Balance
Ogemaw	**$68,804.80**	**$109,476.60**	**$14,074.90**	**$95,401.70**

OSCODA COUNTY OVERVIEW

Projected FY26 Balance	**$49,954.93**

Project	Requested Budget	Remaining County Running Balance
Prevention, Advocacy & Educational Support	$5,559.25	$44,395.68

County	One Year Fund Balance (withheld)	Projected FY26 Available Balance	Sum of Requested Project Amounts	Projected Remaining Balance
Oscoda	**$24,394.80**	**$49,954.93**	**$5,559.25**	**$44,395.68**

OTSEGO COUNTY OVERVIEW

Projected FY26 Balance	**$25,698.76**

Project	Requested Budget	Remaining County Running Balance
Prevention, Advocacy & Educational Support	$16,461.07	$9,237.69

County	One Year Fund Balance (withheld)	Projected FY26 Available Balance	Sum of Requested Project Amounts	Projected Remaining Balance
Otsego	**$105,978.80**	**$25,698.76**	**$16,461.07**	**$9,237.69**

QUALITY ASSESSMENT AND PERFORMANCE EVALUATION

FY25 Evaluation

Approvals:

Quality and Compliance Oversight Committee	January 6, 2026
Internal Operations Committee	January 8, 2026
NMRE Board of Directors	January 28, 2026 (pending)

1. Performance Improvement Projects

The NMRE engages in Performance Improvement Projects (PIPs), addressing clinical as well as non-clinical aspects of care. PIPs involve measurable and objective quality indicators, interventions leading to improvement, as well as evaluation of effectiveness. The goal of PIPs is to improve health outcomes and member satisfaction.

PIP #1 (Opioid Health Home PIP)

The NMRE Quality and Compliance Oversight Committee (QOC) continues to collect data, conduct ongoing analysis, and coordinate with providers to increase the number of individuals enrolled in the Opioid Health Home (OHH) program as part of the Substance Use Health Home (SUDHH). The NMRE collected data and conducted analysis to show evidence of enrollment improvement from the baseline by September 30, 2025. Non-clinical/HSAG Validated

Goals:

a. Increase access to Medication Assisted Treatment (MAT) and integrated behavioral, primary, and recovery-centered services for beneficiaries with Opioid Use Disorder.
b. Decrease opioid overdose deaths.
c. Decrease opioid-related hospitalizations.
d. Increase utilization of peer recovery coaches.
e. Increase the “intangibles” of health status (e.g., the social determinants of health).

The NMRE has aimed to increase enrollment by:

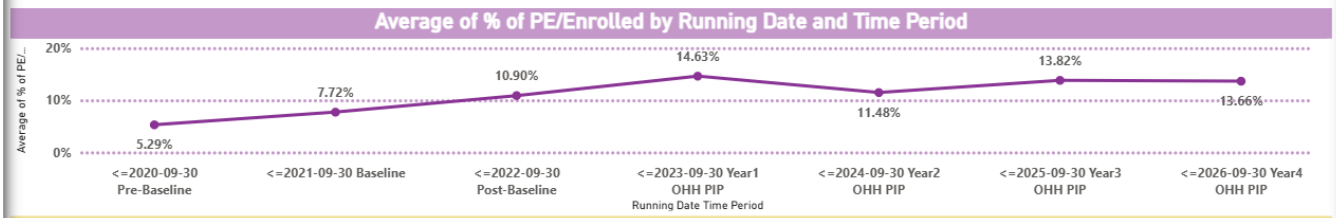
1. Providing monthly meetings with providers. These monthly meetings have helped to keep providers more engaged and motivated.
2. Providing resources and reports regarding Public Health Emergency (PHE) ending.
3. Funding Community Health Worker (CHW) training.
4. Expanding Provider network by adding Health Home Partners (HHP).

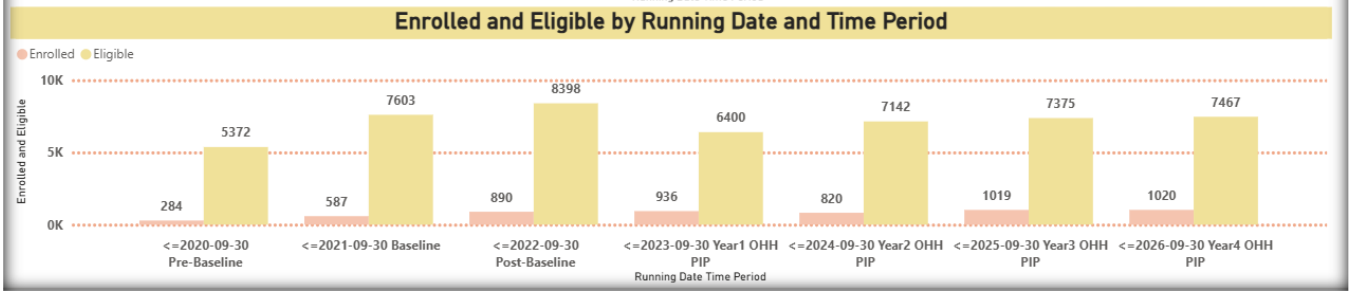
Table with enrollment tracking shows trends and enrollment changes for all the reporting periods (next page):

WSA OHH Breakout: Eligible versus Enrolled

Time Period	Running Date	Enrolled	Eligible	% of PE/Enrolled	% Enrolled Change	% Eligible Change
Pre-Baseline	<=2020-09-30	284	5372	5.29%	0.00%	0.00%
Baseline	<=2021-09-30	587	7603	7.72%	106.69%	41.53%
Post-Baseline	<=2022-09-30	890	8398	10.90%	51.62%	10.46%
Year1 OHH PIP	<=2023-09-30	936	6400	14.63%	5.17%	-23.79%
Year2 OHH PIP	<=2024-09-30	820	7142	11.48%	-12.39%	11.59%
Year3 OHH PIP	<=2025-09-30	1019	7375	13.82%	8.87%	15.23%
Year4 OHH PIP	<=2026-09-30	1020	7467	13.66%	8.97%	16.67%

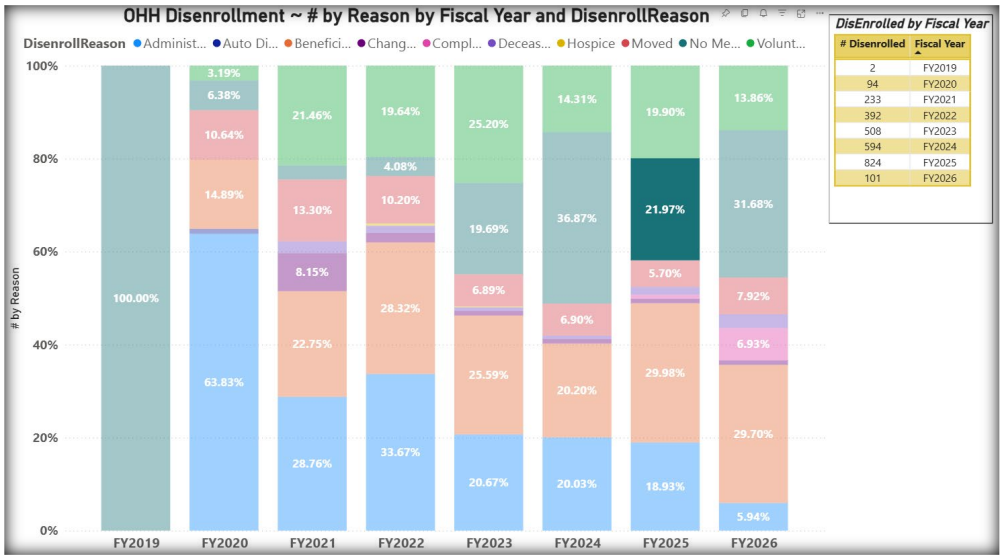
Please note that on 5/14/2024 an update and re-interpretation of the data filters, regarding those eligible, have been put in place for Year1 (New) & Year2 (NEW). The new filter added consists of removing persons eligible who have a "CountOpioid" value <1 from the data uploaded from WSA HHO. On 10/1/2024, MDHHS change to SUDHH adding Stimulant HH and Alcohol HH to the counts. Note: The aforementioned continues per the OHH PIP (08-06-2025). Year 4 OHH PIP has been added (10-01-2025).





Challenges:

Staffing remains a big challenge in the NMRE region, however, the biggest challenge and obstacle for enrollment continues to be disenrollment form Medicaid, resulting in 21.97% of SUDHH clients being disenrolled from the benefit. However, this trend is, once again, increasing in FY26 (FY21, FY22, FY23 trends are low due to PHE). During FY25 NMRE lost one of the biggest SUDHH providers (due to death), and although we aided in the transition of beneficiaries and continuation of care, some beneficiaries chose to not be enrolled again which resulted in enrollment decrease for the region. Even with these noted challenges, HEDIS Measures for the Health Home remain very good, allowing for Pay for Performance funds to be allocated to the HHPs. The NMRE distributed 100% of these funds back to HHPs to further support the implementation of health homes in the region.



SUDHH FUA:

Measure: Follow-up within 30 days after ED visit for Substance Use (FUA 30): Beneficiaries 13 years and older with an ED visit for substance use disorder (SUD) or any diagnosis of drug overdose, that received follow-up within 30 days, reporting period 06/30/2025 shows NMRE Health Home program scoring 80.56 rate compared to Michigan Medicaid Total of 39.11:

Measure	Program	Rate	Reporting Period
FUA-30	MICHIGAN MEDICAID TOTAL	39.11	6/30/2025
FUA-30	NMRE SUDHH	80.56	6/30/2025

Interventions Implemented:

Barriers:	Interventions:
Staff shortage	The PIHP provides orientation training to new home health staff and has regular check-in meetings virtually or face-to-face with its home health partners to offer technical assistance, support, and on-demand answers to their questions or concerns. **PIHP created a meeting/ training platform to support all Peers and CHW.**
Provider capacity	The PIHP reached out to tribal entities and other settings to introduce the concept of expanding provider capacity. **Expansion completed by onboarding Munson.**
Public health emergency ending	The PIHP provided education/resources and training at its monthly provider meetings regarding helping eligible clients from losing Medicaid benefits. **PIHP funded some transitions and assistance to those who lost MA via PA2 funds.**

	Ongoing support and care coordination for MA applications is provided.
Clients concern regarding sharing their protected health information (PHI)	Clients are continuously educated to reassure them that information is only shared securely for care coordination purposes.
Provider's concern around managing PHI.	The PIHP contracted with a third party to provide education to SUD HH providers and their staff on how to safely share PHI for care coordination. Ongoing support is offered.
Clients are disenrolled in health home services if they move from one health home location to another.	The PIHP provided education to home health providers on transfers for health home versus disenrollment, which allows for the individual to remain enrolled without any disruption of service. **Increase in transfers is assisting with the continuation of care and enrollment.**
Financial sustainability of Health Homes	The PIHP provides support to current providers, avoids inaccuracies that lead to delays in payment, monitors payment recoupments and providers who have no submitted claims. 100% of P4P were given to SUDHH.

HSAG Validation:

The Percentage of Individuals Who Are Eligible for OHH Services, Enrolled in the Service, and Are Retained in the Service PIP received a Met validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements across the first eight steps validated, and High Confidence validation status. The PIHP developed a methodologically sound improvement project. The causal/barrier analysis process included the use of appropriate QI tools to identify and prioritize barriers, and interventions were initiated in a timely manner. The PIP received a Met validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements for Step 9, and a High Confidence validation status. The performance indicator sustained statistically significant improvement over the baseline for the second remeasurement period.

PIP #2 (Behavioral Health Home PIP)

The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 5% to 6% by September 30, 2025. Non-Clinical

Goals:

a. Improve care management for beneficiaries with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED).
b. Improve care coordination between physical and behavioral health services.
c. Improve care transitions between primary care, specialty services, and inpatient settings.
d. Improve care coordination for youth and children as well as their families.

HHBH Comparison of Receiving HHBH Waiver Services versus Potential Enrol...

Receiving BHH Waiver Services	Enrolled + Potential Enrollees who are actively enrolled w/CMHSP	Percent Enrolled	CMHSP
150	761	19.71%	Centra Wellness Network
96	2298	4.18%	North Country CMH
122	1469	8.30%	Northeast Michigan CMH
120	3538	3.39%	Northern Lakes CMH
88	1661	5.30%	Wellvance
576	**9727**	**5.92%**	

Although overall enrollment with CMHSPs decreased likely due to the change in the number of covered beneficiaries (in FY25 61 disenrollments were due to no MA) overall enrollment within this region is increasing through FQHC expansion shown below.

Receiving HHBH Waiver Services by Provider

CMHSP	# Enrolled in WSA
Manistee - Benzie CMH (Centra Wellness Network)	150
MidMichigan Community Health Services	132
North Country CMH	96
Northeast CMH	122
Northern Lakes CMH	120
WellVance	88

Challenges:

Provider/ staff capacity remains the biggest challenge for BHH enrollment; however, HEDIS outcomes continue to be very good and 100% of these funds are administered back to CMHSPs.

Expansion of these Health Home programs throughout the region resulted in a wide array of Health Home Partners:

- SUD Providers
- OTP Clinics
- CMH Partners
- Federally Qualified Health Centers

- Physician Offices
- Women's Health Clinic
- Health Care Systems

Success stories:

Due to Roscommon County being ranked 6th in the state for food insecurity, in August of 2025 MidMichigan Health Home opened a food pantry in response to this and in order to assist its beneficiaries with SDOH. So far, they have served over 600 families. Health Home funding was also used to create a Community Closet providing gently used clothing, baby supplies, as well as hygiene products for patients. Over 300 individuals benefited from this initiative so far.

PIP #3 (Clinical PIP 1st year of implementation)

Implementation and monitoring- Regional Clinical PIP implementation started in December 2024. Performance Indicator 3 (PI 3) improvement goal:

Increase percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.

Anticipated Barriers: Staffing and lack of appointment slots due to staffing issues.

Anticipated Strengths/Challenges: Staffing, trained staff, automated appointment reminders, consumers cancelling, rescheduling, or requesting outside of the 14-day window due to their own schedules, no-shows, requesting in-person (not telehealth) services, which significantly reduces the number of available therapists.

Interventions implemented: Ongoing review of performance indicators to learn about trends and potential process changes that may be needed, additional staff training, and availability of telehealth being offered; staffing changes for same day availability; successful strategies are reviewed and shared with QOC members.

In December of 2024, the NMRE set the goal to improve from 67.82%.

Per lasts reporting in Q4, NMRE is scoring somewhat higher at **71.74%** total:

FY24 Q4 Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	194	137	**70.62%**
MIA	337	236	**70.03%**
DDC	76	57	**75.00%**
DDA	30	27	**90.00%**
Total	**637**	**457**	**71.74%**

2. Event Reporting and Notification

The NMRE Quality and Compliance Oversight Committee (QOC), as part of the QAPIP, continues to trend, review, and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. The QOC also continues to work on improving the data quality and timeliness in reporting events.

It is noted that most reported events are trending down throughout FY25, compared for FY24 (shown below).

It was noted that more uniformed reporting of risk events (RI) is needed, and NMRE will use once reporting document across all five boards to accomplish this in FY25.

NMRE FY25 Event Type	# of Events	NMRE FY24 Event Type	# of Events
Harm to Self	47	**Harm to Self**	27
Harm to Others	2	**Harm to Others**	0
Police Call	45	**Police Call**	19
Emergency use of physical management due to a behavioral crisis.	68	**Emergency use of physical management due to a behavioral crisis.**	36
Injury- not due to Physical Management	1	**Injury- not due to Physical Management**	0
Unscheduled Hospitalization	0	**Unscheduled Hospitalization**	0

Training and information

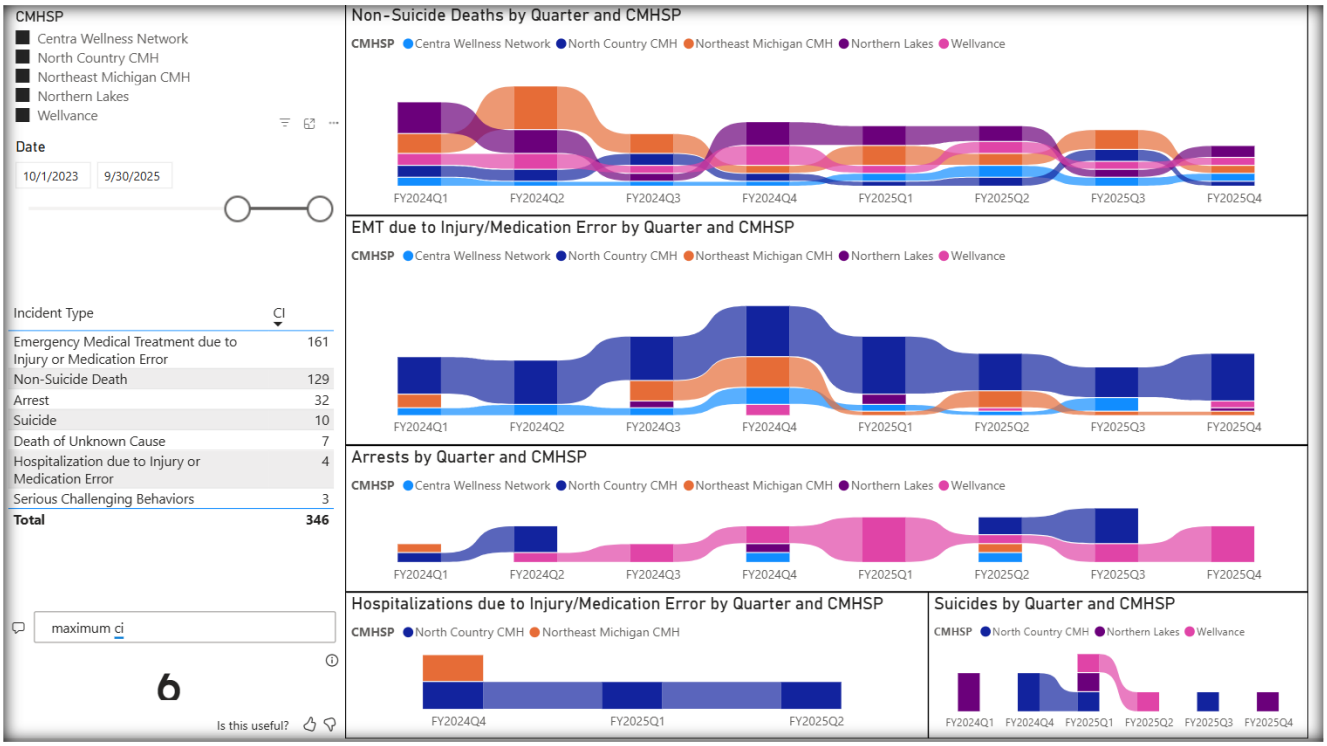
The NMRE provides ongoing training to providers on the type of data to collect, the population involved in this data collection, and timeliness in reporting. The expectation is that providers will continue to train and remind their staff about this process.

Changes to Reporting Platforms

The NMRE completed updates the reporting system within PCE to better meet reporting needs and ensure timely and accurate reporting of these events to PIHP/MDHHS and will be adding a risk event (RE) section shortly.

Data Collection and Review

The NMRE will continue to collect events data quarterly, analyze trends, and implement necessary interventions.



Timeliness of CI reporting remains NMRE's focus and is addressed in FY26 QAPIP Workplan as well. Below, 7% increase in timeliness is shown (next page) between FY24 and FY25.

Percent of CI Timeliness	2024 Count	2024 % Timely	2025 Count	2025 % Timely	Total Count	Total % Timely
Not Timely	22	11.96%	8	4.94%	30	8.67%
Centra Wellness Network	3	1.63%		0.00%	3	0.87%
North Country CMH	1	0.54%	2	1.23%	3	0.87%
Northeast Michigan CMH	1	0.54%	1	0.62%	2	0.58%
Northern Lakes	3	1.63%		0.00%	3	0.87%
Wellvance	14	7.61%	5	3.09%	19	5.49%
Timely	162	88.04%	154	95.06%	316	91.33%
Centra Wellness Network	15	8.15%	17	10.49%	32	9.25%
North Country CMH	69	37.50%	70	43.21%	139	40.17%
Northeast Michigan CMH	43	23.37%	23	14.20%	66	19.08%
Northern Lakes	24	13.04%	21	12.96%	45	13.01%
Wellvance	11	5.98%	23	14.20%	34	9.83%

3. Consumer Experience Assessments

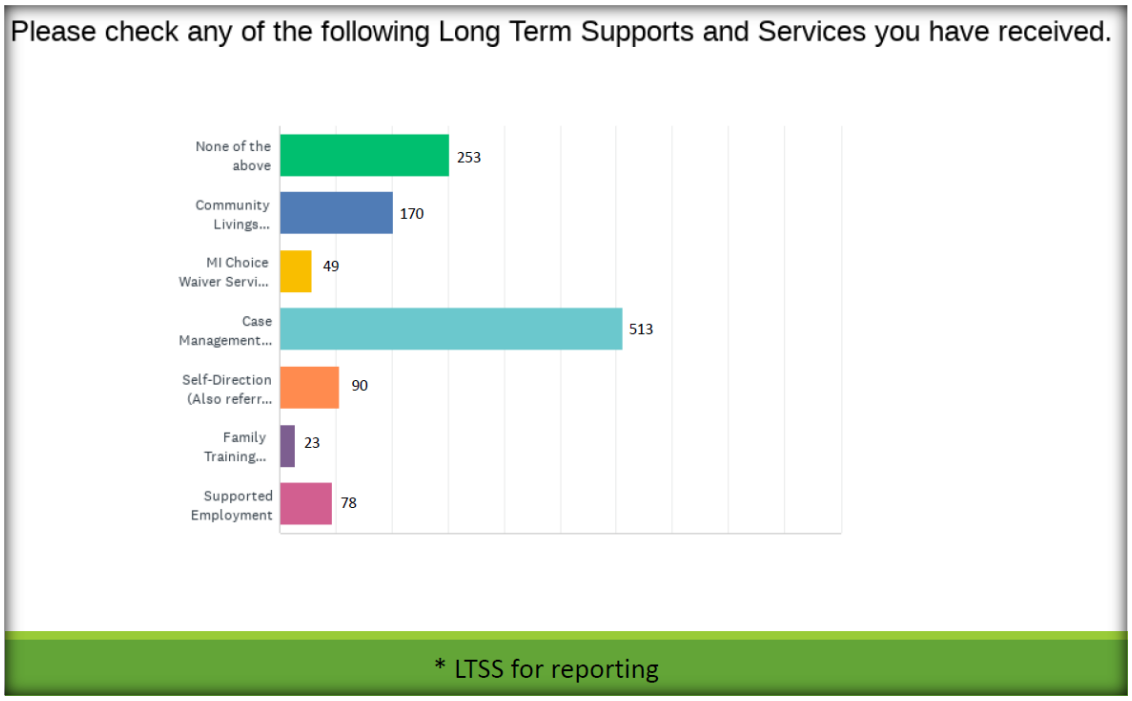
The NMRE will conduct ongoing quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract with the State. Assessment results will be used to improve services, processes, and communication. Outcomes will be shared in the NMRE's annual mailing. The NMRE will identify and provide possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

Number of consumers providing feedback increased in FY25 compared to FY23 and FY24, and so did the percentage of positive feedback:

LTSS (Long Term Supports and Services)

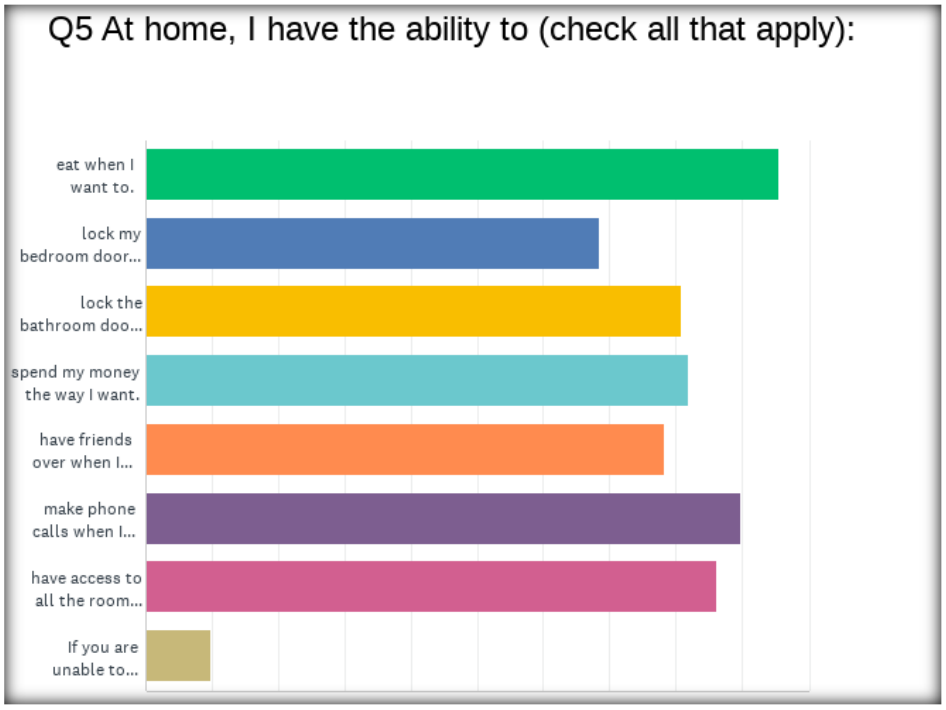
The NMRE incorporates consumers receiving long-term supports or services (LTSS) into the review and analysis of the information obtained from quantitative and qualitative methods. LTSS programs provide service needs from complex-care to assistance with everyday activities of daily living. Focus of the survey, as well as annual site visits, is on community integration of all beneficiaries.

Comparison data will be available in FY26.



Outcomes

The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction. Processes found to be effective will be continued while those less effective or not satisfactory will be revised and followed up with. FY26 QAPIP goal is addressing PIHP follow-up timelines.



Substance Use Disorder (SUD)

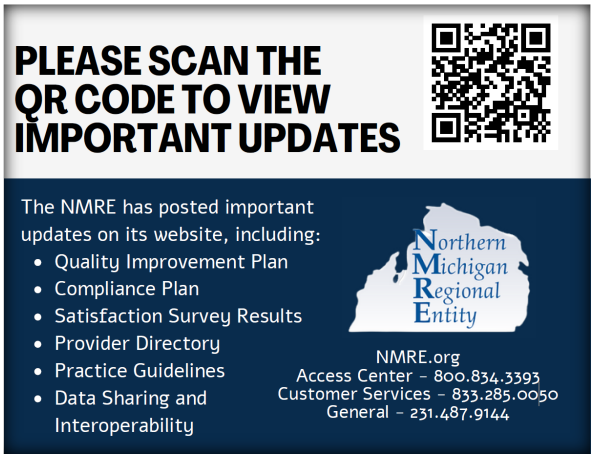
The NMRE conducted separate SUD surveys, including SUD Outpatient, SUD Residential, and Methadone (OTP) surveys, to identify specific member experiences. 77% of OTP clients provided their phone number to further discuss survey results with NMRE, 19 SUD OP clients provided additional feedback with NMRE (shown below), and only 6 provided their number to receive a call back about Residential SUD services in FY25.

18	Ats a long with my help saved my life and I would not be anywhere near where I am today had I not had the opportunity to receive treatment here.	7/9/2025 10:04 AM
19	I love our care here. Me and both of my kids get counseling here and I refer people here.	7/9/2025 9:12 AM
20	I am happy with the services at Harbor Hall Cheboygan & grateful. Thank you!	7/8/2025 4:03 PM

Evaluation Efforts

The NMRE outlines systemic action steps to follow-up on the findings from survey results onan ongoing basis.

The NMRE shares survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), network providers, Board of Directors, and the Regional Consumer Council (Regional Entity Partners), and posts a copy to the NMRE.org website. The NMRE's annual mailer includes instructions to direct consumers to locate the information on the NMRE.org website. Feedback is obtained during the annual Day of Education event as well. Day of Education is an annual conference that provides behavioral health beneficiaries with education on relevant topics to their well-being. The DOE's averages beneficiary attendance is 115.



4. Provider Network Monitoring

To ensure compliance, the NMRE conducts annual (at minimum) monitoring for all directly contracted providers in the region, and out of region as needed and appropriate, utilizing

reciprocity when necessary.

Monitoring

The NMRE will continue to conduct site reviews annually for all contracted service providers. The NMRE monitors and follows up on corrective action plans to ensure Corrective Action Plans (CAPs) are being implemented as stated by network providers.

The NMRE completed enhancement to its SUD monitoring tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Education will be provided to contracted SUD treatment providers informing them that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file. QIPs are created for those providers who scored Partially Met/ Not met:

Individual Standard Ratings		Aggregate Standard Ratings		
2	Standard Met	Completely Met	>1.99	100% Compliance
1	Partially Met	Substantially Met	1.7-1.98	85-99% Compliance
0	Standard Not Met	Partially Met	1.4-1.69	75-84% Compliance
NA	Not Applicable	Not Met	<1.39	74% and Below

In addition, the NMRE ensured that its provider directory, and any delegated CMHSPs' provider directories, include all the required information from 42 CFR 438.10 as listed on the (HSAG) Provider Directory Checklist, and made its provider directory available on the PIHP's website in a machine-readable file and format as specified by the Secretary.

For better trending of outcomes and monitoring NMRE will utilize PCE Auditing tools starting FY2026.

Verification of Medicaid Services

The NMRE will perform quarterly audits to verify Medicaid claims/encounters to ensure Medicaid services were furnished to beneficiaries by CMHSPs, SUD providers, providers, and/or subcontractors. This will include verifying data elements from individual claims/encounters to ensure proper codes are used and proper documentation is in place. CAPs will be developed where appropriate per NMREs MEV policy.

Medicaid Encounter Verification (MEV) trend was noted during FY24 MEV for one of the SUD providers. It resulted in an investigation. The investigative audit provided approximately $7,300 in recovery claims. A CAP and a follow-up audit were conducted to ensure the issue has been resolved, however FY25 MEV findings didn't result in an improvement. Further steps are being considered.

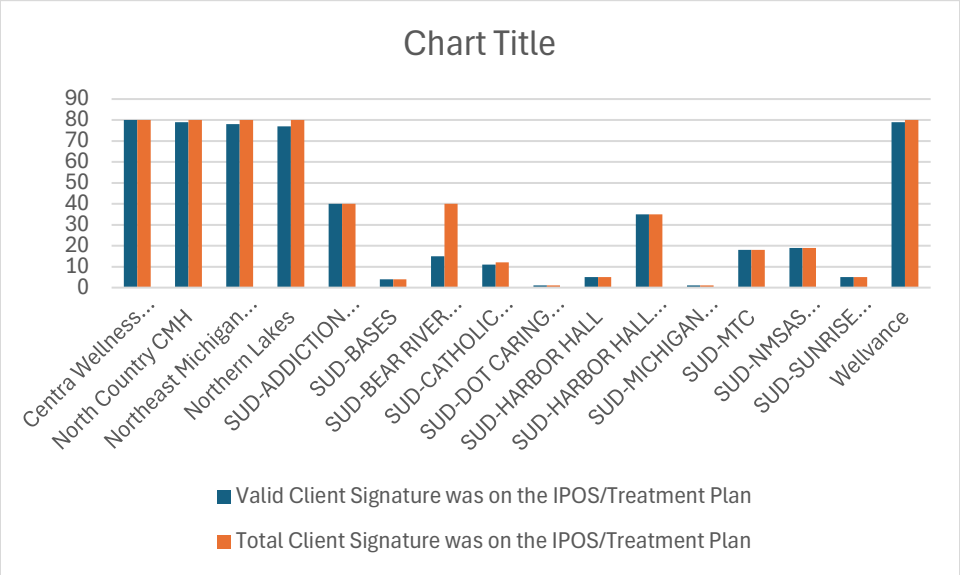
MEV FY25 findings:

Grand totals for the NMRE's FY24 MEV Audit were as follows:

- 14 CMHSPs/SUD Providers in total were audited
- $130,944.35 dollars was audited with $119,287.46 dollars validated resulting in a compliance rate of 91% of total dollar amount audited.

- 580 encounters audited with 522 encounters validated.
- $11,656.89 dollars and 58 encounters were found to be invalid.

The area of highest deficiency, scoring at 94% validity, is Valid Client Signature on the IPOS/Treatment Plan, tied mostly to one SUD provider only (scoring as low as 38% in a Quarter), that is currently on a CAP for this same issue stemming from FY24 and QIP from FY23.



FY25 results in a 1% increase in validity from FY24. Throughout the Fiscal Year FY25, NMRE conducted training on billing, EDV, technical requirements, as well as IPOS training. Additionally, series of training are scheduled January – March 2026 to address all deficiencies noted.

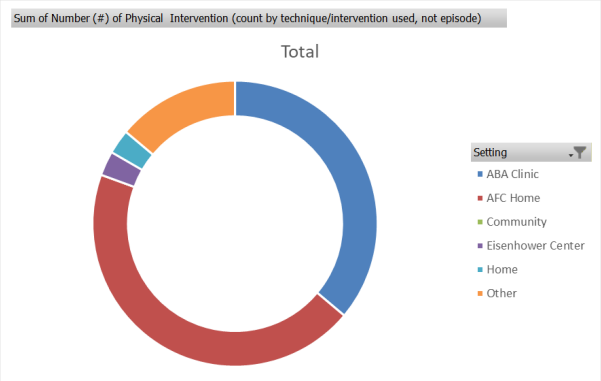
5. Behavior Treatment Review

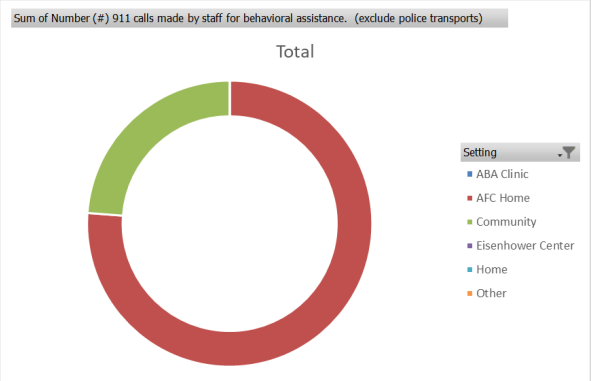
The Regional Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques were approved for use with members and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Trends and patterns will be reviewed to determine if systems and process improvement initiatives are necessary.

Data

Data includes the number of interventions and length of time the interventions were used with the individual(s). CMHSPs BTRC is tasked with reviewing data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that were approved by the members or their guardians during person-centered planning have been used. This is the first full FY of data for NMRE for this trending tool used, comparison will be

available in FY26.





6. Quality Measures (HEDIS measures)

The NMRE reviews the following HEDIS measures to demonstrate and ensure quality care. The NMRE provides HEDIS measure reports to the NMRE QOC on a quarterly basis. Upon review, QOC identifies interventions to improve outcomes where necessary.

Measures

The NMRE collects and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool.

PBIP OUTCOMES

- P.1 Implement data driven outcomes measurement to address social determinants of health.
  - ➢ The narrative report is submitted to MDHHS by the NMRE by July 31st, 2025.
- P.2 Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD).
  - ➢ The NMRE is measured against a minimum standard of 62% per calendar year.

As of March 31, 2025, the NMRE was at 69.04%.

- P.3 Initiation and engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).
  - ➢ The NMRE is measured against a minimum standard of 40% at initiation and 14% at engagement per calendar year.

As of March 31, 2025, the NMRE was at 12% for engagement. NMRE doesn't receive data download for SUD information from MDHHS and continues to struggle to identify events needing Initiation and Engagement due to this. Ongoing efforts are in place daily to reach beneficiaries who may need initiation following an ED visit.

- P.4 Increased participation in patient-centered medical homes.
  - ➢ The NMRE submitted a narrative report of no more than 10 pages by November 15th

summarizing prior FY efforts, activities, and achievements of the NMRE (and component CMHSPs, if applicable) to increase participation in patient-centered medical homes. The specific information to be addressed includes comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

- J.1 Implementation of joint care management processes.
  - The NMRE and MHPs document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. The NMRE must document joint care plans in CC360 for at least 25% of qualified adult enrollees.

As of March 31, 2025, the NMRE was at 80%.

- J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 days using HEDIS descriptions.
  - The NMRE meets set standards for follow-up within 30 days for each rate (ages 6-17 and ages 18 and older). The NMRE is measured against an adult minimum standard of 58% and child minimum standard of 79% per calendar year.

As of March 31, 2025, the NMRE was at 67.54% for adults and 81.69 for children.

- J.3 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.
  - The NMRE is measured against an initiation (IET 14) minimum standard of 40% and an engagement (IET 34) minimum standard of 14% per calendar year.

As of March 31, 2025, the NMRE was at 31.75% for initiation and 12.88% for engagement. Not receiving SUD data from MDHHS continues to be a challenge, and NMRE has addressed this with MDHHS numerous times.

- J.4 Follow-up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence.
  - The NMRE is incentivized to reduce the disparity between the index population and at least one minority group per calendar year. This could be a challenge for the NMRE as the region is predominantly Caucasian, and it may be hard to reach statistically significant numbers for the metrics.

As of March 31, 2025, the NMRE was at 42.50% for overall follow up within 30 days, benchmark is set at 36.3%.

7. Performance Indicators

The NMRE monitors the performance indicators for the NMRE CMHSP network as well as individually. Performance data is reviewed and discussed by QOC on a quarterly basis. The Michigan Mission Based Performance Indicator System (MMBPIS) is utilized by the NMRE to address areas of access, efficiency, and outcomes, and to report to the State as established in the PIHP contract. The NMRE will require corrective action from CMHSPs and providers for each indicator not met twice in a row.

Indicators

The NMRE, as well as CMHSPs, worked towards meeting all MDHHS MMPBIS and a 95% rate or higher for indicators 1, 4a, and 4b.

Work was done to try and improve indicators 2, 2e, and 3 and move them into at least 50th percentile, increasing to 57%, 68.2%, and 72.9% respectively.

These measures will be sunsetting as new HEDIS measures are introduced by MDHHS.

The NMRE will educate providers during the transition process from MMBPIS to HEDIS measures withing new Quality Rollout.

FY2025 PIHP PI					
Indicator: 1					
Population			**Net**	**Met**	**Met%**
Children			620	602	**97.10%**
Adults			2,526	2,486	**98.42%**
			3,146	**3,088**	**98.16%**
Indicator: 2a					
Population			**Net**	**Met**	**Met%**
MIC			1,178	735	**62.39%**
MIA			2,089	1,192	**57.06%**
DDC			382	267	**69.90%**
DDA			138	81	**58.70%**
			3,787	**2,275**	**60.07%**
Indicator: 3					
Population			**Net**	**Met**	**Met%**
MIC			859	598	**69.62%**
MIA			1,323	904	**68.33%**
DDC			356	262	**73.60%**
DDA			118	92	**77.97%**
			2,656	**1,856**	**69.88%**
Indicator: 4a					
Population	**Count**	**Exception**	**Net**	**Met**	**Met%**
Children	255	61	194	185	**95.36%**
Adults	842	341	501	463	**92.42%**
	1,097	**402**	**695**	**648**	**93.24%**
Indicator: 4b					
Population	**Count**	**Exception**	**Net**	**Met**	**Met%**
SA	1,030	477	553	508	**91.86%**

	1,030	**477**	**553**	**508**	**91.86%**
Indicator: 10					
Population	**Count**	**Exception**	**Net**	**Readmit**	**Readmit%**
Children	255	1	254	22	**8.66%**
Adults	845	9	836	101	**12.08%**
	1,100	**10**	**1,090**	**123**	**11.28%**

8. Monitoring and Evaluation

The NMRE continues to provide updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities. QAPIP activities are continuously reviewed and evaluated by QOC. The QAPIP is reviewed and updated at least annually with the input from CMHSPs, providers, stakeholders, and approved by the Governing Board. Update reports will be shared with the Governing Board periodically, but at least annually. This workplan is a living document that may be updated throughout the year. QAPIP activities are shared with consumers through the regional Consumer Council (Regional Entity Partners) and other stakeholders through committees, mailers, and posting to the NMRE.org website.

The NMRE maintains QOC meetings.

9. Practice Guidelines

The NMRE and its network providers implemented a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and Michigan Department of Health and Human Services (MDHHS).

The NMRE, in collaboration with its QOC, Clinical Services Directors, as well as network providers, reviews and adopts practice guidelines established by APA and MDHHS annually, every March, once they are reviewed and adopted by regions clinical directors. The NMRE will disseminate adopted practice guidelines to all affected providers, members, stakeholders, and potential members as needed via the website Practice Guidelines | NMRE, mailer, and/or annual newsletter.

10. Contracting

The NMRE updated Sub-contractual Relationships and Delegation Agreements to include the language: “the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later”.

New Contracts

The NMRE will ensure that in future agreements there is a specific language referencing Sub-contractual Relationships and Delegation Agreements.

Upgrades to PCE

The NMRE implemented upgrades in its PCE system for streamlined monitoring and compliance

management of provider's certifications, licenses, ASAM LOC approvals etc.

11. Credentialing and Recredentialing

Implementation of Credentialing CRM

NMREs five CMHSPs have all completed implementation of Universal Credentialing CRM, with the only limitation being the extent that their normal operations have delayed the transition. Priority has been placed in ensuring the provider network is comprised of providers qualified to perform their services. Four of the NMRE's five CMHSPs have integrated the CRM into their day-to-day operations for practitioners, and three of the CMHs have both added their own providers and subscribed to others in the CRM, the other two or the NMRE's CMHSPs have subscribed to other CMHSPs shared providers. The main challenges have been transitioning from current processes, which many downstream internal operations depend on, while simultaneously ensuring credentialing is completed timely. CMHSPs have essentially been forced to abandon the ways they have been doing tasks, and the change has not been as easy as anticipated.

Regional Education

The PIHP hosted two onsite training days for provider network management staff during FY2025, and additional continued educational discussions as needed during monthly Provider Network Management meetings. The objectives of the onsite trainings were to: 1) educate regional provider network and credentialing staff on the requirements of the MDHHS and PIHP, 2) ensure ongoing compliance in both practice and policy with MDHHS and PIHP standards, and 3) facilitate the adoption of best practices, regionally. The onsite training conducted on January 10th, 2025 covered the history of the CMHSP system, procurement, and organizational credentialing. The onsite training conducted on June 2nd, 2025 covered considerations and best practices regarding provider network insurance types and coverage, the onboarding process (including which parts fall under credentialing requirements), Disclosures of Ownership, and a demonstration of the MDHHS's Universal Credentialing CRM.

12. Exclusion Checks

The NMRE conducted its first annual review of SUD Treatment providers running their own staff's monthly exclusion checks during FY2025. The review is part of comprehensive monitoring. It found six provider organizations to be running each of the three required checks monthly and received fully compliant scores. Three organizations did not receive a perfect score, with the trending issue being that they were not running all three correct exclusion databases. One provider had been running all three databases but had missed some of the month in monitoring samples.

The three providers that did not receive fully compliant scores were required to submit corrective action plans.

13. Utilization Management and Authorization of Services

The NMRE continues to develop standardized utilization management protocols & functions across the region to identify areas of underutilization and overutilization of services. This will ensure access to public behavioral health services in the region is in accordance with the PIHP contract with MDHHS, relevant Michigan Medicaid Provider Manual (MMPM) sections, and Michigan Mental Health Code (MMHC) requirements.

FY25 outcomes:

A) NMRE completed MCG Indicia 17 Integration with PCE Systems for all five member boards. Project Duration: August 4, 2025 – December 29, 2025.

Project Summary

The project delivered a standardized, integrated clinical decision-support solution while supporting site-specific workflows and operational needs.

Key Objectives Achieved

- Deployment of MCG-hosted Non-Production and Production environments
- Successful API integration between Indicia and PCE Systems for all CMHs
- Completion of clinical assessment calls, workflow validation, and readiness reviews
- Delivery of system administrator, functionality, and end-user training
- Staggered site go-lives completed by December 18, 2025

Outcomes & Benefits

- Integrated clinical decision support within existing PCE workflows
- Improved consistency in utilization management practices
- Enhanced clinician adoption through structured education and change management
- Established foundation for future optimization and reporting initiatives

B) All NMRE staff completing SUD service authorizations attend ASAM IV edition training for PIHPs in\ preparation for this new edition to take place, scheduled in 2026.

PCE system changes have been requested for PCE implementation.

Trending

NMRE developed reports to monitor, trend, and review SUD admissions and level of care utilization in the NMRE region. These reports are provided to NMRE SUD Oversight Committee on a regular basis and will be available on NMREs website at www.nmre.org . Reports are available per region, county, provider, as well as level of care.

FY25 admissions continue to trend down for all LOC, likely due to decrease in enrollment, changing the number of eligible beneficiaries. PHE numbers trend much higher due to no redetermination during that timeframe. Utilization of ASAM Continuum assessment and monitoring of its annual completion (required as of FY24) may be another driving force in this decrease, determining medical necessity for continued SUD services and compliance with

funding sources.

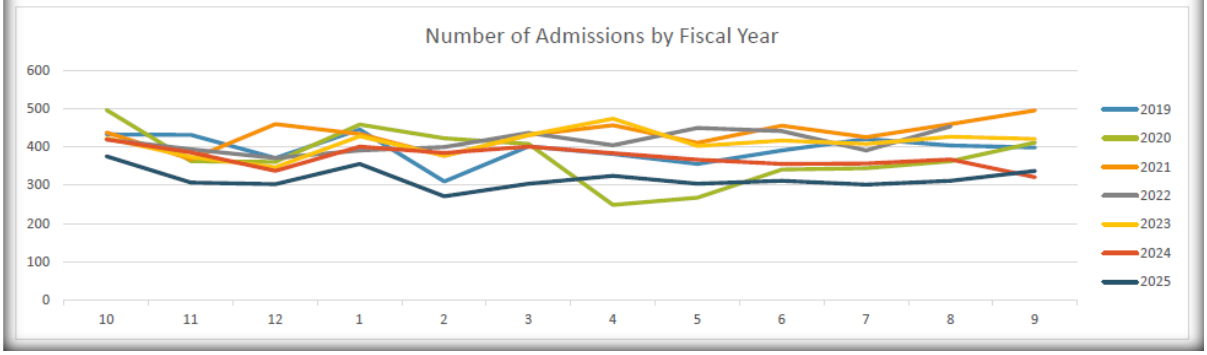
FY25 admissions are 15% lower than in FY24 across all LOC.

Northern Michigan Regional Entity
Substance Use Disorder Services

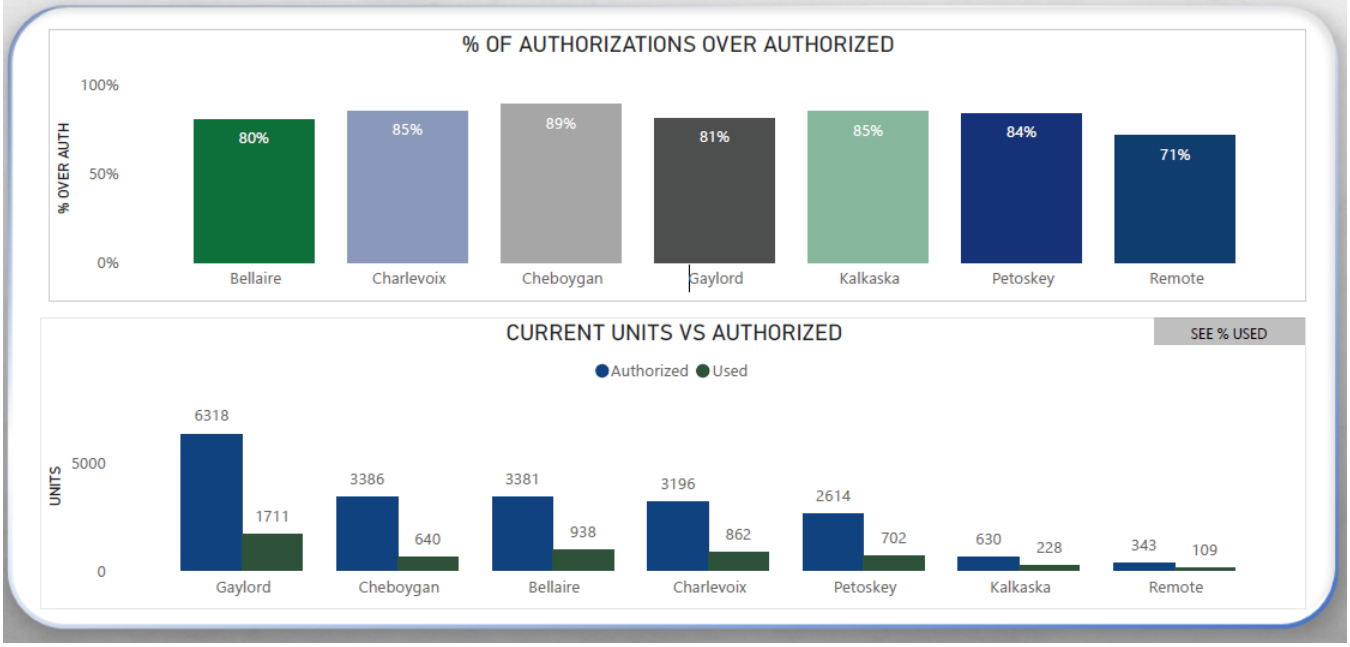
Admission Report

Total Number of Admissions Per Fiscal Year by Month

Count of Case #	Column Labels												
Row Labels	10	11	12	1	2	3	4	5	6	7	8	9	Grand Total
2019	433	432	371	446	310	402	382	356	391	421	404	399	4747
2020	497	363	361	459	423	408	249	268	341	345	363	412	4489
2021	438	368	460	434	377	431	457	411	456	426	460	496	5214
2022	420	394	371	391	400	437	405	450	442	391	454	453	5008
2023	423	374	347	428	378	432	474	403	417	408	427	421	4932
2024	420	386	338	401	385	401	384	367	356	357	368	321	4484
2025	376	307	303	356	271	304	325	304	312	302	312	338	3810
Grand Total	3007	2624	2551	2915	2544	2815	2676	2559	2715	2650	2788	2840	32684

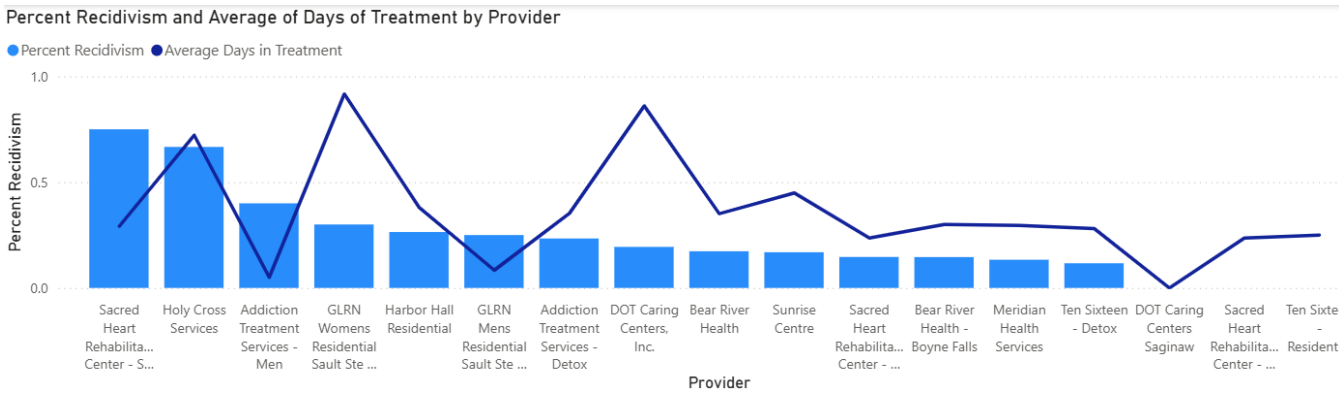


Additional analysis will be conducted for areas with significant variation in utilization patterns to identify root causes and opportunities for improvement when needed. Each CHMSP maintains Utilization Dashboards, and this is reviewed in Regions UR committee quarterly.

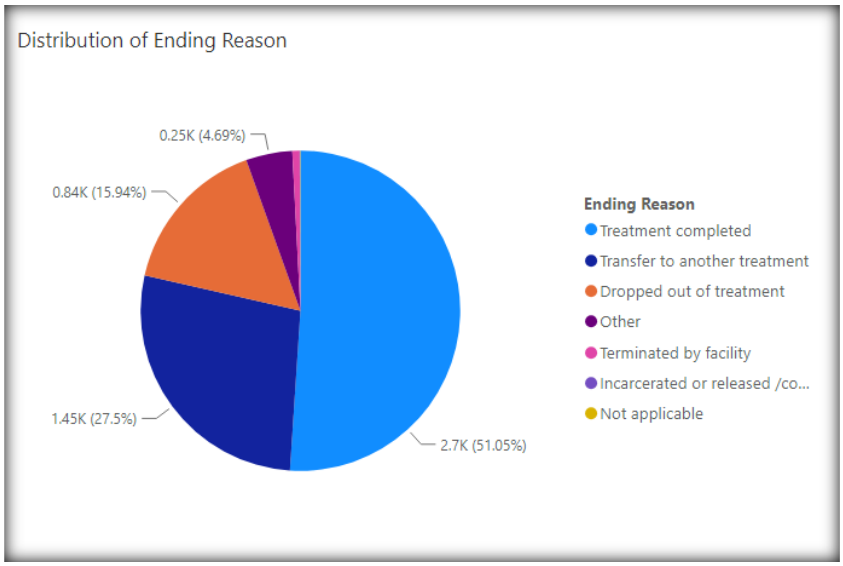


UM Dashboard, NCCMH

In order to determine additional supports, care coordination needs, resources, and technical assistance NMRE tracks recidivism rates per provider to make targeted efforts and informed decisions in service provision and linking and coordinating based on episode *ending reason*. However, 78.5% of episodes are considered completed or transferred to another LOC.

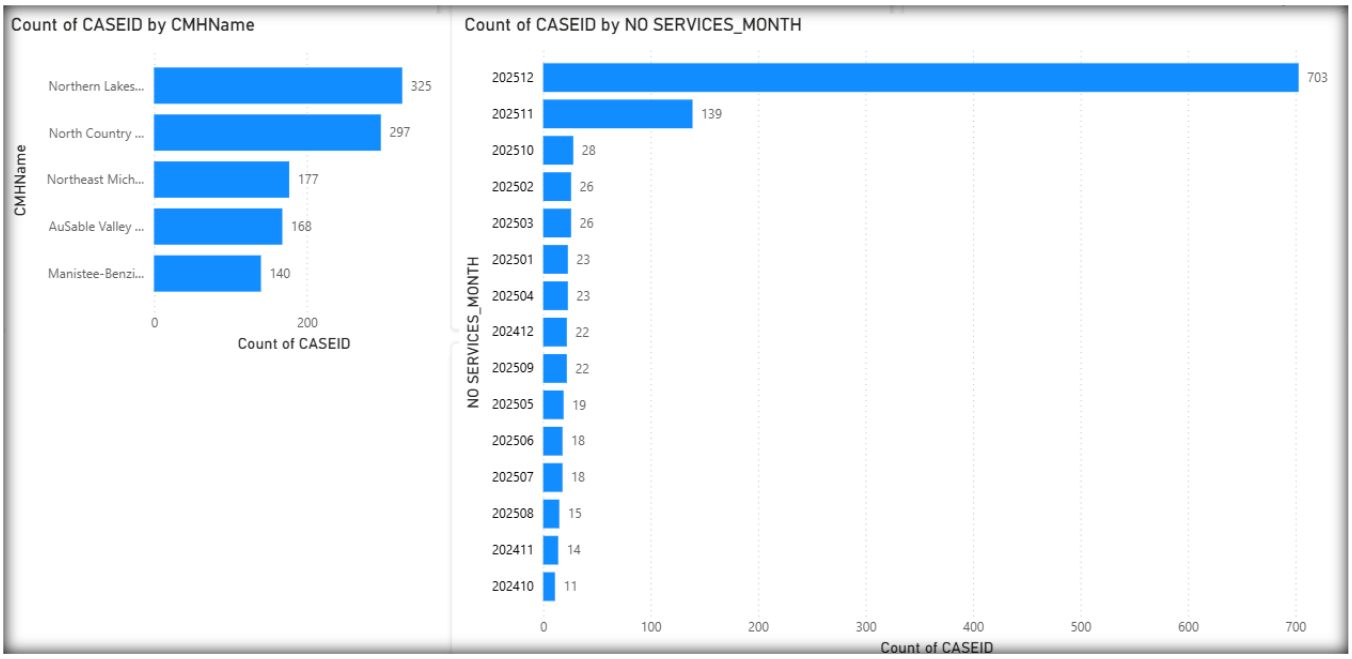


DetoxRecidivism30Days



Additional corrective actions were needed in FY25, resulting in higher enrollment of those receiving qualifying services into 1915(i) SPA. The NMRE continues to monitor Power BI Potential Enrollee Report for discrepancies per board and qualifying service:

To ensure appropriate utilization of HSW waiver slots, the NMRE runs monthly No-Service Report and shares with CMHSPs. (chart below shows numbers for December and November as claims are still processing). Report is reviewed with QOC as well as clinical directors, this claim data is shared with them as well.



March 2026 scheduled – Quality Oversight and Utilization Alignment Regional Training

Focus: Sustaining quality through supervision and utilization management.

Topics

- Service authorization, eligibility, and medical-necessity documentation
- Linking documentation to amount, scope, and duration of services
- Supervisory chart reviews and feedback methods
- Using QA and UM data to guide continuous improvement

Objectives

- Reduce findings related to authorization, eligibility, or supervision
- Embed documentation oversight into everyday supervisory practice

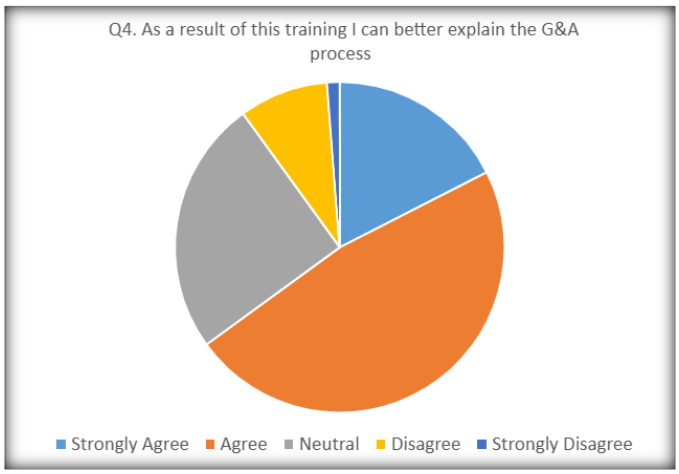
Relevant Review Citations

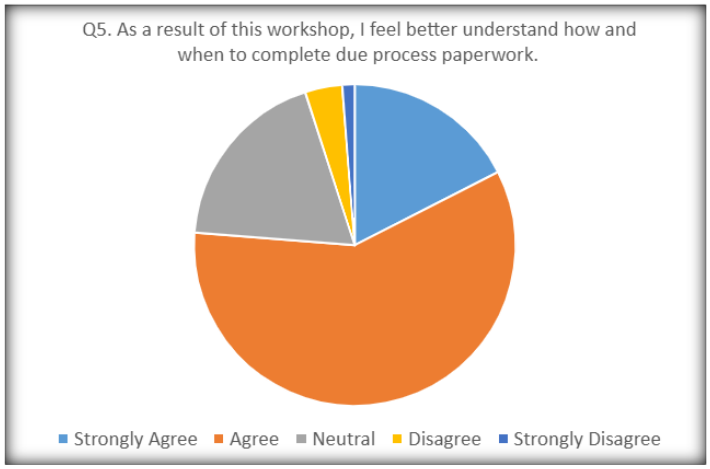
- iSPA E.2.C: Required elements of evaluation/re-evaluation, eligibility timelines, and compliance documentation.
  - Utilization Management Themes: Service authorization (amount, scope, duration), medical necessity, and monitoring authorizations.
  - Clinical Supervisor Role in QA: Best practices for supervisory chart reviews and documentation monitoring.

14. Regional Trainings

The NMRE continues to collect feedback from its member CMHSPs and SUD Providers, as well as record areas of improvement during site visits, and will conduct a series of trainings to aid in process improvement as well as overall compliance.

IPOS training was completed on 10/10-10/11/2024 for all five CMHSPs. Adverse Benefit Determination training was completed 1/23-1/24-2025. Over 200 staff attended these training sessions.





In addition to training, NMRE expanded utilization of its website, adding policy, training information, procedures, reports, as well as resources of all stakeholders for easy and convenient access to information.

Some areas of improvement noted during site visits we remediated by adding more information such as: https://nmre.org/recipients/independent-facilitation

15. Maintaining the Handbook

The NMRE obtained MDHHS approval, in writing, prior to publishing the original and revised editions of its member handbook. The NMRE uses MDHHS-developed model member handbooks and member notices and ensures that its member handbook and member notices include all MDHHS-developed template language. The NMRE, and any delegates performing activities on behalf of the NMRE, will ensure that all written materials for potential members and members use a font size no smaller than 12 point, and are written at or below the 6.9 grade reading level based on the Flesch-Kincaid scale.

16. Adverse Benefit Determinations

The NMRE ensures that each ABD notice meets federal and state-specific requirements, as well as content requirement, and is written at or below the 6.9 reading grade level. The NMRE conducted training and quarterly monitoring of its provider network to measure compliance.

Goal 1: Strengthen compliance with Federal and State laws regarding Adverse Benefit Determinations (ABD) sent to beneficiaries of the NMRE region.

Objective 1: Provide region-wide training emphasizing Federal and State regulations to allow maximum compliance with the ABD standards.

Objective 2: Provide increased oversight of the CMHSPs, requiring each CMHSP to send five examples of an ABD each quarter the NMRE for review.

Objective 3: Provide feedback to each CMHSP to enhance compliance.

FY25 Outcome:

Region-wide training was provided in January 2025, and training was provided to a singular CMHSP in March 2025. Each CMHSP has been compliant with the increased oversight, which has resulted in compliance improvement.

Compliance for FY25 Q1 and Q2 focused on the required 6.9 grade level readability, and time frame compliance, of the ABDs. FY25 Q3 (and Q4 when available) will focus on readability, along with proper citation use.

Q1	Q2	Q3
Readability Compliance: 17% Time frame Compliance: 96%	Readability Compliance: 39% (+22%) Time frame Compliance: 100% (+4%)	Readability Compliance: 53% (+14%) Time frame Compliance: 100% (+/-0% Citation Compliance: 61%

Goal 2: To increase compliance with timely authorization decisions for SUD services.

For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision (the PIHP may be able to extend the standard Service Authorization timeframe in certain circumstances).

The NMRE developed an internal process for timely authorization denials, as well es exceptions and extensions when appropriate.

FY24 SUD denials made within required decision timeframes: 98.71%

FY25 SUD denials made within required decision timeframes: **100%**

Appeals Trends FYs 2023, 2024, and 2025:

Most appeals originated from beneficiaries already authorized for services. Timeframe compliance for expedited appeals (7) was 100%; regular appeals had a 2% non-compliance rate (7). NMRE will continue to monitor the percentage of upheld appeals, which is currently at 57%. Appeals related to termination of services increased by approximately 25% from FY23 to

FY25, likely due to individuals losing Medicaid and the CMHSPs' increased ability to determine medical necessity and training provided. Conversely, appeals related to case management services decreased 17%.

- FY23: 95-Upheld: 52% Overturned:48%
- FY24: 102-Upheld: 54% Overturned:46%
- FY25: 122-Upheld: 57% Overturned:43%

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

FY26 Workplan

Approvals:

Quality and Compliance Oversight Committee	January 6, 2026
Internal Operations Committee	January 8, 2026
NMRE Board of Directors	January 28, 2026 (pending)

INTRODUCTION

The Northern Michigan Regional Entity (**NMRE**) is the Medicaid specialty prepaid inpatient health plan (PIHP) for the five Community Mental Health Services Programs (CMHSPs) serving the northern lower peninsula of Michigan. The member Boards are:

Wellvance (WV, formerly known as AVCMH) serving Iosco, Ogemaw, and Oscoda counties,
Centra Wellness Network (CWN) serving Benzie and Manistee counties,
North Country Community Mental Health Authority (NCCMH) serving Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego counties,
Northeast Michigan Community Mental Health Authority (NEMCMH) serving Alcona, Alpena, Montmorency, and Presque Isle counties,
Northern Lakes Community Mental Health Authority (NLCMH) serving Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford Counties.

The managed care activities are the responsibility of the NMRE.

The QAPIP is intended to outline requirements and provide guidance for carrying out organizational functions.

AUTHORITY

The Quality Assessment and Performance Improvement Program (QAPIP) is reviewed and approved on an annual basis by the NMRE Governing Board. Through this process, the Governing Board gives authority for the implementation of the plan and all its components. This authority is essential to the effective execution of the plan. The Governing Board receives periodic updates on the QAPIP, as well as a year-end effectiveness review.

MISSION & VISION

Mission: Develop and implement sustainable, managed care structures to efficiently support, enhance, and deliver publicly funded behavioral health and substance use disorder services.

Vision: A healthier regional community living and working together.

PURPOSE

As the PIHP for the twenty-one-county region, the NMRE's mission guides quality improvement activities. The QAPIP is intended to serve several functions, including but not limited to:

- Serve as the quality improvement structure for the managed care activities of the NMRE as the PIHP for the twenty-one-county area.
- Provide oversight of the CMHSPs' quality improvement structures and ensure coordination with PIHP activities, as appropriate.
- Provide leadership and coordination for the PIHP Performance Improvement Projects (PIPs).

This written plan describes how these functions will be accomplished. It also describes the organizational structure and responsibilities relative to these functions. A Designated Senior Official (NMREs Chief Clinical Officer) is responsible for coordinating activities related to the design, implementation, management, and evaluation of the quality improvement and compliance programs. On an ongoing basis the Chief Clinical Officer works with various committees to conduct an effectiveness review of the QAPIP and the previous fiscal year's workplan. The effectiveness review includes an analysis to determine whether members experienced any improvement in their quality of healthcare and services as an outcome of QAPIP activities. The effectiveness review is shared with the NMRE Governing Board, network providers, beneficiaries, and the public (via the NMRE website). The effectiveness review is used to inform the following year's QAPIP and Workplan.

STRUCTURE

1. Provider/Beneficiary Involvement

   The involvement of provider and beneficiary representatives is essential to the effectiveness of the QAPIP; this involvement is sought, encouraged, and supported at several levels including:
   a. The NMRE Governing Board includes beneficiaries as members.
   b. The NMRE Consumer Advisory Panel (Regional Entity Partners) provides input on various managed care activities.
   c. The regional Quality and Compliance Oversight Committee (QOC) is comprised of staff from the NMRE, its member CMHSPs, with SUD representative attendance on as needed basis.
   d. Each member CMHSP operates a Consumer Advisory Committee and includes beneficiary representatives on its Governing Board and on various committees.

2. NMRE Internal Operations Committee

   The NMRE Internal Operations Committee (IOC) has the central responsibility for the implementation of the QAPIP. Committee membership consists of key NMRE staff including but not limited to:
   a. Chief Executive Officer
   b. Chief Information Officer/Operations Director
   c. Chief Financial Officer
   d. Chief Clinical Officer
   e. Executive Administrator
   f. Compliance and Customer Services Officer
   g. Provider Network Manager
   h. Human Resources Director

3. NMRE Quality and Compliance Oversight Committee

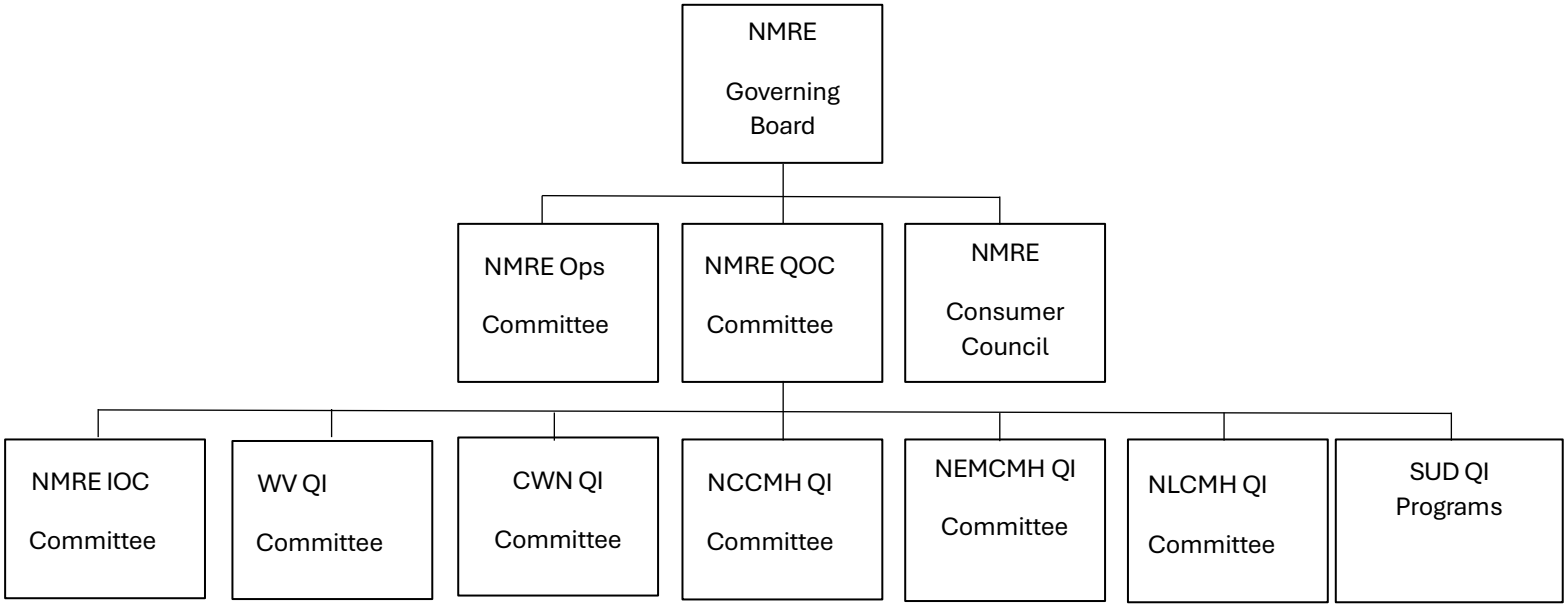
   The regional Quality and Compliance Oversight Committee (QOC) has the responsibility for ensuring that network providers have appropriate quality improvement structures and activities necessary to meet federal and state requirements. This group provides the primary link between the quality improvement structures of network providers and the NMRE. To

create this link, the CEO of each member CMHSP appoints representatives to serve as members of the committee.

4. CMHSP Quality Improvement Committees
   Each member CMHSP has a Quality Improvement process to address quality issues within its operations that meet the requirements of MDHHS and the NMRE.

5. Accountability
   Because one of the tenants of quality improvement and a key element of a successful team is accountability, the success of the NMRE's QAPIP is dependent on the success of its parts. Employees and/or agents of the NMRE and its network providers are accountable to beneficiaries, coworkers, various committees, and their primary employer for the quality and integrity of their work.

   The following table displays the reporting accountability of the various components of the quality improvement system.



NMRE Board Structure

The components of the QAPIP Structure are intended to ensure compliance with the following required activities:

1. Performance Improvement Projects

The NMRE will engage in Performance Improvement Projects (PIPs), addressing clinical as well as non-clinical aspects of care. PIPs will involve measurable and objective quality indicators, interventions leading to improvement, as well as evaluation of effectiveness. The goal of PIPs is to improve health outcomes and member satisfaction.

PIP #1 (Opioid Health Home PIP)

The NMRE Quality and Compliance Oversight Committee (QOC) will continue to collect data, conduct ongoing analysis, and coordinate with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program as part of the broader Substance Use Health Home (SUDHH). The NMRE will collect data and conduct analysis to show evidence of improvement in enrollment from the baseline by September 30, 2026. Non-clinical/HSAG Validated

PIP #2 (Behavioral Health Home PIP)

The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 6% to 7% by September 30, 2026. Non-Clinical

PIP #3 (Clinical PIP Development)

Performance Indicator 3 (PI 3) improvement goal is to increase the percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.

1. Anticipated Barriers: Staffing and lack of appointment slots due to staffing issues.
2. Anticipated Strengths/Challenges: Staffing, trained staff, automated appointment reminders, consumers cancelling, rescheduling, or requesting outside of the 14-day window due to their own schedules, no-shows, requesting in-person (not telehealth) services, which significantly reduces the number of available therapists.
3. Interventions: Ongoing review of performance indicators to learn about trends and potential process changes that may be needed, additional staff training, availability of telehealth being offered; successful strategies to be reviewed and shared with QOC members.

FY26 goal is to achieve above the 50th percentile =72.9%

2. Event Reporting and Notification

The NMRE complies with its Specialty Supports and Services Contract with the State and the Event Notification/Reporting System by providing clear guidance for the reporting and reviewing of critical incidents, sentinel events, risk events, and deaths of beneficiaries. The NMRE analyzes this data quarterly to identify improvement opportunities. The NMRE Quality and Compliance Oversight Committee (QOC), as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of

harm. The QOC continues to improve the data quality and timeliness in reporting events.

Information received from CMHSPs is compiled and analyzed by the NMRE. Trending of the quarterly and annual data is available via a Power BI dashboard created by the NMRE, allowing trends to be shared and reviewed regionwide or specific to a board.

a. Sentinel Events: A sentinel event is a type of critical incident that is an "unexpected occurrence" involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). A sentinel event does **not** include a death attributed to natural causes. Investigation of a sentinel event will be conducted by a staff with the appropriate credentials to review the event; for example, a sentinel event involving a death or serious medical condition will involve a physician or nurse.

To be a sentinel event, the incident must have occurred to a beneficiary in a reportable population and determined, through investigation, to be a sentinel event. Except for arrests/conviction and serious challenging behavior, each incident should be reviewed to determine if it meets sentinel event criteria.

i. Unexpected Death: The death of a beneficiary that is not the result of natural causes. An unexpected death includes any death that results from suicide, homicide, an undiagnosed condition, accident, or where it appears suspicious for possible abuse and/or neglect.

ii. Serious Physical Injury: Serious damage suffered by a beneficiary that a physician or nurse determines caused, or could have caused, the death of the beneficiary, the impairment of his/her bodily functions, loss of limb, or permanent disfigurement. An injury caused by actual or suspected abuse or accident must be treated at a medical facility. The treating medical facility must be noted on the incident report.

iii. Emotional Harm: Impaired psychological functioning, growth, or development that is significant in nature as evidenced by observable physical symptomatology, as determined by a mental health professional or psychiatrist.

iv. Death by Natural Causes: The death of a beneficiary that occurred as the result of a disease process from which death is an anticipated outcome. A death by natural causes is **not** a sentinel event.

v. Physical Illness Requiring Hospital Admission: The unexpected hospitalization of a beneficiary for a previously unknown or undiagnosed illness. Planned surgery, whether outpatient or inpatient, is **not** considered an unexpected occurrence and, therefore, not included in reporting under this definition. A hospital admission for an illness directly related to a

beneficiary's chronic or underlying illness is also **not** reported as a sentinel event.

vi. Serious Challenging Behavior: A behavior that results in significant (over $100) property damage, an attempt at self-inflicted harm or harm to others, or an unauthorized leave of absence. A serious challenging behavior includes behaviors not previously addressed in a Behavior Treatment Plan.

vii. Medication Error: The delivery of medication to a beneficiary that is the wrong medication, wrong dosage, or double dosage, or failure to deliver medication that resulted in death or serious injury or the risk thereof. An instance where a beneficiary refused medication is **not** a medication error.

viii. Arrest/Conviction: Any arrest or conviction of a beneficiary who is in a reportable population at the time of the arrest or conviction. An arrest or conviction will be reported as a sentinel event [through the MDHHS Michigan Crisis and Access Line (MiCAL)] but does not require a root cause analysis.

b. Substance Use Disorder (SUD) Sentinel Event Reporting: Specific sentinel events that occurred to beneficiaries who were living in a 24-hour specialized residential substance abuse treatment settings at the time of the event are required to be reported to MDHHS. The specific categories are:

i. Death
ii. Accident that requires an emergency room visit and/or hospital admission
iii. Physical illness that required a hospital admission
iv. Arrest or conviction
v. Serious Challenging Behavior
vi. Medication error

Information and trends will be analyzed and reviewed quarterly during NMREs SUD Provider meeting.

c. Risk Events: An event that puts a beneficiary who is in a reportable population at risk of harm is categorized as a "risk event." A risk event is reported for internal analysis to determine what actions are needed to remediate the problem or situation and to prevent reoccurrence.

i. Harm to Self: An action taken by a beneficiary that causes them physical harm that requires emergency medical treatment or hospitalization (e.g., pica, head banging, self-mutilation, biting, suicide attempt).

ii. Harm to Others: An action taken by a beneficiary that causes physical harm to an individual(s) (family, friend, staff, peer, public, etc.) that requires emergency medical treatment or hospitalization of the injured person(s).

iii. Unscheduled Hospitalizations: Two or more unscheduled admissions of a beneficiary to a medical hospital within a 12-month period not due to

planned surgery or the natural course of a chronic illness. The use of an emergency room or emergency department is **not** considered a hospital admission.

The NMRE collects this information from its member CMHSPs and trends it and reviews quarterly during QOC.

d. Critical Incidents: The NMRE requires all network providers (both CMHSPs and SUD providers) to report critical incidents to the NMRE monthly. Critical incidents include:

i. Suicide
ii. Non-suicide death
iii. Death of unknown cause
iv. MAT medication error
v. SUD medication error
vi. Seriously challenging behavior

Any unexpected death of a beneficiary who, at the time of their death, was receiving specialty supports and services will be reviewed. The review will include:

i. Confirmation of beneficiary's death (e.g., coroner's reports and/or death certificate)
ii. Involvement of medical personnel in the mortality review
iii. Documentation of the mortality review process, findings, and recommendations
iv. Use of mortality information to review quality of care
v. Aggregate mortality data to identify possible trends over time

The review will be a "formal process" and include areas of clinical risk. The review team will include individuals with appropriate credentials to review the scope of care, individuals who were not involved in the treatment of the beneficiary, and any additional individuals who may contribute to a thorough review process.

e. Root-Cause Analysis (RCA): A root cause analysis is a process for identifying the basic or causal factors that underline variations in performance, including the occurrence or possible occurrence of a sentinel event or other serious event. A root cause analysis should result in an action plan designed to reduce or attempt to reduce future incidents. Within three (3) days of a critical incident, network provider staff will determine whether it meets sentinel event standards; if it does meet that standard network provider staff will initiate a root cause analysis within two (2) days of the determination. A request for additional information, such as a coroner's report or death certificate, constitutes the start of a root cause analysis.

f. Unexpected Death Reporting: All unexpected deaths of Medicaid beneficiaries who, at the time of their death, were receiving specialty supports

and services will be reviewed in accordance with the NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting Policy and Procedure and the NMRE's Specialty Supports and Services Contract with the State. This reporting will include suicide, non-suicide death, homicide, undiagnosed conditions, accidental death, suspicious death, or abuse/neglect.

The NMRE and/or the network provider will immediately report to MDHHS:

i. Any death of a beneficiary who was discharged from a State Facility within 12 months preceding the date of death
ii. Any death that occurs as the result of suspected NMRE or network provider staff action or inaction, or
iii. Any death that is the subject of a Recipient Rights, licensing, or police investigation.

The report will be submitted electronically, utilizing NMRE's EMR, within 24 hours of either the death or the responsible network provider staff's receipt of the death notification, or the responsible network provider staff's receipt of notification that a Recipient Rights, licensing, and/or police investigation has commenced to the NMRE Compliance and Customer Services Officer. The report will include:

i. Name of beneficiary
ii. Beneficiary ID Number (Medicaid or Healthy Michigan Plan)
iii. Consumer ID if there is no beneficiary ID number
iv. Date, time, and place of death (if a licensed foster care facility, include the license #)
v. Preliminary cause of death
vi. Contact person's name and email address

In addition, the network provider will submit a written report of its review/analysis of the death to the NMRE within 45 days from the month in which the death occurred. The NMRE will notify MDHHS within 60 days after the month in which the death occurred.

The NMRE will monitor its network providers for compliance annually, or as needed. All incidents not related to beneficiaries (i.e., staff, volunteers, interns, and visitors) will be reported according to the appropriate NMRE or network provider policy. It is the policy of the NMRE that its network providers will have and implement a process to:

A. Review, investigate, analyze, act upon, internally report, and track critical incidents, sentinel events, and risk events, in an accurate and timely manner.

B. Review, investigate, analyze, act upon, and report critical incidents, risk events and sentinel events to the NMRE in an accurate and timely manner.

C. Identify system factors associated with critical corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events.

D. Develop and implement effective corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events. The NMRE will review, analyze, act upon when necessary, and report critical incidents and sentinel events to MDHHS in an accurate timely manner.

Training and information

The NMRE will continue to provide training to providers on the type of data to collect, the population involved in this data collection, and timeliness in reporting. The expectation is that providers will continue to train and remind their staff about this process.

Changes to Reporting Platforms

The NMRE has an established electronic process for the submission of sentinel events/immediate notification, remediation documentation including written analysis for those deaths that occurred within one year of discharge from state operated services. The NMRE maintains updates to the reporting system within PCE/EMR to better meet reporting needs and ensure timely and accurate reporting of these events to PIHP/MDHHS.

Data Collection and Review goal:

The NMRE will continue to collect events data on a regular basis (monthly, quarterly, as needed) and analyze trends, and implement necessary interventions related to critical incidents, sentinel events, unexpected deaths, as well as risk events. Reporting to MDHHS will be completed within the designated timelines listed above; 90% of events will be submitted timely (date of notification to submission to MDHHS CRM).

3. Consumer Experience Assessments

The NMRE will conduct ongoing quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports (LTSS) and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract with the State. Assessment results will be used to improve services, processes, and communication. Outcomes will be shared in the NMRE's annual mailing. The NMRE will identify and provide possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

Beneficiary satisfaction surveys are conducted annually for both CMHSP and SUD services. Each survey includes a question about beneficiary experience, requesting that any beneficiary who would like a follow up from the provider regarding the beneficiary comment can leave their name and/or telephone number to be contacted. All CMHSP and SUD providers are then given a copy of the comments received during satisfaction survey collection. The provider is then expected to follow up with beneficiaries requesting to speak to someone. In some cases, NMRE has reported information collected from satisfaction surveys to the provider's Office of

Recipient Rights, Licensing and Regulatory Affairs, if appropriate, and the NMRE has opened grievances on behalf of beneficiaries.

Moving forward, the NMRE will monitor service providers' follow up with beneficiaries to measure if the follow up resolves issues and increases overall satisfaction. The NMRE will furnish the providers with the name and contact information of each person wishing to be contacted in a report. The report will include date of outreach (within 5 business days of receipt of report), resolution of outreach (within 60 days of outreach), and a space for a 6-month follow-up (within 6 months of resolution) to measure if satisfaction has been improved. The NMRE will complete the 6-month follow-up to ensure goals and objectives are being met.

Outcomes

The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction. Processes found to be effective will be continued while those less effective or not satisfactory will be revised and followed up with.

Substance Use Disorder (SUD)

The NMRE will conduct separate SUD surveys, including Withdrawal Management/Detox and Methadone surveys, to identify specific member experiences.

Evaluation Efforts

The NMRE will outline systemic action steps to follow-up on the findings from survey results on an ongoing basis.

The NMRE will share survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), Board of Directors, and the Regional Consumer Council (Regional Entity Partners), and post a copy to the NMRE.org website. The NMRE's annual mailer will include instructions to direct consumers to locate the information on the NMRE.org website.

4. Provider Network Monitoring

To ensure compliance, the NMRE conducts annual (at minimum) monitoring for all directly contracted providers in the region, and out of region as needed and appropriate, utilizing reciprocity when necessary.

Monitoring

The NMRE will conduct site reviews annually for all contracted service providers by 9/30/2026. The NMRE will monitor and follow-up on corrective action plans to ensure corrective action plans (CAPs) are being implemented as stated by network providers. The NMRE QOC will

request, on a regular basis, updates from providers regarding the progress of their Quality Improvement Workplans and CAPs.

The NMRE will enhance its SUD monitoring tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Additionally, education will be provided to contracted SUD treatment providers informing them that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file.

The NMRE will ensure that its provider directory, and any delegated CMHSPs' provider directories, include all the required information from 42 CFR 438.10 as listed on the (HSAG) Provider Directory Checklist, and will make its provider directory available on the NMRE's website in a machine-readable file and format as specified by the Secretary.

The NMRE will develop new auditing tools utilizing *PCE Auditing* to increase efficacy and allow for trending and monitoring of outcomes and progress.

LTSS (Long Term Supports and Services)

The NMRE will incorporate consumers receiving long-term supports or services (LTSS) into the review and analysis of the information obtained from quantitative and qualitative methods. LTSS programs provide service needs from complex-care to assistance with everyday activities of daily living.

Long-Term Services and Supports	CPT/HCPCS Codes
Respite	H0045 (Out-of-Home Setting) S5150 (Unskilled caregiver, "family friend") S5151 (In-Home Setting) T1005 (15 minutes)
Community Living Supports	H2015 (Unlicensed Setting) H2016 (Licensed Residential Setting)
Private Duty Nursing	S9123 (Registered Nurse, Hour) S9124 (Licensed Practical Nurse, Hour) T1000 (RN or LPN, 15 minutes)
Supported Integrated Employment	H2023
Out of Home Non-Vocational Rehab	H2014
Goods & Services	T5999
Environmental Modification	S5165
Supports & Service Coordination	T1017
Enhanced Pharmacy	T1999
Personal Emergency Response (PERS)	S5160 (Installation and testing) S5161 (Service fee, per month, excludes installation and testing)
Community Transition Services	T2038

Enhanced Medical Equipment & Supplies (including vehicle modification)	E1399 (Durable Medical Equipment) S5199 (Personal Care Items) T2028 T2029 T2039 (Vehicle Modification)
Family Training	G0177 (Family Education Groups) S5110 (Family Psycho-Education Skills Workshop) S5111 (Home care training; family) T1015 (Family Psychoeducation, Joining)
Non-Family Training	S5116
Specialty Therapies (Music, Art, Massage, etc.)	G0176 (Music, Art, Recreation Therapy) 97124 (Massage) 97530 (Therapeutic Activities)
Children Therapeutic Foster Care	S5140 (age 11 and older) S5145
Therapeutic Overnight Camping	T2036
Transitional Services	T2038
Fiscal Intermediary	T2025
Prevocational Services	T2015

The NMRE has mechanisms in place to assess the quality and appropriateness of case furnished to beneficiaries receiving LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's individualized plan of service. This is accomplished by completing regular and ongoing monitoring of completed standardized assessments, completed IPOS and updates/changes, level of care determination tools, person centered planning requirements etc. All required paperwork for waiver beneficiaries is approved by NMRE prior to enrollment, and monthly monitoring of authorized services is done to ensure the provision of agreed upon services that support community integration of beneficiaries. The NMRE will review all efforts for community integration during scheduled site reviews.

MCPAR outcomes will be monitored as well as a source of feedback for LTSS population and shared with appropriate parties.

The NMRE will obtain a qualitative and quantitative assessment of member experience for this population, utilizing electronic version of the tool annually. Member Experience of Care outcomes are available on the NMRE.org website.

Verification of Medicaid Services

The NMRE will perform quarterly audits to verify Medicaid claims/encounters to ensure Medicaid services were furnished to beneficiaries by CMHSPs, SUD providers, providers, and/or subcontractors. This will include verifying data elements from individual

claims/encounters to ensure proper service codes are used and proper documentation is in place. CAPs will be developed where appropriate per NMREs MEV policy.

The NMRE established consistent methodology for the development and implementation of responsibilities for verification of the claims/encounters submitted within the Provider Network to ensure compliance with federal and state regulations and to provide direction to NMRE Network Providers. It is the policy of the NMRE to ensure that all claims for services are properly documented, and services were provided prior to payment.

The NMRE verification methodology will include testing data elements from individual encounters against EHR and the use of data analytics, as defined within the MDHHS Technical Requirement. Additional elements may be included to support the NMRE quality improvement efforts around encounter data. Statistically representative sample requirements will meet OIG standards. The NMRE sampling process uses Microsoft SQL and Excel.

If an audited sample yields less than 95% accuracy, a Plan of Correction is required. If an audited population falls below 90% accuracy during a 12-month period, a stratified sample will be pulled, and a Plan of Correction is required.

The NMRE will work with its provider network on reaching 95% or higher accuracy during each quarterly review.

FY26 goal is to increase compliance rate from 91% (FY25) to 95% by the second quarter of FY26.

Training and technical support will be provided. Training regarding Documentation Standards and Clinical Compliance will be provided in February of 2026.

Home and Community Based Services (HCBS)

The NMRE and its CMHSPs monitor Home and Community Based Services (HCBS) Under the HCBS Final Rule, the Centers for Medicare and Medicaid (CMS) requirements for both residential and non-residential Home and Community Based Settings. HCBS settings and services must be integrated into the community with full access to jobs, resources and services, to be chosen by the individual from multiple options, ensure privacy, dignity, respect and freedom of coercion and restraint, support autonomy and independence in daily life decisions and allow individuals to choose their services, supports, and providers.
In response to MDHHS CMH CAP, following a site visit, NMRE developed and updated HCBS, HCBS Monitoring, and Conflict Free policies.

The NMRE continues to host HCBS Trainings with the goal of moving this activity to CMHSPs in April of 2026. A new Site Visit Tool addressing all the areas of HCBS monitoring needs will be developed by March of 2026.

Behavioral Treatment Review

The Regional Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques were approved for use with members and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Trends and patterns will be reviewed to determine if systems and process improvement initiatives are necessary.

BTP Data

Data will include the numbers of interventions and length of time the interventions were used with the individual(s). The NMRE's regional BTRC will be tasked with reviewing data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that were approved by the members or their guardians during person-centered planning have been used. By asking the behavior treatment committees to track this data, it provides important oversight to the protection and safeguard of vulnerable individuals including those receiving long-term supports and services.

The quarterly reviews of data from the Behavior Treatment Review Committee is completed in QOC meetings with all member boards identifying trends, barriers, and developing improvement strategies.

5. Quality Measures (HEDIS measures)

The NMRE will review the following HEDIS and other measures to demonstrate and ensure quality care. The NMRE will provide and analyze HEDIS measure reports to the NMRE QOC on a quarterly basis. Upon review, QOC will identify interventions to improve outcomes where necessary. The NMRE will review raw data, used for these metrics, on as needed basis to determine areas of improvement

Measures

The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool:

Measure	NMRE PIHP goals for FY26:
P.1. Implement data driven outcomes measurement to address social determinants of health (40 points)	NMRE will conduct an analysis and submit a narrative report of findings and project plans aimed at improving outcomes, no longer than two pages, by July 31.
P.2. Adherence to antipsychotic medications for individuals with schizophrenia **(SAA-AD)** (20 points)	NMRE will meet or exceed a minimum standard of 62% for this metric.
P.3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **(IET)** (40 points)	The NMRE will meet or exceed a minimum of 40% at initiation and 14% at engagement.
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (25% of total withhold)	The NMRE will submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements regarding increased participation in patient-centered medical homes. The specific information to be addressed in the narrative are: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

Category	NMRE PIHP goals for FY26
J.1. Implementation of Joint Care Management Processes (30 points)	Each paneled MHP and NMRE will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. The NMRE will document joint care plans in CC360 for at least 25% of qualified adult Enrollees. The NMRE will work on increase in enrollment of children.
J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (30 points)	The NMRE will meet and exceed set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older) of 58% for adult and 79% for child population.
J.3 Initiation and Engagement of Alcohol and Other Drug Dependence	The NMRE will meet and exceed (IET 14) minimum standard of 40% and (IET 34) minimum standard of 14%.

As part of the *Behavioral Health Quality Program Overhaul- Year 1* NMRE will meet benchmarks on the metrics below (some overall with the list above is noted):

Code	Measure	Benchmark
ADD	Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication – initiation phase	52.6%
	Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication – continuation phase	61.2%
FUH	Follow-up After Hospitalization for Mental Illness – within 30 days after discharge, between the ages of 6 and 17 years old (FUH-30 CH)	79%
	Follow-up After Hospitalization for Mental Illness – within 30 days after discharge, between the ages of 18 and 64 years old (FUH-30 AD)	58%
	Follow-up After Hospitalization for Mental Illness – within 30 days after discharge, age 6 years or older (FUH-30)	
APM	Metabolic monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing (TOTGC)	27.6%
APP	Use of first line Psychosocial Care for Children and Adolescents on Antipsychotics.	65.6%
FUA	Follow-up After Emergency Department Visit for Substance Use – within 30 days, between the ages of 13 and 17 years old (FUA-30CH)	35.6%
	Follow-up After Emergency Department Visit for Substance Use – within 30 days, 18 years or older (FUA-30AD)	36.3%
	Follow-up After Emergency Department Visit for Substance Use – within 30 days, between the ages 13 years or older (FUA-30)	
FUM	Follow-up After Emergency Department Visit for Mental Illness – within 30 days, age 6 years or older (NCQU) or age 18 or older (CMS)	60.8%
IET	Initiation and Engagement into Substance Use Disorder Treatment – Initiation total within 14 days of diagnosis (IET 14-TOT)	40%
	Initiation and Engagement into Substance Use Disorder Treatment – Engagement total within 34 days, age 13 years or older (NCQA) or age 18 years or older (CMS) (IET 34-TOT)	14%

Red numbers indicate that this benchmark is the median calculated using 2023 PIHP data.
Blue numbers indicate CY2023 statewide average.

6. Performance Indicators

The NMRE will monitor the performance indicator for the NMRE CMHSP network as well as individually. Performance data will be reviewed and discussed by QOC on a quarterly basis. The Michigan Mission Based Performance Indicator System (MMBPIS) will be utilized by the NMRE to address areas of access, efficiency, and outcomes, and to report to the State as established in the PIHP contract. The NMRE will require corrective action from CMHSPs and providers for each indicator not met twice in a row.

Indicator #2

Access: Mental Health and Intellectual and Developmental Disabilities 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 (by four sub-populations: MI-adults, MI-children, I/DD-adults, I/DD-children)

The NMREs FY26 goal is to reach the 75th percentile for this Indicator and maintain that performance, by reaching or exceeding 62%.

The NMRE will educate providers during the transition process from MMBPIS to the HEDIS measures listed above. Ongoing update and review of metrics, and/or areas of improvement, will be provided during QOC meetings.

7. Monitoring and Evaluation

The NMRE will continue to provide updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities. QAPIP activities will be reviewed and evaluated by QOC. The QAPIP is reviewed and updated at least annually with input from CMHSPs, providers, stakeholders, and approved by the Governing Board. Update reports will be shared with the Governing Board periodically, but at least annually. This workplan is a living document that may be updated throughout the year.

QAPIP activities will be shared with consumers through the regional Consumer Council (Regional Entity partners) and other stakeholders through committees, mailers, and posting to the NMRE.org website.

The NMRE will maintain QOC meetings with a goal of meeting monthly.

8. Practice Guidelines

The NMRE and its network providers implemented a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and the Michigan Department of Health and Human Services (MDHHS).

The NMRE' Chief Clinical Officer, in collaboration with QOC members, network providers (including SUD providers) will review and adopt practice guidelines established by APA and MDHHS annually, every March. The NMRE will disseminate adopted practice guidelines to all affected providers, members, stakeholders, and potential members as needed via the NMRE.org website, annual mailer, and/or annual newsletter.

A. Adoption of Practice Guidelines

1. The NMRE has adopted practice guidelines that are based on valid and reliable clinical evidence, or a consensus of providers of mental health, intellectual/developmental disabilities, and/or substance use disorder services.
2. The NMRE has adopted practice guidelines from the American Psychiatric Association (APA), other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), and MDHHS practice guidelines, and region-specific practice guidelines.

3. The NMRE has adopted practice guidelines that consider the needs of its members.
4. The NMRE has adopted practice guidelines in consultation with its network providers.
5. The NMRE has adopted practice guidelines that are reviewed and updated annually, or as updated by the APA and MDHHS.

B. Dissemination of Guidelines

The NMRE will disseminate practice guidelines to:

- All affected providers.
- Members and potential members by an annual mailing which will direct them to the NMRE.org website.
- The public by posting to the NMRE website.

C. Annual Monitoring of Practice Guidelines

1. Practice Guidelines will be distributed to the regional Clinical Leadership Committee, the regional Quality and Compliance Oversight Committee, the regional Provider Network Managers Committee and the Substance Use Disorder Directors one month prior to the meeting during which practice guidelines are scheduled for review (e.g., February).
2. The stated committee members will be asked to provide feedback to the NMRE regarding any changes or recommendations to currently adopted practice guidelines.
3. The stated committees will approve the adoption of new practice guidelines and/or recommend that current practice guidelines be continued during the month in which the guidelines are scheduled for review (e.g., March).
4. Approval of practice guidelines will be recorded in the stated committee's meeting minutes.
5. The NMRE will review and update (if necessary) the practice guidelines posted to its website.
6. The NMRE will review its provider network as necessary, but at least annually, to ensure practice guidelines are followed appropriately.

D. Application of Guidelines

- Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines.
- The NMRE will ensure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines.
- Practice guidelines will be used to guide but not replace clinical judgment.

9. Contracting

The NMRE updated Sub-contractual Relationships and Delegation Agreements to include the language: "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later".

New Contracts

The NMRE will ensure that in future agreements there is a specific language referencing Sub-contractual Relationships and Delegation Agreements.

10. Credentialing and Recredentialing

FY2026 will see the NMRE continuing its collaboration with the MDHHS to implement the universal credentialing module in their CRM platform, continue monitoring on credentialing and recredentialing, and continued regional educational/training sessions.

Implementation of Credentialing CRM

The NMREs five CMHSPs have all completed implementation of Universal Credentialing CRM, with the only limitation being the extent that their normal operations have delayed the transition. Priority has been placed on ensuring the provider network is comprised of providers qualified to perform their services. Four of the NMRE's five CMHSPs have integrated the CRM into their day-to-day operations for practitioners, and three of the CMHs have added both their own providers and subscribed to others in the CRM; the other two of the NMRE's CMHSPs have subscribed to other CMHSPs shared providers. The main challenges have been transitioning from current processes, which many downstream internal operations depend on, while simultaneously ensuring credentialing is completed timely. The CMHSPs have essentially been forced to abandon the ways they have been doing tasks, and the change has not been as easy as anticipated.

The NMRE's goal will be to have all 5 of the regional CMHSPs using the CRM for all their credentialing for day-to-day operations, for both their practitioners and organizations, by April 1, 2026.

Regional Education/Training

The PIHP will continue to host training for provider network management staff.

For FY2026, the goal of the NMRE will be to host an additional 3 training days during the fiscal year, onsite with weather permitting, to further ensure that credentialing citations, credentialing operations, and contract processes are compliant.

11. Exclusion Checks

The NMRE conducted its first annual review of SUD Treatment providers having run their own staff's monthly exclusion checks during FY2025. The review found six provider organizations to be running each of the three required checks monthly and receive fully compliant scores. Three organizations did not receive a perfect score, with the trending issue being that they were not running all three of the required exclusion databases. One provider had been running all three databases but had missed some months.

The three providers that did not receive fully compliant scores were required to submit corrective action plans. For FY26, the NMRE's goal will be to have reviewed the progress made toward corrective action by all three providers by July 1, 2026, pull additional samples for review of the corrective action, and issue new CAPs as necessary

12. Utilization Management and Authorization of Services

The NMRE will continue to develop standardized utilization management protocols & functions across the region to identify areas of underutilization and overutilization of services. This will ensure access to public behavioral health services in the region is in accordance with the PIHP's contract with MDHHS, relevant Michigan Medicaid Provider Manual (MMPM) sections, and Michigan Mental Health Code (MMHC) requirements.

To incorporate best practices and optimize level of care placement protocols member CMHSPs utilize MCG Indicia as a guide alongside other standardized assessments, such as LOCUS, MichiCANS, ASAM Continuum etc.

The goal is to improve the overall quality of consumer outcomes, as well consistency in the amount, scope, and duration of services. A monitoring tool will be created in PCE by March of 2026, to allow for adequate monitoring and trending by service, provider, and standard.

Training on Quality Oversight and Utilization Alignment is scheduled for 3/2026. New ASAM IV edition implementation is scheduled to start in calendar year 2026.

Trending

NMRE developed reports to monitor, trend, and review SUD admissions, level of care, and service utilization by county and provider in the NMRE region. These reports are provided to the NMRE SUD Oversight Committee on a regular basis and are available on NMRE.org website at County Admission Reports | NMRE .

HSW Monthly service utilization reports are generated and shared with CMHSPs on a monthly basis, in order to monitor the provision of services agreed upon in the IPOS. The NMRE is also utilizing Power BI reporting for 1915(i) SPA Potential Enrollees, making sure beneficiaries with certain service codes are properly enrolled into waivers.

Additional analyses will be conducted for areas with significant variation in utilization patterns to identify root causes and opportunities for improvement. The NMRE will develop an internal process for timely authorization denials, as well es exceptions and extensions.

Compensation to individuals or entities that conduct utilization management activities will not be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

13. Regional Trainings

The NMRE continues to collect feedback from its member CMHSPs and SUD Providers, as well as record areas of improvement during site visits, and continues to conduct or fund a series of trainings to aid in process improvement as well as overall compliance.

SUD providers are supported in Co-occurring and Women Specialty Services training needs, while CMHSPs are offered Documentation Standards and Clinical Compliance, Person Centered Planning, and Quality Oversight and Utilization Alignment, all based on documented and reported needs.

14. Maintaining the Handbook

The NMRE will obtain MDHHS approval, in writing, prior to publishing the original and revised editions of its member handbook. The NMRE will use MDHHS-developed model member handbooks and member notices and ensure that its member handbook and member notices include all MDHHS-developed template language. The NMRE, and any delegates performing activities on behalf of the NMRE, will ensure that all written materials available for potential members and members use a font size at least 12-point bold font (conspicuously visible), and are written at or below the 6.9 grade reading level based on Flesch-Kincaid score.

15. Adverse Benefit Determination

The NMRE will ensure that each ABD notice meets federal and state-specific requirements, as well as content requirement, and is written at or below the 6.9 reading grade level. The NMRE will conduct training and quarterly monitoring of its provider network to measure compliance. Additionally, scheduled annual on-site monitoring will continue to include ABD review and monitoring.

To strengthen compliance and optimize level of care decision making with best practices and care guidelines, NMRE implemented MCG Indicia in December of 2025 across all five member CMHSPs. Indicia will be utilized in the ABD process as well.

Improvements made to the ABD Form in PCE EHR have been implemented and are expected to contribute to further compliance with the rules.

16. Stakeholder Engagement and Input

Stakeholder input is of high importance for continued improvement and guides change processes. The NMRE continuously analyzes feedback received from those who currently receive services, who received services in the past, families and support systems, advocates, contracted providers, community partners, coalitions etc.

Grievance and appeals as well as consumer satisfaction surveys are utilized as a source of stakeholder input. Frequent meetings and committees are another platform for feedback to be collected.

NMRE also hosts a Day of Education for its beneficiaries and interested parties. The Day of Education is an annual conference that provides behavioral health beneficiaries with education on relevant topics to their well-being. Topics are selected with beneficiary input.

Northern Michigan Regional Entity
Medicaid Encounter Verification Audit
Results for FY25

	Number Valid	Number Audited	Valid Dollar Amount	Total Dollar Amount Audited
Row Labels	**Sum of VALID**	**VALID2**	**Sum of VALID COST**	**Sum of LineSubmittedChargesPd**
Centra Wellness Network	73	80	$ 22,785.98	$ 24,771.27
North Country CMH	76	80	$ 14,344.12	$ 15,339.72
Northeast Michigan CMH	77	80	$ 19,425.65	$ 19,632.34
Northern Lakes	76	80	$ 24,802.48	$ 26,138.17
SUD-ADDICTION TREATMENT SERVICES	33	40	$ 6,021.88	$ 7,426.92
SUD-BASES	4	4	$ 497.58	$ 497.58
SUD-BEAR RIVER HEALTH	15	40	$ 1,834.05	$ 5,711.63
SUD-CATHOLIC HUMAN SERVICES	9	12	$ 986.77	$ 1,270.73
SUD-DOT CARING CENTERS, INC.	1	1	$ 226.65	$ 226.65
SUD-HARBOR HALL	5	5	$ 1,133.25	$ 1,133.25
SUD-HARBOR HALL INC.	32	35	$ 5,002.14	$ 5,569.18
SUD-MICHIGAN THERAPEUTIC CONSULTANTS PC	1	1	$ 19.00	$ 19.00
SUD-MTC	18	18	$ 461.55	$ 461.55
SUD-NMSAS RECOVERY CENTER	19	19	$ 775.89	$ 775.89
SUD-SUNRISE CENTRE	5	5	$ 843.94	$ 843.94
Wellvance	78	80	$ 20,126.53	$ 21,126.53
Grand Total	**522**	**580**	**$ 119,287.46**	**$ 130,944.35**
		90%		**91%**

	Number Valid	Number Audited	Total Dollar Amount Audited	Valid Dollar Amount	% Valid encounters
Row Labels	**Sum of VALID**	**Count of VALID2**	**Sum of LineSubmittedChar**	**Sum of VALID COST**	
Centra Wellness Network	**73**	**80**	**$ 24,771.27**	**$ 22,785.98**	91%
CMH Contracted Services	33	40	$ 14,543.46	$ 12,558.17	83%
CMH Direct Services	40	40	$ 10,227.81	$ 10,227.81	100%
North Country CMH	**76**	**80**	**$ 15,339.72**	**$ 14,344.12**	95%
CMH Contracted Services	38	40	$ 6,941.62	$ 6,243.68	95%
CMH Direct Services	38	40	$ 8,398.10	$ 8,100.44	95%
Northeast Michigan CMH	**77**	**80**	**$ 19,632.34**	**$ 19,425.65**	96%
CMH Contracted Services	38	40	$ 9,414.30	$ 9,234.65	95%
CMH Direct Services	39	40	$ 10,218.04	$ 10,191.00	98%
Northern Lakes	**76**	**80**	**$ 26,138.17**	**$ 24,802.48**	95%
CMH Contracted Services	37	40	$ 14,724.60	$ 13,919.62	93%
CMH Direct Services	39	40	$ 11,413.57	$ 10,882.86	98%
SUD-ADDICTION TREATMENT SERVICES	**33**	**40**	**$ 7,426.92**	**$ 6,021.88**	83%
SUD top 3	33	40	$ 7,426.92	$ 6,021.88	83%
SUD-BASES	**4**	**4**	**$ 497.58**	**$ 497.58**	100%
SUD except top 3	4	4	$ 497.58	$ 497.58	100%
SUD-BEAR RIVER HEALTH	**15**	**40**	**$ 5,711.63**	**$ 1,834.05**	38%
SUD top 3	15	40	$ 5,711.63	$ 1,834.05	38%
SUD-CATHOLIC HUMAN SERVICES	**9**	**12**	**$ 1,270.73**	**$ 986.77**	75%
SUD except top 3	9	12	$ 1,270.73	$ 986.77	75%
SUD-HARBOR HALL	**5**	**5**	**$ 1,133.25**	**$ 1,133.25**	100%
SUD top 3	5	5	$ 1,133.25	$ 1,133.25	100%
SUD-NMSAS RECOVERY CENTER	**19**	**19**	**$ 775.89**	**$ 775.89**	100%
SUD except top 3	19	19	$ 775.89	$ 775.89	100%
SUD-SUNRISE CENTRE	**5**	**5**	**$ 843.94**	**$ 843.94**	100%
SUD except top 3	5	5	$ 843.94	$ 843.94	100%
SUD-DOT CARING CENTERS, INC.	**1**	**1**	**$ 226.65**	**$ 226.65**	100%
SUD except top 3	1	1	$ 226.65	$ 226.65	100%
SUD-MTC	**18**	**18**	**$ 461.55**	**$ 461.55**	100%
SUD except top 3	18	18	$ 461.55	$ 461.55	100%
SUD-HARBOR HALL INC.	**32**	**35**	**$ 5,569.18**	**$ 5,002.14**	91%
SUD top 3	32	35	$ 5,569.18	$ 5,002.14	91%
Wellvance	**78**	**80**	**$ 21,126.53**	**$ 20,126.53**	98%
CMH Contracted Services	38	40	$ 8,640.76	$ 7,640.76	95%
CMH Direct Services	40	40	$ 12,485.77	$ 12,485.77	100%
SUD-MICHIGAN THERAPEUTIC CONSULTANTS P	**1**	**1**	**$ 19.00**	**$ 19.00**	100%
SUD except top 3	1	1	$ 19.00	$ 19.00	100%
Grand Total	**522**	**580**	**$ 130,944.35**	**$ 119,287.46**	**90%**
				91%	

Northern Michigan Regional Entity
Medicaid Encounter Verification Results
FY25

Total	Number Valid	Number Audited	Valid Dollar Amount	Total Dollar Amount Audited	Percent Valid Number
Row Labels	**Sum of VALID**	**Count of VALID2**	**Sum of VALID COST**	**Sum of LineSubmittedChargesPd**	
CMH Contracted Services	184	200	49596.88	54264.74	92%
CMH Direct Services	196	200	51887.88	52743.29	98%
SUD except top 3	57	60	3811.38	4095.34	95%
SUD top 3	85	120	13991.32	19840.98	71%
Grand Total	**522**	**580**	**119287.46**	**130944.35**	90%
NMRE Contracted SUD	142	180	$ 17,802.70	$ 23,936.32	79%
Grand Total	**522**	**580**	**$ 119,287.46**	**$ 130,944.35**	**90%**

	Number Valid	Number Audited	Valid Dollar Amount	Total Dollar Amount Audited	Percent Valid Number
Row Labels	**Sum of VALID**	**Count of VALID2**	**Sum of VALID COST**	**Sum of LineSubmittedChargesPd**	
1	**130**	**145**	**30248.08**	**32931.26**	**90%**
Centra Wellness Netwo	**20**	**20**	**5937.66**	**5937.66**	**100%**
CMH Contracted Services	10	10	3604.73	3604.73	100%
CMH Direct Services	10	10	2332.93	2332.93	100%
North Country CMH	**20**	**20**	**3041.01**	**3041.01**	**100%**
CMH Contracted Services	10	10	1738.49	1738.49	100%
CMH Direct Services	10	10	1302.52	1302.52	100%
Northeast Michigan CM	**18**	**20**	**5314.83**	**5386.56**	**90%**
CMH Contracted Services	9	10	2247.92	2292.61	90%
CMH Direct Services	9	10	3066.91	3093.95	90%
Northern Lakes	**19**	**20**	**5774.63**	**6025.01**	**95%**
CMH Contracted Services	9	10	3338.89	3589.27	90%
CMH Direct Services	10	10	2435.74	2435.74	100%
NMRE PIHP	**33**	**45**	**4437.21**	**6798.28**	**73%**
SUD except top 3	13	15	706.19	847.53	87%
SUD top 3	20	30	3731.02	5950.75	67%
Wellvance	**20**	**20**	**5742.74**	**5742.74**	**100%**
CMH Contracted Services	10	10	2188.08	2188.08	100%
CMH Direct Services	10	10	3554.66	3554.66	100%
2	**126**	**145**	**29620.99**	**33165.96**	**87%**
Centra Wellness Netwo	**17**	**20**	**6091.1**	**6458.97**	**85%**
CMH Contracted Services	7	10	3302.54	3670.41	70%
CMH Direct Services	10	10	2788.56	2788.56	100%
North Country CMH	**19**	**20**	**2730.59**	**3301.65**	**95%**
CMH Contracted Services	9	10	1383.98	1955.04	90%
CMH Direct Services	10	10	1346.61	1346.61	100%
Northeast Michigan CM	**19**	**20**	**5126.52**	**5261.48**	**95%**
CMH Contracted Services	9	10	2093.8	2228.76	90%
CMH Direct Services	10	10	3032.72	3032.72	100%
Northern Lakes	**18**	**20**	**6551.31**	**7105.91**	**90%**
CMH Contracted Services	8	10	4135.31	4689.91	80%
CMH Direct Services	10	10	2416	2416	100%
NMRE PIHP	**33**	**45**	**4422.6**	**6339.08**	**73%**
SUD except top 3	14	15	1002.32	1144.94	93%
SUD top 3	19	30	3420.28	5194.14	63%
Wellvance	**20**	**20**	**4698.87**	**4698.87**	**100%**
CMH Contracted Services	10	10	2142.54	2142.54	100%
CMH Direct Services	10	10	2556.33	2556.33	100%
3	**134**	**145**	**32716.12**	**34849.84**	**92%**
Centra Wellness Netwo	**20**	**20**	**6589.39**	**6589.39**	**100%**
CMH Contracted Services	10	10	3709.39	3709.39	100%
CMH Direct Services	10	10	2880	2880	100%
North Country CMH	**17**	**20**	**4500.72**	**4925.26**	**85%**
CMH Contracted Services	9	10	1881.62	2008.5	90%
CMH Direct Services	8	10	2619.1	2916.76	80%
Northeast Michigan CM	**20**	**20**	**4525.62**	**4525.62**	**100%**
CMH Contracted Services	10	10	2546.24	2546.24	100%
CMH Direct Services	10	10	1979.38	1979.38	100%
Northern Lakes	**20**	**20**	**6512.4**	**6512.4**	**100%**
CMH Contracted Services	10	10	3892.6	3892.6	100%
CMH Direct Services	10	10	2619.8	2619.8	100%
NMRE PIHP	**38**	**45**	**5356.99**	**6566.17**	**84%**
SUD except top 3	15	15	1012.41	1012.41	100%
SUD top 3	23	30	4344.58	5553.76	77%
Wellvance	**19**	**20**	**5231**	**5731**	**95%**
CMH Contracted Services	9	10	1438.38	1938.38	90%
CMH Direct Services	10	10	3792.62	3792.62	100%
4	**132**	**145**	**26702.27**	**29997.29**	**91%**
Centra Wellness Netwo	**16**	**20**	**4167.83**	**5785.25**	**80%**
CMH Contracted Services	6	10	1941.51	3558.93	60%
CMH Direct Services	10	10	2226.32	2226.32	100%
North Country CMH	**20**	**20**	**4071.8**	**4071.8**	**100%**
CMH Contracted Services	10	10	1239.59	1239.59	100%
CMH Direct Services	10	10	2832.21	2832.21	100%
Northeast Michigan CM	**20**	**20**	**4458.68**	**4458.68**	**100%**
CMH Contracted Services	10	10	2346.69	2346.69	100%
CMH Direct Services	10	10	2111.99	2111.99	100%
Northern Lakes	**19**	**20**	**5964.14**	**6494.85**	**95%**
CMH Contracted Services	10	10	2552.82	2552.82	100%
CMH Direct Services	9	10	3411.32	3942.03	90%
NMRE PIHP	**38**	**45**	**3585.9**	**4232.79**	**84%**
SUD except top 3	15	15	1090.46	1090.46	100%
SUD top 3	23	30	2495.44	3142.33	77%
Wellvance	**19**	**20**	**4453.92**	**4953.92**	**95%**
CMH Contracted Services	9	10	1871.76	2371.76	90%
CMH Direct Services	10	10	2582.16	2582.16	100%
Grand Total	**522**	**580**	**119287.46**	**130944.35**	**90%**

	Valid Code is Included in PIHP/MDHHS Contract	Total Code is Included in PIHP/MDHHS Contract	Valid Beneficiary is Eligibile for Medicaid on the Date of Service	Total Beneficiary is Eligibile for Medicaid on the Date of Service	Valid Service Was Authorized in IPOS/Treatment Plan	Total Service Was Authorized in IPOS/Treatment Plan	Valid Date and Time is Documented	Total Date and Time is Documented	Valid Service was Provided by a Qualified Practitioner That Falls Within Their Scope of Practice	Total Service was Provided by a Qualified Practitioner That Falls Within Their Scope of Practice	Valid Amount Paid Does Not Exceed Contracted Rate of PIHP/CMHSP Contract	Total Amount Paid Does Not Exceed Contracted Rate of PIHP/CMHSP Contract	Valid Appropriate Units Were Reported, for Unit-Based Services	Total Appropriate Units Were Reported, for Unit-Based Services	Valid Client Signature was on the IPOS/Treatment Plan	Total Client Signature was on the IPOS/Treatment Plan
Centra Wellness Network	80	80	80	80	79	80	74	80	79	80	80	80	76	80	80	80
North Country CMH	80	80	80	80	80	80	77	80	80	80	80	80	80	80	79	80
Northeast Michigan CMH	80	80	80	80	80	80	79	80	79	80	80	80	80	80	78	80
Northern Lakes	80	80	80	80	80	80	80	80	80	80	80	80	79	80	77	80
SUD-ADDICTION TREATMENT SERVICES	40	40	40	40	33	40	40	40	40	40	40	40	40	40	40	40
SUD-BASES	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
SUD-BEAR RIVER HEALTH	40	40	40	40	40	40	40	40	40	40	40	40	40	40	15	40
SUD-CATHOLIC HUMAN SERVICES	12	12	12	12	10	12	12	12	12	12	12	12	12	12	11	12
SUD-DOT CARING CENTERS, INC.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
SUD-HARBOR HALL	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
SUD-HARBOR HALL INC.	35	35	35	35	32	35	35	35	35	35	35	35	35	35	35	35
SUD-MICHIGAN THERAPEUTIC CONSULTANTS PC	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
SUD-MTC	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
SUD-NMSAS RECOVERY CENTER	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19
SUD-SUNRISE CENTRE	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Wellvance	80	80	80	80	78	80	80	80	80	80	80	80	80	80	79	80
Grand Total	**580**	**580**	**580**	**580**	**565**	**580**	**570**	**580**	**578**	**580**	**580**	**580**	**575**	**580**	**547**	**580**
		100%		**100%**		**97%**		**98%**		**100%**		**100%**		**99%**		**94%**

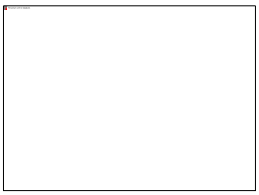
Northern Michigan Regional Entity
Region 2
Medicaid Encounter Verification Report
Fiscal Year 2025

Introduction:

The Northern Michigan Regional Entity (NMRE) is under contract with the Michigan Department of Community Health (MDHHS) as a Prepaid Inpatient Health Plan (PIHP). The NMRE manages Medicaid behavioral health services for substance uses disorder providers and five-member Community Mental Health (CMH) Boards within our twenty-one-county region; AuSable Valley Community Mental Health d.b.a. Wellvance, Manistee-Benzie Community Mental Health d.b.a. Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health, and Northern Lakes Community Mental Health. This verification includes CMHSP (direct and contracted services), and Substance Use Disorder (contracted services), as directed by the MDHHS Contract, Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration- Medicaid Verification Process. The content of the report is presented in the following sections as specified in the technical Requirements:

I. Sampling Methodology
II. Provider Summary including:
- Population of providers
- Number of providers tested
- Number of providers put on corrective action plans
- Number of providers on corrective action for repeat/continuing issues
- Number of providers taken off corrective action plans
- Population of claims/encounters tested (units & dollar value)
- Claims/Encounters tested (units & value)
- Invalid claims/encounters identified (units & dollar value)

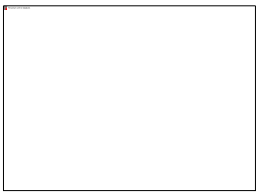
III. NMRE Summary



I. Sampling Methodology

If an audited sample yields less than 95% accuracy, a Plan of Correction will be required. If an audited population falls below 90% accuracy during a 12-month period, a stratified sample will be pulled, and a Plan of Correction will be required. The following is an outline of the populations and samples to be audited:

- CMHSP Direct Provided Services Population (5 Providers Total)
  - ✓ 40 Services per year, 10 per Quarter
- CMHSP Subcontractors Provided Services Population (5 Providers Total)
  - ✓ 40 Services per year, 10 per Quarter
- SUD Provider Population (1 Provider Total)
  - ✓ 60 Services per year, 15 per Quarter
- Financially Significant Population (3 SUD, 0 CMHSP)
  - ✓ 40 Services per year, 10 per Quarter
  - ✓ Any single provider that accounts for more than 10% of the total MH or SUD budgets accordingly.
- Stratified Population-if review yields less than 90% accuracy



II. Provider Summary:

1. Audit Criteria
   - Codes approved under contract.
   - Eligibility of the beneficiary on the date of service.
   - Service is included in the beneficiaries individual Plan of Service.
   - Date and time of service is provided
   - Service provided by a qualified practitioner.
   - Amount Paid does not exceed the payer (PIHPCMHSP) contracted amounts
     Per Technical Reporting Requirement
     a. Population of providers
     b. Number of providers tested
     c. Dollars audited
     d. Claims/Encounters tested
     e. Invalid claims/encounters identified

Five (5) CMHSP Review Summary- see attachment for detailed report

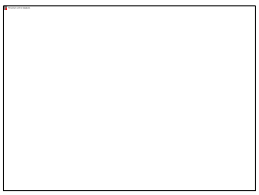
a. For the detail population of providers see Sampling Methodology above.
b. 5 Providers audited (CMH Contracted Services and CMH Direct Services)
c. $130,944.35 dollars audited with $119,287.46 dollars validated.
d. 580 encounters audited and 522 were valid.
e. $11,656.89 dollars invalid

95% of total CMHSP encounters were in compliance. CMHSP Direct Service encounters were 98% compliant, while CMHSP Contracted Service encounters were 92% compliant.

Nine (9) SUD Provider Review Summary-see attachment for detailed report

a. For the detail population of providers see Sampling methodology above.
b. 9 SUD Providers total audited
c. $23,936.32 dollars audited with $17,802.7 dollars validated.
d. 180 encounters audited and 142 were valid.
e. $6,133.62 dollars invalid

79% of total SUD Provider encounters were in compliance.



The Medicaid Encounter Verification Audit for FY25 will result in a few plans of correction which will be due to the NMRE 30 days after the final MEV report is received by the providers. It is noted that many providers struggled with the following issues:

1. On-going staff shortage within the NMRE region, as well as staff turnover.
2. Highest trend across the NMRE region was invalid client signatures on IPOS/Individualized Treatment Plan (ITP). Out of 580 total IPOSs/ITPs reviewed, 547 client signatures were able to be validated, which equals 94% of validated signatures. The Provider noted as having the highest percentage of invalid signatures in FY24 continues that trend despite the CAP they have been placed on last year, as well as QIP a year prior. Additional measures will be discussed in order to remediate this issue.

III. NMRE Summary- see attachments for detailed report

Grand totals for the NMRE's FY24 MEV Audit were as follows:

a. For the detail population of providers see Sampling Methodology above.
b. 14 CMHSPs/SUD Providers in total were audited
c. $130,944.35 dollars was audited with $119,287.46 dollars validated resulting in a compliance rate of 91% of total dollar amount audited.
d. 580 encounters audited with 522 encounters validated.
e. $11,656.89 dollars and 58 encounters were found to be invalid.

This results in a 1% increase from FY24. Throughout the Fiscal Year FY25, NMRE conducted training on billing, EDV, technical requirements, as well as IPOS training. Additionally, series of training are scheduled January – March 2026 to address all deficiencies noted.