Northern Michigan Regional Entity

Board Meeting

May 27, 2026

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – April 22, 2026	Pages 2 - 7
7.	Correspondence	Pages 8 – 56
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – May 2026	Page 57
	c. Financial Report – March 2026	Pages 58 – 79
	d. Operations Committee Report – May 19th	Pages 80 – 84
	e. NMRE SUD Oversight Board Report – May 4th	Pages 85 – 89
11.	New Business - None	
	a. Liquor Tax Request (1)	Pages 90 – 97
12.	Old Business	
	a. CMHSP Updates	
	b. PIHP Contract Dispute COC Update	Pages 98 – 137
	c. Legal Actions Related to PIHP Bid Out	
13.	Presentation	
	MDHHS Michigan Medicaid Program Updates Nicole Hudson, Director, Office of Oversight & Program Coordination Katie Commey, Director, Policy Integration & Evaluation Division	Pages 138 – 164
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – June 24, 2026 at 10:00AM	
16.	Adjourn	

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NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – APRIL 22, 2026
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Dave Freedman, Ron Iseler, Dana Labar, Eric Lawson, Mary Marois, Michael Newman, Jay O'Farrell, Ruth Pilon, Don Smeltzer, Mark Surbrook, Don Tanner**
VIRTUAL ATTENDEES:	**Chuck Varner (Mio)**
ABSENT:	**Ed Ginop, Karen Goodman**
NMRE STAFF/CMHSP CEOs:	**Bea Arsenov, Brian Babbitt, Brady Barnhill, Jodie Balhorn, Carol Balousek, Lisa Hartley, Brooke Kleinert, Eric Kurtz, Brie Molaison, Trish Otremba, Pamela Polom, Nena Sork, Denise Switzer, Chris VanWagoner, Deanna Yockey, Lynda Zeller**
PUBLIC:	**Anonymous (3), Angie Balberde, Erin Barbus, Cindy Evans, Sarah Garthe, Sarah Hegg, Terri Henderson, Larry LaCross, Katie Lorence, Rob Palmer, Kim Rappleyea, Nancy Rhue**

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

ROLL CALL
Let the record show that Ed Ginop and Karen Goodman were excused from the meeting on this date. All other 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 APRIL 22, 2026; SUPPORT BY DON SMELTZER. MOTION CARRIED.

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

MOTION BY DON TANNER TO APPROVE THE MINUTES OF THE MARCH 25, 2026 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY DON SMELTZER. MOTION CARRIED.

CORRESPONDENCE

1) A Detroit News opinion dated March 31, 2026, by Alan Bolter, Chief Executive Officer of the Community Mental Health Association of Michigan (CMHA), titled "MDHHS Mental Health Plan Adds Bureaucracy, Not Care."
2) Communication from CMHA dated January 26, 2026, regarding the 2026 Annual PAC Campaign.
3) Document from the CMHA Guidance Group and its subgroup titled, "CMHA Advocacy Strategy Post Court Decision and Withdrawal of Initial RFP: CMHA System Strengthening and Improvement Initiative."
4) Summary Disposition dated April 8, 2026 from Judge Christopher Yates in the Michigan Court of Claims Case #25-000143-MB (Region 10 PIHP, Southwest Michigan Behavioral Health, Mid-State Health Network, St. Clair County Community Mental Health Association, Integrated Services of Kalamazoo, and Saginaw County Community Mental Health Authority vs. State of Michigan, Michigan Department of Health and Human Services, Michigan Department of Technology, Management, and Budget) allowing MDHHS to reduce the number of PIHPs in the state from 10 to three.
5) Summary Disposition dated April 14, 2026 from Judge Christopher Yates in the Michigan Court of Claims Case #25-000143-MB (Region 10 PIHP, Southwest Michigan Behavioral Health, Mid-State Health Network, St. Clair County Community Mental Health Association, Integrated Services of Kalamazoo, and Saginaw County Community Mental Health Authority vs. State of Michigan, Michigan Department of Health and Human Services, Michigan Department of Technology, Management, and Budget) and #25-000162-MB (Centra Wellness Network, Northeast Michigan Community Mental Health Authority, Wellvance, Gogebic Community Mental Health Authority, North Country Community Mental Health Authority, and Manistee County vs. State of Michigan, Michigan Department of Health and Human Services, Michigan Department of Technology, Management, and Budge) concluding that both cases have been rendered moot due to the cancellation of the original Request for Proposals.
6) House Oversight Subcommittee on Public Health & Food Security report on the Michigan Behavioral Health System.
7) The NMRE regional Performance Indicator report for Quarter 1 of Fiscal Year 2026.
8) Flyer promoting the NMRE's Day of Education at Treetops Resort in Gaylord on May 15, 2026.
9) The draft minutes of the April 15, 2026, regional Finance Committee meeting.

Mr. Kurtz drew attention to the article by Alan Bolter, CEO of CMHAM, in opposition to the state's Mental Health Framework initiative.

Mr. Kurtz next drew attention to the NMRE's Annual Day of Education at Treetops Resort on May 15th.

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 March Board Meeting.

CEO Report

The NMRE CEO Monthly Report for April 2026 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to the hearing in the Michigan Court of Claims on April 9th in (case #24-000198-MZ) the matter between North Care Network, Northern Michigan Regional Entity, the Community Mental Health Partnership of Southeast Michigan, and Region 10 PIHP (Plaintiffs) against the State of Michigan, the State of Michigan Department of Health and Human Services, and Elizabeth Hertel, in her official capacity (Defendants) regarding the FY25 PIHP Contract. This topic will be discussed under "Old Business."

February 2026 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $5,430,882. Carry forward was reported as $2,844,054. The total Medicaid and HMP current year surplus was reported as $8,274,936. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $28,865,025.
- Traditional Medicaid showed $96,521,932 in revenue, and $90,337,684 in expenses, resulting in a net surplus of $6,184,248. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $2,844,054.
- Healthy Michigan Plan showed $11,227,933 in revenue, and $11,981,299 in expenses, resulting in a net deficit of $753,366. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $1,310,689 in revenue, and $1,143,938 in expenses, resulting in a net surplus of $166,751.
- SUD showed all funding source revenue of $9,176,430 and $7,951,132 in expenses, resulting in a net surplus of $1,225,298. Total PA2 funds were reported as $4,588,666.

PA2/Liquor Tax was summarized as follows:

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

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,142,821	$0	$554,155	$4,588,666

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$646,789	$1,624,163	$1,576,554	($504,258)	$2,129,385
HMP	($189,442)	($151,963)	$155,551	($1,037,116)	($135,160)
Total	$457,347	$1,472,200	$1,732,105	($1,541,374)	$1,994,225

Revenue remains flat and stable (similar to September 2025). Milliman's FY26 projections were higher in both revenue and eligibles. An analysis of the impact will be shared with Keith White in the actuarial division of MDHHS.

Healthy Michigan Plan eligibles through March 31, 2926, are 15% lower than Milliman projections, accounting for $5.4M in lost revenue. DAB and TANF eligibles fell 1.96% and 7.13% respectively, accounting for an additional $5,445,243 in lost revenue.

The $2.8M FY25 carry forward will change at the end of April with final numbers from Northern Lakes. The NMRE's ISF is currently funded $1.1M beyond 7.5% of the total Medicaid capitation.

Mr. Freedman asked what the blacked-out cells in the financial report represent. Ms. Yockey responded that the cells are null but cannot be deleted due to formula calculations.

No PA2 payments have been received thus far for FY26. The Quarter 1 payments were used by the Michigan Department of Treasury to pay on debt. Quarter 2 payments are expected at the end of April. It was noted that the NMRE maintains a balance equivalent to one year's receipts for each county. Mr. O'Farrell agreed to raise the PA2 payment issue during an upcoming meeting of the Michigan Association of Counties (MAC).

Eligibility dipped from September 2025 to October 2025 but has stayed fairly consistent since then.

MOTION BY DON TANNER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR FEBRUARY 2026; SUPPORT BY DAVE FREEDMAN. MOTION CARRIED.

Operations Committee Report
The draft minutes from the April 21, 2026, Operations Committee meeting were distributed to Board Members on this date. Much of the meeting centered around the FY26 Performance Bonus Incentive Program findings. This was discussed in detail under the "Presentation" agenda item.

Updates on the Contract Dispute lawsuit (COC #24-000198-MZ) and RFP-related lawsuits (COC #25-000143-MB and COC #25-000162-MB) were provided under "Old Business." The benefits and drawbacks of signing and submitting the FY26 Contract (as written) were discussed. The 7.5% ISF cap is the only remaining issue for the NMRE.

A mental health campus in Northern Michigan, proposed National Alliance on Mental Illness (NAMI) Grand Traverse and other advocates, is gaining legislative support. The Northern Michigan Mental Health Campus (potentially located in Kalkaska) would provide the region with 42 to 52 inpatient and residential beds, and evidence-based mental health therapies and would cost approximately $25M.

NMRE SUD Oversight Committee Report
Let the record show that the next meeting is scheduled for May 4, 2026, at 10:00AM.

<u>NEW BUSINESS</u>
Let the record show that there was no "New Business" on the agenda for the meeting on this date.

OLD BUSINESS

CMHSP Updates

All five CMHSPs will be involved in May is Mental Health Month Activities.

- Centra Wellness
  A search for a new Executive Director and Chief Financial Officer is underway
- North Country
  An Autism Awareness walk is being held on April 26th in Boyne City. A Color Run is taking place on May 30th in Petoskey.
- Northeast Michigan
  2K, 5K, and 10K Runs/Walks are being held on May 16th in Alpena.
- Northern Lakes
  Traverse House Clubhouse is having a 30-year Anniversary Celebration on May 28th in Traverse City.
- Wellvance
  A Mental Health America Bell Seal for Workplace Mental Health was awarded to Wellvance for having a mentally healthy workplace. The 6th Annual Mond Matters event is being held on May 16th in East Tawas.

PIHP Contract Dispute – COC Update

A motion hearing took place on April 9th in Michigan Court of Claims Case #24-000198-MZ regarding the FY25 PIHP Contract.

The Attorney General's office argued that the Plaintiffs have no standing to dispute the FY25 contract since it was not signed. Attorney Chris Ryan (Taft, Stettinius & Hollister) reviewed the three areas of dispute (Waskul settlement, CCBHCs, and 7.5% ISF cap.)

A decision regarding whether Plaintiffs can move forward with the lawsuit will be made by Judge Sima Patel.

Mr. Kurtz noted that the PIHP Contract Negotiations Committee disbanded a few years ago; currently, the PIHPs have no input into contract language.

Legal Actions Related to the PIHP Bid Out

A hearing took place on April 13, 2026, on the Attorney General's motion to dismiss the lawsuits filed against the State related to the PIHP bid out (#25-000143-MB and #25-000162MB).

Judge Christopher Yates issued a Summary Disposition on April 14, 2026, concluding that both cases have been rendered moot due to the cancellation of the original Request for Proposals. A decision is expected regarding whether the case will be dismissed with or without prejudice. If the case is dismissed without prejudice, the Plaintiffs are allowed to refile the lawsuit later.

The state has indicated plans to issue a new RFP, likely in May.

It was noted that the names of applicants/bidders from the previous RFP have not been released despite FOIA requests.

PRESENTATION

Performance Bonus Incentive Program (PBIP)

NMRE Chief Clinical Officer, Bea Arsenov, updated the Board on the FY25 Performance Bonus Incentive Program (PBIP) scoring.

Ms. Arsenov explained that unearned funds for a performance metric were distributed to the PIHP(s) that achieved full points on that metric, proportionally based on their original withhold amounts. For metrics with multiple deliverables scored separately, if no PIHP achieved full points on one deliverable, the unearned funds for that deliverable were distributed to the PIHP(s) that achieved full points on the other deliverable(s) within the same metric.

Total NMRE Withhold	Total NMRE Withhold Unearned	Total Distribution of Unearned (from PIHPs that didn't score points)	Grand Total NMRE Earned
$1,913,249.57	$436,029.56	$1,295,481.76	$2,772,701.77

The metrics related to Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) were not met as NMRE does not have access to the data set. The metrics require PIHPs to intervene at 14 and 34 days post diagnosis; however, claims don't hit the PIHPs for 90 days. Only one PIHP in the state met the metric (Southeast) because of its unique structure within Emergency Departments (embedded clinic) and relationship with the University of Michigan.

Mr. Labar applauded Ms. Arsenov and her Team for the performance and analysis related to PBIP. Ms. Arsenov responded that the credit goes to all the providers in the region (CMHSPs and SUD).

Ms. Arsenov drew attention to scoring changes to the FY26 PBIP. In the "Contractor-only Measures," one metric moved a point value of 40 to 50, another metric moved to a point value of 20 to 40, and one metric moved to a point value of 40 to 10 points, with a 1% benchmark change.

During the April 21st meeting, the regional Operations Committee moved to retain $100K of the PBIP funds for evidence-based and rural best practices research. Payments will be sent to the CMHSPs on May 1st, proportionate to PM/PM, as follows:

NMRE (SUD)	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
$209,105	$222,790	$674,025	$404,695	$803,516	$358,572

It was noted that the CMHSPs can use PBIP funds as local dollars. The NMRE is one of only a few PIHPs in the state that shares PBIP funds with its Member CMHSPs rather than retaining the full amount.

COMMENTS

Board

Mr. Freedman wished everyone a Happy Earth Day.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on May 27, 2026.

ADJOURN

Let the record show that Mr. Lawson adjourned the meeting at 11:31AM.

Email Correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter; David Lowe
Subject:	Core components of a strengthened and improved public mental health system in Michigan - as approved by CMHA Board od Directors
Date:	Thursday, May 14, 2026 1:14:54 PM
Attachments:	Safe Attachments Scan In Progress.msg

To: CMHA Officers; CMHA Board of Directors; CEOs of CMHs, PIHPs, and Provider Alliance members
CC: Members of the CMHA Steering Committee; CMH & PIHP Board Chairpersons
From: Alan Bolter, Incoming CEO, & Robert Sheehan, CEO, CMH Association of Michigan
Re: Core components of a strengthened and improved public mental health system in Michigan - as adopted by CMHA Board of Directors

BACKGROUND: You may remember that, with the recent decision by Judge Yates, halting the MDHHS RFP process, CMHA initiated an effort to build a set of core components of an improved public mental health system in Michigan – **components that, in addition to strengthening the system, will work to privatization-proof the system**. You may also remember that this effort started in the summer of 2025 with the development of an initial document (shared with you and the full CMHA membership), developed by CMHA in partnership with the coalition members who joined us in opposing the RFP process. That coalition included NAMI-Michigan, Arc-Michigan, Michigan Association of Counties, and CMHA.

Using the document developed by this coalition as a starting point, CMHA worked with a "CMHA Guidance Group" - a large and diverse group of CEOs representing CMHA's CMHSP, PIHP, and Provider Alliance members. These members included: Jeff Patton, Cameron Bullock, Bill Ward, Dan Russell, Annette Downey, Chip Johnston, Ric Compton, Matt Maskart, Julia Rupp, Connie Conklin, Tammy Warner, Wil Morris, James White, Traci Smith, Dana Lasenby, Megan Rooney, Eric Kurtz, Joe Sedlock, Carol Mills, Brian Babbitt, Mila Todd, Mandy Padget, Sandra Lindsey, Sam Price, Trish Cortes, Mike Thompson, Fi Spalvieri, Ronnie Tyson, and Jeff Brown.

Additionally, a subgroup of the larger Guidance Group, representing Provider Alliance leadership, and CMHSP, and PIHP CEO representatives, developed a set of recommendations centered around the relationship between the state's CMHSPs/PIHPs and the private providers in their networks. These members included : Mila Todd, Tammy Warner, Traci Smith, Cameron Bullock, Mike Thompson, Ronnie Tyson, Sam Price, Fi Spalvieri, Annette Downey, and Jeff Brown.

The attached Core Components document is the result of the work of these two CMHA-member groups.

CMHA BOARD OF DIRECTORS APPROVES CORE CONCEPTS DOCUMENT: During the early part of May, the members of the CMHA Board of Directors reviewed and approved (via electronic document distribution and voting) this document. CMHA staff will walk through this document and the advocacy efforts which will be based on this document during the June 8, 2026 meeting of the CMHA Board of Directors.

Additionally, between now and the June 8 CMHA Board meeting, we will providing updates on the advocacy efforts founded on this document.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan

Community Mental Health Association of Michigan

Recommended core components of a strengthened and improved public mental health system in Michigan [1]

As adopted by the CMHA Board of Directors May 2026

Origin and purpose of document: This document was developed by the CMHA Guidance Group, a large group representing CMHA's diverse membership of CMHSPs, PIHPs, and private provider organizations. The document is designed to provide a preliminary structure around which the advocacy for more robust and system redesign effort would be designed and pursued, collectively by a broad and diverse coalition of stakeholders.

Opening caveat – centrality of CMHSPs to public system: These components are founded upon the role of the state's Community Mental Health Services Programs (CMHSPs), as defined in the Michigan Mental Health Code as a underscored by Judge Yates in the Region 10 et al vs State of Michigan. In this role, the state's CMHSPs are the core community-based providers and managers of the network of other providers, of services to persons with mental illness, emotional disturbance, intellectual and developmental disabilities, or substance use disorders.

A. Defining public nature and roles of PIHPs (Michigan's Medicaid behavioral health plans) and CMHSPs

1. All of Michigan's Medicaid behavioral health plans [also known, in federal terms as Prepaid Inpatient Health Plans (PIHPs)] should be public/governmental bodies formed via collaboration of the counties, in the region which they are designed to serve, and the state of Michigan. They can be formed via: multi-county authority, Urban Cooperation Act, or Regional Entity section of the Michigan Mental Health Code.

2. The statutorily-defined authorities, responsibilities, functions, and roles of the CMHSPs will not be encroached upon, including by the PIHPs (absent mutual agreement), or by the State of Michigan via contract requirements and policies issued by the State of Michigan.

3. The PIHPs shall not circumvent the authority of the counties in the region which they are designed to serve.

[1] When the terms public mental health or public behavioral health system are used in this document, they reflect the state's CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks – a system which includes services to persons with mental illness, emotional disturbance, intellectual and developmental disabilities, and/or substance use disorder services.

4. The number and size of regions served by the PIHPs should be structured, by the counties and CMHSPs which form them, to ensure: local guidance and responsiveness to local needs, effective management capacity, , and low administrative costs (with greatest level of funding, as possible, dedicated to service delivery), while avoiding dominance in relationships with state policymakers by any one PIHP.

5. There should be no more than one PIHP per defined region to ensure efficiency and effective management capacity.

6. PIHPs should have a well-defined and focused administrative role that ensures the statutory roles and responsibilities of the state's CMHPs. The PIHP roles would include: ensuring high levels of performance and compliance with federal and state requirements by the CMHSPs in the region and providers in its network; and distributing Medicaid funds to CMHSPs within the PIHP's region.

B. Balancing uniformity of service array while ensuring community and person- specific variance

1. The system should ensure uniformity, to the greatest extent possible, 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.

C. Aligning governance with distinct sets of stakeholders

1. The board of directors of the PIHPs should reflect the voices of several distinct sets of key stakeholders:
    - Those individuals served by the region's public mental health system
    - Representatives of the communities served by region's public mental health system

2. Echoing the Michigan Mental Health Code's requirements related to board make up, at least 1/3 of the members of the board of directors of a PIHPs must be persons with lived experience in the receipt of behavioral health service and who live in the region served by the PIHP. These persons can be persons served by the CMHSP system, or an equivalent system, or a family member of a person served.

At least 1/2 of this 1/3 (1/6 of the board) must be persons with direct lived experience (often known as "primary consumers" in the receipt of behavioral health service through the CMHSP system or an equivalent system.

3. The public bodies which appoint these board members should be the public entities which hold unique roles and responsibilities in the design and operation of Michigan's community-based mental health system. Those appointing bodies and the unique roles and responsibilities which they hold include:

> County governments hold unique roles and responsibilities, in statute and in practice, in the structure, governance, and financing of Michigan's public mental health system
>
> CMHSPs hold unique roles and responsibilities, including financial risk, in statute and practice, in the structure, governance, and financing of Michigan's public mental health system.

D: Financing model, risk sharing, and ability to build essential risk reserves

1. The financing of the Michigan behavioral health plan must be in the form of a risk-sharing capitation structure, with the risk sharing structure clearly delineated among the State of Michigan, the PIHP, the CMHSPs, and counties in the region.

2. These capitation payments must be actuarially sound, in accordance with GAAP and GASB, and provide sufficient revenue to the PIHPs and the CMHSPs in their regions to meet the mental health services and supports needs of the residents of their counties.

3. A secondary confirmation of the actuarial soundness of the initial actuarial rate setting should be established by a secondary review by an actuarial firm identified jointly by the public PIHPs and MDHHS. Both sets of actuaries should be required to provide these two parties and other stakeholders with the background documents upon which their actuarial determinations were made. When the two actuarial rate sets do not match, there must be a process including public discussion as to the differences and the resolution of this disagreement. The actuarial rates and projected revenues resulting from this process should be used to drive the annual state appropriations process.

4. An alternative financing design, not a fee-for-service method, will be used by the PIHPs to finance the CMHSPs in their regions.

5. The level of risk reserves allowed to be held by PIHPs and CMHSPs must represent an actuarially sound risk reserve (via a method of ensuring actuarial soundness akin to that outlined above) - thus allowing both of these local public bodies to retain their fiscal stability in this shared risk arrangement.

6. As with any health care, education, governmental, non-profit, or for-profit organization, CMHSPs shall be allowed to hold cost savings, earned incentives, and funds earned through other methods to ensure fiscal stability in light of changing financing and demand factors. As with all fund balances held by CMHSPs and the PIHPs, these reserves must be spent on services to persons with mental health needs, to ensure fiscal stability, and to carry out other statutorily mandated functions of the state's CMHSPs and PIHPs.

7. The fiscal distress of a PIHP or any CMHSP should be addressed jointly by the PIHP, the CMHSP, the county government served by the CMHSP, and the State of Michigan.

8. All of the state's PIHPs and the CMHSPs in their region should be required to provide, on a regular basis, to the counties which formed them, the public, providers in the PIHP's and CMHSP's network, and other stakeholders with a clear lay-person friendly picture of its:

- Financial condition, current and projected
- Service authorization standards and processes
- Service demand patterns

E. Partnership relationship between PIHPs, CMHSPs, and providers in the networks of the health plans and CMHSPs

1. Commitment to increased consistency through uniformity in contract templates, provider costing/rate setting, alternative payment models, billing systems, and data sharing.

2. Commitment to increased transparency through sharing of uniform level of care determinations, funding and fiscal conditions, network adequacy and choice, and changes in direct-run versus contractual services.

3. Commitment to reducing administrative burdens through training reciprocity, streamlining of audit requirements, and consistency in recipient rights processes.

4. Commitment to the value and importance of having an equally strong system for provision of substance use disorder services.

Email Correspondence

From: Info CMHAM
To: Carol Balousek (NMRE)
Subject: Action Alert: Urge Legislators to Support House DHHS Boilerplate Sections 1020-1022
Date: Thursday, May 7, 2026 10:16:05 AM

Recently, the Michigan Department of Health and Human Services (MDHHS) has indicated that it is developing a new PIHP Request for Proposal (RFP) and intends to implement the Mental Health Framework policy by October 1, 2026, despite significant concerns raised by providers, hospitals, CMHs, and stakeholders across the state. Advancing these initiatives without clear legislative direction or broad stakeholder consensus increases the risk of disruption and limits the flexibility of the next administration to evaluate and address the long-term impacts of these changes.

The proposed PIHP RFP and Mental Health Framework would fundamentally restructure the management of a substantial portion of Michigan's Medicaid behavioral health system by shifting greater control to privatized entities. Although these proposals are framed as efforts to improve coordination and access, they raise serious concerns regarding clinical integrity, beneficiary rights, continuity of care, due process protections, and long-term fiscal sustainability.

Throughout the state budget process, we have urged both the House and Senate to include language preventing MDHHS from moving forward with these sweeping changes during the final months of the Whitmer administration. We were encouraged that the House adopted this language in House Bill 5619, the FY27 Omnibus budget, and we must now work to ensure these protections remain in the final negotiated budget.

REQUEST FOR ACTION: We are asking you to contact your House and Senate members and urge them to retain House-passed boilerplate sections 1020, 1021, and 1022 for the Michigan Department of Health and Human Services (MDHHS) in the final budget agreement. As the current administration approaches its conclusion, it is neither prudent nor responsible for MDHHS to pursue major structural changes to Michigan's public mental health system—particularly changes that are likely to increase administrative costs, create additional bureaucracy, and make it more difficult for individuals and families to access needed care.

Please feel free to customize your response as you see fit

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

Action Alert: Urge Legislators to Support House DHHS Boilerplate

Sections 1020-1022

Email Correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter; David Lowe
Subject:	REVISED Statewide FY 26 CMHSP client satisfaction report issued by CMHA's Center for Health Care Integration and Innovation (CHI2)
Date:	Thursday, May 21, 2026 8:20:49 AM
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: REVISED Statewide FY 26 CMHSP client satisfaction report issued by CMHA's Center for Health Care Integration and Innovation (CHI2)

BACKGROUND: You may remember that, over the past several years, CMHA and its members have engaged in an Accurate Picture campaign. That campaign is aimed at providing an accurate picture of Michigan's public mental health system and those whom it serves, countering what are often negative misconceptions attached to Michigan's public mental health system and those who rely upon that system.

The Accurate Picture campaign had a number of components, including the highly successful partnership of CMHA and a number of its members with the Issue Media Group/Common Group publications – a partnership built around the concept of "solutions journalism". This partnership ensures that the work of Michigan's public mental health system is highlighted in IMG's large suite of solutions journalism-focused publications. More about this partnership can be found here.

This email provides the results of another component of this Accurate Picture campaign–a statewide client satisfaction report (Note that this report is a revised version, reflecting several refinements from the report sent to you a week ago.)

STATEWIDE FY 26 CMHSP CLIENT SATISFACTION REPORT: All of Michigan's CMHSPs and PIHPs, and many of the provider organizations in the networks of the state's CMHSPs and PIHPs, conduct client satisfaction surveys of those whom they serve.

Because the CMHSPs, PIHPs, and providers use a variety of client satisfaction instruments, statewide client satisfaction data has been difficult to aggregate.

However, while a number of instruments are used by the provider organizations across the state, there are a set of satisfaction elements or domains found in all of these instruments. These common domains are: Overall Satisfaction/Improvement, Accessibility/Responsiveness, Supportiveness, Dignity, Respect, Cultural Competency, Person-Centered Planning, and Being Heard & Confidentiality

Using these common client satisfaction domains, CMHA's Center for Health Care Integration and Innovation (CHI2) aggregated the client satisfaction data, across these common domains, resulting in a recently published report which provides a picture of client satisfaction with the system. This report, 2026 Accurate Picture Initiative Statewide Satisfaction Survey Report (May 2026) can be found here.

In summary, the findings of this report, demonstrate high levels of satisfaction as noted below.

Statewide Behavioral Health Satisfaction Summary by Domain

Satisfaction Domain	Positive Average (%)
Overall Satisfaction / Improvement	87.48%
Accessibility and Responsiveness	83.53%
Supportiveness, Respect, Dignity	85.35%
Cultural Competency	87.97%
Person-Centered Planning	87.15%
Being Heard & Confidentiality	86.02%

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Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

2025 Accurate Picture Initiative Statewide Satisfaction Survey Report

April 2026

Sarah Zultak

Center for Healthcare Integration and Innovation
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2025 Accurate Picture Initiative Statewide Satisfaction Survey Report

Sarah Zultak
April 2026

Abstract

This project analyzes behavioral health satisfaction survey data collected from Community Mental Health (CMH) organizations and Prepaid Inpatient Health Plans (PIHPs) across Michigan. CMH organizations are local public agencies responsible for delivering mental health and substance use services within specific counties, while PIHPs are regional entities that manage Medicaid behavioral health services and funding, often overseeing multiple CMH organizations or coordinating care across a service region. The primary purpose of this project is to standardize survey results drawn from multiple instruments into a consistent analytical framework so that findings can be compared meaningfully across providers. Because CMH organizations and PIHPs use different survey tools, scoring systems, question wording, and reporting formats, direct comparison is difficult without a common structure.

To address this issue, survey responses were reorganized into six standardized categories: Overall Satisfaction/Improvement, Expedience/Wait Times, Communication/Informedness, Cultural Competency, Person-Centered Planning, and Information Security & Confidentiality. Questions from different instruments were assigned to these categories based on substantive content rather than original numbering or survey source. Positive response values were then converted into comparable percentages and aggregated within each category.

The findings indicate that Communication/Informedness and Overall Satisfaction/Improvement tended to score relatively high across organizations, suggesting generally positive perceptions of service quality and benefit. Cultural Competency also showed consistently strong performance across many providers. In contrast, Person-Centered Planning, Expedience/Wait Times, and Information Security & Confidentiality showed greater variability, indicating uneven performance across organizations and survey types. Overall, this project demonstrates the value of standardizing behavioral health satisfaction data to improve cross-agency comparison, strengthen transparency, and support data-informed evaluation and policy decision-making.

Backround

Behavioral health systems rely heavily on client, family, and stakeholder feedback to assess service quality, identify strengths, and reveal areas needing improvement. Satisfaction surveys are one of the most common tools used to capture these perspectives. However, these instruments vary considerably across CMH organizations and PIHPs in question wording, response options, scoring methods, and domain structure. As a result, even when different organizations attempt to measure similar concepts, such as satisfaction, access, or cultural respect, their results are not automatically comparable.

In Michigan, CMH organizations and PIHPs administer multiple survey tools, including the Mental Health Statistics Improvement Program (MHSIP) Adult Survey, the Youth Satisfaction Survey (YSS), regionally developed NMRE survey instruments, and other organization-specific tools. These instruments often measure overlapping concepts, but they do so in different ways. One survey may assess confidentiality through a single question, while another may combine several items related to rights, information sharing, and privacy. Likewise, one instrument may report percentage agreement, while another reports Likert-scale averages that must be converted before comparison is possible.

Without standardization, this variation limits the usefulness of survey data for statewide comparison, cross-provider benchmarking, and system-level evaluation. This project addresses that challenge by creating a unified category framework and applying a consistent scoring method to survey data from multiple organizations. In doing so, it improves comparability and makes the data more useful for administrative review, policy discussion, and quality improvement planning.

Methods

This project analyzed behavioral health satisfaction survey data from respondents across 25 CMH organizations and PIHPs in Michigan using FY25 survey reports and internal datasets. The dataset included Barry County Community Mental Health, Bay-Arenac Behavioral Health Authority, Centra Wellness Network, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties, Copper Country Community Mental Health, Gratiot Integrated Health Network, Hiawatha Behavioral Health, Huron Behavioral Health, Lakeshore Behavioral Services Program, Lakeshore Regional Entity, LifeWays Community Mental Health, Macomb County Community Mental Health, Mid-State Health Network, Montcalm Care Network, Newaygo County Mental Health, Northern Lakes Community Mental Health, Oakland Family Services, Ottawa County Community Mental Health, Region 10 Prepaid Inpatient Health Plan, Right Door Organization, Saginaw County Community Mental Health Association, Services to Enhance Potential, St. Clair County Community Mental Health Association, The Guidance Center, and Washtenaw County Community Mental Health. Data was compiled between March 31 and April 23 during the FY25 reporting period.

Survey items were reorganized into six standardized domains based on conceptual alignment, with original wording retained for transparency. All question-level results were converted into a common percentage format. Positive response rates were calculated using one of three methods: combining Agree and Strongly Agree responses, using the percentage of Yes responses for binary items, or converting mean Likert scores to percentages using the formula (Mean ÷ 5) × 100. After conversion, category-level scores were calculated by averaging all question-level percentages assigned to the same domain. This method was applied consistently across organizations and survey instruments, even when the number of items within a category varied. Across all organizations, domain-level averages were calculated by averaging question-level percentages within each category and ranged from 82.7% to 87.3%. Cultural Competency (87.3%) was highest, followed by Overall Satisfaction/Improvement (86.9%), Person-Centered Planning (86.2%), Information Security & Confidentiality (85.4%), and Communication/Informedness (85.0%), while Expedience/Wait Times (82.7%) was the lowest-performing domain.

To illustrate this process, a representative provider was labeled Organization A. For the MHSIP survey, Overall Satisfaction/Improvement included Q1–Q3 (83.0%, 82.5%, 82.3%), which were averaged to produce 82.60%. Expedience/Wait Times included Q4–Q7 (78.0%, 76.5%, 74.0%, 76.9%), averaging to 76.10%. Communication/Informedness included Q5–Q7 (84.0%, 81.5%, 81.4%), averaging to 82.30%. Single-item domains included Cultural Competency (Q18: 85.40%) and Person-Centered Planning (Q17: 77.60%), while Information Security & Confidentiality combined Q13 (88.5%) and Q16 (87.3%), averaging to 87.90%. For the YSS survey, Overall Satisfaction/Improvement (Q1: 88.30%) remained a single-item measure. Expedience/Wait Times included Q8–Q9 (90.0%, 89.4%), averaging to 89.70%. Communication/Informedness included Q2–Q6 (90.0%, 89.5%, 89.8%, 89.2%, 89.5%), averaging to 89.60%. Cultural Competency (Q15: 71.20%) and Person-Centered Planning (Q3: 92.10%) were single-item measures, while Information Security & Confidentiality (Q13: 91.20%) was also derived from a single item.

The final dataset was structured in Excel format, with each row containing organization name, survey type, standardized category, aggregate positive percentage, question numbers, and full question text. The method prioritizes conceptual consistency over identical survey design while preserving traceability back to the original survey items.

Table 1: Example of Standardized Survey Mapping and Category Aggregation (Organization A)

Organization	Survey Type	Category	Positive Avg %	Question Numbers	Questions

Organization A	MHSIP	Overall Satisfaction/Improvement	82.60%	Q1–Q3	Q1. I like the services I received here. Q2. If I had other choices, I would still get services from this agency. Q3. I would recommend this agency to a friend or family member.
Organization A	MHSIP	Expedience/Wait Times	76.10%	Q4–Q7	Q4. The location of services was convenient (parking, public transportation, distance, etc.). Q5. Staff were willing to see me as often as I felt it was necessary. Q6. Staff returned my call within 24 hours. Q7. Services were available at times that were good for me.
Organization A	MHSIP	Communication/Informedness	82.30%	Q5–Q7	Q5. Staff were willing to see me as often as I felt it was necessary. Q6. Staff returned my call within 24 hours. Q7. Services were available at times that were good for me.

Organization A	MHSIP	Cultural Competency	85.40%	Q18	Q18. Staff were sensitive to my cultural background (race, religion, language, etc.).
Organization A	MHSIP	Person-Centered Planning	77.60%	Q17	Q17. I, not staff, decided my treatment goals.
Organization A	MHSIP	Information Security & Confidentiality	87.90%	Q13, Q16	Q13. I was given information about my rights. Q16. Staff respected my wishes about who is and who is not to be given information about my treatment.
Organization A	YSS	Overall Satisfaction/Improvement	88.30%	Q1	Q1. Overall, I am satisfied with the services my child received.
Organization A	YSS	Expedience/Wait Times	89.70%	Q8–Q9	Q8. The location of services was convenient for us. Q9. Services were available at times that were convenient for us.
Organization A	YSS	Communication/Informedness	89.60%	Q2–Q6	Q2. I helped to choose my child's services. Q3. I helped to choose my child's treatment goals. Q4. The people helping my child stuck with us no matter

					what. Q5. I felt my child had someone to talk to when she/he was troubled. Q6. I participated in my child's treatment.
Organization A	YSS	Cultural Competency	71.20%	Q15	Q15. Staff were sensitive to my cultural/ethnic background.
Organization A	YSS	Person-Centered Planning	92.10%	Q3	Q3. I helped to choose my child's treatment goals.
Organization A	YSS	Information Security & Confidentiality	91.20%	Q13	Q13. Staff respected my family's religious/spiritual beliefs.

Findings & Analysis

Table 2: Statewide Behavioral Health Satisfaction Summary by Domain

Satisfaction Domain	Positive Average (%)	Range (Low–High)
Overall Satisfaction / Improvement	86.9%	75%–95%
Expedience / Wait Times	82.7%	74%–97%
Communication / Informedness	85.0%	75%–95%
Cultural Competency	87.3%	71%–100%
Person-Centered Planning	86.2%	72%–100%
Information Security & Confidentiality	85.4%	63%–95%

The analysis reveals clear and measurable patterns across CMH organizations and PIHPs, with performance varying by domain and survey instrument. This approach enables direct

comparison across providers using different survey tools while still capturing similar service concepts.

Across the dataset, Overall Satisfaction/Improvement and Communication/Informedness consistently demonstrated the strongest performance. Most results in these categories fell within the high 80% to mid-90% range, with several reaching 95% or higher. Even lower values generally remained in the mid-70% range, indicating that overall satisfaction and communication were strong across nearly all providers. These consistently high scores suggest that respondents broadly reported positive service experiences, felt supported by staff, and believed services were beneficial.

Cultural Competency also showed strong performance overall, most commonly ranging from the mid-80% to high-90% range, with some results approaching 100%. However, compared to satisfaction and communication, this category showed slightly more variation, with some scores dropping into the low 70% range, indicating less consistency across providers.

Greater variability was observed in Expedience/Wait Times and Person-Centered Planning. Expedience scores ranged from approximately the mid-70% range to the upper-90% range, reflecting differences in access to care, scheduling, and service availability. Person-Centered Planning showed a similarly broad range, from the low-to-mid 70% range up to nearly 100%, indicating that client involvement in treatment decisions and goal setting is not implemented consistently across organizations. These differences likely reflect variation in staffing, service capacity, and organizational practices.

Information Security & Confidentiality showed the greatest inconsistency in both measurement and results. Scores ranged from approximately the low-60% to high-90% range, but in many cases this domain was measured using only a single question or was not included at all. This makes comparisons less reliable and suggests that variation reflects both actual performance differences and inconsistencies in survey design.

Overall, the findings demonstrate that standardization is effective for identifying broad trends across organizations, particularly in highlighting consistently strong domains such as satisfaction and communication. However, interpretation must still consider variation in score ranges and differences in how domains are measured.

Conclusion

This project demonstrates that standardizing behavioral health survey data improves the ability to compare outcomes across CMH organizations and PIHPs. By aligning diverse survey instruments into consistent domains, the analysis provides a clearer and more structured view of service quality across Michigan providers.

The results indicate that overall satisfaction, communication, and cultural competency were generally strong across providers, while access-related domains, person-centered planning, and confidentiality-related measures showed greater variation. These patterns highlight areas where organizations may benefit from targeted improvement and where statewide standardization could strengthen interpretation.

More broadly, this project offers a replicable method for organizing and analyzing survey data across nonuniform instruments. This makes the results useful not only for describing current performance, but also for supporting future benchmarking, quality improvement, and policy development within Michigan's behavioral health system.

Annex

A. Standardized Category Framework

Category	Description	Example Question Focus
Overall Satisfaction/Improvement	Measures overall experience and perceived benefit of services	Satisfaction, recommendation, perceived improvement
Expedience/Wait Times	Assesses access to care and timeliness of services	Scheduling, response times, availability of services
Communication/Informedness	Evaluates how well staff communicate and provide information	Clarity, respect, shared information, understanding
Cultural Competency	Measures sensitivity to cultural, ethnic, and personal backgrounds	Respect for identity, inclusivity, cultural awareness
Person-Centered Planning	Assesses involvement in treatment decisions and goal setting	Client choice, participation, autonomy
Information Security & Confidentiality	Evaluates privacy and protection of personal information	Confidentiality, control over information sharing

B. Data Structure Template Example

Organization	Survey Type	Category	Positive Avg %	Question Numbers	Questions
CMH	MHSIP	Overall Satisfaction/Improvement	90%	Q1–Q3	Full question text

C. Standardization Method Notes

"Positive Avg %" is calculated using:

- Agree + Strongly Agree
- Yes responses (binary)
- Mean ÷ 5 × 100 (Likert conversion)

Survey questions are mapped into standardized domains based on conceptual content rather than original numbering or survey instrument. Each domain score is calculated by averaging all question-level percentages assigned to that category, even when the number of items varies across surveys.

Domain-level ranges are calculated by identifying the minimum and maximum category scores observed across all organizations within each standardized domain. Overall domain averages are calculated by averaging category-level scores across all organizations.

Categories may include overlapping items across survey types when questions measure similar concepts. Missing data is recorded only when a domain is not measured by a given survey instrument.

D. Key Limitations

Variation in survey design across CMHs and PIHPs means that not all domains are equally represented. Some organizations do not include direct measures of Information Security & Confidentiality, and differences in wording and structure may still affect comparability despite standardization.

Additionally, some domains are based on a limited number of questions, and in some cases a single item, which may reduce the reliability and stability of those category scores compared to multi-item domains. Differences in response scales and survey design may also introduce minor inconsistencies even after conversion to percentages.

Because category scores are calculated as simple averages, all questions within a domain are weighted equally, which may not reflect differences in importance across items. Variation in sample size across organizations may also influence results, as organizations with fewer respondents may show greater variability in scores.

Finally, while standardization improves comparability, it does not fully eliminate differences in how concepts are measured across survey instruments, meaning that results should be interpreted as approximations of domain performance rather than exact equivalents.

E. Survey Instruments

- Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey: https://www.samhsa.gov/sites/default/files/mhbg-mhsip-consumer-survey.pdf
- Youth Services Survey for Families (YSS-F): https://www.samhsa.gov/sites/default/files/mhbg-youth-services-families-survey.pdf

The Center for Healthcare Integration and Innovation (CHI2) is the research and analysis office within the Community Mental Health Association of Michigan (CMHA). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHA) is the state association representing Michigan's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.

Email Correspondence

From:	Monique Francis
To:	Monique Francis
Cc:	Robert Sheehan; Alan Bolter; David Lowe
Subject:	CMHA analysis of recently issued documents by MDHHS Mental Health Framework; next steps
Date:	Thursday, April 16, 2026 4:42:32 PM
Attachments:	image001.png CMHA analysis - Mental Health Framework 4.26.pdf
Importance:	High

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 analysis of recently issued documents by MDHHS Mental Health Framework; next steps

Earlier this week, the CEOs of Michigan's CMHSPs and PIHPs received, from MDHHS, the email, below, and two documents (Mental Health Framework Language) and (Mental Health Benefit Plan Criteria) which outline additional details related to the proposal that MDHHS has been developing for the past several years, the Mental Health Framework (MHF). **These documents underscore the concerns that the Community Mental Health Association (CMHA), its members, and stakeholders have expressed over the past two years.**

CMHA ANALYSIS: Attached is CMHA's preliminary analysis of the contents of these two documents.

As this analysis indicates, simply stated, the MHF clearly outlines a system which privatizes the management of a large segment of Michigan's Medicaid behavioral health system.

While the MHF is presented as a mechanism to improve coordination and access, the framework introduces significant risks to clinical integrity, beneficiary rights, continuity of care, due process protections, and fiscal sustainability. The concerns outlined in the attached analysis reflect structural misalignment between the framework and the state's nationally recognized public - not privatized - mental health and the Michigan laws. **Again, what is clear is that the MDHHS proposed Mental Health Framework outlines a system which privatizes the management of a large segment of Michigan's Medicaid behavioral health system.**

NEXT STEPS: In the coming days, CMHA staff will be developing an aggressive advocacy effort in opposition to the Mental Health Framework. This plan will draw on the success components of past advocacy efforts. Once developed, we will be engaging you, persons served and their families, our advocacy partners, and the members of the diverse coalition which stood against past privatization threats.

Stay tuned for information on and opportunities to participate in this advocacy effort – just as you have done so many times over the past decade.

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From: Morningstar, Kristen (DHHS) <MorningstarK@michigan.gov>
Sent: Monday, April 13, 2026 11:00:51 AM
To:

Good morning,

The Michigan Department of Health and Human Services (MDHHS) is working to implement a new mental health services benefit plan (BH-COVER), which will be assigned to Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP) who meet specified clinical criteria. Within this draft, beneficiaries assigned to the BH-COVER benefit plan will have all medically necessary mental health services covered by their Prepaid Inpatient Health Plan (PIHP), including outpatient mental health services delivered outside of the Community Mental Health Services Program (CMHSP) network. Additionally, this draft establishes MHP coverage of inpatient psychiatric hospital admissions, outpatient partial hospitalization, and crisis residential services delivered to MHP beneficiaries who are not assigned to the BH-COVER benefit plan. The proposed effective date for this work is October 1, 2026.

This draft contains references to a secondary document related to the BH-COVER Benefit Plan criteria. Please refer to the *DRAFT BH-COVER Benefit Plan Criteria (April 2026)* PDF where applicable.

This is confidential draft language and is subject to change. Please do not share outside of your organization. Feedback should be shared by COB on April 24, 2026, to mdhhs-mentalhlthframework@michigan.gov.

Thank you,

Kristen

Kristen Morningstar
Specialty Behavioral Health Services Director

Areas of Concern Regarding the Mental Health Framework (MHF)

April 2026

BACKGROUND: The Michigan Department of Human Services (MDHHS) has recently circulated additional details, outlined in two documents (Mental Health Framework Language) and (Mental Health Benefit Plan Criteria) of a proposal that MDHHS has been developing for the past several years, the Mental Health Framework (MHF). **These documents underscore the concerns that the Community Mental Health Association (CMHA), its members, and stakeholders have expressed over the past two years.**

Simply stated, the MHF clearly outlines a system which privatizes the management of a large segment of Michigan's Medicaid behavioral health system.

Michigan's public mental health system is not an administrative construct; it is a civil rights system grounded in statute. The Mental Health Code (Public Act 258 of 1974) establishes legal protections that govern access, treatment, planning, and due process for individuals receiving mental health services. The newly proposed Mental Health Framework (MHF), particularly through the introduction of the BH-COVER service model, represents a fundamental shift away from these statutory foundations by moving, to the management of private health insurance companies with less consumer control and more red tape.

While the MHF is presented as a mechanism to improve coordination and access, the framework introduces significant risks to clinical integrity, beneficiary rights, continuity of care, due process protections, and fiscal sustainability. The concerns outlined below reflect structural misalignment between the framework and the state's nationally recognized public - not privatized - mental health and the Michigan laws. **Again, what is clear is that the MDHHS proposed Mental Health Framework outlines a system which privatizes the management of a large segment of Michigan's Medicaid behavioral health system.**

Privatizing the Management of the System

The MHF Clearly outlines a system which privatizes the management of a large segment of Michigan's Medicaid behavioral health system for a large segment of the Medicaid beneficiary population:

- The MHF moves the management of a substantial segment of Michigan's Medicaid enrollees to the management of private health plans - a plan that people served, their families, advocates, and a wide range of stakeholders opposes. This move is done by transitioning care to the private health plan system, all but those who are receiving a small range of CMH services.
- Moves the management of high intensity services psychiatric = inpatient care, crisis residential, and outpatient partial hospitalization services (a core set of CMHSP responsibilities) - to the private health plans - a move strongly opposed by persons served, their families, advocates, and a wide range of stakeholder and in violation of the Michigan Mental Health Code.

A poll commissioned, during a recent privatization proposal (2022) by the Community Mental Health Association of Michigan (CMHA) and conducted by third-party survey provider EPIC-MRA found ***67% of Michigan voters prefer the public mental health system*** to be managed by public entities who specialize in mental health care vs. turning the system over to private, for-profit companies.

- Nearly 3 times as many Michiganders oppose the privatization of the state's mental health services for Medicaid patients. 67% oppose while only 24% support that privatization.
- 76% of voters are concerned that *private health plans do not have a good track record in treating patients with mental health needs* and fear they will make matters worse.
- 73% of voters are concerned that high overhead costs of the private health insurance companies (double that of the public system) and the corporate profits that these companies take out of the taxpayer-funded Medicaid system will lead to less mental health services for those in need.

Private health insurance companies would take over the management of the financing of Michigan's public mental health system. These companies, known as Medicaid Health Plans, have overhead rates, including profits, of 15% (Senate Fiscal Agency Analysis and Milliman's national study data). This overhead rate is 2.5 times higher than the 6.2% overhead rate of the managed care operations of the state's public CMH system. This means that only $85 of every $100 dollars sent to these private health insurance companies is used to provide health care, as compared to the $94 of every $100 provided to the CMH system that is used for care. If these bills become law, this difference would mean that $300 million in funds diverted, annually, from the mental health care of Michiganders to health plan overhead and profits.

The Mental Health Framework would place greater responsibility for Michigan's public mental health system in the hands of private health insurance companies that have struggled for decades to manage even basic mental health services. For more than 20 years, these plans have overseen outpatient psychotherapy and psychiatry for Medicaid enrollees, during which time individuals across the state have consistently reported difficulty finding providers willing or able to serve them. If private insurers have been unable to ensure access for lower-complexity mental health needs, it raises serious concerns about their capacity to manage the far more complex, intensive, and long-term needs of individuals with serious mental illness, substance use disorders, or intellectual and developmental disabilities under the proposed framework.

The Mental Health Framework disregards the views of the people most directly affected by these changes. In recent years, similar proposals have faced consistent and strong opposition from individuals who rely on the Community Mental Health (CMH) system, as well as from their families and community partners. The Mental Health Framework also ignores the broad, consensus recommendations developed through recent public discussions on healthcare integration, in which a wide range of stakeholders emphasized that the CMH system should remain publicly managed and governed. By moving in the opposite direction, the framework runs counter to the expressed priorities of Michiganders who have the most at stake in any changes to the mental health system.

Inadequate Protection of Recipient Rights

The Mental Health Framework eliminates recipient rights protections for individuals moved to the management of the private health plans, given that the **recipient rights protections guaranteed by the Michigan Mental Health Code, apply only to those services provided or purchased by a CMHSP.**

Recipient rights are legally enforceable protections under the Mental Health Code (MCL 330.1704). Yet the draft MHF provides insufficient attention to how these rights will be preserved under a "*separate-responsibility"* model.
The framework does not clearly ensure:

- *Timely access to medically necessary services;*
- *Provision of care in the least restrictive environment;*
- *Freedom from unnecessary financial or administrative burden; or*
- *Clear accountability when rights violations occur.*

Recipient rights are not optional policy considerations; they are legal mandates that must be explicitly protected.

Reflects a lack of an understanding clinical measures and services

The Mental Health Framework demonstrates a lack of understanding as to use of the system's clinical assessment tools (LOCUS and MichiCANS). This plan calls for the movement of a large segment of Medicaid beneficiaries to private health plan management with scores that would, when used appropriately, place these beneficiaries outside of the mild to moderate level of need currently managed by the private health plans and squarely within the benefit managed by the public PIHPs.

The Mental Health Framework raises additional clinical concerns. MDHHS, through this Framework, is proposing eligibility standards that would allow individuals assessed as having mild to moderate needs to be placed in acute inpatient psychiatric settings, a shift that fundamentally contradicts established principles of medical necessity, the use of least restrictive settings,, and clinically supported level-of-care standards. This approach is particularly alarming in Michigan, where psychiatric inpatient and Crisis Residential bed capacity is already severely constrained. Allowing individuals without acute medical necessity to occupy inpatient psychiatric beds directly reduces access for people experiencing more severe psychiatric emergencies. These lifesaving resources cannot be made unavailable for those that need it.

This misalignment threatens the safety of persons served, delays care for high-acuity individuals- if not eliminating it altogether - and exacerbates the statewide psychiatric bed shortage which MDHHS well documents.

Absence of Required Due Process Protections

The most significant legal issue in the MHF is the absence of clearly defined due-process procedures associated with the BH-COVER benefit. Any adverse benefit determination under Medicaid requires a dispute resolution mechanism, yet the draft framework fails to establish such mechanisms:

- *Notice to recipients when BH-COVER assignment is initiated or removed (MCL 330.1706);*
- *Formal appeal rights tied specifically to benefit plan decisions;*
- *Access to a fair hearing before an impartial decision-maker;*
- *Continuation of benefits pending appeal; and*
- *Timely decision-making standards.*

MDHHS technical advisories are clear: "*Nothing about managed care changes these due process requirements*." Adopting a framework that effectively allows service determinations without due process would place Michigan in direct conflict with both state law and Medicaid requirements. This concern is magnified by recent audit findings across multiple health plans, which have already documented:

- *Ineffective compliance programs;*
- *Improper access limitations;*
- *Erroneous or delayed coverage determinations; and*
- *Inadequate or unclear beneficiary notices.*

Introducing additional complexity without enforceable due-process safeguards will only exacerbate these systemic failures.

Conclusion

The proposed Mental Health Framework poses serious threats to Michigan's public mental health system by privatizing management of large segments of Medicaid behavioral health care. By transferring oversight and high-intensity services to private health plans, the framework erodes public accountability and introduces financial incentives that conflict with individualized care. It removes many beneficiaries from the legally enforceable recipient rights guaranteed under the Mental Health Code, while relying on assessment tools in ways that misunderstand their clinical purpose and risk inappropriate care transitions within a system that has failed Michiganders historically.

The Mental Health Framework would place greater responsibility for Michigan's public mental health system in the hands of private health insurance companies that have struggled for decades to manage even basic mental health services. For more than 20 years, these plans have overseen outpatient psychotherapy and psychiatry for Medicaid enrollees, during which time individuals across the state have consistently reported difficulty finding providers willing or able to serve them. If private insurers have been unable to ensure access for lower-complexity mental health needs, it raises serious concerns about their capacity to manage the far more complex, intensive, and long-term needs of individuals with serious mental illness, substance use disorders, or intellectual and developmental disabilities under the proposed framework.

Email Correspondence

From:	Morningstar, Kristen (DHHS)
To:	Carol Balousek (NMRE); James Colaianne; Eric Kurtz (NMRE); JAMES WHITE (7) ; Joseph Sedlock; kalbfleisch@region10pihp.org; Kathy Porter; Dana Lasenby; mariond@lsre.org; Mary Marlatt-Dumas; michelle.jacobs@swmbh.org; Mila Todd (SWMI); Megan Rooney; sandy.hays@mccmh.net; Shelia Young; Sheryl Kletke; Sandra Lambert; Traci Smith; vanwormer@region10pihp.org; wearys@cmhpsm.org; Brian Babbitt (NC); Brooke Sankiewicz; bkrogman; Bullock, Cameron; Carol Mills; Cassandra Watson; Chris Pinter; Connie Conklin; Courtney Grant; Russell, Dan; Debra Hess; djohnson; Jeannie Goodrich; Jeff Patton; Chip Johnston (CWN); Julia Rupp; jmajeske; kszewczuk; Possehn, Kerry; Lisa Graham; Lynda Zeller; Mandy Padget; Mark Witte; Matt Maskart; mbach@cccmh.org; Michael Brashears; Michael Mallory; Michelle Stillwagon; Nena Sork (NEM); Ric M. Compton; Rich Francisco; Rich Thiemkey; Ryan Painter; Sandra Lindsey; luriesa; Sue M. Germann; Tammy J. Warner; Tess Greenough; tracey; Trish Cortes; Trish Otremba; wmorris; William Ward
Cc:	Mills, Michelle (DHHS); Groen, Meghan (DHHS); Parsons, Audra (DHHS); Rutledge, Penny (DHHS); Landfair, Theresa (DHHS); Gillmore, Rebecca (DHHS)
Subject:	UPDATE: Mental Health Framework Policy Language
Date:	Friday, May 15, 2026 4:20:47 PM

Good afternoon,

Thank you for reviewing the draft MHF Coverage Responsibility policy.

When MDHHS gathered input directly from beneficiaries and providers in 2022, a consistent theme emerged: limited coordination between the MHP and PIHP delivery systems and confusion around what constitutes “mild-to-moderate” need. Beneficiaries were often told they did not qualify for services in one system and left to navigate another on their own. Providers were unsure which system to bill and people at risk of escalating needs struggled to access care.

To address these concerns, MDHHS began looking at improvements to service delivery based on the level of need of Medicaid beneficiaries, not the place or type of service.

This includes standardizing how needs are identified and clarifying which plan is responsible for each beneficiary, including care management, care coordination, and quality. MDHHS will use existing PIHP assessment tools (MichiCANS screener and LOCUS) across the Medicaid program to ensure a consistent, shared approach.

Improving coordination, access, and quality of care remains a top priority. In support of this goal and in response to your feedback, **MDHHS will temporarily delay the MHF Coverage Responsibility policy to allow time for system-wide preparation.**

During this preparation period, MDHHS will continue advancing key Mental Health Framework activities, including:

- Increasing the number of beneficiaries with LOCUS and MichiCANS assessments on file and using these scores to assign the BH-COVER benefit plan.
- Reviewing utilization data to better understand service needs.
- Strengthening care coordination across MHP and PIHP systems, including joint care planning and expanded joint quality measures.
- Enhancing referral pathways to ensure beneficiaries are connected to and receive appropriate care and support when moving between systems.
- Continuing to clarify coverage responsibility for existing covered services to minimize provider confusion and abrasion.
- Deepening relationships between PIHPs/CMHs and MHPs to improve service delivery and overall health outcomes.

Additional details surrounding MHF related expectations will be addressed in respective MHP and PIHP standing meetings.

We look forward to continued collaboration as we work together to improve service delivery and support the needs of Medicaid beneficiaries across the state.

Thank you,

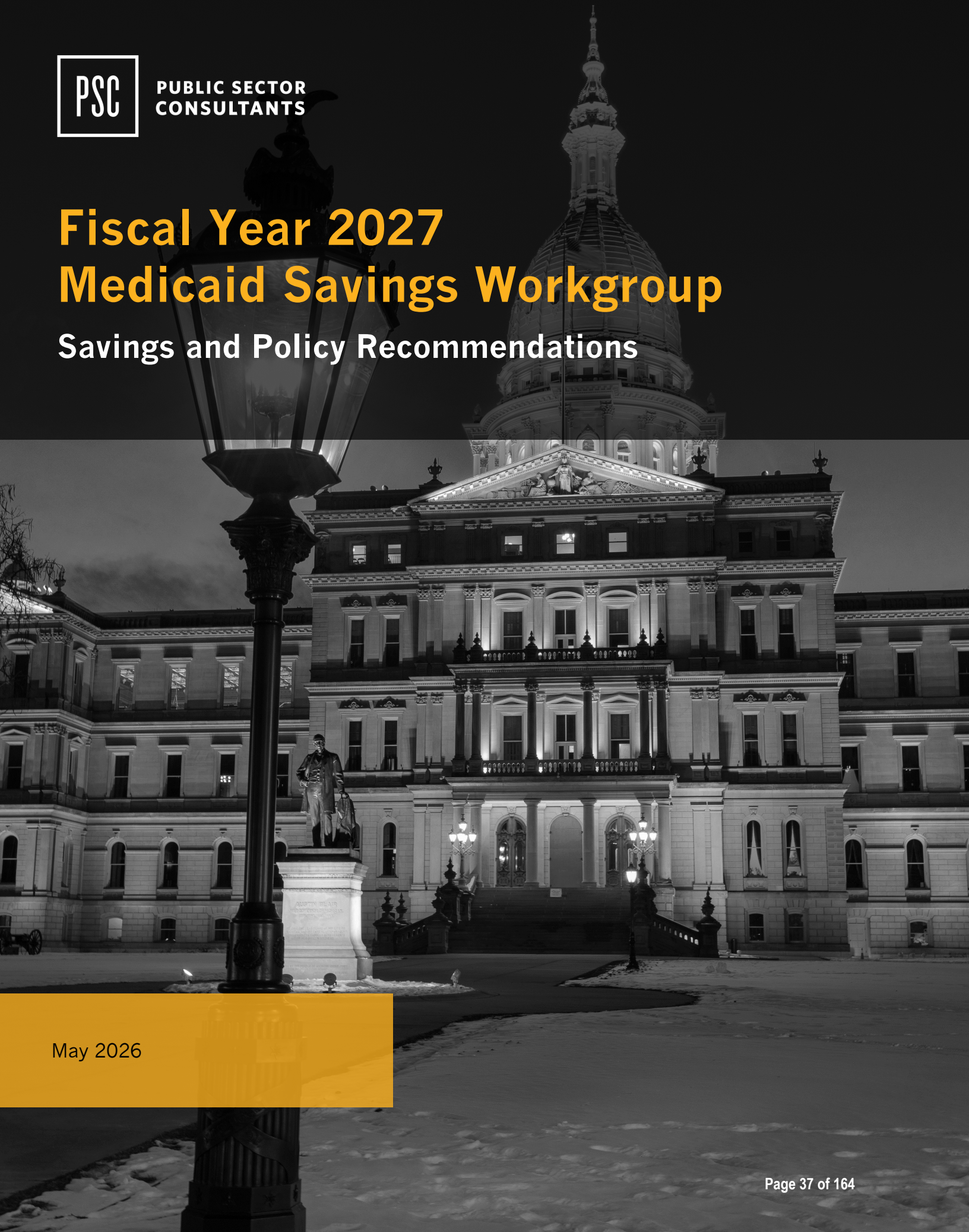
Kristen

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

PUBLIC SECTOR CONSULTANTS

Fiscal Year 2027 Medicaid Savings Workgroup

Savings and Policy Recommendations



May 2026

PUBLIC SECTOR CONSULTANTS

Prepared by

Public Sector Consultants
www.publicsectorconsultants.com

Prepared for

The Michigan State Budget Office

Table of Contents

Introduction

The Michigan Medicaid program provides health coverage to approximately 2.5 million residents, or about one in four Michiganders. As one of the largest components of the state's budget, Medicaid plays a critical role in supporting access to care, improving health outcomes, and maintaining the stability of the healthcare system.

The governor's fiscal year (FY) 2027 executive budget recommendation for the Michigan Department of Health and Human Services (MDHHS) totals roughly $41 billion, including Medicaid and other programs, with the majority of the funding coming from the federal government. However, nearly $7 billion, or 17 percent, comes from the state's general fund. As a result, changes in Medicaid spending have a direct and meaningful impact on the state's overall fiscal position.

The state is facing increasing fiscal pressure driven by rising healthcare costs, sicker enrollees, and reduced revenues. Additionally, recent federal legislation (H.R. 1) is expected to increase state costs significantly, further compounding these challenges.

Therefore, **the FY 2027 executive budget included the creation of a Medicaid stakeholder workgroup charged with identifying $150 million in general fund Medicaid reductions. This report provides an overview of this workgroup and the savings ideas they put forward.**

Workgroup Members and Staffing

State Budget Director Jen Flood convened representatives from the following organizations to participate as voting members of the workgroup:

- Area Agencies on Aging Association of Michigan (4AMI)
- Blue Cross Blue Shield of Michigan (BCBSM)
- Delta Dental of Michigan
- Detroit Wayne Integrated Health Network
- Health Care Association of Michigan
- Hope Network
- Incompass Michigan
- Michigan Association of Health Plans
- Michigan Dental Association (MDA)
- Michigan Health & Hospital Association (MHA)
- Michigan League for Public Policy (MLPP)
- Michigan Primary Care Association (MPCA)
- SEIU Healthcare MI

Representatives from the following agencies participated as nonvoting members:

- MDHHS
- House Fiscal Agency
- Senate Fiscal Agency
- Executive Office of the Governor

Technical support was provided by the State Budget Office and MDHHS.

External support was provided by Public Sector Consultants.

Workgroup Charge

The State Budget Director charged this workgroup with:

- Identifying opportunities to optimize existing programs while protecting access to care for Michiganders who rely on Medicaid
- Generating ideas that could save at least $150 million in general fund Medicaid efficiencies or savings
- Considering solutions related to both administrative efficiencies and programmatic changes

Guiding Principles

The group agreed on a set of guiding principles to help evaluate and vote on ideas:

- Protect access to care and essential Medicaid benefits
- Avoid shifting costs to providers or patients
- Use transparent, data-driven decision-making
- Prioritize administrative efficiencies and operational improvements
- Focus on options that can be implemented within the next fiscal year

Recommendations

The workgroup recommends that policymakers consider the following set of savings proposals. Any member opposition or abstention is noted. While savings estimates are provided where available, some proposed initiatives currently lack clear projections; **therefore, if they are adopted, their fiscal impacts remain uncertain.**

Savings Category	Potential Approaches to Achieve Savings	FY 2027 General Fund Savings Estimate[1]
Pharmacy savings	• Realize savings through increased pharmaceutical supplemental rebates, driven by drug manufacturers providing Michigan access to most-favored-nation prices, through programs such as the federal government's GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model.[2] *(Delta Dental, MDA, MLPP, and SEIU Healthcare MI abstained.)* • Pursue higher usage of biosimilars and generics for medications through avenues such as modifying the Single Preferred Drug List.[3] *(Delta Dental, MDA, MLPP, and SEIU Healthcare MI abstained.)* • Eliminate coverage for GLP-1 medications prescribed for the sole purpose of addressing obesity. *(Delta Dental, MDA, MHA, and MLPP abstained. SEIU Healthcare MI opposed.)* • Redefine the criteria used to identify independent pharmacies to ensure enhanced dispensing fees are directed to intended pharmacies, while access to care is protected (requires statutory change). *(Delta Dental, MDA, and MHA abstained.)*	Category Total: $0 to $96 million

[1] Estimates provided and/or informed by MDHHS and fiscal agency reports from the House and Senate.

[2] Estimated savings from most-favored-nation (MFN) pricing under new federal models remain uncertain. MDHHS analysis, along with preliminary information from the Centers for Medicare & Medicaid Services, shows that rebate-model negotiations with manufacturers are still underway. Final terms have not been released, and it is not yet clear whether these models will generate savings beyond what Michigan already achieves through multistate purchasing pools.

[3] The workgroup adopted the Senate's pharmacy savings proposal and amounts; however, MDHHS provided technical data that strongly conflicts with the assumption that increasing use of generics and biosimilars would generate savings. The State already uses generics and biosimilars when they provide the greatest net value, and in many cases, brand drugs result in lower net costs to the State because of substantial federal rebates available only to Michigan Medicaid programs. MDHHS's repricing analysis, conducted by its contracted actuarial firm, shows that a broad shift from brand drugs to generics and biosimilars would increase costs by approximately $85 million gross ($18.7 million general fund) due to the loss of these rebates. Savings under MFN-style rebate models depend heavily on brand drug rebates, which decline with greater generic or biosimilar use. As a result, using more generics and biosimilars would significantly increase the likelihood that projected MFN savings are materially overstated.

Savings Category	Potential Approaches to Achieve Savings	FY 2027 General Fund Savings Estimate[1]
Administrative savings in MDHHS	• Expand the Estate Recovery program (requires statutory change) with a broader definition of estate to include ownership interests that pass outside of probate (such as trusts) and more closely reflect the federal statute; add MDHHS to the list of parties who shall be paid from small estates; and remove the 3-year bar to filing claims against estates for Estate Recovery. *(Delta Dental, Incompass Michigan, MDA, and MHA abstained. MLPP and SEIU Healthcare MI opposed.)* • Reduce MDHHS third-party consulting contracts and lower contract costs. (*Delta Dental and MDA abstained.)* • Enhance efforts to find more cost-effective options or savings in contracts for nonemergency transport services without reducing access. *(Delta Dental, MHA, and MPCA abstained.)*	Category Total: $15 million
Administrative savings in managed care	• Require MDHHS and contracted managed care organizations to jointly identify and implement contract changes that streamline existing requirements without reducing access to care and achieve at least 1 percent savings *(changes to be agreed upon prior to implementation). (BCBSM abstained. 4AMI opposed.)* • Eliminate or reduce redundant audit tasks that are duplicative of other reporting requirements.	Category Total: $3.8 million
Benefit modifications	• Ensure applied behavioral analysis (ABA) benefits delivered are being held to existing contract standards between MDHHS and prepaid inpatient health plans regarding clinical appropriateness and management, without reducing access. *(Delta Dental and MDA abstained.)*	Category Total: $9.8 million[4]

[4] The $9.8 million estimate reflects MDHHS's modeling of the statewide savings from reducing the average number of ABA service hours by one hour per week across all individuals currently receiving services.

Other Policy Considerations

The workgroup considered additional ideas related to the Medicaid program's structure, administration, and coverage. These ideas did not directly produce FY 2027 savings but were discussed as potential future policy considerations. These ideas were not voted on; therefore, their inclusion in this report does not indicate majority support of the workgroup.

- Continue to expand cross-departmental data sharing to reduce costly enrollee churn
- Invest in and expand certified community behavioral health clinics, especially in high-need areas
- Evaluate costly, long-standing technology platforms
- Evaluate whether the mental and behavioral health system structure is meeting patient needs, and look for opportunities to improve and protect access to services
- Pursue pharmacy management arrangements that improve medication price transparency

Conclusion

Using estimates provided and/or informed by MDHHS, publicly available reports, and fiscal agency reports from the House and Senate, the Medicaid savings workgroup was able to identify ideas expected to yield $124.9 million in Medicaid program savings for FY 2027.[5] Because some ideas could not be fully developed with the time and data available to the group, their fiscal impacts remain uncertain.

[5] The $124.9 million estimate relies on assumptions that conflict with technical analysis from MDHHS and includes projected revenue from federal programs whose availability and design remain uncertain and outside the state's control.

Community Mental Health Association of Michigan

April 30, 2026

MEMORANDUM

To: Executive Directors
Executive Secretaries/Assistants

FROM: Monique Francis

RE: Voting Delegates

Voting Delegates are Responsible for Voting at the SUMMER CONFERENCE in Traverse City on ***June 8, 2026*** and must be present to vote. PLEASE REMEMBER THAT MEMBER ASSEMBLY MEETINGS ARE HELD ON THE EVENING ***PRIOR*** TO THE START OF THE CONFERENCE. DELEGATES MUST BE ABLE TO ARRIVE BY 5:30PM THAT EVENING.

VOTING DELEGATES
Member Assembly Meeting

Please fill out and email this form to Monique at mfrancis@cmham.org by ***May 22, 2026***

You may choose different voting delegates for each CMHA Member Assembly Meeting.

Please list your board's voting delegates for the Association Member Assembly Meeting to be held on ***MONDAY, JUNE 8, 2026, at 5:40PM*** at The Grand Traverse Resort, Traverse City.

Your board's 3 voting delegates (or 5 for Stand Alone PIHP's) must sign in at the conference registration to receive their voting card on June 8, 2026. ***EARLY BIRD REGISTRATION WILL OPEN AT 2:30PM TO ACCOMMODATE FOR THIS.***

Voting Privileges of CMHSPs/PIHPs: According to Association By-Laws, Article III (D): Voting privileges in the meetings of the Member Assembly shall be composed of three (3) delegates from each member CMHSP: two (2) board members and one (1) CMHSP executive director, OR, three (3) delegates from each member Regional Entity PIHP: two (2) board members and one (1) PIHP executive director, OR five (5) delegates for each member Stand Alone PIHP: four (4) board members and one (1) PIHP executive Director. *The executive director's vote may* ***NOT*** *be reassigned to any other individual.* ***Voting by proxy is expressly prohibited***.

	Macomb/Oakland/Detroit Wayne PIHPs Only:
Name of CMH/PIHP: _____	***Name of PIHP***: _____
Ex. Director _____	Ex. Director _____
Bd. Member _____	Bd. Member _____
Bd. Member _____	Bd. Member _____
	Bd. Member _____
	Bd. Member _____

Communication with Those Charged with Governance during Planning

May 18, 2026

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

We are engaged to examine Northern Michigan Regional Entity's (the PIHP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and General Fund Contract for the year ended September 30, 2025. Professional standards require that we provide you with the following information related to our compliance audit.

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

Our Responsibilities under U.S. Generally Accepted Auditing Standards and *Government Auditing Standards*

As stated in our engagement letter, our responsibility, as described by professional standards, is to express opinions about whether the PIHP complied with the requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and General Fund Contract. Our compliance audit does not relieve you or management of your responsibilities.

As part of our audit, we will consider the system of internal control of the PIHP. Such considerations are solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control.

As part of obtaining reasonable assurance about whether the PIHP complied with the requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and General Fund Contract, we will also perform tests of the PIHP's compliance with certain provisions of laws, regulations, and other contracts.

Our responsibility is to plan and perform the compliance audit to obtain reasonable, but not absolute, assurance that the PIHP complied with the requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and General Fund Contract. We are responsible for communicating significant matters related to the audit that are, in our professional judgement, relevant to your responsibilities in overseeing the compliance process. However, we are not required to design procedures specifically to identify such matters.

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

An audit includes examining, on a test basis, evidence supporting the PIHP's compliance with the requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material noncompliance and to design the nature, timing, and extent of further compliance audit procedures. Noncompliance may result from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity.

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

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

- Management override of controls
- Improper expenditure allocation due to fraud

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

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

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

Sincerely,

Roslund, Prestage & Company, P.C.

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

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	51.41	2,838	1,459
Lakeshore Regional Entity	66.67	480	320
Macomb Co CMH Services	56.84	651	370
Mid-State Health Network	65.26	2,484	1,621
NorthCare Network	62.50	488	305
Northern MI Regional Entity	58.12	862	501
Oakland Co CMH Authority	34.10	393	134
Region 10	54.08	834	451
CMH Partnership of Southeast MI	62.98	551	347
Southwest MI Behavioral Health	75.06	397	298
Statewide Total		**9,978**	**5,806**

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	51.29	657	337
Lakeshore Regional Entity	66.02	206	136
Macomb Co CMH Services	49.22	193	95
Mid-State Health Network	64.43	790	509
NorthCare Network	69.23	182	126
Northern MI Regional Entity	61.74	264	163
Oakland Co CMH Authority	37.80	127	48
Region 10	51.65	242	125
CMH Partnership of Southeast MI	78.05	123	96
Southwest MI Behavioral Health	71.60	81	58
Statewide Total		**2,865**	**1,693**

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

	Percentage	# MI Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.75	1,401	795
Lakeshore Regional Entity	69.02	184	127
Macomb Co CMH Services	66.25	323	214
Mid-State Health Network	68.19	1,383	943
NorthCare Network	59.92	257	154
Northern MI Regional Entity	55.32	479	265
Oakland Co CMH Authority	36.72	177	65
Region 10	55.10	412	227
CMH Partnership of Southeast MI	56.87	313	178
Southwest MI Behavioral Health	69.85	199	139
Statewide Total		**5,128**	**3,107**

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	39.45	692	273
Lakeshore Regional Entity	69.49	59	41
Macomb Co CMH Services	33.33	96	32
Mid-State Health Network	49.17	242	119
NorthCare Network	46.15	26	12
Northern MI Regional Entity	60.23	88	53
Oakland Co CMH Authority	22.73	44	10
Region 10	50.34	147	74
CMH Partnership of Southeast MI	64.52	93	60
Southwest MI Behavioral Health	87.13	101	88
Statewide Total		**1,588**	**762**

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	61.36	88	54
Lakeshore Regional Entity	51.61	31	16
Macomb Co CMH Services	74.36	39	29
Mid-State Health Network	72.46	69	50
NorthCare Network	56.52	23	13
Northern MI Regional Entity	64.52	31	20
Oakland Co CMH Authority	24.44	45	11
Region 10	75.76	33	25
CMH Partnership of Southeast MI	59.09	22	13
Southwest MI Behavioral Health	81.25	16	13
Statewide Total		**397**	**244**

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – MAY 13, 2026
VIA TEAMS

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

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

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

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

MONTHLY FINANCIALS
March 2026 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $543,878. Carry forward was reported as $2,844,054. The total Medicaid and HMP current year surplus was reported as $3,387,932. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $23,978,021.
- Traditional Medicaid showed $15,574,883 in revenue, and $112,178,716 in expenses, resulting in a net surplus of $3,396,167. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $2,844,054.
- Healthy Michigan Plan showed $13,430,188 in revenue, and $16,282,477 in expenses, resulting in a net deficit of $2,852,289. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $1,569,239 in revenue, and $1,383,976 in expenses, resulting in a net surplus of $185,263.
- SUD showed all funding source revenue of $11,019,605 and $9,512,296 in expenses, resulting in a net surplus of $1,507,309. Total PA2 funds were reported as $4,938,372.

PA2/Liquor Tax was summarized as follows:

Projected FY26 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$5,137,481	$1,847,106	$2,096,443	$4,913,143

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,137,481	$507,324	$706,433	$4,938,372

Medicaid revenue remains steady for the first five months of FY26 after the initial decline from September to October. Clarification was provided that the $2,844,054 carry forward shown is accurate as Northern Lakes' Final FSR was received on May 1st.

The NMRE's FY25 financial audit is scheduled for the week of May 18th. Roslund, Prestage, and Company (RPC) will report to the NMRE Board in June.

Chip asked about the region's net position at the end of FY25, as he is in discussions with the CEOs in Region 1 pertaining to Bridge Health. Deanna confirmed that, despite the $7.3M swing for Northern Lakes from Interim to Final FSR, the region was able to carry forward $2.8M from FY25 into FY26. A $1.7 retroactive adjustment (for minimum wage and ESTA) was reflected in the FY25 carry forward.

MOTION BY ERINN TRASK TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2026; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

EDIT UPDATE
The April 15th minutes were included in the meeting materials.

- The MDHHS Bureau of Children's Coordinated Health Policy & Supports (BCCHPS) is considering the possibility of allowing the entire G0276 code array (recreation, music, art & equine therapies, but **not** massage therapy) for use with group modifiers.
- 97155 (Adaptive Behavior Treatment with Protocol Modification) "reporting and costing considerations" column was updated to state "may" rather than "must" for co-occurring with those same codes.
- CCBHCs are asking whether they can use the H0039 (Assertive Community Treatment/ACT services, provided face-to-face, per 15 minutes) code with a modifier (WN) to identify crisis services.
- The support broker modifier (WM), to be used with T1017 (Targeted Case Management per 15 minutes), has been added to the code chart effective April 1, 2026.
- A new section has been added to the Encounter Data Intake & Data Support Section.
- The SUD Health Home team is proposing a change to current coding: S0280 is being proposed for initiation of services and S0281 for ongoing services.
- 22 updates were made to the Code Chart and Provider Qualifications on March 30, 2026. Reporting Requirements
- Community Living Supports (CLS) and Overnight Health and Safety (OHSS) changes:
  - The H0043 per diem code may be used for those individuals in the non-licensed setting that are authorized for 10 or more hours of CLS per day.
  - The TJ modifier may be used to allow for flagging beneficiaries with high utilization or 16+ hours of daytime CLS.
  - OHSS was an added service to the (i)SPA (pending approval of amendment).
  - The OHSS per diem code T2026 has been added.
  - Per diem code use for both CLS and OHSS is only approved for HSW and (i)SPA. Children who are on the SEDW or CWP and would meet the criteria to utilize per diem CLL and OHSS can be enrolled in the (i)SPA to utilize these per diem codes.

Eric asked whether anyone from OIG's office is on EDIT. Donna responded no, she does not think so. This question is in response to "duplicate" encounters found during OIG auditing. Clarification was made that what was found were not duplicate, but more than one 15-minute unit codes billed on the same day with unique start/stop times. A meeting is being scheduled with OIG, PCE, and others, possibly CIO Forum.

Donna noted that her retirement at the end of September will open up a spot for another member from the region to serve on EDIT. Anyone interested may contact the NMRE. The next EDIT meeting is scheduled for July 16th at 10:00AM.

EQI UPDATE

The Period 1 FY26 EQI Report is due to MDHHS on May 29th. The data pull date will be May 4th. Reports were requested from the CMHSPs by May 18th.

ELECTRONIC VISIT VERIFICATION (EVV)

A monthly leads meeting is taking place on this date at 11:00AM. There has not been any movement on with tying claims adjudication to the HHAeX system, but it is on the meeting agenda. The Regional group has suspended meetings but will resume when the adjudication piece moves forward.

HSW OPEN SLOTS UPDATE

The region currently has 704 of its 711 slots filled. Bea noted that a couple packets were in the queue, but some packets received were incomplete. The NMRE would like these finalized by May 15th. The CMHSPs were tasked with monitoring inactivity to secure payments.

CHAMPS Fix HSW Update & Verification Research Project

The May payment included $334K in FY25 recoupments (going back to May of 2024 – September 2025) for individuals coded as being in nursing facilities. The May payment was for 665 enrollees, which is short 39. Details will be provided to the CMHSPs in ShareFile.

Donna asked whether any information has been received regarding the recoupment of the October and November HSW (higher rate) payments. Deanna responded that she hasn't heard anything.

NMRE REVENUE & ELIGIBLES ANALYSIS

October 2025 through April 2026 revenue looks like September 2025; however, the NMRE observed a 5.3% decrease in eligibles between DAB, TANF, and HMP.

Overall, April revenue (all funding sources) was $450,247 lower than September 2025.

DAB			
	October 2023	April 2026	% Change
Revenue	$10,003,003	$11,059,335	10.56%
Enrollees	28,444	25,162	-11.54%
Average Payment per Enrollee	$352	$440	24.98%

HMP			
	October 2023	April 2026	% Change
Revenue	$2,369,569	$2,179,965	-8.00%
Enrollees	47,550	28,148	-40.80%
Average Payment per Enrollee	$50	$77	55.41%

TANF			
	October 2023	April 2026	% Change
Revenue	$2,865,200	$2,744,885	-4.20%
Enrollees	66,801	50,293	-24.71%
Average Payment per Enrollee	$43	$55	27.25%

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

HSW			
	October 2023	April 2026	% Change
Revenue	$4,638,399	$5,131,480	10.63%
Enrollees	650	699	7.54%
Average Payment per Enrollee	$7,136	$7,341	2.88%

SED			
	October 2023	April 2026	% Change
Revenue	$40,846	$30,918	-24.31%
Enrollees	21	42	100%
Average Payment per Enrollee*	$1,945	736	-62.15%

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

TOTAL			
	October 2023	April 2026	% Change
	$19,953,899	$21,178,204	6.14%

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

Mid-Year Rate Adjustment
No date has been specified, but MDHHS is looking at a mid-year rate adjustment for FY26. Without a rate adjustment, the state shortfall for DAB/TANF/HMP is $80M. Although the NMRE accounts for 5% of the states capitated revenue, the NMRE accounts for 15% of the shortfall.

House Resolution 1/HR1
Chip has observed a huge shift from HMP to TANF, likely tied to HR1. For FY27, each CMHSP will have a huge shift from HMP (due to work requirements and six-moth redeterminations) to GF unless MDHHS moves to individuals to TANF. Chip is concerned that the legislature is allocating FY27 revenue based on current dynamics, when this big change goes into effect January 1, 2027.

CMS is expected to release HR1 final rule/guidance on June 1, 2026.

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

Chief Executive Officer Report

May 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.

April 24: Attended and participated in statewide CIO Forum.

April 30: Attended NMRE Internal Operations Committee meeting.

May 1: Met with legal regarding COC PIHP contract opinion and order.

May 4: Attended and participated in NMRE SUD Oversight Committee meeting.

May 5: Attended and participated in PIHP CEO meeting.

May 7: Attended and participated in MDHHS PIHP Operations meeting.

May 13: Attended and participated in Regional Finance Committee meeting.

May 14: Attended NECMHA Board Planning session.

May 19: Chaired NMRE Regional Operations Committee Meeting.

May 22: Attended and participated in statewide CIO Forum.

Northern Michigan Regional Entity

March 2026 Finance Report

March 2026 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	3,396,167	2,844,054	13,519,285
Healthy Michigan	(2,852,289)	-	7,070,804
	$ 543,878	$ 2,844,054	$ 20,590,089

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	(3,046,183)	1,332,387	(3,665,167)	1,786,567	1,367,349	2,379,325	389,600	$ 543,878
Carry Forward		-	-	-	-	-	-	2,844,054
Total Med/HMP Current Year Surplus	(3,046,183)	1,332,387	(3,665,167)	1,786,567	1,367,349	2,379,325	389,600	$ 3,387,932
Medicaid & HMP Internal Service Fund								20,590,089
Total Medicaid & HMP Net Surplus								$ 23,978,021

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through March 31, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 113,304,818	$ 2,270,065						$ 115,574,883
CMHSP Distributions	(111,076,355)		35,937,634	30,162,791	18,205,891	16,987,814	9,782,225	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	2,228,463	2,270,065	35,937,634	30,162,791	18,205,891	16,987,814	9,782,225	115,574,883
Expense								
PIHP Admin	1,669,579	23,245						1,692,824
PIHP SUD Admin		55,264						55,264
SUD Access Center		-						-
Insurance Provider Assessment	467,508	7,280						474,788
Hospital Rate Adjuster	1,735,874							1,735,874
Services	-	1,486,003	38,172,543	28,217,830	16,779,344	14,447,212	9,117,034	108,219,966
Total expense	3,872,961	1,571,792	38,172,543	28,217,830	16,779,344	14,447,212	9,117,034	112,178,716
Net Actual Surplus (Deficit)	$ (1,644,498)	$ 698,273	$ (2,234,909)	$ 1,944,961	$ 1,426,547	$ 2,540,603	$ 665,191	$ 3,396,167

Notes

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

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through March 31, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 8,701,552	$ 4,728,636						$ 13,430,188
CMHSP Distributions	(8,389,101)		3,060,629	2,378,079	1,085,661	1,137,575	727,157	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	312,451	4,728,636	3,060,629	2,378,079	1,085,661	1,137,575	727,157	13,430,188
Expense								
PIHP Admin	163,836	60,563						224,399
PIHP SUD Admin		143,989						143,989
SUD Access Center		-						-
Insurance Provider Assessment	46,651	18,234						64,885
Hospital Rate Adjuster	1,503,649							1,503,649
Services	-	3,871,736	4,490,887	2,536,473	1,144,859	1,298,852	1,002,748	14,345,555
Total expense	1,714,136	4,094,522	4,490,887	2,536,473	1,144,859	1,298,852	1,002,748	16,282,477
Net Surplus (Deficit)	$ (1,401,685)	$ 634,114	$ (1,430,258)	$ (158,394)	$ (59,198)	$ (161,277)	$ (275,591)	$ (2,852,289)

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

Net Surplus (Deficit) MA/HMP	**$ (3,046,183)**	**$ 1,332,387**	**$ (3,665,167)**	**$ 1,786,567**	**$ 1,367,349**	**$ 2,379,325**	**$ 389,600**	**$ 543,878**
Medicaid/HMP Carry Forward								**2,844,054**
Total Med/HMP Current Year Surplus								$ 3,387,932
Medicaid & HMP ISF - based on current FSR								**20,590,089**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 23,978,021**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2025 through March 31, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 492,112		191,981	197,947	254,804	160,744	271,651	$ 1,569,239
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	492,112	-	191,981	197,947	254,804	160,744	271,651	1,569,239
Expense								
PIHP Admin	20,950							20,950
BHH Admin	23,724							23,724
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	262,175		191,981	197,947	254,804	160,744	271,651	1,339,302
Total expense	306,849	-	191,981	197,947	254,804	160,744	271,651	1,383,976
Net Surplus (Deficit)	$ 185,263	$ -	$ -	$ -	$ -	$ -	$ -	$ 185,263

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2025 through March 31, 2026

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 2,270,065	$ 4,728,636	$ 2,043,640	$ 1,270,833	$ 706,431	$ 11,019,605
Expense						
PIHP Admin						110,870
SUD Admin						406,839
Administration	78,509	204,552	91,401	143,247		517,709
OHH Admin			47,286	-		47,286
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	7,280	18,234	-			25,514
Services:						
Treatment	1,486,003	3,871,736	1,730,032	723,934	706,431	8,518,136
Prevention	-	-	-	403,651	-	403,651
Healing and Recovery Grant				-		-
Alcohol Use Disorder Services				-		
ARPA Grant	-	-	-	-	-	-
Total expense	1,571,792	4,094,522	1,868,719	1,270,833	706,431	9,512,296
PA2 Redirect			-	-		-
Net Surplus (Deficit)	$ 698,273	$ 634,114	$ 174,921	$ 0	$ -	$ 1,507,309

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2025 through March 31, 2026

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 113,304,818	$ 2,270,065	$ -	$ 115,574,883
Medicaid Savings	2,636,820	-	-	2,636,820
Healthy Michigan	8,701,552	4,728,636	-	13,430,188
Healthy Michigan Savings	-	-	-	-
Health Home	1,569,239	-	-	1,569,239
Opioid Health Home	-	2,043,640	-	2,043,640
Substance Use Disorder Block Grant	-	1,270,833	-	1,270,833
Public Act 2 (Liquor tax)	-	706,431	-	706,431
Affiliate local drawdown	297,408	-	-	297,408
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	-	-	-
Healing & Recovery Revenue	-	-	-	-
Veteran Navigator Grant	75,104	-	-	75,104
SOR Grant Revenue	-	800,602	-	800,602
Gambling Grant Revenue	-	84,194	-	84,194
Other Revenue	105	-	2,023	2,128
Total operating revenue	126,585,046	11,904,401	2,023	138,491,470
Operating expenses				
General Administration	1,965,235	406,839	-	2,372,074
Prevention Administration	-	64,441	-	64,441
OHH Administration	-	47,286	-	47,286
BHH Administration	23,724	-	-	23,724
Insurance Provider Assessment	514,159	25,514	-	539,673
Hospital Rate Adjuster	3,239,523	-	-	3,239,523
Payments to Affiliates:				
Medicaid Services	106,733,963	1,486,003	-	108,219,966
Healthy Michigan Services	10,473,819	3,871,736	-	14,345,555
Health Home Services	1,339,302	-	-	1,339,302
Opioid Health Home Services	-	1,730,032	-	1,730,032
Community Grant	-	723,934	-	723,934
Prevention	-	339,210	-	339,210
State Disability Assistance	-	-	-	-
Alcohol Use Disorder Services	-	-	-	-
ARPA Grant	-	-	-	-
Public Act 2 (Liquor tax)	-	706,432	-	706,432
Local PBIP	-	-	-	-
Local Match Drawdown	297,408	-	-	297,408
Miscellanous Grant	-	-	-	-
Healing & Recovery Grant	-	-	-	-
Veteran Navigator Grant	75,104	-	-	75,104
SOR Grant Expenses	-	800,602	-	800,602
Gambling Grant Expenses	-	84,194	-	84,194
Total operating expenses	124,662,237	10,286,223	-	134,948,460
CY Unspent funds	1,922,809	1,618,178	2,023	3,543,010
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	656,477	10,539,756	20,586,761	31,782,994
Unspent funds - ending	$ 2,579,286	$ 12,157,934	$ 20,588,784	$ 35,326,004

Northern Michigan Regional Entity

Statement of Net Position

March 31, 2026

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 46,880,429	$ 11,576,397	$ 20,588,784	$ 79,045,610
Accounts Receivable	9,225,844	2,150,194	-	11,376,038
Prepaids	59,988	-	-	59,988
Total current assets	56,166,261	13,726,591	20,588,784	90,481,636
Noncurrent Assets				
Capital assets	373,818	-	-	373,818
Total Assets	56,540,079	13,726,591	20,588,784	90,855,454
Liabilities				
Current liabilities				
Accounts payable	53,672,697	1,568,657	-	55,241,354
Accrued liabilities	288,096	-	-	288,096
Unearned revenue	-	-	-	-
Total current liabilities	53,960,793	1,568,657	-	55,529,450
Unspent funds	$ 2,579,286	$ 12,157,934	$ 20,588,784	$ 35,326,004

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 229,702,368	$ 114,851,184	$ 113,304,818	$ (1,546,366)	(1.35%)
Carryover	4,449,500	2,224,750	2,636,820	412,070	0
Healthy Michigan					
Capitation	17,969,268	8,984,634	8,701,552	(283,082)	(3.15%)
Carryover	-	-	-	-	0.00%
Health Home	2,844,551	1,422,276	1,569,239	146,964	10.33%
Affiliate local drawdown	594,816	297,408	297,408	-	0.00%
Performance Bonus Incentive	2,184,505	2,184,505	-	(2,184,505)	(100.00%)
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	55,002	75,104	20,102	36.55%
Other Revenue	-	-	105	105	0.00%
Total operating revenue	257,855,008	130,019,759	126,585,046	(3,434,713)	(2.64%)
Operating expenses					
General Administration	4,481,376	2,143,712	1,965,235	178,477	8.33%
Health Home Administration	-	-	23,724	(23,724)	0.00%
Insurance Provider Assessment	2,038,488	1,019,244	514,159	505,085	49.55%
Hospital Rate Adjuster	7,687,213	3,843,607	3,239,523	604,084	15.72%
Local PBIP	2,184,505	-	-	-	0.00%
Local Match Drawdown	594,816	297,408	297,408	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	135,336	56,610	75,104	(18,494)	(32.67%)
Payments to Affiliates:					
Medicaid Services	218,897,134	109,448,567	106,733,963	2,714,604	2.48%
Healthy Michigan Services	15,738,212	7,869,106	10,473,819	(2,604,713)	(33.10%)
Health Home Services	2,844,551	1,422,276	1,339,302	82,974	5.83%
Total operating expenses	254,601,631	126,100,529	124,662,237	1,438,292	1.14%
CY Unspent funds	$ 3,253,377	$ 3,919,230	1,922,809	$ (1,996,421)	
Transfers in			-		
Transfers out			-	124,662,237	
Unspent funds - beginning			656,477		
Unspent funds - ending			$ 2,579,286	1,922,809	

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 7,015,245	$ 3,507,623	$ 2,270,065	$ (1,237,558)	(35.28%)
Healthy Michigan	12,312,158	6,156,079	4,728,636	(1,427,443)	(23.19%)
Substance Use Disorder Block Grant	3,525,032	1,601,123	1,270,833	(330,290)	(20.63%)
Opioid Health Home	3,556,831	1,778,416	2,043,640	265,225	14.91%
Public Act 2 (Liquor tax)	1,794,486	-	706,431	706,431	0.00%
Miscellanous Grants	4,000	2,000	-	(2,000)	(100.00%)
Alcohol Disorder Grant	285,600	142,800	-	(142,800)	(100.00%)
Healing & Recovery Grant	150,000	75,000	-	(75,000)	(100.00%)
SOR Grant	1,546,979	773,490	800,602	27,113	3.51%
Gambling Prevention Grant	200,000	100,000	84,194	(15,806)	(15.81%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	30,390,331	14,136,529	11,904,401	(2,232,128)	(15.79%)
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,025,044	449,366	406,839	42,527	9.46%
Prevention Administration	143,928	71,964	64,441	7,523	10.45%
Insurance Provider Assessment	120,208	60,104	25,514	34,590	57.55%
Medicaid Services	3,700,000	1,850,000	1,486,003	363,997	19.68%
Healthy Michigan Services	8,634,200	4,317,100	3,871,736	445,364	10.32%
Community Grant	2,130,419	1,065,210	723,934	341,276	32.04%
Prevention	838,096	257,655	339,210	(81,556)	(31.65%)
State Disability Assistance	93,043	46,522	-	46,522	100.00%
Alcohol Use Disorder Services	285,600	142,800	-	142,800	100.00%
ARPA Grant	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	47,286	(47,286)	0.00%
Opioid Health Home Services	3,556,813	1,778,407	1,730,032	48,374	2.72%
Miscellanous Grants	4,000	2,000	-	2,000	100.00%
Healing & Recovery Grant	150,000	75,000	-	75,000	100.00%
SOR Grant	1,546,979	773,490	800,602	(27,113)	(3.51%)
Gambling Prevention	200,000	100,000	84,194	15,806	15.81%
PA2	1,794,492	-	706,432	(706,432)	0.00%
Total operating expenses	24,222,822	10,989,616	10,286,223	703,393	6.40%
CY Unspent funds	$ 6,167,509	$ 3,146,914	1,618,178	$ (1,528,736)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			10,539,756		
Unspent funds - ending			$ 12,157,934		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 2,442,372	$ 1,221,186	$ 1,055,301	$ 165,885	13.58%
Fringes	768,300	376,674	334,781	41,893	11.12%
Contractual	952,800	386,902	441,098	(54,196)	(14.01%)
Board expenses	13,500	6,750	8,518	(1,768)	(26.19%)
Day of recovery	14,000	7,000	350	6,650	95.00%
Facilities	133,000	66,498	73,471	(6,973)	(10.49%)
Other	157,404	78,702	51,716	26,986	34.29%
Total General Admin	$ 4,481,376	$ 2,143,712	$ 1,965,235	$ 178,477	8.33%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

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

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 646,392	$ 323,196	$ 258,939	$ 64,257	19.88%
Fringes	227,940	113,970	86,312	27,658	24.27%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	114,000	-	49,200	(49,200)	0.00%
Board expenses	5,000	2,500	1,530	970	38.80%
Day of Recover	9,000	4,500	150	4,350	96.67%
Facilities	-	-	-	-	0.00%
Other	22,712	5,200	10,708	(5,508)	(105.92%)
Total operating expenses	$ 1,025,044	$ 449,366	$ 406,839	$ 42,527	9.46%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2025 through March 31, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	3,500	1,750	2,023	273	15.60%
Total operating revenue	3,500	1,750	2,023	273	15.60%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 3,500	$ 1,750	2,023	$ 273	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,586,761		
Unspent funds - ending			$ 20,588,784		

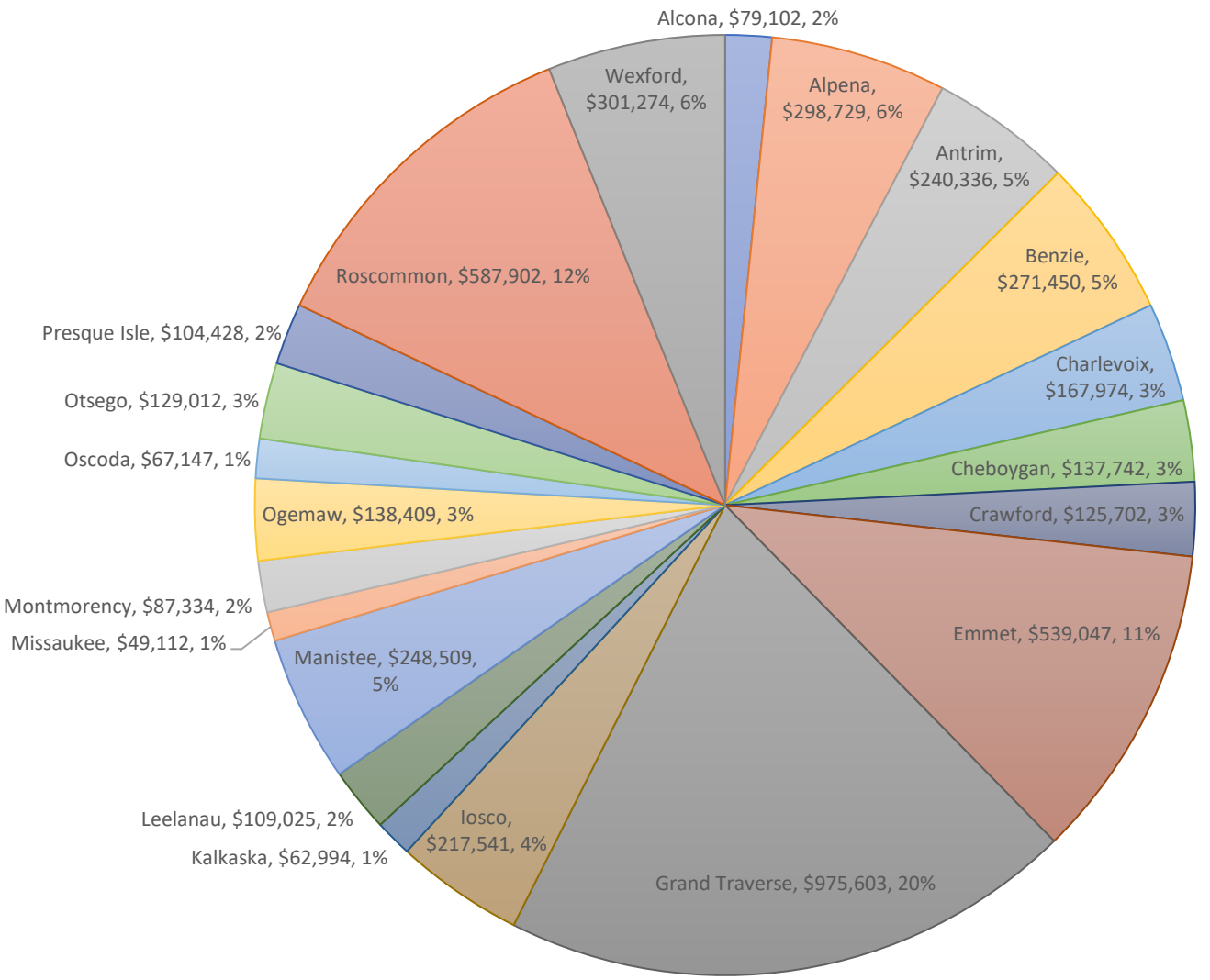
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2025 through March 31, 2026

	Projected FY26 Activity				Actual FY26 Activity			
	Beginning Balance	FY26 Projected Revenue	FY26 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 79,981	$ 23,013	$ 24,001	$ 78,993	$ 5,860	6,739	$ -	$ 79,102
Alpena	315,153	81,249	87,854	308,548	23,248	39,673	-	298,729
Antrim	247,799	71,430	46,424	272,805	19,924	27,387	-	240,336
Benzie	276,050	64,021	47,793	292,278	17,520	22,120	-	271,450
Charlevoix	180,985	106,977	92,341	195,621	28,595	41,606	-	167,974
Cheboygan	161,840	85,508	81,361	165,987	23,808	47,907	-	137,742
Crawford	127,739	36,205	33,849	130,095	11,928	13,965	-	125,702
Emmet	573,810	182,951	332,159	424,602	48,924	83,688	-	539,047
Grand Traverse	1,036,830	464,163	698,152	802,841	126,337	187,564	-	975,603
Iosco	217,704	84,319	66,511	235,512	23,374	23,536	-	217,541
Kalkaska	53,910	41,796	3,936	91,770	11,520	2,436	-	62,994
Leelanau	109,318	63,811	44,237	128,892	16,333	16,626	-	109,025
Manistee	250,122	82,480	40,719	291,883	22,657	24,271	-	248,509
Missaukee	48,934	22,352	7,175	64,112	6,353	6,175	-	49,112
Montmorency	85,825	30,318	14,262	101,881	6,970	5,461	-	87,334
Ogemaw	123,654	68,787	26,413	166,029	19,339	4,585	-	138,409
Oscoda	65,547	21,668	17,149	70,065	6,847	5,247	-	67,147
Otsego	135,933	105,067	111,286	129,714	29,432	36,352	-	129,012
Presque Isle	104,651	24,977	20,080	109,548	7,335	7,558	-	104,428
Roscommon	613,222	87,317	130,060	570,480	23,737	49,057	-	587,902
Wexford	328,472	98,696	145,681	281,487	27,281	54,479	-	301,274
	5,137,481	1,847,106	2,071,443	4,913,143	507,324	706,433	-	4,938,372
PA2 Redirect								-
								4,938,372

PA2/Liquor Tax Fund Balances by County

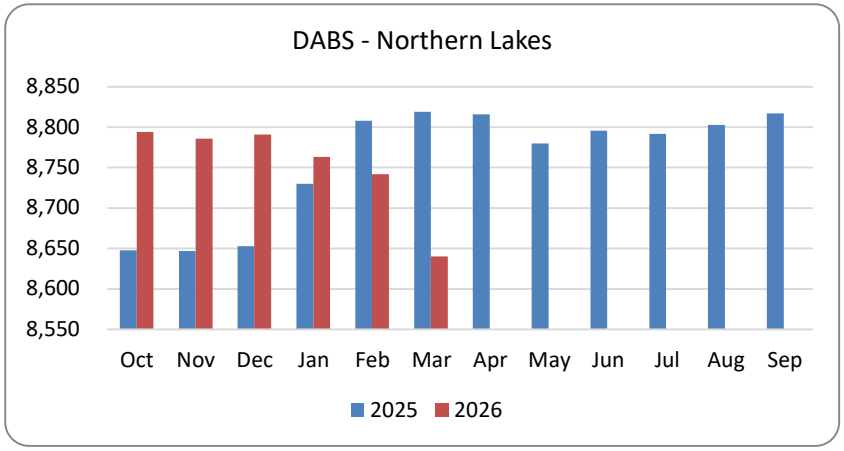


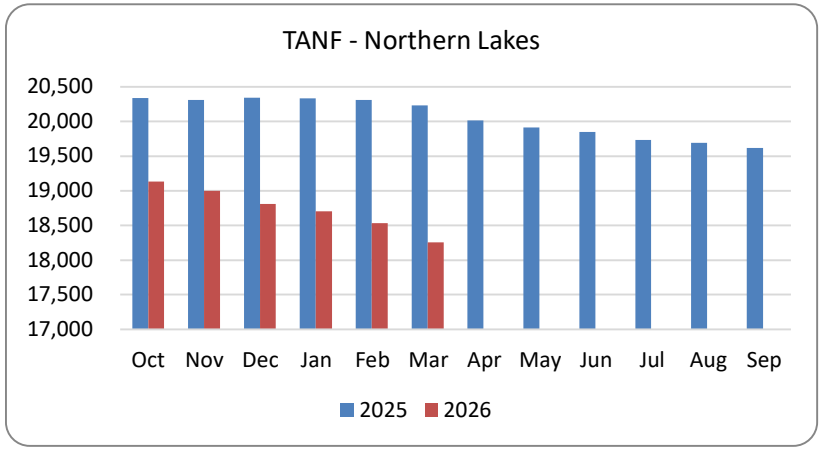
Northern Michigan Regional Entity

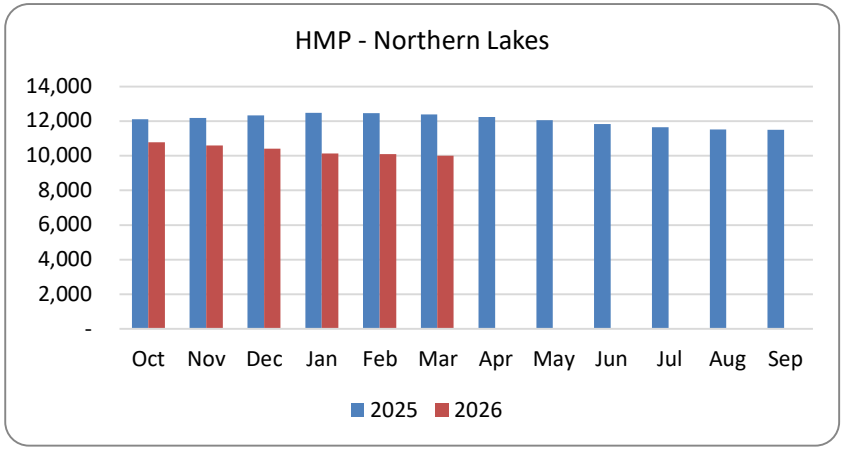
Narrative

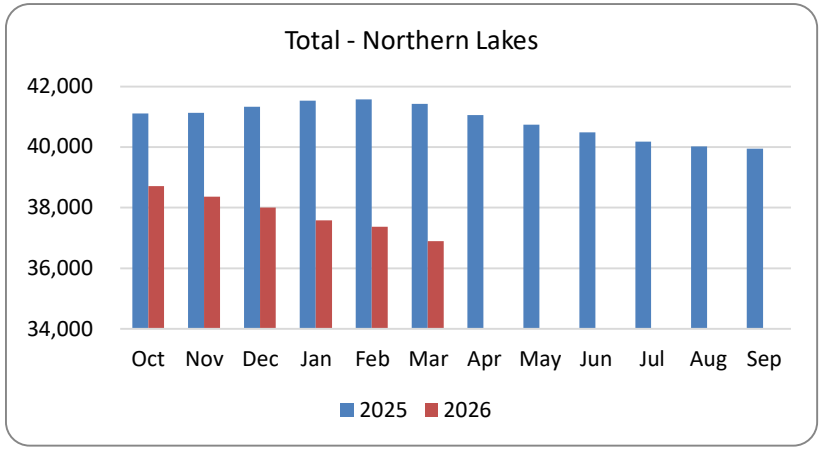
October 1, 2025 through March 31, 2026

Northern Lakes Eligible Members Trending - based on payment files







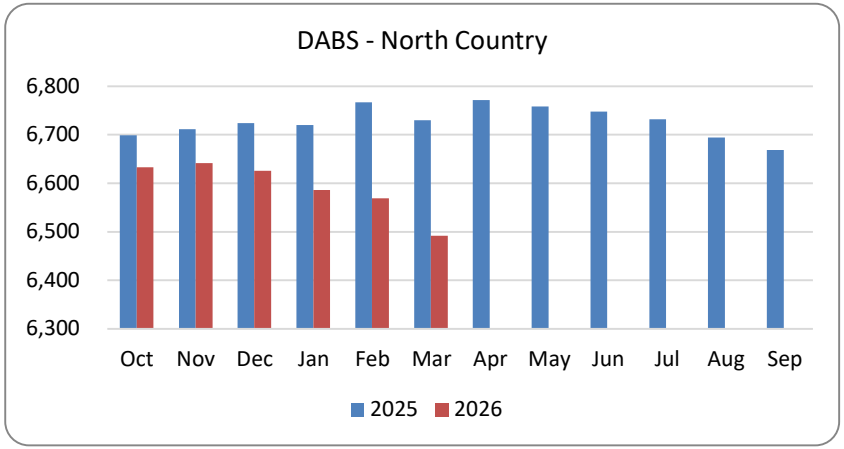


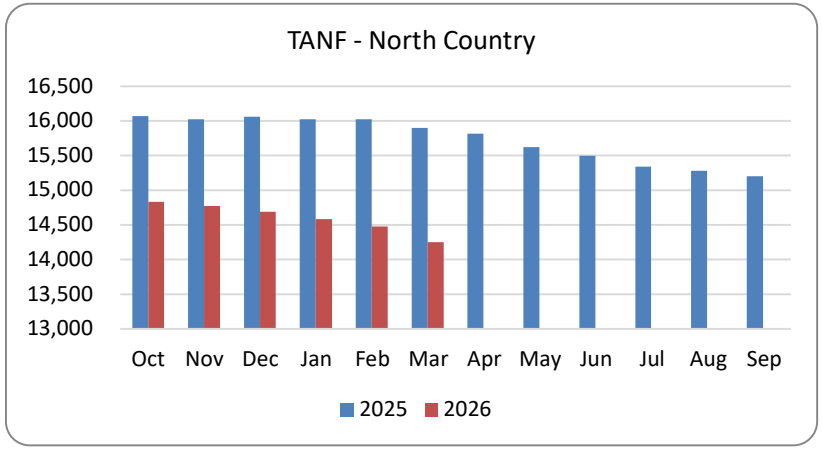
Northern Michigan Regional Entity

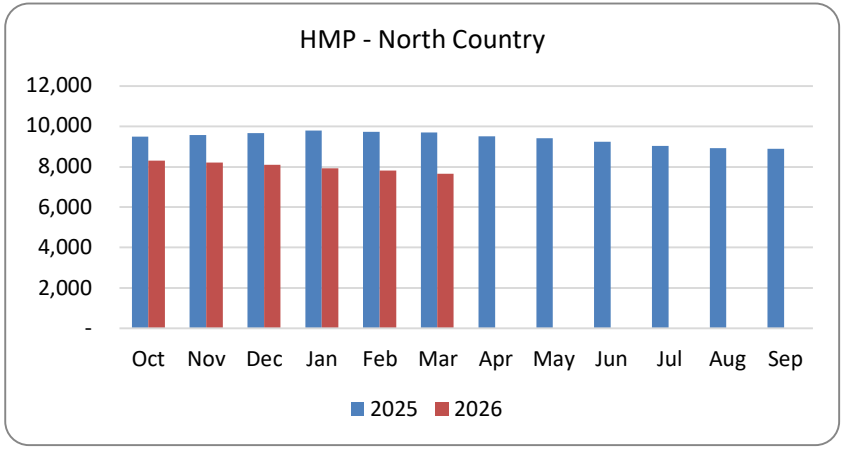
Narrative

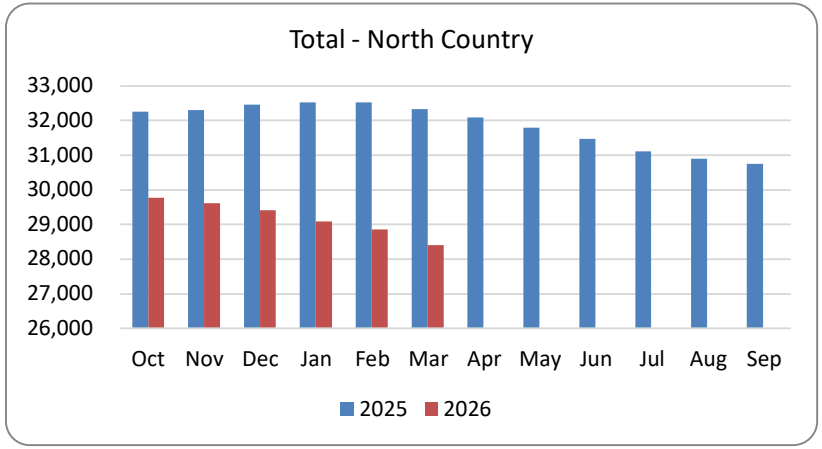
October 1, 2025 through March 31, 2026

North Country Eligible Members Trending - based on payment files







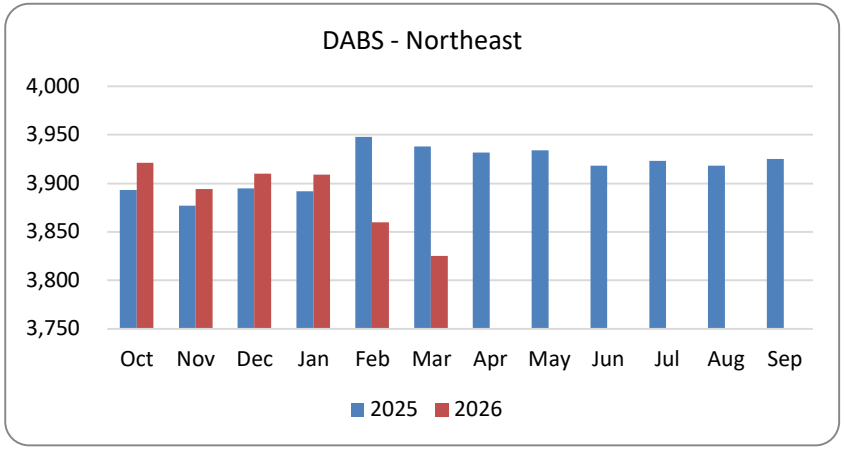


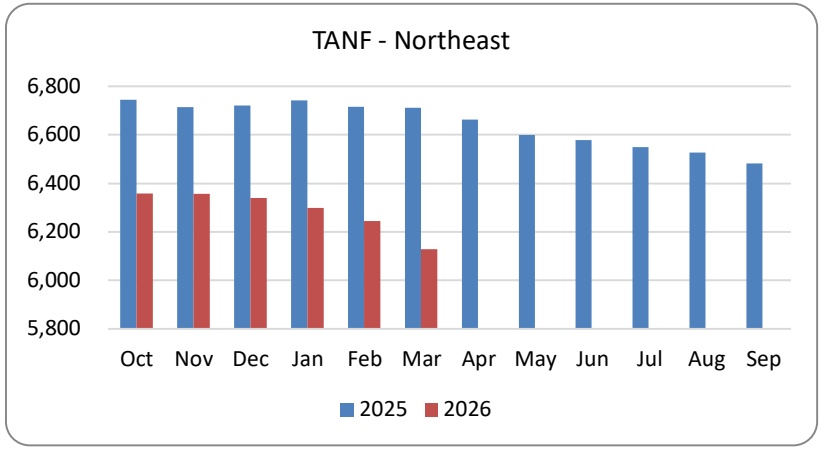
Northern Michigan Regional Entity

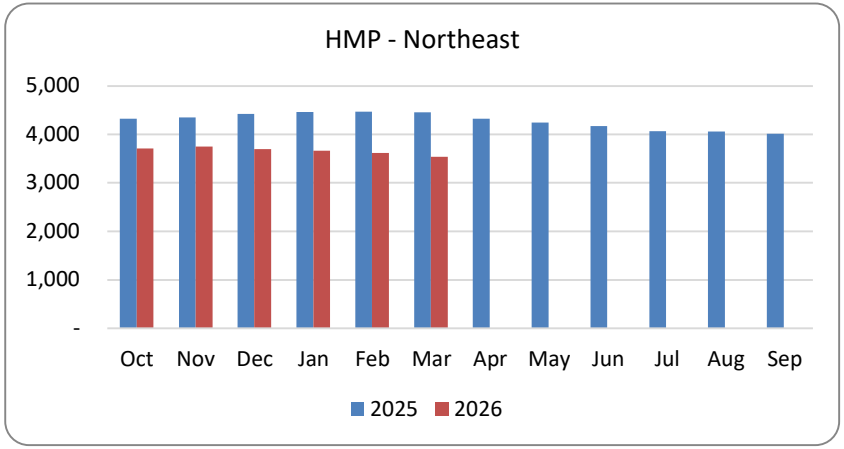
Narrative

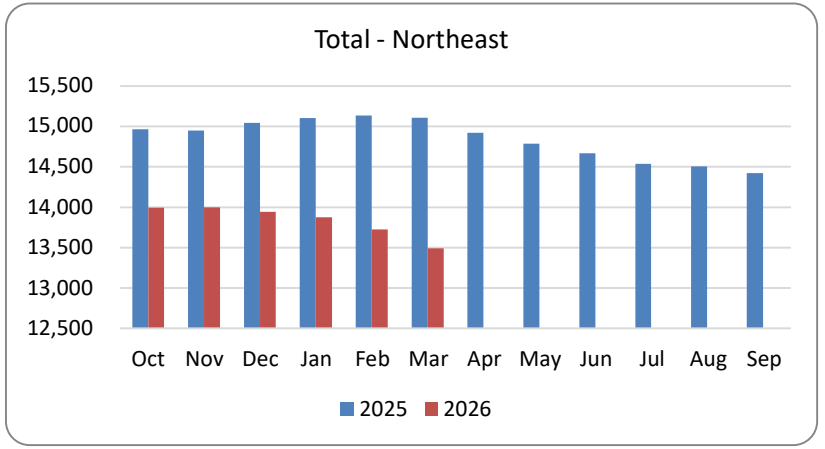
October 1, 2025 through March 31, 2026

Northeast Eligible Members Trending - based on payment files







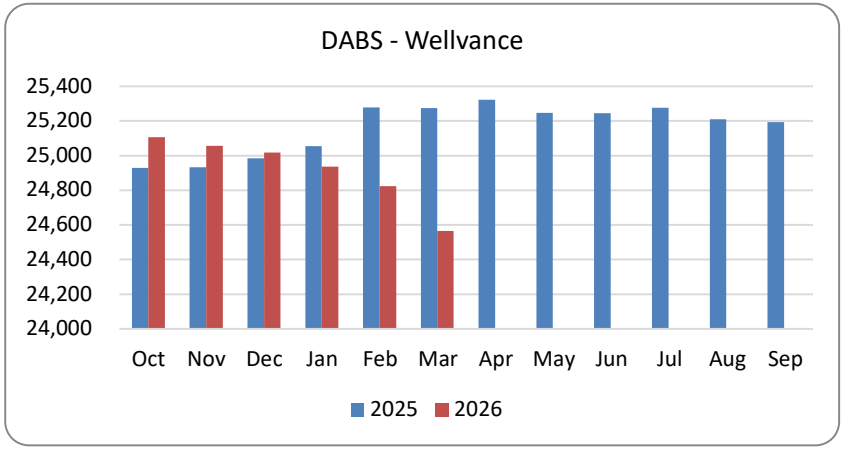


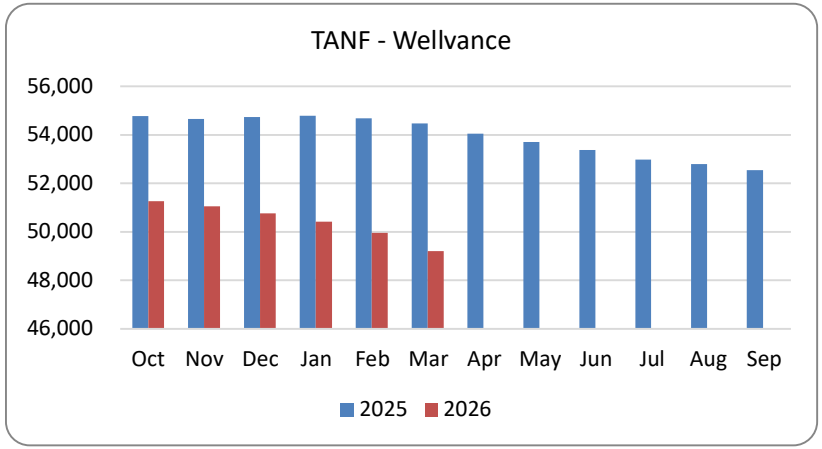
Northern Michigan Regional Entity

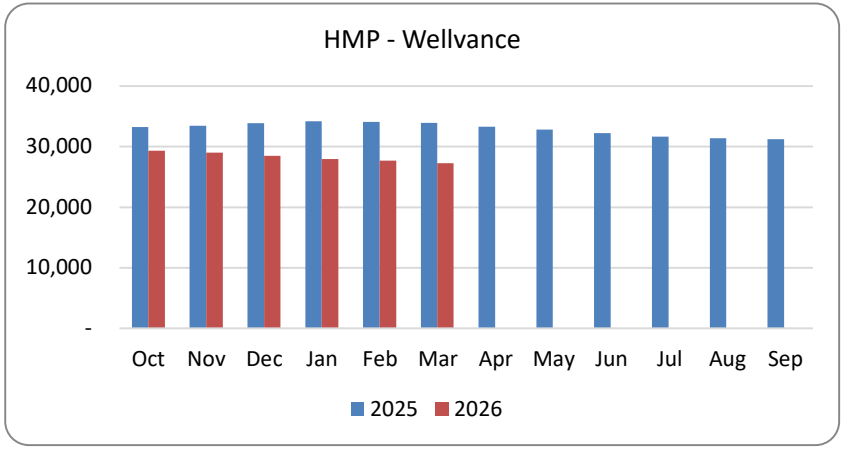
Narrative

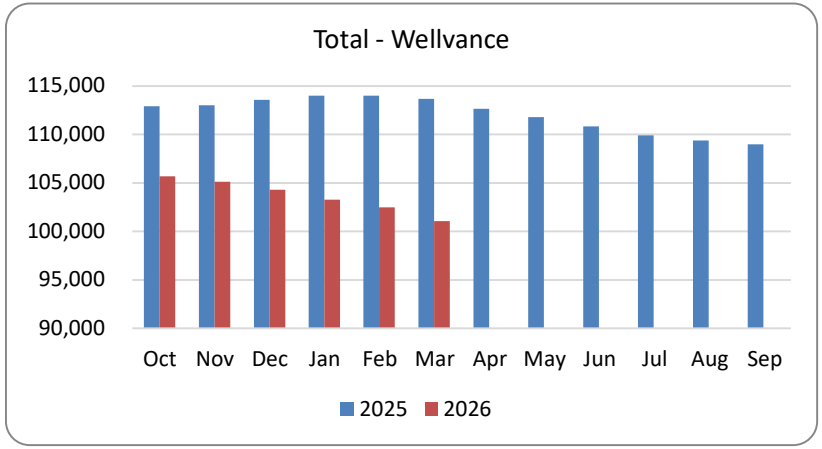
October 1, 2025 through March 31, 2026

Wellvance Eligible Members Trending - based on payment files







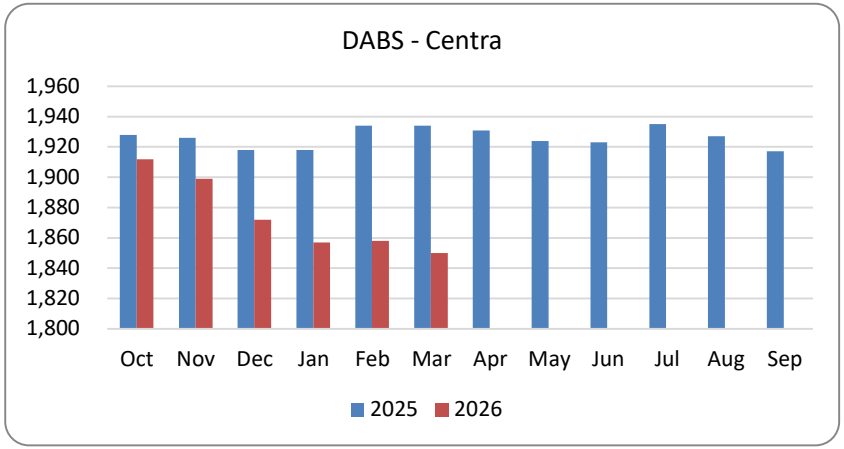


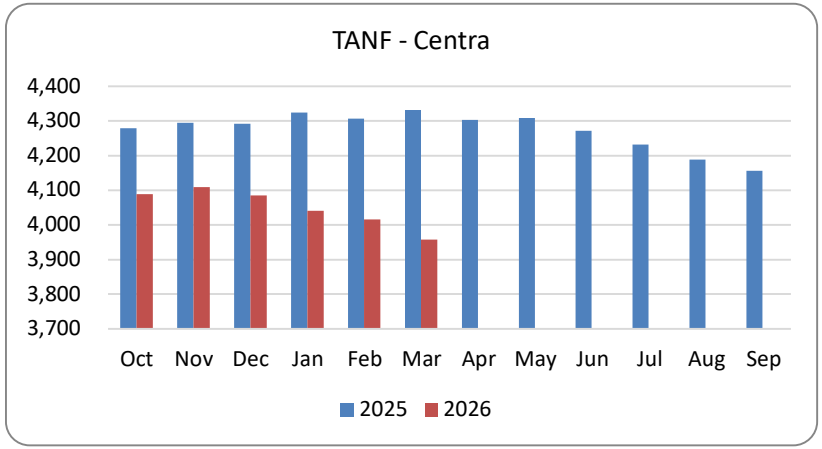
Northern Michigan Regional Entity

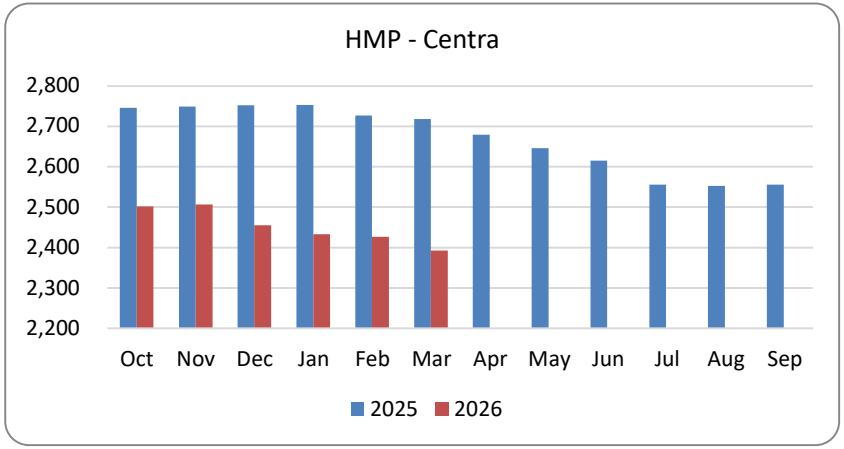
Narrative

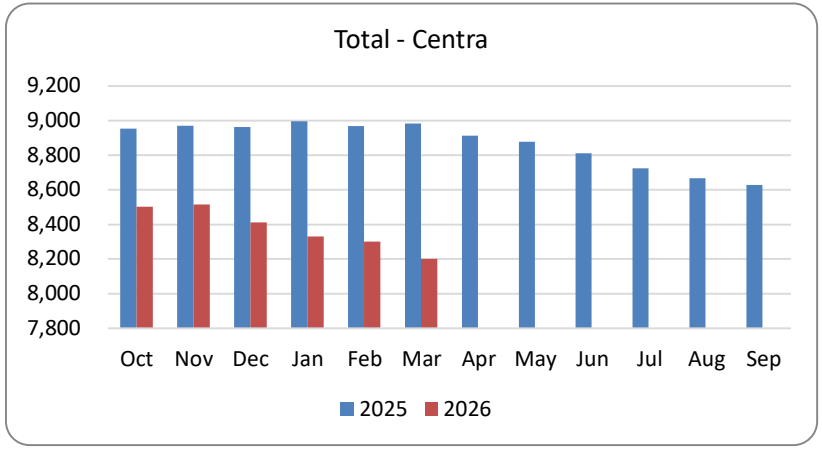
October 1, 2025 through March 31, 2026

Centra Wellness Eligible Members Trending - based on payment files







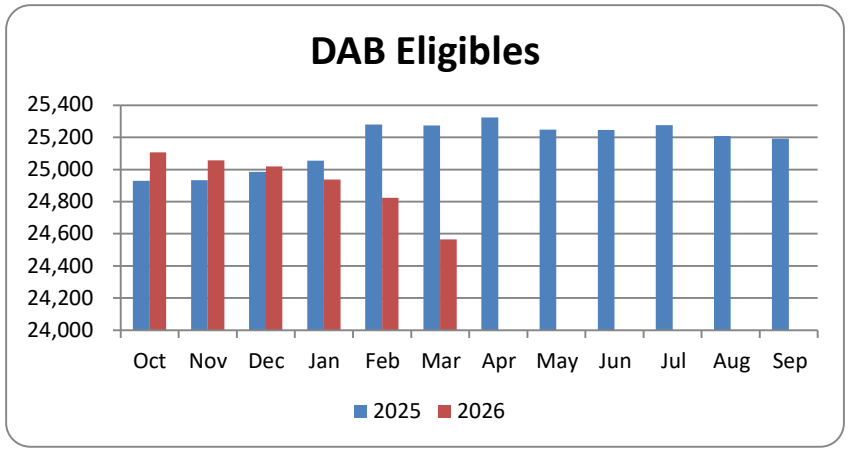


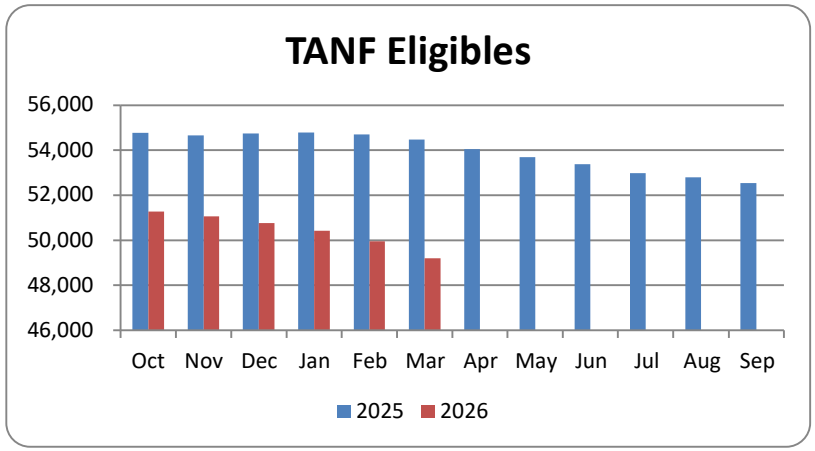
Northern Michigan Regional Entity

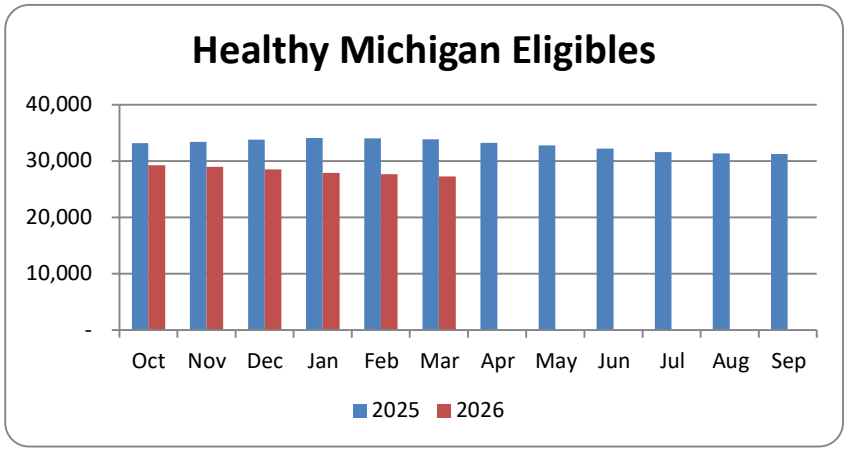
Narrative

October 1, 2025 through March 31, 2026

Regional Eligible Trending





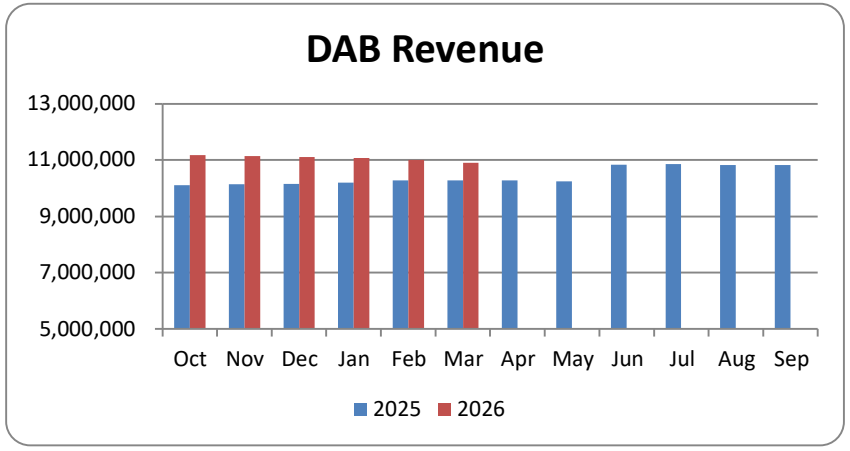


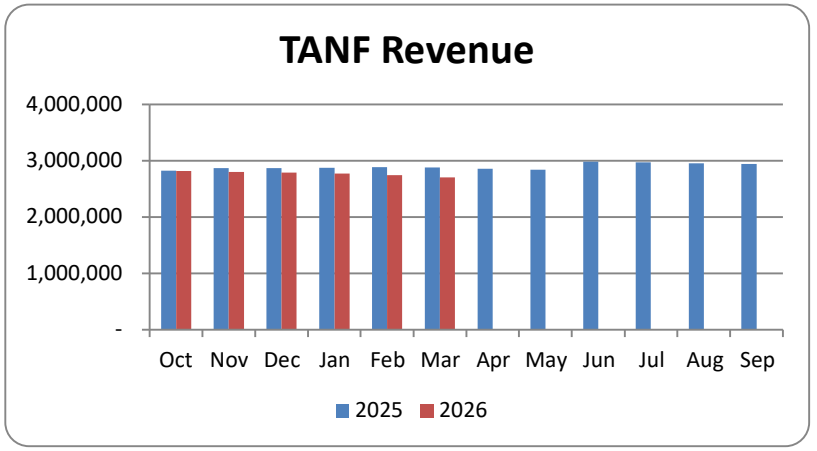
Northern Michigan Regional Entity

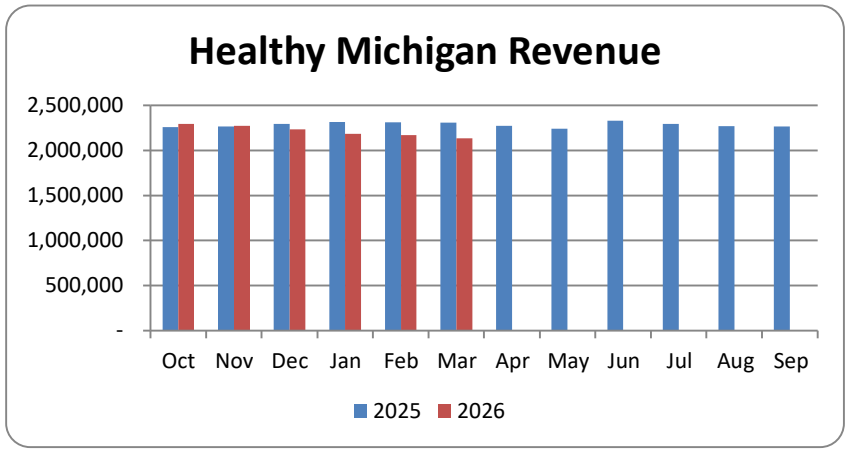
Narrative

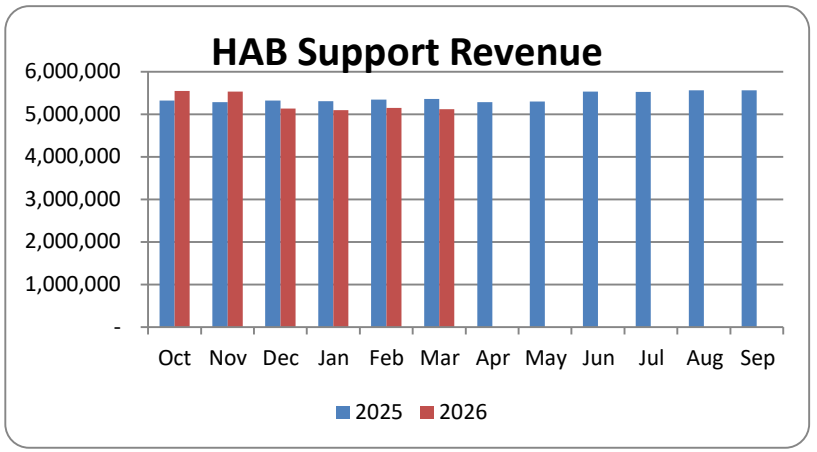
October 1, 2025 through March 31, 2026

Regional Revenue Trending









NORTHERN MICHIGAN REGIONAL ENTITY
OPERATIONS COMMITTEE MEETING
9:30AM – MAY 19, 2026
GAYLORD CONFERENCE ROOM

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

REVIEW OF AGENDA AND ADDITIONS

Mental Health Framework was added to the meeting agenda. Ms. Otremba offered to provide an update on the current situation with Serenity House.

APPROVAL OF PREVIOUS MINUTES

The minutes from April 21st were included in the meeting materials.

MOTION BY NENA SORK TO APPROVE THE APRIL 21, 2026 MINUTES OF THE NORTHERN MICHIGAN REGIONAL ENTITY OPERATIONS COMMITTEE; SUPPORT BY TRISH OTREMBA. MOTION CARRIED.

FINANCE COMMITTEE AND RELATED

March 2026 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $543,878. Carry forward was reported as $2,844,054. The total Medicaid and HMP current year surplus was reported as $3,387,932. The total Medicaid and HMP Internal Service Fund was reported as $20,590,089. The total Medicaid and HMP net surplus was reported as $23,978,021.
- Traditional Medicaid showed $15,574,883 in revenue, and $112,178,716 in expenses, resulting in a net surplus of $3,396,167. Medicaid ISF was reported as $13,519,285 based on the current FSR. Medicaid Savings was reported as $2,844,054.
- Healthy Michigan Plan showed $13,430,188 in revenue, and $16,282,477 in expenses, resulting in a net deficit of $2,852,289. HMP ISF was reported as $7,070,804 based on the current FSR. HMP savings was reported as $0.
- Health Home showed $1,569,239 in revenue, and $1,383,976 in expenses, resulting in a net surplus of $185,263.
- SUD showed all funding source revenue of $11,019,605 and $9,512,296 in expenses, resulting in a net surplus of $1,507,309. Total PA2 funds were reported as $4,938,372.

PA2/Liquor Tax was summarized as follows:

Projected FY26 Activity			
Beginning Balance	Projected Revenue	Approved Projects	Projected Ending Balance
$5,137,481	$1,847,106	$2,096,443	$4,913,143

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,137,481	$507,324	$706,433	$4,938,372

	Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
Medicaid	$665,191	$1,944,961	$1,426,547	($2,234,909)	$2,540,603
HMP	($275,591)	($158,394)	($59,198)	($1,430,258)	($161,277)
Total	$389,600	$1,786,567	$1,367,349	($3,665,167)	$2,379,325

The $1,149,000 that the ISF was funded beyond 7.5% total Medicaid capitation was moved into FY25 revenue which boosted the carry forward. HMP continues to be overspent. $2.8M (surplus) Medicaid was moved into HMP. Revenue is not where Milliman projected, particularly for HMP.

Mr. Babbitt drew attention to the NMRE MH Net Surplus (Deficit) MA/HMP amount listed as -$3,046,183. Clarification was provided that this is an IPA or HSA accrual, rather than an overspend.

SUD surplus funding is largely due to the lower number of individuals seeking services (people dropping off Medicaid, reluctant to enter into 90-day residential programs). Outpatient admissions fell 39% from FY19 to FY25, likely due to the drop in HMP eligible populations and availability of these services through the SUD Health Home, primary care, and telehealth providers.

Ms. Zeller shared that local providers often don't accept individuals into treatment who have a primary diagnosis of SUD if they also have co-occurring mental health concerns. The region really has no providers that cover all the aspects of the 3.7 level of care. It was noted that, effective October 1, 2026, 3.7 residential and withdrawal management will be combined under a new ASAM change. Mr. Kurtz stressed the need for the Gand Traverse Mental Health Crisis Center to loop the NMRE in on SUD referrals.

Ms. Sork referenced the recoupment of the October and November HSW (higher rate) payments. Ms. Yockey responded that she hadn't heard anything regarding the timing of the recoupment.

MOTION BY TRISH OTREMBA TO RECOMMEND APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2026; SUPPORT BY LYNDA ZELLER. MOTION APPROVED.

PM/PM Revenue Projections
October 2025 through April 2026 revenue looks like September 2025; however, the NMRE observed a 5.3% decrease in eligibles between DAB, TANF, and HMP.

Overall, April revenue (all funding sources) was $450,247 lower than September 2025.

No date has been specified, but MDHHS is looking at a mid-year rate adjustment for FY26. Without a rate adjustment, the state shortfall for DAB/TANF/HMP is $80M. Although the NMRE accounts for 5% of the states capitated revenue, the NMRE accounts for 15% of the shortfall.

COC PIHP CONTRACT

Judge Sima Patel issued an opinion on April 29, 2026 Court of Claims case #24-000198-MZ regarding the FY25 PIHP Contract. The Court issued a mixed ruling. MDHHS succeeded in dismissing claims related to the proposed FY25 contract and any alleged right to future contracts. However, the plaintiffs preserved significant claims related to the ongoing FY24 transition period, and those issues will move into discovery. The parties were encouraged to enter into mediation rather than further litigation.

Mr. Kurtz signed and submitted the FY26 PIHP Contract (as written) on May 1st though it has not yet been countersigned by MDHHS. NorthCare Network CEO, Megan Rooney, also signed and submitted a signed FY26 contract. As stated previously, the NMRE reduced its ISF to 7.5% of total Medicaid capitation to comply with contract requirements. Ms. Sork suggested signing and submitting the FY25 PIHP contract as well.

It is suspected that MDHHS is working on a new RFP to be released soon.

MDHHS DISCUSSION

In conversation with MDHHS, Mr. Kurtz indicated that Region 2 will not be exploring Crisis Stabilization Units (CSU), mainly due to the 72-hour release requirement, cost, and lack of demand for such services. The region feels that Rural Health Funding (rural transformation funding held by MDHHS) would be better spent in other areas.

The Grand Traverse Mental Health Crisis Center utilizes a team from Northern Lakes alongside a team from Munson. Ms. Zeller has informed Munson that Northern Lakes will not be operating the CRU, however, Munson intends to direct-operate it. The Center also offers a psychiatric urgent care. Munson has obtained licensing to open a 6-bed pediatric crisis residential and a 9-bed adult crisis residential scheduled to open between August and December.

Mr. Babbitt suggested that the NMRE/CMHSPs cost settle with private rural hospitals for psychiatric inpatient services.

FMS

A memorandum from Kristen Morningstar dated May 12, 2026, regarding the Proper Use of Financial Management Services (FMS) Providers was included in the meeting materials. The memorandum states that FMS involvement is allowable for direct hire and purchase of service managements, but FMS should not be involved in agency supported self-direction arrangements.

The CMHSPs confirmed that they do not involve FMS in agency supported self-direction arrangements.

HR1 PREP

MDHHS provided a Michigan Medicaid Program update during the CEO retreat on May 11th. Michigan is required to implement HR1 by January 1, 2027, but CMS is not expected to issue final guidance until June 2026. Despite the late release of federal guidance, CMS has indicated it will not offer a good-faith-effort exemption or allow states to delay implementation.

Major Eligibility Changes include:

- **New Work Requirements** – Applies to many Healthy Michigan Plan (HMP) enrollees 19-64, who must work, train or volunteer at least 80 hours for one month. Non-compliance will lead to loss of coverage.
- **Six-Month Redeterminations** – Eligibility checks for HMP every six months, instead of annually. Increased risk of coverage interruptions due to paperwork gaps.
- **Limited Retroactive Eligibility** – 90-day retroactive coverage ceases. HMP = one month prior to application. Other Medicaid enrollees = two months prior to application.
- **Limits on Non-Citizen Eligibility** – Fewer pathways to coverage for lawfully present non-citizens. Affected individuals will lose full coverage. Moving to Emergency Services Only (ESO) coverage.

MDHHS will check if a beneficiary met the work requirements when they apply for Medicaid or renew their Medicaid coverage. Individuals applying for Medicaid (Healthy Michigan Plan) must meet the work requirements for at least one month immediately preceding the month during which the individual applies. Per CMS, the state may not dictate the specific months during which a beneficiary must demonstrate work requirements.

Ms. Sork asked whether any of the CMHSPs are considering adding staff. The CMHSPs responded that currently no staffing increases are planned.

BRIDGE HEALTH

Whether or not MDHHS issues a new RFP to procure the state's PIHPs, the NMRE and NorthCare Network will continue their collaborative efforts regarding the provision of mental health services in rural northern Michigan. The 10 CMHSP CEOs in the region are holding regular meetings. Mr. Babbitt stressed that a discussion about what Bridge Health is (and is not) needs to occur. Business Associate Agreements and a Memoranda of Understanding are currently in the works to share EQI and encounter data.

MENTAL HEALTH FRAMEWORK

In an email dated May 15, 2026, Kristin Morningstar stated that, "MDHHS will temporarily delay the MHF Coverage Responsibility policy to allow time for system-wide preparation." During the preparation period, MDHHS intends to continue advancing key Mental Health Framework activities.

CMHSP UPDATES (if any)

In the interest of time, no CMHSP updates were offered.

OTHER

Ms. Sork shared that she is meeting with Rep. Cam Cavitt (106th District) on May 22nd. She asked the CEOs to forward any talking points to her attention. A preliminary list included crisis residential units and cost-settling with private rural hospitals for inpatient services.

Mr. Babbitt asked whether any update was available regarding moving individuals back to the region, as the regional Clinical Leadership Committee was asked to include Olmstead considerations as a standing agenda item. Mr. Kurtz suggested that the committee be given a little more time before its efforts are evaluated.

Mr. Kurtz stated that the Autism Alliance is conducting a research study to standardize the quality with which autism services should be delivered.

The OIG identified "duplicate" encounters its auditing process. Clarification was made that what was found were not duplicate, but more than one 15-minute unit codes billed on the same day with unique start/stop times. The OIG fails to understand that PIHPs do not bill on a fee-for-service basis and are not Medicaid Health Plans. Ms. Zeller requested detailed clarification regarding what needs to be included in the Overpayment Reporting form. Ms. Sork suggested that zeros be included on the form with clarification be provided in a narrative format.

NEXT MEETING

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

RTHERN MICHIGAN REGIONAL ENTITY
SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING
10:00AM – MAY 4, 2026
GAYLORD CONFERENCE ROOM & MICROSOFT TEAMS

Alcona	☐ Adam Brege	**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		**Presque Isle**	☐ Dana Labar
Traverse	☐ Dave Freedman	**Roscommon**	☒ Darlene Sensor
Iosco	☒ Jay O'Farrell	**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:	Sarah Hegg, Becki King, Larry LaCross, Kayla Thomas	

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 Adam Brege, David Comai, Dave Freedman, Tim Markey, and Ron Quackenbush 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 January minutes were included in the materials for the meeting on this date.

MOTION BY TERRY NEWTON TO APPROVE THE MINUTES OF THE JANUARY 5, 2026, NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE MEETING; SUPPORT BY GARY TAYLOR. MOTION CARRIED.

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

MOTION BY CHUCK VARNER TO APPROVE THE AGENDA FOR THE MAY 4, 2026 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE; SUPPORT BY TERRY NEWTON. MOTION CARRIED.

ANNOUNCEMENTS
PIHP Contract Dispute
Mr. Kurtz spoke about a motion hearing that took place on April 9th in Michigan Court of Claims Case #24-000198-MZ regarding the FY25 PIHP Contract.

The Attorney General's office argued that the Plaintiffs have no standing to dispute the FY25 contract since it was not signed. Attorney Chris Ryan (Taft, Stettinius & Hollister) reviewed the three areas of dispute (Waskul settlement, CCBHCs, and 7.5% ISF cap.)

Judge Sima Patel issued an opinion on April 29, 2026 stating that. The Court issued a mixed ruling. MDHHS succeeded in dismissing claims related to the proposed FY2025 contract and any alleged right to future contracts. However, the plaintiffs preserved significant claims related to the ongoing FY2024

Mr. Kurtz signed and submitted the FY26 PIHP Contract on May 1st though it has not yet been countersigned by MDHHS.

PIHP Bid Out
A hearing took place on April 13, 2026, on the Attorney General's motion to dismiss the lawsuits filed against the State related to the PIHP bid out (#25-000143-MB and #25-000162MB).

Judge Christopher Yates issued a Summary Disposition on April 14, 2026, concluding that both cases have been rendered moot due to the cancellation of the original Request for Proposals. A decision is expected regarding whether the case will be dismissed with or without prejudice. If the case is dismissed without prejudice, the Plaintiffs are allowed to refile the lawsuit later.

The state has indicated plans to issue a new RFP, likely this month.

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 March 31, 2026, was included in the materials for the meeting on this date. Admissions were down 15.86% 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 36%; residential withdrawal management was the second

highest level of treatment at 29%. Alcohol was the most prevalent primary substance at 60%, all methamphetamine were the second most prevalent primary substance at 17%, and all opiates (including heroin) was the third most prevalent primary substance at 16%.

It was noted that Outpatient admissions fell 39% from FY19 to FY25, likely due to the availability of these services through primary care providers and telehealth services.

It was also noted that DAB, HMP, and TANF eligibles have dropped 7.78% when comparing October 2024 through April 2025 with October 2025 through April 2026.

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.

Mr. Newton announced that Community Recovery Alliance (CRA) lost its site in Petoskey. Although the NMRE is unable to fund a location, some activities have shifted to block grant funding to help CRA secure a building.

Financial Report
The February SUD report showed all funding source revenue of $9,176,430 and $7,951,132 in expenses, resulting in a net surplus of $1,225,298. Total PA2 funds were reported as $4,588,666.

Year-to-date block grant funding is underspent when compared to fiscal years 2024 and 2025.

PA2/Liquor Tax was summarized as follows:

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

Actual FY26 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$5,142,821	$0	$554,155	$4,588,666

The Quarter 2 FY26 PA2 payments are expected at the end of April. The Quarter 1 payments were used by the Michigan Department of Treasury to pay "debt services." The NMRE maintains a balance equivalent to one year's receipts for each county.

Mr. O'Farrell raised the PA2 payment issue during a recent meeting of the Michigan Association of Counties (MAC). MAC agreed to investigate the matter. Clarification was made that the counties did not receive their 60% payment either. Quarter 2 payments were received at the end of April but looked lower than normal. Mr. O'Farrell emphasized that PA2 belongs to the counties, not the state. Ms. Singer suggested contacting legislators. Mr. O'Farrell responded that legislative input is always welcome.

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. Charlevoix County Jail Individual Counseling Charlevoix $25,000 Continuation

   Meets PA2 Parameters? ☒ Yes ☐ No

   Discussion:
   Clarification was made that, if approved, this request would be retroactive to October 1, 2025.

   MOTION BY ANNEMARIE CONWAY TO APPROVE THE REQUEST FROM CHARLEVOIX COUNTY FOR LIQUOR TAX DOLLARS FROM CHARLEVOIX COUNTY IN THE TOTAL AMOUNT OF TWENTY-FIVE THOUSAND DOLLARS ($25,000.00) TO PROVIDE INDIVIDUAL COUNSELING TO INMATES OF THE CHARLEVOIX COUNTY JAIL; SUPPORT BY PAM SINGER. 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 May 4, 2026	Projected Remaining Balance
Charlevoix	$88,644.40	$25,000.00	$63,644.40

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

PRESENTATION

Medications for Opioid Use Disorder (MOUD) Jail-Based Program

Catholic Human Services' Chief Operating Officer and Clinical Supervisor, Sarah Hegg, was in attendance present on medications used in jail-based programs to treat opioid use disorders.

MOUD is the gold standard treatment for Opioid Use Disorder (OUD). Medications used are Methadone, Buprenorphine, and Naltrexone.

MDHHS emphasizes that jail-based MOUD programs should not be isolated services but part of a full continuum from intake → incarceration → reentry. "Identify early, treat with evidence-based medications during incarceration, and ensure seamless continuation of care after release." Key elements of the program include:

- Identifying people with OUD at booking/intake.
- Providing evidence-based MOUD during incarceration.
- Ensuring warm handoffs to community providers at release.
- Maintaining continuity of medication and support services post-release because overdose risk spikes immediately after release.

Both National Institute on Drug Abuse-supported research and MDHHS-aligned programs emphasize that MOUD during incarceration saves lives.

CHS Jail-Based Substance Use Disorder (SUD) Services Program Objectives:
- Expand access to evidence-based SUD treatment in county jails
- Provide medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) services during incarceration and re-entry
- Improve recovery outcomes and reduce overdose risk
- Strengthen coordination between jail, clinical, and community systems

CHS Comprehensive Jail-Based SUD Services include:
- Clinical SUD Therapy
- Case Management
- Peer Recovery Coaching
- Re-entry Planning and Support
- MOUD/MAUD Coordination
- Internal/External Community Collaboration

CHS currently operates jail programs in Antrim, Benzie, Grand Traverse, Leelanau, Manistee, and Roscommon, and Wexford Counties. Limited or developing programs are located in Alpena, Crawford, and Missaukee Counties.

Catholic Human Services' CEO, Larry LaCross, thanked the SUD Oversight Committee for its continued support through liquor tax funding. The state is shifting to viewing SUD services as a core component in jails; it is becoming the standard of care. It was noted that jail medical staff provide withdrawal management services in the jail (not CHS).

Mr. LaCross congratulated Ms. Hegg on receiving the MCBAP award for Clinical Supervisor of the Year.

Overdoses Among the Older Adult Population
Dr. David McGreaham from the Northern Michigan Opioid Response Consortium (NMORC) was unavailable to present on this date but will be invited to attend a future meeting.

PUBLIC COMMENT
Let the record show that no comments from the public were offered.

NEXT MEETING
The next meeting was scheduled for July 6, 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 MAY 4, 2026; SUPPORT BY DOUG JOHNSON. MOTION CARRIED.

Let the record show that Mr. O'Farrell adjourned the meeting at 11:17 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.

CHARLEVOIX JAIL INDIVIDUAL COUNSELING - CONTINUATION

Organization/Fiduciary:	**Charlevoix County**
County:	**Charlevoix**
Project Total:	**$ 25,000**

DESCRIPTION:

Inmates are reluctant to identify trauma as an underlying causal factor in their choices often avoid working on this in a meaningful manner, rather they will often use substances to help escape from the impact of trauma. Focusing on trauma and substance use to help individuals connect with the impact on their life choices. Qualified/State Certified Licensed Masters Social Worker will provide inmates with various tools; Adverse Childhood Experiences (ACES) survey to identify childhood trauma and identify adult trauma experienced.

By providing individuals with information about trauma and SUD in conjunction with a supportive environment, they can begin to recognize the patterns of choices they made as a result of trauma.

Recommendation: Approve

County	Project	Requested Budget
Charlevoix	Charlevoix Jail Individual Counseling	$25,000

Name of Project

Jail Counseling

Name of Organization/Agency	Fiduciary (if different from Organization/Agency)
Charlevoix County	
Street Address	Street Address
1000 Grant Street	
City, State Zip Code	City, State Zip Code
Charlevoix, MI 49720	

ORGANIZATION/AGENCY SUBSTANCE ABUSE LICENSE INFORMATION

License Number	Type of License	Expiration Date

PERSON SUBMITTING APPLICATION	**FIDUCIARY CONTACT**
Name	Name
John Thorp, LMSW	Becki King, Finance Director
Phone Number	Phone Number
231-439-9560	231-237-9184
Email Address	Email Address
thorpj100@gmail.com	kingb@charlevoixcounty.org

Time Period Funds are Being Requested For

Start Date (end date will be end of fiscal year): **October 1, 2025 thru September 30, 2026**

Applications must be submitted by the first of the month prior to the SUD Board Meeting. Any requests received after this date will be reviewed at the next meeting

Total Amount Requested **$ 25,000.00**

If Fringe is greater than 25% of Salaries/Wages or if Indirect is greater than 10%, please provide on the orange explanation

County or Counties that Funding will be used for (place an x next to your selection)

For multiple county requests, amounts will be separated by county per county population

	Alcona		Leelanau
	Alpena		Manistee
	Antrim		Missaukee
	Benzie		Montmorency
X	Charlevoix		Ogemaw
	Cheboygan		Oscoda
	Crawford		Otsego
	Emmet		Presque Isle
	Grand Traverse		Roscommon
	Iosco		Wexford
	Kalkaska		

Project is for (place and x next to your selection)

	PREVENTION of Substance Misuse/Use Disorder
X	TREATMENT for a Substance Use Disorder
	RECOVERY from a Substance Use Disorder

Project Addresses the Need

X	Expansion of Availability of ASAM Levels of Care
X	Increase Access to Prevention, Treatment or Recovery Supports
	Increase the Provision of Care (quality, outcomes, etc)
	Increase Workforce Competencieis
	Increases Recognition Within the Health Care System
	Continuation of Successful Project Currently Receiving Funding
	Addresses the NMRE Strategic Plan (if a copy of the workplan is needed, please request)
	Other, please name:

For Prevention Services, Please Note the Strategy and Target (if multiple, please indicate the percent per selection)

	Info. Dissemination		Universal Direct
	Education		Universal Indirect
	Alternatives		Selective
	Problem ID and Referral		Indicated
	Community Based Process		
	Environmental		
	Other, please name:		

Explanation of the project

Inmates are reluctant to identify trauma as an underlying causal factor in their choices often avoid working on this in a meaningful manner, rather they will often use substances to help escape from the impact of trauma. Focusing on trauma and substance use to help individuals connect with the impact on their life choices. Qualified/State Certified Licensed Masters Solcial Worker will provide inmates with various tools; Adverse Childhood Experiences (ACES) survey to identify childhood trauma and identify adult trauma experienced.

Briefly Explain how your project will address the need(s) identified above

By providing individuals with information about trauma and sud in conjunction with a supportive environment, they can begin to recognize the patterns of choices they made as a result of trauma.

Are you planning to use other sources of funding in conjunction with money received for this project?

Not at this time

If yes, please provide the name of the other funding agency(ies) and amount(s).

X	I understand as a condition of receiving liquor tax funding from NMRE, your organization/agency will be required to complete quarterly reports. Reports will be submitted to NMRE by the 15th of the month following the close of each quarter.
X	I understand by accepting liquor tax funds, your organization/agency agrees to acknowledge the NMRE on all material and announcements related to the project funding by including the following statement: *"Local Michigan Public Act 2 funds (liquor tax) managed by the Northern Michigan Regional Entity have been used in support of this project."* The NMRE logo may be used in lieu of the statement and all materials must be approved by NMRE prior to distribution.
X	I certify that the information contained in this proposal is accurate and that I have the authority for the organization/agency to request funding, propose services and establish service costs contained in this application.

If your application is approved, you will receive an award letter confirming the amount approved along with the quarterly report form and Financial Summary Report (FSR) form to be used for requesting reimbursement.

NMRE Reviwer Comments

PROGRAM BUDGET - COST DETAIL SCHEDULE

ATTACHMENT B.2

View at 100% or Larger MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES Page Of

Use WHOLE DOLLARS Only

PROGRAM	BUDGET PERIOD		DATE PREPARED
Charlevoix County Jail Counseling	From:	To:	
	10/1/2025	9/30/2026	9/5/2025
GRANTEE NAME	BUDGET AGREEMENT		AMENDMENT #
Charlevoix County	☑ ORIGINAL	☐ AMENDMENT	
Address - City, State Zip			
1000 Grant Street			

1. SALARY & WAGES: POSITION DESCRIPTION	COMMENTS & EMPLOYEE'S NAME	POSITIONS (FTE) REQUIRED	TOTAL SALARY
	1. TOTAL SALARY & WAGES:		$ -

2. FRINGE BENEFITS: **Details Upon Request** Composite Rate %

(Specify)

☐ FICA ☐ LIFE INS ☐ HEARING INS
☐ HOSPITAL INS ☐ VISION ☐ WORK COMP
☐ UNEMPLOYMENT INS ☐ DENTAL INS ☐ Tuition Remission (list amount)
☐ RETIREMENT ☐ OTHER:specify-

2. TOTAL FRINGE BENEFITS: $ -

3. TRAVEL: (Specify Total Expenditures - Include Mileage Reimbursement Rate)

3. TOTAL TRAVEL: $ -

4. SUPPLIES & MATERIALS: (Specify if category exceeds 10% of Total Expenditures)

Material such as books on daily meditation, inspirational or educational	$ 1,000
4. TOTAL SUPPLIES & MATERIALS:	$ 1,000

5. CONTRACTUAL: (Subcontracts/Subrecipients)

Name	Address	
John Thorp		$ 24,000
5. TOTAL CONTRACTUAL:		$ 24,000

6. EQUIPMENT: (Specify) List only per items over $5,000

6. TOTAL EQUIPMENT: $ -

7. OTHER EXPENSES: (Specify category if exceeds 10% of Total Expenditures)

Communication:
Space Cost:
Others (explain):

7. TOTAL OTHER EXPENSES: $ -

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7) 8. TOTAL DIRECT EXPENDITURES: $ 25,000

9. INDIRECT COST CALCULATIONS: (limit of 10%, if higher complete Explanation tab)

Rate #1 Base $ x Rate =

**** MUST submit a detailed (with amounts) explanation in Explanation tab*

9. TOTAL INDIRECT EXPENDITURES: $ -

10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9) $ 25,000

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

DCH-0386(E) (Rev 8/15) (EXCEL) Previous Edition Obsolete

Use Additional Sheets as Needed

CHARLEVOIX COUNTY OVERVIEW

Projected FY26 Balance	**$88,644.40**

Project	Requested Budget	Remaining County Running Balance
Charlevoix Jail Individual Counseling	$25,000	$63,644.40

County	One Year Fund Balance (withheld)	Projected FY26 Available Balance	Sum of Requested Project Amounts	Projected Remaining Balance
Charlevoix	**$103,674.40**	**$88,644.40**	**$25,000.00**	**$63,644.40**

STATE OF MICHIGAN

COURT OF CLAIMS

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

Plaintiffs,

v

Case No. 24-000198-MZ

Hon. Sima G. Patel

STATE OF MICHIGAN, MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, and ELIZABETH HERTEL, in her official capacity,

Defendants.
_____ /

OPINION AND ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION FOR SUMMARY DISPOSITION

Plaintiffs, NorthCare Network Mental Health Care Entity (NorthCare), Northern Michigan Regional Entity, Community Mental Health Partnership of Southeast Michigan (CMHPSM), and Region 10 PIHP (Region 10), filed this declaratory and mandamus action against defendants, the State of Michigan, the Michigan Department of Health and Human Services (MDHHS), and Elizabeth Hertel (in her official capacity as Director of MDHHS), in this dispute over MDHHS's proposed 2025 fiscal year contract (FY25 Contract), as well as certain terms of the fiscal year 2024 contract (FY24 Contract), under which the parties continue to operate during a transition period that will expire no later than the end of the 2026 fiscal year. Defendants move for summary disposition under MCR 2.116(C)(5) and (8) before significant discovery has occurred. Having

heard arguments on the motion on April 9, 2026, the Court will GRANT IN PART and DENY IN PART defendants' motion for summary disposition.

I. BACKGROUND

A. MICHIGAN'S PIHP SYSTEM

Plaintiffs are four out of 10 regional Prepaid Inpatient Health Plans (PIHPs)[1] that facilitate specialty behavioral health services for individuals with mental illnesses, developmental disabilities, and substance use disorders. MDHHS is the state agency charged with administering the State's Medicaid program. In Michigan, specialty behavioral health services are carved out from traditional medical services provided by Medicaid health plans. MCL 400.109f. Community mental health service programs (CMHSPs) operate at the county level to provide behavioral health services funded by Michigan's Medicaid program. The counties may either establish their own CMHSPs or join together to form regional PIHPs. MDHHS historically contracted with PIHPs to provide services on a fiscal-year basis through a standardized contract.

Plaintiffs' most recent contract with MDHHS was for fiscal year 2024, which was effective from October 1, 2023 to September 30, 2024.[2] The contract contained the following provision requiring plaintiffs to provide continued services through a transition period:

> **26. Transition Responsibilities**. Upon termination or expiration of this Contract for any reason, Contractor must, for a period of time specified by the State (not to exceed 2 years) provide all reasonable transition assistance requested by the

[1] There is no dispute that the total number of PIHPs has changed over time, and there is no statutory mandate that 10 PIHP regions exist. As discussed later, MDHHS has recently expressed its intent to decrease the number of PIHP regions to three, which was the subject of two separate Court of Claims matters, Case Nos. 25-000143-MB and 25-000162-MB.

[2] Each PIHP executed a separate contract with MDHHS but there is no dispute the language of each FY24 Contract was the same for each PIHP.

> State, to allow for the expired or terminated portion of the Contract Activities to continue without interruption or adverse effect, and to facilitate the orderly transfer of such Contract Activities to the State or its designees.

The parties negotiated the terms of the FY25 Contract in 2024 but were unable to agree on several key terms. Plaintiffs did not sign the FY25 Contract as proposed by MDHHS because they believed certain provisions violated federal law. According to plaintiffs, on October 23, 2024, MDHHS provided them with "an ultimatum," via e-mail, which was to "[s]ign MDHHS's proposed contract, or Defendants would terminate the relationship[.]" MDHHS gave plaintiffs until October 31, 2024, to electronically sign the FY25 Contract as proposed by MDHHS; otherwise, the relationship would be terminated. There is no dispute plaintiffs never signed the FY25 Contract as proposed by MDHHS. Rather, plaintiffs provided MDHHS with signed, redlined versions of the proposed contract, which they argue eliminated the unlawful provisions. MDHHS did not sign the version of the contract proposed by plaintiffs. According to MDHHS, other PIHPs *did* sign the FY25 Contract as proposed by MDHHS and operated under the terms of that contract for the 2025 fiscal year. The FY25 Contracts with those PIHPs expired on September 30, 2025.

B. MDHHS'S INTENDED SHIFT TO COMPETITIVE BIDDING

Following the negotiations of the FY25 Contract, MDHHS decided to transition from a single-source procurement system to a competitive procurement system beginning in fiscal year 2027. In August 2025, MDHHS and the Michigan Department of Technology, Management, and Budget (DTMB) issued a request for proposals (RFP) to participate as PIHPs for fiscal year 2027. Additionally, MDHHS also expressed its intent to reduce the total number of PIHP regions from 10 to three beginning in October 2026. This change prompted two additional lawsuits in this Court: Court of Claims Case Nos. 25-000143-MB and 25-000162-MB, which were consolidated.

Region 10 is a named plaintiff in Case No. 25-000143-MB; however, the other PIHPs named as plaintiffs in this case are *not* plaintiffs in either of those matters. Although 25-000143-MB and 25-000162-MB involve fiscal year 2027 and later, the rulings in those cases have some bearing on the legal issues presented in this case.

Specifically, in October 2025, Judge YATES, who presides over Case Nos. 25-000143-MB and 25-000162-MB, ruled that MDHHS had the discretion under Michigan law to transition from a single-source procurement system to a competitive procurement system, as well as to reduce the overall number of PIHP regions. Judge YATES concluded that "a competitive procurement system is not only compatible with state law, but also regarded as the preferred nationwide model." *Region 10 PIHP v Michigan*, opinion of the Court of Claims, issued October 14, 2025 (Case No. 25-000143-MB), p 8. Judge YATES explained that while Michigan historically obtained a waiver from the federal government to avoid engaging in the preferred competitive procurement system, MDHHS had no assurance that a waiver would be granted in the future and was "simply taking proactive steps to bring Michigan into compliance with the federal mandate of competitive procurement." *Id.* Judge YATES concluded that Michigan law permitted MDHHS to engage in a competitive procurement system. *Id*. at 8-9. As for the issue of the reduction in PIHP regions, Judge YATES ruled that "nothing in Michigan law" precluded MDHHS from altering the number and geographic scope of the PIHP regions. *Id*. at 10. Judge YATES concluded, however, that a question of fact existed on whether the terms of the 2025 RFP complied with Michigan law. *Id*. at 10-11.

Later, in January 2026, following an evidentiary hearing, Judge YATES ruled that the 2025 RFP violated Michigan law by preventing the CMHSPs from fulfilling numerous statutory requirements in the Michigan Mental Health Code, MCL 330.1011 *et seq*. *Region 10 PIHP v*

Michigan, opinion of the Court of Claims, issued January 8, 2026 (Docket Nos. 25-000143-MB and 25-000162-MB), p 3. However, Judge YATES declined to prohibit MDHHS from selecting PIHPs through a competitive-bidding process, instead allowing MDHHS the option to determine how to bring the RFP into compliance with Michigan law. *Id*. MDHHS later rescinded the RFP in question, and the matters in Case Nos. 25-000143-MB and 25-000162-MB were dismissed without prejudice as moot. See *Region 10 PIHP v Michigan*, order of the Court of Claims, issued April 23, 2026 (Docket Nos. 25-000143-MB and 25-000162-MB); *Region 10 PIHP v Michigan*, order of the Court of Claims, issued April 14, 2026 (Docket Nos. 25-000143-MB and 25-000162-MB).

At this stage, the future landscape of PIHP contracting is in limbo. While Judge YATES ruled that the competitive-bidding model and decrease in the total number of PIHP regions was lawful, MDHHS has rescinded the RFP for contracts scheduled to begin in October 2026. However, MDHHS has indicated it intends to move forward with the competitive-bidding process and the reduction on PIHP regions, presumably with a new RFP. The parties represented during the hearing in this matter that they continue to operate under the transition clause of the FY24 Contract, which by its terms will expire no later than September 30, 2026. As of the date of this opinion and order, Judge YATES's rulings have been neither appealed nor stayed. Although neither party argues that Judge YATES's rulings have a preclusive effect on the issues related in this matter, the Court finds the rulings persuasive on certain issues raised in this case, as discussed later.

C. CONTRACT PROVISIONS AT ISSUE

Turning to the questions involved in this case, plaintiffs' claims relate to several provisions of the FY24 and FY25 Contracts. The first provision in question relates to the internal service funds (ISFs) maintained by the PIHPs. ISFs function like savings accounts for PIHPs. PIHPs are

funded in advance on a capped basis. They use ISFs as a method for saving funds to cover risk exposure, which is shared between the PIHPs and MDHHS, in case their expenses exceed the amount of the MDHHS capitated payments. The ISFs are subject to certain federal regulations.

The FY24 Contract capped the amount that the PIHPs could contribute annually to their ISFs to 7.5% of their annual operating budget. The FY24 Contract provision stated, in relevant part: "Contractor may transfer Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization to the ISF in any given year. Contractor may not transfer any funds in excess of that percentage to the ISF in any year."

However, the FY25 Contract changed the language of this provision and capped the total amount the PIHPs could save in their ISF account to 7.5% of their annual operating budget. The relevant contractual provision stated:

> The contractor may not reflect an ISF that exceeds 7.5% on any of Contractor's reporting requirements contained in this contract. If the Department determines that the ISF is over-funded, the ISF must be reduced within one fiscal year through the abatement of current charges. If such abatements are inadequate to reduce the ISF to the appropriate level, it must be reduced through refunds in accordance with [federal regulations].

The contract explains that the ISF maximum contribution limit reflected the PIHP's total risk liability, which is 100% of cost overruns between 100% and 105% of revenue and 50% of cost overruns between 105% and 110%. Plaintiffs assert that this provision differs materially from the one in the FY24 Contract because the cap on the total amount in the ISF limits each PIHP's ability to determine the appropriate amount in their ISF account "based on actuarial analyses and generally accepted accounting principles," as required under federal regulations.

For their part, defendants contend that this requirement did not change from the FY24 Contract to the FY25 Contract, despite the change in the language of the relevant provision. They argue other provisions within the FY24 Contract made it clear that the PIHPs could not maintain a total account balance of more than 7.5% of their annual operating budget. They argue the provision is designed to ensure the Medicaid funds are allocated for beneficiary services. Plaintiffs allege that MDHHS waived its position that the FY24 Contract prohibited plaintiffs from having an ISF balance over 7.5% because MDHHS accepted Region 10's and NorthCare's Risk Management Strategies in late 2023, despite that the Risk Management Strategies reported an ISF balance at a higher amount than 7.5% of the annual operating budget.

In late 2024, MDHHS notified plaintiffs that if any of their Fiscal Year 2024 Financial Status Reports (FSRs) showed an ISF balance of more than 7.5% of the annual operating budget, then the submissions would be returned for corrections, and if not corrected, would be considered late for purposes of determining plaintiffs' eligibility for bonus payments. Plaintiffs assert that the threat of "withheld bonuses" amounted to a sanction. Although plaintiffs do not allege that any sanctions have been imposed yet, they argue they are entitled to procedural due process before any sanctions are imposed on them both under the Mental Health Code and under the terms of the FY24 Contract, which contained a provision allowing for the opportunity for a hearing to contest or dispute the State's findings and sanction before the sanction is imposed.

Another contractual dispute involves modifications to the FY25 Contract in response to a settlement agreement from a 2016 case filed against MDHHS, *Waskul v Washtenaw Co Comm Mental Health*, United States District Court for the Eastern District of Michigan, Case No. 2:16-cv-10936. The *Waskul* case involved the budgeting process for community living supports (CLS) services for individuals with disabilities allowing them to live independently in their communities.

The CLS services are funded under a Medicaid waiver known as the Habilitation Supports Waiver. Each recipient has an Individualized Plan of Service, which is developed and implemented through a budgeting process. The *Waskul* case challenged the budgeting process and resulted in an arrangement in which a minimum fee schedule set forth within the *Waskul* Settlement Agreement must be used to establish rates.

The FY25 Contract contains an explicit provision requiring PIHPs to comply with the *Waskul* Settlement Agreement. The FY24 Contract did not refer expressly to the *Waskul* Settlement, but defendants argue that requirement was incorporated in a provision requiring that the parties abide by " 'Medicaid Policy.' " Plaintiffs maintain that the *Waskul* Settlement Agreement violated federal regulations prohibiting MDHHS from regulating PIHP expenditures. Alternatively, plaintiffs argue that defendants were required to comply with the Administrative Procedures Act (APA), MCL 24.201 *et seq*., to implement any changes outlined in the *Waskul* Settlement Agreement. Plaintiffs have attached the *Waskul* Settlement Agreement to their second-amended complaint.

Next, plaintiffs allege that, during the FY24 transition period, MDHHS has shifted certain responsibilities to them in relation to Certified Community Behavioral Health Clinics (CCBHCs), which aid in providing funding for substance use disorder and mental health services, without providing adequate funding. Plaintiffs additionally argue that in late November 2024, MDHHS notified several PIHPs that MDHHS would not provide funding for the substance use disorder health home (SUDHH) program because plaintiffs did not sign the FY25 Contract. The SUDHH program is intended to provide care management and coordination for Medicaid program beneficiaries suffering from opioid, alcohol, or stimulant use disorders. After the original complaint was filed in this case, the parties negotiated a preliminary injunction requiring MDHHS

to continue to fund the SUDHH program while this case is being litigated, which this Court entered in December 2024.

D. PROCEDURAL BACKGROUND

Plaintiffs filed this declaratory and mandamus action in December 2024. Plaintiffs amended their complaint twice with leave of the Court. The March 6, 2025 second-amended complaint is the operative complaint and raises the following six counts:

- Count I: A claim for declaratory and mandamus relief on behalf of all plaintiffs in relation to the ISF contract provision and the issue of the FY24 FSRs.
- Count II: A claim for declaratory relief on behalf of all plaintiffs regarding the contract provision about the *Waskul* Settlement.
- Count III: A claim for declaratory relief regarding the added responsibilities for the CCBHC demonstration in relation to plaintiffs CMHPSM and Region 10.
- Count IV: A claim for declaratory relief and damages for violation of the Headlee Amendment regarding the CCBHC demonstration program on behalf of plaintiffs CMHPSM and Region 10.
- Count V: A claim for declaratory relief requiring continued Medicaid funding on behalf of all plaintiffs.
- Count VI: A claim for a writ of mandamus on behalf of all plaintiffs on the basis that plaintiffs were entitled to due process before MDHHS could issue a sanction in relation to the FSRs or terminate the parties' relationship.

Before significant discovery occurred in this case,[3] defendants moved for summary disposition under MCR 2.116(C)(5) and (8), arguing that (1) plaintiffs are not the real party in interest and lack standing in relation to the FY25 Contract (and any other future contract claims) considering that the FY24 Contract has expired; (2) plaintiffs fail to state a claim in relation to the

[3] This Court stayed discovery pending the resolution of the motion for summary disposition of the second-amended complaint.

ISF contributions because the plain language of the FY24 Contract limits the ISF annual contribution and account balance; (3) plaintiffs fail to state a claim on which relief may be granted in relation to the *Waskul* Settlement because the settlement complied with the law, was binding on MDHHS, and did not require formal rulemaking; (4) plaintiffs failed to state a valid Headlee Amendment claim in relation to the CCBHC demonstration because relevant section of the Headlee Amendment cannot be independently enforced, the CCBHC demonstration did not impose any additional responsibilities on the PIHPs, and MDHHS was not required to comply with the APA when imposing those requirements; (5) plaintiffs' claims for continued payment and a writ of mandamus fail because no actual controversy or clear legal duty exists, and MDHHS was not required to fund plaintiffs after fiscal year 2024 or provide them with procedural due-process protections. MDHHS further argued that the legality of the FY25 Contract should not be questioned considering that it was approved by the federal Centers for Medicare and Medicaid Services (CMS).

Plaintiffs respond that they have standing and are the real parties in interest because they signed the FY25 Contract after redlining certain provisions. They argue that MDHHS terminated the relationship between the parties without required due process. They further contend that even if they do not have standing in relation to the FY25 Contract, the FY24 Contract, under which the parties continue to operate, contained many of the same unlawful provisions. Plaintiffs argue that they stated a claim for relief in relation to the ISF account because the FY24 Contract did not contain a limit on the cumulative amount that could be held in an ISF account, and the 7.5% limit is not based on sound actuarial principles. Plaintiffs further argue that MDHHS lacks legal authority to restrict plaintiffs' ability to use their ISF funds to pay for prior years. As it relates to the *Waskul* Settlement, plaintiffs reiterate that compliance with the settlement agreement would

violate federal law. Alternatively, plaintiffs argue the terms of the *Waskul* Settlement are unenforceable in relation to plaintiffs and were not promulgated in compliance with the APA.

Plaintiffs argue defendants' argument pertaining to the Headlee Amendment amounts to a question of fact, and defendants failed to impose the changes to the CCBHC Handbooks in accordance with the APA. Plaintiffs further argue that defendants were required to continue to provide Medicaid funding through plaintiffs under various provisions of the Mental Health Code and argue that they could not be sanctioned or terminated without due process. Thus, plaintiffs argue they are entitled to both declaratory and mandamus relief in relation to fiscal year 2025 and future fiscal years.

Defendants reply that plaintiffs do not have an exclusive right to an MDHHS contract or procedural due process for what amounts to a failed contract negotiation. They deny that Medicaid recipients will be severely impacted by the failure to contract with plaintiffs, noting that they are working on finding a replacement PIHP for each affected region (again, through a competitive-bidding process). They reiterate that the FY25 Contract provisions, as applied during the FY24 Contract transition period, are lawful and do not violate federal regulations.

II. STANDARD OF REVIEW

Defendants request summary disposition under MCR 2.116(C)(5) and (8). A motion under MCR 2.116(C)(5) tests a party's legal capacity to sue. *Sakorafos v Lyon Charter Twp*, 349 Mich App 176, 185; 27 NW3d 329 (2023). "In reviewing a grant of a motion for summary disposition pursuant to MCR 2.116(C)(5), [the court] must consider the pleadings, depositions, admissions, affidavits, and other documentary evidence submitted by the parties." *Flint Cold Storage v Dep't of Treasury*, 285 Mich App 483, 492; 776 NW2d 387 (2009) (cleaned up).

In contrast, "[a] motion for summary disposition under MCR 2.116(C)(8) tests the legal sufficiency of the complaint and is properly granted when, accepting all well-pleaded factual allegations of the complaint as true, the claims alleged are unenforceable as a matter of law and no factual development could justify recovery." *Sakorafos*, 349 Mich App at 186.[4] Additionally, plaintiffs have attached the written instruments on which their claims are based (including the FY24 and FY 25 Contracts), which are considered part of the pleadings for purposes of the motion for summary disposition under MCR 2.116(C)(8). See MCR 2.113(C)(1) and (2).

To the extent the Court is required to analyze certain statutory provisions to resolve the issues in this case, the Court is guided by the following legal principles:

> When interpreting a statute, [the] foremost rule of construction is to discern and give effect to the Legislature's intent. Because the language chosen is the most reliable indicator of that intent, [a court will] enforce clear and unambiguous statutory language as written, giving effect to every word, phrase, and clause. If the statutory provision at issue is clear and unambiguous, it must be enforced as written, and no judicial construction is permitted or required. [*Lockport Twp v Three Rivers*, 319 Mich App 516, 520; 902 NW2d 430 (2017) (cleaned up).]

III. FY25 CONTRACT

Defendants first challenge whether plaintiffs are the real party in interest to challenge any provisions of the FY25 Contract. Resolution of this issue turns on whether the parties either had

[4] The Michigan Court of Appeals recently clarified that motions relating to standing are more appropriately considered under MCR 2.116(C)(8) than MCR 2.116(C)(5), the latter of which pertains solely to legal capacity to sue. *Sakorafos*, 349 Mich App at 185-186. In this situation, because defendants maintain that plaintiffs are not the real party in interest, the Court will analyze the issue under MCR 2.116(C)(5) but notes that, for practical purposes, the analysis will not differ significantly under either subrule because all the key documents were attached to and incorporated in the second-amended complaint. See MCR 2.113(C)(1) and (2).

a valid FY25 Contract or whether plaintiffs have a recognizable legal interest in a future contract with MDHHS.

MCR 2.605 governs declaratory relief. MCR 2.605(A)(1) provides, "In a case of actual controversy within its jurisdiction, a Michigan court of record may declare the rights and other legal relations of an interested party seeking a declaratory judgment, whether or not other relief is or could be sought or granted." The court rule incorporates concepts of justiciability, such as standing, ripeness, and mootness. *Int'l Union, United Auto, Aerospace & Agricultural Implement Workers of America v Central Mich Univ Trustees*, 295 Mich App 486, 495; 815 NW2d 132 (2012).

MCR 2.201(B) provides that, in general, "[a]n action must be prosecuted in the name of the real party in interest." "A plaintiff must assert his own legal rights and interests and cannot rest his claim to relief on the legal rights or interests of third parties." *Barclae v Zarb*, 300 Mich App 455, 483; 834 NW2d 100 (2013) (cleaned up). "The real party in interest is one who is vested with the right of action as to a particular claim, or, stated otherwise, is the party who under the substantive law in question owns the claim asserted." *Pontiac Police & Fire Retiree Prefunded Group Health & Ins Trust Bd of Trustees v Pontiac No 2*, 309 Mich App 611, 622; 873 NW2d 783 (2015). For standing, the plaintiff must "have a sufficient interest in the outcome of litigation to ensure vigorous advocacy and in an individual or representative capacity some real interest in the cause of action, or a legal or equitable right, title, or interest in the subject matter of the controversy." *Id*. at 621 (cleaned up). Put another way, "[s]tanding generally is the right of the plaintiff initially to invoke the power of the trial court to adjudicate a claimed injury, while capacity to sue concerns whether there is a legal barrier, such as mental incompetency, that deprives a party of the legal ability to bring an action." *Sakorafos*, 349 Mich App at 185 (cleaned up).

The Court concludes that, whether cast as an issue of the real party in interest or of standing, plaintiffs cannot sue for relief under the FY25 Contract or on the basis that they had a right to a future contract. By plaintiffs' own admission, there was never a meeting of the minds on certain contract provisions for fiscal year 2025. It is a longstanding principle of Michigan law that a contract requires an offer, acceptance, and "mutual assent or a meeting of the minds on all the essential terms." *Kloian v Domino's Pizza, LLC*, 273 Mich App 449, 452-453; 733 NW2d 766 (2006). Acceptance occurs "where the individual to whom an offer is extended manifests an intent to be bound by the offer, and all legal consequences flowing from the offer, through voluntarily undertaking some unequivocal act sufficient for that purpose." *Id*. at 453-454 (cleaned up).

Additionally, one party may not unilaterally modify the parties' preexisting contract. See *Quality Prods & Concepts Co v Nagel Precision, Inc*, 469 Mich 362, 364; 666 NW2d 251 (2003) ("However, with or without restrictive amendment clauses, the principle of freedom to contract does not permit a party *unilaterally* to alter the original contract."). "The mutuality requirement is satisfied where a modification is established through clear and convincing evidence of a written agreement, oral agreement, or affirmative conduct establishing mutual agreement to waive the terms of the original contract." *Kloian*, 273 Mich App at 455 (cleaned up).

In this case, plaintiffs recognize they did not sign the FY25 Contract proposed by MDHHS and instead sent back a redlined version of the contract, altering provisions they assert violated federal law. Plaintiffs acknowledge that MDHHS would not sign plaintiffs' version of the contract and gave plaintiffs a deadline to accept MDHHS's version of the contract. That deadline expired without the formation of a contract because there was no acceptance of an offer on either side, and no meeting of the minds on what plaintiffs characterize as essential contractual terms. Plaintiffs lacked the ability to modify unilaterally the parties' preexisting contract. The Court therefore

agrees with defendants that they did not terminate the FY25 Contract; rather, no such contract ever existed between the parties.

This conclusion is further supported by Judge YATES's recent rulings in Court of Claims Case Nos. 25-000143-MB and 25-000162-MB, in which a final judgment was recently entered. Those cases have not been appealed as of the date of this opinion and order. Although Judge YATES concluded that certain provisions of MDHHS's proposed RFP violated Michigan law, that conclusion did not invalidate his earlier ruling that MDHHS could lawfully switch to a competitive-bidding model and reduce significantly the total number of PIHP regions. Judge YATES's ruling for fiscal year 2027 and beyond supports that MDHHS did not have a legal obligation to execute the FY25 Contracts as redlined by plaintiffs (or to execute any contract with these PIHPs). Therefore, plaintiffs are not the real parties in interest and lack standing as it relates to any challenge to the terms of the FY25 Contract because they did not have a binding contract with MDHHS for this year.

IV. CLAIM FOR CONTINUED FUNDING

A related question exists on whether plaintiffs had a right under the Mental Health Code to a continued relationship with MDHHS for future years absent certain procedural due process protections. Plaintiffs argue in Count V of their second-amended complaint that they were entitled to notice and the opportunity for a hearing under MCL 330.1232b before MDHHS terminated its relationship with them. Count VI raises a related claim for a writ of mandamus premised on the same allegations. The Court concludes that plaintiffs did not have a right to a continued relationship with MDHHS.

Again, Judge YATES addressed the issue whether MDHHS could shift to a competitive procurement system and reduce the number of regional PIHPs. Judge YATES's opinion supports that plaintiffs had no continued right to an MDHHS contract because MDHHS could lawfully transition to a new contract-bidding process with fewer PIHPs. However, those cases did not address the provision of the Mental Health Code involving termination of the Medicaid contract. Nevertheless, the Court concludes that plaintiffs were not entitled to due process because the FY24 Contracts expired, and the FY25 Contracts were never executed so they could not be "terminated" as contemplated under the Mental Health Code.

The Mental Health Code provides, in relevant part:

> (5) Contracts with specialty prepaid health plans shall indicate the sanctions that the department may invoke if it makes a determination that a specialty prepaid health plan is not in substantial compliance with promulgated standards and with established federal regulations, that the specialty prepaid health plan has misrepresented or falsified information reported to the state or to the federal government, or that the specialty prepaid health plan has failed substantially to provide necessary covered services to recipients under the terms of the contract. Sanctions may include intermediate actions including, but not limited to, a monetary penalty imposed on the administrative and management operation of the specialty prepaid health plan, imposition of temporary state management of a community mental health services program operating as a specialty prepaid health plan, *or termination of the department's [M]edicaid managed care contract with the community mental health services program*.
>
> (6) *Before imposing a sanction* on a community mental health services program that is operating as a specialty prepaid health plan, the department shall provide that specialty prepaid health plan with timely written notice that explains both of the following:
>
> (a) The basis and nature of the sanction.
>
> (b) The opportunity for a hearing to contest or dispute the department's findings and intended sanction, prior to the imposition of the sanction. A hearing under this section is subject to the provisions governing a contested case under the [APA], unless otherwise agreed to in the specialty prepaid health plan contract. [MCL 330.1232b(5)-(6) (emphasis added).]

MCL 330.1232b requires notice and the opportunity for a hearing in the context of imposing a sanction, which includes termination of the contract. See MCL 330.1232b(6). It is plaintiffs' position that MDHHS terminated the contract, and they were owed notice and the opportunity for a hearing beforehand. However, MDHHS did not terminate the contracts with plaintiffs as a sanction for any misconduct outlined in MCL 330.1232b(5). Rather, the FY24 Contract expired, and no FY25 Contract was executed because the parties could not agree on the relevant terms. Again, the Court finds a distinction between termination, as contemplated in MCL 330.1232b, and expiration of the contract by its own terms, which is what occurred in this case.

In contrast, MCL 400.109f(1) provides, in relevant part, that "Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans *chosen by the department*." (Emphasis added.) There is nothing in the language of MCL 330.1232b that suggests that due process is required when a prior contract expires and MDHHS declines to execute a new contract with a PIHP on terms the PIHP deems acceptable. As Judge YATES previously concluded, MCL 400.109f grants MDHHS discretion to select PIHPs. *Region 10*, op at 10. The Court agrees with this reason and concludes it applies with equal force in the context of this case.

Plaintiffs also suggest that MDHHS had no option but to continue to contract with them because MDHHS could not engage another regional entity to act as the PIHP for the geographical area covered by plaintiffs. They rely on MCL 330.1204b(2)(b), a provision of the Mental Health Code that provides:

> (2) Except as otherwise stated in the bylaws, a regional entity has all of the following powers:
>
> * * *

> (b) The power to contract with the state to serve as the [M]edicaid specialty service prepaid health plan for the designated service areas of the participating community mental health services programs.

Plaintiffs' claim presumes that they will always exist as the PIHP for their respective regions, which is not necessarily true, particularly considering Judge YATES's opinion regarding fiscal year 2027 and beyond. Indeed, the statute allowing for the formation of PIHPs provides that "[a] combination of community mental health organizations or authorities *may* establish a regional entity by adopting bylaws that satisfy the requirements of this section." MCL 330.1204b(1) (emphasis added). The use of the permissive word "may" suggests that PIHPs are not required to be formed under the Mental Health Code. See *True Care Physical Therapy, PLLC v Auto Club Group Ins Co*, 347 Mich App 168, 182-183; 14 NW3d 456 (2023) (explaining that the term "may" has a permissive meaning). Accordingly, plaintiffs have not cited a legal basis to support a declaratory judgment on the basis of a right to a continuing contractual relationship.

Similarly, plaintiffs' claim for a writ of mandamus is without merit. Mandamus is an extraordinary remedy and a discretionary writ. *Johnson v Bd of State Canvassers*, 341 Mich App 671, 684; 991 NW2d 840 (2022). "The primary purpose of the writ of mandamus is to enforce duties created by law, where the law has established no specific remedy and where, in justice and good government, there should be one." *Id.* at 684-685 (cleaned up).

> To obtain the extraordinary remedy of a writ of mandamus, the plaintiff must show that (1) the plaintiff has a clear, legal right to performance of the specific duty sought, (2) the defendant has a clear legal duty to perform, (3) the act is ministerial, and (4) no other adequate legal or equitable remedy exists that might achieve the same result. In relation to a request for mandamus, a clear, legal right is one clearly founded in, or granted by, law; a right which is inferable as a matter of law from uncontroverted facts regardless of the difficulty of the legal question to be decided. [*Berry v Garrett*, 316 Mich App 37, 41; 890 NW2d 882 (2016) (cleaned up).]

For the reasons discussed earlier, plaintiffs do not have a clear legal right to require MDHHS to either execute a new contract or to provide plaintiffs with notice and a hearing in relation to the FY25 Contract. Nor does MDHHS have a clear legal duty to perform in this scenario. So plaintiffs are not entitled to mandamus relief in relation to fiscal year 2025 or any future fiscal years.[5] Therefore, summary disposition is GRANTED on Counts V and VI of the second-amended complaint, as well as Counts I and II, to the extent these claims are based on the FY25 Contract or alleged rights to future contracts.

V. FY24 CONTRACT CLAIMS

A. ISF PROVISIONS

Plaintiffs also argue that certain provisions of the FY25 Contract are being imposed on them unlawfully during the FY24 Contract transition period and that they have standing to pursue these claims because the parties continue to operate under the FY24 Contract. The transition period of the FY24 Contract cannot continue beyond September 2026. However, because the parties agree that they continue to operate under the terms of the FY24 Contract during a transition period that is currently in effect, plaintiffs have standing and are the real parties in interest to challenge MDHHS's enforcement of the FY24 Contract. Because the parties are currently operating under the FY24 Contract, the claims are not moot. Therefore, the Court will analyze the legal issues presented in the motion to the extent they affect the FY24 Contract.

The following contract-interpretation principles apply in this case:

> The main goal in the interpretation of contracts is to honor the intent of the parties. This is done by giving the plain and unambiguous words of a contract their plain

[5] The Court will discuss in the next section plaintiffs' mandamus claim as it relates to the ISF accounts.

> and ordinary meaning. The words and phrases of the contract cannot be read in isolation but must be construed in context and read in light of the contract as a whole. If the contract, although inartfully worded or clumsily arranged, fairly admits of but one interpretation, it is not ambiguous. [*Allen Park Retirees Ass'n, Inc v Allen Park*, 347 Mich App 1, 11; 13 NW3d 865 (2023) (cleaned up).]

When a contract is ambiguous, the proper interpretation of the contract is a question of fact for the trier of fact to decide. *Patel v FisherBroyles, LLP*, 344 Mich App 264, 272; 1 NW3d 308 (2022).

Count I of the second-amended complaint is a claim for declaratory relief about the ISF account limit. Count VI also adds a claim for mandamus relief to prohibit MDHHS from issuing sanctions in relation to the FY24 FSR without procedural due process. Although plaintiffs appear to recognize that the FY24 Contract capped the amount that could be deposited into the ISF account in any given year, they allege that the FY24 Contract did not contain a limit on the cumulative amount that could be maintained in their ISF accounts. They argue, instead, that the only limit on the ISF account total was established under a federal regulation, which requires that the ISF account be maintained in accordance with generally accepted accounting principles and practices and in a manner that is actuarially sound. See 42 CFR 438.6(b)(1).

Plaintiffs allege that MDHHS has required plaintiffs to follow the new language in the FY25 Contract during the FY24 Contract transition period by threatening to withhold bonus payments for fiscal year 2024, which plaintiffs characterize as a sanction. Plaintiffs assert that this change to the ISF provision violates federal regulations because it is arbitrary, not based on acceptable actuarial methods and accounting practices, and not actuarially sound.

Starting with plaintiffs' argument that the FY24 Contract did not limit the overall amount of the ISF account to 7.5%, the relevant provision stated:

> Contractor may transfer Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization to the ISF in any given year. Contractor may not transfer any funds in excess of that percentage to the ISF in any year.

The FY24 Contract further explains that plaintiffs "may use funds in the ISF only for this defined purpose of paying for liabilities in excess of the 100% of the risk corridor-related operating budget." When read in isolation, this provision of the FY24 Contract is limited to the contributions per year—and not the total amount in the ISF account. The provision does not say anything about a limit on the total amount in the ISF account. And no other restrictions appear in the ISF section of the contract, other than a broad suggestion that "[t]he ISF fund balance should be kept at a minimum to assure that the overall level of Contractor funds is directed toward consumer services." The Contract does not specify that the "minimum" must be capped at 7.5% of the annual operating budget.

Defendants argue, however, that a separate section within the FY24 Contract, known as the "Risk Corridor" section, limited the total amount to 7.5% that could be contributed and present in the ISF account. The Risk Corridor section provided, in relevant part: "Contractor [plaintiffs] must be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted." Additionally, under the Risk Corridor section, plaintiffs were "responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted." According to defendants, when these provisions are read together, it becomes clear that plaintiffs are responsible for 107.5% of their liabilities (100% of the liabilities up to the total amount of capitation payments and 7.5% of additional liabilities). Thus, the only plausible interpretation of the FY24 Contract in defendants' view is that it limits the amount to 7.5% that can be both contributed *and* present in the ISF account.

The Court agrees with plaintiffs that, at the very least, the contractual language contains an ambiguity because it could be interpreted either way—as allowing a cumulative total of over 7.5% in the ISF and as prohibiting a total exceeding that amount. It is unclear from the statutory language whether the Risk Corridor section of the contract was intended to apply to the ISF account provision in the manner defendants suggest and, if so, whether it would apply to cap the total amount in the ISF funds to 7.5%. Both parties' interpretations of the statutory language are plausible. Because the meaning of the contractual provision in the FY24 Contract is not inherent in the plain language, the provision is ambiguous, and discovery is appropriate to develop the factual record on this issue. See *Patel*, 344 Mich App at 272. Therefore, summary disposition under MCR 2.116(C)(8) is improper on Count I as it relates to the FY24 Contract.

Even assuming that defendants were correct that the FY24 Contract limits the amount that could be contributed *and* present in the ISF accounts, a further factual question exists for discovery: whether this restriction was actuarially sound. Plaintiffs allege that the ISF provision in the FY24 Contract violates 42 CFR 438.6(b)(1), which requires that risk-sharing mechanisms between the State and a PIHP are formed through "generally accepted actuarial principles and practices," and 42 CFR 438.4(a), which requires actuarial soundness in relation to capitation rates. The parties also dispute whether the provision violates 42 CFR 438.6(c)(1), which prohibits MDHHS from directing plaintiffs' expenditures under the contract.

Plaintiffs assert that the 7.5% limit is not actuarially sound or developed following generally accepted actuarial principles or practices. Plaintiffs allege that NorthCare retained an actuarial firm, Milliman, Inc., to perform an analysis of its ISF, which resulted in a conclusion that it should be funded at a higher rate of 12.3% of the annual operating budget. Plaintiffs also cite as evidence 2 CFR Pt 200, App V, which is a Code of Federal Regulations Appendix relating to state

and local government central service cost allocation plans, to support that the ISF limit should be closer 16.4%, rather than 7.5%. In sum, plaintiffs suggest that the entire mechanism through which defendants restrict their use of their ISFs violated the federal regulations and fundamental actuarial principles.[6]

The issue whether the 7.5% limit complied with the federal regulations involves questions of fact on what an actuarially sound level is and whether the actuarial methods were used, which require development of the factual record in discovery. Moreover, whether the various ISF requirements in the FY24 Contract directed plaintiffs' expenditures in violation of 42 CFR 438.6(c)(1) also involves a factual dispute about whether the ISF provision constituted a direction of expenditures. While defendants argue that the ISF limit is not an expenditure, this conclusion is not mandated by the text of the regulation. Yet another factual dispute exists relating to plaintiffs' allegation that MDHHS waived its position that the FY24 Contract prohibits plaintiffs from having an ISF balance over 7.5% of the annual operating budget by accepting Region 10's and NorthCare's Risk Management Strategies. Plaintiffs plead that waiver occurred and have not had the opportunity to develop that claim through discovery. Also, plaintiffs rely on Government Accounting Standards Board (GASB) Statement No. 10, which was cited in the FY24 Contract and which plaintiffs argue permits funding of the ISF account over a reasonable period without a specific cap on contributions. Thus, they have cited a factual basis to support their claim.

[6] Plaintiffs arguably waived this issue as it relates the 7.5% limit on annual contributions, which was included in the plain language FY24 Contract terms when plaintiffs signed those contracts. However, plaintiffs assert that the FY24 Contract did not include a 7.5% cap on overall funding into the ISF accounts, which is their primary allegation involving the ISF provision and is again a question requiring factual development in discovery.

Plaintiffs also raise a broader argument that MDHHS may not restrict their ability to use ISF funds to pay for services rendered in a prior fiscal year. Defendants argue that the FY24 Contract allows this restriction because it requires PIHPs to return unexpended risk corridor funds over 7.5%. They also argue that the Mental Health Code grants MDHHS broad powers, including those necessary to fulfill its duties and powers. See MCL 330.1116(3)(g). Once again, plaintiffs have stated a valid claim that this limitation would violate 42 CFR 438.6(c)(1), which prohibits MDHHS from directing expenditures under the contract "in any way." Plaintiffs allege defendants violate this federal regulation by mandating that ISF funds can only be used for future expenses and never for expenditure for prior years. Again, whether the contract provision violates these federal regulations involves questions of fact warranting discovery. Plaintiffs have therefore articulated a valid claim for declaratory relief as it relates to whether MDHHS is improperly restricting their ability to use ISF funds.

As it relates to plaintiffs' request for mandamus relief to prohibit MDHHS from issuing sanctions relating to plaintiffs' alleged failure to comply with the ISF provision of the FY24 Contract without notice and a hearing, plaintiffs have stated a valid claim that the withheld bonus payments function as sanctions, thus supporting a claim for declaratory and mandamus relief. Defendants, citing the contract language, argue that the bonuses are "award[s] to support program initiatives based on yearly metrics," to determine the amount each PIHP receives. Plaintiffs argue that the scenario in this case is like that present in *Mich Federation for Children & Families v Mich Dep't of Health & Human Servs*, Court of Claims Case No. 24-000195-MZ, a case involving an administrative rate that MDHHS was required to pay foster care service providers. In that case, this Court ruled that MDHHS's division of a legislatively selected administrative rate into base and incentive rates violated the relevant statute. *Mich Federation for Children & Families v Mich*

Dep't of Health & Human Servs, order of the Court of Claims, issued March 4, 2025 (Case No. 25-000195-MZ), pp 8-13.

Plaintiffs argue MDHHS is doing essentially the same thing in this case by recasting payments owed to plaintiffs under the law as "bonuses" over which MDHHS has discretionary authority. They argue the FY24 Contract provided a right to the bonus payments upon timely submission of the required reports, and MDHHS does not contend that any report was untimely. Whether the money in question is a bonus or funding owed to the PIHPs under the law is a factual dispute to be addressed in discovery.[7] If plaintiffs are correct that MDHHS is sanctioning them, then plaintiffs would be entitled to the procedural due process outlined in MCL 330.1232b(6).

As pleaded, plaintiffs' second-amended complaint alleges a colorable claim that plaintiffs have a clear legal right to continued funding and procedural protections, and that MDHHS has a clear legal duty to provide due process before issuing a sanction under MCL 330.1232b(6). And while the outcome of the administrative hearing would involve some level of discretion, the act of providing notice and the opportunity for a hearing is ministerial in nature. See *Hayes v Parole Bd*, 312 Mich App 774, 781; 886 NW2d 725 (2015) ("Mandamus is an extraordinary remedy that may lie to compel the exercise of discretion, but not to compel its exercise in a particular manner.") (cleaned up). Finally, plaintiffs allege they have no other available remedy at law to achieve the same results, and MDHHS does not outline any viable alternatives. Considering the factual allegations in the light most favorable to plaintiffs, they have stated a valid claim for declaratory

[7] Defendants also argue that CMS reviewed and approved the FY24 Contract but provide no factual support for this argument or explain why CMS's approval of the contract would negate any need to provide plaintiffs the amount they are owed under the contract absent a sanction following notice and the opportunity for a hearing.

and mandamus relief warranting discovery on the issue. Summary disposition is DENIED on Count I of the second-amended complaint as it relates to the FY24 Contract.

B. *WASKUL* SETTLEMENT

Plaintiffs further contend, in Count II of the second-amended complaint, that the requirement that the PIHPs create a CLS budget using a minimum fee schedule as required in the *Waskul* Settlement violates 42 CFR 438.6(c)(1) by improperly directing Medicaid expenditures. The language requiring direct compliance with the *Waskul* Settlement Agreement appeared only in the proposed FY25 Contract. According to plaintiffs, MDHHS has imposed the requirement on them during the FY24 Contract transition period as a form of "Medicaid policy."

The central dispute is whether the *Waskul* Settlement Agreement is an improper direction of plaintiffs' Medicaid expenditures, in violation of 42 CFR 438.6(c)(1). This federal regulation provides, in relevant part, that, with certain exceptions, "the State may not in any way direct the . . . PIHP's . . . expenditures under the contract." 42 CFR 438.6(c)(1). Plaintiffs assert that the *Waskul* Settlement requires plaintiffs to pay certain rates for certain services when developing a budget with recipients who self-direct their services, thus constituting a direction of their expenditures under the FY24 Contract.[8] Although 42 CFR 438.6(c)(1)(*iii*)(A) contains an exception allowing MDHHS to require a PIHP to "[a]dopt a minimum fee schedule for providers that provide a particular service under the contract using State plan approved rates," plaintiffs argue that this limited exception does not apply because the *Waskul* Settlement Agreement did not involve payments for providers. Plaintiffs further argue that the exception, even if it applied, is being

[8] Defendants suggest that the federal court rejected that argument in *Waskul* but does not assert a collateral-estoppel defense or provide evidence to support that argument.

applied in violation of federal regulations because it treats providers providing services via a self-determination modality different than other providers, in violation of 42 CFR 438.6(C)(2)(*ii*)(B). And even if the exception *did* apply more generally, plaintiffs argue that it does not apply in this case because providers are treated differently depending on the modality of services. The parties dispute whether defendants have improperly directed plaintiffs' expenditures for services. The language of the *Waskul* Settlement Agreement does not settle these questions. Thus, the pleadings sufficiently allege a claim in relation to the *Waskul* Settlement for the FY24 Contract, and the issue may be developed further in discovery.

Additionally, plaintiffs assert that defendants were required to follow the notice and hearing requirements outlined in the APA to implement any form of new "Medicaid policy." Defendants argue they were exempt from those requirements for policies outlined in the Medicaid Provider Manual under MCL 24.207(o) and MCL 400.6(4). MCL 24.207(o), a provision of the APA, exempts from the meaning of the term "rule" under the APA "[a] policy developed by the department of health and human services under section 6(4) of the social welfare act, 1939 PA 280, MCL 400.6, to implement requirements that are mandated by federal statute or regulations as a condition of receipt of federal funds." MCL 400.6(4) additionally provides:

> The family independence agency may develop policies to implement requirements that are mandated by federal statute or regulations as a condition of receipt of federal funds. Policies developed under this subsection are effective and binding on all those affected by the programs. Policies described in this subsection are exempt from the rule promulgation requirements of [the APA].

This issue is another one that requires development of the factual record. Specifically, defendants argue that "every policy provision of the *Waskul* Settlement implements a Medicaid statute or regulation setting forth a condition of receipt of federal Medicaid funds that Michigan follows these provisions in the Social Security Act." But defendants cite no federal statute or

regulation that requires the provisions of the *Waskul* Settlement Agreement. Nor do they cite any caselaw to support that a federal lawsuit settlement is binding on the PIHPs in this context. The record has not been developed on this issue beyond the language of the Settlement Agreement, which does not affirmatively establish whether its language is implementing a Medicaid statute or regulation. Plaintiffs are therefore entitled to conduct discovery on whether each policy provision of the *Waskul* Settlement is intended to, and does, implement a Medicaid statute or regulation. Therefore, summary disposition is DENIED on Count II of the second-amended complaint as it relates to the FY24 Contract.

C. CCBHC CLAIMS

In Counts III and IV of the second-amended complaint, plaintiffs request declaratory relief and relief under the Headlee Amendment, Const 1963, art 9, §§ 25-34, on the basis that MDHHS shifted responsibilities onto CMHPSM and Region 10 through modification of the CCBHC Handbook without providing additional funding. This issue relates to action taken during the fiscal year 2024 transition period. Defendants argue that plaintiffs cannot maintain an independent claim under § 25 of the Headlee Amendment, and that the changes in the contract did not add financial burdens on these PIHPs.

The Headlee Amendment is designed to protect against a legislative attempt "to shift responsibility for services to the local government . . . in order to save the money it would have had to use to provide the services itself." *Adair v Michigan*, 470 Mich 105, 112; 680 NW2d 386 (2004) (cleaned up). Const 1963, art 9, § 25 provides, in relevant part, that "[t]he state is prohibited from requiring any new or expanded activities by local governments without full state financing, from reducing the proportion of state spending in the form of aid to local governments, or from shifting the tax burden to local government."

Even accepting MDHHS's argument that § 25 does not create an independent cause of action, plaintiffs also cite Const 1963, art 9, § 29, which provides, in relevant part:

> The state is hereby prohibited from reducing the state financed proportion of the necessary costs of any existing activity or service required of units of Local Government by state law. A new activity or service or an increase in the level of any activity or service beyond that required by existing law shall not be required by the legislature or any state agency of units of Local Government, unless a state appropriation is made and disbursed to pay the unit of Local Government for any necessary increased costs.

Plaintiffs assert that they and the CMHs they serve are local units of government for purposes of the Headlee Amendment, a position that is not challenged by defendants in their motion for summary disposition. Additionally, the Michigan Court of Appeals has clarified that this Court has subject-matter jurisdiction over Headlee Amendment claims filed against state entities. See *Telford v Michigan*, 327 Mich App 195, 201; 933 NW2d 347 (2019) (involving a Headlee Amendment claim against the State of Michigan, the Governor of Michigan, the State Treasurer, and various state agencies). Defendants do not challenge plaintiffs' ability to raise a claim under § 29.

Plaintiffs' Headlee Amendment claim is premised on MCL 21.235(1), which relates to state budgeting and requires that "[t]he legislature shall annually appropriate an amount sufficient to make disbursements to each local unit of government for the necessary cost of each state requirement pursuant to this act, if not otherwise excluded by this act." MCL 21.235(2) adds, in relevant part, that the first advance disbursement must be made at least 30 days before the effective date of the state requirement in question.

Beyond the threshold argument regarding § 25, defendants do not raise an argument that plaintiffs' claims are not Headlee Amendment claims or that they do not fall within the meaning

of the constitutional provisions or MCL 21.235. Rather, defendants maintain that the changes to the CCBHC Handbook clarified responsibilities but did not add responsibilities on the part of the PIHPs. Plaintiffs plead just the opposite and cite the Handbook provisions at issue within their complaint. A finding in defendants' favor would require the Court to ignore plaintiffs' allegations in the second-amended complaint, which the Court cannot do when deciding a motion for summary disposition under MCR 2.116(C)(8). Therefore, this argument goes to the merits of the issue rather than the adequacy of the pleadings.

Defendants further point out that plaintiffs' actuarial expert, Milliman, Inc., indicates in its report, which is attached to the second-amended complaint, that " 'many of the PIHP responsibilities for the CCBHC Demonstration are currently being performed as part of the existing program.' " However, the actuarial report is not dispositive on whether the amendments to the CCBHC Handbook amounted to new responsibilities without funding in violation of the Headlee Amendment. Plaintiffs assert that the Milliman Report actually supports their position by referring to "new 'major responsibilities,' " thus giving rise to a factual issue to be explored during discovery. Once again, this issue presents a question of fact rather than a question about the adequacy of the pleadings.

Similarly, plaintiffs have stated a claim that MDHHS was required to follow the APA to modify the CCBHC Handbook. MCL 330.1232b(1) provides, in relevant part, that "[t]he department shall establish standards for community mental health services programs designated as specialty prepaid health plans under the [M]edicaid managed care program . . . . The standards established under this section shall be published in a departmental bulletin or by an updating insert to a departmental manual." It is unclear from the language of this statute whether compliance with the APA is required, or whether the CCBHC Handbook provisions would fall under the category

of "standards for community mental health service programs" in MCL 330.1232b(1). This is true even assuming plaintiffs agreed to follow the most current iteration of the CCBHC Handbook when they signed the FY 24 Contract. The fact that plaintiffs agreed to follow the current version of the CCBHC Handbook does not amount to a waiver of MDHHS's obligation to follow APA procedures. Therefore, plaintiffs have stated a valid claim for relief in Counts III and IV of their second-amended complaint.

VI. CONCLUSION

IT IS ORDERED:

1. Defendants' motion for summary disposition is GRANTED IN PART as it relates to all claims in Counts I, II, V, and VI arising from the FY25 Contract and any claim for a future contract or continued funding after the FY24 transition period.

2. Plaintiffs' claims in Counts I, II, V, and VI arising from the FY25 Contract and any claim for a future contract or continued funding after the FY24 transition period are DISMISSED WITH PREJUDICE.

3. Defendants' motion for summary disposition is DENIED IN PART as it relates to all claims for declaratory and mandamus relief in Counts I, II, V, and VI arising from or relating to the FY24 Contract and DENIED as it relates to Counts III and IV.

4. The stay on discovery is LIFTED. The Court contemporaneously requests by letter that the parties submit a stipulated Scheduling Order.

5. The December 23, 2024 preliminary injunction relating to the SUDHH funding will remain in full force and effect until further order of the Court.

6. This order is not a final order and does not resolve all claims.

Date: April 29, 2026

Sima G. Patel
Judge, Court of Claims

April 29, 2026

Case Name: Northcare Network Mental Health Care Entity v State of Michigan
Case No.: 24-000198-MZ

Dear Counsel:

The above-referenced case has been assigned to me, and it is time to enter a scheduling order. My preference is to allow counsel to draft a scheduling order since you know the case and its needs better than I do.

Within the next 14 days, please prepare a stipulated scheduling order. If the parties cannot agree on dates, each party should submit a scheduling proposal and the Court will choose the dates.

The stipulation and order should provide dates for the following:

1. **Exchange of Initial Disclosures Per MCR 2.302 –** The parties shall file a copy of their initial disclosures with the Court Clerk.

2. **Witness List Deadline –** Witness lists for all parties shall be due the same day. The parties may request different dates for the filing of lay witnesses and expert witnesses.

3. **Completion of Mediation –** Parties are strongly encouraged to engage in alternative dispute resolution. If a mediator is selected, the parties shall notify the Court of their selection and the expected date of mediation. If the parties wish to mediate but are unable to agree on a mediator, they should advise the Court and the Court will appoint one with costs to be split equally between the parties. The parties may also request a mediation or settlement conference conducted by a Court of Claims judge not assigned to the matter.

4. **Completion of Discovery –** The parties may stipulate to an extension of discovery providing it does not require adjournment of any other dates. Otherwise an extension of discovery shall be granted only on a showing of good cause.

Deadline for Filing of Dispositive Motions – Dispositive motions must comply with MCR 2.116 and shall be filed before the deadline established in the scheduling order. Response briefs are due 21 days after the motion is filed and reply briefs are due 7 days after the response is filed. The court will set a hearing date if it determines that a hearing is necessary. Parties are strongly encouraged to move for summary disposition on all grounds available at the time the motion is filed and avoid serial summary disposition motions. Parties are directed to bookmark all PDF exhibits filed with a motion. As relates to dispositive motions under MCR 2.116(C)(6), MCR

2.116(C)(7), MCR 2.116(C)(8), and MCR 2.116(C)(10), one and only one motion may be filed as a matter of right. Any additional dispositive motions require leave of the Court.

WARNING: If the non-movant fails to timely file a response to a motion, including a dispositive motion, the Court may, in its discretion, consider the motion unopposed and grant the motion on that basis. The parties may stipulate or move for an extension of response deadlines.

6. **Related Circuit Court Cases** - If the case has a companion Circuit Court matter pending, the stipulation should include the name, county of filing and docket number of the Circuit Court case. If a scheduling order has been issued in the Circuit Court case, it should be submitted with the proposed scheduling order. If consolidation will be sought, the Court should be notified as early as possible.

The parties are also advised as to the following:

Motion Practice – Non-dispositive motions may be filed at any time and should comply with MCR 2.119. Response briefs to non-dispositive motions are due 14 days after the filing of the motion and reply briefs are due 7 days after the filing of the response. Parties are directed to bookmark all PDF exhibits filed with a motion.

Trial, Final Pretrial and Motions in Limine – Dates for trial and final pre-trial will be set by the Court. All motions in limine shall be filed no less than 21 days before trial and heard no less than 7 days before trial. Parties are encouraged to file motions in limine as early as possible. Parties are directed to bookmark all PDF exhibits filed with a motion.

Status Conferences – The Court will schedule status conferences as needed. If the parties believe that a status conference is needed at any point during the litigation the Court should be notified.

Settlement Conference – If the parties believe a settlement conference would be helpful, a different Court of Claims judge will conduct a conference upon request.

Thank you for your cooperation.

Very truly yours,

Sima G. Patel,
Court of Claims Judge

Court of Claims
TUEBOR
CIRCUMSPICE
State of Michigan

SGP/jb

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

NORTHCARE NETWORK MENTAL HEALTH CARE ENTITY, et al.

Plaintiffs,

v

STATE OF MICHIGAN, et al.

Defendants.

Case No. 24-000198-MZ

Hon. Sima G. Patel

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PLAINTIFF'S 05/19/2026 MOTION FOR RECONSIDERATION AND CLARIFICATION OF 04/29/2026 OPINION AND ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION FOR SUMMARY DISPOSITION

INTRODUCTION

This Motion requests the Court reconsider a very narrow aspect of its ruling with regard to MDHHS's obligation to continue providing funding to Plaintiffs following the expiration of the two year transition period of the FY24 Contract. Plaintiffs respectfully submit that the Court reached its conclusion by concluding that the terms "regional entity" and "PIHP" are used synonymously in the Mental Health Code. Plaintiffs respectfully submit they are not, and recognition of the distinction compels a different result.

This Motion also seeks clarification of the Court's ruling relating to the dismissal of Plaintiffs' claims for declaratory relief "arising from the FY25 Contract." The Court concluded that because Plaintiffs and MDHHS never had a fully executed FY25, Plaintiffs did not have standing to challenge the legalities of certain provisions in FY25 Contract. However, Plaintiffs

also sought a declaratory ruling that MDHHS could not impose any FY25 Contract provisions on them. Given the balance of the Court's ruling, Plaintiffs do not believe that the Court intended to dismiss that request for declaratory relief. Accordingly, Plaintiffs respectfully request clarification.[1]

MOTIONS FOR RECONSIDERATION

MCR 2.119(F) governs motions for rehearing or reconsideration and gives the Court broad authority to reconsider a decision. Contrary to common misconception, a showing of palpable error is not required—it is merely a guideline. *Michigan Bank-Midwest v DJ Reynaert, Inc.*, 165 Mich App 630; 419 NW2d 439 (1988). Sound judicial administration supports reconsideration when it prevents perpetuating error: "It would be a strange result to perpetuate an error on the grounds that it was not 'palpable' or more generally upon a reluctance to reconsider issues (especially when the same error, if not harmless, would be subject to correction on appeal, but at a much greater expense)." *Id.* quoting Martin, Dean & Webster, Michigan Court Rules Practice, Rule 2–119, p 537. The Supreme Court established this principle over a century ago: "this court will always regard a motion for rehearing with favor, which will call our attention to something contained in the record or briefs of counsel that has been inadvertently or otherwise overlooked or omitted, which is material to be considered in making a proper disposition of the case, or which will challenge our attention to a misapplication of the law." *Smith v Walker*, 57 Mich 456, 488; 26 NW 783 (1886). This motion presents precisely such a situation warranting reconsideration.

[1] Plaintiffs respectfully disagree with the Court's conclusion that they do not have standing to challenge provisions in the FY25 Contract. However, for the most part, the reasons they believe they have standing was set forth in their Response to Defendants' MSD or to the Court during oral argument. Merely reiterating the same arguments is generally not appropriate grounds to bring a motion for reconsideration, and accordingly, Plaintiffs do not do so here. Instead, the issue raised in this Motion is narrowly tailored to show palpable error, which, after correction, should result in a different disposition of the Motion, at least in part. MCR 2.119(f)(3).

ARGUMENT

I. Plaintiffs are entitled to continued funding under the Mental Health Code because MDHHS is required to contract with them.

Plaintiffs are regional entities. SAC, ¶ 9. In its Opinion, the Court held that MDHHS was not required to continue providing funding or execute a new contract with Plaintiffs for FY25 and beyond because Plaintiffs do not have a clear legal right to operate as the PIHPs for their designated service areas. Opinion at 17-18. Respectfully, the Court's analysis treated the terms "regional entity" and "PIHP" as synonymous, when in fact they are distinct legal entities under the Mental Health Code. The Court held:

> Plaintiffs also suggest that MDHHS had no option but to continue to contract with them because MDHHS could not engage another regional entity to act as the PIHP for the geographical area covered by plaintiffs. They rely on MCL 330.1204b(2)(b), a provision of the Mental Health Code that provides:
>
> > (1) Except as otherwise stated in the bylaws, a regional entity has all of the following powers:
> >
> > * * *
> >
> > (b) The power to contract with the state to serve as the [M]edicaid specialty service prepaid health plan for the designated service areas of the participating community mental health services programs.
>
> Plaintiffs' claim presumes that they will always exist as the PIHP for their respective regions, which is not necessarily true, particularly considering Judge YATES'S opinion regarding fiscal year 2027 and beyond. Indeed, the statute allowing for the formation of PIHPs provides that "[a] combination of community mental health organizations or authorities may establish a regional entity by adopting bylaws that satisfy the requirements of this section." MCL 330.1204b(1) (emphasis added). The use of the permissive word "may" suggests that PIHPs are not required to be formed under the Mental Health Code. See *True Care Physical Therapy, PLLC v Auto Club Group Ins. Co.*, 347 Mich App 168, 182-183; 14 NW3d 456 (2023) (explaining that the term "may" has a permissive meaning). Accordingly, plaintiffs have not cited a legal basis to support a declaratory judgment on the basis of a right to a continuing contractual relationship.
>
> Opinion at 17-18 (emphasis added).

The Court's analysis concluded that *PIHPs* are not required to be formed under the Mental Health Code, by citing the statute stating that *regional entities* are not required to be formed under the Mental Health Code. The terms "prepaid inpatient health plan"—or, PIHP—and "regional entity" are not synonyms. While it is true that all regional entities currently operate as PIHPs, regional entities are not required to do so. Likewise, some PIHPs are not regional entities, but rather CMHSPs that chose not to join with other CMHSPs to form a regional entity (i.e., the CMHSPs for Wayne, Oakland, and Macomb, each of whom operate as the PIHP for their counties).

The distinction between regional entities and PIHPs matters. As the Court noted, MCL 330.1204b(1) provides that "a combination of community mental health organizations or authorities may establish a regional entity." The statute's use of "may establish" vests the formation authority exclusively in the CMHSPs. But once CMHSPs exercise this authority by adopting bylaws, MCL 330.1204b(2)(b) grants the resulting regional entity "the power to contract with the state to serve as the [PIHP] for the designated service areas of the participating [CMHSPs]." The statute thus creates a two-step process controlled by CMHSPs: first, CMHSPs decide whether to form a regional entity; second, that regional entity possesses statutory power to contract as the PIHP for the collective service areas of its member CMHSPs.

The phrase "power to contract" is not surplusage. A statutory "power" is a legal capacity to create binding obligations. *Black's Law Dictionary* (12th ed. 2024) (defining "power" as "[t]he ability to act or not act"). In the context of the Mental Health Code, when the Legislature granted regional entities the "power" to act as the PIHP for their region, it necessarily conferred the *right* to exercise that power. A power that the State may nullify at will—by simply refusing to contract—is no power at all. Interpreting MCL 330.1204b(2)(b) otherwise would render the grant of "power" meaningless.

Because Plaintiffs are regional entities possessing the statutory power to contract with MDHHS as the PIHPs for their designated service areas, MDHHS cannot unilaterally terminate the relationship by refusing to execute a contract, claiming that the "termination" was really just an "expiration." The Court's contrary conclusion rested on treating the terms "regional entity" and "PIHP" synonymously, thereby misapplying the permissive "may establish" language in MCL 330.1204b(1) to the distinct "power to contract" provision in MCL 330.1204b(2)(b). Correcting this error compels the conclusion that MDHHS is obligated to continue funding Plaintiffs.

II. Plaintiffs seek clarification regarding their request for a declaration that MDHHS cannot force them to comply with the FY25 Contract during the FY24 transition period.

Plaintiffs seek clarification of the scope of the Court's partial dismissal of Counts I-II. The Court dismissed portions of those counts to the extent they "aris[e] from the FY25 Contract" on the ground that no FY25 Contract was ever fully executed. Opinion at 14-15. The Court reasoned that because Plaintiffs signed and sent back redlined versions of the proposed contract rather than signing MDHHS's version, there was no meeting of the minds, and therefore "no such contract ever existed between the parties." *Id.* at 15. From this, the Court concluded that Plaintiffs "are not the real parties in interest and lack standing as it relates to any challenge to the terms of the FY25 Contract." *Id.*

But Plaintiffs did not sue to enforce the FY25 Contract or merely for a declaration that certain provisions in it are illegal. Plaintiffs also sued seeking a declaration that MDHHS could not enforce the FY25 Contract against them. In other words, Plaintiffs requested a declaration that they were not subject to the FY25 contract. The trial court's dismissal of "all claims in Counts I, II, V, and VI arising from the FY25 Contract" arguably swept Plaintiffs' "negative-declaration" theory into the dismissal. Opinion at 19.

Given its reasoning elsewhere in the Opinion, Plaintiffs anticipate the Court did not intend to dismiss this aspect of Plaintiffs' Complaint. For example, the Court acknowledged that Plaintiffs alleged MDHHS was attempting to impose "certain provisions of the FY25 Contract" on Plaintiffs "unlawfully during the FY24 Contract transition period," and permitted Plaintiffs' FY24 related claims to proceed to discovery. Opinion at 19-26. The Court likewise recognized Plaintiffs' allegations that "MDHHS has required plaintiffs to follow the new language in the FY25 Contract during the FY24 Contract transition period by threatening to withhold bonus payments for fiscal year 2024…." *Id.* at 20. Indeed, the Court specifically found that Plaintiffs had stated valid claims that MDHHS was (1) attempting to enforce the more restrictive FY25 ISF cap during the FY24 transition period, (2) imposing the Waskul Settlement requirements as "Medicaid policy" even though that requirement appeared only in the FY25 Contract, and (3) shifting new CCBHC responsibilities to Appellants without funding in connection with the FY25 Contract. Opinion at 20-31.

Yet the summary language employed in the Opinion arguably dismissed Plaintiffs' claim for the very relief that would remedy the State's unlawful conduct: a judicial declaration that the FY25 Contract is not binding on Plaintiffs. This warrants clarification. If MDHHS is unlawfully imposing FY25 Contract provisions on Plaintiffs as Plaintiffs have pled, then Plaintiffs are entitled to declaratory relief establishing that the MDHHS cannot do so. The fact that no contract was formed is not a barrier to standing; it is a basis for the claim that MDHHS cannot hold Plaintiffs to its terms.

MCR 2.605(A)(1) authorizes declaratory relief "[i]n a case of actual controversy within its jurisdiction." An "actual controversy" exists where a party is asserting a legal right against another, and that assertion is being denied. *UAW v Cent. Mich. Univ. Trustees*, 295 Mich App 486, 495;

814 NW2d 652 (2012). Here, MDHHS asserts that Plaintiffs must comply with provisions of the FY25 Contract during the FY24 transition period. Plaintiffs deny that obligation. That presents an actual controversy, and Plaintiffs respectfully request that the Court clarify its ruling in this regard.

CONCLUSION

For the reasons stated above, Plaintiffs respectfully request that the Court: (1) reconsider its ruling that MDHHS has no obligation to continue contracting with Plaintiffs; and (2) clarify that its dismissal of claims "arising from the FY25 Contract" does not preclude Plaintiffs from obtaining a declaration that the FY25 Contract has no binding effect on them during the FY24 transition period.

TAFT, STETTINIUS & HOLLISTER, LLP

Dated: May 18, 2026

By: */s/Christopher J. Ryan*

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Michigan Medicaid Program Updates

Nicole Hudson, Director, Office of Oversight & Program Coordination

Katie Commey, Director, Policy Integration & Evaluation Division

May 11, 2026

MDHHS

Michigan Department of Health & Human Services

Key Medicaid H.R. 1 Updates

MDHHS
Michigan Department of Health & Human Services

Key MDHHS Updates

- MDHHS is committed to helping as many Michiganders stay enrolled in Medicaid as possible; while ensuring we meet federal community engagement rules.
- MDHHS is electing to only require beneficiaries to meet work requirements for one month.
- Michigan is required to implement H.R. 1 by January 1, 2027, but CMS will not issue final guidance until June 2026.
  - In the meantime, CMS has only released limited, non-binding guidance, and all verbal direction remains pre-decisional and iterative.
  - To stay on schedule, the state must lock in system design and operational processes now, well before federal requirements are finalized.
  - Despite the late release of federal guidance, CMS has indicated they will not offer a good-faith-effort exemption or allow states to delay implementation.

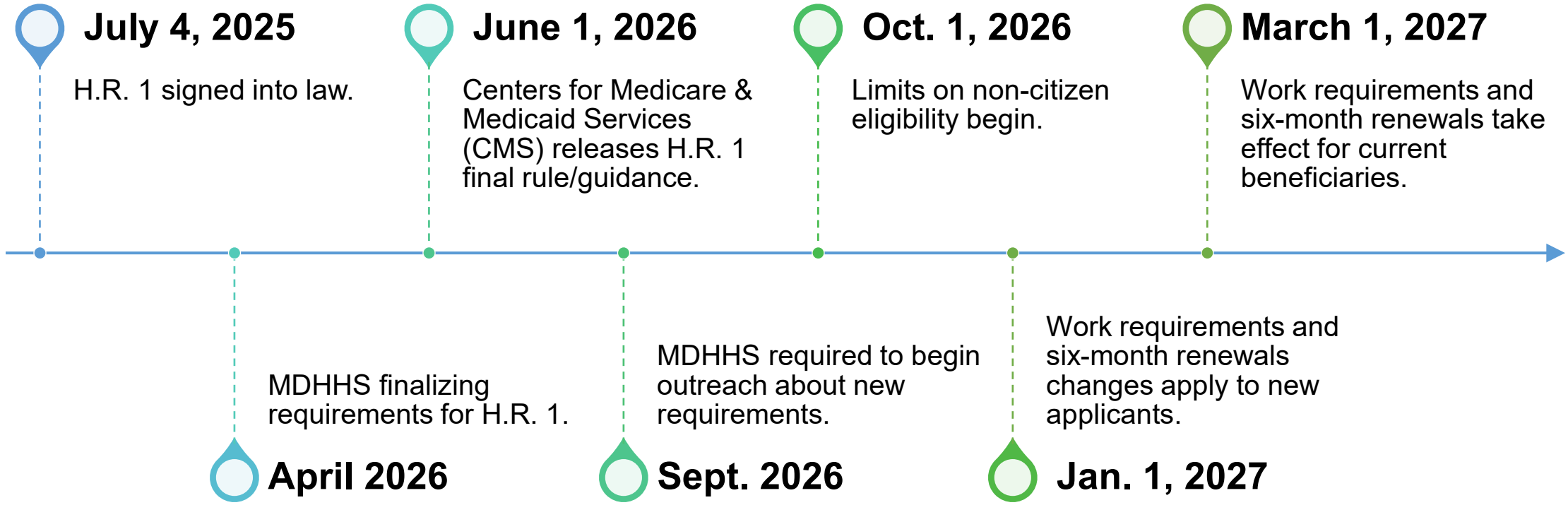
Key MDHHS Updates (cont.)

- Communications Language Adoption:
  - Work Requirements
    - In alignment with SNAP
    - Instead of Community Engagement
  - H.R. 1 of 2025
    - Using H.R. 1 in instead of One Big Beautiful Bill, Working Families Tax Cut Legislation, Public Law 119-21 for consistency.

Key Medicaid Provisions in H.R. 1

MDHHS
Michigan Department of Health & Human Services

Important H.R. 1 Dates



Major Eligibility Changes

MDHHS Michigan Department of Health & Human Services

New Work Requirements

- Applies to many Healthy Michigan Plan (HMP) enrollees 19-64.
- Must work, train or volunteer at least 80 hours for one month.
- Non-compliance will lead to loss of coverage.

Effective Date:
January 1, 2027

Six-Month Redeterminations

- Eligibility checks for HMP now every six months, instead of annually.
- Increased risk of coverage interruptions due to paperwork gaps.

Effective Date:
January 1, 2027

Retroactive Eligibility Limited

- No more 90-day retroactive coverage.
- HMP: One month prior to application.
- Other Medicaid enrollees: Two months prior to application.

Effective Date:
January 1, 2027

Limits on Non-Citizen Eligibility

- Fewer pathways to coverage for lawfully present non-citizens.
- Affected individuals will lose full coverage → Moving to Emergency Services Only (ESO) coverage.

Effective Date:
October 1, 2026

Deep Dive: Medicaid Work Requirements

MDHHS Michigan Department of Health & Human Services

Qualifying Activities

80 hours per month of:

- Work.
- Community service.
- Participation in a work program.

- Half time + enrollment in an education.
- Any combination of the above totaling 80 hours per month.
- Monthly income that is not less than the federal minimum wage x 80 hours ($580/month).
- Seasonal worker with an average monthly income over the preceding six months that is not less than the federal minimum wage x 80 hours.

Exemptions

Parent, guardian, or caretaker of:

- Dependent children under age 13.
- Disabled individuals.

- Pregnant or postpartum individuals.
- Foster youth or former foster youth under age 26.
- Medically frail.
- Participating in a substance use disorder (SUD) program.
- Meeting SNAP/TANF work requirements.
- American Indians and Alaska Natives.
- Disabled veterans.
- Incarcerated or released from incarceration within the past 90 days.

Hardship Exceptions

Individuals who were in:

- Inpatient hospital.
- Nursing facility.
- Intermediate care facility.
- Inpatient psychiatric hospital.

- Individuals who reside in a county with:
  - A federally-declared emergency or disaster.
  - High unemployment - above 8% or 1.5× national rate.
- Individuals who traveled outside their community for extended medical care for self or dependent.

Medical Frailty Definition

- This definition is based on early information and is subject to change.
- An individual who is medically frail or otherwise has special medical needs:
  - who is blind or disabled;
  - with a substance use disorder;
  - with a disabling mental disorder;
  - with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
  - with a serious or complex medical condition.

- CMS has indicated that it does not intend to provide states with flexibility to add other types of individuals to the definition of medical frailty, beyond those listed in the statute.
- States will have to distinguish between permanent (to be reverified at least every 12 months) vs. temporary (to be reverified at least at every renewal) medical frailty exclusions.
- CMS will expect states to implement an auditable approach to verify medical frailty.

Work Requirement Verification

MDHHS will check if a beneficiary met the work requirements when they:

- Apply for Medicaid.
- Renew their Medicaid coverage.

This check will be part of their regular eligibility review.

Six-Month Renewals: What Changes

Six-Month Renewals

- Beginning in 2027, HMP enrollees must renew coverage every six months instead of annually.
- Six-month renewals apply to nearly all HMP enrollees; the only exemption is for American Indians and Alaska Natives.
  - Those receiving exemptions/exclusions from work requirements will still be required to complete their renewal every 6 months.

Six-Month Renewal Timing

- First six-month renewal cohort: **March 2027**

Timeline Example of Work Requirements at Application

- This timeline is based on information we know now and is subject to change based on guidance issued by CMS.
- For a beneficiary who would have a apply for coverage in April 2027, this is what a it would like if they qualify for Healthy Michigan Plan:

Potential Medicaid Work Requirement at Application	
Application Month	**Work Requirements Compliance Required**
April 2027	March 2027

- Individuals applying for Medicaid (Healthy Michigan Plan) **must** meet the work requirements for at least one month immediately preceding the month during which the individual applies.

Timeline Example of Work Requirements & Six Month Renewals

- This timeline is based on information we know now and is subject to change based on guidance issued by CMS
- For a beneficiary who would have a renewal in April 2027, this is what a new timeline for them could potentially look like:

Potential Medicaid Work Requirement & 6 Months Eligibility Timeline		
Renewal Month	**Work Requirements Compliance Required**	**Renewal Packet Mailed to Beneficiary**
April 2027	Demonstrate one month of compliance, in between renewal months	March 2027
October 2027	Demonstrate one month of compliance, in between renewal months	September 2027

- Per CMS, the state may not dictate the specific months during which a beneficiary must demonstrate work requirements.

Retroactive Coverage Limits

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Starting **January 2027**

- Individuals who apply for Medicaid or forget to turn in a piece of paperwork and have a gap in coverage will see a change in how far coverage can go back (called retroactive coverage).

- **HMP**: Will cover one month back instead of three months.
- **Other Medicaid Programs**: Will cover two months back instead of three months.

Non-Citizen Eligibility

- Beginning **October 2026**, some people who are legally residing in the U.S., but are not citizens, will not qualify for full Medicaid coverage.

Remain Eligible	No Longer Eligible
• Lawful permanent residents (generally subject to a five-year waiting period). • Cuban/Haitian Entrants. • Compact of Free Association (COFA) migrants.	• Refugees. • Humanitarian parolees. • Asylum grantees. • Certain abused spouses and children. • Victims of human trafficking.

Anticipated Impacts

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Impacts of H.R. 1 on MDHHS Staff

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Central Office

- Significant IT upgrades to Bridges eligibility system to meet Minimum Viable Product specifications.
- Outreach and education to beneficiaries, providers and community partners on H.R. 1.
- Increased mailing outreach required because of eligibility changes due to work requirements and 6-month renewals.
- Increased opportunity for oversight and program coordination.

Local Office

- Double workload: processing renewals twice a year.
- Substantial new outreach to beneficiaries by staff.
- Increased administrative burden of reviewing new forms, self attestations and other compliance documents.
- Administration of fair hearings for beneficiaries.

Impact of Eligibility Provisions

What's at stake for Michigan:

- Significant new administrative costs to support implementation needs, including system upgrades, staffing and compliance efforts.
- Potential loss of coverage for more than **200,000** individuals.

Significance of these changes:

Administrative Burden = Coverage Loss
Many enrollees meet requirements, but may lose coverage due to complex paperwork and red tape.

Higher Churn Rates → Delayed Care
Frequent churn caused by paperwork issues disrupts care continuity, hinders access and leaves individuals vulnerable during medical emergencies.

Rising Uninsured Rates
Parallel Affordable Care Act changes limiting Marketplace access could leave many individuals without access to coverage, driving up the uninsured rate across the state.

Increased Uncompensated Care and Medical Debt
Hospitals and local safety nets will be forced to absorb the costs of caring for those who have lost coverage, while patients face unaffordable bills and medical debt.

Communications & Outreach

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Communications Plan

MDHHS will implement a communications plan with several key goals for informing beneficiaries and partners about the upcoming changes, with emphasis on HMP Work Requirements. Goals include:

Support Beneficiaries	Equip Community Partners	Prepare Local Office Staff
• Help beneficiaries understand upcoming changes, including Work Requirements and renewal expectations.	• Provide partners with clear messaging, materials, and resources to support outreach and navigation.	• Build awareness and readiness to support consistent implementation and respond to beneficiary questions.

Message Development Strategy

Messaging Focus

- Build public awareness.
- Prepare beneficiaries and partners.
- Support awareness to action.

Accessible and Community-Informed Messaging

- Use plain and culturally responsive language.
- Support trusted community messengers.
- Provide translation in English, Spanish, and Arabic.

Trusted Messengers

- **Community Partners**: leverage network of partners to amplify messaging, distribute resources and messaging at the local level. Provide training and support to providers, navigators, and community-based partners.
- **Managed Care Organizations**: Help educate Medicaid members on requirements, provide MDHHS with feedback to inform material and process refinement.
- **Local Office Staff**: MDHHS will provide training, support, and beneficiary facing materials to local office eligibility staff, aid in eligibility determinations

Outreach Activities

- **Direct Beneficiary Outreach:**
  - Mail **formal notices** to provide awareness to changes and drive action.
  - Provide **alerts** and formal notices within MIBridges self-service portal.
  - **Text, email & robocall** messages sent directly to beneficiaries.
  - A **paid media** campaign that includes traditional and social media channels.

- **Partner & Provider Engagement:**
  - Customizable **toolkits** for providers and partners available on the MDHHS website.
  - Additional **FAQs** for external partner and internal staff use.
  - Recorded and live **virtual presentations** to connect with providers, partners and beneficiaries about upcoming changes.

- **Stakeholder Engagement:**
  - **Presentations** to advisory groups such as the Beneficiary Advisory Council and Medicaid Advisory Committee.

Beneficiary Notice Journey

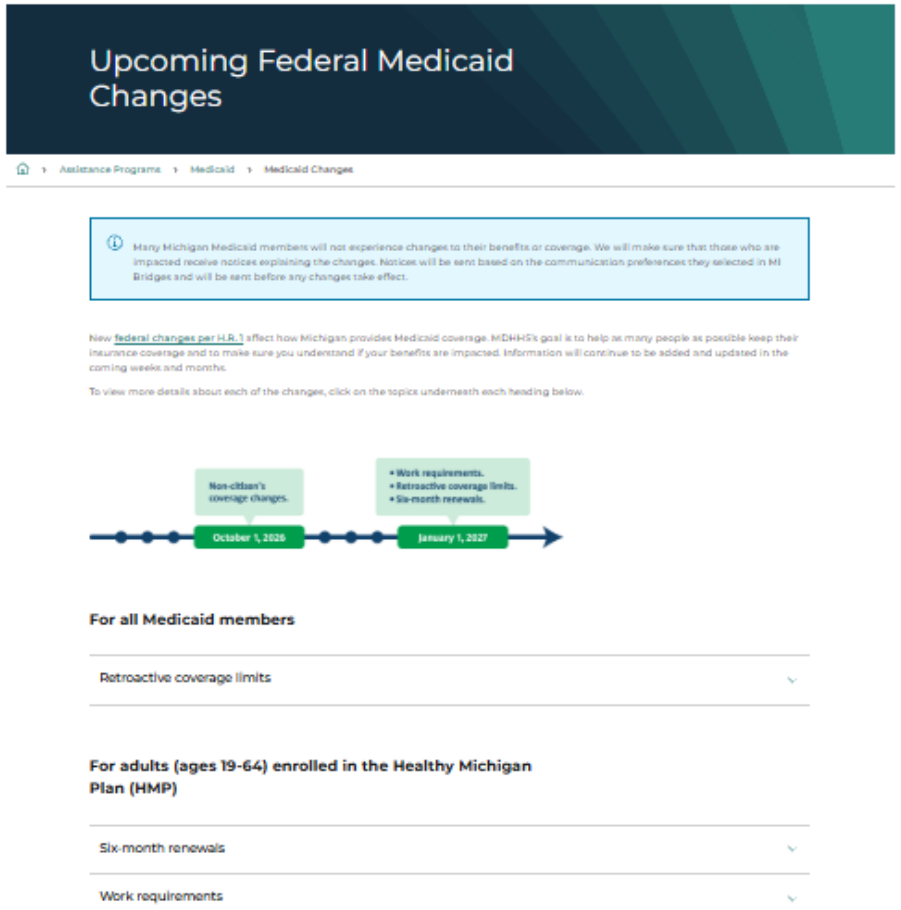
Communication	Purpose	Timing
Awareness Letter	A letter to inform individuals with HMP coverage that they could be impacted by the upcoming changes. This letter will also remind beneficiaries to keep their information up to date in MIBridges or by contacting their local office	Summer 2026
Formal Notice	A formal notice that provides all information required by HR1. A copy of this notice will also be populated on the MDHHS website.	Fall/Winter 2026
Verification Request	A notice for individuals that MDHHS does not have enough information to support identifying or verifying an exemption or if they are already meeting work requirements. This notice will provide 30 calendar days to verify and avoid being disenrolled or having their application denied.	As needed at application or redetermination

Direct Outreach Considerations

MDHHS has text, email, and robocall capabilities that were largely successful among the Medicaid population in previous awareness and activation campaigns related to COVID-19 Public Health Emergency return to normal operations.

Objective	Potential Timing	Potential Channels	Communication Goal
Awareness	Prior to implementation	Text/email	Introduce changes
Preparation	Prior to renewal/application	Text/email	Help beneficiaries prepare
Action	Verification or renewal	Text/email/robocall	Prompt required action
Continued Support	Before deadlines	Text/robocall	Reduce incomplete actions

Community Partner Resources



- Medicaid HR1 Information Hub webpage: Upcoming Federal Medicaid Changes
- Facts about Changes to Medicaid and Supplemental Nutrition Assistance Program: English | Spanish | Arabic

Questions?

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