Northern Michigan Regional Entity

Board Meeting

April 22, 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 – March 25, 2026	Pages 2 – 8
7.	Correspondence	Pages 9 – 41
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – April 2026	Page 42
	c. Financial Report – February 2026	Page 43 – 64
	d. Operations Committee Report – Meeting on April 21st	
	e. NMRE SUD Oversight Board Report – Next Meeting is May 4th	
11.	New Business - None	
12.	Old Business	
	a. CMHSP Updates	
	b. PIHP Contract Dispute COC Update	
	c. Legal Actions Related to PIHP Bid Out	
13.	Presentation	
	Performance Bonus Incentive Program (PBIP)	Pages 65 – 70
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
15.	Next Meeting Date – May 27, 2026 at 10:00AM	
16.	Adjourn	

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

ATTENDEES:	**Bob Adrian, Dave Freedman, Ed Ginop, Karen Goodman, Ron Iseler, Eric Lawson, Mary Marois, Michael Newman, Jay O'Farrell, Ruth Pilon, Don Smeltzer, Mark Surbrook, Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Dana Labar**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Jodie Balhorn, Carol Balousek, Ann Friend, Gail Grangood-Griffin, Lisa Hartley, Chip Johnston, Brooke Kleinert, Eric Kurtz, Teresa McGee, Pamela Polom, Brandon Rhue, Nena Sork, Chris VanWagoner, Deanna Yockey, Lynda Zeller**
PUBLIC:	**Anonymous (2), Erin Barbus, Lori Enos, Genevieve Groover, Terri Henderson, Sarah Hegg, Patricia Henkel, Larry LaCross, Tobias Neal, Rob Palmer**

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

ROLL CALL
Let the record show that all Board Members were in attendance either in person or virtually.

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

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

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

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

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

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

CORRESPONDENCE

1) A letter to Mr. Kurtz dated February 2, 2026, from Kristen Morningstar at MDHHS approving the NMRE's Fiscal Year 2026 Risk Management Strategy.
2) A document from the Community Mental Health Association of." Michigan (CMHA) titled, "Comments regarding Michigan's 2026 HSW Amendment."
3) Email correspondence to PIHP and CMHSP CEOs dated March 6, 2026, from CMHA CEO, Robert Sheehan, requesting that they participate in a 2026 Special Assessment with supporting documents, including a Q&A document.
4) Email correspondence to PIHP and CMHSP CEOs dated March 5, 2026, from CMHA CEO, Robert Sheehan, regarding statements made by the CMHSP and PIHP leaders during recent Listening Session with MDHHS.
5) A document from the CMHA Rural Caucus titled, "Protecting Rural Access to Behavioral Health Services Proposed FY27 Budget Boilerplate."
6) Michigan House Bill 4536 to amend 1956 PA 218, entitled "The insurance code of 1956," stating that "a health insurance policy shall not deny, modify, or delay a claim based on a review using artificial intelligence."
7) Michigan Medicaid Policy Bulletin 26-01 dated March 18, 2026, regarding Medicaid Health Plan (MHP) Provider Mental Health Assessment Requirements for Comprehensive Health Care Program (CHCP) Enrollees.
8) The draft minutes of the March 11, 2026, regional Finance Committee meeting.

Mr. Kurtz drew attention to the CMHA special assessment. Prior funds were directed to combating the MDHHS RFP to bid out the state's PIHPs. Special Assessment funds may also be used in this manner should a new RFP be issued.

The document from the Rural Caucus supplied proposed boilerplate language to standardize "rural" and "frontier" definitions. Currently three different definitions are being used. Mr. Freedman disagreed with Grand Traverse County not being considered rural because of its lakes.

Mr. Kurtz next drew attention to Michigan HB 4536, which prohibits health insurers from using artificial intelligence (AI) as the sole basis for denying, modifying, or delaying claims; it requires human oversight in claims processing.

ANNOUNCEMENTS

New Board Member, Mark Surbrook, representing Wellvance, was introduced to the group.

Centra Wellness Network's Executive Director, Chip Johnston, announced his retirement effective September 30, 2026.

Former NMRE Board Chair, Gary Klacking, was unable to attend the meeting but plans to join in April to accept a Certificate of Appreciation from the Board.

PUBLIC COMMENT

Catholic Human Services' Chief Executive Officer, Larry LaCross, addressed the Board regarding the state withholding Quarter 1 FY26 PA2/liquor tax funding. Mr. LaCross encouraged County

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Commissioners to provide feedback and advocate for PA2 funds. No prior notification was sent to the PIHPs or the counties about the withhold. The reduction in liquor tax funds will likely affect projects already approved by the Board. PA2 funds are intended to be used for substance abuse prevention and treatment programs in the county from which the proceeds originated.

Mr. Kurtz responded that CMHA has been asked to reach out to the Michigan Association of Counties (MAC) regarding the use of PA2 funds for "debt services."

REPORTS

Executive Committee Report

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

CEO Report

The NMRE CEO Monthly Report for March 2026 was included in the materials for the meeting on this date. Mr. Kurtz drew attention to the February 23rd meeting with legal counsel regarding next steps should MDHHS issue a new RFP to secure the state's PIHPs and the upcoming hearing on related to the lawsuit filed by NorthCare Network, NMRE, CMH Partnership of Southwest MI, and Region 10 PIHP (24-000198-MZ) on April 9th.

January 2026 Financial Report

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

PA2/Liquor Tax was summarized as follows:

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

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

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

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

Ms. Yockey noted that revenue for October 2025 through January 2026 looks similar to September 2025, on which the FY26 budget was based; however, the number of eligibles is declining. Overall, February revenue (all funding sources) was $460K lower than September 2025. There is talk about a mid-year rate adjustment (possibly in April/May). There is no indication that eligibles will increase. No changes to Medicaid eligibility have been made at the federal level. CMHSPs work closely with DHHS workers to keep individuals on Medicaid. The NMRE IT Department is closely monitoring eligibility.

As stated previously, 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. Historically, the Quarter 1 payment is lower than the other three annual payments; it is hoped that the projected FY26 PA2 revenue of $1,847,106 will not be significantly impacted.

MOTION BY MARY MAROIS TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JANUARY 2026; SUPPORT BY ERIC LAWSON. MOTION CARRIED.

Operations Committee Report
The draft minutes from the March 17, 2026, Operations Committee meeting were included in the materials for the meeting on this date.

NMRE SUD Oversight Committee Report
Let the record show that the March 2, 2026, meeting of the NMRE Substance Use Disorder Oversight Committee was cancelled due to a lack of agenda items. The next meeting is scheduled for May 4, 2026, at 10:00AM.

NEW BUSINESS
Nominating Committee Report/Election of Officers
The NMRE Board Nominating Committee met on this date at 9:30AM. Mr. O'Farrell reported that the Nominating Committee voted in favor of electing Ed Ginop as Board Chair, and continuing Eric Lawson, and Ruth Pilon in their roles as Vice-Chair and Secretary as they were elected in January. Don Tanner was selected for appointment to the NMRE Board Executive Committee, representing Centra Wellness Network.

- Chair – Ed Ginop (North Country)
- Vice-Chair – Eric Lawson (Northeast Michigan)
- Secretary – Ruth Pilon (Northern Lakes)
- Additional Executive Committee Members: Don Tanner (Centra Wellness) and Chuck Varner (Wellvance)

Mr. Tanner called three times for additional nominations. Let the record show that no additional nominations were brought forth.

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MOTION BY JAY O'FARRELL ELECT ED GINOP AS CHAIR OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS, RETAIN ERIC LAWSON AS VICE-CHAIR, AND RUTH PILON AS SECRETARY AND APPOINT DON TANNER AND RETAIN CHUCK VARNER AS MEMBERS OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD EXECUTIVE COMMITTEE; SUPPORT BY DON SMELTZER. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, K. Goodman, R. Iseler, E. Lawson, M. Marois, J. O'Farrell, R. Pilon, M. Newman, D. Smeltzer, M. Surbrook, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

OLD BUSINESS

CMHSP Updates

The five regional CEOs met on March 5th and 6th to discuss moving toward obtaining a rural exemption, particularly regarding strict requirements for MDHHS-mandated programs and Evidence-Based Practices' (EBP) model fidelity.

Mr. Johnston spoke about addressing the topic at the federal level at conferences such as the National Association of County Behavioral Health and Developmental Disability Directors and National Rural Association.

Mr. Johnston explained how Centra Wellness Network is meeting the intent of MDHHS' Intensive Crisis Stabilization Services program in a way that works for Benzie and Manistee Counties. He argued against being held to standards required by MDHHS that are best suited for Southeast Michigan. Northeast Michigan CMHA is working on submitting three Concept Papers to secure Health Endowment Grant funding.

The group discussed the Crisis Intervention Team (CIT) program model. CIT is a community partnership, typically requiring a 40-hour training curriculum for law enforcement and first responders to safely and effectively handle mental health crises. Core requirements include, at minimum, 32-40 hours of training in de-escalation, mental health disorders, and scenario-based role-playing. Although meeting these training requirements is an arduous task for rural communities, many rural communities have implemented innovative ways to keep individuals with mental illness out of jail and in treatment. Several areas in the NMRE region have implemented, or are interested in implementing, Crisis Response Officers.

Mr. LaCross reported that Catholic Human Services has received a grant to embed two recovery coaches in public safety buildings to assist when individuals with substance use disorders are placed under arrest.

Legal Actions Related to the PIHP Bid Out

The Attorney General's office has submitted a motion to dismiss the lawsuits filed against the State related to the PIHP bid out (25-000143-MB and 25-000162MB) due to the cancellation of the RFP. A hearing is scheduled for April 13, 2026, at 1:00PM in Lansing.

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A statewide guidance group is meeting to develop boilerplate language to keep Michigan's mental health system public. A smaller group is meeting with attorney Neil Marchand (Miller Johnson) and the CMHA leadership about potential next steps if a new RFP is issued.

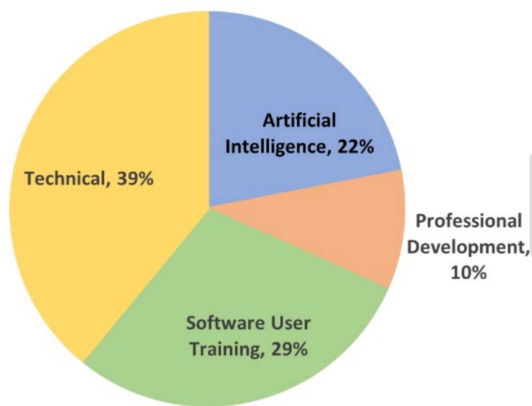
PRESENTATION

New Horizons Learning Credit Request and Usage Report

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

The NMRE's Chief Information Officer/Operations Manager, Brandon Rhue, summarized FY25 learning credit usage.

Training Usage by Topic:



Training Usage by CMHSP:

	Number of Courses Taken	Dollar Amounts Used
Centra Wellness	5	$2,128
North Country	18	$19,318
Northeast MI	0	$0
Northern Lakes	1	$2,495
Wellvance	12	$16,530
NMRE	5	$1,975
Total	**41**	**$42,446**

Ms. Sork clarified that Northeast Michigan CMHA utilizes an alternative training platform.

MOTION BY JAY O'FARRELL TO APPROVE THE PURCHASE OF NEW HORIZONS TRAINING CREDITS IN THE AMOUNT OF THIRTY THOUSAND DOLLARS ($30,000.00); SUPPORT BY CHUCK VARNER. ROLL CALL VOTE.

"Yea" Votes: R. Adrian, D. Freedman, E. Ginop, K. Goodman, R. Iseler, E. Lawson, M. Marois, J. O'Farrell, R. Pilon, M. Newman, D. Smeltzer, M. Surbrook, D. Tanner, C. Varner

"Nay" Votes: Nil

MOTION CARRIED.

COMMENTS

Board

Mr. Tanner thanked the Board for the honor of acting as Board Chair since Mr. Klacking's resignation in January.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on April 22, 2026.

ADJOURN

Let the record show that Mr. Tanner adjourned the meeting at 11:10AM.

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The Detroit News

Bolter: MDHHS mental health plan adds bureaucracy, not care

Alan Bolter

Updated March 31, 2026, 9:26 p.m. ET

When your car is working, you don't generally take it to your mechanic and demand they replace the engine, or the transmission.

Yet Michigan's Department of Health and Human Services (MDHHS) is proposing to do just that by pushing to enact new unnecessary layers of bureaucracy for many Michigan mental health patients.

Unfortunately, this is now the second instance of the MDHHS advancing a costly proposal without regard for true need, financial cost or human impact. Just last year, we fought a legal battle against the MDHHS proposal to bid out the management of the state's public mental health system. Rather than simplifying the system, the deeply flawed and legally dubious proposal added complexity and failed to address real concerns raised by Michiganians.

The MDHHS spent more than $3 million aggressively pursuing that process, only to pull it from consideration after a judge ruled it unlawful.

Now, the MDHHS continues to pursue a similarly ill-informed idea known as the "Mental Health Framework." As designed, this effort will likely introduce additional layers of bureaucracy and new hurdles for individuals seeking mental health services.

The agency is proposing to pass individuals with mild to moderate mental health needs off to private health insurance companies. This is a dangerous departure from the current structure that allows local specialized Community Mental Health (CMH) agencies to provide expert support.

By definition, the framework's focus on individuals with "mild to moderate" mental health conditions raise additional questions about the types of services being discussed. Services such as psychiatric inpatient care, crisis residential treatment, or intensive targeted case management are designed for individuals experiencing severe symptoms or acute crises.

It is difficult to understand how these services would suddenly appropriately apply to individuals whose needs are categorized as mild or moderate. This change would create confusion and blur

important distinctions in levels of care. Public policy should reinforce clear clinical pathways, ensuring that the most intensive services remain focused on individuals with the most serious needs. This proposal does the opposite.

The proposal also introduces new assessments, administrative processes and shifting lines of responsibility between CMH agencies and private Medicaid health plans. For someone already struggling to navigate the mental health system, additional steps can easily become barriers to care rather than improvements.

Hospitals and providers across the state have already warned that the framework's training, billing and operational requirements could slow access to treatment. The impact would be a new strain on an already overextended behavioral health workforce.

Importantly, the framework also appears to disrupt a system that already has clearly defined responsibilities under Michigan law. The Michigan Mental Health Code outlines that CMH agencies are responsible for coordinating services, including psychiatric inpatient admissions. The proposal to shift management of certain psychiatric inpatient benefits for individuals with mild to moderate conditions to private Medicaid health plans could break the supportive relationship that currently exists between hospitals, community providers and CMH agencies.

Today, when someone is admitted for psychiatric care, the public mental health system works to coordinate discharge planning and connect that person to housing, medication management and ongoing treatment in the community. Sound clinical decisions about psychiatric hospitalization depend on a working knowledge of available community-based alternatives, and Michigan's CMH system is the only entity that currently has both the responsibility and the infrastructure to manage that coordination effectively.

Equally troubling is the lack of clarity around why this sweeping change is being proposed in the first place. There has been no clear explanation as to how the MDHHS framework proposal will improve care. Period.

Care providers, CMH agencies, hospitals and advocacy organizations have all raised concerns noting this proposal appears to address a relatively small number of disputes. In an attempt to reduce a few small issues between health plans, the MDHHS's answer is to impose a large administrative burden on the entire mental health system — truly a "solution" in search of a problem.

From our vantage point, we see both opportunities and risks for change in the mental health space. We are open to sharing our perspective to help make the process more seamless for patients and practitioners, whose experience remains central to our work. At the same time, any proposed changes must prioritize affordability and ensure that resources are directed as

much as possible toward direct services. We should move away from administrative changes that add cost without meaningfully improving patient experience or outcomes.

We are urging the MDHHS to forgo yet another pointless proposal and join with us in looking for collaborative opportunities to drive meaningful change for Michigan residents.

Alan Bolter is CEO of the Community Mental Health Association of Michigan.

January 26, 2026

To: CMH Board Members/Executive Directors (CMH & PIHP)/Management Staff (CMH & PIHP)/Provider Alliance Members

From: PAC Committee

Re: 2026 Annual PAC Campaign

This memorandum is being sent to all CMH boards, PIHPs and Provider Alliance members to announce and solicit participation in this year's CMH-PAC campaign. The CMH-PAC is a political action committee that helps support representatives and senators in leadership positions and those who champion the funding, legislation, and policy initiatives that help support and improve the provision of community-based mental health and substance use disorder services.

Your donations to the CMH PAC help support candidates who are supportive of our efforts at CMHA. The money that is raised for the CMH PAC helps raise awareness of our issues. While we are not able to match dollar for dollar the contributions of the larger interest groups your efforts go a long way and give CMHA a "seat at the table".

The 2026 is an election is going to be historic in Michigan – everything will be up for grabs: Governor, US Senate, US House, Attorney General, Secretary of State and control of the Michigan Legislature. The demand for PAC dollars has never been higher, we receive fundraising requests almost daily.

The threat of privatization remains under the current administration in Lansing and may continue in future administrations. Efforts to downsize government and reprioritize spending are being advanced at both the state and federal levels. We must remain vigilant and prepared to defend against potential threats. Equally important, we must be ready to advance our own priorities with the new Legislature elected this November.

Behavioral health continues to be part of the legislative dialogue, but maintaining that visibility requires consistent engagement. To do so, we must build the CMH-PAC to a new level and support the key leaders who are willing to work with us.

A recent analysis of PAC contributions to legislators, legislative caucus funds, and the Governor over the past eight years shows that the insurance industry and for-profit health plan executives have contributed nearly **$8.5 million**. By comparison, the CMH-PAC has contributed approximately **$50,000**.

Contributions can now be made securely online via credit card using the link below. Your participation is critical to protecting and advancing Michigan's community mental health system. Thank you for your continued support and commitment.

https://cmham.org/public-policy/cmh-pac/

426 S. Walnut St. • Lansing, MI 48933 • (517) 374-6848 • Fax (517) 374-1053 • www.cmha

2026 CMH PAC CAMPAIGN
Details and Timeline

As always, our PAC goal is to have as many boards and members participate as possible. Typically, in past years we only had about 1/3 of our membership participate in the PAC campaign – **our goal is 100% member participation, we MUST increase our contributions.**

****PAC FUNDRAISING GOAL****

Our new annual fundraising goal is $20,000 / year! We believe we can reach that goal if all of our membership participates – **we need 40 organizations (CMHs, PIHPs, and Provider Alliance members) to each contribute $500.** If you are a CMH and all of your board members donated 1 meeting per diem and the CEO contributed the same amount the $500 goal would be reached.

In past years as an incentive to increase participation we have been able to provide Tiger game suite tickets (12 tickets) donated by Muchmore Harrington Smalley and Associates that went into a drawing of all the eligible members – we will send out the date and time once it becomes available. **In order to qualify for the Tiger ticket drawing members must meet the new $500 goal contributions, which can come from the board members and/or staff.**

The campaign is being announced early with the hope that more boards will have time to discuss its merits locally and increase the participation rate. The PAC Committee requests that CMH directors and board chairpersons announce and discuss the campaign over the next three months at their regular monthly meetings.

Again, we will have the details on the Tiger game later this year if it becomes available. In order to qualify for the special drawing members should expect to forward their campaign and donations to CMHA by late June / early July.

In addition to the Tiger drawing CMHA staff will be looking into special recognition for those CMH boards who have 100% participation in the PAC by contributing at least a ½ day per diem.

Again, you can pay online at the link below to use our secure online checkout function or make checks payable to: CMH PAC ~ 507 S. Grand Ave ~ Lansing, MI 48933 (no corporate checks, please).

https://cmham.org/public-policy/cmh-pac/

If you have any questions regarding this year's campaign, please contact Robert Sheehan or Alan Bolter at CMHAM. Thank you for your participation.

Community Mental Health Association of Michigan
CMHA advocacy strategy, post court decision and withdrawal of initial RFP:
CMHA System Strengthening and Improvement Initiative

Guidance Group and Small Group

Note: Most of the information, outlined below, may look familiar to CMHA members, given that the core components of this effort have been shared with CMHA members during late 2025 and early 2026. [1]

Background: The CMHA advocacy strategy, post court decision and withdrawal of initial RFP, is made up of several parallel aims and advocacy efforts:

A. Readying for a second privatization-centered RFP process
B. Taking a pro-active approach at strengthening and advancing improvements to Michigan's public mental health system in statute, policy, and practice
C. Renewal/continuation of contracts between MDHHS and PIHPs who signed contract negotiated with MDHHS yet not signed by MDHHS

This document centers around the work and membership of the CMHA System Strengthening and Improvement Guidance Group and the Small Group (subgroup of the full Guidance Group)

CMHA System Strengthening and Improvement Guidance Group

Purpose of group: This Guidance Group will identify:

- Refinements to be proposed in the Core Components document and related efforts[2]
- Components in the Core Components document which:
    1. Could be pursued without or in advance of statutory changes
    2. Will require statutory changes

Membership of the Guidance Group: The Guidance Group is made up of representatives of the three types of CMHA members: CMHSPs, PIHPs, leadership of the CMHA Provider Alliance (representing private providers in the CMHSP and PIHP networks).

These members include:
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

[1] The description of the advocacy plan of which this effort is one component is provided as an attachment to this document.

[2] Core Components documents was developed via consensus of coalition: CMHA,NAMI-Michigan, Arc-Michigan, and MAC; and shared with CMHA membership and other stakeholders throughout late 2025 and early 2026

Todd, Mandy Padget, Sandra Lindsey, Sam Price, Trish Cortes, Mike Thompson, Fi Spalvieri, Ronnie Tyson, Jeff Brown

Small group (subgroup of Guidance Group)

Purpose of Small Group: Develop recommendations, related to the three items listed below, centered around the relationship between the state's CMHSPs/PIHPs and the private providers in their networks.

- Refinements to be proposed in the Core Components document and related efforts
- Components in the Core Components document which:
  - Could be pursued without or in advance of statutory changes
  - Will require statutory changes

Membership: This subgroup would include representatives of CMHSPs and PIHPs and members of the Executive Committee of CMHA's Provider Alliance.

These members include: Mila Todd, Tammy Warner, Traci Smith, Cameron Bullock, Mike Thompson, Ronnie Tyson, Sam Price, Fi Spalvieri, Annette Downey, Jeff Brown

Attachment 1

Strengthening and Improving Michigan's Public Mental Health System[3]
Advocacy strategy post court decision and withdrawal of initial RFP
Revised February 10, 2026

This strategy is made up of several parallel aims and advocacy efforts:

D. Readying for a second privatization-centered RFP process (added to strategy with announcement of Special Assessment)
E. Taking a pro-active approach at strengthening and advancing improvements to Michigan's public mental health system in statute, policy, and practice
F. Renewal/continuation of contracts between MDHHS and PIHPs who signed contract negotiated with MDHHS yet not signed by MDHHS

Aim A: Taking a pro-active approach at strengthening and advancing improvements to Michigan's public mental health system in statute, policy, and practice

Core components document

1. Core components of redesigned system: Use the document "Recommended Core Components of a strengthened and improved public mental health system in Michigan" – jointly developed by NAMI-Michigan, Arc-Michigan, Michigan Association of Counties, and CMHA as the foundation for this advocacy effort.

The chief authors of this document - NAMI-Michigan, Arc-Michigan, Michigan Association of Counties, and CMHA – will continually refine and revise this document, integrating the views of allies into the document.

2. Use this document as foundation for advocacy effort and for dialogue with other allies in the refinement and advocacy around the contents of this document – including:

- Members of four core Coalition organizations (See Attachment A for approach which CMHA will be taking to develop agreement and support of the Core Components document by its diverse membership)
- Other organizations who are likely to be allies in this effort
- MDHHS, Governor's Office, State Legislators
- Media

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[3] The term "public mental health system" refers to system in Michigan made up of the state's Community Mental Health Services Programs, its Prepaid Inpatient Health Plans, and the private providers in the networks of these public organizations – who provide publicly funded services to persons with mental illness, intellectual and developmental disabilities, emotional disturbance, and/or substance use disorders.

Working for adoption of components in statute and practice

1. Continue outreach to MDHHS and Governor's Office inviting collaborative system strengthening and improvement. The aim of this outreach is that MDHHS and Governor's Office foster the collaborative development of a system strengthening and improvement effort that would be founded on both **administrative and statutory changes** to implement the contents in Core Components document.

2. Initiate legislative advocacy around statutory changes to reflect contents of Core Components document.

The four core coalition organizations will work with legal counsel to develop draft statutory language reflecting core components:

- FY 26 Budget Supplemental of FY 27 Budget boilerplate
- Statutory changes to ensure protection and strength of public mental health system

Once the core components document if refined, CMHA and MAC staff to build draft statutory and/or policy language based on this document – with this draft language to be refined through dialogue among the members of this coalition.

3. Engage the incoming administration to advance shared priorities and share relevant information with all three (main) gubernatorial campaigns.

4. Regular and frequent communication with members of four core coalition organizations and allies regarding advocacy effort.

5. Engage in continual media relations effort to highlight contents of opinion of Judge Yates and the contents of Core Concepts document.

Aim B: Renewal/continuation of contracts between MDHHS and PIHPs who signed contract negotiated with MDHHS yet not signed by MDHHS

1. Foster solidarity with PIHPs who signed contract negotiated with MDHHS yet not signed by MDHHS. CMHA to underscore, to CMHA members, the need to ensure that MDHHS renews/continues the MDHHS contract with these PIHPs past October 1, 2026 and agrees to contracts that meet with actuarial standards for risk reserves and financing of costs related to MDHHS settlement in Waskul case.

2. Work to obtain prompt and positive opinion in MDHHS-PIHP contract suit

Attachment A to "Strengthening and Improving Michigan's Public Mental Health System Advocacy strategy post court decision and withdrawal of initial RFP"

CMHA's dialogue with its diverse membership

1. Development of a **Guidance Group** made up of representatives of the three types of CMHA members:
   - CMHSPs
   - PIHPs
   - Leadership of the CMHA Provider Alliance (representing private providers in the CMHSP and PIHP networks)

2. This Guidance Group will identify:
   - **Refinements** to be proposed in the Core Components document and related efforts
   - Components in the Core Components document which:
     3. Could be pursued **without or in advance of statutory changes**
     4. **Will require statutory changes**

3. During the initial meeting of the Guidance Group, a call would be made for a **small workgroup of this larger group** to develop recommendations, related to the three items listed above, **centered around the relationship between the state's CMHSPs/PIHPs and the private providers in their networks.**

This subgroup would include representatives of CMHSPs and PIHPs and members of the Executive Committee of CMHA's Provider Alliance.

STATE OF MICHIGAN

COURT OF CLAIMS

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

Plaintiffs,

v

Case Nos. 25-000143-MB

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

Hon. Christopher P. Yates

Defendants.

_____________________________________/

ORDER DENYING PLAINTIFFS' 11/04/2025 MOTION FOR RECONSIDERATION

On October 14, 2025, this Court issued an 11-page opinion and order resolving the parties' requests for summary disposition. On November 4, 2025, plaintiffs moved for reconsideration of that opinion and order. A motion for reconsideration under MCR 2.119(F) enables this Court to afford relief if the moving parties "demonstrate a palpable error by which the court and the parties have been misled and show that a different disposition of the motion must result from correction of the error." To be sure, courts can "revisit issues they previously decided, even if presented with a motion for reconsideration that offers nothing new to the court." *Hill v City of Warren*, 276 Mich App 299, 307; 740 NW2d 706 (2007). But MCR 2.119(F)(3) strongly suggests that something in the motion must impel the Court to conclude that its chosen outcome is so erroneous that it must be rectified. Nothing discussed in plaintiffs' motion approaches that level.

In seeking reconsideration, plaintiffs challenge one aspect of the Court's decision, i.e., that the Michigan Department of Health and Human Services (the MDHHS) "may unilaterally reduce the number of regions from ten to three." The Court observed that "no Michigan statute sets the number of regions that must exist or defines the geographic boundaries of such regions." Nothing in that observation is challenged by plaintiffs, which nonetheless contend that community mental-health services programs (CMHSPs), rather than the MDHHS, have "exclusive authority to form regional entities tied to their statutorily defined service areas." Accordingly, Michigan law "gives CMHSPs the authority to define the regions." All the MDHHS can do is enter into contracts with the regional entities that the CMHSPs create. The Court rejects that formulation of Michigan law. The MDHHS reduced the number of regions from 18 to ten in 2013, and it did so without creating significant concerns. The MDHHS, as the contracting and paying entity, had – and still has – the ability to determine the number and the geographic locations of the regions. Nothing in Michigan law dictates (or even suggests) another approach, so the Court reaffirms its decision on that matter. Consequently, plaintiffs' motion for reconsideration is hereby denied.

IT IS SO ORDERED.

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

Date: April 8, 2026

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

STATE OF MICHIGAN

COURT OF CLAIMS

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

Plaintiffs,

v

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

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

Hon. Christopher P. Yates

Defendants.

_______________________________________/

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

Plaintiffs,

v

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

Defendants.

_______________________________________/

ORDER ON DEFENDANTS' SUMMARY DISPOSITION MOTION FOR MOOTNESS

For the reasons stated on the record at a hearing held on April 13, 2026, the Court concludes that both of the cases have been rendered moot because defendants have rescinded the Request for Proposal challenged by plaintiffs in both cases, and that no exception to the mootness doctrine can be invoked by the Court to keep either case open. But because the Court could not decide at the hearing whether dismissal based on mootness should be with or without prejudice, the Court shall permit the competing parties to submit supplemental briefs on or before Monday, April 20, 2026. After reviewing all supplemental briefs filed by that deadline, the Court shall enter a final order of dismissal.

IT IS SO ORDERED.

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

Date: April 14, 2026

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

HOUSE OVERSIGHT SUBCOMMITTEE
on Public Health & Food Security

MICHIGAN BEHAVIORAL HEALTH SYSTEM

— REPORT & RECOMMENDATIONS —

Executive Summary

Beginning in May, the Oversight Subcommittee on Public Health and Food Security launched an investigation into the underperforming behavioral health system in Michigan. Sixteen presenters from across the state testified at six different subcommittee hearings over two months to identify flaws in the system and voice their recommendations. The sixteen presenters included current and retired judges, county jail administrators, practicing physicians, behavioral health therapists, hospital executives, Michigan Department of Health and Human Services (MDHHS) physicians, behavioral health advocates, national nonprofit association board presidents and board members, and local community mental health (CMH) CEOs. Through our work, this subcommittee found a health system that is being held back by rigid administrative burdens, workplace shortages and insufficient inpatient capacity. These limitations are the central drivers reducing access to care and causing the behavioral health crisis to deepen across the state. This report walks through key findings and provides recommendations to develop solutions to those problems.

Background

The history of the root problem is not distant nor hard to trace. The "deinstitutionalization" movement, the closing of state behavioral health facilities, swept across the United States in the 1960s.[1] Michigan joined the movement late, but it joined in a strong way by immediately closing more than a dozen facilities in 1997 with insufficient infrastructure ready to support the released population. Emergency rooms, psychiatric units with limited beds, courtrooms, county jails, and constrained CMH facilities have been struggling to fill the gap since.[2] All of this has led to increased spending to address the behavioral health crisis without the state seeing measurable improvements in outcomes. Experts who came in front of our subcommittee consistently identified two policy approaches: **1)** reopening state psychiatric facilities for severe cases with a "step down" approach or **2)** reducing administrative

[1] Gutierrez, Andres, "The State of Mental Health Care in Michigan," CBS News, Oct. 10, 2022.

[2] See, Judge Richard L. Hillman's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (55th District Court Judge; Mental Health Treatment Court – Full Testimony from 9:45 to 50:41). May 20, 2025.; See also, Grand Traverse County Sheriff's Office: Sara Bush's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Jail Diversion Counselor – Full Testimony from 1:17:56 to 1:23:37). July 1, 2025.

burdens on local CMH providers through the PIHP, RFP, and Certificate of Need program to give providers increased flexibility. A move in either direction could meaningfully reduce Michigan's current behavioral health treatment backlog, which currently ranks 47th nationally in psychiatric bed space availability.[3]

Waitlists as of June 3, 2025

MDHHS

Operation	Persons Waiting
Probate Process Admissions Adult	4
Forensic Process Admissions	269
Pediatric Admissions	25
Forensic Process Evaluations	480

Lack of Flexibility – PIHPs and Certificate of Need

Michigan providers currently offer about 19 psychiatric beds per every 100,000 residents, while the national average and most expert recommendations are for 30 psychiatric beds per 100,000 residents.[4] The Michigan Constitution deems public health of "primary public concern" and remains silent on how to carry that out – providing both flexibility and responsibility to state policymakers.[5] Michigan statutes give the Department of Public Health (now MDHHS) and local health departments broad authority to improve public health across the state.[6] One of the few limitations on the administration of public health is in MCL 500.3513(1), which simply requires the care be done "in a manner that ensures continuity and acceptable quality of health care."[7] The statutes that establish and govern CMH facilities were amended right before the shutdown of state facilities in 1997, because the Legislature intended local control to take a larger role after the 1997 shutdowns.[8] Despite the statutory preference for flexibility and local control, one consensus reached by all presentations and submitted written recommendations is that Michigan's behavioral health system lacks flexibility.

[3] Michigan Health and Hospitals Association: Adam Carlson's and Taylor Alpert's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 52:17 to 1:15:04). May 20, 2025.

[4] Central Michigan University: Dr. Kai Anderson's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 29:00 to 45:40). June 24, 2025.

[5] Mich. Const. Art. IV § 51.

[6] MCL 333.2221; MCL 333.2433.

[7] MCL 500.3513.

[8] MCL 330.1204; MCL 330.1206.

We have identified through subcommittee hearings that MDHHS has delegated much of its duty to provide behavioral health care to regional CMH CEOs who administer Medicaid-funded Pre-Paid Inpatient Health Plans (PIHPs). Because private insurance coverage for behavioral health care can be limited, many providers in Michigan rely on Medicaid as their primary funding source. Michigan's CMHs are organized into 10 regions, each with a PIHP CEO responsible for all policies, guidelines, Medicaid funding, and administrative support. This results in inconsistencies across regions with different PIHPs issuing different criteria to qualify for their plans and utilize them to the best possible extent. Testimony further indicated that planned changes may further increase variation in criteria across regions going forward. The department originally planned to open up bids for PIHPs to for-profit and out-of-state administrative organizations.[9] After months of work exploring the drawbacks of that potential decision in our committee, those plans are now on hold. We listened to behavioral health specialists, patient advocates, and local healthcare professionals urge the state to halt the plan, and it has now been tabled.[10]

On top of the limited flexibility afforded under the current PIHP structure, MDHHS also requires a Certificate of Need (CON) for health facilities to do anything outside of their annual treatment plans submitted for PIHP approval in Michigan. MDHHS states that the purpose of the CON program is to ensure that only necessary services are provided in Michigan.[11] While the CON program is often cited as a strong candidate for additional flexibility and reform, it does help to prevent excess low-quality care in its current form. Under the CON program, any psychiatric hospital or unit needs to submit a proposal to be reviewed by an 11-member board before doing any of the following: **1)** increasing the number of beds or relocating beds from one site to another; **2)** acquiring an existing facility; **3)** operating a new facility; **4)** initiating, replacing, or expanding covered clinical services; or **5)** changing an extended care services program. The extent of these requirements limits flexibility for shifting beds to use a "step-down" approach, something most of the professionals with whom we spoke argued would work best.[12] Under the current format, CMH providers get one chance per year to perfectly guess the number of beds that they will need for each population of patients, or else they are stuck in an imperfect situation. Several presenters used a common example to explain this issue: The need for adolescent psychiatric beds is high in the summer, while the need for adult beds is low. However, CMHs are unable to shift available beds in their facility to accommodate on an as-needed basis due to the combination of the PIHPs' policies and the CON requirement. In addition to the rigidity of the policy, these issues raise questions regarding how 'need' is defined and evaluated within the CON process and by the current makeup of the CON board.

[9] MDHHS Seeking Proposals to Improve Specialty Behavioral Health Care for Medicaid Beneficiaries. (Aug. 5, 2025)

[10] Ret. Probate Judge Steven Burnham's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (32:20 – 58:26). July 1, 2025.

[11] MDHHS Certificate of Need Informational Sheet (2022).

[12] Universal Health Services: Steve Vernon's (CEO of Cedar Creek Hospital) and Jamie White's (CEO of Havenwyck Hospital) Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 6:10 to 28:14). June 24, 2025.

Lack of Staffing

Another consistent message from concerned presenters was that the "shortage of psychiatric beds" does not necessarily mean beds are not physically there, but a lack of staffing creates an effective shortage. A graduate student studying to enter the behavioral health field, among many others, illustrated well the gravity of the growing shortage of behavioral health professionals.[13] Michigan is running short on physicians in every field, and the behavioral health field is no different. Unfortunately, many presenters have suggested that the PIHP model, lack of viable student loan programs, and other administrative burdens play a large role in staff not entering the field or staying in the field long-term.

The lack of flexibility in bed space also makes it difficult to hire the right staff. Some CMH CEOs discussed that certain staff are needed for high-risk patients, while other staff can work for lower risk patients that just need to be monitored, but Michigan's system does not allow operational flexibility. Instead, CMHs must submit their annual plans and hire staff accordingly under the assumption that nothing changes. They must hope they lose no one along the way in an incredibly taxing and high turnover field and that their specialized needs do not change materially throughout the year. Of course, those needs do change, thus creating shortages. The staffing shortages have resulted in emergency room doctors and corrections officers in jails and prisons being forced to serve as fill-in psychiatrists and treat populations for which they lack the expertise necessary to help.

Lack of Administrative Support – Overall, and Especially in Northern Michigan

Inconsistencies in administration and guidance in a difficult field with dynamic challenges make the staffing shortage worse. One useful example of a lack of administrative support came through in testimony before our subcommittee: one patient attacked a fellow patient, and the offender was locked in a room to cool off while being monitored. This resulted in a fine from MDHHS for locking the door. When the same incident happened again, the facility called instead of locking a door, and then MDHHS fined them for not doing anything. The lack of clear guidance and inconsistent enforcement punished the already-stretched staff and left the organization unclear on how to proceed in the future.

One CMH CEO outlined the daily struggle he has with having to report to his CMH Board while also having to report to a PIHP CEO and work through MDHHS policy all at the same time.[14] That official noted that he was able to deviate from policy to provide better care and keep his job after, but that most CMH CEOs would be unlikely to take that risk and unlikely to survive it if they did. A consistent theme with all who

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[13] See, Licensed Professional Counselor and Behavioral Health Master's Student Sarah Lee Sullivan's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 14:40 to 19:50). July 22, 2025.; See also, Licensed Child and Family Services Counselor Megan Morrissey's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 20:15 to 32:20). July 22, 2025.; See also, Former State Representative Felicia Brabec's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 1:14:09 to 1:28:04). July 22, 2025.

[14] Bay Arean Bay Arenac CMH CEO Chris Pinter's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 20:15 to 32:20). July 1, 2025.

provided presentations or written recommendations to this subcommittee is the feeling of being trapped by administrative burdens with very limited avenues for administrative guidance or escalation. Additionally, the administration – whether MDHHS or local hospital administrators – have failed to invest in a robust Electronic Health Records (EHR) system.[15] This makes communication across regions arbitrarily divided by PIHP and between private hospitals delayed, difficult, or impossible. Several presentations urged for more EHR investments to clear up the confusion.

Michigan's 47th place ranking and below-average psychiatric bed availability is bad enough, but countless presenters also highlighted the particular needs of Northern Michigan and the Upper Peninsula. Experts and staff in these regions feel left behind by the administration with many presenters referring to "deserts" for psychiatric care in Northern Michigan with patients even having to drive 100 miles at a time to reach a facility. The Traverse City Group has presented their need multiple times and even brought county jail administrators to point out that over 30% of their inmates were suffering from severe behavioral health and/or substance abuse disorders.[16] The National Alliance on Mental Illness even went as far as submitting a written business proposal for a new facility in Northern Michigan to raise the state up to the national average of 30 beds per 100,000 residents.

Recommendations

1. Amend PIHP policy requirements to allow providers greater operational flexibility in treating severe behavioral health crises.
2. Authorize CMH providers the flexibility they need to reallocate and reorganize bed capacity within facilities within the current Certificate of Need program administered by MDHHS.
3. Enhance local control and flexibility in behavioral health business decisions in future department regulatory and business-side decision-making.
4. Create a Northern Michigan Behavioral Health Campus to treat all populations and address the gap with the service deserts in Northern Michigan and the UP.
5. Target state funding more specifically toward staff training, staff safety, and educational incentives to grow and help keep the field of behavioral health professionals stable across the state.
6. Invest in Electronic Health Record systems so hospitals across Michigan can modernize their systems and better share data/records with each other.

[15] Universal Health Services: Steve Vernon's (CEO of Cedar Creek Hospital) and Jamie White's (CEO of Havenwyck Hospital) Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 6:10 to 28:14). June 24, 2025.

[16] NAMI President Kate Dahlstrom's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 54:37 to 1:13:44). July 22, 2025.

Conclusion

The state of behavioral health care in Michigan is far past its own crisis point. With one in five adults across the United States experiencing some level of mental illness every year and over 1.4 million Michiganders having a behavioral health condition, timely intervention is needed.[17] Shutting down over a dozen state psychiatric facilities in 1997 without enough local CMHs in place or flexibility allowed to cover the gap has left a lasting impact. Our jails and courtrooms are now spending limited resources on behavioral health patients who need real psychiatric treatment, not incarceration. Too many patients are falling through the cracks due to facilities with limited bed space or a full capacity jail. Public health is a primary concern under our Constitution, and it is incumbent upon the state to give behavioral health professionals the resources they need to address the problem. Addressing these challenges will require coordinated action across state agencies, providers, and the Legislature. The Subcommittee believes the recommendations outlined above provide a practical framework for improving access, flexibility, and outcomes in Michigan's behavioral health system. In short, enable providers to deliver care, support them along the way, and cut the administrative burdens.

Chair Matthew Bierlein
Michigan House of Representatives
Oversight Subcommittee on Public Health & Food Security

[17] NAMI, "Mental Health in Michigan Fact Sheet," Feb. 2021.

FY2026 Q1 PIHP Final PI Numbers

Access – Timeliness/First Request/First Service

10/01/2025 – 12/31/2025

FY2026 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2025 – 12/31/2025

NORTHERN MICHIGAN REGIONAL ENTITY

Table 2a – Access – Timeliness/First Request

Benchmark Standards: 50th Percentile: 57.0% 75th Percentile: 62.0%

Population	New Clients	In 14 Days	% In 14 Days
MIC	264	163	**61.74%**
MIA	479	265	**55.32%**
DDC	88	53	**60.23%**
DDA	31	20	**64.52%**
Total	**862**	**501**	**58.12%**

Table 3 – Access – Timeliness/First Service

Benchmark Standards: 50th Percentile: 72.9% 75th Percentile: 83.8%

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	214	146	**68.22%**
MIA	308	217	**70.45%**
DDC	87	67	**77.01%**
DDA	25	15	**60.00%**
Total	**634**	**445**	**70.19%**

Produced by: Valerie McBain 4/7/2026

CWN - Medicaid Only

Table 2a – Access – Timeliness/First Request

Benchmark Standards: 50th Percentile: 57.0% ***75th Percentile:*** 62.0%

Population	New Clients	In 14 Days	% In 14 Days
MIC	30	26	86.67%
MIA	37	29	78.38%
DDC	4	3	75.00%
DDA	4	4	100.00%
Total	75	62	82.67%

Table 3 – Access – Timeliness/First Service

Benchmark Standards: 50th Percentile: 72.9% ***75th Percentile:*** 83.8%

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	22	16	72.73%
MIA	26	17	65.38%
DDC	3	1	33.33%
DDA	3	3	100.00%
Total	54	37	68.52%

FY2026 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2025 – 12/31/2025

NCCMH - Medicaid Only

Table 2a – Access – Timeliness/First Request

Benchmark Standards: 50th Percentile: 57.0% ***75th Percentile:*** 62.0%

Population	New Clients	In 14 Days	% In 14 Days
MIC	61	41	67.21%
MIA	91	57	62.64%
DDC	39	26	66.67%
DDA	8	5	62.50%
Total	199	129	64.82%

Table 3 – Access – Timeliness/First Service

Benchmark Standards: 50th Percentile: 72.9% ***75th Percentile:*** 83.8%

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	43	33	76.74%
MIA	46	31	67.39%
DDC	38	31	81.58%
DDA	6	5	83.33%
Total	133	100	75.19%

FY2026 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2025 – 12/31/2025

NEMCMH - Medicaid Only

Table 2a – Access – Timeliness/First Request

Benchmark Standards: 50th Percentile: 57.0% ***75th Percentile:*** 62.0%

Population	New Clients	In 14 Days	% In 14 Days
MIC	42	16	38.10%
MIA	54	14	25.93%
DDC	6	1	16.67%
DDA	5	3	60.00%
Total	107	34	31.78%

Table 3 – Access – Timeliness/First Service

Benchmark Standards: 50th Percentile: 72.9% ***75th Percentile:*** 83.8%

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	34	17	50.00%
MIA	32	18	56.25%
DDC	5	4	80.00%
DDA	3	1	33.33%
Total	74	40	54.05%

FY2026 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2025 – 12/31/2025

NLCMH - Medicaid Only

Table 2a – Access – Timeliness/First Request

Benchmark Standards: 50th Percentile: 57.0% ***75th Percentile:*** 62.0%

Population	New Clients	In 14 Days	% In 14 Days
MIC	83	51	61.45%
MIA	184	91	49.46%
DDC	34	19	55.88%
DDA	11	7	63.64%
Total	312	168	53.85%

Table 3 – Access – Timeliness/First Service

Benchmark Standards: 50th Percentile: 72.9% ***75th Percentile:*** 83.8%

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	73	43	58.90%
MIA	117	81	69.23%
DDC	32	24	75.00%
DDA	10	4	40.00%
Total	232	152	65.52%

FY2026 – Q1 PIHP Final PI Numbers - Medicaid Only

10/01/2025 – 12/31/2025

Wellvance - Medicaid Only

Table 2a – Access – Timeliness/First Request

Benchmark Standards: 50th Percentile: 57.0% ***75th Percentile:*** 62.0%

Population	New Clients	In 14 Days	% In 14 Days
MIC	48	29	60.42%
MIA	113	74	65.49%
DDC	5	4	80.00%
DDA	3	1	33.33%
Total	169	108	63.91%

Table 3 – Access – Timeliness/First Service

Benchmark Standards: 50th Percentile: 72.9% ***75th Percentile***: 83.8%

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	42	37	88.10%
MIA	87	70	80.46%
DDC	9	7	77.78%
DDA	3	2	66.67%
Total	141	116	82.27%

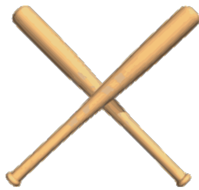
Northern Michigan
Regional Entity
Day of Education

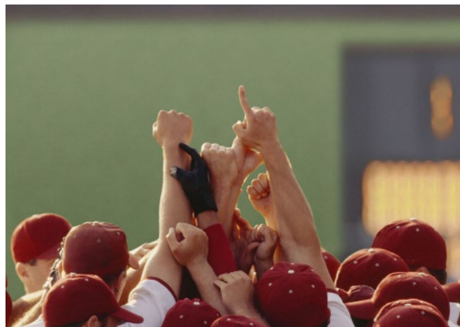
SPRING
TRAINING

NMRE Annual Day of Education

For beneficiaries of NMRE Mental Health and Substance Use Disorder services

Spring Training: Teamwork!





Friday, May 15, 2026, from 9:30a.m. to 3 p.m.
Treetops Resort, 3962 Wilkinson Rd., Gaylord, MI

-Offering multiple sessions to choose from for your specific interest
-Informational /Swag Tables from providers
-A light continental breakfast and lunch provided

*Wear your favorite sports team t-shirt

To Register (limited spaces available!):

New this year:
Scavenger Hunt!

Link: NMRE Day of Education Tickets, Friday, May 15 from 9:30 am to 3:30 pm | Eventbrite

For questions or assistance, call Brie at the NMRE (833) 285-0050

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – APRIL 15, 2026
VIA TEAMS

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

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

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

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

MONTHLY FINANCIALS
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

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

The Q2 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."

A $23.43 rate increase for BHH is expected, which will be retroactive to October 1, 2025. The MDHHS Actuarial Division is considering a gross adjustment approach, which may mean that updates to encounters will not be necessary; the total rate difference would be distributed to Lead Entities. The rate increase will be passed onto the CMHSPs; however, the NMRE retains 10% of BHH payments for administrative overhead.

MOTION BY DONNA NIEMAN TO RECOMMEND APPROVAL OF THE REVISED NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR FEBRUARY 2026; SUPPORT BY LYNDA ZELLER. MOTION APPROVED.

EDIT UPDATE

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

Agenda items include:

- EQI Update
- Music Therapy Groups
- Autism Updates – change in 97151 code
- H0039 Crisis Modifier for CCBHCs
- CLS and Overnight Health and Safety Supports – H0043 and H2015 codes
- Code Chart and Provider Qualifications Chart Updates

Erinn noted that 97151 should be coded to autism (vs. outpatient).

Erinn stated that the EQI billing crosswalk with BC/BS codes is causing some issues. Erinn requested that the state either reconsider adding (telehealth) codes 98005 and 98006 to the code chart or not require the CMHSPs to bill these codes out to BC/BS.

Because duplicate encounters were found during OIG auditing, Brandon has requested clarification on duplicate billing/duplicate threshold documentation. He will follow up with Vincenza Randazzo.

EQI UPDATE

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

Lynda reported that Northern Lakes is very close to finishing the process of rebuilding its general ledger. The target date for Northern Lakes to submit the FY25 EQI is May 1st, after an extension was granted. Melissa will strive to meet the May 18th date for Period 1 FY26.

DRAFT

ELECTRONIC VISIT VERIFICATION (EVV)
Reviews of compliance rates began on April 1st. Notifications were rolled out today to EVV administrative staff through a secure email message from HHAeX. Brandon received all the reports directly so there is no need for the CMHSPs to send them to him. The reports will be shared with the regional EVV workgroup for monitoring.

It is unclear whether the H0043 per diem code will help resolve the congregate living requirement. It was noted that adjudication is not currently tied to the HHAeX system.

HSW OPEN SLOTS UPDATE
The region currently has 706 of its 711 slots filled. Packets are in the queue to fill the remaining five slots.

CHAMPS Fix HSW Update & Verification Research Project
The NMRE received payment for 669 HSW enrollees in April (short approximately 40). North Country tested the "HSW Payment Tracking" Power BI report created by the NMRE IT Department. The report can now be rolled out to the other CMHSPs. There is also a "Monitoring Payment Report" available. To access these reports, the CMHSP staff must be PCE user in the NMRE system and have access to encounter reporting. Expected recoupments are also identified.

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 March 2026 revenue looks like September 2025; however, the NMRE observed a 5.4% decrease in eligibles between DAB, TANF, and HMP.

Overall, March revenue (all funding sources) was $373,245 lower than September 2025.

An analysis of October 2023 – March 2026 Revenue and Eligibles showed:

DAB			
	October 2023	March 2026	% Change
Revenue	$10,003,003	$11,080,945	10.78%
Enrollees	28,444	25,019	-12.04%
Average Payment per Enrollee	$352	$443	25.94%

HMP			
	October 2023	March 2026	% Change
Revenue	$2,369,569	$2,202,254	-7.06%
Enrollees	47,550	28,120	-40.86%
Average Payment per Enrollee	$50	$78	57.16%

TANF			
	October 2023	March 2026	% Change
Revenue	$2,865,200	$2,766,019	-3.46%
Enrollees	66,801	50,358	-24.61%
Average Payment per Enrollee	$43	$55	28.06%

DRAFT

Children's Waiver Program			
	October 2023	March 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	March 2026	% Change
Revenue	$4,638,399	$5,149,349	11.02%
Enrollees	650	698	7.38%
Average Payment per Enrollee	$7,136	$7,377	3.38%

SED			
	October 2023	March 2026	% Change
Revenue	$40,846	$25,019	-38.75%
Enrollees	21	34	61.90%
Average Payment per Enrollee*	$1,945	736	-62.17%

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

TOTAL			
	October 2023	March 2026	% Change
	$19,953,899	$21,255,206	6.52%

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.

Shortage Analysis
The PIHP CFOs are doing some preliminary estimates for the rest of FY26 based on eligibles using Appendix 4 of the Milliman rate report.

Average Eligibles Actual October 2025 – March 2026			
	Appendix 4	Actual	Difference
DAB	25,266	24,770	-1.96%
HMP	33,084	27,926	-15.59%
TANF	53,867	50,028	-7.13%
Total	**112,217**	**102,724**	**-8.46%**

Annualized Eligibles October 2025 – September 2026			
	Appendix 4	Actual	Difference
DAB	303,192	297,240	-1.96%
HMP	397,008	335,112	-15.59%
TANF	646,404	600,336	-7.13%
Total	**1,346,604**	**1,232,604**	**-8.46%**

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Annualized Revenue October 2025 – September 2026				
	Appendix 4	Actual	Difference	% Difference
DAB	$139,322,788	$136,587,725	-2,735,063	-1.96
HMP	$34,960,524	$29,509,963	-5,450,562	-15.59
TANF	$38,027,947	$35,317,767	-2,710,180	-7.13
Total	**$212,311,260**	**$201,415,454**	**-10,895,805**	**-5.13**

As noted in the chart above, the annualized revenue for the fiscal year is approximately $11M short of Milliman projections.

This analysis (for all 10 PIHPs) was presented to Keith White in the Actuarial Division at MDHHS. The need to advocate for a mid-year rate adjustment was recognized.

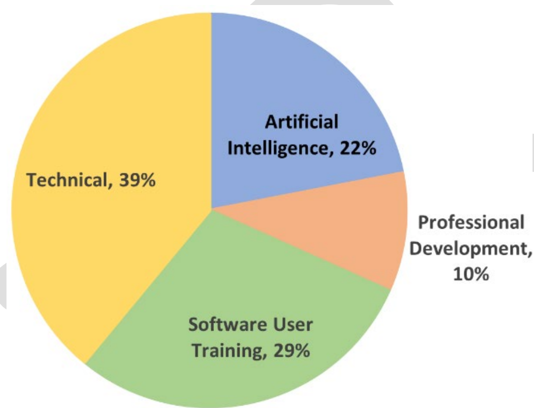
Brandon shared data showing that the number of distinct clients served in the region fell 5.63% when comparing Quarter 1 of FY24 to Q1 of FY25. The number of encounters fell 6.5% when comparing Quarter 1 of FY24 to Q1 of FY25.

Tricia noted that the age range classifications for DAB/TANF were reduced from 8 to 3 (0-18, 19-64, and 65+).

REGIONAL TRAINING

The request for New Horizons regional training credits in the amount of $30,000 (for a total of $60,000 in credits) recommended by the Committee in March was approved by NMRE Board of Directors on March 25th.

Training topics for FY25 were summarized as:



Trainings may be accessed at: Northern Michigan Regional Entity Training Portal | New Horizons

NEXT MEETING

The next meeting was scheduled for May 13th at 9:00AM.

Chief Executive Officer Report

April 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.

March 23: Attended and participated in PIHP compliance officers meeting.

March 25: Met with CMHAM guidance group.

March 25: Met with MDHHS children's administration regarding CCI billings.

March 26 and 27: Attended and participated in CMHAM Directors' Forum.

April 2: Attended and participated in MDHHS PIHP Operations meeting.

April 2: Attended NMRE Internal Operations meeting.

April 7: Attended and participated in PIHP CEO meeting.

April 9: Attended COC hearing on PIHP contract dispute.

April 13: Attended virtually COC hearing regarding RFP.

April 15: Attended and participated in NMRE Finance Committee Meeting.

April 16: Attended NMRE Internal Operations meeting.

April 17: Attended and participated in Rural and Frontier Caucus.

April 21: Plan to chair NMRE Operations Committee Meeting.

February 2026 Finance Report

February 2026 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	6,184,248	2,844,054	13,519,285
Healthy Michigan	(753,366)	-	7,070,804
	$ 5,430,882	$ 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	274,456	1,041,923	(1,541,374)	1,472,200	1,732,105	1,994,225	457,347	$ 5,430,882
Carry Forward		-	-	-	-	-	-	2,844,054
Total Med/HMP Current Year Surplus	274,456	1,041,923	(1,541,374)	1,472,200	1,732,105	1,994,225	457,347	$ 8,274,936
Medicaid & HMP Internal Service Fund								20,590,089
Total Medicaid & HMP Net Surplus								$ 28,865,025

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health

October 1, 2025 through February 28, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 94,628,746	$ 1,893,186						$ 96,521,932
CMHSP Distributions	(92,781,110)		29,994,810	25,147,496	15,290,094	14,168,728	8,179,982	(0)
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	1,847,636	1,893,186	29,994,810	25,147,496	15,290,094	14,168,728	8,179,982	96,521,932
Expense								
PIHP Admin	1,229,989	17,888						1,247,877
PIHP SUD Admin		36,819						36,819
SUD Access Center		-						-
Insurance Provider Assessment	467,508	7,280						474,788
Hospital Rate Adjuster	-							-
Services	-	1,269,723	30,499,068	23,523,333	13,713,540	12,039,343	7,533,193	88,578,200
Total expense	1,697,497	1,331,710	30,499,068	23,523,333	13,713,540	12,039,343	7,533,193	90,337,684
Net Actual Surplus (Deficit)	$ 150,139	$ 561,476	$ (504,258)	$ 1,624,163	$ 1,576,554	$ 2,129,385	$ 646,789	$ 6,184,248

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 February 28, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 7,284,626	$ 3,943,307						$ 11,227,933
CMHSP Distributions	(6,995,967)		2,551,010	1,985,576	904,354	947,217	607,810	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	288,659	3,943,307	2,551,010	1,985,576	904,354	947,217	607,810	11,227,933
Expense								
PIHP Admin	117,691	46,523						164,214
PIHP SUD Admin		95,760						95,760
SUD Access Center		-						-
Insurance Provider Assessment	46,651	18,234						64,885
Hospital Rate Adjuster	-							-
Services	-	3,302,343	3,588,126	2,137,539	748,803	1,082,377	797,252	11,656,440
Total expense	164,342	3,462,860	3,588,126	2,137,539	748,803	1,082,377	797,252	11,981,299
Net Surplus (Deficit)	$ 124,317	$ 480,447	$ (1,037,116)	$ (151,963)	$ 155,551	$ (135,160)	$ (189,442)	$ (753,366)

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

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	**$ 274,456**	**$ 1,041,923**	**$ (1,541,374)**	**$ 1,472,200**	**$ 1,732,105**	**$ 1,994,225**	**$ 457,347**	**$ 5,430,882**
Medicaid/HMP Carry Forward								**2,844,054**
Total Med/HMP Current Year Surplus								**$ 8,274,936**
Medicaid & HMP ISF - based on current FSR								**20,590,089**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 28,865,025**

Northern Michigan Regional Entity

Funding Source Report - PIHP
Mental Health
October 1, 2025 through February 28, 2026

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 1,310,689							$ 1,310,689
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	1,310,689	-	-	-	-	-	-	1,310,689
Expense								
PIHP Admin	15,684							15,684
BHH Admin	14,977							14,977
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	1,113,277							1,113,277
Total expense	1,143,938	-	-	-	-	-	-	1,143,938
Net Surplus (Deficit)	$ 166,751	$ -	$ -	$ -	$ -	$ -	$ -	$ 166,751

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2025 through February 28, 2026

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 1,893,186	$ 3,943,307	$ 1,717,430	$ 1,068,353	$ 554,154	$ 9,176,430
Expense						
PIHP Admin						92,486
SUD Admin						285,865
Administration	54,707	142,283	61,989	119,373		378,351
OHH Admin			33,325	-		33,325
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	7,280	18,234	-			25,514
Services:						
Treatment	1,269,723	3,302,343	1,438,742	616,733	554,154	7,181,695
Prevention	-	-	-	332,247	-	332,247
Healing and Recovery Grant				-		-
Alcohol Use Disorder Services				-		
ARPA Grant	-	-	-	-	-	-
Total expense	1,331,710	3,462,860	1,534,056	1,068,353	554,154	7,951,132
PA2 Redirect			-	-		-
Net Surplus (Deficit)	$ 561,476	$ 480,447	$ 183,374	$ -	$ -	$ 1,225,298

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2025 through February 28, 2026

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 94,628,746	$ 1,893,186	$ -	$ 96,521,932
Medicaid Savings	-	-	-	-
Healthy Michigan	7,284,626	3,943,307	-	11,227,933
Healthy Michigan Savings	-	-	-	-
Health Home	1,310,689	-	-	1,310,689
Opioid Health Home	-	1,717,430	-	1,717,430
Substance Use Disorder Block Grant	-	1,068,353	-	1,068,353
Public Act 2 (Liquor tax)	-	554,154	-	554,154
Affiliate local drawdown	297,408	-	-	297,408
Performance Incentive Bonus	-	-	-	-
Miscellanous Grant Revenue	-	-	-	-
Healing & Recovery Revenue	-	-	-	-
Veteran Navigator Grant	53,840	-	-	53,840
SOR Grant Revenue	-	639,825	-	639,825
Gambling Grant Revenue	-	55,617	-	55,617
Other Revenue	105	-	1,668	1,773
Total operating revenue	103,575,414	9,871,872	1,668	113,448,954
Operating expenses				
General Administration	1,455,850	285,865	-	1,741,715
Prevention Administration	-	44,837	-	44,837
OHH Administration	-	33,325	-	33,325
BHH Administration	14,977	-	-	14,977
Insurance Provider Assessment	514,159	25,514	-	539,673
Hospital Rate Adjuster	-	-	-	-
Payments to Affiliates:				
Medicaid Services	87,308,477	1,269,723	-	88,578,200
Healthy Michigan Services	8,354,097	3,302,343	-	11,656,440
Health Home Services	1,113,277	-	-	1,113,277
Opioid Health Home Services	-	1,438,742	-	1,438,742
Community Grant	-	616,733	-	616,733
Prevention	-	287,410	-	287,410
State Disability Assistance	-	-	-	-
Alcohol Use Disorder Services	-	-	-	-
ARPA Grant	-	-	-	-
Public Act 2 (Liquor tax)	-	554,155	-	554,155
Local PBIP	-	-	-	-
Local Match Drawdown	297,408	-	-	297,408
Miscellanous Grant	-	-	-	-
Healing & Recovery Grant	-	-	-	-
Veteran Navigator Grant	53,840	-	-	53,840
SOR Grant Expenses	-	639,825	-	639,825
Gambling Grant Expenses	-	55,617	-	55,617
Total operating expenses	99,112,085	8,554,089	-	107,666,174
CY Unspent funds	4,463,329	1,317,783	1,668	5,782,780
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	10,733,799	10,929,769	20,586,761	42,250,329
Unspent funds - ending	$ 15,197,128	$ 12,247,552	$ 20,588,429	$ 48,033,109

Northern Michigan Regional Entity

Statement of Net Position

February 28, 2026

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 46,640,052	$ 11,856,816	$ 20,588,429	$ 79,085,297
Accounts Receivable	1,946,641	1,703,480	-	3,650,121
Prepaids	29,988	-	-	29,988
Total current assets	48,616,681	13,560,296	20,588,429	82,765,406
Noncurrent Assets				
Capital assets	377,692	-	-	377,692
Total Assets	48,994,373	13,560,296	20,588,429	83,143,098
Liabilities				
Current liabilities				
Accounts payable	33,581,428	1,312,744	-	34,894,172
Accrued liabilities	215,817	-	-	215,817
Unearned revenue	-	-	-	-
Total current liabilities	33,797,245	1,312,744	-	35,109,989
Unspent funds	$ 15,197,128	$ 12,247,552	$ 20,588,429	$ 48,033,109

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health

October 1, 2025 through February 28, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 229,702,368	$ 95,709,320	$ 94,628,746	$ (1,080,574)	(1.13%)
Carryover	4,449,500	1,853,958	-	(1,853,958)	(1)
Healthy Michigan					
Capitation	17,969,268	7,487,195	7,284,626	(202,569)	(2.71%)
Carryover	-	-	-	-	0.00%
Health Home	2,844,551	1,185,230	1,310,689	125,459	10.59%
Affiliate local drawdown	594,816	297,408	297,408	-	0.00%
Performance Bonus Incentive	2,184,505	-	-	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	45,835	53,840	8,005	17.46%
Other Revenue	-	-	105	105	0.00%
Total operating revenue	257,855,008	106,578,946	103,575,414	(3,003,532)	(2.82%)
Operating expenses					
General Administration	4,481,376	1,786,427	1,455,850	330,577	18.50%
Health Home Administration	-	-	14,977	(14,977)	0.00%
Insurance Provider Assessment	2,038,488	849,370	514,159	335,211	39.47%
Hospital Rate Adjuster	7,687,213	3,203,005	-	3,203,005	100.00%
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	47,175	53,840	(6,665)	(14.13%)
Payments to Affiliates:					
Medicaid Services	218,897,134	91,207,139	87,308,477	3,898,662	4.27%
Healthy Michigan Services	15,738,212	6,557,588	8,354,097	(1,796,509)	(27.40%)
Health Home Services	2,844,551	1,185,230	1,113,277	71,953	6.07%
Total operating expenses	254,601,631	105,133,342	99,112,085	6,021,257	5.73%
CY Unspent funds	$ 3,253,377	$ 1,445,604	4,463,329	$ 3,017,725	
Transfers in			-		
Transfers out			-	99,112,085	
Unspent funds - beginning			10,733,799		
Unspent funds - ending			$ 15,197,128	4,463,329	

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2025 through February 28, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 7,015,245	$ 2,923,019	$ 1,893,186	$ (1,029,833)	(35.23%)
Healthy Michigan	12,312,158	5,130,066	3,943,307	(1,186,759)	(23.13%)
Substance Use Disorder Block Grant	3,525,032	1,334,269	1,068,353	(265,916)	(19.93%)
Opioid Health Home	3,556,831	1,482,013	1,717,430	235,417	15.88%
Public Act 2 (Liquor tax)	1,794,486	-	554,154	554,154	0.00%
Miscellanous Grants	4,000	1,667	-	(1,667)	(100.00%)
Alcohol Disorder Grant	285,600	119,000	-	(119,000)	(100.00%)
Healing & Recovery Grant	150,000	62,500	-	(62,500)	(100.00%)
SOR Grant	1,546,979	644,575	639,825	(4,750)	(0.74%)
Gambling Prevention Grant	200,000	83,333	55,617	(27,716)	(33.26%)
Other Revenue	-	-	-	-	0.00%
Total operating revenue	30,390,331	11,780,441	9,871,872	(1,908,569)	(16.20%)
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,025,044	374,472	285,865	88,607	23.66%
Prevention Administration	143,928	59,970	44,837	15,133	25.23%
Insurance Provider Assessment	120,208	50,087	25,514	24,573	49.06%
Medicaid Services	3,700,000	1,541,667	1,269,723	271,944	17.64%
Healthy Michigan Services	8,634,200	3,597,583	3,302,343	295,240	8.21%
Community Grant	2,130,419	887,675	616,733	270,942	30.52%
Prevention	838,096	214,712	287,410	(72,698)	(33.86%)
State Disability Assistance	93,043	38,768	-	38,768	100.00%
Alcohol Use Disorder Services	285,600	119,000	-	119,000	100.00%
ARPA Grant	-	-	-	-	0.00%
Opioid Health Home Admin	-	-	33,325	(33,325)	0.00%
Opioid Health Home Services	3,556,813	1,482,005	1,438,742	43,263	2.92%
Miscellanous Grants	4,000	1,667	-	1,667	100.00%
Healing & Recovery Grant	150,000	62,500	-	62,500	100.00%
SOR Grant	1,546,979	644,575	639,825	4,750	0.74%
Gambling Prevention	200,000	83,333	55,617	27,716	33.26%
PA2	1,794,492	-	554,155	(554,155)	0.00%
Total operating expenses	24,222,822	9,158,013	8,554,089	603,924	6.59%
CY Unspent funds	$ 6,167,509	$ 2,622,428	1,317,783	$ (1,304,645)	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			10,929,769		
Unspent funds - ending			$ 12,247,552		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2025 through February 28, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 2,442,372	$ 1,017,655	$ 701,428	$ 316,227	31.07%
Fringes	768,300	313,895	245,966	67,929	21.64%
Contractual	952,800	322,418	397,384	(74,966)	(23.25%)
Board expenses	13,500	5,625	6,221	(596)	(10.60%)
Day of recovery	14,000	5,833	-	5,833	100.00%
Facilities	133,000	55,415	61,566	(6,151)	(11.10%)
Other	157,404	65,585	43,285	22,300	34.00%
Total General Admin	$ 4,481,376	$ 1,786,427	$ 1,455,850	$ 330,577	18.50%

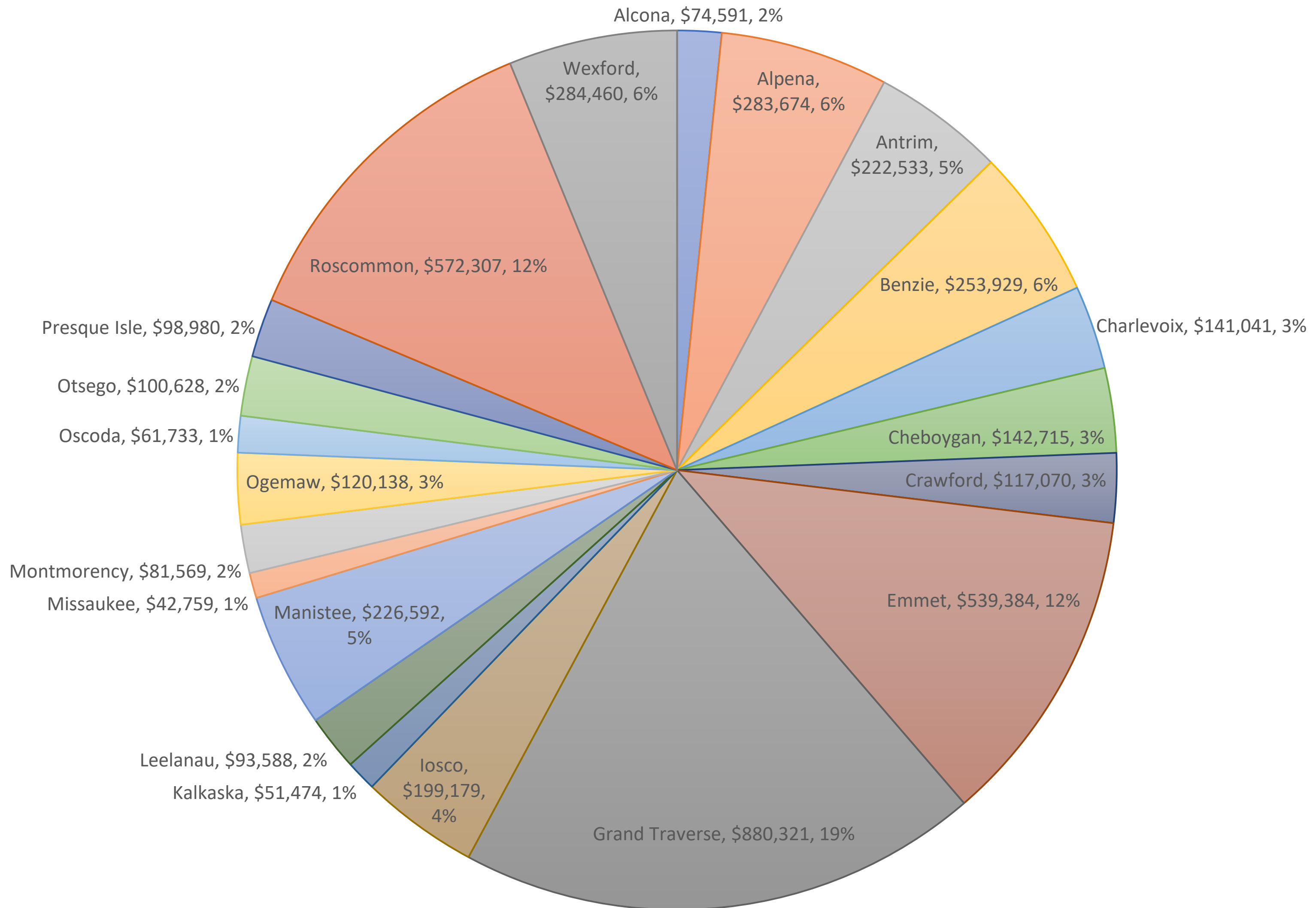
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2025 through February 28, 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
						Actual Expenditures by County		
County								
Alcona	$ 79,981	$ 23,013	$ 24,001	$ 78,993	$ -	5,390	$ -	$ 74,591
Alpena	315,893	81,249	87,854	309,288	-	32,219	-	283,674
Antrim	248,419	71,430	46,424	273,425	-	25,887	-	222,533
Benzie	276,050	64,021	47,793	292,278	-	22,120	-	253,929
Charlevoix	180,985	106,977	92,341	195,621	-	39,943	-	141,041
Cheboygan	161,840	85,508	81,361	165,987	-	19,125	-	142,715
Crawford	127,739	36,205	33,849	130,095	-	10,668	-	117,070
Emmet	574,150	182,951	332,159	424,942	-	34,766	-	539,384
Grand Traverse	1,037,930	464,163	698,152	803,941	-	157,610	-	880,321
Iosco	217,704	84,319	66,511	235,512	-	18,525	-	199,179
Kalkaska	53,910	41,796	3,936	91,770	-	2,436	-	51,474
Leelanau	109,318	63,811	44,237	128,892	-	15,730	-	93,588
Manistee	250,862	82,480	40,719	292,623	-	24,271	-	226,592
Missaukee	48,934	22,352	7,175	64,112	-	6,175	-	42,759
Montmorency	85,825	30,318	14,262	101,881	-	4,256	-	81,569
Ogemaw	123,674	68,787	26,413	166,049	-	3,537	-	120,138
Oscoda	65,547	21,668	17,149	70,065	-	3,813	-	61,733
Otsego	135,933	105,067	111,286	129,714	-	35,305	-	100,628
Presque Isle	104,871	24,977	20,080	109,768	-	5,891	-	98,980
Roscommon	613,562	87,317	130,060	570,820	-	41,256	-	572,307
Wexford	329,692	98,696	145,681	282,707	-	45,231	-	284,460
	5,142,821	1,847,106	2,071,443	4,918,483	-	554,155	-	4,588,666
PA2 Redirect								-
								4,588,666

PA2/Liquor Tax Fund Balances by County



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2025 through February 28, 2026

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 646,392	$ 269,330	$ 170,663	$ 98,667	36.63%
Fringes	227,940	94,975	62,911	32,064	33.76%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	114,000	-	41,000	(41,000)	0.00%
Board expenses	5,000	2,083	1,530	553	26.56%
Day of Recover	9,000	3,750	-	3,750	100.00%
Facilities	-	-	-	-	0.00%
Other	22,712	4,333	9,761	(5,428)	(125.25%)
Total operating expenses	$ 1,025,044	$ 374,472	$ 285,865	$ 88,607	23.66%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF
October 1, 2025 through February 28, 2026

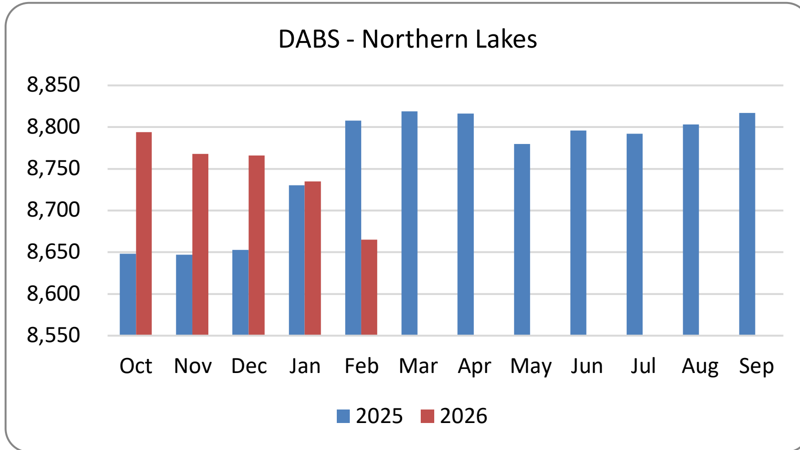
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	3,500	1,458	1,668	210	14.38%
Total operating revenue	3,500	1,458	1,668	210	14.38%
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 3,500	$ 1,458	1,668	$ 210	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,586,761		
Unspent funds - ending			$ 20,588,429		

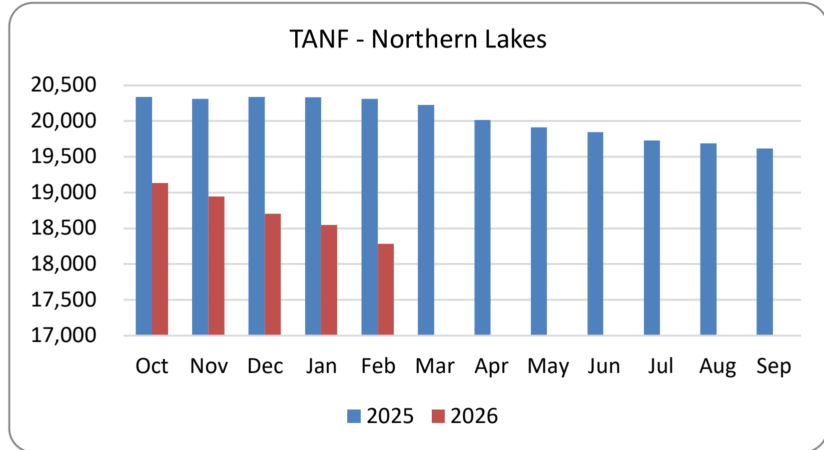
Northern Michigan Regional Entity

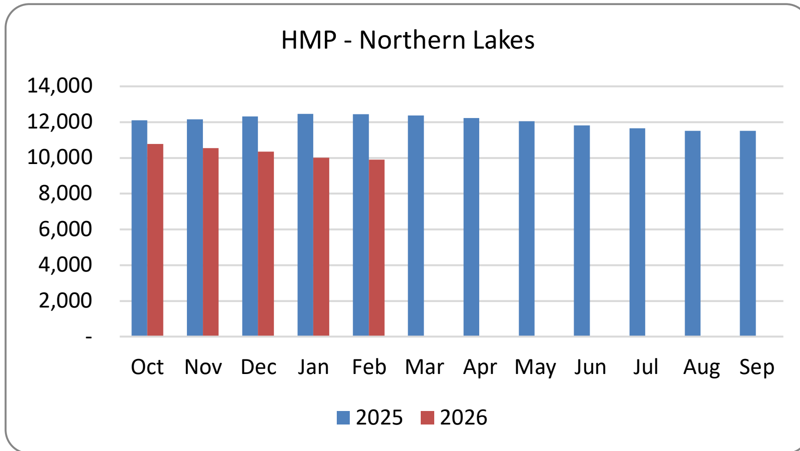
Narrative

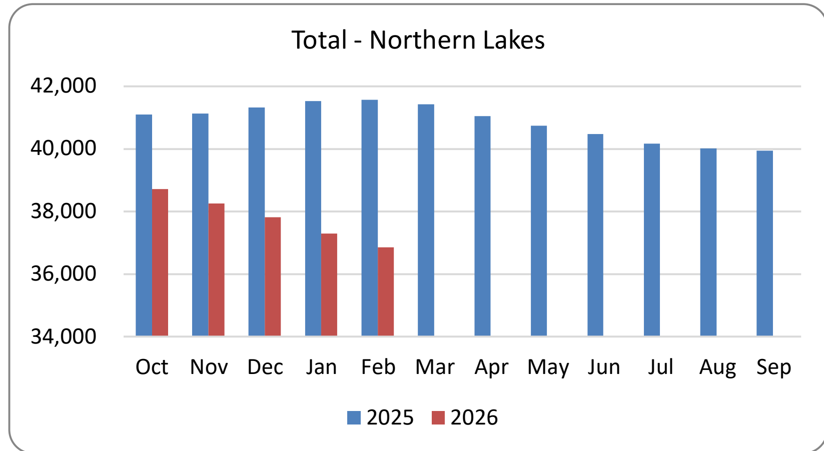
October 1, 2025 through February 28, 2026

Northern Lakes Eligible Members Trending - based on payment files







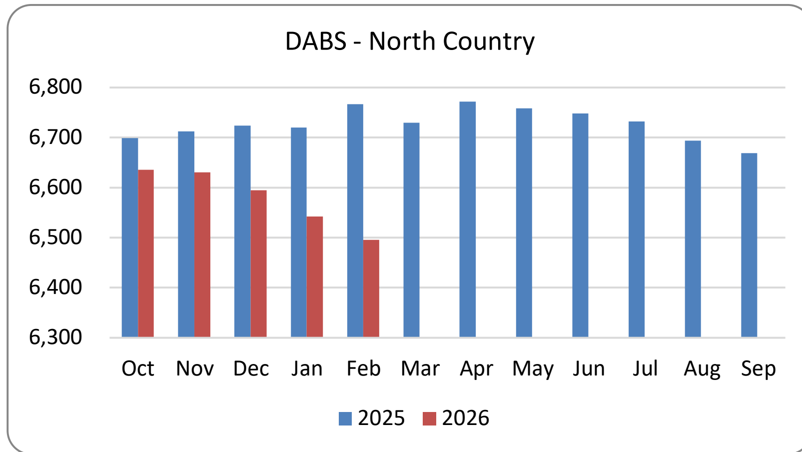


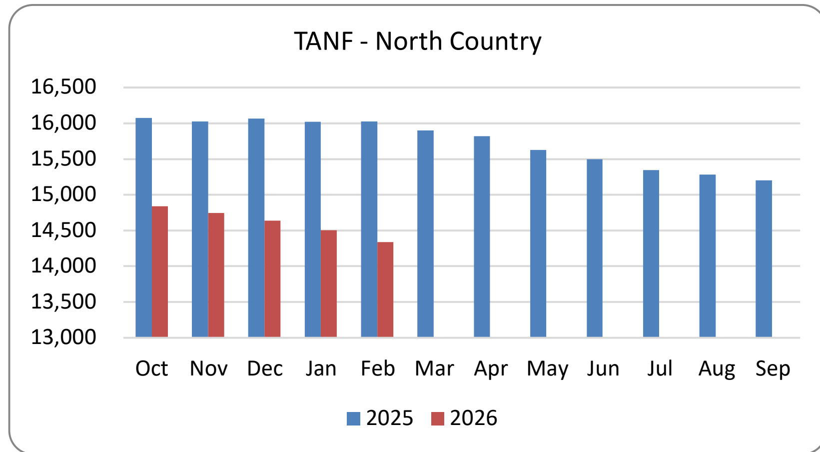
Northern Michigan Regional Entity

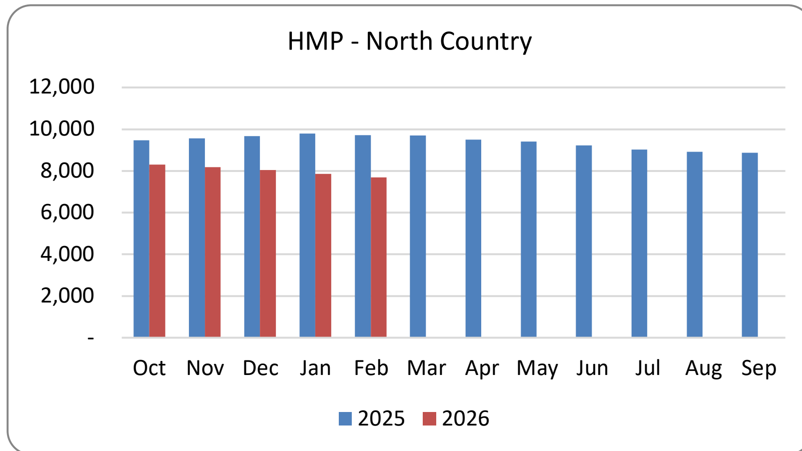
Narrative

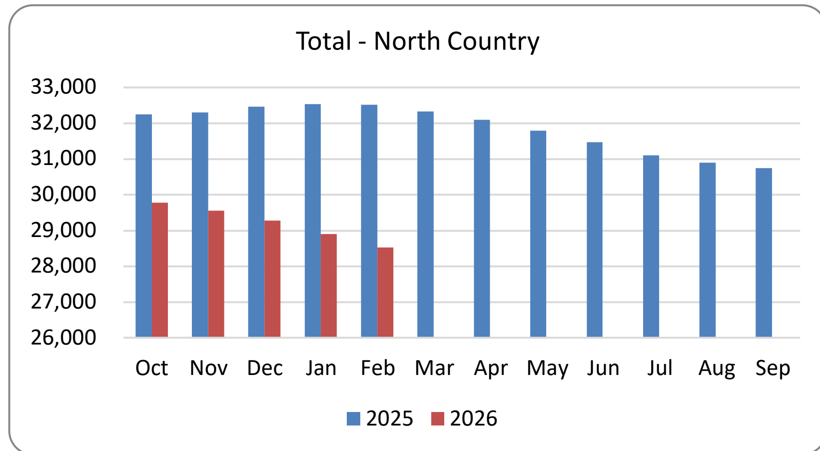
October 1, 2025 through February 28, 2026

North Country Eligible Members Trending - based on payment files







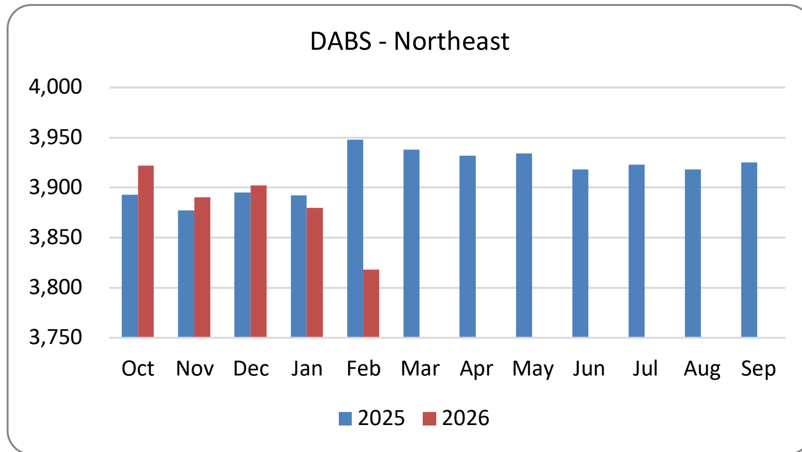


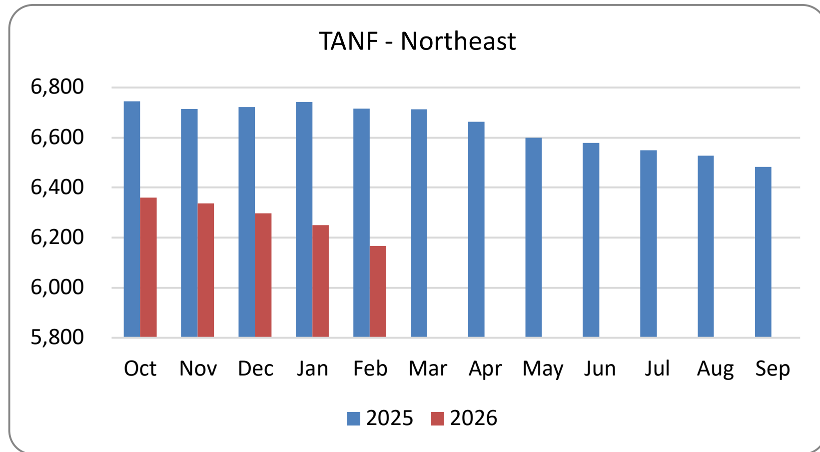
Northern Michigan Regional Entity

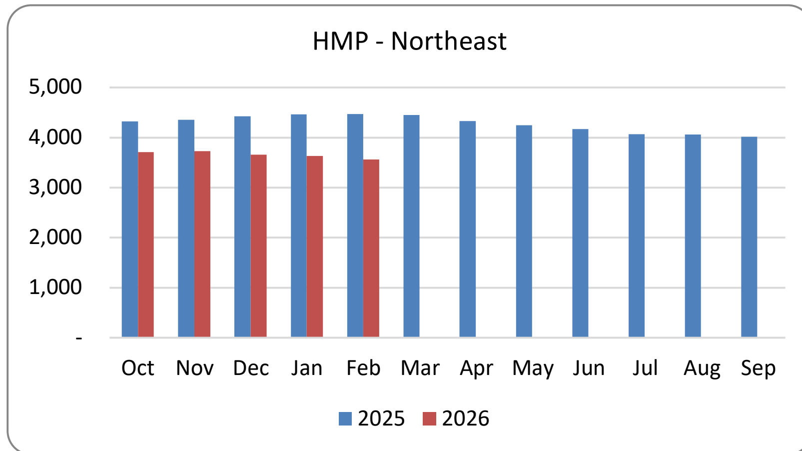
Narrative

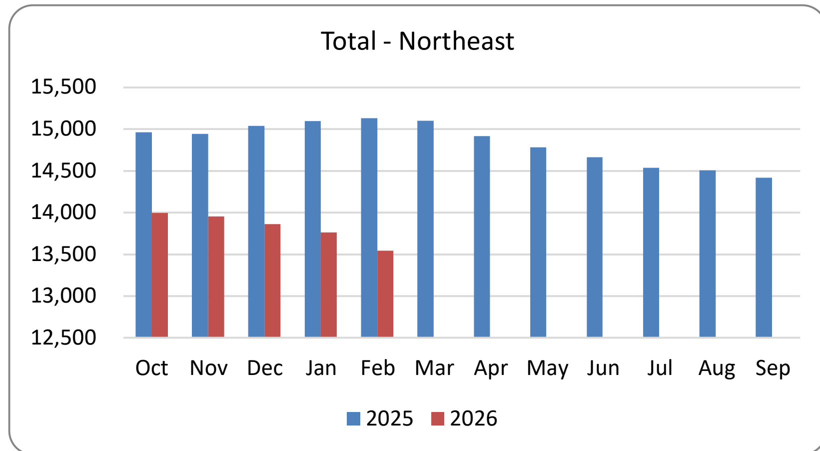
October 1, 2025 through February 28, 2026

Northeast Eligible Members Trending - based on payment files







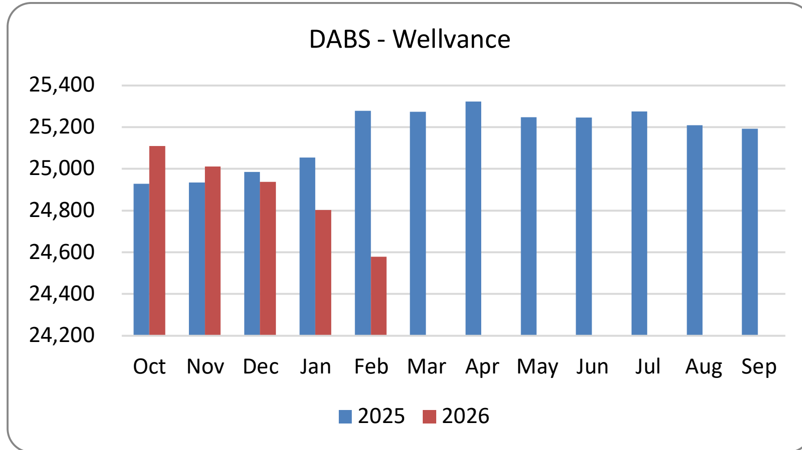


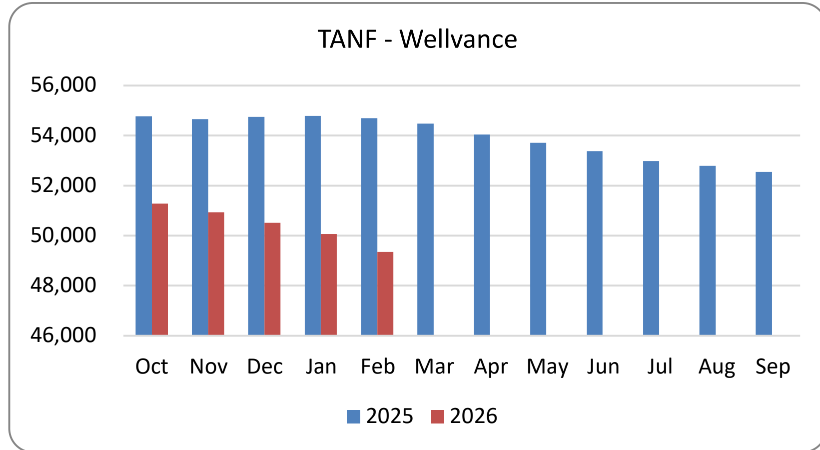
Northern Michigan Regional Entity

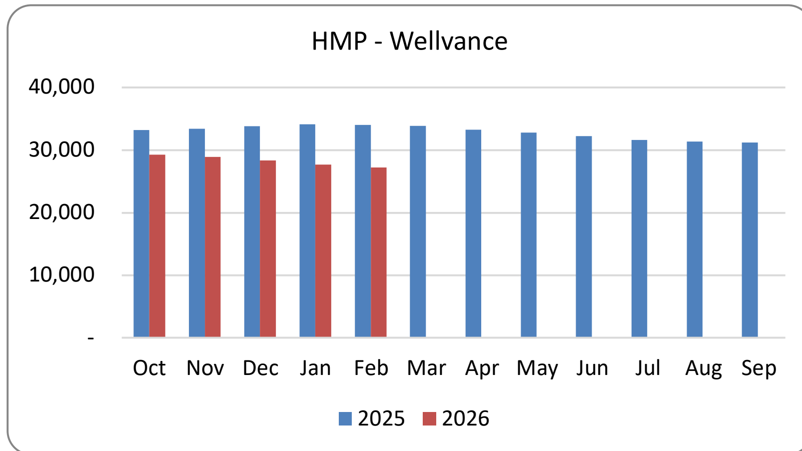
Narrative

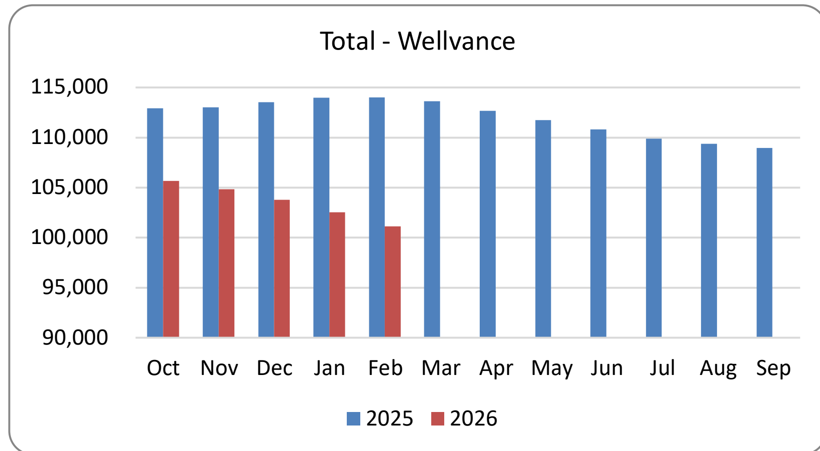
October 1, 2025 through February 28, 2026

Wellvance Eligible Members Trending - based on payment files







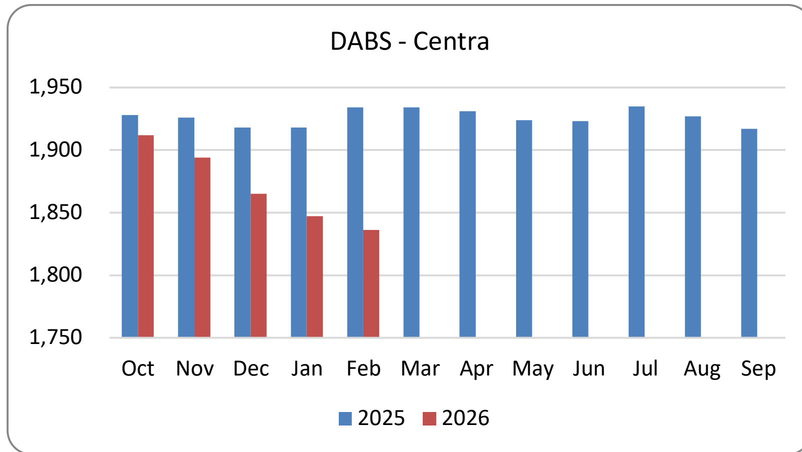


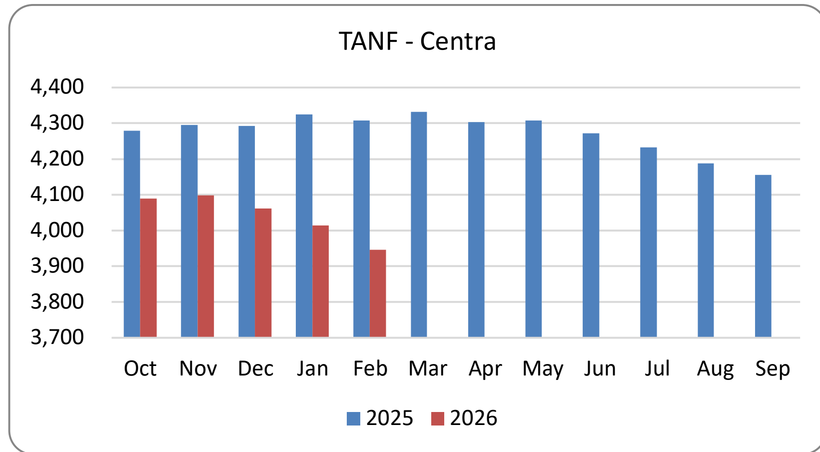
Northern Michigan Regional Entity

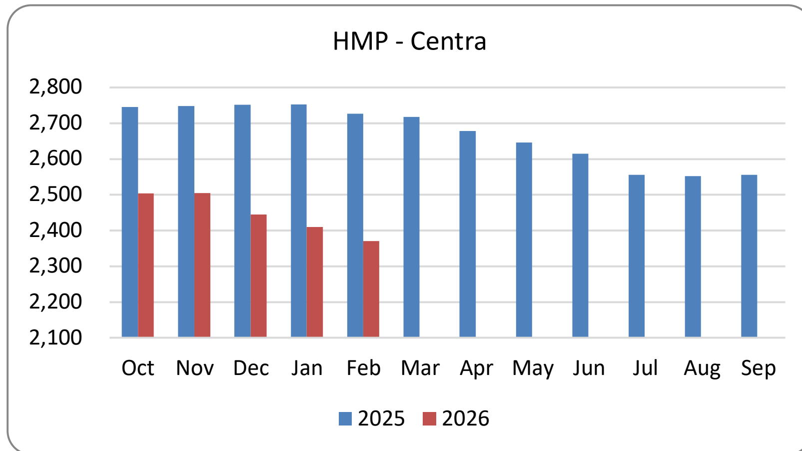
Narrative

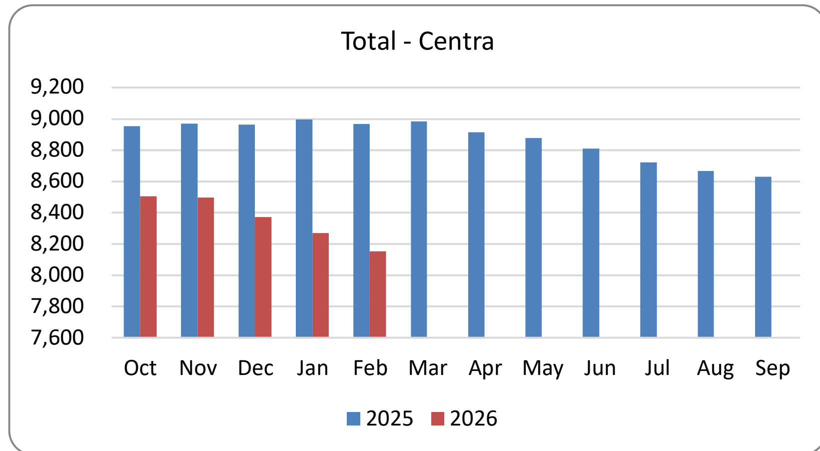
October 1, 2025 through February 28, 2026

Centra Wellness Eligible Members Trending - based on payment files







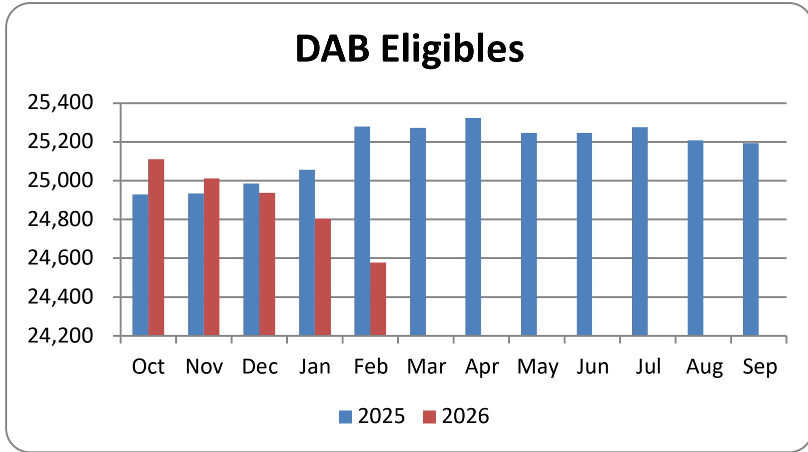


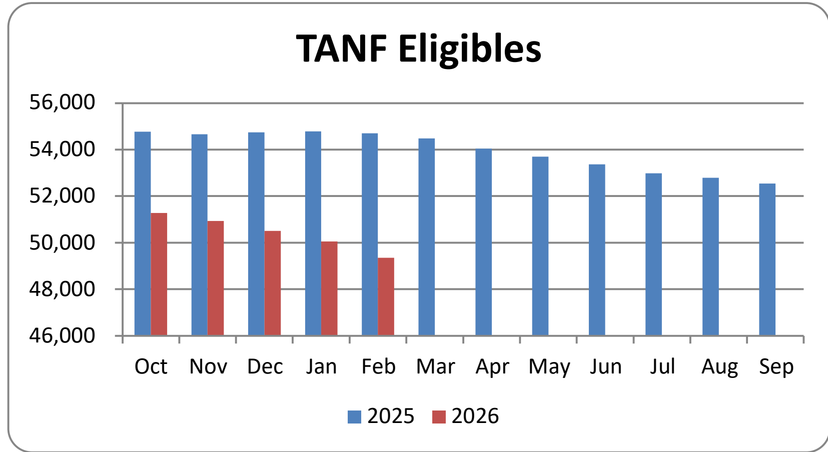
Northern Michigan Regional Entity

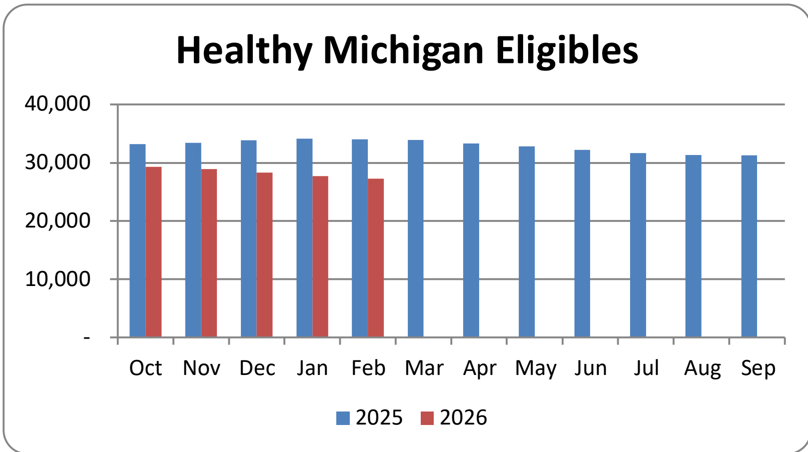
Narrative

October 1, 2025 through February 28, 2026

Regional Eligible Trending





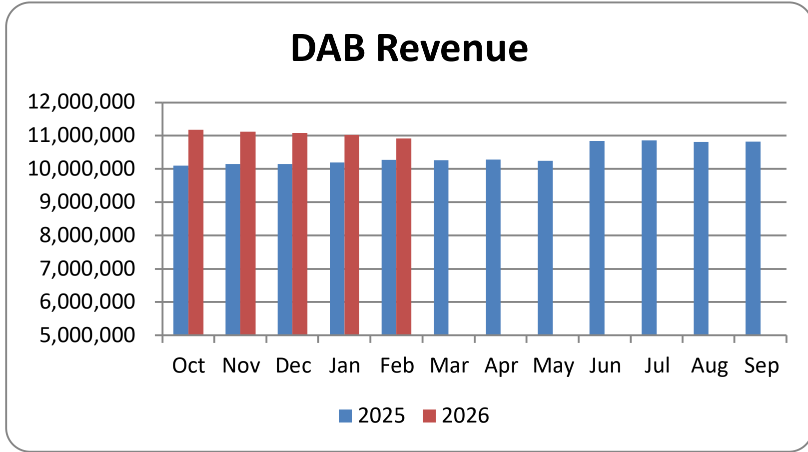


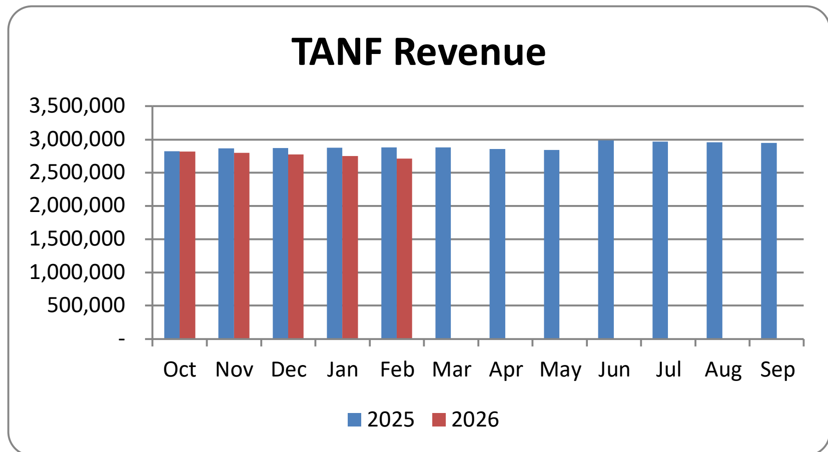
Northern Michigan Regional Entity

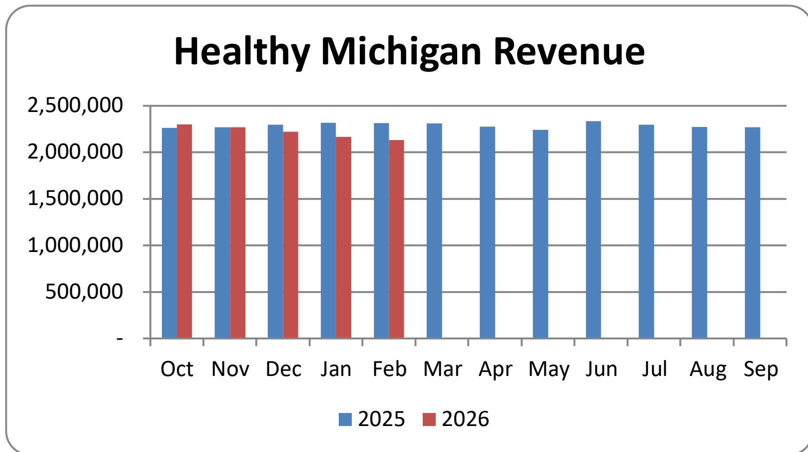
Narrative

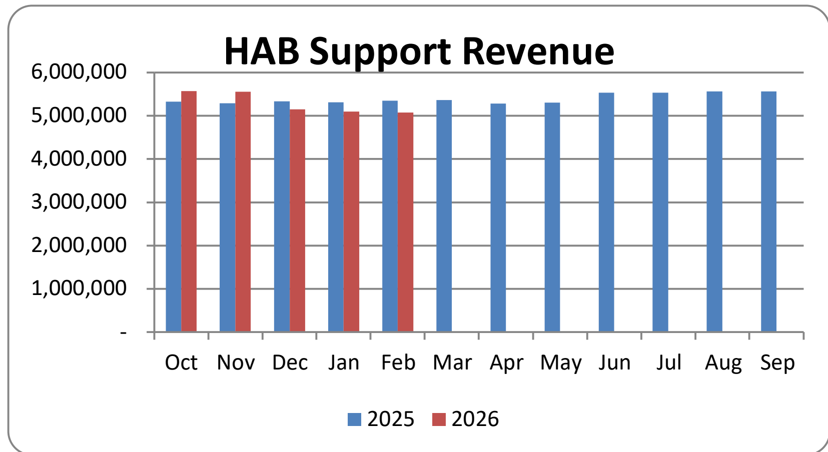
October 1, 2025 through February 28, 2026

Regional Revenue Trending









Northern Michigan Regional Entity PIHP – Region 2

FINAL

FY25 Performance Bonus Incentive Pool (PBIP) Contractor-only and MHP/Contractor Joint Metrics Deliverables/Narratives Scoring

This communication serves as the response to your PIHP regarding the FY2025 performance bonus, contract section A.8.D.
Scoring is based on Contractor-only and MHP/Contractor Joint Metrics deliverables.

TOTAL NMRE WITHHOLD	TOTAL NMRE WITHHOLD UNEARNED (subtract)	TOTAL DISTRIBUTION OF UNEARNED *from all PIHPs that didn't score points* (add)	GRAND TOTAL NMRE EARNED
$1,913,249.57	**$436,029.56**	**$1,295,481.76**	**$2,772,701.77**

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

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
P.1 Implement data driven outcomes measurement to address social determinants of health *NMRE Scored all the points*	**$344,384.93**	**$0**	**$107,463.15**	**$451,848.08**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
P.2 Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) *NMRE Scored all the points*	**$172,192.46**	**$0**	**$51,996.55**	**$224,189.01**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
P.3 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)-Initiation *NMRE scored 0 points*	**$172,192.46**	**$172,192.46**	**$0**	**$0**
P.3 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)-Engagement *NMRE scored 0 points*	**$172,192.46**	**$172,192.46**	**$0**	**$0**

If unearned funds exist for a performance metric, those funds are 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 achieves full points on one deliverable, the unearned funds for that deliverable are distributed to the PIHP(s) that achieved full points on the other deliverable(s) within the same metric.

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

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
P.4 PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes *NMRE Scored all the points*	**$478,312.39**	**$0**	**N/A**	**$478,312.39**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	NMRE AVAILABLE POINTS	NMRE POINTS EARNED	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	GRAND TOTAL NMRE EARNED
CONTRACTOR - only TOTAL summary	**$1,339,274.70**	**$344,384.92**	**200**	**160**	**$159,459.70**	**$1,154,349.48**

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

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMREWITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
J.1 Implementation of Joint Care Management Processes. *NMRE Scored all the points*	**$172,192.47**	**$0**	**N/A**	**$172,192.47**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
J.2.1 Follow-up after Hospitalization (FUH) within 30 days. *NMRE Scored all the points*	**$86,096.24**	**$0**	**$32,739.25**	**$118,835.49**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
J.2.2 Follow-up after Hospitalization (FUH) within 30 days stratified by race/ethnicity. *NMRE Scored all the points*	**$86,096.23**	**$0**	**$102,211.35**	**$188,307.58**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
J.3.1 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)- Initiation *NMRE Scored 0 points*	**$28,698.74**	**$28,698.74**	**$354,191.23**	**$354,191.23**
J.3.1 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)- Engagement *NMRE Scored 1.5 out of 5 points*	**$28,698.74**	**$21,524.05**	**$402,129.71**	**$409,304.40**

How is this possible???:

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
J.3.2 Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET) within 14 days stratified by race/ethnicity. *NMRE Scored 4.44 out of 5 points*	**$28,698.74**	**$3,156.86**	**$101,414.93**	**$126,956.81**
	TOTAL NMRE WITHHOLD AMOUNT	**TOTAL NMRE WITHHOLD UNEARNED AMOUNT**	**TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs**	**TOTAL NMRE EARNED**
J.3.2 Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) within 34 days stratified by race/ethnicity. *NMRE Scored all the points*	**$28,698.74**	**$0**	**$143,335.59**	**$172,034.33**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	TOTAL NMRE EARNED
J.4 Follow-up after (FUA) Emergency Department visit for Alcohol and Other Drug Dependency within 30 days stratified by race/ethnicity. *NMRE Scored 13.33 out of 20 points*	**$114,794.97**	**$38,264.99**	**$0**	**$76,529.98**

	TOTAL NMRE WITHHOLD AMOUNT	TOTAL NMRE WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED	TOTAL DISTRIBUTION OF UNEARNED received from other PIHPs	GRAND TOTAL NMRE EARNED
MHP/CONTRACTOR JOINT METRICS TOTAL *summary*	**$573,974.87**	**$91,644.64**	**100**	**84.02**	**$1,136,022.06**	**$1,618,352.29**

FY25 Summary PBIP Payable in FY26

	NMRE SUD	NL	NC	NE	AV	CW	Total	
		28	24	4	35	51		
	NMRE SUD	NL	NC	NE	AV	CW	Total	Calculation Based on PMPM
Totals	19,129,938	73,509,654	61,663,135	37,023,525	32,803,945	20,381,931	244,512,128	
PBIP		$ 833,580	$ 699,243	$ 419,837	$ 371,988	$ 231,126	$ 2,555,773	Code: 10-**-295-2100-80000
	$ 216,928						$ 2,772,702	
	6,942,931	68,049,634	57,435,684	35,113,644	30,795,021	19,182,527	217,519,441	Medicaid FY25 PMPM
	12,187,007	5,460,020	4,227,451	1,909,881	2,008,924	1,199,404	26,992,687	HMP FY25 PMPM
	19,129,938	73,509,654	61,663,135	37,023,525	32,803,945	20,381,931	244,512,128	

Available	$ 1,477,220
Additional PBIP Earned	$ 1,295,482
Additional PIHP Retained	$ -
Net	$ 2,772,702

Total PBIP $ 2,772,702
(NMRE received deposit on 2026 04-16)