Northern Michigan Regional Entity

Board Meeting

October 22, 2025

1999 Walden Drive, Gaylord

10:00AM

Agenda

		Page Numbers
1.	Call to Order	
2.	Roll Call	
3.	Pledge of Allegiance	
4.	Acknowledgement of Conflict of Interest	
5.	Approval of Agenda	
6.	Approval of Past Minutes – September 24, 2025	Pages 2 – 10
7.	Correspondence	Pages 11 – 61
8.	Announcements	
9.	Public Comments	
10.	Reports	
	a. Executive Committee Report – Has Not Met	
	b. CEO's Report – October 2025	Page 62
	c. Financial Report – August 2025	Page 63 – 84
	d. Operations Committee Report – Meeting October 21st	
	e. NMRE SUD Oversight Board Report – Meeting November 3rd	
11.	New Business	
	a. PA 152 Opt Out	Pages 85 – 87
12.	Old Business	
	a. Northern Lakes Lookback and Update	
	b. FY25 PIHP Contract Injunction and Complaint - Update	
	c. Region 10 et al. Complaint	Pages 88 – 100
	c. CMH Complaint Filing	Pages 101 – 127
13.	Presentation	
	NMRE Compliance Plan	Pages 128 - 142
14.	Comments	
	a. Board	
	b. Staff/CMHSP CEOs	
	c. Public	
14.	Next Meeting Date – December 3, 2025 at 10:00AM	
15.	Adjourn	

Join Microsoft Teams Meeting

+1 248-333-6216 United States, Pontiac (Toll)

Conference ID: 497 719 399#

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM – SEPTEMBER 24, 2025
GAYLORD BOARDROOM

ATTENDEES:	**Bob Adrian, Dave Freedman, Ed Ginop, Ron Iseler, Gary Klacking, Dana Labar, Eric Lawson, Mary Marois, Michael Newman, Jay O'Farrell, Ruth Pilon, Don Smeltzer, Don Tanner, Chuck Varner**
VIRTUAL ATTENDEES:	**Karen Goodman**
NMRE/CMHSP STAFF:	**Bea Arsenov, Brian Babbitt, Jodie Balhorn, Carol Balousek, Brady Barnhill, Eugene Branigan, Curt Cummins, Gail Grangood-Griffin, Lisa Hartley, Chip Johnston, Sue Kler, Eric Kurtz, Brian Martinus, Trish Otremba, Pamela Polom, Nena Sork, Denise Switzer, Chris VanWagoner, Tricia Wurn, Deanna Yockey**
PUBLIC:	**Anonymous (3), Erin Barbus, Catherine Darrah, Ann Friend, Genevieve Groover, Kevin Hartley, Greg McMorrow, Tobias Neal, Lori Stendel, Lynda Zeller**

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

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

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

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

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

MOTION BY DON TANNER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING AGENDA FOR SEPTEMBER 24, 2025; SUPPORT BY DAVE FREEDMAN. MOTION CARRIED.

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

MOTION BY JAY O'FARRELL TO APPROVE THE MINUTES OF THE AUGUST 27, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY ED GINOP. MOTION CARRIED.

CORRESPONDENCE

1) An Action Alert from the Community Mental Health Association of Michigan (CMHAM) dated September 3, 2025, urging the public to reach out to legislators and the Governor and Lt. Governor to express concerns with the Michigan Department of Health and Human Services' (MDHHS) RFP procurement process for the state's PIHP contracts.
2) A poster supplied by CMHAM titled, "Bidding Out the Management of Michigan's Public Mental Health System: Myth vs. Fact."
3) An article from CMHAM dated August 29, 2025, praising the lawsuit filed by Region 10 PIHP, Southwest Michigan Behavioral Health, MidState Health Network, St. Clair County Community Mental Health Authority, Integrated Services of Kalamazoo, and Saginaw County Community Mental Health Authority to stop the PIHP bid process.
4) An Open Letter to the Governor and the State Legislature on behalf of coalition of advocates and stakeholders expressing "Deep concerns over bid-out of management of Michigan's public mental health system."
5) A list of mental health providers and systems opposed to the bid out of the management of state's public mental health system.
6) A press release from MDHHS dated September 9, 2025, declaring September Substance Use Disorder Recovery Month.
7) The draft minutes of the September 10, 2025, regional Finance Committee meeting.

Mr. Kurtz drew attention to the numerous correspondence items related to the bid out of the PIHPs by MDHHS.

ANNOUNCEMENTS

Let the record show that new Board Member, Ron Iseler, representing Nort Country Community Mental Health Authority was introduced.

PUBLIC COMMENT

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

REPORTS

Executive Committee Report

The Executive Committee met at 9:15AM on this date to review the FY25 NMRE CEO Evaluation. A full report will be given under "New Business."

CEO Report

The NMRE CEO Monthly Report for September 2025 was included in the materials for the meeting on this date. Mr. Kurtz highlighted his attendance at the Great Lakes Rural Mental Health Association (GLRMHA) Conference on September 8th & 9th; he noted that the NMRE and its member CMHSPs have been invited to join GLRMA, an association formed by the CMHSPs located in the Upper Peninsula to address the needs, resources, and challenges of the rural northern region.

July 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $5,947,042. Carry forward was reported as $736,656. The total Medicaid and HMP current year surplus was reported as $6,683,698. FY24 HSW revenue was reported as $1,289,241. The total Medicaid and HMP adjusted current year surplus was reported as $5,394,457. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $27,259,854.
- Traditional Medicaid showed $188,587,274 in revenue, and $180,305,927 in expenses, resulting in a net surplus of $8,281,347. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $25,253,970 in revenue, and $27,588,276 in expenses, resulting in a net deficit of $2,334,306. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $2,719,756 in revenue, and $2,133,025 in expenses, resulting in a net surplus of $586,731.
- SUD showed all funding source revenue of $24,167,453 and $18,698,782 in expenses, resulting in a net surplus of $5,468,672. Total PA2 funds were reported as $4,211,377.

PA2/Liquor Tax was summarized as follows:

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

Actual FY25 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$835,755	$1,389,609	$4,211,377

The impact from the extra revenue (from Amendment 3 of the PIHP Contract) is helping to lower pervious deficits. Medicaid has maintained a surplus, while HMP has maintained a deficit. This is likely to continue through FY26. It was noted that four of the five member CMHSPs are currently in a surplus position.

MOTION BY CHUCK VARNER TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR JULY 2025; SUPPORT BY MARY MAROIS. MOTION CARRIED.

Operations Committee Report

The draft minutes from September 16, 2025, were included in the materials for the meeting on this date. In October 2021 the regional Operations Committee passed a motion to allow the NMRE to financially support the creation of an adult crisis residential unit in the region at a cost of up to two million dollars ($2,000,000.00) over two years. The facility opened in Gaylord in March of 2023 and received CMS certification in December of 2023. In August 2023, the regional Operations Committee passed a motion allowing the NMRE to fund the facility on a 1/12th payment arrangement through August 31, 2024. In August 2024, the regional Operations Committee passed a motion to extend the payment arrangement through August 31, 2025. Mr. Kurtz noted that the NMRE will be transitioning out of the funding arrangement. The CMHSPs will be paying the facility on a fee-for-service basis at a rate of $800.

NMRE SUD Oversight Committee Report
The draft minutes from September 8, 2025, were included in the materials for the meeting on this date. Liquor tax requests will be discussed under "New Business."

NEW BUSINESS
FY26 Liquor Tax Requests
The following liquor tax requests were recommended for approval by the NMRE Substance Use Disorder Oversight Committee on September 8, 2025.

	Requesting Entity	Project	County	Amount
1.	217 Recovery	Recovery Stories: Message of Hope Series	Grand Traverse	$16,500
2.	BASES	Charlevoix County Jail Group Counseling	Charlevoix	$22,000
3.	Catholic Human Services	Montmorency Students Leading Students Prevention Program	Montmorency	$31,769
4.	Catholic Human Services	Presque Isle Students Leading Students Prevention Program	Presque Isle	$67,483
5.	Catholic Human Services	Roscommon County Drug Free Coalition	Roscommon	$116,748
6.	Catholic Human Services	Wexford County Jail SUD Program	Wexford	$20,000
7.	Centra Wellness Network	Benzie Area Youth (BAY) Initiative	Benzie	$15,500
8.	Health Department of Northwest Michigan	Michigan Profile for Health Youth (MIPHY) Incentive for Schools	Alcona, Alpena, Antrim, Charlevoix, Cheboygan, Emmet, Grand Traverse, Kalkaska, Leelanau, Montmorency, Oscoda, Otsego, Presque Isle	$52,500
9.	Health Department of Northwest Michigan	Drug Free Northern Michigan 21-County Alliance	All 21 Counties	$60,000
10.	Sunrise Centre	Building and Enhancing Recovery Capital in Northeast Michigan	Alpena, Alcona, Montmorency, Oscoda, Presque Isle	$74,665

MOTION BY DAVE FREEDMAN TO APPROVE THE FISCAL YEAR 2026 LIQUOR TAX REQUESTS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT COMMITTEE ON SEPTEMBER 8, 2025 IN THE TOTAL AMOUNT OF THREE HUNDRED SIXTY-SIX THOUSAND THREE HUNDRED SEVENTEEN DOLLARS ($366,317.00); SUPPORT BY MARY MAROIS.

Discussion: Mr. Lawson asked about the expenses for the request from 217 Recovery for the Recovery Stories: Message of Hope Series. He noted that $9,000 was requested for food and

catering and an additional $3,600 for printing, decorations, drinks and desserts. Mr. Lawson asked for assurance that the event involves more than supplying food. Mr. Freedman disclosed that he works with 217 Recovery on these events, which are attended by approximately 150 people including children and families of individuals in recovery. Mr. Freedman called it a "valuable community service." It was also noted that the request is for three sessions so the cost per session is $5,500 ($3,000 for food and $1,200 for printing, decorations, drinks and desserts). Clarification was made that speakers do not receive a fee. NMRE staff verify billing against the project's budget.

ROLL CALL VOTING TOOK PLACE ON MR. FREEDMAN'S MOTION.

"Yea" Votes:	R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, D. Tanner, C. Varner
"Nay" Votes:	Nil
Abstention:	R. Iseler

MOTION CARRIED.

FY26 PIHP Contract
On September 10, 2025, the FY26 Contract was issued to the 10 PIHPs by the Bureau of Grants and Purchasing. Key changes include the elimination of Community Behavioral Health Clinics (CCBHC) language and the removal of Recovery Incentive Pool language (as those programs will no longer be funded through the PIHP), the addition of language to outline recovery and monthly reporting of provider overpayments, revised OIG reporting requirements, and the addition of a provision to require, upon Contract cancelation or expiration, that any funds remaining in the ISF, and all of the related claims and liabilities be returned to the state.

Mr. Kurtz noted that the FY26 Contract was released without negotiations. The NMRE intends to strike language related to the ISF as in the previous year and return a signed Contract to the Department. The NMRE will add the prior Contract language stating that any remaining ISF funds would be transferred to a successor agency.

Mr. Freedman asked what is included in the OIG reporting requirements. Mr. Kurtz responded that the PIHP is required to track overpayments, underpayments, questions about complaints, resolutions of grievances and appeals, suspicions of fraud, waste, and abuse, and data mining activities. The change to the contract requires the PIHP to report details of all overpayments identified, recovered, and adjusted monthly.

NMRE CEO Evaluation and Contract
The NMRE Executive Committee met earlier on this date to review the NMRE Chief Executive Officer FY25 Evaluation Report and contract terms. The FY25 CEO Evaluation Survey Report was distributed to Board members during the meeting. The decision was made to offer Mr. Kurtz a 2.5% cost of living adjustment (COLA) for FY26, which is the same amount that has been budgeted for NMRE staff; Ms. Yockey confirmed that both increases are included in the FY26 budget.

MOTION BY DON SMELTZER TO APPROVE A TWO AND A HALF PERCENT (2.5%) COST OF LIVING ADJUSTMENT TO THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUTIVE OFFICER'S SALARY FOR FISCAL YEAR 2026 CONTINGENT ON THE SAME PERCENTAGE FOR NORTHERN MICHIGAN REGIONAL ENTITY STAFF; SUPPORT BY JAY O'FARRELL. ROLL CALL VOTE.

"Yea" Votes:	R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, D. Smeltzer, D. Tanner, C. Varner
"Nay" Votes:	Nil
Abstention:	R. Iseler

MOTION CARRIED.

FY26 NMRE Board Meeting Schedule
The proposed meeting schedule for fiscal year 2026 was included in the meeting materials. It was noted that the Board often opts to forego the November and December meetings as they conflict with the Thanksgiving and Christmas holidays and, instead, hold a combined meeting between the two dates. The decision was made to not hold a meeting in November and move the December meeting date to December 3, 2025.

MOTION BY ERIC LAWSON TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS MEETING SCHEDULE FOR FISCAL YEAR 2026; SUPPORT BY DON SMELTZER. MOTION CARRIED.

The FY26 meeting schedule will be posted on the NMRE website calendar.

OLD BUSINESS
Northern Lakes Lookback and Update
In follow-up to conversations that occurred during the August 13th Executive Committee meeting and August 27th Board meeting, Mr. Kurtz and Ms. Yockey met with Northern Lakes' Board Chair Greg McMorrow, Medical Director and Interim CEO Curt Cummins, and Chief Financial Officer, Kevin Hartley on September 11, 2025 regarding the FY18 – FY22 cost misallocation lookback conducted by Rehmann and the close out of FY23 and FY24.

Based on findings from the Rehmann report, funds due to Northern Lakes for the cost settlement of fiscal years 2023 and 2024 are offset by what is owed to NMRE based on the Cost Misallocation Lookback. The net difference between the cost misallocation ($11,164,302 owed to NMRE) and cost settlement ($10,065,474 owed to Northern Lakes) is $1,098,828 owed to NMRE from Northern Lakes.

During the Northern Lakes CMHA Board meeting on August 21st, however, the Board disagreed with Rehmann's process of applying a weighted average percent of the questioned costs for fiscal in fiscal years 2018 and 2019. As a result, a motion by Northern Lakes CMHA was passed requesting that the 2018 and 2019 results be stricken pending review of the Rehmann assessment by Roslund, Prestage, and Co. The NLCMHA Board passed a second motion to deduct the amount owed to the NMRE for fiscal years 2018 and 2019 ($4,139,139) from the findings and request $3,040,311 from the NMRE. This request was reiterated by Mr. McMorrow during the meeting on September 11th.

Because the cost misallocation lookback was conducted at the request of the NMRE Board, Mr. Kurtz stressed that any decisions on the matter must be made by the Board.

Mr. Freedman reported that Northern Lakes is working diligently to "right the ship." A balanced budget was passed for FY26, an offer will be made to hire Lynda Zeller as the new CEO, staff have been reduced, and senior management salaries have been cut. Mr. Freedman implored the Board to consider the request.

Mr. Kurtz clarified that Standard Cost Allocation principles have always been in place. The issue with Northern Lakes isn't how costs were allocated within Medicaid; it is charging Medicaid for physical health through the Integrated Health Clinic, MIChoice program, or other grants. Administrative costs for these (non-Medicaid) programs or programs outside of the behavioral health shared risk contract, which is not allowed.

MOTION BY DAVE FREEDMAN TO PAY NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY THE DIFFERENCE BETWEEN THE FISCAL YEAR 2020 THROUGH 2022 COST MISALLOCATION CHARGES LESS THE FISCAL YEAR 2023 AND 2024 CLOSEOUT PAYMENTS DUE TO NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY IN THE AMOUNT OF THREE MILLION FORTY THOUSAND THREE HUNDRED ELEVEN DOLLARS ($3,040,311.00) WITH THE UNDERSTANDING THAT NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY WILL NOT PURSUE ANY FURTHER REVIEW OF FISCAL YEARS 2018 THROUGH 2022; SUPPORTED BY DON SMELTZER.

Discussion: Mr. Tanner acknowledged that the Board previously moved to task Rehmann with conducting a five- to seven-year cost allocation lookback; he would like to see the job finished. It was noted that the information needed to complete the lookback for FY18 and FY19 is in Cadillac basement. Mr. Smeltzer stressed the need to weigh the cost of obtaining the information against the cost of having the information. Mr. Adrian asked whether paying the $1M owed to the NMRE would put Northern Lakes into a financial crisis. Mr. Freedman responded that the impact would be significant.

Mr. O'Farrell asked whether there is any assurance that passing Mr. Freedman's motion will put the matter to rest. Mr. Kurtz responded that the State Audit Division has the final say and could request the findings for FY18 and FY19, but it is unlikely. Clarification was made that the state has a copy of the Rehmann forensic report.

ROLL CALL VOTING TOOK PLACE ON MR. FREEDMAN'S MOTION.

"Yea" Votes:	R. Adrian, D. Freedman, G. Klacking, M. Marois, J. O'Farrell, R. Pilon, D. Smeltzer. C. Varner
"Nay" Votes:	E. Ginop, D. Labar, E. Lawson, M. Newman, D. Tanner
Abstention:	R. Iseler

MOTION CARRIED.

FY25 PIHP Contract Injunction and Complaint Update
The complaint filed by Taft, Stettinius & Hollister, LLP, on behalf of Northcare Network Mental Health Care Entity, Northern Michigan Regional Entity, Community Mental Health Partnership of

Southeast Michigan, and Region 10 PIHP (Plaintiffs) against the State of Michigan, State of Michigan Department of Health and Human Services, a Michigan State Agency, and its Director, Elizabeth Hertel, in her official capacity (Defendants) is currently in a waiting period pending the appointed judge's decision.

A separate injunction related to the PIHP RFP was filed by Christopher Ryan (Taft, Stettinius & Hollister, LLP) in the Court of Claims on August 28, 2025 on behalf of Region 10 PIHP, Southwest Michigan Behavioral Health, Mid-State Health Network, St. Clair County Community Mental Health Authority, Integrated Services of Kalamazoo, And Saginaw County Community Mental Health Authority (Plaintiffs) against State of Michigan, State of Michigan Department of Health And Human Services, a Michigan State Agency, and State of Michigan Department of Technology, Management & Budget, a Michigan State Agency (Defendants). An evidentiary hearing has been scheduled for October 9, 2025, at which time a decision will be made on whether the injunction will move forward.

The NMRE, along with NorthCare Network CNHSPs, intend to move forward with an injunction filing of its own.

Clarification was made that the PIHP RFP is due October 13, 2025.

PRESENTATION

NMRE FY26 Budget

The NMRE's proposed budget for FY26 was included in the meeting materials.

The total operating revenue for FY26 was projected as $285,864,323, which represents a 4% increase from FY25. Total FY26 expenses were projected as $ 277,275,713, which represents a 3.7% increase from FY25. The projected FY26 surplus was provided as $1,530,487.

To calculate the PMPM projections, NMRE CFO, Deanna Yockey, took the YTD August PMPM and estimated September for FY25 annual PMPM. This figure was then added to the anticipated FY26 rate increase provided by draft Milliman rates. FY26 CMHSP funding was provided as:

Centra Wellness	North Country	Northeast MI	Northern Lakes	Wellvance
$21,222,217	$64,244,320	$38,673,889	$76,410,550	$34,084,370

MOTION BY DON TANNER TO APPROVE THE PROPOSED NORTHERN MICHIGAN REGIONAL ENTITY FISCAL YEAR 2026 BUDGET, SUPPORT BY CHUCK VARNER. ROLL CALL VOTE.

"Yea" Votes:	R. Adrian, D. Freedman, E. Ginop, G. Klacking, D. Labar, E. Lawson, M. Marois, M. Newman, J. O'Farrell, R. Pilon, D. Smeltzer, D. Tanner, C. Varner
"Nay" Votes:	Nil
Abstention:	R. Iseler

MOTION CARRIED.

COMMENTS

Board

- Ms. Marois asked what will happen if the State doesn't pass an approved budget by October 1, 2025. Mr. Kurtz responded that a continuation budget is likely.
- Ms. Marois voiced appreciation for the support that the NMRE Board has given to Northern Lakes CMHA and its Board. Mr. Lawson noted that although he voted against the motion to approve the $3,040,311 payout to Northern Lakes, he still supports the organization and the Board.
- Mr. Freedman reported that Northern Lakes' Board voted to draft a letter to the Governor and Attorney General in opposition of the privatization of the PIHPs, with a copy sent to MDHHS. Leelanau County also passed a resolution opposing the same. Other counties are also receptive to passing similar resolutions.
- Mr. Tanner shared that he heard on the news that HIV infections are up 214% in northern Michigan, primarily due to intravenous drug use.
- Mr. Tanner relayed the story of a 19-year-old who escaped 8-year captivity in his parents' basement by walking into War Memorial. Reports state that there are other children in the home. The parents have not been located.

Staff/CMHSP CEOs

- NMRE staff thanked the Board for approving the 2.5% cost of living increase for NMRE staff that was included in the FY26 budget.
- Mr. Babbitt welcomed Lynda Zeller to the region.
- Mr. Johnston reported that Manistee County intends to enjoin the pending lawsuit on behalf of the region's CMHSPs.
- Ms. Otremba attended a recent CMHAM Legislative and Policy Committee meeting Over 8,000 Call to Action letters have been sent to legislators, the Governor, and Lt. Governor opposing the PIHP bid out. CMHAM has revised, and is distributing, an advocacy video that has been effective in the past.

NEXT MEETING DATE

The next meeting of the NMRE Board of Directors was scheduled for 10:00AM on October 22, 2025.

ADJOURN

Let the record show that Mr. Klacking adjourned the meeting at 11:43AM.

MOTION BY CHUCK VARNER TO ADJOURN THE SEPTEMBER 24, 2025 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY ED GINOP. MOTION CARRIED.

Email Correspondence

Subject: Proposed PIHP procurement boilerplate and emerging concepts for system redesign
Date: Friday, September 19, 2025 2:56:43 PM

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Proposed PIHP procurement boilerplate and emerging concepts for system redesign

Over the last several weeks, as Alan talks with legislators and Alan and I talk with our allies in the large and growing coalition opposing the PIHP contract bid out, a number of opportunities for halting or pausing the bid out have emerged.

BOILERPLATE LANGUAGE: Through Alan's work with key legislative leaders and in partnership with Senator Stabenow we are seeing a potential for boilerplate language (language attached to an appropriations bill) to halt or staff the current PIHP contract bid out process.

There are two boilerplate options that have emerged during these discussions, each with their own strengths and weaknesses. Both of those options – the newly emerging language and the language proposed by CMHA and allies several weeks ago – are outlined below. For legislators of both parties, the motivation for introducing and passing this boilerplate language stems from two concerns: concerns around the movement of the management of state's public mental health system to private health insurance companies and concerns over this effort, by MDHHS, to bypass the legislature and unilaterally restructure more than $4 billion in mental health funding and put new contracts in place 30 days before the next election for the next Governor.

We will let you know the status of the consideration and introduction of these boilerplate additions over the next several weeks.

1. NEW Language to pause RFP and form a workgroup

PIHP Procurement – Sec. 1009.

(1) From the funds appropriated in part 1, the department shall pause and withdraw the request for proposal process for PIHPs during the current fiscal year. In place of continuing the request for proposal process as currently designed, the department shall convene a workgroup comprised of key stakeholders, including but not limited to representatives of the Community Mental Health Association of Michigan, mental health providers, statewide advocacy groups, and the Michigan Association of Counties. The workgroup shall review the current PIHP system and make recommendations on ways to improve the system, with the goal of ensuring a simplified, workable structure that improves behavioral health outcomes. The workgroup's recommendations shall address at least all of the following factors:

(a) Improved behavioral health outcomes.
(b) Conflict of interest provisions.
(c) Uniform contractual and benefit standards.
(d) Increased accountability and transparency for payers and providers.
(e) Reduced administrative overhead costs.

(2) Not later than April 1 of the current fiscal year, the workgroup shall submit a report to the department and the standard report recipients. The report shall include the workgroup's findings and detailed recommendations for improving the existing PIHP system. These recommendations shall be based on the review described in subsection (1) and address, at a minimum, the factors outlined in that subsection, with the goal of creating a simplified and workable structure that strengthens behavioral health outcomes.

(3) The department shall not implement any substantive changes to the PIHP system or move forward with a new procurement process without the express approval of the legislature.

2. Original language we gave legislators to prohibit RFP process (we previously sent this

Sec. XXX. Prohibition on Competitive Procurement for PIHP Contracts

(1) From the funds appropriated in part 1 for Medicaid mental health services and managed care functions, the department shall not expend funds for the planning, development, issuance, implementation, or evaluation of any request for proposals (RFP), request for qualifications (RFQ), or any other procurement process intended to competitively bid, re-bid, or otherwise solicit proposals for contracts relating to the functions currently performed by the Pre-Paid Inpatient Health Plans (PIHPs).

(2) The department shall not take any action to alter, dissolve, or reorganize existing PIHPs for the purpose of implementing a new managed care model for specialty behavioral health services.

(3) The department shall continue to contract with existing PIHPs, in their current governance and operational structure, for the administration of specialty behavioral health services and supports as outlined in the state's Medicaid plan.

(4) This section does not preclude the department from working collaboratively with PIHPs and Community Mental Health Services Programs (CMHSPs) to identify and implement reforms that improve access to care, reduce administrative burden, support workforce development, or enhance service quality—so long as those reforms do not require or initiate a procurement process as described in subsection (1).

(5) Any attempt to circumvent this prohibition shall be considered a violation of legislative intent and subject to legislative oversight and enforcement action.

COMPONENTS OF ALTERNATIVE SYSTEM DESIGN: As you may remember, CMHA and the members of the diverse coalition opposing the bid out have made two points at the core of our advocacy work. In fact, it is this two part message that has brought, to the coalition, the state's major advocacy groups, MAC, other state and local officials and organizations, and a number of key legislative allies. Those two points – points that you have seen over the past several months echoing themes that were first sounded in 2016 with the original Section 298 privatization threat - are:

1. The current system needs to be boldly and dramatically restructured (with alternate structure models proposed by all of us, the state's advocacy groups, and our allies) while keeping core principles and system design elements intact
and
2. This procurement plan is not the way to get to such restructuring (this message brought home with strong political and legal opposition to the plan).

The first boilerplate language proposal, above, underscores these two messages and echoes the call by CMHA, its members, and our allies, for a collaborative development of a redesigned system in lieu of the RFP process.

As our allies in the Administration and the State Legislature work to oppose the RFP and foster this collaborative approach, they have asked for a preliminary set of concepts that would serve as the foundation for the collaborative effort which we are seeking. They need this set of concepts to be clear enough to give guidance in the redesign of the system and broad enough to appeal to key allies in this effort – the state's major advocacy groups who have joined in this opposition effort, the Michigan Association of Counties, and CMHA. The development of this broad set of concepts has been the work of CMHA, MAC, and several advocacy organization allies. It draws from proposals that all of these parties have put forth, in the past, and reflects both synergy and compromise.

We hope to have this set of concepts completed, by the coming week, for our use with allies in the Administration and the State Legislature. This set of concepts will be sent to you in advance of our use with these allies.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
2nd Floor
507 South Grand Avenue
Lansing, MI 48933
517.374.6848 main
517.237.3142 direct
www.cmham.org

The Detroit News
SERVING MICHIGAN SINCE 1873

MICHIGAN

Privatizing state's mental health services is meant to aid care. Critics fear the opposite

Kara Berg
The Detroit News

Sept. 23, 2025, 11:01 p.m. ET

Lansing — When Bethany Boik found herself with no insurance at 18, her only option for treatment for her schizoaffective disorder was to go to a Wayne County Community Mental Health office.

There, the treatment she desperately needed was affordable for her, partially paid by the state.

More than 15 years later, Boik, 34, said she has built up a network of mental health providers who help her keep her life on track — and help keep her alive. Without CMH, she said, she doesn't know what her care — or her life — would look like.

"To think at any moment I could lose the people who helped keep me alive in a period where I didn't have anyone ... it's scary," said Boik, who lives in Wayne County. "You're threatening to take away the only things I have left to keep me whole."

Losing some CMH services is a real possibility, mental health advocates said, as the Michigan Department of Health and Human Services is allowing private outfits in addition to public entities to apply to handle its Prepaid Inpatient Health Plans, which are responsible for behavioral health and intellectual/developmental disabilities services for Medicaid and Healthy Michigan enrollees.

The state issued a request for proposals Aug. 5 under this plan that opponents have labeled privatization, but which state health department officials reject. Officials said they had reports of inconsistent service and were looking for improvements. The bids are due back Sept. 29.

Mental health services in Michigan are coordinated through local Community Mental Health Service programs and nonprofits across the state, large agencies that often handle millions of dollars in funding from a range of sources, such as Medicaid health care for low-income residents, and serve thousands of residents.

The Detroit Wayne Integrated Health Network, the primary agency for mental health services in Wayne County, has an approximately $1 billion budget and serves about 123,000 children and adults in the county, according to its website. The Oakland County Health Network has a budget of roughly $300 million and serves about 30,000 people.

Community mental health agencies offer services for those with mental health issues, developmental disabilities, and substance use disorders.

State officials said expanding its Prepaid Inpatient Health Plans to include outside private providers to deliver such care could improve services.

Department of Health and Human Services spokesperson Lynn Sutfin said the department is committed to "ensuring that Medicaid beneficiaries in Michigan have timely access to high-quality behavioral health care services.

Expanding the plans to be serviced by private companies will improve service quality, increase accountability and enhance administrative efficiency across the system, starting in fiscal year 2027, which begins Oct. 1, 2026, she said. The Department of Health and Human Services is committed to "ensuring that Medicaid beneficiaries in Michigan have timely access to high-quality behavioral health care services," Sutfin said.

But any privatization being pursued by the administration of Democratic Gov. Gretchen Whitmer will do the opposite, said the critics, who include fellow Democrats.

Jeff Patton, the CEO of Integrated Services of Kalamazoo, called the proposed changes "radical and careless," and said they will disrupt care for many people served by the public CMH system. He said the state department has made it pretty much impossible for a public entity to submit a bid.

"This does not mean that we are opposed to meaningful ways to improve and bring about changes to the public Community Mental system," Patton said. "In fact, some of us have proposed changes to the system, but we firmly oppose the privatization of Michigan's community mental health system to bring about this change."

The governor's office didn't immediately respond for comment Tuesday.

State: Care interruptions won't happen

Michigan has 10 Prepaid Inpatient Health Plans, divided up by region. The plans manage provider networks, including Community Mental Health programs, and behavioral health providers. They monitor network providers to ensure Medicaid funds are used properly, according to the Michigan Department of Health and Human Services. One PIHP manages each region, so providers can either contract with the PIHP or not provide services to Medicaid recipients.

The state issued its request for proposals following extensive feedback collected earlier this year from 2,500 Medicaid beneficiaries, family members, advocacy organizations, community-based groups and other stakeholders, Sutfin said.

"Respondents cited fragmentation, service inconsistency, and lack of accountability as persistent issues within the existing 10-region PIHP structure," she said in an emailed statement to The Detroit News.

The competitive bidding process is designed to address these concerns by creating a more "unified, transparent and balanced system," Sutfin said.

"The state is still committed to maintaining the public foundation of behavioral health care in Michigan," she said.

"The (request for proposals) preserves the system's 'carve-out' structure, restricts eligibility to nonprofit entities and gives preference to proposals submitted by public or public-private partnerships," she added.

Kristen Morningstar, the state bureau administrator of the department's Bureau of Specialty Behavioral Health Services, wrote in an affidavit to the Michigan Court of Claims in response to a lawsuit filed by three PIHPs and three CMH agencies that, with the timeline of the request for proposals, "beneficiary services and continuity of care will not be interrupted."

What privatization could change

At a rally last week on the steps of the state Capitol in Lansing, hundreds from all over the state gathered to speak out about the privatization plan facing community mental health agencies. The "Walk a Mile in My Shoes" rally was organized by the Community Mental Health Association of Michigan.

Boik read slam poetry at the rally as she wore red heeled boots. On her left boot, she taped little pieces of paper with the reasons she needed help from CMH: Complex-Post Traumatic Stress Disorder, fear, voices, poverty, violence, schizoaffective, pain and assault.

On her right, she wrote the services that have helped her in her recovery and kept her alive: Art therapy, writing, found family, her psychiatrist, the right medications, love, her case manager and gratitude.

"If privatization happens, my continuity of care might be altered," Boik said. "If an insurance company is in charge of my services, I worry my umbrella of care would

not be there to meet my needs. ... How will my care change if, at the end of the day, the corporation decides it wants to make money?"

Kevin Fischer, the executive director of the National Alliance on Mental Illness in Michigan, said during a press conference prior to last week's rally that while Michigan's public behavioral health system is not perfect, it's not broken.

"This request for proposals process doesn't help us achieve those issues we want to address," Fischer said. "Self-determination, person-centered planning, all the things that private organizations don't understand, that's what's most important to us."

The state health department remains committed to maintaining the public foundation of behavioral health care in Michigan, Sutfin said. The bid process preserves the system's "carve-out" structure, which means giving the responsibility of some aspects of care, like substance abuse, to an outside entity, she said. It also restricts the eligibility for bids to nonprofit entities and gives a preference to proposals submitted by public or public-private partnerships.

Critics of the state's plan, such as the Community Mental Health Association of Michigan, said the proposal will create a more bureaucratic and costly framework of services that fails to address the real concerns, such as adequate funding for the public behavioral health system and the need to fix the shortage of mental health and substance use providers.

Teresa Dannon, 54, of Madison Heights, said she depends on the services of Easterseals Disability and Community Services, a Chicago-based nonprofit with locations across the country, for the care of her 31-year-old son, Dannon Scott, who has autism.

Going private would mean Scott's care would turn to "what they give him, and not what's best for him," Dannon said, and may rob him of his ability to choose how his own care is handled.

Doctors said Scott would never walk or talk, Dannon said, but now he has his high school diploma and has become a mentor, advocate and public speaker. He lives a semi-independent life because of the services he's received, she said.

"I think he'd be limited (without those services) and that's what we don't want, because he already has those limitations on him," Dannon said. "He's doing well in life. ... I don't want privatization to ruin that."

Why the state is seeking change

Three existing PIHPs and three community mental health agencies filed a lawsuit Aug. 29 in the Michigan Court of Claims against the state Department of Health and Human Services and the state, alleging the state is unlawfully attempting to eliminate the statutory authority of community mental health programs to serve as PIHPs.

The state asked a Court of Claims judge to dismiss the case because the lawsuit ignores that the state health department has the power under state law to choose which entities will serve as PIHPs.

The department that later became the Michigan Department of Health and Human Services switched to its current mental health management method in 1998, which temporarily waived the federal requirement that Medicaid managed plans be competitively bid, Attorney General Dana Nessel's office argued in its motion to dismiss the suit. The state now believes the move to competitive procurement is in the public's interest, Nessel's office said.

The request for bids does not prevent the current PIHP regions from forming a new entity and submitting a bid, and it has no effect on the existence of the CMH organizations throughout Michigan, Nessel's office argued for the state health department. Whichever organizations end up as PIHPs must contract with CMH to provide specialty services and support, the state said.

Morningstar, the state bureau administrator of the Bureau of Specialty Behavioral Health Services, wrote in an affidavit to the Court of Claims that moving to a competitive procurement of PIHPs is in the public's interest because half of the state's PIHPs declined to sign contracts with the state starting in fiscal year 2025, from Oct. 1, 2024, to Sept. 30, 2025.

The five PIHPs the state says didn't sign the contract did so because the state added several unnegotiated amendments that they did not agree with, said Community Mental Health Association of Michigan CEO Bob Sheehan. This included uneven pay raises for care workers and no guarantee the state would pay the rate difference and reducing the risk reserve below what actuaries determined was needed.

Sheehan added that the five PIHPs did sign their original, negotiated contract with the state, but the state refused to sign that one.

The transition clause of the latest contract they signed runs through September 2026, so the state determined changes were necessary to ensure beneficiaries are covered under an active contract, Morningstar wrote.

The administrator also said the PIHPs are not effectively overseeing whether CMH is providing medically necessary services. Separating the PIHPs and CMH will eliminate any conflicts of interest, Morningstar wrote.

The federal government will not approve Michigan's behavioral health Medicaid waiver until Michigan takes drastic steps to fix the conflict of interest problems, she said. This puts the state at risk of losing federal Medicaid funding.

Local advocates push back

Macomb County Commissioner Antoinette Wallace said the state Department of Health and Human Services never really explained why its proposal is necessary. The proposal would shift the control of 90% of funding from county-based public entities to commercial or private ones that would have no direct accountability to residents, the Mount Clemens Democrat said.

“We probably acknowledge that no program or system is ever perfect, like we heard, but all of us in public life have to keep listening, keep your ears open, keep looking, keep trying to improve," Wallace said. "That's what we are doing. If you have someone in private, I think we've learned that their ears are pretty closed.”

The Macomb County Board of Commissioners passed a resolution in August opposing the state's proposal.

Tree Myers, a client services specialist with Clinton Eaton Ingham Community Mental Health, said the bottom line should be people's well-being, not the making of a profit.

"I've not spoken with anyone who believes that those with enough money need to make more money at the expense of our communities," Myers said. "But privatization injects this debilitating motive into the system, and in turn, diminishes the resources, purpose and mission of CMH."

Former U.S. Sen. Debbie Stabenow, D-Lansing, said the state's plan is going to take Michigan's behavioral health resources in the wrong direction. She urged the department run by Whitmer's administration to pause the proposal so it can evaluate the impact federal cuts will have on services, as well as listen to families, providers and those who need the services themselves about what they think would improve the system.

The proposal would replace a managed care system that is transparent and takes about 2% in overhead costs to run with one that is not transparent and would take about 15% in overhead costs, resulting in $500 million in additional costs, said Stabenow, who was a mental health advocate during her time in Congress.

"What we should be doing is working together right now to pause this process, go back to the drawing board and to find ways to really solve these problems without adding costs or risking service," Stabenow said. "Are there serious gaps in our public mental health system? Yes. Is the MDHHS solution the right one? No."

Rep. Carrie Rheingans, D-Ann Arbor, said she worries that if private companies manage the money for behavioral health care the way they do for physical health care, people would lose access to the care they need.

"At the end of the year, they want to make a profit, so their incentive is to deny physical health care to make sure that they keep that profit," Rheingans said. "There's not savings to be had in behavioral health care, the way there could potentially be in physical health care."

Rheingans expressed frustration that the state health department chose to do this without any input from legislators.

"Right now, in September of 2025, when we have not even a year and a half left of Gov. Whitmer's administration, I just don't think it's right for her to walk out the door and leave us holding the bag with no accountability if this doesn't even work," she said.

kberg@detroitnews.com

Email Correspondence

Subject: Third leg of advocacy strategy against privatization: alternative system design components open door to collaborative process
Date: Thursday, September 25, 2025 10:46:45 AM

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Third leg of advocacy strategy against privatization: alternative system design components document

CORE COMPONENTS OF ADVOCACY EFFORT AGAINST PRIVATIZATION: As you may remember, the advocacy strategy of CMHA, its members, and allies has a three-part action platform:

- Political action: strong opposition to the RFP being pursued (including political and media efforts) recognizing that the RFP can be withdrawn by MDHHS at any time.
- Legal action
- Development of models, by CMHA members, that retain the strength of the public system for use as alternatives to the RFP-driven system redesign approach or, if we are unsuccessful in halting the RFP process, as bids in response to the RFP

In the most recent updates on our collective advocacy efforts – provided in a series of emails over the past few weeks and the live update earlier this week (attended by over 100 CMHA members and Board members) – we discussed the progress on these three fronts.

Below is an update on the work of CMHA and a core group of loyal allies on the alternative system design front – the third leg of three-part strategy.

COMPONENTS OF ALTERNATIVE SYSTEM DESIGN: As you may remember, CMHA and the members of the diverse coalition opposing the bid out have made the two messages, listed below, the core of our advocacy work**. In fact, it is this two-part message that has brought to the coalition, the state's major advocacy groups, MAC, other state and local officials and organizations, and a number of key legislative allies.** Those two points – points that you have seen over the past several months echoing themes that were first sounded in 2016 with the original Section 298 privatization threat - are:

1. The current system is more than willing to co-design bold changes to Michigan's public mental health system (with alternate structure models proposed by the leaders of the public system, persons served,, the state's major advocacy groups, Michigan counties, and our allies) while keeping and strengthening core principles and system design elements intact

and

2. The MDHHS procurement plan is not the way to get to such restructuring (this message brought home with strong political and legal opposition to the plan).

The proposed boilerplate language, referenced in our earlier email and during the recent live update, and CMHA's advocacy tools underscore these two messages and echoes the call by CMHA, its members, and our allies, for a

collaborative development of a redesigned system in lieu of the RFP process.

As our allies in the Administration and the State Legislature work to oppose the RFP and foster this collaborative approach, they have asked for a preliminary set of concepts that would serve as the foundation for the collaborative effort which we are seeking. **They indicated that they needed a set of concepts that were clear enough to give guidance in the redesign of the system and broad enough to appeal to key allies in this effort – the state's major advocacy groups who have joined in this opposition effort, the Michigan Association of Counties, persons served, Legislative allies, and CMHA.**

In response to this request – a request with a narrow time window given the fast approaching RFP close date - a broad set of system design concepts has been developed by CMHA, MAC, and several advocacy organization allies. The document, attached, outlining these design elements:

- Draws from proposals that CMHA members, CMHA, and all of these parties have put forth in the past (Many of you will recognize themes, in this document, that CMHA and its members have developed since the earliest privatization threats, a decade ago, and echoed every year since)
- Keeps and strengthens core principles and system design elements intact
- Reflects both the convergence of views and compromise among this group of allies

The document that resulted from these discussions is attached and outlines broad design elements and **is intentionally not detailed** – **leaving the details to be developed and even some of these broad concepts to be refined in the collaborative process that is the aim of our advocacy efforts.**

This document is intended to provide our allies in the Administration and in the State Legislature with a **broad set of system design elements to serve as a counterweight to the MDHHS bid out approach and serve to open the door for this collaborative process to be pursued in lieu of the RFP process.**

We will keep you informed as this document is shared with our allies in the Administration and State Legislature. Feel free to share this document as you see fit.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
2nd Floor
507 South Grand Avenue
Lansing, MI 48933
517.374.6848 main
517.237.3142 direct
www.cmham.org

Recommended components of a redesigned public mental health system in Michigan

The following recommended components provide a preliminary structure around which a more robust and system redesign effort would be built. It is recommended that this redesign effort be a collective effort involving representatives from MDHHS, Michigan's major advocacy groups, persons served by Michigan's public mental health system, the Michigan Association of Counties (MAC), CMHA [with CMHA representatives drawn from the state's Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHP), and providers in the CMHSP and PIHP networks].

Identity of Medicaid behavioral health plan or plans[1]

Public Medicaid behavioral health plans formed via collaboration of the counties and the state of Michigan. (via any of a number of mechanisms: multi-county authority, Urban Cooperation Act, Regional Entity section of the Michigan Mental Health Code)

These bodies would not circumvent the authority of the counties forming this body.

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

Governance of public Medicaid behavioral health plan

Membership of governing board: 1/3 persons served and/or families (1/2 of which are persons served); Several members of major statewide advocacy groups. Remainder of board appointed to ensure that the interests of the counties served by this body are pursued and protected.

Appointment of governing board members: appointment by counties with recommendations by knowledgeable parties

Bearing financial risk

A **shared risk arrangement** in which the public Medicaid behavioral health plans and the State of Michigan share the risk.

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

Funding methodology of Community Mental Health Services Programs (CMHSPs)

As per the Michigan Mental Health Code, the CMHSPs, as the mental health/intellectual and developmental disability services hubs in each community, are the only organizations with whom the public Medicaid behavioral health plan will contract and finance for the provision of mental health and intellectual/developmental disability services. As per the Code, the CMHSPs can provide these services directly or through a contract with another party. As per the Code, The public Medicaid behavioral health plan can fund other provider organizations to provide substance use disorder services.

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

A **subcapitation** financing design will be used by the public Medicaid behavioral health plans

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

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

Financial and operational transparency

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

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

System performance and compliance with federal and state statutes, regulations, and Medicaid waivers: Public Medicaid behavioral health plan

Claims payment: Public Medicaid behavioral health plan.

Authorization of services and utilization management: The responsibility for these functions, held by the public Medicaid behavioral health plan and CMHSPs, must ensure that no conflict of interest exists that would foster over-authorization (provision of clinically unnecessary services) nor under-authorization (failure to provide clinically necessary services).

Appeals of authorization decisions: Received and resolved by the public Medicaid behavioral health plan.

Authorization dispute resolution: Persons served with authorization appeals or disputes would be able to request a review by an outside body commissioned by the State of Michigan with ability to fund decisions overturning initial authorization

Provider network management (developing network, holding contracts with providers, ensuring quality of care provided by providers and provider compliance with statutes, regulations, and Medicaid waivers:

CMHSP responsibility as per Michigan Mental Health Code for mental health and intellectual/developmental disability services.

As per the Code, the public Medicaid behavioral health plan can fund other provider organizations to provide substance use disorder services.

Recipient Rights

Hearing and resolving recipient rights appeals: Public Medicaid behavioral health plan would hear and resolve recipient rights appeals **with sufficient recipient rights staff to hear appeals and resolve them**

Initial investigation and resolution of recipient rights complaints: CMHSP responsibility as per Michigan Mental Health Code.

FY2025 Q3 PIHP Final PI Numbers

CMHSP Medicaid Only & SUD All-Funding

04/01/2025 – 06/30/2025

FY2025 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2025 – 06/30/2025

NORTHERN MICHIGAN REGIONAL ENTITY

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	156	148	**94.87%**
Adults	615	607	**98.70%**
Total	**771**	**755**	**97.92%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	296	189	**63.85%**
MIA	488	269	**55.12%**
DDC	113	70	**61.95%**
DDA	38	23	**60.53%**
Total	**935**	**551**	**58.93%**

Table 2b – Access – Timeliness/First Request - Substance Use Disorder

Population	Admissions	Expired	In 14 Days	% In 14 Days
SA	Calculated	384	Calculated	Calculated **%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	232	172	**74.14%**
MIA	327	231	**70.64%**
DDC	103	76	**73.79%**
DDA	37	27	**72.97%**
Total	**699**	**506**	**72.39%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	68	18	50	48	**96.00%**
Adults	202	78	124	119	**95.97%**
Total	**270**	**96**	**174**	**167**	**95.98%**

Table 4b – Access – Continuity of Care - Substance Use Disorder

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
SA	266	132	134	126	**94.03%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	68	0	68	6	**8.82%**
Adults	202	2	200	28	**14.00%**
Total	**270**	**2**	**268**	**34**	**12.69%**

Produced by: Valerie McBain

FY2025 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2025 – 06/30/2025

CWN - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	4	4	**100.00%**
Adults	18	18	**100.00%**
Total	**22**	**22**	**100.00%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	34	27	**79.41%**
MIA	36	28	**77.78%**
DDC	3	2	**66.67%**
DDA	2	2	**100.00%**
Total	**75**	**59**	**78.67%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	24	20	**83.33%**
MIA	21	14	**66.67%**
DDC	2	2	**100.00%**
DDA	3	1	**33.33%**
Total	**50**	**37**	**74.00%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	6	2	4	3	**75.00%**
Adults	12	2	10	10	**100.00%**
Total	**18**	**4**	**14**	**13**	**92.86%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	6	0	6	1	**16.67%**
Adults	12	0	12	5	**41.67%**
Total	**18**	**0**	**18**	**6**	**33.33%**

FY2025 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2025 – 06/30/2025

NCCMH - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	37	32	**86.49%**
Adults	121	116	**95.87%**
Total	**158**	**148**	**93.67%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	58	43	**74.14%**
MIA	111	68	**61.26%**
DDC	50	35	**70.00%**
DDA	8	7	**87.50%**
Total	**227**	**153**	**67.40%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	40	33	**82.50%**
MIA	73	63	**86.30%**
DDC	40	29	**72.50%**
DDA	9	7	**77.78%**
Total	**162**	**132**	**81.48%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	18	3	15	15	**100.00%**
Adults	37	9	28	28	**100.00%**
Total	**55**	**12**	**43**	**43**	**100.00%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	18	0	18	0	**0.00%**
Adults	37	0	37	7	**18.92%**
Total	**55**	**0**	**55**	**7**	**12.73%**

FY2025 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2025 – 06/30/2025

NEMCMH - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	16	14	**87.50%**
Adults	68	65	**95.59%**
Total	**84**	**79**	**94.05%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	27	9	**33.33%**
MIA	44	12	**27.27%**
DDC	1	0	**0.00%**
DDA	3	1	**33.33%**
Total	**75**	**22**	**29.33%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	23	17	**73.91%**
MIA	21	13	**61.90%**
DDC	4	3	**75.00%**
DDA	4	2	**50.00%**
Total	**52**	**35**	**67.31%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	5	1	4	3	**75.00%**
Adults	15	1	14	14	**100.00%**
Total	**20**	**2**	**18**	**17**	**94.44%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	5	0	5	0	**0.00%**
Adults	15	0	15	2	**13.33%**
Total	**20**	**0**	**20**	**2**	**10.00%**

FY2025 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2025 – 06/30/2025

NLCMH - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	61	60	**98.36%**
Adults	325	325	**100.00%**
Total	**386**	**385**	**99.74%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	115	63	**54.78%**
MIA	192	80	**41.67%**
DDC	51	27	**52.94%**
DDA	20	10	**50.00%**
Total	**378**	**180**	**47.62%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	98	62	**63.27%**
MIA	130	70	**53.85%**
DDC	49	35	**71.43%**
DDA	16	13	**81.25%**
Total	**293**	**180**	**61.43%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	28	8	20	20	**100.00%**
Adults	128	64	64	60	**93.75%**
Total	**156**	**72**	**84**	**80**	**95.24%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	28	0	28	2	**7.14%**
Adults	128	2	126	14	**11.11%**
Total	**156**	**2**	**154**	**16**	**10.39%**

FY2025 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2025 – 06/30/2025

Wellvance (formerly AVCMH) - Medicaid Only

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# Less Than 3 Hrs.	% Less Than 3 Hrs.
Children	38	38	**100.00%**
Adults	83	83	**100.00%**
Total	**121**	**121**	**100.00%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	In 14 Days	% In 14 Days
MIC	62	47	**75.81%**
MIA	105	81	**77.14%**
DDC	8	6	**75.00%**
DDA	5	3	**60.00%**
Total	**180**	**137**	**76.11%**

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	In 14 Days	% In 14 Days
MIC	47	40	**85.11%**
MIA	82	71	**86.59%**
DDC	8	7	**87.50%**
DDA	5	4	**80.00%**
Total	**142**	**122**	**85.92%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
Children	11	4	7	7	**100.00%**
Adults	10	2	8	7	**87.50%**
Total	**21**	**6**	**15**	**14**	**93.33%**

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	Readmit In 30 Days	% Readmit In 30 Days
Children	11	0	11	3	**27.27%**
Adults	10	0	10	0	**0.00%**
Total	**21**	**0**	**21**	**3**	**14.29%**

FY2025 – Q3 PIHP Final PI Numbers - Medicaid Only

04/01/2025 – 06/30/2025

Substance Use Disorder

Table 2b – Access – Timeliness/First Request - Substance Use Disorder

Population	Expired
SA	384

Table 4b – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	In 7 Days	% In 7 Days
SA	266	132	134	126	**94.03%**

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

	Percentage	Number of Emergency Referrals for Children	Number Completed in Three Hours for Children
Detroit Wayne Mental Health Authority	98.27	753	740
Lakeshore Regional Entity	99.48	381	379
Macomb Co CMH Services	92.03	276	254
Mid-State Health Network	98.71	927	915
NorthCare Network	100.00	56	56
Northern MI Regional Entity	94.87	156	148
Oakland Co CMH Authority	99.69	325	324
Region 10	99.64	278	277
CMH Partnership of Southeast MI	100.00	178	178
Southwest MI Behavioral Health	99.12	228	226
Statewide Total		**3,558**	**3,497**

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

	Percentage	Number of Emergency Referrals for Adults	Number Completed in Three Hours for Adults
Detroit Wayne Mental Health Authority	97.20	2,426	2,358
Lakeshore Regional Entity	99.07	1,504	1,490
Macomb Co CMH Services	94.76	993	941
Mid-State Health Network	99.68	2,499	2,491
NorthCare Network	100.00	268	268
Northern MI Regional Entity	98.70	615	607
Oakland Co CMH Authority	95.14	1,441	1,371
Region 10	97.77	941	920
CMH Partnership of Southeast MI	98.72	623	615
Southwest MI Behavioral Health	99.74	756	754
Statewide Total		**12,066**	**11,815**

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

	Percentage	# of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	56.14	3,162	1,775
Lakeshore Regional Entity	68.37	1,350	923
Macomb Co CMH Services	55.38	901	499
Mid-State Health Network	59.52	3,982	2,370
NorthCare Network	59.74	534	319
Northern MI Regional Entity	58.93	935	551
Oakland Co CMH Authority	49.14	928	456
Region 10	57.96	2,186	1,267
CMH Partnership of Southeast MI	45.50	1,156	526
Southwest MI Behavioral Health	74.19	2,383	1,768
Statewide Total		**17,517**	**10,454**

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

	Percentage	# MI Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	60.13	755	454
Lakeshore Regional Entity	63.33	559	354
Macomb Co CMH Services	47.92	265	127
Mid-State Health Network	61.92	1,334	826
NorthCare Network	61.50	200	123
Northern MI Regional Entity	63.85	296	189
Oakland Co CMH Authority	42.73	344	147
Region 10	57.91	613	355
CMH Partnership of Southeast MI	54.98	271	149
Southwest MI Behavioral Health	70.00	660	462
Statewide Total		**5,297**	**3,186**

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

	Percentage	# MI Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# MI Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	62.82	1,579	992
Lakeshore Regional Entity	72.14	585	422
Macomb Co CMH Services	68.15	449	306
Mid-State Health Network	62.54	2,213	1,384
NorthCare Network	57.39	291	167
Northern MI Regional Entity	55.12	488	269
Oakland Co CMH Authority	60.08	476	286
Region 10	58.87	1,240	730
CMH Partnership of Southeast MI	40.28	715	288
Southwest MI Behavioral Health	75.36	1,530	1,153
Statewide Total		**9,566**	**5,997**

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

	Percentage	# DD Children Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Children Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	36.57	711	260
Lakeshore Regional Entity	73.11	119	87
Macomb Co CMH Services	33.57	140	47
Mid-State Health Network	32.21	326	105
NorthCare Network	69.23	26	18
Northern MI Regional Entity	61.95	113	70
Oakland Co CMH Authority	25.00	40	10
Region 10	51.39	251	129
CMH Partnership of Southeast MI	51.64	122	63
Southwest MI Behavioral Health	82.27	141	116
Statewide Total		**1,989**	**905**

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

	Percentage	# DD Adults Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# DD Adults Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service
Detroit Wayne Mental Health Authority	58.97	117	69
Lakeshore Regional Entity	68.97	87	60
Macomb Co CMH Services	40.43	47	19
Mid-State Health Network	50.46	109	55
NorthCare Network	64.71	17	11
Northern MI Regional Entity	60.53	38	23
Oakland Co CMH Authority	19.12	68	13
Region 10	64.63	82	53
CMH Partnership of Southeast MI	54.17	48	26
Southwest MI Behavioral Health	71.15	52	37
Statewide Total		**665**	**366**

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

		Admissions			
	Percentage	# of Non-Urgent Admissions to a Licensed SUD Treatment Facility as reported in BH TEDS	# of Expired Requests Reported by the PIHP	Total	# of Persons Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request
Detroit Wayne Mental Health Authority	69.21	3,460	960	4,420	3,059
Lakeshore Regional Entity	70.01	1,406	258	1,664	1,165
Macomb Co CMH Services	94.37	1,101	1	1,102	1,040
Mid-State Health Network	80.43	2,342	208	2,550	2,051
NorthCare Network	67.52	423	125	548	370
Northern MI Regional Entity	59.21	881	384	1,265	749
Oakland Co CMH Authority	81.04	738	127	865	701
Region 10	76.44	1,526	337	1,863	1,424
CMH Partnership of Southeast MI	62.42	805	246	1,051	656
Southwest MI Behavioral Health	70.49	1,091	234	1,325	934
Statewide Total		**13,773**	**2,880**	**16,653**	**12,149**

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

	Percentage	# of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# of Persons Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	93.33	2,624	2,449
Lakeshore Regional Entity	60.92	1,200	731
Macomb Co CMH Services	68.83	648	446
Mid-State Health Network	65.08	3,047	1,983
NorthCare Network	70.59	425	300
Northern MI Regional Entity	72.39	699	506
Oakland Co CMH Authority	98.59	711	701
Region 10	77.47	1,571	1,217
CMH Partnership of Southeast MI	68.79	785	540
Southwest MI Behavioral Health	72.42	2,012	1,457
Statewide Total		**13,722**	**10,330**

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

	Percentage	# MI Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	93.69	650	609
Lakeshore Regional Entity	50.47	531	268
Macomb Co CMH Services	59.20	174	103
Mid-State Health Network	63.26	1,048	663
NorthCare Network	68.45	168	115
Northern MI Regional Entity	74.14	232	172
Oakland Co CMH Authority	96.56	262	253
Region 10	78.33	466	365
CMH Partnership of Southeast MI	65.30	219	143
Southwest MI Behavioral Health	72.48	545	395
Statewide Total		**4,295**	**3,086**

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

	Percentage	# MI Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# MI Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	91.29	1,252	1,143
Lakeshore Regional Entity	64.79	463	300
Macomb Co CMH Services	69.19	344	238
Mid-State Health Network	64.75	1,597	1,034
NorthCare Network	71.69	219	157
Northern MI Regional Entity	70.64	327	231
Oakland Co CMH Authority	99.71	341	340
Region 10	74.05	871	645
CMH Partnership of Southeast MI	66.26	412	273
Southwest MI Behavioral Health	72.36	1,288	932
Statewide Total		**7,114**	**5,293**

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

	Percentage	# DD Children Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Children Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	96.73	611	591
Lakeshore Regional Entity	82.03	128	105
Macomb Co CMH Services	79.05	105	83
Mid-State Health Network	72.20	313	226
NorthCare Network	62.50	24	15
Northern MI Regional Entity	73.79	103	76
Oakland Co CMH Authority	100.00	43	43
Region 10	88.37	172	152
CMH Partnership of Southeast MI	76.72	116	89
Southwest MI Behavioral Health	65.65	131	86
Statewide Total		**1,746**	**1,466**

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

	Percentage	# DD Adults Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services	# DD Adults Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment
Detroit Wayne Mental Health Authority	95.50	111	106
Lakeshore Regional Entity	74.36	78	58
Macomb Co CMH Services	88.00	25	22
Mid-State Health Network	67.42	89	60
NorthCare Network	92.86	14	13
Northern MI Regional Entity	72.97	37	27
Oakland Co CMH Authority	100.00	65	65
Region 10	88.71	62	55
CMH Partnership of Southeast MI	92.11	38	35
Southwest MI Behavioral Health	91.67	48	44
Statewide Total		**567**	**485**

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

	Percentage	# Children Discharged from Psychiatric Inpatient Unit	# Children Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	95.16	62	59
Lakeshore Regional Entity	97.14	105	102
Macomb Co CMH Services	70.79	89	63
Mid-State Health Network	96.18	157	151
NorthCare Network	96.43	28	27
Northern MI Regional Entity	96.00	50	48
Oakland Co CMH Authority	90.38	52	47
Region 10	98.68	76	75
CMH Partnership of Southeast MI	90.38	52	47
Southwest MI Behavioral Health	100.00	91	91
Statewide Total		**762**	**710**

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

	Percentage	# Adults Discharged from Psychiatric Inpatient Unit	# Adults Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	97.27	695	676
Lakeshore Regional Entity	95.24	315	300
Macomb Co CMH Services	69.83	348	243
Mid-State Health Network	96.15	649	624
NorthCare Network	98.98	98	97
Northern MI Regional Entity	95.97	124	119
Oakland Co CMH Authority	92.56	309	286
Region 10	96.35	301	290
CMH Partnership of Southeast MI	83.96	187	157
Southwest MI Behavioral Health	96.60	324	313
Statewide Total		**3,350**	**3,105**

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

	Percentage	# SA Discharged from Substance Abuse Detox Unit	# SA Seen for Follow-up Care within 7 Days
Detroit Wayne Mental Health Authority	96.83	441	427
Lakeshore Regional Entity	97.98	99	97
Macomb Co CMH Services	100.00	208	208
Mid-State Health Network	93.83	162	152
NorthCare Network	96.88	32	31
Northern MI Regional Entity	94.03	134	126
Oakland Co CMH Authority	100.00	102	102
Region 10	95.51	89	85
CMH Partnership of Southeast MI	96.39	83	80
Southwest MI Behavioral Health	100.00	139	139
Statewide Total		**1,489**	**1,447**

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

	Percentage	Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients
Detroit Wayne Mental Health Authority	6.99	48,626	695,219
Lakeshore Regional Entity	6.84	18,708	273,625
Macomb Co CMH Services	5.39	11,992	222,394
Mid-State Health Network	8.63	34,426	399,072
NorthCare Network	8.53	5,436	63,758
Northern MI Regional Entity	7.89	9,219	116,786
Oakland Co CMH Authority	9.13	17,600	192,855
Region 10	9.06	18,189	200,868
CMH Partnership of Southeast MI	7.95	10,204	128,318
Southwest MI Behavioral Health	8.98	18,925	210,835
Statewide Total		**193,325**	**2,503,730**

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

	Percentage	# of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	Total Number of HSW Enrollees
Detroit Wayne Mental Health Authority	96.13	994	1,034
Lakeshore Regional Entity	92.64	604	652
Macomb Co CMH Services	92.94	421	453
Mid-State Health Network	98.37	1,444	1,468
NorthCare Network	98.63	359	364
Northern MI Regional Entity	93.33	616	660
Oakland Co CMH Authority	97.07	763	786
Region 10	98.59	491	498
CMH Partnership of Southeast MI	94.95	658	693
Southwest MI Behavioral Health	96.40	670	695
Statewide Total		**7,020**	**7,303**

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

	Percentage	Number of Children Discharged from Inpatient Care	# Children Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	14.67	225	33
Lakeshore Regional Entity	12.50	136	17
Macomb Co CMH Services	12.07	116	14
Mid-State Health Network	9.28	237	22
NorthCare Network	16.67	30	5
Northern MI Regional Entity	8.82	68	6
Oakland Co CMH Authority	9.33	75	7
Region 10	7.14	98	7
CMH Partnership of Southeast MI	13.43	67	9
Southwest MI Behavioral Health	12.00	125	15
Statewide Total		**1,177**	**135**

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

	Percentage	Number of Adults Discharged from Inpatient Care	# Adults Discharged that were Readmitted Within 30 Days
Detroit Wayne Mental Health Authority	17.43	1,629	284
Lakeshore Regional Entity	13.71	496	68
Macomb Co CMH Services	16.09	553	89
Mid-State Health Network	12.51	1,071	134
NorthCare Network	14.17	120	17
Northern MI Regional Entity	14.00	200	28
Oakland Co CMH Authority	7.25	510	37
Region 10	12.76	533	68
CMH Partnership of Southeast MI	12.06	282	34
Southwest MI Behavioral Health	12.50	528	66
Statewide Total		**5,922**	**825**

Michigan Department of Health and Human Services
Health Services

MEMORANDUM

To: **Executive Directors of Pre-Paid Inpatient Health Plans (PIHP)**

From: **Belinda Hawks, Division Director**

Date: **October 7, 2025**

RE: **Habilitation Supports Waiver (HSW) Slot Allocation**

Prior to the beginning of every fiscal year, the Federal Compliance section of the Adult Home and Community Based Services Division reviews Habilitation Supports Waiver (HSW) slot allocation and utilization. As part of the review for this fiscal year, Pre-Paid Inpatient Health Plans (PIHPs) were asked to provide the HSW Federal Compliance staff the following information:

- The number of beneficiaries who are eligible for the HSW and waiting for a slot to become available.
- The number of available slots within a region and if a PIHP was willing to give up any of those slots to other PIHPs for beneficiaries who are waiting.

Based on the response from the PIHPs, review of past/current utilization of slots and beneficiaries waiting for HSW slots to become available the HSW Federal compliance teams made the following determination for reallocation of HSW slots for fiscal year 2026. The new slot allocation will be reflected in the Waiver Support Application (WSA) under the HSW Slot Maintenance page for fiscal year 2026. This will be updated on or before September 30, 2025.

PIHP	FY25 HSW Slots	Reallocated	Received	FY26 HSW Slots
Region 1-Northcare	379	0	+13	392
Region 2-NMRE	697	0	+14	711
Region 3-LRE	676	0	+10	686
Region 4-SWMBH	720	0	+10	730
Region 5-MSHN	1,577	0	0	1,577
Region 6-CMHPSM	747	0	0	747
Region 7-DWIHN	1,125	0	0	1,125
Region 8-OCHN	870	-10	0	860

Region 9-MCCMH	477	0	+6	483
Region 10	627	-43	0	584

If you have any questions about the reallocation of HSW slots, please contact Lyndia Deromedi at deromedil@michigan.gov.

Thank you.

c: Kristen Morningstar, Bureau Director
Lyndia Deromedi, Manager

Substance Use Disorder Grants FY2026

State Opioid Response (SOR) 4 - $1,546,979 (10/1/2025 – 9/30/2026)			
$10,961	**Administration**		
$100,001	**Prevention** Implementation of evidence-based substance use disorder prevention services		
	Catholic Human Services	*$71,204*	*Sub-Recipient*
	DHD 10	*$28,797*	*Sub-Recipient*
$400,623	**Peer Outreach and Linkage** The grant will fund the continuation of Project ASSERT and SBIRT peers in emergency departments or Quick Response/post overdose rapid response teams. Peers utilized in this Grant must be MDHHS Trained Peers.		
	Catholic Human Services	*$400,623*	*Contractor*
$239,628	**Jail MAT** The grant will provide Medication Assisted Treatment (MAT) for inmates. Specifically, substance use disorder treatment services in the form of individual services or group services, peer recovery coach services, and care coordination for the provision of medication. Medication is NO LONGER covered by the NMRE separately from this project. This includes GPRA incentives for clients receiving services in this funding category.		
	Bear River Health	*$45,000*	*Contractor*
	Catholic Human Services	*$194,628*	*Contractor*
$121,905	**Jail MAT Medication**		
	Besse – noted as supplies for Jail MAT		
$373,861	**OUD/StUD Treatment** The grant will provide case management services to inmates. This includes GPRA incentives for clients receiving services in this funding category.		
	Catholic Human Services	*$317,710*	*Contractor*
	Bear River Health	*$26, 151*	*Contractor*
	BASES	*$30,000*	*Contractor*
$300,000	**Recovery** Recovery Community Organization		
	217 Recovery Center	*$150,000*	*Contractor*
	Community Recovery Alliance	*$150,000*	*Contractor*
Gambling Disorder Prevention - $200,000			
Spectrum Reach			
Tobacco 4000 - $4,000			
217 Recovery			
MIPAC-PFS $322,787			
Catholic Human Services			

NORTHERN MICHIGAN REGIONAL ENTITY
FINANCE COMMITTEE MEETING
10:00AM – OCTOBER 8, 2025
VIA TEAMS

ATTENDEES:	**Bea Arsenov, Brian Babbitt, Connie Cadarette, Ann Friend, Chip Johnston, Nancy Kearly, Eric Kurtz, Allison Nicholson, Donna Nieman, Pamela Polom, Brandon Rhue, Nena Sork, Kara Steinke, Erinn Trask, Jennifer Warner, Tricia Wurn, Deanna Yockey, Carol Balousek**

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

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

MOTION BY CONNIE CADARETTE TO APPROVE THE MINUTES OF THE SEPTEMBER 10, 2025, NORTHERN MICHIGAN REGIONAL ENTITY REGIONAL FINANCE COMMITTEE MEETING; SUPPORT BY DONNA NIEMAN. MOTION APPROVED.

MONTHLY FINANCIALS
August 2025 Financial Report

- Net Position showed a net surplus for Medicaid and HMP of $7,097,525. Carry forward was reported as $447,383. The total Medicaid and HMP current year surplus was reported as $7,544,908. FY24 HSW revenue was reported as $1,289,241. The total Medicaid and HMP adjusted current year surplus was reported as $6,255,667. The total Medicaid and HMP Internal Service Fund was reported as $20,576,156. The total Medicaid and HMP net surplus was reported as $28,121,064.
- Traditional Medicaid showed $209,643,258 in revenue, and $199,756,038 in expenses, resulting in a net surplus of $9,887,220. Medicaid ISF was reported as $13,514,675 based on the current FSR. Medicaid Savings was reported as $0.
- Healthy Michigan Plan showed $27,757,971 in revenue, and $30,547,666 in expenses, resulting in a net deficit of $2,789,695. HMP ISF was reported as $7,068,394 based on the current FSR. HMP savings was reported as $736,656.
- Health Home showed $2,967,387 in revenue, and $2,481,752 in expenses, resulting in a net surplus of $485,635.
- SUD showed all funding source revenue of $26,964,463 and $21,636,400 in expenses, resulting in a net surplus of $5,328,063. Total PA2 funds were reported as $3,894,705.

PA2/Liquor Tax was summarized as follows:

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

Actual FY25 Activity			
Beginning Balance	Current Receipts	Current Expenditures	Current Ending Balance
$4,765,231	$835,755	$1,706,281	$3,894,705

Bea reported that approximately $1M in PA2 will be moved to block grant funding for FY25. The final amount will be available after the November 6th claims deadline. It was noted that the state has only released 2 quarters of PA2 revenue for FY25.

Deanna clarified that, although MDHHS returned the FY21 cost settlement in the amount of $8.9M pending litigation, it remains on the books as a liability. Hopefully, the NMRE will receive a favorable ruling. Currently, the ISF is funded $3.1M beyond 7.5% of capitated revenue.

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

EDIT UPDATE

The next EDIT meeting is scheduled for 10:00AM on October 23, 2025. Per Donna's email on October 3rd, codes H2014 (skills training and development, per 15 minutes) and H2023 (supported employment, per 15 minutes) are no longer allowed under the HMP benefit.

NMRE Provider Network and Contract Manager, Chris VanWagoner, has indicated that the 0905 (Intensive Outpatient) revenue code was removed from the contract for MyMichigan Health because it is no longer listed in the code chart. Brandon requested that the removal of the code be placed on the EDIT meeting agenda.

EQI UPDATE

There was nothing new to report on this topic. The Period 2 EQI is due from the CMHSPs to the NMRE October 17th. The NMRE will submit the report to the state by the November 10th due date.

ELECTRONIC VISIT VERIFICATION (EVV)

Brandon reported that an EVV Leads meeting is scheduled for 11:00AM on this date.

HSW OPEN SLOTS UPDATE

New Slots for FY26

A memorandum from Belinda Hawks to PIHP Directors dated October 7, 2025 regarding HSW slot allocations was included in the meeting materials. NMRE gained 14 slots (the most of any PIHP in the state) for a total of 711. If fully utilized, this equates to an additional $1.1M in revenue for the region. Three of the additional slots have been filled. Additional packets have been requested from the CMHSPs. Bea is confident that all the slots will be filled in the next couple of months.

PIHP	FY25 HSW SLOTS	REALLOCATED	RECEIVED	FT26 HSW SLOTS
Region 1 – NorthCare	379	0	+13	392
Region 2 – NMRE	697	0	+14	711
Region 3 – Lakeshore	676	0	+10	686
Region 4 – SWMBH	720	0	+10	730
Region 5 – MidState	1,577	0	0	1,577
Region 6 – CMHPSM	747	0	0	747

Region 7 – DWIHN	1,125	0	0	1,125
Region 8 - Oakland	870	-10	0	860
Region 9 – Macomb	477	0	+6	483
Region 10	627	-43	0	584
Total	**7,895**			**7,895**

CHAMPS Fix Update

A new issue(s) having to do with HSW payments has been discovered in CHAMPS. MDHHS has recognized it and is assessing the situation before working on a fix. Brandon is gathering information/analytics to provide to MDHHS. There are three potential issues: 1) check numbers were provided for payments to the NMRE that don't line up with payments received, 2) payment for a number of beneficiaries went to MidState, which might rightfully belong to MidState, although enrollment in the WSA lists the NMRE, and 3) enrollment issues, possibly associated with beneficiaries on spenddown (creating unenrolled status in CHAMPS).

Verification Research Project

Brandon uploaded reports to ShareFile for each CMHSP showing beneficiaries that used to be on DAB but no longer are, dating back to October 1, 2019, (some are currently showing as GF).

NMRE REVENUE & ELIGIBLES ANALYSIS

An analysis of October 2023 – September 2025 Revenue and Eligibles was emailed to the committee during the meeting.

Children's Waiver Program			
	October 2023	September 2025	% Change
Revenue	$36,882	$31,620	-14.27%
Enrollees	11	9	-118.18%
Average Payment per Enrollee	$3,353	$3,513	4.78%

DAB			
	October 2023	September 2025	% Change
Revenue	$10,003,003	$10,854,858	8.52%
Enrollees	28,444	25,336	-10.93%
Average Payment per Enrollee	$352	$428	21.83%

HMP			
	October 2023	September 2025	% Change
Revenue	$2,369,569	$2,273,352	-4.06%
Enrollees	47,550	31,351	-34.07%
Average Payment per Enrollee	$50	$73	45.51%

HSW			
	October 2023	September 2025	% Change
Revenue	$4,638,399	$5,492,828	18.42%
Enrollees	650	684	5.23%
Average Payment per Enrollee	$7,136	$8,030	12.53%

SED			
	October 2023	September 2025	% Change
Revenue	$40,846	$28,016	-31.41%
Enrollees	21	38	80.95%
Average Payment per Enrollee*	$1,945	$737	-62.10%

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

TANF			
	October 2023	September 2025	% Change
Revenue	$2,865,200	$2,947,777	2.88%
Enrollees	66,801	52,672	-21.15%
Average Payment per Enrollee	$43	$56	30.48%

TOTAL			
	October 2023	September 2025	% Change
	$19,953,899	$21,628,451	8.39%

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

	DAB	HMP	HSW	TANF	Total
YTD Sept. 2024	$115,077,441	$24,938,868	$56,277,045	$31,978,822	$228,272,176
YTD Sept. 2025	$123,292,923	$27,453,535	$65,631,480	$34,726,560	$251,104,518
Increase	$8,215,482	$8,215,482	$9,354,436	$2,747,757	**$22,832,343**

FY25 INTERIM FSR
The FY25 Interim FSR is due from the CMHSPs to NMRE November 3rd. The NMRE will submit the to MDHHS by the November 10th due date.

Sending out FY25 Medicaid & HMP PMPM Totals
The FY25 Medicaid and HMP totals will be sent to the CMHSPs by October 13th.

BHH Totals Will be After the November 6th Claims Deadline
After the November 6th claims deadline, the NMRE will be able to send BHH revenue to reconcile FY25.

FY26 REVENUE PROJECTIONS
After receiving final FY26 rates from Milliman, Finance compared September eligibles and FY26 rates to see if they line up with the projections included in the FY26 budget presented to the Finance Committee in September. The actual numbers are slightly higher than the projections which gives a little buffer in the event the eligibles continue to decline.

NEXT MEETING
The next meeting was scheduled for November 12th at 10:00AM.

Chief Executive Officer Report

October 2025

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

Oct 1: Attended and participated in meeting with CMHSPs and NMRE legal.

Oct 2: Attended and participated in NMRE Internal Operations Committee Meeting.

Oct 7: Attended and participated in PIHP CEO Meeting.

Oct 8: Attended and participated in Regional Finance Committee Meeting.

Oct 9: Attended Court of Claims Hearing re: PIHP bid out.

Oct 16: Attended and participated in MDHHS PIHP Operations Meeting.

Oct 16: Attended and participated in NMRE Internal Operations Committee Meeting.

Oct 21: Chaired NMRE Operations Committee Meeting.

August 2025 Finance Report

August 2025 Financial Summary

Funding Source	YTD Net Surplus (Deficit)	Carry Forward	ISF
Medicaid	9,887,220	-	13,514,675
Healthy Michigan	(2,789,695)	447,383	7,068,394
	$ 7,097,525	$ 447,383	$ 20,583,069

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Net Surplus (Deficit) MA/HMP	2,341,901	4,971,719	(5,399,330)	1,811,564	957,061	1,333,091	1,081,518	$ 7,097,525
Carry Forward		-	-	-	-	-	-	447,383
Total Med/HMP Current Year Surplus	2,341,901	4,971,719	(5,399,330)	1,811,564	957,061	1,333,091	1,081,518	$ 7,544,908
FY24 Hab Support Waiver Revenue								$ (1,289,241)
Total Med/HMP Current Year Surplus Adjusted								$ 6,255,667
Medicaid & HMP Internal Service Fund								20,576,156
Total Medicaid & HMP Net Surplus								$ 28,121,064

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through August 31, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Traditional Medicaid (inc Autism)								
Revenue								
Revenue Capitation (PEPM)	$ 203,227,173	$ 6,416,085						$ 209,643,258
CMHSP Distributions	(192,331,424)		62,041,526	52,498,425	32,193,430	28,071,116	17,526,927	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	10,895,749	6,416,085	62,041,526	52,498,425	32,193,430	28,071,116	17,526,927	209,643,258
Expense								
PIHP Admin	2,861,366	52,637						2,914,004
PIHP SUD Admin		124,347						124,347
SUD Access Center		-						-
Insurance Provider Assessment	1,682,290	32,413						1,714,703
Hospital Rate Adjuster	3,187,626							3,187,626
Services	689,206	3,464,871	64,281,175	50,296,100	31,050,480	26,304,087	15,729,440	191,815,359
Total expense	8,420,488	3,674,268	64,281,175	50,296,100	31,050,480	26,304,087	15,729,440	199,756,038
Net Actual Surplus (Deficit)	$ 2,475,261	$ 2,741,817	$ (2,239,649)	$ 2,202,325	$ 1,142,950	$ 1,767,029	$ 1,797,487	$ 9,887,220

Notes

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

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through August 31, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Healthy Michigan								
Revenue								
Revenue Capitation (PEPM)	$ 16,471,826	$ 11,286,145						$ 27,757,971
CMHSP Distributions	(13,584,311)		5,005,843	3,879,451	1,755,418	1,843,620	1,099,979	-
1st/3rd Party receipts			-	-	-	-	-	-
Net revenue	2,887,515	11,286,145	5,005,843	3,879,451	1,755,418	1,843,620	1,099,979	27,757,971
Expense								
PIHP Admin	280,599	129,781						410,380
PIHP SUD Admin		306,585						306,585
SUD Access Center		-						-
Insurance Provider Assessment	162,489	77,019						239,508
Hospital Rate Adjuster	2,577,787							2,577,787
Services	-	8,542,858	8,165,525	4,270,211	1,941,306	2,277,558	1,815,948	27,013,406
Total expense	3,020,875	9,056,243	8,165,525	4,270,211	1,941,306	2,277,558	1,815,948	30,547,666
Net Surplus (Deficit)	$ (133,360)	$ 2,229,902	$ (3,159,682)	$ (390,760)	$ (185,888)	$ (433,938)	$ (715,969)	$ (2,789,695)

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

Net Surplus (Deficit) MA/HMP	**$ 2,341,901**	**$ 4,971,719**	**$ (5,399,330)**	**$ 1,811,564**	**$ 957,061**	**$ 1,333,091**	**$ 1,081,518**	**$ 7,097,525**
Medicaid/HMP Carry Forward								**447,383**
Total Med/HMP Current Year Surplus								$ 7,544,908
Medicaid & HMP ISF - based on current FSR								**20,576,156**
Total Medicaid & HMP Net Surplus (Deficit) including Carry Forward and ISF								**$ 28,121,064**

Northern Michigan Regional Entity

Funding Source Report - PIHP

Mental Health
October 1, 2024 through August 31, 2025

	NMRE MH	NMRE SUD	Northern Lakes	North Country	Northeast	Wellvance	Centra Wellness	PIHP Total
Health Home								
Revenue								
Revenue Capitation (PEPM)	$ 1,056,005		438,712	360,095	398,351	203,914	510,310	$ 2,967,387
CMHSP Distributions	-							-
1st/3rd Party receipts								-
Net revenue	1,056,005	-	438,712	360,095	398,351	203,914	510,310	2,967,387
Expense								
PIHP Admin	36,597							36,597
BHH Admin	36,154							36,154
Insurance Provider Assessment	-							-
Hospital Rate Adjuster								
Services	497,619		438,712	360,095	398,351	203,914	510,310	2,409,001
Total expense	570,370	-	438,712	360,095	398,351	203,914	510,310	2,481,752
Net Surplus (Deficit)	$ 485,635	$ -	$ -	$ -	$ -	$ -	$ -	$ 485,635

Northern Michigan Regional Entity

Funding Source Report - SUD

Mental Health

October 1, 2024 through August 31, 2025

	Medicaid	Healthy Michigan	Opioid Health Home	SAPT Block Grant	PA2 Liquor Tax	Total SUD
Substance Abuse Prevention & Treatment						
Revenue	$ 6,416,085	$ 11,286,145	$ 3,887,319	$ 3,668,636	$ 1,706,278	$ 26,964,463
Expense						
Administration	176,984	436,366	168,172	184,623		966,145
OHH Admin			70,451	-		70,451
Block Grant Access Center	-	-	-	-		-
Insurance Provider Assessment	32,413	77,019	-			109,432
Services:						
Treatment	3,464,871	8,542,858	3,292,352	1,603,036	1,706,278	18,609,395
Prevention	-	-	-	892,403	-	892,403
Healing and Recovery Grant				447,821		447,821
ARPA Grant	-	-	-	540,753	-	540,753
Total expense	3,674,268	9,056,243	3,530,975	3,668,636	1,706,278	21,636,400
PA2 Redirect			-	0		0
Net Surplus (Deficit)	$ 2,741,817	$ 2,229,902	$ 356,344	$ 0	$ -	$ 5,328,063

Northern Michigan Regional Entity

Statement of Activities and Proprietary Funds Statement of

Revenues, Expenses, and Unspent Funds
October 1, 2024 through August 31, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Operating revenue				
Medicaid	$ 203,227,173	$ 6,416,085	$ -	$ 209,643,258
Medicaid Savings	-	-	-	-
Healthy Michigan	16,471,826	11,286,145	-	27,757,971
Healthy Michigan Savings	736,656	-	-	736,656
Health Home	2,967,387	-	-	2,967,387
Opioid Health Home	-	3,887,319	-	3,887,319
Substance Use Disorder Block Grant	-	3,668,636	-	3,668,636
Public Act 2 (Liquor tax)	-	1,706,278	-	1,706,278
Affiliate local drawdown	594,816	-	-	594,816
Performance Incentive Bonus	1,653,705	-	-	1,653,705
Miscellanous Grant Revenue	-	4,000	-	4,000
Healing & Recovery Revenue	-	-	-	-
Veteran Navigator Grant	100,109	-	-	100,109
SOR Grant Revenue	-	1,383,973	-	1,383,973
Gambling Grant Revenue	-	187,040	-	187,040
Other Revenue	1,740	-	3,336	5,076
Total operating revenue	225,753,412	28,539,476	3,336	254,296,224
Operating expenses				
General Administration	3,436,918	707,789	-	4,144,707
Prevention Administration	-	112,327	-	112,327
OHH Administration	-	70,451	-	70,451
BHH Administration	36,154	-	-	36,154
Insurance Provider Assessment	1,844,779	109,432	-	1,954,211
Hospital Rate Adjuster	5,765,413	-	-	5,765,413
Payments to Affiliates:				
Medicaid Services	188,350,488	3,464,871	-	191,815,359
Healthy Michigan Services	18,470,548	8,542,858	-	27,013,406
Health Home Services	2,409,001	-	-	2,409,001
Opioid Health Home Services	-	3,292,352	-	3,292,352
Community Grant	-	1,603,036	-	1,603,036
Prevention	-	780,076	-	780,076
State Disability Assistance	-	-	-	-
ARPA Grant	-	540,753	-	540,753
Public Act 2 (Liquor tax)	-	1,706,278	-	1,706,278
Local PBIP	1,579,647	-	-	1,579,647
Local Match Drawdown	594,816	-	-	594,816
Miscellanous Grant	-	4,000	-	4,000
Healing & Recovery Grant	-	447,821	-	447,821
Veteran Navigator Grant	100,109	-	-	100,109
SOR Grant Expenses	-	1,383,973	-	1,383,973
Gambling Grant Expenses	-	187,040	-	187,040
Total operating expenses	222,587,873	22,953,057	-	245,540,930
CY Unspent funds	3,165,539	5,586,419	3,336	8,755,294
Transfers In	-	-	-	-
Transfers out	-	-	-	-
Unspent funds - beginning	3,466,474	4,765,230	20,583,069	28,814,773
Unspent funds - ending	$ 6,632,013	$ 10,351,649	$ 20,586,405	$ 37,570,067

Northern Michigan Regional Entity

Statement of Net Position

August 31, 2025

	PIHP MH	PIHP SUD	PIHP ISF	Total PIHP
Assets				
Current Assets				
Cash Position	$ 56,063,271	$ 9,606,528	$ 20,586,405	$ 86,256,204
Accounts Receivable	1,991,602	2,602,072	-	4,593,674
Prepaids	84,521	-	-	84,521
Total current assets	58,139,394	12,208,600	20,586,405	90,934,399
Noncurrent Assets				
Capital assets	479,259	-	-	479,259
Total Assets	58,618,653	12,208,600	20,586,405	91,413,658
Liabilities				
Current liabilities				
Accounts payable	51,754,196	1,856,951	-	53,611,147
Accrued liabilities	232,444	-	-	232,444
Unearned revenue	-	-	-	-
Total current liabilities	51,986,640	1,856,951	-	53,843,591
Unspent funds	$ 6,632,013	$ 10,351,649	$ 20,586,405	$ 37,570,067

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health
October 1, 2024 through August 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid					
* Capitation	$ 187,752,708	$ 172,106,649	$ 203,227,173	$ 31,120,524	18.08%
Carryover	11,400,000	-	-	-	-
Healthy Michigan					
Capitation	19,683,372	18,043,091	16,471,826	(1,571,265)	(8.71%)
Carryover	5,100,000	-	736,656	736,656	0.00%
Health Home	1,451,268	1,330,329	2,967,387	1,637,058	123.06%
Affiliate local drawdown	594,816	594,816	594,816	-	0.00%
Performance Bonus Incentive	1,334,531	1,334,531	1,653,705	319,174	23.92%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,000	100,837	100,109	(728)	(0.72%)
Other Revenue	-	-	1,740	1,740	0.00%
Total operating revenue	227,426,695	193,510,253	225,753,412	32,243,159	16.66%
Operating expenses					
General Administration	3,819,287	3,452,695	3,436,918	15,777	0.46%
Health Home Administration	-	-	36,154	(36,154)	0.00%
Insurance Provider Assessment	1,897,524	1,739,397	1,844,779	(105,382)	(6.06%)
Hospital Rate Adjuster	4,571,328	4,190,384	5,765,413	(1,575,029)	(37.59%)
Local PBIP	1,737,753	-	1,579,647	(1,579,647)	0.00%
Local Match Drawdown	594,816	594,816	594,816	-	0.00%
Miscellanous Grants	-	-	-	-	0.00%
Veteran Navigator Grant	110,004	84,073	100,109	(16,036)	(19.07%)
Payments to Affiliates:					
Medicaid Services	176,618,616	161,900,398	188,350,488	(26,450,090)	(16.34%)
Healthy Michigan Services	17,639,940	16,169,945	18,470,548	(2,300,603)	(14.23%)
Health Home Services	1,415,196	1,297,263	2,409,001	(1,111,738)	(85.70%)
Total operating expenses	208,404,464	189,428,971	222,587,873	(33,158,902)	(17.50%)
CY Unspent funds	$ 19,022,231	$ 4,081,282	3,165,539	$ (915,743)	
Transfers in			-		
Transfers out			-	222,587,873	
Unspent funds - beginning			3,466,474		
Unspent funds - ending			$ 6,632,013	3,165,539	

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse
October 1, 2024 through August 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Medicaid	$ 4,678,632	$ 4,288,746	$ 6,416,085	$ 2,127,339	49.60%
Healthy Michigan	11,196,408	10,263,374	11,286,145	1,022,771	9.97%
Substance Use Disorder Block Grant	6,467,905	5,928,913	3,668,636	(2,260,277)	(38.12%)
Opioid Health Home	3,419,928	3,134,934	3,887,319	752,385	24.00%
Public Act 2 (Liquor tax)	1,533,979	1,022,653	1,706,278	683,625	66.85%
Miscellanous Grants	4,000	3,667	4,000	333	9.09%
Healing & Recovery Grant	-	-	-	-	0.00%
SOR Grant	2,043,984	1,873,652	1,383,973	(489,679)	(26.14%)
Gambling Prevention Grant	200,000	183,333	187,040	3,707	2.02%
Other Revenue	-	-	-	-	0.00%
Total operating revenue	29,544,836	26,699,271	28,539,476	1,840,205	6.89%
Operating expenses					
Substance Use Disorder:					
SUD Administration	1,127,295	982,084	707,789	274,295	27.93%
Prevention Administration	131,394	121,525	112,327	9,198	7.57%
Insurance Provider Assessment	113,604	104,137	109,432	(5,295)	(5.08%)
Medicaid Services	3,931,560	3,603,930	3,464,871	139,059	3.86%
Healthy Michigan Services	10,226,004	9,373,837	8,542,858	830,979	8.86%
Community Grant	2,074,248	1,901,394	1,603,036	298,358	15.69%
Prevention	634,056	581,218	780,076	(198,858)	(34.21%)
State Disability Assistance	95,215	87,281	-	87,281	100.00%
ARPA Grant	-	-	540,753	(540,753)	0.00%
Opioid Health Home Admin	-	-	70,451	(70,451)	0.00%
Opioid Health Home Services	3,165,000	2,901,250	3,292,352	(391,102)	(13.48%)
Miscellanous Grants	4,000	3,667	4,000	(333)	(9.09%)
Healing & Recovery Grant	-	-	447,821	(447,821)	0.00%
SOR Grant	2,043,984	1,873,652	1,383,973	489,679	26.14%
Gambling Prevention	200,000	183,333	187,040	(3,707)	(2.02%)
PA2	1,533,978	1,022,652	1,706,278	(683,626)	(66.85%)
Total operating expenses	25,280,338	22,739,960	22,953,057	(213,097)	(0.94%)
CY Unspent funds	$ 4,264,498	$ 3,959,311	5,586,419	$ 1,627,108	
Transfers in			-		
Transfers out			-		
Unspent funds - beginning			4,765,230		
Unspent funds - ending			$ 10,351,649		

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Mental Health Administration
October 1, 2024 through August 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
General Admin					
Salaries	$ 2,023,189	$ 1,863,038	$ 1,847,549	$ 15,489	0.83%
Fringes	704,786	580,822	577,812	3,010	0.52%
Contractual	770,808	713,873	733,411	(19,538)	(2.74%)
Board expenses	18,000	16,500	21,319	(4,819)	(29.21%)
Day of recovery	14,000	14,000	8,968	5,032	35.94%
Facilities	152,700	139,975	121,327	18,648	13.32%
Other	135,804	124,487	126,532	(2,045)	(1.64%)
Total General Admin	$ 3,819,287	$ 3,452,695	$ 3,436,918	$ 15,777	0.46%

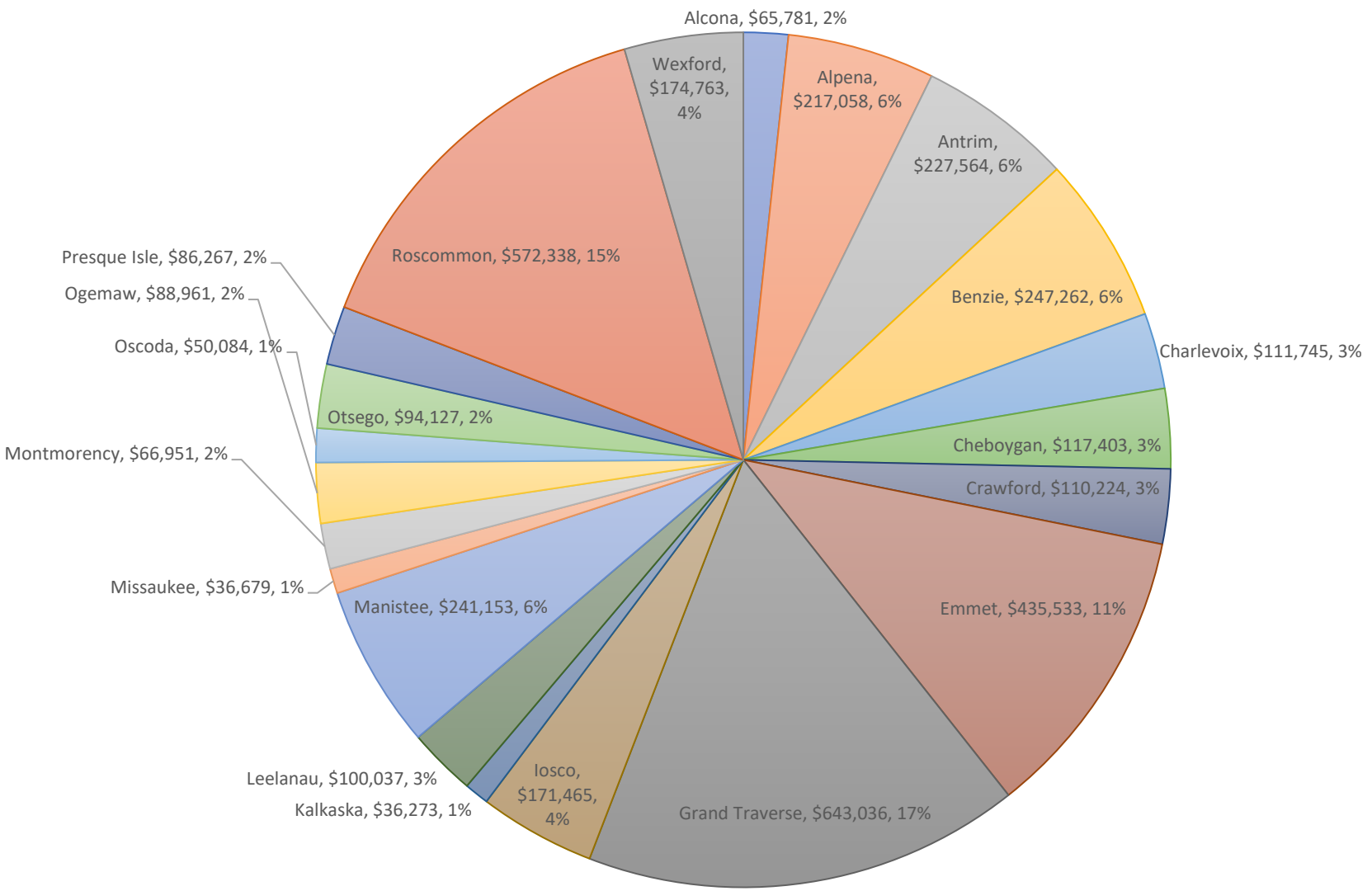
Northern Michigan Regional Entity

Schedule of PA2 by County

October 1, 2024 through August 31, 2025

	Projected FY25 Activity				Actual FY25 Activity			
	Beginning Balance	FY25 Projected Revenue	FY25 Approved Projects	Projected Ending Balance	Current Receipts	County Specific Projects	Region Wide Projects by Population	Ending Balance
County						Actual Expenditures by County		
Alcona	$ 71,885	$ 23,013	$ 21,562	$ 73,336	$ 9,914	16,017	$ -	$ 65,781
Alpena	276,605	81,249	115,352	242,502	38,033	97,580	-	217,058
Antrim	225,891	71,430	37,276	260,045	33,812	32,139	-	227,564
Benzie	257,777	64,021	52,479	269,320	29,286	39,801	-	247,262
Charlevoix	240,410	106,977	204,773	142,613	46,677	175,343	-	111,745
Cheboygan	141,238	85,508	65,816	160,930	40,575	64,409	-	117,403
Crawford	126,884	36,205	68,993	94,096	17,924	34,584	-	110,224
Emmet	604,860	182,951	363,695	424,117	82,567	251,894	-	435,533
Grand Traverse	947,150	464,163	558,074	853,238	205,396	509,509	-	643,036
Iosco	186,997	84,319	73,780	197,537	38,690	54,221	-	171,465
Kalkaska	25,843	41,796	2,436	65,203	18,678	8,248	-	36,273
Leelanau	97,166	63,811	39,737	121,240	27,988	25,118	-	100,037
Manistee	259,014	82,480	104,210	237,284	36,904	54,764	-	241,153
Missaukee	30,683	22,352	20,908	32,127	10,850	4,854	-	36,679
Montmorency	59,540	30,318	8,457	81,401	13,074	5,664	-	66,951
Ogemaw	64,110	68,787	11,101	121,797	30,828	5,977	-	88,961
Oscoda	44,727	21,668	7,577	58,818	10,432	5,074	-	50,084
Otsego	112,969	105,067	98,424	119,612	48,085	66,927	-	94,127
Presque Isle	82,660	24,977	11,701	95,936	11,445	7,838	-	86,267
Roscommon	576,714	87,317	55,007	609,024	39,501	43,877	-	572,338
Wexford	332,107	98,696	229,583	201,220	45,098	202,441	-	174,763
	4,765,231	1,847,106	2,150,940	4,461,397	835,755	1,706,281	-	3,894,705
PA2 Redirect								-
								3,894,705

PA2 FUND BALANCES BY COUNTY



Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - Substance Abuse Administration
October 1, 2024 through August 31, 2025

	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
SUD Administration					
Salaries	$ 768,091	$ 707,810	$ 422,564	$ 285,246	40.30%
Fringes	212,604	194,887	144,610	50,277	25.80%
Access Salaries	-	-	-	-	0.00%
Access Fringes	-	-	-	-	0.00%
Access Contractual	-	-	-	-	0.00%
Contractual	129,000	68,750	100,557	(31,807)	(46.26%)
Board expenses	5,000	4,587	4,535	52	1.13%
Day of Recover	-	-	13,971	(13,971)	0.00%
Facilities	-	-	-	-	0.00%
Other	12,600	6,050	21,552	(15,502)	(256.23%)
Total operating expenses	$ 1,127,295	$ 982,084	$ 707,789	$ 274,295	27.93%

Northern Michigan Regional Entity

Proprietary Funds Statement of Revenues, Expenses, and Unspent Funds

Budget to Actual - ISF

October 1, 2024 through August 31, 2025

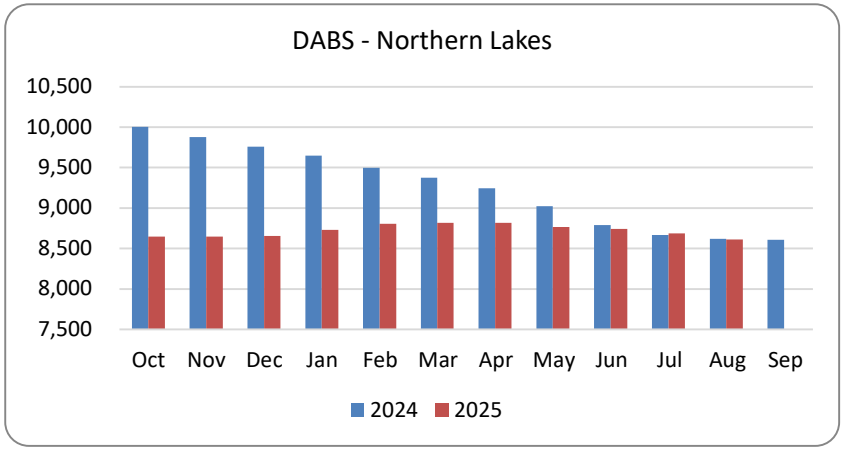
	Total Budget	YTD Budget	YTD Actual	Variance Favorable (Unfavorable)	Percent Favorable (Unfavorable)
Operating revenue					
Charges for services	$ -	$ -	$ -	$ -	0.00%
Interest and Dividends	7,500	6,875	3,336	(3,539)	(51.48%)
Total operating revenue	7,500	6,875	3,336	(3,539)	(51.48%)
Operating expenses					
Medicaid Services	-	-	-	-	0.00%
Healthy Michigan Services	-	-	-	-	0.00%
Total operating expenses	-	-	-	-	0.00%
CY Unspent funds	$ 7,500	$ 6,875	3,336	$ (3,539)	
Transfers in			-		
Transfers out			-	-	
Unspent funds - beginning			20,583,069		
Unspent funds - ending			$ 20,586,405		

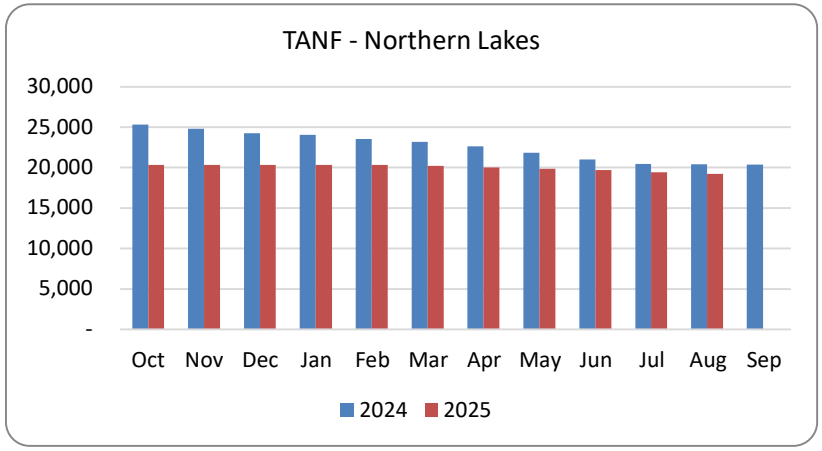
Northern Michigan Regional Entity

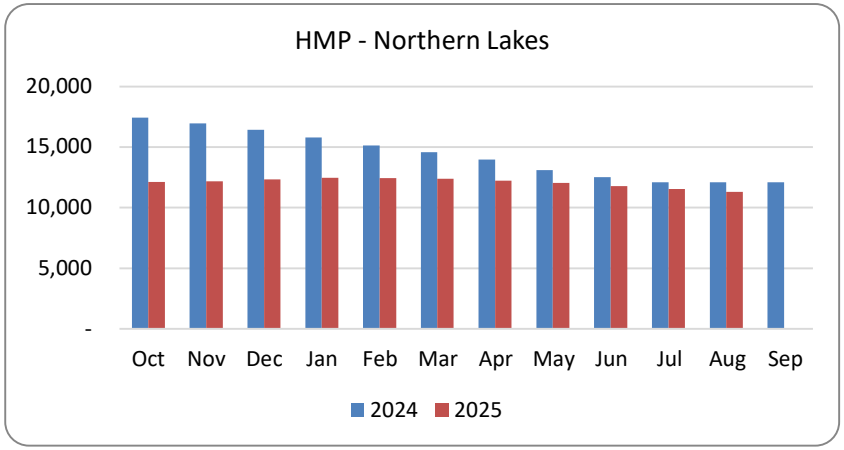
Narrative

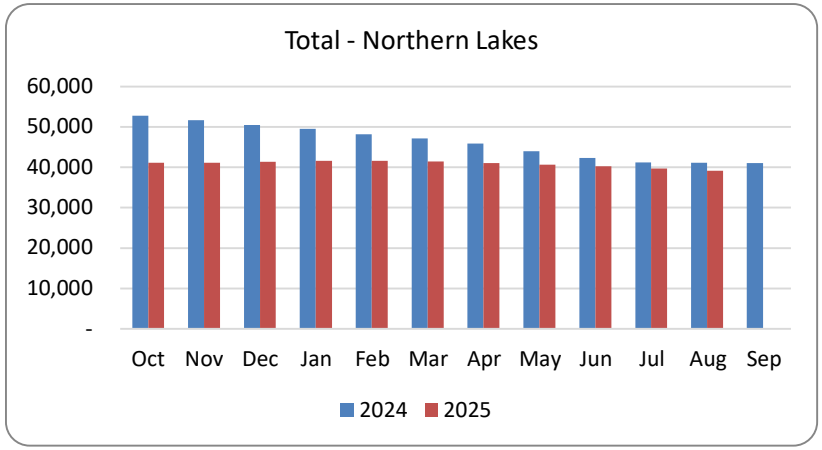
October 1, 2024 through August 31, 2025

Northern Lakes Eligible Members Trending - based on payment files







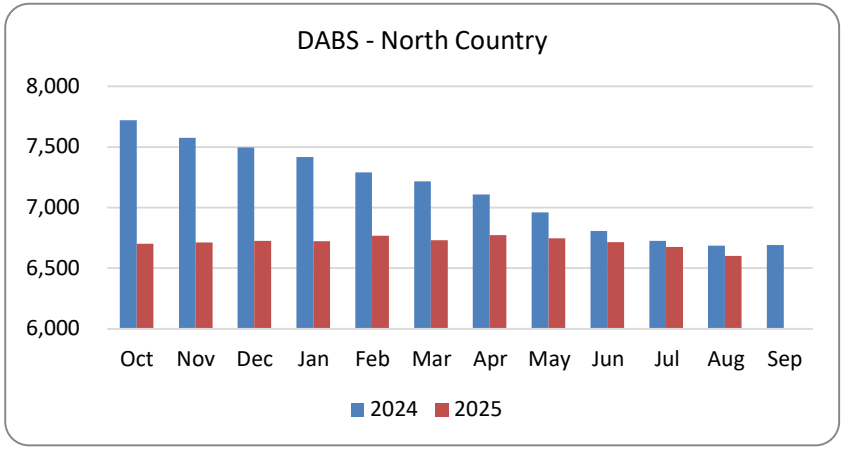


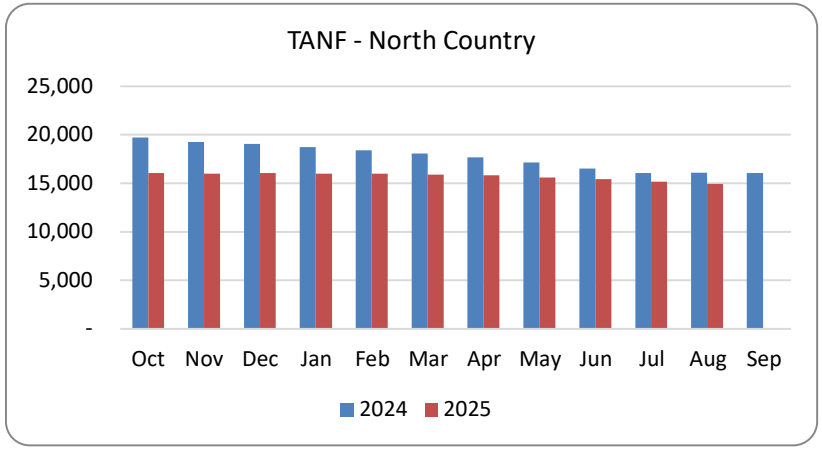
Northern Michigan Regional Entity

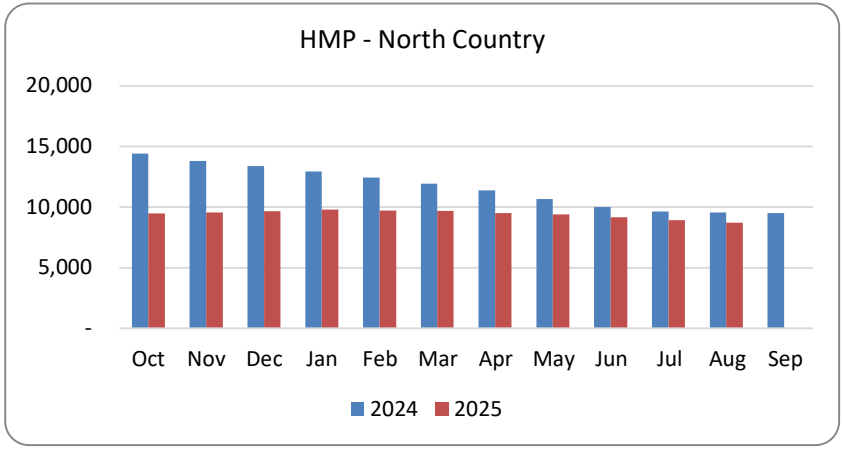
Narrative

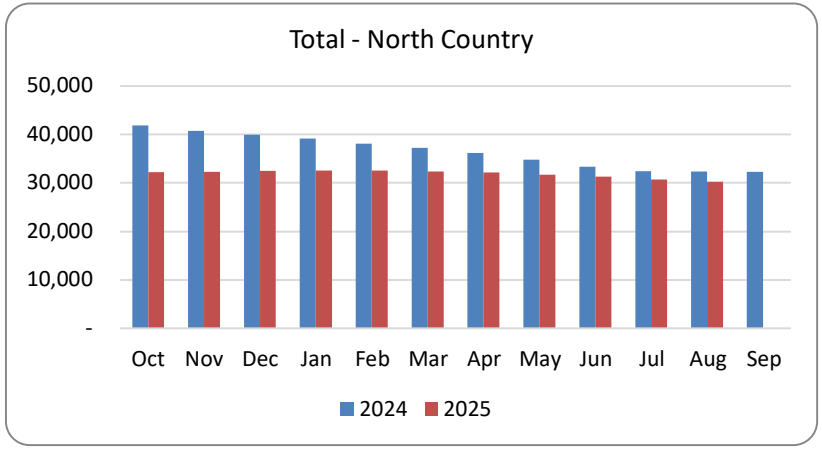
October 1, 2024 through August 31, 2025

North Country Eligible Members Trending - based on payment files







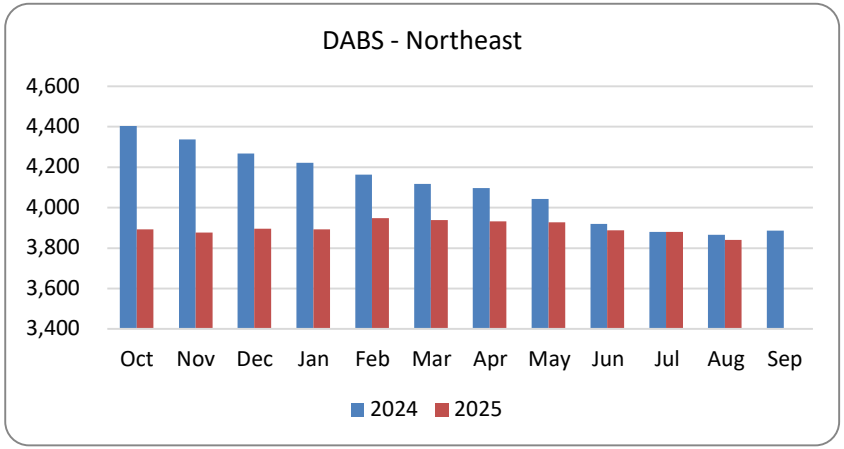


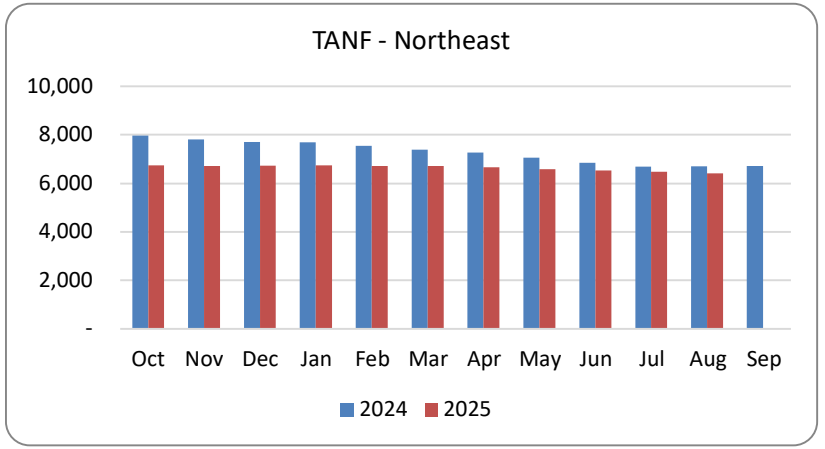
Northern Michigan Regional Entity

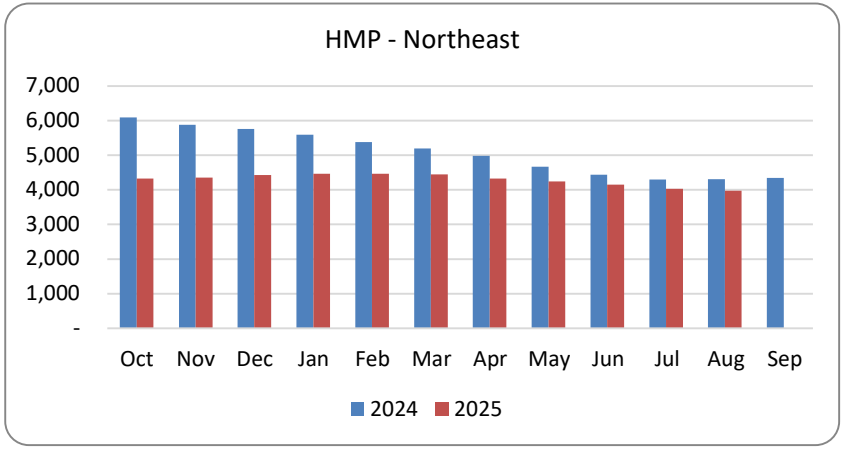
Narrative

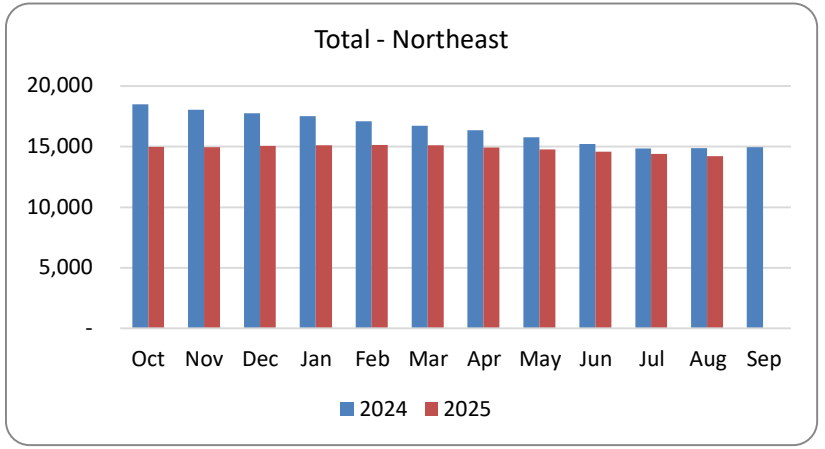
October 1, 2024 through August 31, 2025

Northeast Eligible Members Trending - based on payment files







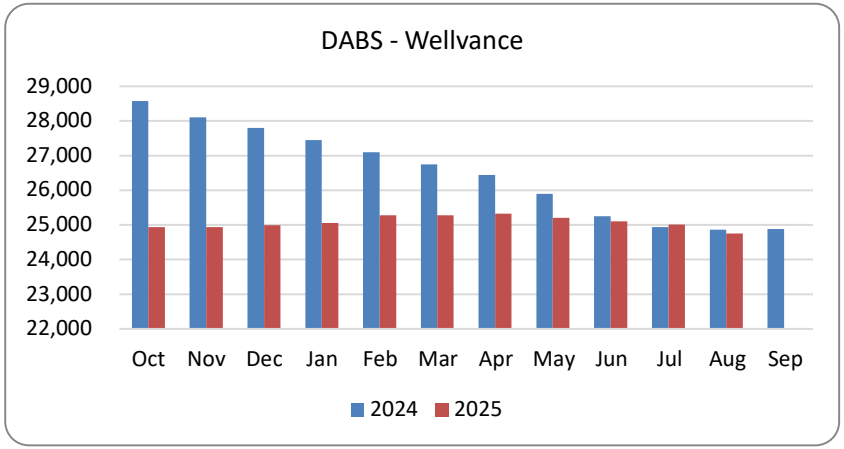


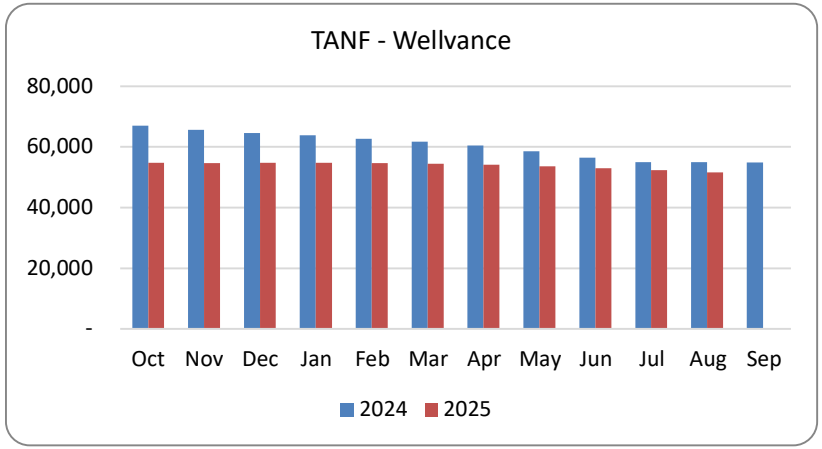
Northern Michigan Regional Entity

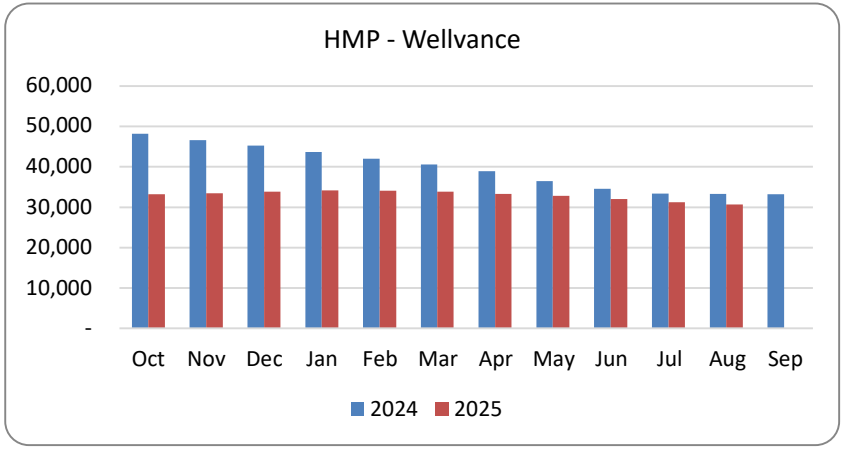
Narrative

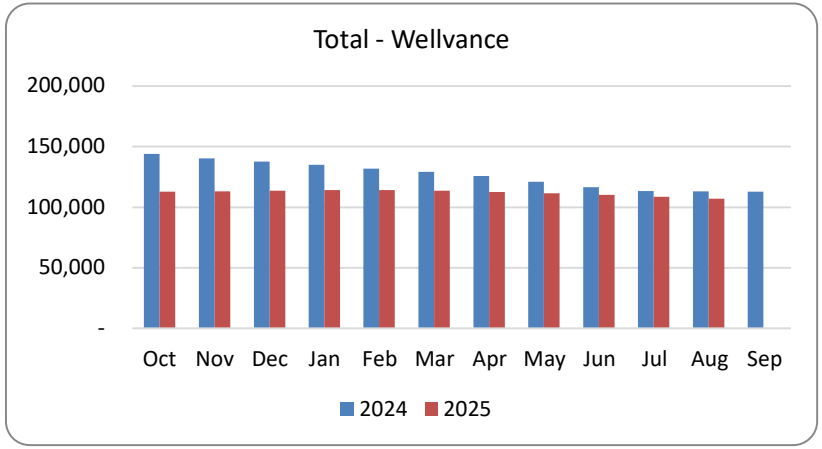
October 1, 2024 through August 31, 2025

Wellvance Eligible Members Trending - based on payment files







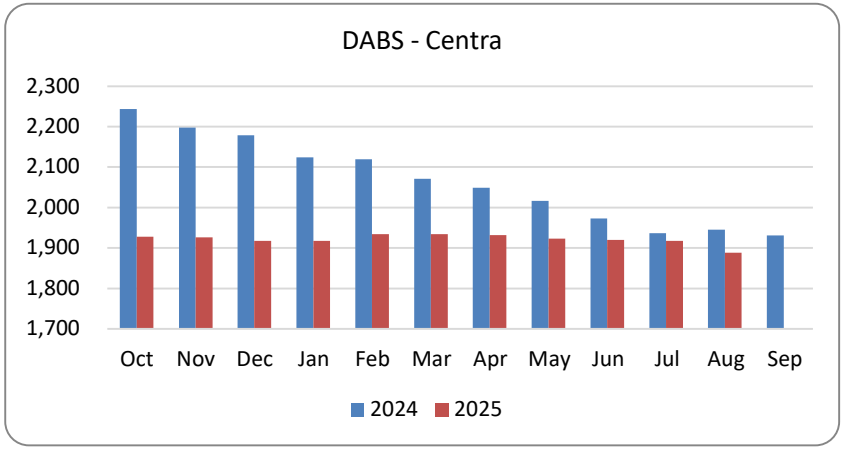


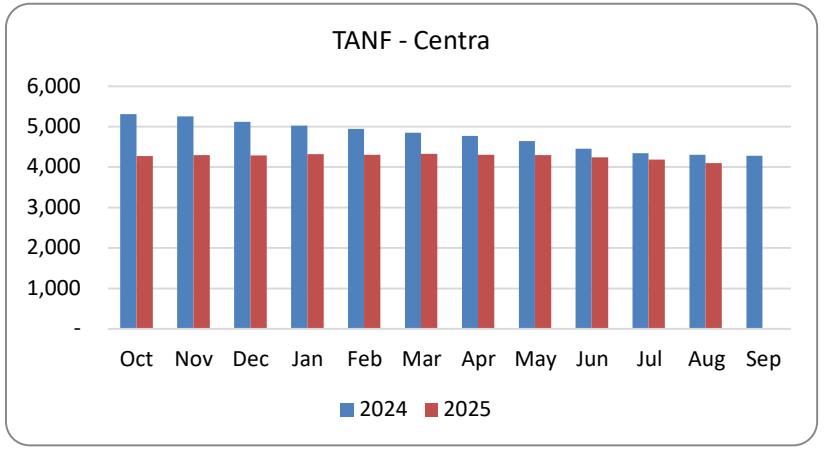
Northern Michigan Regional Entity

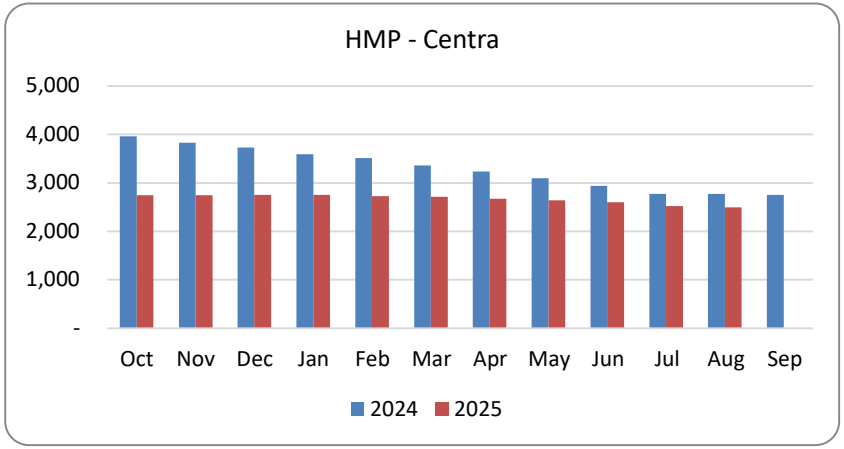
Narrative

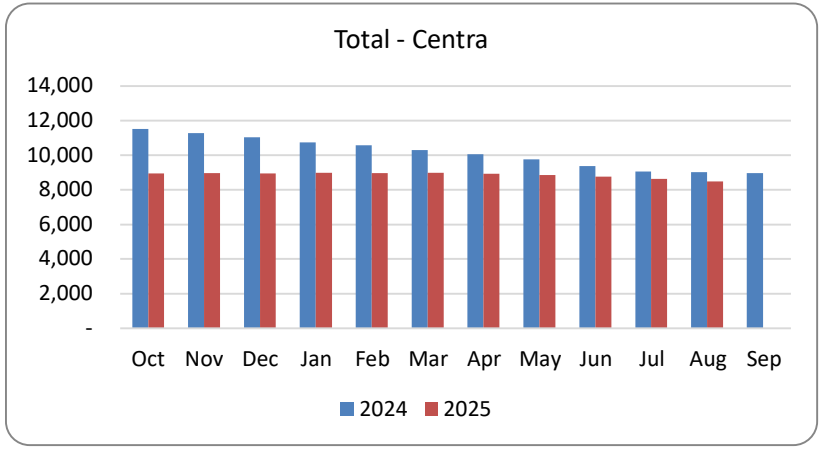
October 1, 2024 through August 31, 2025

Centra Wellness Eligible Members Trending - based on payment files







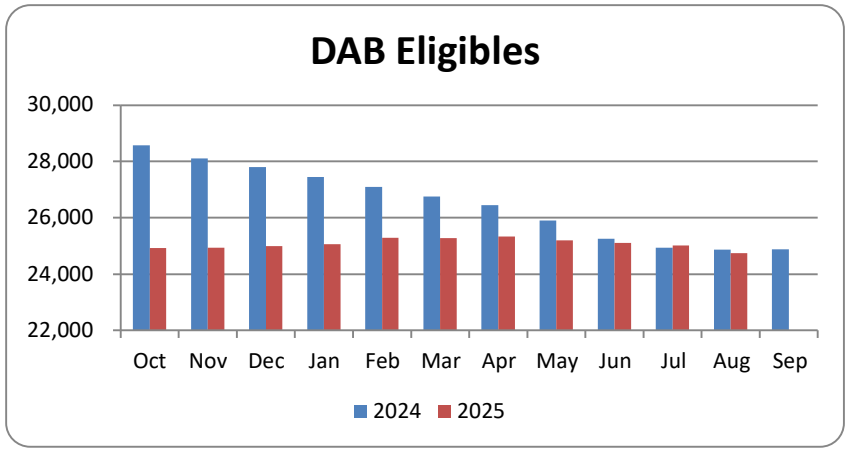


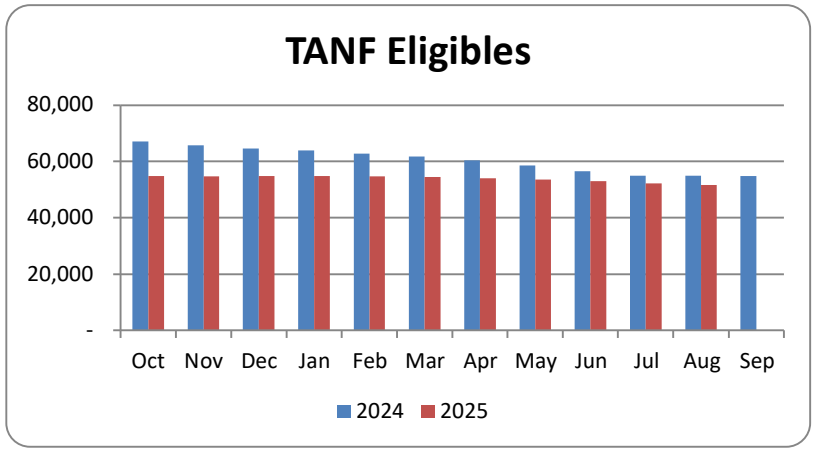
Northern Michigan Regional Entity

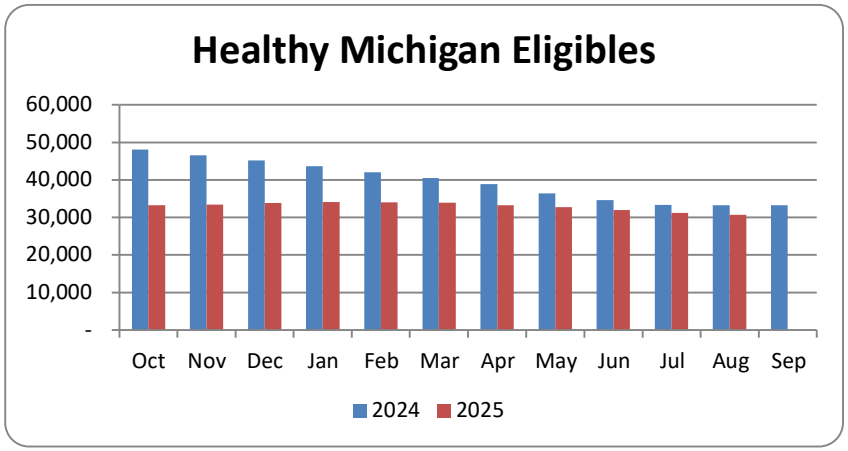
Narrative

October 1, 2024 through August 31, 2025

Regional Eligible Trending





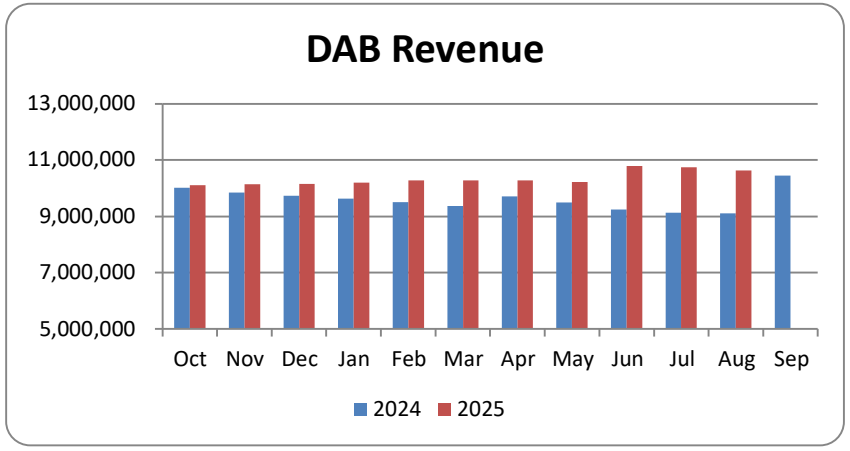


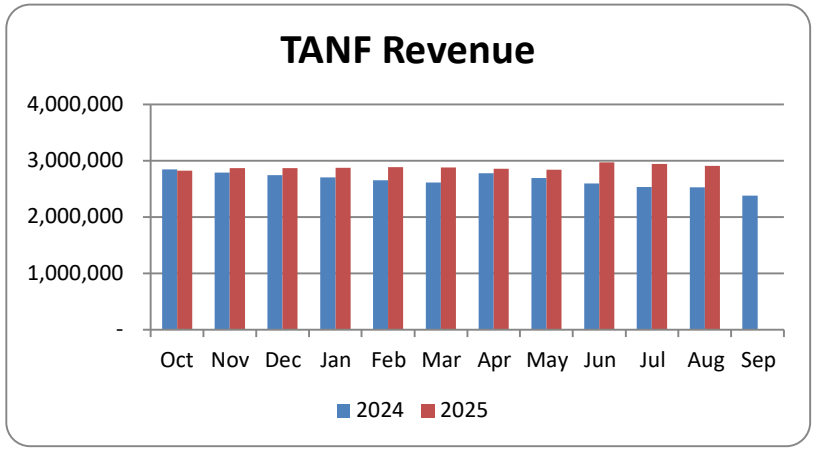
Northern Michigan Regional Entity

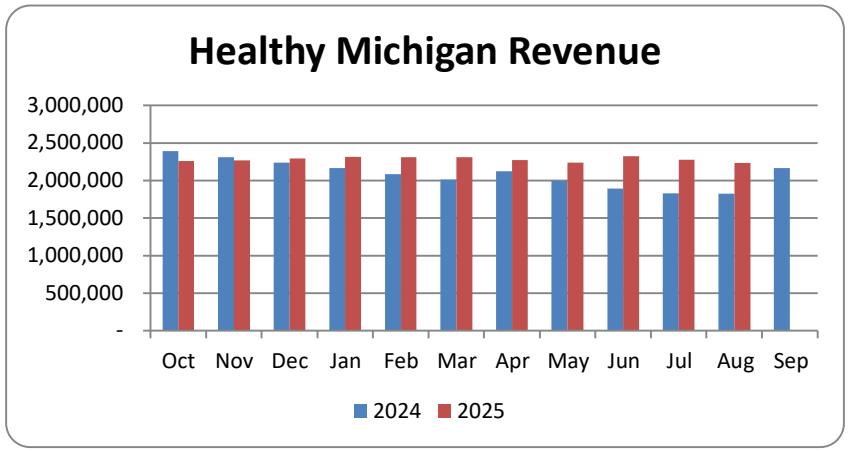
Narrative

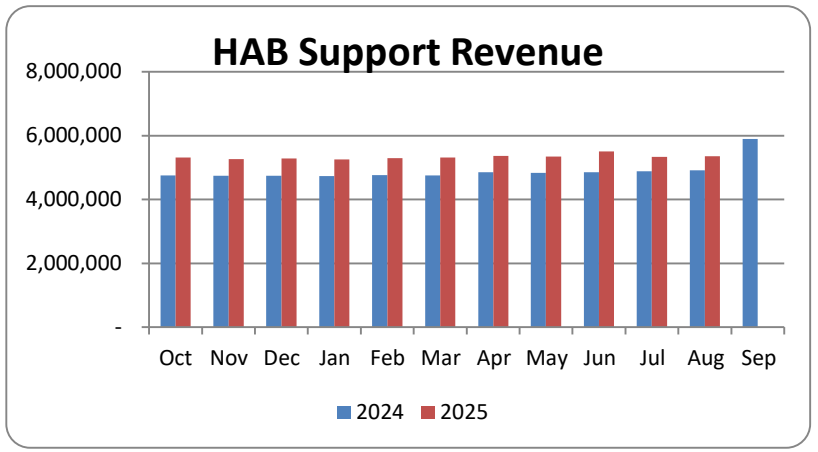
October 1, 2024 through August 31, 2025

Regional Revenue Trending









STATE OF MICHIGAN
DEPARTMENT OF TREASURY

GRETCHEN WHITMER
GOVERNOR

RACHAEL EUBANKS
STATE TREASURER

March 28, 2025

PUBLIC EMPLOYER CONTRIBUTIONS TO MEDICAL BENEFIT PLANS ANNUAL COST LIMITATIONS – CALENDAR YEAR 2026

For a medical benefit plan coverage year beginning on or after January 1, 2012, MCL 15.563, as last amended by 2018 Public Act 477, sets a limit on the amount that a public employer may contribute to a medical benefit plan.

For medical benefit plan coverage years beginning on or after January 1, 2013, MCL 15.563 provides that the dollar amounts that are multiplied by the number of employees with each coverage type be adjusted annually. Specifically, the dollar amounts shall be adjusted, by October 1 of each year after 2011 and before 2019, by the change in the medical care component of the United States consumer price index for the most recent 12-month period for which data are available. By April 1 of each year after 2018, the dollar amounts shall be adjusted by the change in the medical care component of the U.S. consumer price index for the most recent 12-month period for which data are available. For calendar year 2025, the limit on the amount that a public employer may contribute to a medical benefit plan was set to the sum of the following:

- $7,718.26 times the number of employees and elected public officials with single-person coverage
- $16,141,28 times the number of employees and elected public officials with individual-and-spouse coverage or individual-plus-1-nonspouse-dependent coverage
- $21,049.85 times the number of employees and elected public officials with family coverage.

The limits for 2026 equal the 2025 limits increased by **2.9 percent**. The 2.9 percent is the percentage change in the medical care component from the period March 2023-February 2024 to the period March 2024-February 2025.

Thus, for medical benefit plan coverage years beginning on or after January 1, 2026, the limit on the amount that a public employer may contribute to a medical benefit plan equals the sum of the following:

- $7,942.09 times the number of employees and elected public officials with single-person coverage
- $16,609.38 times the number of employees and elected public officials with individual -and-spouse coverage or individual-plus-1-nonspouse-dependent coverage
- $21,660.30 times the number of employees and elected public officials with family coverage.

Rachael Eubanks
State Treasurer

March 28, 2025

STEVEN E BURNHAM
ATTORNEY AT LAW
10286 N RIVERVIEW
PLAINWELL, MICHIGAN 49080-9688

October 12, 2011

Chip Johnston
Chief Executive Officer
Centra Wellness Network
310 N Gloucheski Drive
Manistee, Michigan 49660-0335

RE: Publicly Funded Health Insurance Contribution Act, SB7 of 2011

Dear Mr. Johnston:

You have requested that I provide a brief legal opinion regarding the recently enacted Publicly Funded Health Insurance Contribution Act, otherwise known as Senate Bill 7 or Public Act 152 of 2011.

You have specifically requested comment on two particular questions. The first is whether the act applies to Centra Wellness Network. The second is a brief explanation on the ability to opt out of the Act's application.

I will answer your questions sequentially. I will start with a brief overview of the Act itself. This is not intended to be an exhausted discussion of the Act or it's implications or ramifications- simply a brief wave of the hand description. Beginning January 1, 2012, public employers who offer medical benefit plans to their employees or elected official may not pay more than 80% of the total annual costs of all the medical benefit plans they offer to said employees or elected officials. Additionally, any collective bargaining agreement or contract settled on or after the effective date would have to comply with the requirements of the act as well. The Act defines what are 'costs', 'total costs', 'medical benefit plan' and what is a local unit of government and a public employer. The Act makes allowances for having either an 80/20 cap or a 'hard cap' of an overall dollar amount- ($5,500 for individual coverage, $11,000 for individual and spousal coverage and $15,000 for employees with family coverage).

The first question posed is whether or not your agency is subject to the Act. The simple answer to that question is **YES**. A local unit of government is defined as a city, county,

village, township or authority (SEE Sec 2 (d) of Act). Further a 'public employer' is defined as the "...state, a local unit of government or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision; a school district, a public school academy, or an intermediate school district..... (SEE Sec 2(f) of Act). As you are aware you agency is formed under the auspices of the Urban Cooperation Act and the Mental Health Code. Your agency is clearly a public employer and therefore subject to the Act.

The second question you have requested a brief response to is whether or not your board may opt out of the Act. Interestingly enough the Act does permit a public employer to opt out the Act. Section 8 of the Act indicates that "**by a 2/3 vote of its governing body each year, a local unit of government may exempt itself from** the **requirements of this act for the next succeeding year**." Each succeeding year requires a new vote. There are penalty provisions if a public employer does not comply with the Act- Section 9. The penalty provision imposes a financial reduction of certain state funding- specifically funding coming from the economic vitality incentive program and certain funding under the state school aid act of 1979. However a quick review of these sections would seem to indicate that your agency does not receive funding from either of those sources. I do not see the penalty provision as being a reason to not opt out if that is the boards' direction. I would recommend that in the event the board pursues this option that a roll call vote be taken on the motion.

I hope this brief correspondence covers the two questions you have posed. The statute is new- just signed into law on September 27, 2011 and therefore a bit untested as to the direction is will ultimately take. For purposes of Centra Wellness Network two statements are true- you are a public employer subject to the Act and you are eligible to opt out of the provisions of the Act through a 2/3's vote of your board.

If you have additional questions please do not hesitate to contact me. Thank you for the opportunity to be of service to you and your board.

Steven E. Burnham
Attorney At Law
269.744.1489
seburn@kalcounty.com

STATE OF MICHIGAN

COURT OF CLAIMS

REGION 10 PIHP, SOUTHWEST MICHIGAN BEHAVIORAL HEALTH, MID-STATE HEALTH NETWORK, ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY, INTEGRATED SERVICES OF KALAMAZOO, and SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY,

Plaintiffs,

v

Case No. 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.
_____/

OPINION AND ORDER RESOLVING REQUESTS FOR SUMMARY DISPOSITION

This dispute involves a decision by Defendant Michigan Department of Health and Human Services (MDHHS) to make a transition from a single-source procurement system to a competitive procurement system for furnishing public mental-health services to Medicaid beneficiaries. Even though the MDHHS concedes that this transition was not caused by any statutory amendment, the MDHHS claims existing law supports the change, which takes the form of conditions in a Request for Proposal (RFP) issued by Defendant Michigan Department of Technology, Management, and Budget (DTMB) in 2025. According to plaintiffs, which include several prepaid inpatient health plans (PIHPs) that serve some of the ten existing regions in Michigan, the terms of the 2025 RFP

conflict with Michigan law. In contrast, the MDHHS contends that Michigan law not only affords it discretion to reduce from ten to three the number of regions in the state, but also permits the shift from single-source procurement through the PIHPs to a competitive procurement system in which all of the existing PIHPs can no longer participate. The Court concludes that the MDHHS has the discretion to move from a single-source procurement system to a competitive procurement system, but the language of the 2025 RFP may run afoul of Michigan law in important respects.

I. FACTUAL BACKGROUND

The MDHHS is the state agency charged with administering the state's Medicaid program, including "specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance or substance abuse disorder[,]" which are "carved out" or provided through a different delivery system than medical services that are provided by Medicaid health plans. MCL 400.109f. Currently, this delivery system involves contracts with ten regional PIHPs, which in turn administer Medicaid funds through contracts with community mental-health services programs (CMHSPs) and other service providers. For decades, the MDHHS has sought and received a waiver from the federal government allowing it to contract with PIHPs without a competitive bidding process. But the MDHHS has received no promise that its waiver will remain in place, and its current application for renewal of its waiver is now awaiting a decision from the federal government.

Michigan uses a community-based model for offering public mental-health services that is codified in chapter 2 of the Mental Health Code, MCL 330.1201 *et seq*. Each county in Michigan may establish a CMHSP either on its own or by joining with other counties and/or an institution of higher education located in the county. MCL 330.1204; MCL 330.1204a; MCL 330.1218; MCL

330.1219. Community mental-health organizations established by counties may join together to form a regional entity under MCL 330.1204b, which is how the PIHPs in this lawsuit were formed. A CMHSP's purpose is "to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic services area, regardless of the individual's ability to pay." MCL 330.1206(1). According to MCL 330.1206(1), a CMHSP must provide: (a) "[c]risis stabilization and response"; (b) "[i]dentification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services"; (c) "[p]lanning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services"; (d) "[s]pecialized mental health recipient training, treatment and support"; (e) "[r]ecipient rights services"; (f) "[m]ental health advocacy"; (g) "[p]revention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction"; and (h) "[a]ny other service approved by the [MDHHS]." Also, a "community mental-health entity shall coordinate the provision of substance use disorder services in its region and shall ensure services are available for individuals with substance use disorder." MCL 330.1210(2). Under Michigan law, CMHSPs may be "designated as specialty prepaid health plans under the medicaid managed care program" and may contract with the MDHHS with respect to that. MCL 330.1232b.

A. THE 2025 RFP

On August 4, 2025, the DTMB and the MDHHS issued an RFP for bids to those interested in serving as PIHPs beginning on October 1, 2026.[1] Mandatory minimum requirements for bidders state that the organization must be a nonprofit, governmental entity, or public university. Bidders

[1] The 2025 RFP is officially identified as "Request for Proposal No. 250000002670" for "Prepaid Inpatient Health Plan (PIHP)."

"must submit proposals by region as defined in the RFP, not by individual counties," and although bidders "may bid on more than one" of the three regions, the bidders "must demonstrate the ability to be fully operational across the entire geographic area of the region for which they are submitting a proposal." As the RFP emphasizes, "[b]idders that cannot provide services throughout the entire region will not be considered." The Statement of Work in the RFP requires that the PIHP for each region "hold contracts with each [CMHSP] in its region and . . . minimize duplication of contracts and reviews for providers contracting with multiple CMHSPs . . . ." The contractors are "expected to provide managed care functions to beneficiaries," and all those functions "cannot be delegated to contracted network providers with the exception of Preadmission screening for emergency intervention services per Mental Health Code MCL 330.1409 which shall be performed by the CMHSP with Contractor authorization of inpatient admissions as indicated by the preadmission screening unit." "Managed care functions include, but are not limited to, eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities." The PIHPs selected through the RFP "may not directly provide or deliver health care services beyond these managed care functions."

The chosen PIHPs must provide services in one or more of three regions pre-determined by the MDHHS.[2] Each PIHP is responsible for "development of the service delivery system and establishment of sufficient administrative capabilities to carry out the requirements and obligations of the Contract" without any discrimination. Each PIHP is "not required to contract with providers beyond the number necessary to meet the needs of its beneficiaries and is not precluded from using

[2] In contrast, the existing system divides the State of Michigan into ten regions.

different practitioners in the same specialty." Each PIHP has to notify the state of any significant changes in its provider network both in and out of network. Also, each PIHP is "solely responsible for the composition, compensation and performance of its contracted provider network." The RFP requires PIHPs to work collaboratively with Medicaid Health Plans (MHPs) "to regularly identify and coordinate the provision of services to shared beneficiaries who have significant behavioral health issues and complex physical comorbidities," and to work with the MHPs to "identify and coordinate the provision of services to shared beneficiaries who have significant behavioral health issues and complex physical comorbidities," as well as to "provide care management services. . . to shared beneficiaries." Each PIHP has an exclusive right to serve Medicaid beneficiaries within its service area. But "[i]n a region with a single Contractor, Medicaid beneficiaries are mandatorily enrolled with the single Contractor" unless the covered service or a provider is not available in the network.

B. THIS SUIT CHALLENGING THE 2025 RFP

On August 29, 2025, plaintiffs – including several of the existing PIHPs covering some of the ten existing regions in the state - filed this action seeking a declaratory judgment and injunctive relief concerning the 2025 RFP. Plaintiffs contend that MCL 330.1204b authorizes a CMHSP to form a regional entity with another CMHSP and then contract as a PIHP for the designated service areas of the participating CMHSPs, that the 2025 RFP's "full-region bid requirement" contravenes that authority "by precluding bids confined to a regional entity's designated service area," and that by issuing the 2025 RFP, both the DTMB and the MDHHS exceeded their statutory authority and violated MCL 330.1204b.

Plaintiffs note that the 2025 RFP solicits competitive bids from non-profit, governmental, and educational institutions that are interested in contracting with the MDHHS to serve as PIHPs in one of three regions beginning in fiscal year 2027. The RFP represents a significant, structural change in the delivery of Medicaid funds for public mental-health services in Michigan. There are currently ten PIHPs serving ten geographic regions, and several of them are plaintiffs in this case. None of the ten current PHIPs can satisfy the requirements to bid under the 2025 RFP, so all ten of them will be dismantled after fiscal year 2026. Other plaintiffs in this case are CMHSPs created under the Mental Health Code, and specifically MCL 330.1204. Those CMHSPs have contracts with the current PIHPs and receive Medicaid funds to carry out their duties prescribed by Michigan law. They, too, support the existing single-source procurement system based on ten regions, which would be upended by the 2025 RFP.

Plaintiffs not only filed the complaint demanding declaratory and injunctive relief, but also moved for a preliminary injunction to prevent the MDHHS and the DTMB from "proceeding with and awarding any bids" submitted in response to the 2025 RFP. Defendants opposed injunctive relief and requested summary disposition under MCR 2.116(C)(8) and (10), claiming that the 2025 RFP was developed pursuant to the MDHHS's authority under state and federal law. In response, plaintiffs opposed defendants' request for summary disposition and demanded such relief in their own right under MCR 2.116(I)(2). The Court agreed to address all of the motions on an expedited basis. Hence, on October 9, 2025, the Court conducted oral argument on the competing requests for summary disposition. The Court also took testimony on plaintiffs' motion for injunctive relief. In this opinion, however, the Court shall focus exclusively on the parties' competing requests for summary disposition. Plaintiffs' motion for a preliminary injunction will be resolved in a separate opinion and order.

II. LEGAL ANALYSIS

Defendants moved for summary disposition under MCR 2.116(C)(8) and (10). Plaintiffs responded by requesting similar relief under MCR 2.116(I)(2), which provides that, "[i]f it appears to the court that the opposing party, rather than the moving party, is entitled to judgment, the court may render judgment in favor of the opposing party." A motion requesting summary disposition "under MCR 2.116(C)(8) tests the *legal sufficiency* of a claim based on the factual allegations in the complaint." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159; 934 NW2d 665 (2019). In contrast, a summary disposition motion under MCR 2.116(C)(10) "tests the *factual sufficiency* of a claim." *Id.* at 160. Because the parties supplied materials to the Court to consider as part of the competing requests for summary disposition, the Court shall consider whether relief is proper under MCR 2.116(C)(10). See *Cary Investments, LLC v Mount Pleasant*, 342 Mich App 304; 312-313; 994 NW2d 802 (2022). Summary disposition under MCR 2.116(C)(10) may be granted only if "there is no genuine issue of material fact." *El-Khalil*, 504 Mich at 160. Such a genuine issue of material fact exists "'when the record leaves open an issue upon which reasonable minds might differ.'" *Id.* With these standards in mind, the Court will first consider whether the MDHHS has the legal authority to shift from a single-source procurement system to a competitive procurement system. Next, the Court will decide whether the MDHHS violated Michigan law by reducing the number of PIHP regions from ten to three. Finally, the Court will evaluate whether the 2025 RFP conforms to the requirements of Michigan law.

A. THE SHIFT IN THE PROCUREMENT SYSTEM

By all accounts, the 2025 RFP shifts Michigan from a single-source procurement model to a competitive procurement model. Plaintiffs argue that Michigan law disallows such a transition,

but the Court concludes that a competitive procurement system is not only compatible with state law, but also regarded as the preferred nationwide model. The federal preference for competitive procurement is so strong that, for years, the MDHHS has had to obtain federal authorization in the form of a waiver of governing provisions the Social Security Act, "under which the State operates the Managed Specialty Services and Supports Program," to maintain its single-source procurement system. See Plaintiffs' Exhibit 2 (letter to James K. Haveman, Jr., dated February 20, 2001). The state's most recent request for a waiver is still pending, and the MDHHS has no assurance that its request will be granted. Thus, the MDHHS is simply taking proactive steps to bring Michigan into compliance with the federal mandate of competitive procurement.

Plaintiffs insist that the shift from single-source procurement to competitive procurement cannot be squared with Michigan law, which contemplates the formation and support of CMHSPs, see MCL 330.1202(1); 330.1204(1), and expressly permits "a combination of community mental health organizations or authorities to establish a regional entity" in the form of a PIHP. See MCL 330.1204b(1). To be sure, Michigan law requires CMHSPs and allows for PIHPs, but the approach in the 2025 RFP to move to a competitive procurement system meets the requirements of Michigan law by maintaining CMHSPs and PIHPs, albeit in a modified configuration that provides for three PIHPs, but no more than that.

Plaintiffs' principal complaint rests on the fact that no existing PIHP can bid for a contract under the 2025 RFP because each existing PIHP covers one of the ten existing geographic regions, whereas the 2025 RFP recognizes only three larger geographic regions, so the existing PIHPs will not be able to provide services across any of the three newly recognized regions. But that concern has nothing to do with the legality of the competitive procurement system. Instead, the complaint arises from the existing PIHPs' inability to qualify as a bidder under the 2025 RFP, which explains

that "[b]idders that cannot provide services throughout the entire region will not be considered." In other words, although plaintiffs describe their own treatment as impermissible under Michigan law, they cannot establish that the shift from a single-source procurement system to a competitive procurement system impermissibly alters the structure of PIHPs and CMHSPs. Consequently, the Court must turn to the propriety of the alteration of the regions accomplished by the 2025 RFP to ascertain whether plaintiffs are entitled to relief.

B. THE REDUCTION FROM TEN REGIONS TO THREE REGIONS

Without question, the 2025 RFP divides the state into just three regions, and each region is substantially larger than any of the existing ten regions. Reduction of the number of regions is not unprecedented. In 2013, the MDHHS reduced the number of regions from 18 to ten, and that was done without creating significant concerns. To be sure, plaintiffs insist that that was accomplished through a truly collaborative process, whereas the reduction of regions mandated by the 2025 RFP appears to be the unilateral work of the MDHHS. Moreover, the requirement in the 2025 RFP that "[b]idders that cannot provide services throughout the entire region will not be considered" has an adverse impact on the existing PIHPs, which are effectively foreclosed from bidding because they lack the capacity to provide services throughout any of the three new regions. But those facts do not render the reduction of regions from ten to three incompatible with Michigan law.

Under MCL 330.1204b(1), "[a] combination of community mental health organizations or authorities may establish a regional entity" in the form of a PIHP, but no Michigan statute sets the number of regions that must exist or defines the geographic boundaries of such regions. Therefore, the MDHHS has no statutory mandate to maintain the existing regions. Divesting the established PIHPs of their coverage areas, and concomitantly closing those PIHPs out of the bidding process

by mandating that bidders must serve the entirely a new region, seems unwise given the history of those existing PIHPs with the program and their strong connections with CMHSPs and providers. But assessing the wisdom of such changes is a matter of policy reserved for the MDHHS, not the courts. Indeed, as our Legislature made clear in MCL 400.109f(1), "Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans chosen by the department" of Health and Human Services. However unwise the changes may seem, nothing in Michigan law precludes the MDHHS from making them. Thus, the Court lacks the authority to invalidate the changes in the number and geographic scope of the regions serviced by PIHPs.

C. THE PARTICULAR REQUIREMENTS OF THE 2025 RFP

Having acknowledged the authority of the MDHHS to make the structural changes at issue, the Court must consider the propriety of the specific requirements set forth in the 2025 RFP. One particular aspect of the 2025 RFP gives rise to a genuine issue of material fact, which prevents the Court from awarding summary disposition to either side on plaintiffs' challenge to the 2025 RFP. Michigan law does not empower the MDHHS to rewrite the Mental Health Code by permitting a PIHP to directly provide or contract out services that a CMHSP is statutorily obligated to provide. In its current form, the Statement of Work (that is Schedule A to the 2025 RFP) states that PIHPs "are expected to provide managed care functions to beneficiaries[,]" and "[t]hose functions cannot be delegated to contracted network providers" as a general matter. See Statement of Work, § 1.1. That assignment of non-delegable functions to PIHPs appears to conflict with MCL 330.1206(1), which assigns those functions to CMHSPs, rather than PIHPs.

Beyond that, nothing in the 2025 RFP itself or the attached Statement of Work requires a PIHP to provide Medicaid funds to a CMHSP for services that the CMHSP is obligated to provide.

Medicaid funding presumably is just one source of the CMHSP's funding, but Medicaid funds are vital to CMHSPs in carrying out their responsibilities. Indeed, nothing in the record even suggests that a CMHSP can exist and operate without Medicaid funds. Without question, the MDHHS has discretion to select a PIHP, see MCL 400.109f(1), but the MDHHS cannot exercise that discretion in a manner that renders CMHSPs unable to carry out their statutory obligations. The record does not enable the Court to determine whether CMHSPs are actually or potentially fatally impaired by the language of the 2025 RFP (including the Statement of Work), so the Court cannot yet enter an order awarding summary disposition to either side of this dispute.[3]

III. CONCLUSION

Defendants are granted summary disposition under MCR 2.116(C)(10) on the claims that the MDHHS may switch from a single-source procurement system to a competitive procurement system and that the MDHHS may reduce the number of PIHP regions from ten to three. Summary disposition is denied to both sides with regard to the legality of the terms in the 2025 RFP.

IT IS SO ORDERED.

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

Dated: October 14, 2025

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

[3] The lingering concerns primarily involve CMHSPs, not PIHPs, but those concerns can be raised by several plaintiffs in this case. Thus, the Court must resolve those concerns before declaring a winner in this dispute. See *Associated Builders and Contractors of Mich v Dep't of Technology, Mgt, and Budget*, ___ Mich ___, ___; ___ NW3d ___ (2024) (Docket No. 363601); slip op at 5 (holding that "standing to sue for declaratory relief" exists when "bidders on state contracts" seek "declaratory relief against a policy" that they claim is "in contravention of state law").

STATE OF MICHIGAN

COURT OF CLAIMS

REGION 10 PIHP, SOUTHWEST MICHIGAN BEHAVIORAL HEALTH, MID-STATE HEALTH NETWORK, ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY, INTEGRATED SERVICES OF KALAMAZOO, and SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY,

Plaintiffs,

v

Case No. 25-000143-MB

Hon. Christopher P. Yates

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

Defendants.
_____ /

OPINION AND ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION

In this case contesting a decision by Defendant Michigan Department of Health and Human Services (MDHHS) to make a transition from a single-source procurement system to a competitive procurement system for providing public mental-health services, plaintiffs have filed a motion for a preliminary injunction preventing the MDHHS from proceeding with the bidding process for the selection of prepaid inpatient health plans (PIHPs) to serve three regions in the State of Michigan. The Court conducted an evidentiary hearing on plaintiffs' motion on October 9, 2025. Based upon the record developed at that hearing, the Court finds that plaintiffs have made a substantial showing that they will suffer irreparable harm in the absence of injunctive relief. Specifically, the plaintiffs

that now serve as PIHPs in several of the state's ten existing regions will be forced out of business in a matter of months if the MDHHS proceeds with its challenged bidding process, which in turn will result in job losses for the employees of those PIHPs. But the Court shall deny the motion for a preliminary injunction against the MDHHS and the other state defendants because "declaratory relief normally will suffice to induce the legislative and executive branches" to conform to the law. *Davis v Detroit Fin Review Team*, 296 Mich App 568, 614; 821 NW2d 896 (2012). "Only when declaratory relief has failed should the courts even begin to consider additional forms of relief in these situations." *Id.* Here, although the Court has not yet granted plaintiffs any declaratory relief, the possibility of such an outcome is significant, and the Court will act expeditiously to address what remains of the complaint seeking a declaratory judgment.

In a separate opinion and order issued today, the Court has made clear that a genuine issue of material fact remains as to the legality of the 2025 Request for Proposal concerning the matters at issue, so the Court cannot yet grant summary disposition in full to either side. If circumstances develop after the issuance of this opinion and order denying injunctive relief that cause the Court to revisit the necessity of a preliminary injunction, the Court will reconvene the hearing addressing plaintiffs' motion. At that time, but not before, the Court will address the admissibility of the tape recording surreptitiously obtained by plaintiffs and marked as plaintiffs' proposed exhibit 10.

IT IS SO ORDERED.

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

Dated: October 14, 2025

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

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY, MANISTEE COUNTY Plaintiffs	Case No. 2025- -MB Hon.

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, a Michigan State Agency, and, STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY AND BUDGET, a Michigan State Agency.

Defendants.

Christopher K. Cooke (P35034)
SECREST WARDLE
2025 East Beltline, SE, Suite 600
Grand Rapids, MI 49546
616-285-0143 / 616-285-0145 (f)
ccooke@secrestwardle.com
zlambert@secrestwardle.com – Sec.
Attorney for Plaintiffs

There is another case currently pending before this Court which arises out of the same set of facts and circumstances but involves other parties as plaintiffs; Region 10 PIHP v. State of Michigan, case number 25-000143-MB

COMPLAINT

1. Plaintiffs community mental health organizations (hereinafter "Community Mental Health Services Programs" CMHSPs) have been and are providing community mental health

services to qualifying recipients within their geographical territory. Individual plaintiff CMHSPs are identified as follows:

a. Manistee-Benzie Community Mental Health d/b/a Centra- Wellness Network, an inter-local affiliation between Manistee and Benzie counties, with its principal office located at 310 Glocheski, Manistee, MI 49660.

b. AuSable Valley Community Mental Health Authority, d/b/a Wellvance, providing mental health services in Iosco, Ogemaw and Oscoda, with its principal office located at 511 Griffin Road, West Branch, MI 48661

c. Gogebic Community Mental Health Authority, with its principal office located at 103 US-2 Wakefield, MI 49968.

d. Northeast Michigan Community Mental Health Authority, providing mental health services in Alcona, Alpena, Montmorency and Presque Isle Counties, with its principal office located at 400 Johnson Street, Alpena, MI 49707.

e. North Country Community Mental Health Authority, providing mental health services in Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego counties, with its principal office located at 515 S. Birch Street, Kalkaska, MI 49646.

2. Plaintiff Manistee County, a Michigan county governments with its principal office located at 415 Third Street, Manistee, MI 49660, as with all Michigan counties, has specific legal responsibilities to provide, contract for, oversee and obtain funds for community mental health services within their county limits depending on the organization of the CMHSP. (MCL 330.1204)

3. Regional Entities, now designated as Prepaid Inpatient Health Plans ("PIHPs"), are currently, governmental entities organized, per statute, by CMHSPs that facilitate the delivery of

mental health services to qualifying individuals through a funding contract with the Defendant Michigan Department of Health and Human Services. (MCL 330.1204b)

4. Currently there are 10 regional PIHPs which cover designated areas of the State and disburse capitated Medicaid payments to CMHSPs that it receives from the State of Michigan through a written annual contract.

5. "Capitated payments" are disbursed monthly by the State to the PIHPs and are passed down to the CMHSPs based on an estimate of Medicaid recipients ("lives") the CMHSPs expect to serve in the upcoming year.

6. All plaintiffs have the statutory obligation to provide mental health services within their geographical territories for individuals suffering from mental illness, developmental disabilities and substance use disorders, regardless of the individual's ability to pay (MCL 330.1204, MCL 330.1206, MCL 330.1232b).

7. Thus, if the recipient is not covered by Medicaid, the CMHSPs are charged with the responsibility to find an alternate payment source which might be private insurance, private pay or county funds.

8. The recipient could also qualify for Medicaid at the onset of treatment but become disqualified during treatment and the CMHSP would be, once again, called upon to find an alternate funding source.

9. Defendant Department of Health and Human Services ("DHHS") is a Michigan state agency that provides public assistance, child and family welfare services, and oversees health policy and management.

10. Defendant Department of Technology, Management and Budget ("DTMB") supports the business operations of state agencies through a variety of services, including building

management and maintenance, information technology, centralized contracting and procurement, budget and financial management, space planning and leasing, construction management, motor vehicle fleet operations, and oversight of the state retirement systems.

11. On August 4, 2025, Defendant DTMB, in conjunction with Defendant DHHS, issued a Request for Proposals (RFP) soliciting bids from public and private non-profit non-governmental entities to act as PIHPs (Exhibit 1) that dramatically and detrimentally changes the way mental health services will be delivered and coordinated in the state in the following ways among others:

a. it allows for the provision of mental health services by private non-profit, non-governmental entities ("privatization");

b. it prohibits the selected PIHPs from delegating core functions, which are statutorily designated to CMHSPs, to the CMHSPs such as utilization management, network development and claims processing (MCL 330.1204; MCL 330.1206)

c. it solicits bids from qualifying private non-profit entities that will not have the same administrative cost restrictions as the current PIHPs;

d. it changes the geographical territories wherein which the existing PIHPs operate by reducing the number of regions from 10 to 3 and refusing to consider any bids wherein the bidder is unable to cover all of the new territory, thereby eliminating the ability of most of the existing PIHPs and CMHSPs from bidding[1];

e. it illegally prohibits the CMHSPs from contracting for provider services within its service area by placing all contracting responsibility in the hands of the newly created PIHP, dramatically reducing or eliminating the CMHSPs from providing a full

[1] T*his specific issue is the subject of Region 10 PIHP vs. State of Michigan, 25-000143-MB currently pending before this Court.*

array of behavioral health services, which is an essential tool particularly in times of crisis, for a beneficiary;

f. it illegally mandates the composition of the PIHP board by prohibiting members of the CMHSPs from participating on the PIHP board contrary to MCL 330.1204b, MCL 330.1212 and MCL 330.1222;

g. it requires the winning contractor to comply with the Open Meetings Act and the Freedom of Information Act, however, if the winning contractor is a private entity it has no legal obligation to comply with either Act, thereby, jeopardizing the transparency that the Mental Health Code requires, eliminating the statutory right of a citizen to demand documentation and voiding the associated powers and penalties provided by the two Acts for non-compliance;

h. it eliminates the Recipient Rights system that applied to public entities, requiring timely investigation of recipient rights complaints, privacy protections, appellate remedies and administrative hearings and, instead, replaces it with some undefined "internal grievance procedure" with no access to administrative review;

i. it adds another layer of administration and, thereby, additional cost to the system contrary to the stated purpose of the Mental Health Code to structure the provision of mental health services in the most cost-efficient way possible;

j. it ignores a much more comprehensive analysis undertaken by the Defendant DHHS in 2000 when it published its "Revised Plan of Procurement of Medicaid Specialty Prepaid Health Plans" concluding that "certain important considerations and characteristics made market selection of specialty PHPs *impractical and undesirable*." (Exhibit 2).

A brief history of the development of the delivery of mental health services

12. Plaintiffs incorporate paragraphs 1 through 11 as if fully set forth herein.

13. Prior to 1963, individuals suffering from mental illness, developmental disabilities or substance use disorders were housed in county or state jails or state hospitals.

14. On April 29, 1963, Governor George Romney signed into law Act 54 of the Public Acts of 1963- Michigan's Community Mental Health Services Act. Sections 190-192 of the Act describe its scope and purpose:

> "Increasing numbers of persons afflicted with psychiatric disorders require care and treatment in mental institutions. The human suffering and social and economic losses caused by these costly infirmities are a matter of grave concern to the people of the state. This act is designed to encourage the development of preventative, rehabilitative and treatment services through new community mental health programs and the improvement and expansion of existing community services."

15. On October 31, 1963, President John F. Kennedy signed into law the Community Mental Health Act which drastically altered the delivery of mental health services from in-patient "warehousing" of people with mental illness to the establishment of comprehensive community mental health centers throughout the country. It helped people with mental illnesses who were "warehoused" in hospitals and institutions move back into their communities.

16. In 1974**,** Public Act 54 was replaced with Act 258 of the Public Acts of 1974, the Mental Health Code. Its scope and purpose was described as:

> "An act to codify, revise, consolidate, and classify the laws relating to mental health; to prescribe the powers and duties of certain state and local agencies and officials and certain private agencies and individuals; to regulate certain agencies

and facilities providing mental health services; to provide for certain charges and fees; to establish civil admission procedures for individuals with mental illness or developmental disability; to establish procedures regarding individuals with mental illness or developmental disability who are in the criminal justice system; to provide for penalties and remedies; and to repeal acts and parts of acts."

17. In 1979, Governor William Milliken appointed the Committee on Unification of the Public Mental Health System which issued its report in January of 1980. The report recommended a single point of responsibility for entry into and exit from the public mental health system. It further recommended that local mental health authorities made up of one or more counties be established to act as that single point of responsibility and to manage and deliver services. The report recommended that there be a sharing in system governance between the Department of Mental Health and the local community mental health authorities, that shared responsibility be extended, via a contract, to the operation of state psychiatric facilities and centers for developmental disabilities, and that increased control over direct services personnel and fiscal resources be recommended for CMH boards.

18. Acting on these recommendations**,** new ways were sought to accelerate the transfer of responsibility for direct delivery of mental health services from the state to county CMH boards as mandated by Section 116 of the Mental Health Code. In 1980, the Alger-Marquette, Kent, St. Clair and Washtenaw boards were selected to pilot a new method of contracting with the Department of Mental Health. This became known as "full management" contracting and provided flexibility within a CMH board's budget to purchase inpatient care or develop community-based alternative services. After a successful pilot experience, the opportunity to enter into full

management contracts was available to the entire system. Eventually all CMH boards sought and achieved full management status.

19. Medicaid became the major source of funding for mental health services during the 1980s and 1990s as Michigan added clinic, home and community-based, children's model II, habilitation, and rehabilitation coverages to its Medicaid state plan.

15. The growth of community-based, alternative services made possible by full management contracting and new sources of Medicaid revenue have resulted in the major expansion of community-based services and the significant decline in census at state operated psychiatric hospitals which occurred throughout the 80's and 90's. Since 1965, thirty-six (36) hospitals serving adults with mental illnesses, centers serving persons with developmental disabilities and programs serving emotionally disturbed children have been closed by the State of Michigan. CMH boards have become the primary providers of long term care for persons with severe and persistent mental illness and developmental disabilities.

20. The growth of the CMH system may best be illustrated by the increase in the amount of funds, both state General Funds, Medicaid, Health Michigan Plan (Medicaid expansion), PA2, and Federal Block Grant dollars, appropriated annually for CMH services.

1970 $13.1 million

1980 $104.2 million

1990 $626.7 million

2000 $1.1 billion

2010 $2.5 billion

2020 $3.5 billion

(Source: History of the System and the Association, Community of Mental Health Association, 2020, Exhibit 3)

21. There is a long and generally successful history in Michigan's development of a public mental health treatment system designed to move beneficiaries from in-patient "warehouse" treatment modalities to community based, locally responsive and legally regimented community mental health systems providing person-centered treatment.

22. From 1998 to 2000, the Defendant DHHS considered moving to a competitive procurement model. In its paper, "Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans" (September 2000) (Exhibit 2), the Defendant DHHS extensively reviewed the advisability of moving to a competitive procurement model for the obtainment of Medicaid Specialty Prepaid Health Plans in an effort to comply with the Federal Regulations that require competitive procurement of contracts supported by Federal Medicaid dollars (45 CFR Part 74). This 27-page analysis was the culmination of eighteen months of, "extensive discussions with beneficiaries, family members of disabled individuals, advocacy organizations, public officials, providers and CMHSPs regarding procurement of specialty PHPs," and *ten public hearings and 750 written comments.* This analysis also examined, "outcomes of competitive managed specialty arrangements in other states." The analysis by the Defendant DHHS concluded that competitive procurement *would not be* in the best interests of Medicaid recipients because:

a. Medicaid as a funding source might be "split off and placed under separate governance" which would introduce "inefficiencies, service fragmentation and coordination problems that have historically hindered effective care for beneficiaries with serious mental illness, developmental disabilities and addictive disorders." (Exhibit 2 at p. 5)

b. Competition would diminish local control and oversight of community-based systems. (Exhibit 2 at p. 6)

c. Open meetings, consumer participation on governing boards, self-determination, person-centered planning would be lost under market arrangements that stress efficiency over freedom and equity considerations. (Exhibit 2, p. 6)

d. Profit incentives would compromise access and quality, "encouraging managing entities to expropriate (in a revenue/profit stream) funds that should go to enhance services or promote independence for disabled beneficiaries," (Exhibit 2 at p. 6).

e. There would be disruptions in care continuity if new managers were selected.

f. There would be a loss of, "seamless access to a range of other services supported through different funding streams," as certain beneficiaries with special needs move in and out of Medicaid eligibility. (Exhibit 2, p. 7).

g. "If Medicaid specialty services were handled separately from these other services, care coordination and cost-shifting problems could intensify." (Exhibit 2, p. 7).

h. Non-governmental entities selected as the Medicaid specialty PHP would not be under statutory obligations to implement certain activities that facilitate participation, integration and inclusion of persons with mental illness, developmental disabilities and addictive disorders. (Exhibit 2, p. 7).

23. The culmination of the Defendant DHHS analysis was that a competitive market model would not be in the best interests of the Medicaid beneficiaries of mental health specialty services as, "the activity or services being procured is rather involved and difficult to specify at the outset and the transaction entails an ongoing relationship between the parties." Further:

a. The purchaser needs the seller to make significant asset- specific investments (e.g. specialized facilities, dedicated programs, distinctive workforce) to organize, produce and/or deliver certain unique goods or services;

b. Frequent interaction and close collaboration between the parties is required to achieve certain common objectives; and

c. Continuous adaptations or adjustments to the arrangement must be made in response to changing circumstances or unanticipated contingencies. (Exhibit 2, p. 9).

24. Defendant DHHS research into privatization of Medicaid specialty services in other states led it to conclude:

a. "Due to consolidation in the for-profit managed behavioral health care sector, competitive procurement in other states has degenerated from the standard market model into an oligopolistic market situation, in which a few large organizations dominate the bid process." (Exhibit 2, p. 11).

25. Defendant DHHS paper also affirmatively states the rationale for maintaining local control of behavioral health services in the CMHSP governmental structure"

> "…a significant portion of the public care system for individuals with the most disabling conditions extends beyond health care services to rehabilitation and support services, including housing, job counseling, literacy and other programs. The coordination of these services requires collaboration and cooperative relationships among many agencies, including public health, social services, housing, education, criminal justice and others. Most of these services are not covered by private insurance and have not been developed by most private behavioral health care companies." (Exhibit 2 at p. 13).

26. Despite the Defendant DHHS extensive analysis of the pros and cons of privatizing the delivery of mental health specialty services, it has now published an RFP that does the exact opposite of its own research without explaining how the delivery of mental health services differs today than it did in 2000, it ignores the statutory requirements of local CMHSP control of the contracting for and provision of necessary services, it hamstrings the ability of the CMHSPs to contract with various providers to provide a flexible array of ongoing services, emergency intervention, crisis stabilization, housing, counseling, drop in centers, jail diversion and other necessary emergent services that cannot await authorization from a private insurer.

27. Currently Plaintiff CMHSPs are funded through a capitation rate that estimates the amount of Medicaid dollars that will be needed throughout the ongoing year based on the local Medicaid population to be served. This allows the Plaintiff CMHSPs to respond immediately to any mental health crisis situation of the client, to mix funding sources as appropriate to assure that beneficiaries do not lose coverage during treatment, allows the development of diversion programs that aid in preventing recidivism and crisis hospitalizations and maintains the local county control and tailoring of mental health assistance for their populations as required by State law.

28. A statutory system of grievance procedures affords the beneficiary a timely legal review of the beneficiary's rights with an appellate remedy. Something a private insurer cannot implement. An internal grievance procedure of a private insurer does not have the force of law.

COUNT I – DECLARATORY RELIEF

29. Plaintiffs incorporate paragraphs 1 through 28 as if fully set forth herein.

30. There are a number of actual controversies between the Plaintiffs, who have a statutory duty to provide mental health services within their geographical territories for individuals suffering from mental illness, developmental disabilities and substance use disorders regardless of

the individual's ability to pay (MCL 330.1204, MCL 330.1206, MCL 330.1232b), and the defendants who have issued an RFP requesting competitive bids for the provision of Medicaid specialty services, yet, have successfully applied for a waiver of the Federal Procurement rules for many years reasoning that sole source procurement of mental health services was in the best interests of the recipients, including but not limited to:

a. Whether the Defendant DHHS has the legal authority to override statutory mandates that require the boards of CMHSPs to, "approve and authorize all contracts for the provision of services." MCL 330.1226

b. Whether Defendant DHHS has the legal authority to usurp the individual CMHSPs statutory power to form Regional Entities of their choosing and force them to form some inter-local or Urban Cooperation group in order to be eligible to bid on the provision of mental health services in much larger Regions chosen by the Department. MCL 330.1204b

c. Whether Defendant DHHS has the legal authority to solicit bids from non-governmental entities to act as PIHPs thus eliminating the statutory protections and powers of the Freedom of Information Act, the Open Meetings Act and the Recipient Rights investigative and administrative remedies.

d. Whether the Defendant DHHS is acting in the best interests of the recipient of mental health, developmental disabilities or substance use disorder services by allowing the privatizing of the distribution of Medicaid monies to the CMHSPs which will inject a profit motive into a system designed to maximize benefits to the recipients.

e. Whether the implementation of the RFP, which eliminates the CMHSPs ability to contract with local providers and fund, as required by statute, specialty mental

health services within its geographical territory will prevent the CMHSPs from seeking alternate funding sources for recipients who go on and off Medicaid and those whose deductibles are funded by CMHSPs general funds that, thereby, allow for continued Medicaid coverage.

f. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substance use disorder services by allowing privatization when it has acknowledged that Medicaid as a funding source might be, "split off and placed under separate governance," which would introduce, "inefficiencies, service fragmentation and coordination problems that have historically hindered effective care for beneficiaries with serious mental illness, developmental disabilities and addictive disorders." (Exhibit 2 at p. 5)

g. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substance use disorder services by allowing privatization when it has acknowledged that competition would diminish local control and oversight of community-based systems. (Exhibit 2 at p. 6)

h. Whether the Defendant DHHS has the legal authority to remove local control and oversight of community-based systems now in the hands of County Commissioners whose counties retain the statutory obligation to provide mental health services to residents regardless of their ability to pay and turn this control over to private non-governmental entities which will not have the same legal obligation as it pertains to the distribution of Medicaid funds.

i. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substances use disorder services by allowing

privatization when it has acknowledged open meetings, consumer participation on governing boards, self-determination and person-centered planning would be lost under market arrangements that stress efficiency over freedom and equity considerations. (Exhibit 2, p. 6)

j. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substance use disorder services by allowing privatization when it has acknowledged that profit incentives would compromise access and quality, "encouraging managing entities to expropriate (in a revenue/profit stream) funds that should go to enhance services or promote independence for disabled beneficiaries" (Exhibit 2 at p. 6).

k. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substance use disorder services by allowing privatization when it has acknowledged that there would be disruptions in care continuity if new managers were selected.

l. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substance use disorder services by allowing privatization when it has acknowledged that there would be a loss of, "seamless access to a range of other services supported through different funding streams," as certain beneficiaries with special needs move in and out of Medicaid eligibility. (Exhibit 2, p. 7).

m. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substance use disorder services by allowing privatization when it has acknowledged, "[I]f Medicaid specialty services were handled

separately from these other services, care coordination and cost-shifting problems could intensify." (Exhibit 2, p. 7).

n. Whether the Defendant DHHS is acting in the best interests of the recipients of mental health, developmental disabilities or substance use disorder services by allowing privatization when it has acknowledged that non-governmental entities selected as the Medicaid specialty PHP would not be under statutory obligations to implement certain activities that facilitate participation, integration and inclusion of persons with mental illness, developmental disabilities and addictive disorders. (Exhibit 2, p. 7).

o. Whether Defendant DHHS has conducted any surveys, studies, analysis, meetings, reviews of a substantial nature that would call into question its conclusions in its 2000 paper where it convincingly supported its decision to obtain a waiver of the Federal Procurement rules for the provision of specialty Medicaid services to recipients of mental health, developmental disabilities or substance use disorder services in the state of Michigan.

WHEREFORE, Plaintiff CMHSPs and County respectfully request this Court to declare the rights and responsibilities of the parties and to:

a. Issue a preliminary injunction prohibiting the Defendants from soliciting bids under the RFP or, in the alternative, prohibiting the Defendants from contracting with bidders under the current RFP framework;

b. Issue judgment and a permanent injunction prohibiting the Department from privatizing the provision of mental health services;

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY, MANISTEE COUNTY Plaintiffs v STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, a Michigan State Agency, and, STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY AND BUDGET, a Michigan State Agency. Defendants.	Case No. 2025- -MB Hon.

Christopher K. Cooke (P35034)
SECREST WARDLE
2025 East Beltline, SE, Suite 600
Grand Rapids, MI 49546
616-285-0143 / 616-285-0145 (f)
ccooke@secrestwardle.com
zlambert@secrestwardle.com – Sec.
Attorney for Plaintiffs

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

NOW COMES Plaintiffs, CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY

MENTAL HEALTH AUTHORITY, and MANISTEE COUNTY, by and through their attorneys of record, Secrest Wardle, and, hereby, request this Honorable Court to issue a Preliminary Injunction prohibiting the Defendants from continuing to solicit, accept proposals or contract, under its RFP for specialty Prepaid Inpatient Health Plan (PIHP), Contractors Request for Proposal No. 250000002670, Prepaid Inpatient Health Plan (PIHP) (Exhibit 1 from Complaint), pursuant to MCR 3.310 for the following reasons among others:

a. The RFP allows for the provision of mental health services by private non-profit, non-governmental entities ("privatization");

b. The RFP prohibits the selected PIHPs from delegating core functions, which are statutorily designated to CMHSPs, to the CMHSPs such as utilization management, network development and claims processing (MCL 330.1204; MCL 330.1206)

c. The RFP solicits bids from g private non-profit entities that will not have the same administrative cost restrictions as the current PIHPs;

d. The RFP changes the geographical territories wherein which the existing PIHPs operate by reducing the number of regions from 10 to 3 and refusing to consider any bids wherein the bidder is unable to cover all of the new territory, thereby eliminating the ability of most of the existing PIHPs and CMHSPs from bidding[1];

e. The RFP illegally prohibits the CMHSPs from contracting for provider services within its service area by placing all contracting responsibility in the hands of the newly created PIHP, dramatically reducing or eliminating the CMHSPs from providing a

[1]This specific issue is the subject of ongoing litigation entitled "*Region 10 PIHP vs. State of Michigan, 25-000143-MB"* currently pending before this Court.

full array of behavioral health services which is an essential tool particularly in times of crisis for a beneficiary;

f. The RFP illegally mandates the composition of the PIHP board by prohibiting members of the CMHSPs from participating on the PIHP board contrary to MCL 330.1204b; MCL 330.1212; MCL 330.1222;

g. The RFP requires the winning contractor to comply with the Open Meetings Act and the Freedom of Information Act, however, if the winning contractor is a private entity it has no legal obligation to comply with either Act, thereby, jeopardizing the transparency that the Mental Health Code requires, eliminating the statutory right of a citizen to demand documentation and voiding the associated powers and penalties provided by the two Acts for non-compliance;

h. The RFP eliminates the Recipient Rights system that applied to public entities requiring timely investigation of recipient rights complaints, privacy protections, appellate remedies and administrative hearings and, instead, replaces it with some undefined "internal grievance procedure" with no access to administrative review;

i. The RFP adds another layer of administration and, thereby, additional cost to the system contrary to the stated purpose of the Mental Health Code to structure the provision of mental health services in the most cost-efficient way possible;

j. The RFP ignores a much more comprehensive analysis undertaken by the Defendant DHHS in 2000 when it published its "Revised Plan of Procurement of Medicaid Specialty Prepaid Health Plans" concluding that, "certain important considerations and characteristics made market selection of specialty PHPs *impractical and undesirable*." (Exhibit 2 from Complaint).

1. Irreparable injury will result if a preliminary injunction is not issued pending a full review on the merits as:

a. The RFP, as indicated above, is without statutory authority and directly violates a number of state statutes that mandate a community based, locally responsive and legally regimented community mental health systems providing person-centered treatment.

b. A bidder that otherwise qualifies under the RFP, if chosen by the Defendant DHHS, will have an enforceable right to perform under the Statement of Work and a contractual right to enforce the agreement or sue for damages if the Court later determines that the RFP is illegal or otherwise not in the best interests of recipients of specialty mental health services.

c. It would be impossible for the Court to return the system to its pre-RFP status should a full hearing on the merits establish that a permanent injunction should issue, yet, the Defendants have contracted with a successful bidder and implemented the changes in the system spelled out in the RFP.

d. The proposed changes to the delivery of mental health services in the state spelled out in the RFP should not be allowed to be implemented until the Court has ruled on the critical issues raised by the Plaintiff's regarding the drastic changes proposed to the system.

WHEREFORE, Plaintiff CMHSPs and Manistee County respectfully request this Court grant a Preliminary Injunction prohibiting the Defendants from continuing to solicit bids under the RFP and/or contracting with any bidders under the terms of the RFP pending a full hearing on the merits.

Respectfully submitted,
SECREST WARDLE
Attorney for Plaintiffs

Dated: October 9, 2025

By: */s/Christopher K. Cooke*
Christopher K. Cooke (P35034)
2025 E. Beltline Ave SE, Suite 600
Grand Rapids, MI 49546
(616) 285-0143

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY, MANISTEE COUNTY Plaintiffs v STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, a Michigan State Agency, and, STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY AND BUDGET, a Michigan State Agency. Defendants.	Case No. 2025- -MB Hon.

Christopher K. Cooke (P35034)
SECREST WARDLE
2025 East Beltline, SE, Suite 600
Grand Rapids, MI 49546
616-285-0143 / 616-285-0145 (f)
ccooke@secrestwardle.com
zlambert@secrestwardle.com – Sec.
Attorney for Plaintiffs

PLAINTIFFS' BRIEF IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

NOW COMES Plaintiffs, CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY

MENTAL HEALTH AUTHORITY, and MANISTEE COUNTY, by and through their attorneys of record, Secrest Wardle, and, hereby submit Plaintiffs' Brief in Support of Motion for Preliminary Injunction.

I. Whether a preliminary injunction is necessary to prevent irreparable harm to the Plaintiffs and the mental health services delivery system of the State should the Defendants be allowed to continue soliciting bids under the RFP and, thereafter, enter into any contracts with successful bidders under the RFP.

Plaintiffs answer: Yes

Defendants answer: No

This Court should answer: Yes

Plaintiffs seek a preliminary injunction from this Court prohibiting the Defendants from continuing to solicit bids under RFP No. 250000002670, Prepaid Inpatient Health Plan (PIHP), for those reasons laid out in their Complaint and Motion and submit to the Court that a Preliminary Injunction is necessary as irreparable injury will occur to the Plaintiffs and the entirety of the mental health services delivery system in this State if the RFP and the changes contained therein are implemented.

The purpose of a preliminary injunction is to preserve the "status quo pending a final hearing regarding the parties' rights." *Mich. AFSCME Council 25, 293 Mich.App. at 145, 809 N.W.2d 444*. "A court's issuance of a preliminary injunction is generally considered equitable relief." *Id.* To obtain a preliminary injunction, the moving party, "bears the burden of proving that the traditional four elements favor the issuance of a preliminary injunction." *Detroit Fire Fighters Ass'n, IAFF Local 344 v. Detroit, 482 Mich. 18, 34, 753 N.W.2d 579 (2008)*. This four-part test involves the trial court's determination that:

A. The likelihood that the party seeking the injunction will prevail on the merits.

As set forth in Plaintiff's Complaint and Motion in Support of Preliminary Injunction, the Defendants, through the use of an RFP, seek to remove the statutory rights of the Plaintiffs as:

a. it allows for the provision of mental health services by private non-profit, non-governmental entities ("privatization");

b. it prohibits the selected PIHPs from delegating core functions, which are statutorily designated to CMHSPs, to the CMHSPs such as utilization management, network development and claims processing (MCL 330.1204; MCL 330.1206)

c. it solicits bids from qualifying private non-profit entities that will not have the same administrative cost restrictions as the current PIHPs;

d. it changes the geographical territories wherein which the existing PIHPs operate by reducing the number of regions from 10 to 3 and refusing to consider any bids wherein the bidder is unable to cover all of the new territory, thereby eliminating the ability of most of the existing PIHPs and CMHSPs from bidding;[1]

e. it illegally prohibits the CMHSPs from contracting for provider services within its service area by placing all contracting responsibility in the hands of the newly created PIHP, dramatically reducing or eliminating the CMHSPs from providing a full array of behavioral health services which is an essential tool particularly in times of crisis for a beneficiary;

[1]This specific issue is the subject of ongoing litigation entitled: *Region 10 PIHP vs. State of Michigan, 25-000143-MB* currently pending before this Court.

f. it illegally mandates the composition of the PIHP board by prohibiting members of the CMHSPs from participating on the PIHP board contrary to MCL 330.1204b; MCL 330.1212; MCL 330.1222;

g. it requires the winning contractor to comply with the Open Meetings Act and the Freedom of Information Act, however, if the winning contractor is a private entity it has no legal obligation to comply with either Act, thereby, jeopardizing the transparency that the Mental Health Code requires, eliminating the statutory right of a citizen to demand documentation and voiding the associated powers and penalties provided by the two Acts for non-compliance;

h. it eliminates the Recipient Rights system that applied to public entities requiring timely investigation of recipient rights complaints, privacy protections, appellate remedies and administrative hearings and, instead, replaces it with some undefined "internal grievance procedure" with no access to administrative review;

i. it adds another layer of administration and, thereby, additional cost to the system contrary to the stated purpose of the Mental Health Code to structure the provision of mental health services in the most cost-efficient way possible;

j. it ignores a much more comprehensive analysis undertaken by the Defendant DHHS in 2000 when it published its "Revised Plan of Procurement of Medicaid Specialty Prepaid Health Plans" concluding that "certain important considerations and characteristics made market selection of specialty PHPs *impractical and undesirable* ." (Exhibit 2 from Complaint).

k. Further, Plaintiffs have solicited comments from Executive Directors of a number of CMHSPs and Regional Entities who have years of combined experience in

working in the mental health field (Exhibit 4). Their input on the proposed changes is uniform as to the damage that will be done to the system if the RFP is allowed to continue.

1. Michael Bach, Executive Director of Copper Country Mental Health Service Board: "When a consumer loses Medicaid, it can take many hours of phone calls, waiting on hold, and completing paperwork to get reinstated. Almost all of this is unbillable time." "…we often take people to and from medical appointments without billing…Many areas have no public transportation. How will a fee for service agency ensure that someone gets to chemotherapy treatments or follow up appointments?" (Exhibit 4A)

2. Brian Babbit- Chief Executive Officer, North Country Community Mental Health Authority: "This will destabilize the CMHSP and I am unable to pick just one or two services that are at risk. Any activity without a HCPS code (safety net) are most likely to fall through the cracks but I think no service will be unaffected." "Little or no local control. Per the RFP, the entity replacing the current PIHP, "must have a separate and distinct board structure that is not shared with any contracted provider entity…Counties will be responsible for services without the ability to direct those services." (Exhibit 4B).

3. Joseph "Chip" Johnston, Executive Director, Centra-Wellness Network: "The proposed structure would significantly limit Case management support for individuals seeking to maintain or obtain Medicaid. Current state funds are insufficient to fill this gap, leaving many unable to access necessary services." "… Centralizing service management removes the personal, community-based connections that are vital to effective care. Local staff know the individuals and

families they serve, a familiarity that cannot be replicated by distant administrative body." "The RFP could trigger staff turnover if current providers are not awarded contracts, leading to the loss of trusted relationships and institutional knowledge. Recruitment and training of new staff would further delay service delivery." "Inadequate Case management and care coordination will inevitably result in more frequent crises, leading to higher emergency room visits, hospitalizations and interactions with law enforcement." (Exhibit 4C).

4. Tess Greenough, Chief Executive Officer, Gogebic Community Mental Health Authority: "the individuals that we work with in the CMH system have intensive service needs that aren't always addressed in a typical office-based setting. Moving to a fee for service model will place community-based service programs such as intensive case management, community living support, home-based services or youth and families and specialized residential services at risk. GCMHA currently employs 100 staff in our own community. GCMHA operates 3 separate AFC homes with specialized residential services." (Exhibit 4D)

5. Dan McKinney, Chief Executive Officer, Hiawatha Behavioral Health: "intensive home and community-based services. These programs are expensive to administer and not provided in an office/medical setting but rather individualized than in the community. Programs like ACT (Assertive Community Treatment), wraparound, peer, home-based are centered around the community mental health system and likely will not be provided in a fee-for-service system due to cost. Programs like self-determination would be questionable as well." (Exhibit 4E)

FY2026

COMPLIANCE PROGRAM DESCRIPTION

and

WORKPLAN

Approved By	Date
Quality and Compliance Oversight Committee (QOC)	
Internal Operations Committee (IOC)	
Board of Directors	

Contents

I. INTRODUCTION

A. The NMRE is committed to establishing and maintaining an effective compliance program in accordance with the compliance program guidance published by the Office of Inspector General and the U.S. Department of Health and Human Services. The compliance program is about prevention, detection, collaboration, and enforcement of the law, requirements from regulatory bodies, contractual obligations, and NMRE's policies, procedures, and Standards of Conduct.

B. The Compliance Program:

1. Ensures that NMRE staff and partners adhere to all pertinent federal, state, and contractual obligations and guidelines.

2. Serves as a mechanism for preventing and reporting any breach of those laws and regulations that fall within specified criteria.

3. Applies the guidelines of the Office of Inspector General (OIG), requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR 438.608, 42 CFR Part 2, 2 CFR 200, and Title 45 CFR.

   An effective compliance program includes the following elements:

   a. Written policies, procedures, and standards of conduct.

   b. Compliance Program oversight.

   c. Effective training and education.

   d. Effective lines of communication.

   e. Well-publicized disciplinary guidelines.

   f. Internal and external monitoring and auditing activities.

   g. Prompt response to detected offenses and the development of corrective actions.

II. STRUCTURE OF THE COMPLIANCE PROGRAM

A. The NMRE Board of Directors: The NMRE's Board of Directors is responsible for the review and approval of the Compliance Plan, review of the Annual

Compliance Report, and review of matters related to the Compliance Program. The NMRE Board of Directors has the highest level of responsibility for the oversight of the Compliance Program.

B. Compliance Officer: The NMRE's Compliance Officer has the primary responsibility for ensuring that the NMRE maintains an effective Compliance Program. Specifically, the Compliance Officer oversees the implementation and effectiveness of the Compliance Plan, Standards of Conduct and other policies and procedures, and provides technical assistance to NMRE staff and the provider network. The Compliance Officer is responsible for the day-to-day operation of the Compliance Program.

C. The Quality and Compliance Oversight Committee (QOC): The NMRE regional Quality and Compliance Committee provides guidance, supervision, and coordination of compliance efforts at the NMRE and its partners. The QOC advises on matters involving compliance with contractual requirements and all related federal and state laws and regulations, including the Office of Inspector General guidelines and 42 CFR 438.608 and 42 CFR Part 2. The QOC is comprised of the NMRE's Chief Executive Officer, Chief Information Officer/Operations Director, Compliance Officer, Clinical Director, Customer Service Specialist, Quality Analyst, Provider Network Manager and representatives from all five member Community Mental Health Services Programs (CMHSPs). The Medical Director is an ad-hoc member of the committee.

III. ELEMENTS

A. Implementing Written Standards, Policies, and Procedures

Written Standards of Conduct and written policies and procedures are a central element of the Compliance Program. The Standards of Conduct demonstrates the NMRE's ethical attitude and its emphasis on compliance with all applicable laws and regulations. NMRE policies and procedures are living documents and provide guidelines on the day-to-day operations of the organization. Written policies and

procedures also ensure good quality of care as well as patient confidentiality and privacy. These compliance standards apply equally to ALL NMRE staff and partners. It is the responsibility of each employee to become familiar with the Standards of Conduct and the written policies and procedures that apply to their job duties.

B. Designating Compliance Oversight

1. The NMRE's Compliance Officer has the authority and responsibility to administer and manage all tasks related to establishing, monitoring, and updating the Compliance Program. To ensure success of the program, the Compliance Officer will:

    a. Have direct access to the Chief Executive Officer and the NMRE Board of Directors. This will ensure that a system of checks and balances is established to effectively achieve the goals of the Compliance Program.

    b. Coordinate and collaborate with NMRE leadership and NMRE partners to assess and mitigate risks, develop and implement policies and procedures, and develop and implement the Compliance Program.

    Methods used to ensure an effective Compliance Program include:

    i. Work with NMRE network providers and other partners to coordinate and implement compliance activities.

    ii. Analyze reports generated as part of the auditing and monitoring initiatives and other processes to identify trends and implement corrective actions.

    iii. Analyze all allegations of abuse, waste, or fraud and reporting requirements/process and providing notifications to MDHHS/Office of Inspector General (OIG), as necessary.

    iv. Act as the Special Investigative Unit (SIU) for investigations of fraud, waste, and abuse allegations.

    v. Review and analyze compliance activities and provider agencies via ongoing and annual contract monitoring processes.

c. Ensure that appropriate screening and evaluation checks are completed to eliminate sanctioned individuals and contractors from participating in the federal or state healthcare programs for the provision of items or services. This will include the following activities:

   i. Ensure NMRE complies with all requirements to obtain, maintain, disclose, and furnish required information about ownership and control interest, business transactions, and criminal convictions.

   ii. Ensure that all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided with federal and state healthcare funds are compliant with applicable federal and state regulations.

   iii. Ensure that the NMRE and its partners comply with 42 USC 1320a-7(b), which imposes penalties for "arranging (by employment or otherwise) with an individual or entity that the person knows, or should know, is excluded from participation in a federal health care program for the provision of items or services for which payment may be made under such a program."

d. Take appropriate steps to confirm that an individual or provider has not been excluded pursuant to the NMRE Excluded Provider Screening Policy and Procedure prior to employment or contracting and monthly thereafter.

   i. Develop and implement an educational training program for NMRE staff and partners that furnish services to ensure understanding of federal and state laws and regulations involving ethical and legal business practices.

   ii. Investigate and act on matters related to compliance and privacy in an independent and confidential manner.

2. The NMRE Quality and Compliance Oversight Committee will be responsible to:

   a. Guide the implementation of the Compliance Program.

b. Assist with the implementation of compliance policies and procedures and the Standards of Conduct.

c. Encourage employees to raise concerns and report non-compliant issues including suspected fraud, waste, abuse, or inappropriate behavior without fear of retaliation.

C. Conducting Effective Training and Education

Education and training are the first and possibly the most important lines of defense of a Compliance Program. All NMRE staff and Board Members will receive training and have access to the NMRE Compliance Plan, compliance policies, and Standards of Conduct. Additional training may be required for employees involved in specific areas of risk, or as new regulations are issued. Records will be maintained on all formal training and educational activities for 10 years. The Compliance Officer will receive training from an appropriate source other than themself. Training is considered a condition of employment and failure to comply will result in disciplinary action up to and including termination. All employees will receive mandatory compliance training during the first 30 days of their employment and annually thereafter.

Educational activities include, but are not limited to, face-to-face training and online training in programs related to:

1. Federal and state regulations and guidelines
2. Contractual obligations
3. Policies, procedures, and the Standards of Conduct
4. Coding and billing requirements
5. False Claims Act implications including fraud, waste, and abuse

The Compliance Officer will provide ongoing information and education on matters related to healthcare fraud, waste, and abuse as disseminated by the Office of Inspector General, the Department of Health and Human Services, and other regulatory bodies.

It is the responsibility of NMRE staff to maintain licensures and certifications that are specific to their job responsibilities.

The NMRE Provider Network Management Committee will review and recommend regional training requirements to ensure consistent training requirements throughout the provider network. The NMRE will monitor the provider network to ensure adherence to the identified training requirements. When necessary, the NMRE will offer related compliance training and educational materials to the provider network.

D. Developing Effective Lines of Communication

There will be open communication between the Compliance Officer, The NMRE Board of Directors, the Quality and Compliance Oversight Committee, and all NMRE staff and partners. With open lines of communication, the potential for fraud, waste, and abuse is substantially reduced. Examples of ways to maintain lines of communication include:

1. Face-to-face with the Compliance Officer
2. Compliance Hotline: 866 789 5774 (can be anonymous or identified)
3. Compliance E-mail: compliancesupport@nmre.org
4. NMRE website: https://www.nmre.org/recipients/compliance-and-quality
5. Mail to: 1999 Walden Drive, Gaylord, MI, 49735

Confidentiality and Non-Retaliation policies and procedures are in place and accessible to all employees to encourage the reporting of incidents of potential or suspected fraud, waste, or abuse in a safe environment without fear of retaliation.

All reported incidents will be documented and investigated promptly to determine validity.

Communication System

The Compliance Program's system for effective communication will include the following:

1. Require that all staff must report suspected misconduct, that a reasonable person acting in good faith would believe to be misconduct, without fear of retaliation.
2. Create a user-friendly process, such as the compliance hotline; where staff can anonymously and promptly report fraudulent, unethical, or erroneous conduct.
3. Enforce policies and procedures that state that failure to report fraudulent, unethical, or erroneous conduct is a violation of the Compliance Program.
4. Implement a simple and readily accessible procedure to investigate reports of fraudulent, unethical, or erroneous conduct.
5. Implement a process that maintains the confidentiality of the persons involved in alleged fraudulent, unethical, or erroneous conduct and the person making the allegation.
6. Enforce policies and procedures that guarantee that reporting conduct that a reasonable person, acting in good faith, would believe to be fraudulent, unethical, or erroneous will not be retaliated against.

E. Enforcing Standards through Well-Publicized Disciplinary Guidelines

The Standards of Conduct and NMRE policies and procedures apply to employees at all levels and NMRE partners. Enforcement applies regardless of the employee's position or years of service. Failure by any employee to comply with applicable regulations, NMRE's Standards of Conduct, or policies and procedures will subject the employee and the supervisor who ignored or failed to detect misconduct, or who has knowledge of the misconduct and failed to correct it, to disciplinary action that could range from verbal warnings to suspension, privilege revocation, or termination from employment, based on the seriousness and type of violation. The NMRE's Sanctions Policy and Procedure sets forth the degree of disciplinary action that may be imposed

on employees for failing to abide by the Compliance Program.

F. Conducting Internal and External Monitoring and Auditing Activities

Auditing and monitoring activities are critical to a successful compliance program and should be an ongoing activity under the direction of the Compliance Officer. Auditing and monitoring is a key component of the annual review of the effectiveness of the Compliance Program. The auditing activities will focus on compliance with specific regulations and policies that have been identified by the Centers for Medicare & Medicaid Services (CMS), the OIG, and MDHHS-PIHP contractual obligations. The NMRE utilizes a variety of monitoring and auditing techniques including:

1. Periodic questionnaires, surveys, and interviews with staff within the NMRE, its member CMHSPS, and subcontracted providers regarding their perceived levels of compliance and the effectiveness of training/education within their departments and areas of responsibilities.
2. Periodic audits that comply with federal and state regulations, MDHHS-PIHP contractual obligations, and other guidelines.
3. Service verification audits.
4. Input from regional Compliance Officers.
5. Internal/external audit results for specific compliance guidelines.
6. Information from past investigations of noncompliance.
7. Information from exit interviews.

Quarterly Submissions to the OIG:

1. Grievance report
2. Data mining and analysis of paid claims
3. Audits performed
4. Overpayments collected

5. Identification and investigations of fraud, waste, and abuse
6. Corrective action plans implemented
7. Provider disenrollment
8. Contract termination

Reporting/Reviewing Compliance Data:

1. Quarterly reports of issues
2. Quarterly results of Medicaid service verification audits
3. Annual reviews of the Compliance Plan
4. Annual summaries of compliance activities, including the number of investigations, summaries of results of investigations, and summaries of disciplinary actions
5. Trend analysis that identifies deviations (positive or negative) in specific risk areas over a given period
6. Annual reports of Medicaid Encounter Verification (MEV)
7. Annual reports to MDHHS of MEV results
8. Annual reports to MDHHS of compliance with annual training on the Deficit Reduction Act (DRA) from all network providers
9. Annual reports to the OIG of any non-compliance communication resulting in OIG involvement.

HIPAA Privacy and Information Security audits, such as:

1. Use and disclosure of protected health information (PHI),
2. Employee access to protected information
3. Validation and reliability of data,
4. Information security risk assessment,

5. Electronic and physical safeguards.

Clinical/Quality of Care, review of:

1. Performance indicators
2. Peer reviews
3. Chart reviews
4. Scope of work and qualification

Consumer rights review of:

1. Rights complaints and concerns
2. Consumer satisfaction survey
3. Rights Officers' responsibilities
4. Risk Events and Critical Incidents
5. Sentinel Events and Root Cause Analyses (RCA)

G. Responding to Detected Offenses, Developing Corrective Actions and Prevention.

According to the OIG, one of the seven essential elements for an effective Compliance Program is the investigation and remediation of identified systemic problems. If there should ever be a reason to believe that misconduct or wrongdoing has occurred, the organization must respond appropriately. The OIG notes that violations of the Compliance Program and other types of misconduct threaten an organization's status as a credible, honest, and trustworthy provider capable of participating in federal healthcare programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the

NMRE. The OIG calls for prompt reporting of misconduct to the appropriate authority within a reasonable period, but not more than 60 days after determination that credible evidence of a violation exists, and not more than 30 days to avoid stricter fines.

Audit and review follow-up are important parts of good management and evidence of an effective Compliance Program. To ensure that identified problems and/or weaknesses do not recur, it is essential that corrective action is taken.

Approval Signature

_____

NMRE Chief Executive Officer Date

V. 2026 COMPLIANCE PROGRAM WORKPLAN

Goal 1: Strengthen the quarterly reporting elements to the OIG.

Objective 1: Run at least one data mining scenario and complete at least one investigation per quarter.

Objective 2: Ensure that each Community Mental Health Services Program (CMHSP) will complete one data mining scenario and one regular audit per quarter, as well.

Objective 3: Provide necessary feedback to CMHSPs to create stronger compliance program.

Goal 2: Provide deeper review of trends discovered during the Medicaid Encounter Verification (MEV).

Objective 1: Work closely with the designated staff to communicate any prevalent areas of concern during the MEV review.

Objective 2: Collaborate with designated staff to open full audit investigations into MEV trends and concerns.

Objective 3: Issue Corrective Action Plans (CAP) as appropriate.

Goal 3: Strengthen compliance with Federal and State laws regarding Adverse Benefit Determinations (ABD) sent to beneficiaries of the NMRE region.

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

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

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

Goal 4: Strengthen compliance with Federal and State laws regarding Grievance and Appeal documentation to beneficiaries of the NMRE region.

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

Objective 2: Provide increased oversight of the CMHSPs, requiring each CMHSP to send three examples of a grievance, and three examples of an appeal, each quarter the NMRE for review.

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

Goal 5: Implementation of MCH Indicia (evidence based care guidelines) to monitor data providing insight into critical benchmarks of care such as length of stay, readmissions, reduction of denials, and most importantly, optimize level of care.

Objective 1: Provide staff training and assist with implementation.

Objective 2: Monitor critical benchmarks for milestones.

Objective 3: Compile evidence of success and present a report of the findings