NORTH COUNTRY
COMMUNITY MENTAL HEALTH

PROVIDER MEETING MINUTES

Tuesday, June 6, 2025
'TEAMS VIRTUAL MEETING'

PROVIDERS REPRESENTED:
Candice Shepler, Sherry Kidd, Vicky Otto – Crossroads, Deb Daly, Kelsey Kennedy, Nancy Wood, Jean Faivor, Lacy (Straits Area Services), Roxanne McLintock, Barb Sands, Fran Damoth Bigelow, Jean Faivor, Elizabeth Carlson, Carrie Borowiak, Tracy Trasky, Amy Carter, Karmen Ball Cornerstone, Tom Quakenbush-Community Homes, Amy Carter, Meredith Aleccia (North Arrow ABA), GTI Mancelona, Katelyn Kloss, Dennis Atkins, Mandy Horacek, Craig Kimble, Laporte-Montero, Keri, Theresa Sorenson, Chris VanWagoner (NMRE), Aaron Biery (NMRE), Micah Haven

NCCMH REPRESENTED:
Katie Lorence, Kim Rappleyea, Angela Balberde, Jennifer Nolan, Dominique Cook, Brian Babbitt, Jennifer Pewinski, Patrick McCleary, Linda Kleiber, David Hornibrook, Meagan Scott, Andrea Rose, Donna M. Wixon, Samantha Kerr, Andi Rushford, Emily Ramirez, Pam Krasinski-Wespiser, Stefanie Miller, Joseph Balberde, Barb Woodhams

Agenda and Introductions at 10:00am: Katie Lorence, Contract Manager

Welcome: Brian Babbitt, Chief Executive Officer, shared the following information:

- Stories that were shared in the NCCMH Annual Report regarding the impact that NCCMH services have on clients.
- Rebuilding of provider capacity in northern Michigan and working on moving clients back up to this area.
- NCCMH has been working on developing qualitative recovery outcome measures over the last 4 years and are beginning to develop a baseline with the results. Those 5 key indicators and their results are: 68.83% say they use healthy ways to cope with difficult situations, 83% say they're accepted for who they are, 91% indicate their basic needs are met, 76.62% are hopeful about the future, and 81.87% learn, work, volunteer, participate in activities that they enjoy. There will also be a dashboard on the NCCMH website with this information.
- Funds appropriated by the legislature that have not been distributed into the system from FY24 and FY25.
- Estimated FY25 Medicaid overspend is $2,000,000.
- MDHHS RFP is a clear effort to privatize the public mental health system. It would force division of access to services. Several organizations have joined in opposition of the RFP.
- Medicaid cuts are proposed in the federal budget. Medicaid work requirements are proposed which would require redetermination to be done twice a year. Provider tax reforms could decrease payments to the State of MI. Reduction of federal matching rates.

Reimbursement Updates: Dominique Cook, Reimbursement Supervisor shared the following information:

- EVV (Electronic Visit Verification) for codes H2015 and T1005, if they are performed in the home, will need to be recorded via EVV. It is a soft launch currently. There is a live-in caregiver attestation that can be filed with the NCCMH finance office to apply for annual exemption.
- Time Studies are due within 30-days of a new placement and annually thereafter. These help determine the split between CLS and Personal Care.
- NorthStar access and termination can be requested by sending the NorthStar form to Dominique Cook.

Training Updates: Stefanie Miller, on behalf of Amanda Cordova, Training Specialist, discussed the following information:

- Please use the Training Hub to request training transcripts and deactivating staff by using the staff ID that was sent in an email on April 17th.
- Use legal names.
- Staff email addresses should not be the email address of the organization or home; it should be their personal email address.
- If you do not receive a registration confirmation email, please wait a day or two because it will come. Please do not submit the registration again as it will cause duplicates.

Compliance Training & MDHHS Audit Findings: Kim Rappleyea, Chief Operating Officer, reviewed the following information:

- Annual Compliance Training is completed by attending this presentation.
- You may adopt NCCMH's Compliance Program or develop your own.
- OIG has determined 7 elements of a Compliance Program:
    - *Compliance Leadership and Oversight* – Board of Directors and /or leadership are responsible for this.
    - *Written Policies and Procedures* – Reviewed the NCCMH policies on: Conflict of Interest, Code of Conduct, Code of Ethics.
    - *Training and Education* – Deficit Reduction Act of 2005 requires Medicaid providers to implement training. Defined and presented examples of Waste, Fraud, and Abuse. Laws and Acts that apply here are the federal Affordable Care Act, Michigan Medicaid Provider Statutes, federal Stark Law and the Michigan Self-Referral Law, federal Anti-Kickback Statute and Michigan Health Care False Claims Act, HIPAA and MI Identity Theft Protection Act, and federal and state Whistleblower protections.
    - *Risk Assessment, Auditing, and Monitoring* – Reviewed examples of NCCMH risk management program, audits that are performed, and regular monitoring that occurs.
    - *Enforcing Standards: Consequences and Incentives* – Reviewed possible consequences and incentives.
    - *Effective Lines of Communication with the Compliance Officer* – All suspected waste, fraud, or abuse must be reported to the Compliance Officer. If you suspect the Compliance Officer is part of the concern, you may report to the Chief Executive Officer. If you suspect that the CEO is part of the concern, you may report it to the Board of Directors, and if you think that the entire organization is part of the concern, you may report directly to the PIHP (NMRE).

- *Responding to Detected Offenses and Developing Corrective Action Initiatives* - All reports are investigated. Credible allegations are forwarded to the OIG and AG.

- MDHHS Audit Findings – NCCMH results were not acceptable.
  - Criminal Background Checks must be completed prior to hire, and every 3 years thereafter.
  - Training requirements are located online in the NCCMH Training Hub. Key areas that need improvement are: bloodborne pathogens, emergency procedures, first aid, and plans of service.
  - NCMMH may face sanctions if these areas are not corrected. Sanctions will be passed on to providers.

HCBS: Aaron Biery, Waiver Coordinator at NMRE, reviewed the following information:
- Michigan State University is working on HCBS provider setting training.
- MDDHS HCBS survey results from last summer. NMRE will meet with CMH to discuss areas that are not in compliance.
- Updates on:
  - Alarm/Delayed Egress update. Effective 09/30/2025, all IPOS's of individuals who live in setting that employe alarms must include either an HCBS compliant modification or identify how the individual will be able to bypass the alarm easily.
  - LARA Resident Care Agreement: CMS concern – house rules and resident funds
  - Summary of Resident Rights template
  - Complaint Door Handles
  - Restrictions within Settings
  - Modifications and Restrictions

Open Discussion: No added discussions.

Closed at 11:22am

NEXT MEETING: August 5, 2025, IN PERSON at the University Center, Gaylord

ARCHIVED MATERIAL: **https://www.norcocmh.org/provider-bulletins/**

If you would like to hear about a specific topic at our quarterly provider meetings or wish to have staff from your program added to our invitation list, please email: providerrelations@norcocmh.org and let us know!

NORTH COUNTRY
COMMUNITY MENTAL HEALTH

QUARTERLY PROVIDER NETWORK MEETING

June 2025

AGENDA

10:00 am	Meeting Begins
Introductions	Katie Lorence, Contract Manager
Welcome	Brian Babbitt, Chief Executive Officer
Reimbursement Updates	Dominique Cook, Reimbursement Supervisor
Training Requirements	Stafanie Miller, IT Business Analyst, on behalf of Amanda Cordova, Training Specialist
Compliance Training & MDDHS Audit Findings	Kim Rappleyea, Chief Operating Officer
HCBS	Aaron Biery, Waiver Coordinator, NMRE
11:45 am	Open Discussion

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Where our **clients** and
community are the mission.

HOPE RECOVERY RESILIENCE WELLNESS

Access to Services:
1-877-470-7130

24-Hour Crisis Help Line:
1-877-470-4668

Customer Services:
1-877-470-3195

Office of Recipient Rights:
1-800-281-0481

NORTH COUNTRY
COMMUNITY MENTAL HEALTH

THANK YOU

Next Meeting
Tuesday, August 5th
IN-PERSON at University Center - Gaylord

Contract Manager
Katie Lorence – klorence@norcocmh.org

Provider Network Manager
Angie Balberde – abalberde@norcocmh.org

Drivers of Budget Shortfalls

in Michigan's Public Mental Health System

Community Mental Health Association of Michigan

Michigan's public mental health system is facing significant funding challenges due to several factors, chief among them the loss of Medicaid funds as people lose coverage, flat funding for core services being outpaced by rising medical inflation, skyrocketing program costs, and an unrelenting administrative burden from state regulators.

Loss of Medicaid Covered Lives + Increased Demand for Services

Michigan's public mental health system receives a payment for everyone enrolled in Medicaid. The public mental health system consistently services 300,000 – 350,000/year.

Enrollees have decreased by 700K since the end of the Public Health Emergency (PHE)

Demand for services continues to increase

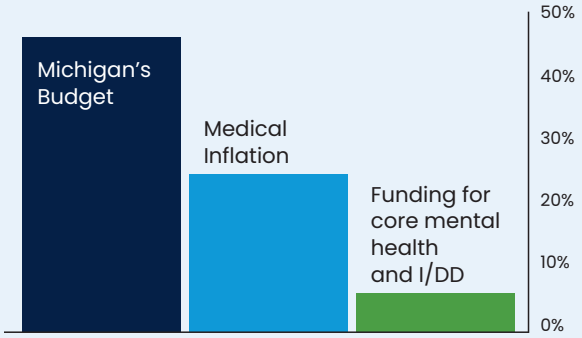
Skyrocketing Inpatient Psychiatric Hospital Costs

30%+
Increase in psychiatric hospitalizations since the end of the PHE. (Demand)

$1250+
Daily rates of community inpatient care. (Cost)

Demand & Cost of Autism Services Continue to Increase

Across the state demand for Applied Behavioral Analysis (ABA) services have steadily increased. ABA costs continue to increase. In FY25 the legislature approved a rate increase to $66/hour. Autism services continue to be underfunded in the budget.



Flat funding not keeping up with inflation

Above is a comparison of the increase (during the past 5 Fiscal Years) to Michigan's Budget, Medical Inflation, and Funding for core mental health and I/DD services, respectively.

System Funding Falls Far Below Appropriated Levels

MDHHS sent out hundreds of millions (or 2/3 of billion) less to the system, for the past three years, than was intended by the State Legislature and Governor

FY 2023
$246M

FY 2024
$137M

FY 2025 (projected)
$210M

NEARLY **600M** Projected total underspending between FY23 and end of FY25

Unsustainable Specialized Residential Costs

Since 2020 rates for specialized residential **services have increased by over 70%.** Some CMHs are forced to pay over $2000/day for this service.

70%
Increase in rates for services

$2K/day
Cost to some CMHs.

MDHHS Administrative Burdens Overwhelming the Workforce

Since the end of the Public Health Emergency (PHE), **administrative burdens on the public mental health system have exploded**.

25%+
Increase in requirements, reports and documentation demands

In just the past five years, new requirements, reports and documentation demands have increased by more than 25%.

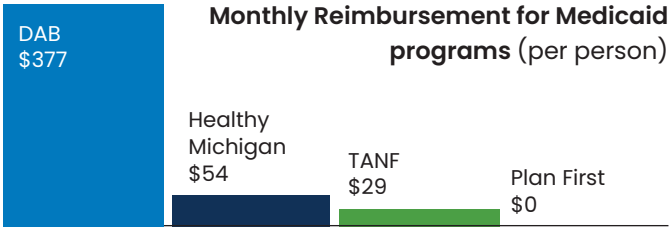
Community Mental Health agencies are now responsible for completing nearly 70 audits, reports and data submissions within a two-year period—that's more than three per month.

Medicaid Redetermination Irregularities

The movement of disabled, aged, and blind (DAB) beneficiaries to other Medicaid categories, has dramatically reduced the revenue expected and needed by the state's PIHPs.

$300M
Loss in revenue to the Prepaid Inpatient Health Plan (PIHP)

182%
Decrease in DAB months caused by the movement



Monthly Reimbursement for Medicaid programs (per person)

What we are asking

- Adjust Medicaid rates to accurately offset the disenrollment of the program.
- Urge MDHHS to push out already appropriated funds – STOP the Impoundment of Funds.
- Ensure that enrollees are slotted into the correct Medicaid bucket.
- Adjust Medicaid rates to accurately reflect the costs of services – Inpatient Hospitalization, specialized residential and autism.
- Dramatically reduce the unnecessary administrative burdens that go beyond federal requirements and that do not improve the lives of people served.

CMHA
Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.

CMHAM.org /CMHAMich @CMHAMich

Protecting People Over Profit

Public Management of Michigan's Behavioral Health System

Community Mental Health Association of Michigan

On February 28, 2025 the Michigan Department of Health and Human Services (MDHHS) announced that they are seeking public input through an online survey as the department moves to a competitive procurement process for the state's Pre-Paid Inpatient Health Plan (PIHP) contracts. **Our concern is that such bid-out plans, in the past, have opened the door to the privatization of Michigan's public mental health system.**

Unmandated Competitive Procurement: A Risky Proposal That Adds Chaos to Care

Potential funding cuts on the horizon

Disrupts care and creates confusion for those relying on critical services

Procurement process is NOT being driven by Federal rules or requirements

Rather Than a Chaotic Competitive Procurement Process, Take Real Steps to Collectively Solving Core Issues

HOW BEST TO IMPROVE ACCESS TO CARE & SERVICES FOR PEOPLE IN NEED

Sufficient Funding + **Ensure & Enhance Local Voice** + **Reduce Administrative Overhead** + **Increase Workforce & Network Capacity**

- **Sufficient Funding**
  Funding for the core mental health and I/DD services has remained FLAT over the past 5 fiscal years (including $0 general fund increase) while medical inflation has increased by over 10%* and Medicaid expenses have increased by nearly 25%. **Inadequate funding leads to shortages in available services, long wait times, and a lack of quality mental health providers.**
- **Ensure & Enhance Local Voice**
  Only a publicly managed system protects local input. **Privatization removes people's power, shifting care decisions to out-of-state boards with no direct ties to Michigan communities.**
- **Reduce Administrative Overhead**
  Collectively PIHPs have a MLR (Medical Loss Ratio) of 96.3%. The ONLY way to reduce layers and ensure more money goes directly into services is by reducing administrative overhead, which has dramatically increased over the past 5 years. **More bureaucracy means longer wait times, more hoops to jump through, and fewer resources for essential care.**
- **Increase Workforce & Network Capacity**
  3/4 of Michigan's public mental health organizations are experiencing workforce gaps despite salary increases or retention bonuses. Top reasons people leave the public mental health field: (1) too much paperwork / administrative hoops to jump through, and (2) better pay and work life balance. **A shortage of mental health workers means longer wait times, fewer available services—leaving Michigan's most vulnerable without the support they need.**

*According to the U.S. Bureau of Labor Statistics

Community Mental Health Association of Michigan

Analysis of MDHHS PIHP procurement plan

May 2025

Background

Recently, MDHHS issued a press release and posted on its Specialty Behavioral Services webpage information regarding the proposed PIHP procurement process. The webpage includes:

A recorded webinar providing an overview of the procurement process.

And information about the PIHP procurement please see resources below:

1. Anticipated PIHP contract requirements.
2. PIHP public survey summary (Based on public survey solicitation in February 2025).
3. PIHP regions map.
4. PIHP regions detail table.
5. PIHP network adequacy standards.

CMHA analysis of MDHHS proposed PIHP procurement to private health plans

The details provided in the materials on the MDHHS Specialty Behavioral Services webpage (webinar and links) serve to **underscore the negative impact of the Department's proposed PIHP procurement process on Michigan's public mental health system and those who rely on that system for their mental health services.** Below is an analysis of the content of these materials. Throughout this analysis, the term "Michigan's public mental health system" will be used to mean the state's CMHSPs, PIHPs, and the providers in the networks of the CMHSPs and PIHPs.

A. COMPONENTS OF MDHHS PLAN OF GREATEST CONCERN

The components of the MDHHS PIIHP procurement plan that pose the greatest concern plan include:

1. Prioritizing bids from private non-profit health plans/health insurance companies. Some of Michigan's largest private health plans/health insurance companies are private non-profit organizations: Blue Cross/Blue Shield, Priority Health, McLaren Health Plan, and HAP.

2. The current public PIHPs would be prohibited from bidding on this opportunity. Because the current PIHPs were formed and governed by appointees from the state's CMHSPs (who are providers, as required by law, of mental health services)– a structure selected by MDHHS as the structure through which Michigan would fulfill its statutory requirement to fund the state's CMHSPs (see endnote) – these PIHPs are prohibited from applying.

3. Eliminating longstanding roles of CMHSPs in managing care: The CMHSPs have been managing their local provider networks (as required by state law; see endnote) including: provider network development, paying claims, authorizing care, carrying out utilization management, credentialing staff, and related functions for over 60 years. The MDHHS PIHP procurement would prohibit them from carrying out these functions, instead moving them to the private health plans who may be awarded the managed care contracts.

4. Implies that CMHSPs would be one of a number of providers with whom the newly selected managed care organizations could contract for services.

B. PLAN FAILS TO ACHIEVE STATED AIMS OF EFFORT: The design of the procurement requirements actually work against the stated aims of this effort. Those aims include and the disconnect between the procurement and those aims are highlighted below:

Aim: Provide high-quality, timely services:

1. Michigan's public mental health system currently provides more evidence-based and promising practices than any other system in the state and has consistently met MDHHS-established timeliness standards. Timeliness and access issues have occurred, as they have for all behavioral health care providers, since the pandemic, created by the deep and prolonged behavioral health workforce shortage. This workforce shortage and financing insufficiency are two most significant causes of access timeliness issues. This procurement process addresses neither of these.

2. The lack of timely access to the Medicaid behavioral healthcare services that have been managed by the state's private health plans for the past 28 years - office based psychotherapy and psychiatry – has been a glaring gap of that privately managed system since 1997 – a gap unaddressed by MDHHS over these 28 years.

3. The dramatically higher managed care overhead of the private Medicaid health plans, an overhead rate of 15%, far above that of the state's PIHPs with an overhead rate of 2%, will result in a dramatic loss of dollars available for Medicaid behavioral health services to Michiganders – hindering and not improving access nor timeliness.

Aim: Improve choice and consistency across regions:

1. Currently, Michigan's Medicaid beneficiaries have access to a large number of high-quality behavioral health providers in communities across the state. The right to request a qualified provider is a fundamental principle of the system. Given the inability of the private health plans to provide choice of providers for the Medicaid behavioral health services currently managed by the private health plans – due to low rates paid those providers - the choice of high-quality providers will not be increased through the movement to a privately managed system.

2. If the choice among more than one plan per region is an aim of this procurement (unclear at this reading) consistency will be hampered by this procurement, with two sets of standards, rates, and requirements per region rather than the current single set of standards, rates, and requirements.

Aim: Ensure accountability and transparency:

1. The current public PIHP structure is directly accountable to the elected county commissioners elected in each county served by the PIHP. The MDHHS proposal would remove the involvement of these county officials in managing the Medicaid dollars intended to serve their communities' residents.

2. Corrective action plans and performance incentive payments have proven key tools in promoting the accountability of the public PIHP system. Additionally, throughout the year, the requirements placed on the public PIHPs are revised and refined, ensuring accountability of the system to these higher standards.

3. The accountability of the private health plans to contractual standards is enforced only upon the department's decision as to continuing the contract with a given private health plan upon completion of the contract period. Given that the private health plans have contracts ranging from 3 to 5 years, the accountability issues under a privatized managed care structure can remain unresolved for years.

4. The transparency of the public mental health system is assured via their compliance, as public bodies, with the Michigan Open Meetings Act and the Freedom of Information Act. No such transparency requirements exist for private health plans.

Simplify the system with reduced bureaucracy:

1. This procurement increases rather than reducing the complexity and bureaucracy of the system by moving from the current subcapitated payment system used to fund the state's CMHSPs, through the PIHPs, to a fee-for-service system requiring distant authorizations. This complexity and bureaucracy of privately managed care firms are concerns frequently voiced by providers and persons served/clients.

Ensure the strength of the state's CMH system:

1. Unless the state's CMHs, in compliance with state law, are the sole party charged with meeting the mental health needs of Michiganders – a guarantee that MDHHS, private health plans, nor this procurement plan have made - this procurement process violates the statutory obligations of the state will erode the financing for and ability of the local CMHs and Michigan counties to meet their longstanding statutory obligations to provide mental health care to Michiganders. This plan, without the guarantee of the support for the longstanding role and financing of the CMH system:

- violates the statutory obligation of the State to promote, maintain, and fund the CMHSP system (See endnote for statutory and regulatory description of role and responsibilities of Michigan's CMHSPs) [i]
- violates the state's obligation to fund CMHSP system as the party responsible for meeting the State's mental health services obligation
- removes public local control over the use of these dollars with these funds going to the private health plans without oversight by the local CMHSP thereby eliminating public oversight and accountability for those dollars

C. PLAN IGNORES WARNINGS FROM SIMILAR APPROACHES IN OTHER STATES: As noted above,, turning the management of Medicaid mental health benefit over to private health plans does not achieve the stated aims of this procurement process.

In fact, the procurement process and its standards move the state's mental health system backwards to a system with the weaknesses found in the privately managed Medicaid behavioral health systems in other states.

A set of studies, conducted over the past several years, underscores the negative impact that the management of a state's Medicaid behavioral health system by private health plan has on persons served and the provider network serving them. Those studies include:

- Impact of the Movement to Private Managed Care System for Publicly Sponsored Mental Health Care: Perspectives from Other States (2022)
- Medicaid funding consolidation: Key themes identified in an examination of the experience of other states (2016)
- Beyond Appearances: Behavioral Health Financing Models and the Point of Care (2016)

D. PLAN IS NOT TRANSPARENT IN SHARING VIEWS OF RESPONDENTS TO SURVEY AND FAILS TO GET A FULL PICTURE OF THE VIEWS OF STAKEHOLDERS: In spite of the MDHHS interpretation of public comment (an interpretation without revealing actual responses), there is significant opposition, among Michiganders, to the private management of Michigan's public mental health system.

Earlier proposals to privatize this system were met by vocal and widespread opposition from Michiganders from across the state. This anti-privatization sentiment remains strong among the large and vocal stakeholders of Michigan's public mental health system. See the summary of the results of the statewide poll, conducted by the respected Michigan-based polling group, EPIC-MRA.

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[i] The Michigan Mental Health Code is clear in describing the uniquely singular nature and required state funding of Michigan's CMHSPs. The relevant code citations are provided below.

Unique role: The State of Michigan must promote and maintain the state's CMHSP system, with Michigan's CMHSPs designated as the only bodies to which the responsibility for the direct delivery of public mental health services has been shifted from the state.

Excerpts from the Code:

> *Section 116 (b) (The State of Michigan must) Administer the provisions of chapter 2 so as to* ***promote and maintain an adequate and appropriate system of community mental health services programs throughout the state****.*
> *In the administration of chapter 2, it shall be the* ***objective of the department to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program*** *whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.*

State obligation to fund CMHSP system: The State of Michigan must fund the CMHSP system to carry out its responsibilities and its core functions.

Excerpts from the Code:

> *Section 116 (b) (The State of Michigan must) (Administer the provisions of chapter 2 so as to* ***promote and maintain an adequate and appropriate system of community mental health services programs throughout the state****.*

Section 202 (1) ***The state shall financially support, in accordance with chapter 3, community mental health services programs*** *that have been established and that are administered according to the provisions of this chapter.*

Obligation to provide a broad range of services to the entire community: The Michigan Mental Health Code, Administrative Rules, and PIHP contractual obligations are clear in describing the responsibility of the state's CMHSPs/PIHPs in **meeting the needs of their entire community and Medicaid beneficiary pool (an obligation that goes beyond those of the CCBHCs to serve only those who present themselves to the CCBHC.**

Excerpts from the Michigan Administrative Rules

Rule 330.2005. ***A community mental health board shall ensure that the following minimum types and scopes of mental health services are provided to all age groups directly by the board, by contract, or by formal agreement with public or private agencies or individuals contingent on legislative appropriation of matching funds for provision of these services****:*
(a) Emergency intervention services.
(b) Prevention services.
(c) Outpatient services.
(d) Aftercare services.
(e) Day program and activity services.
(f) Public information services.
(g) Inpatient services.
(h) Community/caregiver services

(CMHA note: The detailed descriptions of each of these services are outlined in the remainder of this section of the Michigan Administrative Rules)

Responsibility of the CMHSPs to determine the providers in its provider network and ensure that these providers comply with Medicaid regulations.

Excerpts from the Michigan Administrative Rules

Rule 330.2005. A community mental health board shall ensure that the following minimum types and scopes of mental health services are provided to all age groups **directly by the board, by contract, or by formal agreement with public or private agencies or individuals**

MDHHS
Michigan Department of Health & Human Services

Executive Directive 2025-3

Executive Summary

Medicaid is the nation's largest provider of health insurance, covering roughly one in five Americans and more than 2.6 million Michigan residents. The program is a cost-efficient means of ensuring those with the greatest need have access to vital services, particularly in under-served communities and rural areas, and central to Michigan's economic well-being for individuals and industries alike. Despite its proven success and efficacy, Congress and the current Administration are seeking major cuts to the Medicaid program. In accordance with Executive Directive 2025-3, the Michigan Department of Health and Human Services has reviewed these proposals and found the following impacts:

Proposal	Potential Impact
Reducing Federal Matching Rates	**$1.1 billion annual loss** for Michigan's budget; without these funds, *30% of Medicaid beneficiaries will lose health care.*
Medicaid Work Requirements	**$75–$155 million administrative cost** for Michigan and ***loss of health care coverage for 100,000–290,000 beneficiaries*** in the first year.
Provider Tax Reforms	**$3 billion annual loss** for Michigan's budget–up to **$2.3 billion decrease** in payments to Michigan hospitals and upwards of **$325 million less** in payments to nursing homes in the state.
Implementing Per-Capita Caps	**$4.1–$13.4 billion loss** over the next 10 years.

Federal proposals will result in a loss of health care coverage for tens of thousands of Michiganders, reduce access to care providers for all residents, increase the financial burden on hospitals and small businesses, significantly strain the state's budget, and cause undue hardship on those with the greatest need. The physical and fiscal health of our state will be placed at risk if Washington is allowed to defund Medicaid and direct Michigan policies.

Impact of Federal Medicaid Cuts

Medicaid is the nation's largest health insurance program and serves a central role in Michigan's health care system, providing comprehensive coverage to more than one in four Michiganders each month. Totaling 2.6 million individuals, the state's Medicaid beneficiaries include more than 1 million children and over a third of people in rural areas. Jointly funded by the state and federal government, Michigan's Fiscal Year 2025 Medicaid budget is approximately $27.8 billion. A majority of this funding – around 70%, or $19 billion – comes from the federal government.

Medicaid is also one of the most cost-efficient forms of coverage. It has lower total and per capita costs than all other major health programs, including Medicare and private health insurance. Since 2003, Michigan Medicaid spending per enrollee increased only 18% compared to over 100% growth in health insurance premiums, national health expenditures per capita, and Medicare spending per enrollee.

Across Michigan, Medicaid patients make up an average of 22% of hospital patient volume. The stability Medicaid provides also supports a workforce of over 217,000 hospital employees. According to the Michigan Health and Hospital Association, the state's health care industry is the largest private sector employer, generating $77 billion annually.

Medicaid's impact is also felt well beyond our hospitals:

- Medicaid supports the local Community Mental Health system with nearly **$3.5 billion** annually.
- Michigan's nursing homes receive over **$3 billion** in Medicaid funding per year.
- Home and Community Based Services (HCBS) providers—who support vulnerable seniors and persons with disabilities living in the community—receive more than **$1.5 billion** in Medicaid dollars each year.
- Michigan's safety net health centers receive **$483 million** from Medicaid each year, accounting for **63%** of their patient services-related revenue.
- During the 2023 school year, Michigan schools received **$160.5 million** to help provide Medicaid-funded services to students.
- Michigan's EMS providers receive **$130.5 million** from Medicaid annually to support the lifesaving emergency services they provide.
- More than **200,000** Medicaid-enrolled providers across our communities deliver essential care, helping sustain the program for the **one in four** residents who depend on it.

The state's Federal Medical Assistance Percentage (FMAP) for traditional Medicaid enrollees is 65%, meaning that for every dollar the state invests in Medicaid, the federal government contributes an additional $1.87, covering 65% of the total cost. Meanwhile, the FMAP for Michigan's Medicaid expansion program (known as the Healthy Michigan Plan, or HMP), is even higher at 90%. Under this enhanced match, Michigan only has to contribute 10 cents for every $1 spent. This favorable match has allowed Michigan and other states to expand access to care and improve health outcomes for Medicaid beneficiaries and reduce uncompensated care costs for hospitals and health systems.

Since the launch of the Medicaid expansion in 2014, Michigan has seen uncompensated hospital care fall by more than 50%, easing financial pressures on hospitals and allowing them to keep essential services open, especially in areas where Medicaid covers nearly 40% of the population. Michigan's uninsured rate is one of the best in the nation—currently right around 5.4%. Cuts to Medicaid will undoubtedly cause this rate to increase, reversing gains and increasing the amount of uncompensated health care and medical debt.

Medicaid pays for 45% of births in Michigan statewide, with that figure increasing substantially in rural areas—for example, 61% of babies delivered at Munson Hospital in Cadillac are covered by Medicaid. Rural hospitals under financial distress have been forced to eliminate essential services like labor and delivery, which not only affects Medicaid beneficiaries but disrupts access for entire communities. In many rural areas, the local hospital is both a critical health care provider and the largest employer.

Nationally, rural hospitals in non-expansion states have closed at significantly higher rates, with hospitals in those states six times more likely to shut their doors. By contrast, Michigan's expanded Medicaid coverage has helped stabilize hospital finances and preserve access to care, particularly for services like emergency and maternal care where timely treatment is vital.

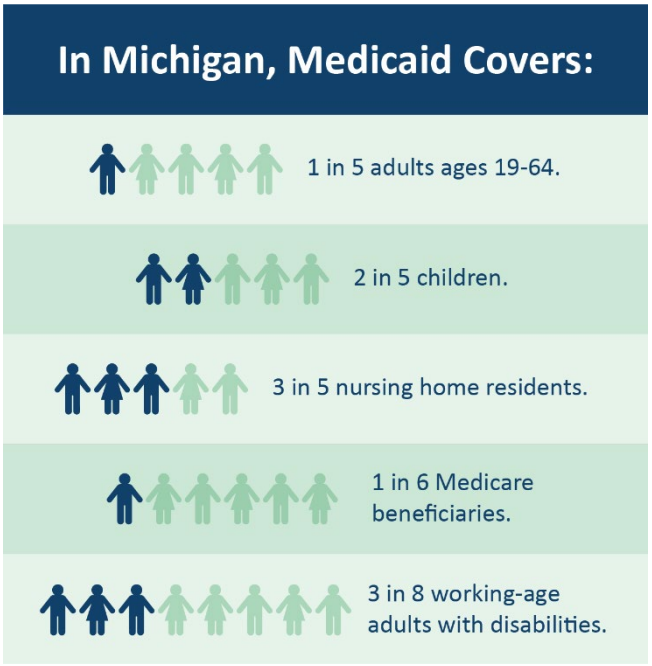
The cuts currently being considered at the federal level threaten to reverse this progress—compromising health outcomes, straining the remaining health care infrastructure, and driving up rates of morbidity, mortality, and uncompensated care. Maintaining robust Medicaid support is essential to protecting Michigan's health care safety net and ensuring continued access to life-saving services.

Congress and the Administration have proposed major changes and deep cuts to the Medicaid program including, but not limited to, lowering the enhanced federal match for the Medicaid expansion population, reducing allowable provider tax thresholds, imposing work requirements, and replacing the current FMAP structure with either per-enrollee caps or insufficient block grants. This report examines the fiscal and enrollment impacts of these proposals across all layers of Michigan's health care delivery system, highlighting the risks to health care access not only for Medicaid beneficiaries, but for all Michiganders who rely on a stable network of hospitals, clinics, and service providers.

Overview: Traditional Medicaid

1,917,640 Beneficiaries (December 2024) People eligible for traditional Medicaid coverage have historically included low-income children and their parents, pregnant women, people with disabilities, and people 65 years of age and older. Michigan's Medicaid program provides health coverage each month to more than one million children, 300,000 people with disabilities, and 168,000 seniors. As of December 2024, there were 1,917,640 traditional Medicaid beneficiaries.

It is important to distinguish between three key components of Medicaid coverage in Michigan: federally mandated benefits, which are provided in all states to eligible children, families, pregnant women, seniors, and individuals with disabilities; the Michigan State Plan, which includes both federally required and state-specific benefits; and Michigan Medicaid waiver programs, which are time-limited initiatives that offer additional services beyond standard coverage. Eligibility for these benefits and waivers is primarily determined by household income relative to the federal poverty level (FPL), with thresholds varying based on factors such as age, household size, and health status.



Most Medicaid services in Michigan are provided either through Medicaid Health Plans or on a fee-for-service arrangement. Fee-for-service means that Medicaid pays providers directly for each service an enrollee receives, rather than paying the health plan. The fee-for-service population includes individuals who are dually eligible for Medicaid and Medicare, migrant populations, Native Americans, and individuals receiving long-term care or those on spend-down. However, the majority of Medicaid beneficiaries are enrolled in a Medicaid Health Plan, which manages and pays for most of the services and is reimbursed by Medicaid.

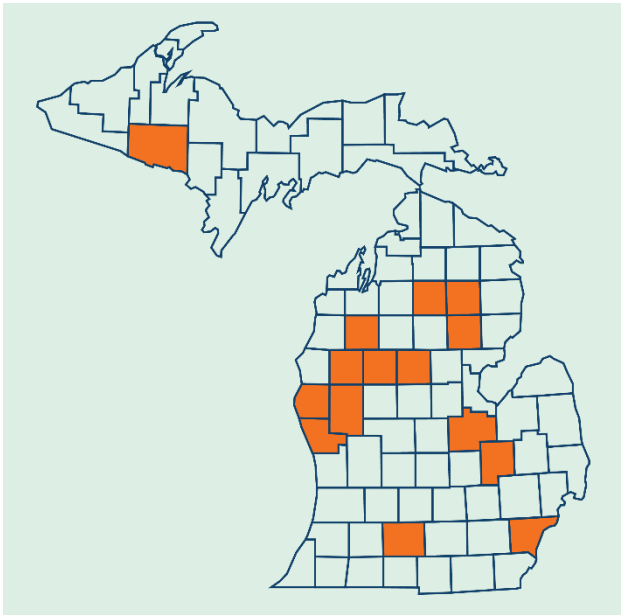


Figure 1 Top 15 Counties by Traditional Medicaid + CHIP Enrollment as a Percentage of County Population

While coverage rates are high in some urban counties, Medicaid also plays a vital role in rural areas, where a significant share of residents rely on it for access to health care.

Understanding Medicaid's role requires recognizing the scope and importance of the services it provides. Federal law mandates that states offer a core set of services but also gives states the flexibility to provide additional "optional" benefits based on local needs and priorities.

In practice, many of these so-called "optional" services are essential to maintaining cost-effective, community-based care. Prescription medications and Home and Community-Based Services (HCBS), for example, help prevent costly hospitalizations and delay or avoid institutional placement for seniors and individuals with disabilities.

Reducing or eliminating these supports doesn't target unnecessary spending—it removes the very tools that keep people stable and out of high-cost settings like emergency rooms or nursing homes.

The result can be higher overall spending and greater strain on families, caregivers, and state systems.

In FY 2024, the Michigan Department of Health and Human Services (MDHHS) estimates that over 90% of Medicaid expenditures are tied to mandatory services, plus pharmacy and HCBS.

Overview: Healthy Michigan Plan

749,375 Beneficiaries (December 2024)

Michigan launched its Medicaid expansion program, known as the Healthy Michigan Plan (HMP), in 2014. HMP provides health care benefits to Michigan residents who are 19-64 years of age with incomes up to 133%[1] of the federal poverty level, do not qualify for Medicare or traditional Medicaid, and meet Michigan residency and Medicaid citizenship requirements. The expansion currently extends coverage to more than 700,000 Michiganders.

The program has been extremely successful in terms of reducing uninsurance rates and uncompensated care for providers, while also promoting primary care use and addressing access to services. An evaluation by the University of Michigan (U of M) found that, in the first few years alone, HMP effectively reduced the number of adults ages 19 to 64 that did not have health insurance. This was true both in terms of the proportion of uninsured residents in each of the state's prosperity regions and in relation to non-expansion states. The same trend held for uncompensated care, which was cut in half following the expansion, while at the same time beneficiaries enjoyed increased access to primary care and preventative services. By providing access to timely, effective care, individuals were able to better control chronic conditions and avoid more expensive visits to emergency departments.

In addition to improvements for individual health outcomes and healthcare systems, the Medicaid expansion has also supported the financial well-being of beneficiaries. The interim evaluation from U of M provided qualitative evidence that participation in HMP minimized the strain of healthcare costs and allowed individuals more freedom when it came to use of their resources. Some even stated that gaining access to medical treatments allowed them to begin or continue working. Still other reports have noted the massive impact of HMP on Michigan's economy. The Medicaid expansion alone has created more than 30,000 new jobs every year, which have raised the personal spending power for Michigan residents by $2.3 billion annually and resulted in an additional $150 million tax revenue.

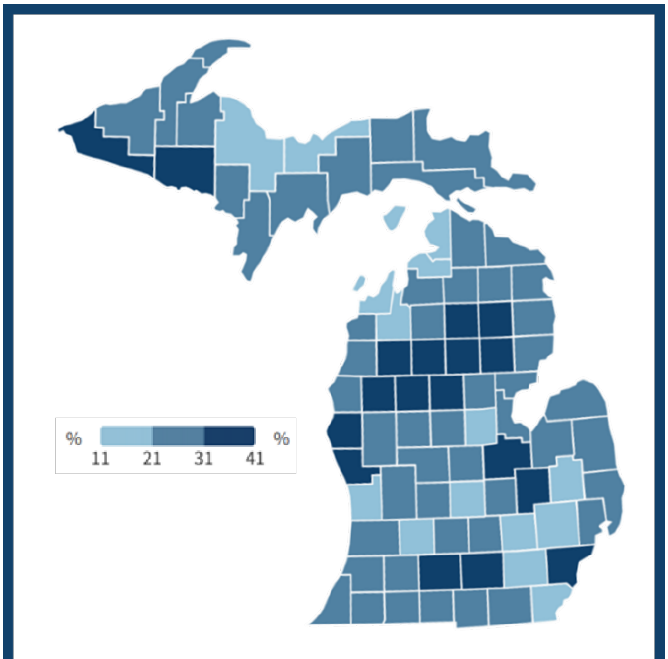


Figure 2 Medicaid and Healthy Michigan Plan Enrollment as a Percentage of County Population

[1] 1.33 * $15,650 = $20,814.50 = $1,734 per month. For 2025, the FPL for a household of 1 is $15,650 and increases by $5,500 for subsequent household members. In context, this is $1,734 monthly income for a single person and $3,563 per month for a four-person family.

Federal Proposals

Reduced Federal Matching Rates

Background

Federal Medical Assistance Percentage (FMAP) rates are calculated based on each state's per capita income in comparison to the U.S. per capita income. FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%, with exceptions for certain programs, providers, populations, activities, and services. Unlike the traditional Medicaid program, which has an FMAP of around 65%, HMP has an FMAP of 90%.

This enhanced match has been a critical factor in state decisions to expand Medicaid, significantly reducing the financial burden on state budgets. By covering the vast majority of expansion costs, the federal match makes it fiscally feasible for states, like Michigan, to extend coverage to low-income adults while supporting local health systems and economies.

In fact, 12 of the 41 states that have expanded coverage have trigger laws that would automatically end their expansion program if federal funding drops. Michigan does not have such a law on the books, meaning that legislative action—whether in the form of an appropriation to continue the program or statutory changes to limit or ending the program—would be necessary to respond to any federal funding reductions.

Proposal

The proposed reduction would cut the FMAP for the expansion population to match the rate for traditional Medicaid, decreasing the deficit by an estimated $561 billion between 2025 and 2034. To respond to this, states would either need to significantly increase the level of state support for their expansion programs, scale the programs back, or end them entirely.

Another proposal under consideration would reduce the enhanced federal match for certain administrative activities. Currently, the federal government covers 50% of general administrative costs and 70–100% for 25 specified categories. Cutting these rates would similarly require states to make tough decisions as to whether to either increase the amount of state general fund or scale back essential functions like nursing home inspections, eligibility systems, and program integrity efforts. It would cost Michigan hundreds of millions in state funding annually, including $115 million simply to maintain existing information technology operations and projects.

Impact

Aligning the expansion match rate with Michigan's traditional federal match would cost the state $1.1 billion annually. Absent additional state investment to cover the lost funding, the more than

700,000 individuals who rely on HMP would lose their health care coverage. This equates to 30% of Michigan's Medicaid population that would lose their health coverage, resulting in major financial impacts for all counties, particularly those with a higher proportion of Medicaid beneficiaries. Health care systems and providers in all regions will see a significant increase in the rate of uncompensated care and a decrease in total reimbursement due to the loss in coverage (see appendix).

It's important to note that parallel conversations are occurring federally about not renewing the enhanced subsidies that have made Marketplace plans more affordable since 2021. If these expire, premiums will rise for everyone. Approximately 90% of Michigan's Marketplace enrollees receive enhanced subsidies. Premiums will increase in Michigan across the board if the subsidies are not extended. This would place many individuals at risk of being priced out of the Marketplace just as the Healthy Michigan Plan faces cutbacks—an overlap that is likely to drive up uninsured rates across the state.

Work Requirements

Background

In 2018, The Centers for Medicare and Medicaid (CMS) issued guidance allowing states to implement work requirements for certain Medicaid beneficiaries. Public Act 208 (Senate Bill 897) was signed by Governor Snyder that same year, requiring MDHHS to submit a waiver to CMS to add work requirements to HMP for able-bodied recipients, 19 to 62 years of age, regardless of income level or time enrolled in the program. Following CMS's approval, Michigan implemented work requirements for HMP, and individuals were required to report 80 hours per month of work or other activities, such as job searching.

Michigan's Medicaid work requirement policy was expected to cost nearly $70 million in administrative funds. More than $30 million was spent on IT system upgrades, staff training, and beneficiary outreach when the policy was discontinued in March of 2020 when the implementation was halted by a federal court ruling.

Despite these efforts, 80,000 individuals were still at risk of losing their health care coverage in the first month that coverage terminations were to occur, and an estimated 100,000 individuals were expected to lose coverage in the first year of implementation.

An analysis by the Institute for Healthcare Policy & Innovation (IHPI) of work requirements in Michigan found that 49% of Medicaid beneficiaries were already working, and 10% were students or homemakers, suggesting that many of those at risk of losing coverage were already meeting requirements, but faced loss of coverage due to the administrative burden and red tape associated with documenting and reporting their employment status.

Additional research on Medicaid work requirements and results from states that implemented work requirements show a significant degree of negative outcomes for Medicaid enrollees.

- Arkansas' policy left 18,000 uninsured, including some that may have been exempt from work requirements.
    - Not only did this effort increase bureaucratic red tape for beneficiaries and cause massive confusion, but there was also no significant impact on employment levels in the state.
    - A follow-up study found supported findings that work requirements did not improve employment and often resulted in adverse consequences for those who lost coverage.
- In Georgia, employment or job training requirements for a Medicaid expansion (Georgia Pathways) resulted in less than 2,400 new enrollees in the first six months out of 345,000 identified as eligible.
    - By 2025, the initiative had just 6,500 participants with a price tag of $86 million for taxpayers.
    - This equates to more than $13,000 per individual, while the average cost per enrollee in Georgia is just $5,184.

Proposal

As Congress considers reinstating work requirements as part of the reconciliation process, one estimate from the Congressional Budget Office in 2023 stated that imposing work requirements could save $109 billion over the course of a decade.

It is unclear how work requirements would be implemented in terms of qualifying activities, populations, and other key aspects. During the previous Trump administration, Section 1115 waivers for work requirements were encouraged and approved, but the specifics varied by:

- **Population Covered:** Most states applied work requirements to adults in Medicaid expansion groups, though some included all adults or specific non-expansion populations. Age ranges varied—from 19–55 under a prior federal model to 19–64 in some states.
- **Exemptions:** Older adults and medically frail individuals were typically exempt. Parents or caregivers often faced reduced activity requirements.
- **Qualifying Activities:** Beyond employment, activities such as education, job training, job search, and community service were often accepted.
- **Hours Required:** States generally required 80–100 hours/month or 20–35 hours/week, though some allowed weekly averages. One state set no hour minimum but required job-related activities if working under 30 hours/week.
- **Noncompliance Consequences:** Most states imposed disenrollment for noncompliance. Others required meeting conditions before enrollment or tied benefit access to participation.

Impact

In Fiscal Year 2026, Michigan could see nearly 39% of eligible adult Medicaid beneficiaries lose coverage as a result of implementing work requirements. These projected losses are not primarily due to individuals failing to meet the work criteria but rather stem from administrative barriers such as lack of knowledge about the requirements, as well as the complexity and burden of compliance and reporting.

The resulting coverage losses are expected to drive up the uninsured rate and increase uncompensated hospital care, disproportionately impacting rural hospitals that often operate on thin margins. These developments pose a broader economic risk, including job losses in the health care sector and potential disenrollment of children whose parents lose coverage, even when the children remain eligible.

While Michigan had completed a significant amount of system redesign and prep work for work requirements in 2020, with many lessons learned, how much of the work that can be salvaged, reused, and/or replicated will depend completely on any new rules or requirements that may not align with Michigan's prior implementation. The ability to leverage any previous work is highly dependent on policy details that have yet to be released.

Due to the uncertainty surrounding implementation details, the analysis below presents a range of possible impacts.

	HMP Work Requirements 2020 Implementation *(Actual)*	Broad Medicaid Work Requirements *(Estimated)*	Medicaid Expansion (HMP) Work Requirements *(Estimated)*
Potential Administrative Cost Comparison for Work Requirement	$30 million (spent) $40 million (planned)	$155 million	$75 million
Potential Medicaid Coverage Loss - Year 1	100,000 individuals	512,000 individuals	290,000 individuals

Note: Additional detail can be found in the Appendix section.

The broader effects of implementing Medicaid work requirements are expected to create significant ripple effects across Michigan's health care and economic landscape. Uncompensated care costs are likely to surge, particularly straining rural hospitals that often serve as their communities' primary health care providers and largest employers. Many may face staff reductions, service cuts, or even closure—disruptions that can be difficult, if not impossible, to reverse once health care talent is lost.

These projections also do not fully account for the potential impact on children. When parents lose Medicaid coverage, they may be less likely to complete renewal paperwork for their children, leading to avoidable terminations in coverage. Research shows that Medicaid coverage for children is associated with improved health outcomes, higher educational attainment, increased future earnings, and greater tax contributions. The loss of these long-term benefits would represent a significant setback, both for the individuals affected and the state as a whole. Overall, Michigan stands to face substantial financial and social costs from the implementation of Medicaid work requirements.

Provider Tax Reforms

Background

Most states finance a portion of their Medicaid programs through taxes collected from health care providers. Because Medicaid typically reimburses at lower rates than both commercial insurance and Medicare, it can be challenging for providers to serve a large Medicaid population without supplementary revenue. To address this, states often seek federal approval to use provider taxes to enhance Medicaid funding. Payments to providers are generally tied to the volume of Medicaid patients they serve, with those serving more beneficiaries receiving greater reimbursement—creating an incentive to maintain or expand access for Medicaid enrollees.

In Michigan, approximately 20% of the state's non-federal Medicaid funding is generated through provider taxes, which include contributions from hospitals, nursing homes, ambulance providers, and the managed care organization tax—also known as the Insurance Provider Assessment (IPA).

Together, these taxes are leveraged to make up $3 billion of Michigan's state share of Medicaid costs. The tax dollars fund both the base Medicaid program and the broader state budget (through state retention) and increased reimbursement to the taxed provider classes. While some facilities or providers with a lower volume of Medicaid patients may pay more in taxes than they receive in rate increases, the system is beneficial for a majority of providers and has a net-positive impact on funding for the state.

Proposals

There are several options rumored to be under consideration related to limiting provider taxes. The first is reducing the provider tax limit from 6% of a provider's net patient revenue to 3% or 4%. Michigan's current tax on Nursing Facilities and Hospitals is between 5.01% and 5.5%, while its taxes on managed care organizations and ambulance providers is less than or equal to 3.5%. One version reduces the tax from the current limit of 6% to 4% in 2026 and 2027, and then 3% in 2028 and after.

A second version caps provider taxes as a share of state general funding, while states' ability to leverage provider tax revenue to finance their Medicaid program would be eliminated under a third proposal. Congress could use the budget reconciliation process to enact legislation to reduce or eliminate the ability of states to use provider taxes. Lastly, administrative action through rulemaking could be used to require wholesale restructuring. This may take the form of the Executive branch directing agencies to initiate rulemaking and develop guidance to restrict the use of provider taxes.

Impacts

Hospital and Skilled Nursing Facility Tax

In Fiscal Year 2025, the hospital provider tax is projected to generate enough revenue to support a total of $5.84 billion in Medicaid payments to hospitals—leveraging both tax revenue and the substantial federal matching funds this revenue draws down. However, if the hospital provider tax were limited to 3%, reimbursement to hospitals would drop by an estimated $2.33 billion. Shifting provider tax limits would reduce payments to hospitals and skilled nursing facilities, as well as drop managed care rates from the average commercial rate to those paid by Medicare.

Proposed Changes with Impact to State and Providers

	Funding Category	Decrease in State Retention*	Decrease in Payments to Providers
Provider Tax Limits Shifts from 6% to 5%	Hospitals	$20,731,600	$221,150,900
	Skilled Nursing Provider Tax	$4,845,100	$44,422,900
Provider Tax Limits Shifts from 6% to 4%	Hospitals	$111,487,600	$1,160,010,500
	Skilled Nursing Provider Tax	$20,293,600	$185,132,200
Provider Tax Limits Shifts from 6% to 3%	Hospitals	$223,506,300	$2,329,942,300
	Skilled Nursing Provider Tax	$35,723,300	$325,896,500
Managed Care Reduction from Average Commercial Rate (ACR) to Medicare	Hospitals		$1,836,700,000
Public Entity Physician Payments from ACR to Medicare	Physicians		$308,792,300

** State retention refers to the portion of revenue from these taxes that is not redistributed back to providers in the form of enhanced rates or supplemental payments. This retained revenue helps fund the state's non-federal share of Medicaid, reducing pressure on other parts of the state budget.*

These potential reductions would not only weaken the state's ability to draw down federal funds but could also destabilize hospital finances, particularly in rural and safety-net facilities, and increase the risk of service cuts or closures. The hospital provider tax has long served as a cost-effective tool that allows the state to maximize federal support without increasing general fund spending.

Managed Care Organization Provider Tax

An additional provider tax that may be at risk is Michigan's Insurance Provider Assessment (IPA)—a state-level tax applied to health insurers, including Medicaid managed care organizations. It is designed to generate revenue that the state uses to help fund its share of Medicaid expenditures. The IPA is structured to draw down federal matching funds, making it a critical financing mechanism for sustaining the state's Medicaid program without requiring equivalent increases in general fund spending.

The State of Michigan has taxed managed care entities to provide revenue to support the State's Medicaid program since 2013. This approach has helped contain general fund spending by leveraging federal matching dollars—using insurer-paid assessments to fulfill part of the state's Medicaid funding obligation.

However, proposals under consideration this year—either through budget reconciliation or federal rulemaking—could restrict states' ability to use such financing strategies. If enacted, these changes could jeopardize more than $450 million currently supporting Michigan Medicaid's core services. Replacing this funding would likely require substantial cuts, tax increases, or reductions in coverage and access to care.

Per-Capita Caps

Background

Medicaid is currently an entitlement program wherein states must cover all eligible individuals, and the federal government must provide the federal share of funding for the costs of that coverage. Currently, states receive open-ended federal matching funds based on the cost of providing services, with guaranteed continued support for states regardless of whether costs go up or outcomes are not achieved. Per capita caps and block grants are mechanisms to shift financial costs and risk to states.

A per-capita cap would limit federal funding to a fixed amount per enrollee. This amount would be adjusted annually by a set amount/inflationary factor. Because funding is set on a per enrollee basis, federal funding available to states under this model would adjust for enrollment fluctuations. States exceeding their "cap" would need to find alternative revenue to maintain spending or find new ways to reduce costs.

Similarly, block grants would cap federal Medicaid funding at a fixed amount, limiting the state's ability to respond to changing needs. While traditional block grants may include annual inflation adjustments, they do not account for increases in enrollment during economic downturns—precisely when demand for Medicaid coverage tends to rise—creating added financial pressure and risk for states.

Proposal

There has not been a concrete proposal to change Medicaid from its current funding model to a per-capita cap or block-grant structure. However, multiple plans (including the influential Project 2025 blueprint and the fiscal year 2025 Republican Study Committee budget plan) support the use of block grants for Medicaid as both a cost-savings measure and to increase state flexibility. Using a proposal from 2017 as an example, block grant funding could be broadly cut funding by 10% within the first few years. Subsequent reductions would result in a loss of more than 25% over 10 years and 30% over 20 years. This proposal could hit Medicaid-expansion states much harder, while non-expansion states may even see an increase.

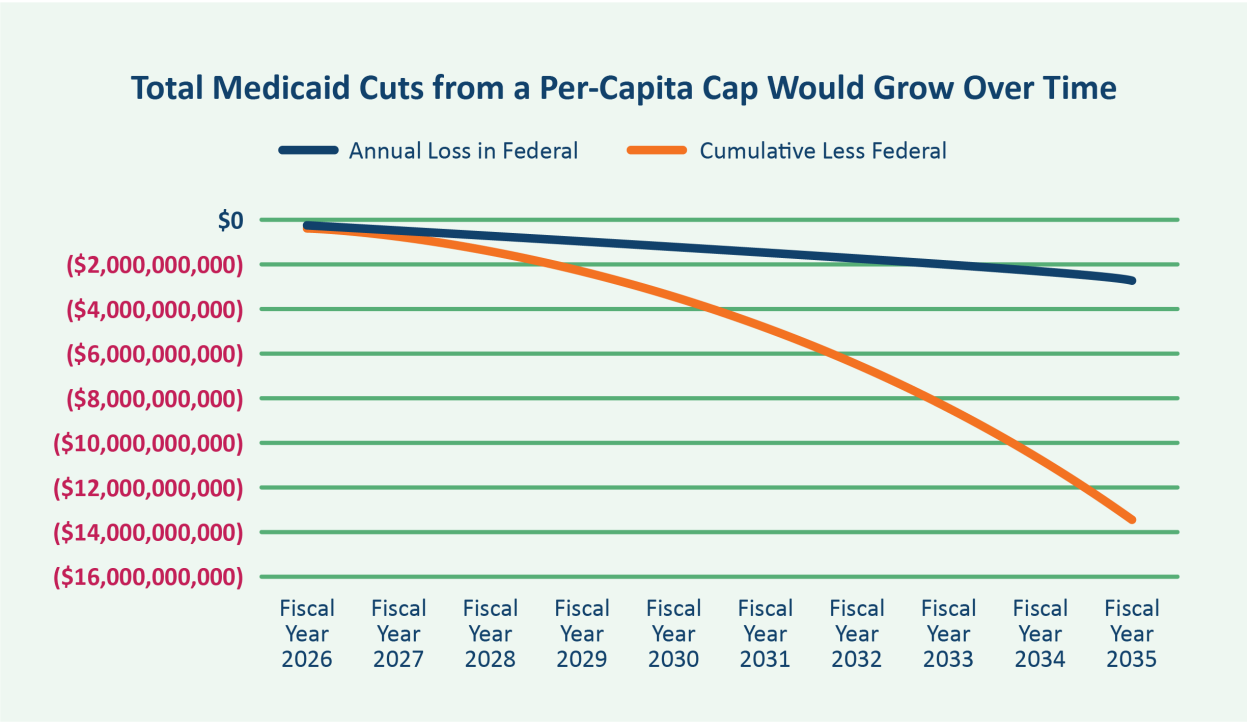
Impacts

A shift to per-capita funding would drastically impact Medicaid in Michigan, but projections are difficult without specific proposals. Using a model that is consistent with previous proposals, the Department projects an estimated loss of federal funds totaling $4.1 billion if per-capita grants were restricted to the Medicaid-expansion population.

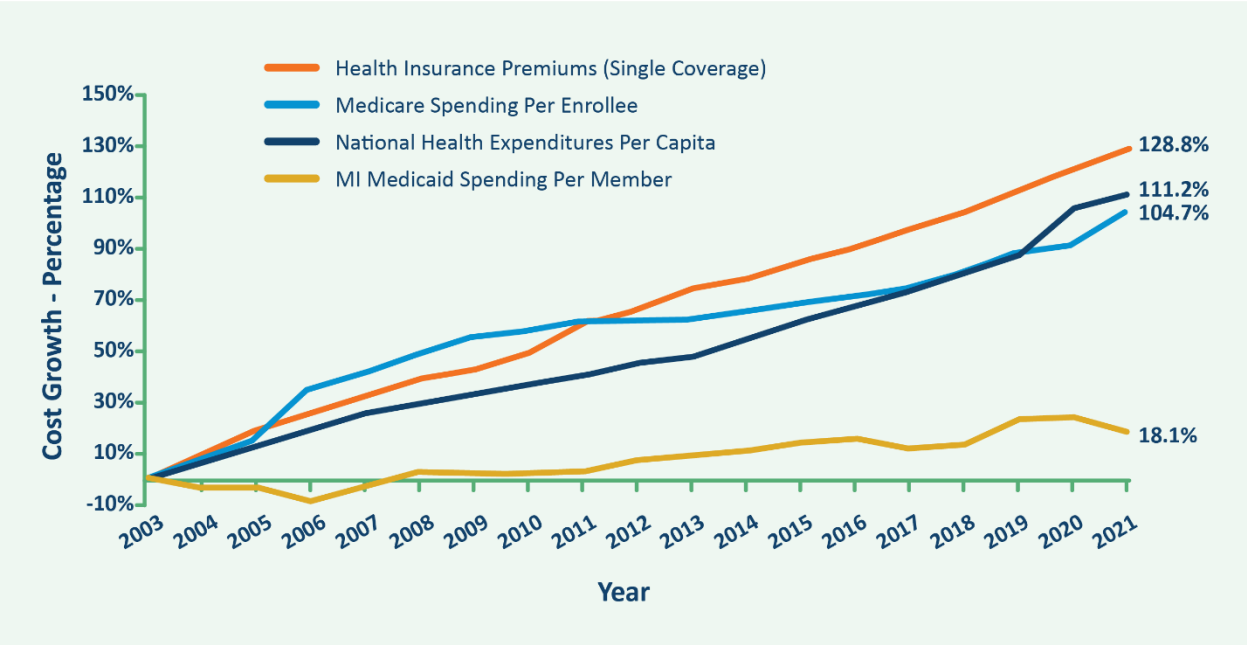
HMP Only	Total Federal (Status Quo)	Total Federal (Est. Per Capita Cap)	Annual Loss in Federal	Cumulative Less Federal
Base Period	$4,724,075,000	$4,724,075,000		
Fiscal Year 2026	$5,061,411,000	$4,980,874,000	$80,537,000	$80,537,000
Fiscal Year 2027	$5,316,507,000	$5,176,573,000	$139,934,000	$220,471,000
Fiscal Year 2028	$5,584,459,000	$5,379,960,000	$204,498,000	$424,970,000
Fiscal Year 2029	$5,865,915,000	$5,591,339,000	$274,576,000	$699,546,000
Fiscal Year 2030	$6,161,557,000	$5,811,022,000	$350,535,000	$1,050,081,000
Fiscal Year 2031	$6,472,100,000	$6,039,338,000	$432,762,000	$1,482,844,000
Fiscal Year 2032	$6,798,294,000	$6,276,623,000	$521,671,000	$2,004,514,000
Fiscal Year 2033	$7,140,928,000	$6,523,232,000	$617,696,000	$2,622,210,000
Fiscal Year 2034	$7,500,830,000	$6,779,529,000	$721,301,000	$3,343,511,000
Fiscal Year 2035	$7,878,872,000	$7,045,897,000	$832,975,000	$4,176,487,000

Should per-capita grants be extended to all Medicaid beneficiaries, this number will increase to a total loss of $13.4 billion over the same time period.

Overall	Total Federal (Status Quo)	Total Federal (Est. Per Capita Cap)	Annual Loss in Federal	Cumulative Less Federal
Base Period	$15,190,024,000	$15,190,024,000		
Fiscal Year 2026	$16,274,714,000	$16,015,750,000	$258,964,000	$258,964,000
Fiscal Year 2027	$17,094,959,000	$16,645,008,000	$449,951,000	$708,915,000
Fiscal Year 2028	$17,956,545,000	$17,298,991,000	$657,554,000	$1,366,469,000
Fiscal Year 2029	$18,861,555,000	$17,978,668,000	$882,887,000	$2,249,356,000
Fiscal Year 2030	$19,812,177,000	$18,685,050,000	$1,127,127,000	$3,376,483,000
Fiscal Year 2031	$20,810,711,000	$19,419,186,000	$1,391,526,000	$4,768,009,000
Fiscal Year 2032	$21,859,571,000	$20,182,166,000	$1,677,406,000	$6,445,414,000
Fiscal Year 2033	$22,961,293,000	$20,975,123,000	$1,986,171,000	$8,431,858,000
Fiscal Year 2034	$24,118,543,000	$21,799,235,000	$2,319,307,000	$10,750,892,000
Fiscal Year 2035	$25,334,117,000	$22,655,727,000	$2,678,390,000	$13,429,282,000

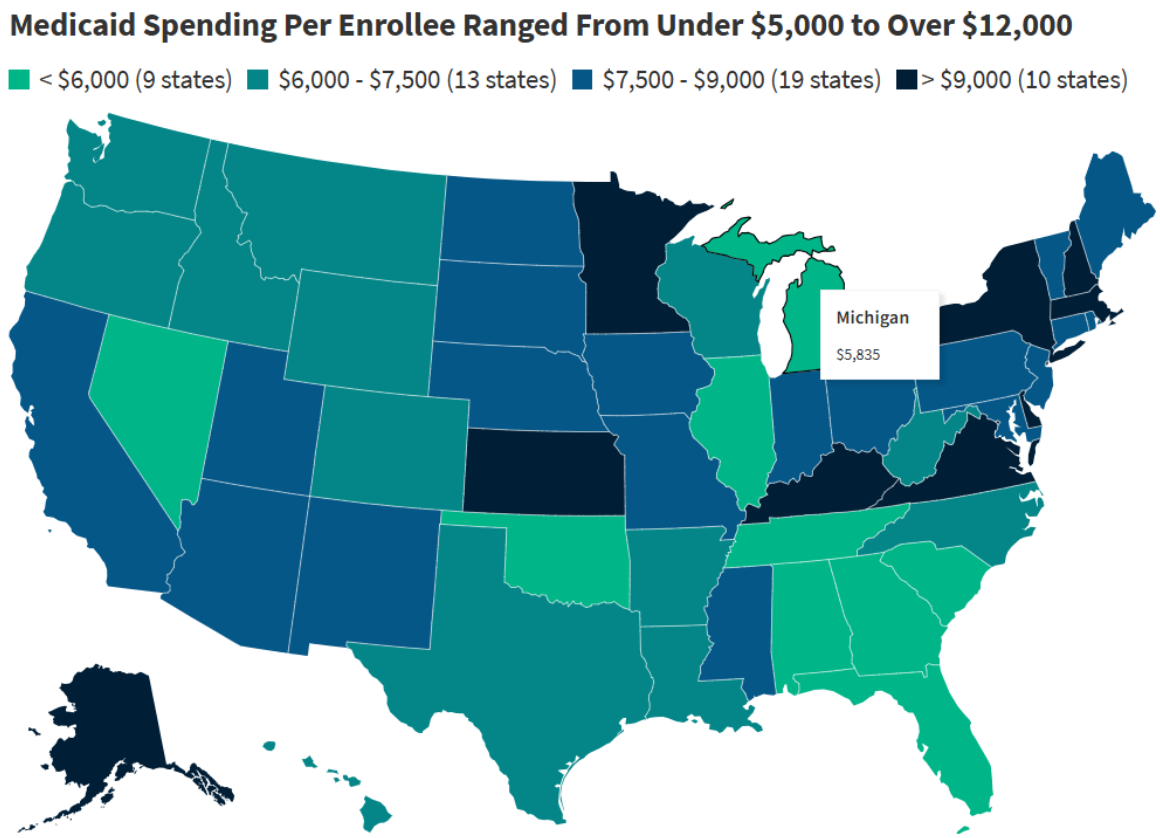


Michigan's Medicaid program has long been recognized for its cost-effectiveness, providing high-quality coverage to millions while maintaining per-enrollee spending below the national average. However, this efficiency means the program has less room to absorb additional financial constraints, making it especially vulnerable under a per-capita cap structure. Fixed federal funding would limit the state's flexibility to respond to rising health care costs or changes in enrollment, placing additional strain on an already lean and efficient system.



The chart above compares cost growth from 2003 to 2021 across four health care spending categories--Health Insurance Premiums (Single Coverage), National Health Expenditures Per Capita, Medicare Spending Per Enrollee, and Michigan Medicaid Spending Per Member.

From 2003 to 2021, Michigan Medicaid spending per member grew far more slowly than other major health spending categories, highlighting the program's cost containment and efficiency.



This map from the Kaiser Family Foundation illustrates state-by-state variation in Medicaid spending per enrollee. Michigan ranks among the lowest-spending states on a per-enrollee basis. This reinforces the cost-efficiency of Michigan's Medicaid program, spending less per enrollee than most while still maintaining broad Medicaid coverage. This comparatively low baseline spending highlights the challenge Michigan would face under federal funding caps, as the state already operates a lean program with limited flexibility to absorb funding reductions.

Conclusion

Summary of findings

Medicaid has long provided millions of Americans with access to health care and supported beneficiaries at their most vulnerable moments. As clearly demonstrated in this report:

- Reducing federal matching rates will hurt Michigan residents and its health care systems.
- Work requirements will cost taxpayers and Medicaid beneficiaries without added benefit.
- Limiting state options for funding will reduce payments to hospitals, nursing facilities, providers, and the state's budget.
- Per-capita funding will severely limit the state's ability to consistently provide support matching needs.

The supposed cost-savings associated with gutting this vital program will result in a loss of access to care providers, increased burden on hospitals and small businesses, lost tax dollars, and undue hardship on those with the greatest need. These changes place Washington in the driver's seat and restrict the rights of Michiganders to pursue policies that best serve our state.

Limitations

The findings of this report are limited by the lack of federal transparency in terms of pending and future proposals, including intentional efforts to obfuscate federal actions from public comment.

Appendix

Executive Directive

EXECUTIVE DIRECTIVE

No. 2025-3

To: State Department Directors and Autonomous Agency Heads

From: Governor Gretchen Whitmer

Date: April 17, 2025

Re: Impact of Federal Medicaid Cuts

Medicaid was established 60 years ago to ensure that all Americans had access to healthcare and the dignity of a good life, but today Republicans in Congress are rushing to gut this program that provides health care for millions of Americans and Michiganders. These are our friends and neighbors – people who are battling cancer, veterans who are disabled, and children. The cuts being discussed would be the largest cuts to Medicaid in history, terminating healthcare for millions of Americans. It would force providers in Michigan to close their doors, reduce the quality of services, and strip coverage from millions of the most vulnerable Americans, including children and pregnant and postpartum women. We must understand as many specifics about the impact that terminating healthcare will have on Michiganders who get their insurance through Medicaid.

Medicaid is the largest health insurance program in the U.S., providing coverage for one in five individuals. In Michigan, the coverage rate is even higher: one in four Michiganders receive their health insurance through Medicaid. That coverage enables individuals across the state to access health care so that they can continue to live healthy, productive lives.

Jointly funded by the state and federal government, Michigan's Medicaid program affords health coverage to over 2.6 million Michiganders each month, including:

- 1 million children;
- 300,000 people living with disabilities; and
- 168,000 seniors.

Additionally, 45% of births in Michigan are covered by Medicaid.

Healthcare coverage provides real returns. The Congressional Budget Office estimates that long-term fiscal effects of Medicaid spending on children could offset half or more of the program's initial outlays. And Medicaid enrollment for children has been shown to 2

increase not only positive health outcomes but also educational attainment, wages in adulthood, and future tax revenue from increased earnings for those who are covered.

Medicaid is not only critical for the health of individuals – its coverage is also essential for assuring the sustainability of hospitals, community health centers, physician practices, and nursing homes across the state. I led bipartisan efforts to expand access to Medicaid, which took effect in 2014. Since Michigan expanded Medicaid, hospital uncompensated care has fallen by more than 50%. Hospitals in Michigan receive nearly $7 billion in Medicaid funding annually, accounting for almost one-fifth of the state's hospitals' net patient revenue.

More than 70% of Michigan's Medicaid budget comes from federal funding. Cuts to federal funding will jeopardize coverage for more than 2.6 million Michiganders and threaten Michigan's hospitals, community health centers, and nursing homes with closure. These threats are especially acute in small towns and rural communities, where coverage rates are higher than in other parts of the state. 37.3% of small town and rural Michiganders are covered by Medicaid.

In addition, local hospitals are often the largest employer in many of Michigan's rural communities. According to the Michigan Health and Hospital Association, Michigan's health care industry has a total economic impact of $77 billion per year: greater than any other industry in the state. Medicaid expansion alone sparked the creation of more than 30,000 new jobs: one-third in healthcare and 85% in the private sector. These jobs boost the personal spending power for Michigan residents by about $2.3 billion each year and result in approximately additional $150 million in tax revenue annually. Having Medicaid also reduces medical debt for Michiganders and ensures our healthcare professionals are compensated for their work.

States that did not expand Medicaid offer a case study of what will happen to our healthcare infrastructure if federal officials choose to undermine this important program. Hospitals are six times more likely to close in non-expansion states, and rural communities suffered the most. In Michigan, rural hospitals will struggle to keep critical functions like labor and delivery units open if Medicaid payments are reduced.

House Republicans have proposed cutting up to $880 billion from Medicaid, which could mean that Michigan loses as much as $2 billion each year. That is a 42% reduction in the share of state Medicaid spending per resident. This executive directive will enable us to better understand the impact of those cuts on Michigan.

Section 1 of article 5 of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the governor.

Section 8 of article 5 of the Michigan Constitution of 1963 places each principal department under the supervision of the governor.

Acting under the Michigan Constitution of 1963 and Michigan law, I direct the following:

Impact of Federal Medicaid Cuts

1. Within thirty days of this order, the Michigan Department of Health and Human Services (MDHHS) must review federal budget proposals and prepare a report illustrating potential scenarios related to the impact of Congress' proposal. The report, drawing from available analyses and based upon reasonable assumptions, should delineate the specific impact of proposed cuts to Medicaid, including:

    1. The number of Michiganders who could lose health care if the proposed cuts go into effect.
    2. The effect of the proposed cuts on hospitals and other relevant service providers, especially in rural and other underserved communities, including reductions in services and closures of facilities.
    3. The impact on timely access to care for Michiganders, such as the creation or expansion of healthcare deserts in areas of the state.
    4. The ways in which reductions in federal money could impact the state's budget, including the need for cuts to other vital services.
2. The Department of Insurance and Financial Services and the State Budget Office must provide support to MDHHS in assessing the scope and impact of the proposed cuts.
3. All state departments and agencies must coordinate and cooperate with MDHHS in executing the duties outlined by this directive.

This directive is effective immediately.

Thank you for your cooperation in its implementation.

_____

GRETCHEN WHITMER

GOVERNOR

Medicaid Enrollees and Expenditures by Michigan Congressional District

Representative	Congressional District	Medicaid Enrollees December 2024	Medicaid Expenditures Fiscal Year 2023
Jack Bergman	1	184,245	$2,269,042,734
John Moolenaar	2	195,291	$2,063,158,846
Hillary Scholten	3	188,531	$1,673,770,896
Bill Huizenga	4	184,843	$1,628,757,903
Tim Walberg	5	211,101	$1,920,689,956
Debbie Dingell	6	122,630	$1,918,490,694
Tom Barrett	7	152,432	$1,451,455,867
Kristen McDonald Rivet	8	244,347	$2,354,680,023
Lisa McClain	9	145,427	$1,647,255,310
John James	10	212,401	$1,754,417,526
Haley Stevens	11	137,894	$1,291,943,064
Rashida Tlaib	12	321,435	$2,603,482,835
Shri Thanedar	13	366,438	$2,790,043,887
Total		2,667,015	$25,367,189,539

Medicaid Enrollees and Expenditures by Michigan County

County	County Population 2020 Census	Total Medicaid Enrollees December 2024	Total Enrollees Percent of Population	Total Medicaid Expenditures Fiscal Year 2023
Alcona MI	10,167	2,877	28%	$26,387,716
Alger MI	8,842	1,725	20%	$21,097,071
Allegan MI	120,502	24,770	21%	$224,595,422
Alpena MI	28,907	8,024	28%	$87,954,021
Antrim MI	23,431	5,474	23%	$61,858,969
Arenac MI	15,002	4,555	30%	$46,162,442
Baraga MI	8,158	2,177	27%	$35,679,092
Barry MI	62,423	12,327	20%	$114,707,501
Bay MI	103,856	27,099	26%	$288,958,855
Benzie MI	17,970	3,781	21%	$45,537,256
Berrien MI	154,316	42,564	28%	$421,691,799
Branch MI	44,862	13,192	29%	$118,272,565
Calhoun MI	134,310	42,394	32%	$381,124,466
Cass MI	51,589	14,168	27%	$128,872,969
Charlevoix MI	26,054	5,213	20%	$64,321,769
Cheboygan MI	25,579	7,460	29%	$84,055,837
Chippewa MI	36,785	8,525	23%	$146,046,447
Clare MI	30,856	10,594	34%	$115,443,662
Clinton MI	79,128	13,009	16%	$108,050,527
Crawford MI	12,988	4,070	31%	$42,662,839
Delta MI	36,903	8,714	24%	$102,628,230
Dickinson MI	25,947	5,723	22%	$60,881,502
Eaton MI	109,175	23,284	21%	$216,863,537
Emmet MI	34,112	6,033	18%	$81,982,547
Genesee MI	406,211	140,360	35%	$1,292,337,885
Gladwin MI	25,386	7,279	29%	$72,707,491
Gogebic MI	14,380	4,577	32%	$56,565,948
Grand Traverse MI	95,238	16,161	17%	$196,007,628

County	County Population 2020 Census	Total Medicaid Enrollees December 2024	Total Enrollees Percent of Population	Total Medicaid Expenditures Fiscal Year 2023
Gratiot MI	41,761	10,685	26%	$120,401,532
Hillsdale MI	45,746	12,657	28%	$124,019,206
Houghton MI	37,361	7,853	21%	$97,393,317
Huron MI	31,407	6,962	22%	$95,457,736
Ingham MI	284,900	73,037	26%	$729,138,373
Ionia MI	66,804	13,812	21%	$140,056,408
Iosco MI	25,237	7,464	30%	$83,222,705
Iron MI	11,631	3,712	32%	$48,367,053
Isabella MI	64,394	16,053	25%	$168,787,227
Jackson MI	160,366	65,541	41%	$417,949,278
Kalamazoo MI	261,670	60,929	23%	$575,915,681
Kalkaska MI	17,939	5,348	30%	$55,109,632
Kent MI	657,974	152,348	23%	$1,423,252,083
Keweenaw MI	2,046	511	25%	$3,454,254
Lake MI	12,096	4,570	38%	$45,608,227
Lapeer MI	88,619	17,918	20%	$170,212,937
Leelanau MI	22,301	3,043	14%	$28,600,155
Lenawee MI	99,423	21,738	22%	$212,634,058
Livingston MI	193,866	22,104	11%	$225,432,705
Luce MI	5,339	1,622	30%	$19,618,114
Mackinac MI	10,834	2,409	22%	$35,610,159
Macomb MI	881,217	232,740	26%	$2,062,968,575
Manistee MI	25,032	6,224	25%	$74,771,062
Marquette MI	66,017	12,799	19%	$159,203,509
Mason MI	29,052	7,697	26%	$79,576,425
Mecosta MI	39,714	11,396	29%	$107,650,499
Menominee MI	23,502	5,103	22%	$70,733,607
Midland MI	83,494	16,825	20%	$177,794,044

County	County Population 2020 Census	Total Medicaid Enrollees December 2024	Total Enrollees Percent of Population	Total Medicaid Expenditures Fiscal Year 2023
Missaukee MI	15,052	4,616	31%	$41,869,236
Monroe MI	154,809	31,049	20%	$317,293,035
Montcalm MI	66,614	17,232	26%	$172,772,535
Montmorency MI	9,153	2,719	30%	$28,006,717
Muskegon MI	175,824	54,752	31%	$527,552,884
Newaygo MI	49,978	15,172	30%	$141,243,771
Oakland MI	1,274,395	204,539	16%	$2,122,811,476
Oceana MI	26,659	8,676	33%	$78,008,934
Ogemaw MI	20,770	7,006	34%	$73,929,212
Ontonagon MI	5,816	1,457	25%	$13,127,538
Osceola MI	22,891	7,171	31%	$68,663,846
Oscoda MI	8,219	2,911	35%	$26,748,603
Otsego MI	25,091	6,446	26%	$76,257,816
Ottawa MI	296,200	42,742	14%	$376,926,594
Presque Isle MI	12,982	3,189	25%	$36,698,972
Roscommon MI	23,459	7,450	32%	$69,871,759
Saginaw MI	190,124	62,110	33%	$612,655,895
Sanilac MI	40,611	11,182	28%	$106,524,777
Schoolcraft MI	8,047	2,223	28%	$29,511,702
Shiawassee MI	68,094	17,519	26%	$175,898,138
St. Clair MI	160,383	41,082	26%	$396,796,111
St. Joseph MI	60,939	17,233	28%	$157,008,493
Tuscola MI	53,323	13,735	26%	$157,729,174
Van Buren MI	75,587	22,281	29%	$217,463,235
Washtenaw MI	372,258	60,165	16%	$593,070,696
Wayne MI	1,793,561	722,356	40%	$6,450,968,525
Wexford MI	33,673	10,777	32%	$101,385,313
Total	**10,077,331**	**2,667,015**	**26%**	**$25,367,189,539**

Medicaid Work Requirements Estimate- Details and Assumptions

In January of 2020, Michigan had approximately 664,677 enrollees in the Healthy Michigan Plan. Michigan had the flexibility to exempt from work requirements certain populations based on approvals from CMS in Michigan's 1115 waiver. To better provide an apples-to-apples comparison in this analysis, MDHHS used 11% as proxy for the disabled beneficiaries or those exempted for other medical reasons as opposed to the previous HMP work requirement exemption numbers.

This 11% figure is from the Institute for Healthcare Policy & Innovation (IHPI), who completed evaluation of work requirements in HMP as part of the 1115 waiver.[2] IHPI found that 11% of beneficiaries in the HMP population reported that during the time work requirements were in place, they were unable to work. MDHHS is using this as a proxy for the number of beneficiaries who could potentially be ineligible for work requirements under Congressional proposals. MDHHS does not envision that this includes the full population of all beneficiaries who are disabled, medically frail, or unable to work for medical reasons, but believes this is a solid estimate in determining who to screen out of the eligible population pool.

Medicaid Work Requirement Projections

While details of federal work requirement proposals vary, MDHHS does not have a clear picture of what populations would be included or excluded from potential work requirements. The following analyses will provide the best overall picture of potential administrative costs to the State, potential Medicaid coverage loss to beneficiaries based on previous work requirement experience and analyses, and potential expenditure reductions to the State from Medicaid beneficiary reductions. The following analyses will look at if work requirements are extended to the full Medicaid population or if work requirements are only implemented in the Medicaid expansion population (Healthy Michigan Plan).

<u>Administrative Cost Implications of Medicaid Work Requirements</u>
Implementing work requirements to the entire Medicaid population would be the most significant, disruptive, and labor intensive to roll out. Assuming work requirements in the full Medicaid population of adults 18 to 65 years old, including the expansion population (HMP) but excluding those receiving Medicaid through the non-Modified Adjusted Gross Income pathways because they are likely aged, blind, or disabled, then Michigan's population that would be subject to work requirements is 1,317,576 million.

This group would likely include those who are otherwise not disabled or medically frail and therefore able to work. Like Michigan's previous work requirement rules, we assume they would be required to report 80 hours of work, work-related, or community activities per month.

Given that MDHHS had nearly $70 million budget previously to cover administrative costs for the first years of work requirements, MDHHS estimates that in Fiscal Year 2026, a proportional administrative budget of approximately $155 million would be necessary to stand up work

[2] University of Michigan Institute for Healthcare Policy & Innovation. What Do We Know About Medicaid and Work? Evidence from Michigan. Accessed on 29 April 2025 from https://ihpi.umich.edu/sites/default/files/2025-03/Medicaid%20Work%20requirements%20brief_3.24.25_0.pdf.

requirements again. Without knowing policy and regulatory requirements, it is impossible to know if any of the previous work can be reused, reworked, or turned back on at this point. Depending on the implementation timeline, States will be vying for limited IT vendors resources concurrently, which could drive prices up, and the need to train staff on new policies and procedures and potentially hire new staff to handle the workload.

If MDHHS had to implement work requirements only the HMP population, for beneficiaries 18-65, then this population would be significantly smaller. As of April 2025, approximately 716,778 beneficiaries are enrolled in HMP and likely a portion of these individuals would be exempted from work requirements due to disability. Based on the previous reports that 11% of beneficiaries were unable to work, we would assume that 637,933 beneficiaries in HMP would be required to provide proof work 80 hours of work, work-related, or community activities per month. We would anticipate that MDHHS would need at least an administrative budget of $75 million to implement work requirements in the HMP population based on the experiences from Michigan's previous experiences. The increase in budget takes into accounts systems upgrades, training, advertising, and the limited availability of contractors as all States will be vying for limited IT vendors concurrently,

Table #1	HMP Work Requirements Administrative Costs 2020 Implementation (Actual)	Projected Administrative Costs for Broad Medicaid Work Requirements	Projected Administrative Costs for Medicaid Expansion (HMP) Work Requirements
Potential Administrative Cost Comparison for Work Requirement	$30 million (spent) $40 million (planned)	$155 million	$75 million

Table #2	HMP Beneficiaries Eligible for Work Requirements Jan 2020 Implementation	Projected All* Medicaid Beneficiaries Eligible for Work Requirements	Projected Medicaid Expansion (HMP) Beneficiaries Eligible for Work Requirements
Potential Medicaid Beneficiary Eligible for Work Requirements	591,562	1,317,576	637,933

* Would likely exclude those receiving Medicaid through the non-Modified Adjusted Gross Income pathways because they are likely aged, blind, or disabled

Enrollment Impacts of Work Requirements

Based on Michigan's brief experience with work requirements previously, MDHHS does anticipate significant reductions in enrolled beneficiaries due to knowledge about reporting requirements, barriers to reporting, and a plethora of other issues. Before work requirements were paused in 2020, Michigan was on track to lose 80,000 beneficiaries in the first month, and 100,000 HMP beneficiaries in the first year.

Michigan experienced a similar phenomenon when it came to restarting Medicaid renewals at the end of the Public Health Emergency (PHE) Unwinding. While Michigan was able to ex parte (or passively) renewal about 40% of Medicaid beneficiaries, a significant number of beneficiaries did

not return their renewal packets. Of those who were procedurally terminated, 95% were terminated for failure to respond to their renewal, despite significant efforts by MDHHS in adopting CMS waivers, a robust media campaign, phone call and text reminders, and providing beneficiaries and additional month to submit their renewal paperwork.

To help estimate what beneficiary enrollment disenrollment may look like, MDHHS is leveraging State Health & Value Strategies (SHVS) toolkit, *Analyzing the Impact of Potential Medicaid Cuts: Overview of a Toolkit for States*.[3] SHVS assumptions align with MDHHS's experiences during the PHE unwind, assuming 50% of employment and/or exemptions can be determined using data or IT systems and of the remaining work requirements have to be verified through paper forms or other means. Based on experiences previously with work requirements, the PHE Unwind, and regular Medicaid renewals, along with SHVS estimates, of those not renewed automatically, approximately 80% of the remaining beneficiaries would lose coverage.

Based on these assumptions, Michigan could expect to see the following coverage losses in Medicaid:

Table #3	Fiscal Year 2026 Impact	Fiscal Years 2025-2034 Impact
Potential Medicaid Enrollment Losses Across Entire Medicaid Population	512,000	523,000

Table #4	Fiscal Year 2026 Impact	Fiscal Years 2025-2034 Impact
Potential Medicaid Enrollment Losses Across Expansion (HMP) Population	290,000	299,000

The above tables only account for losses in the adult population and do not account for any losses in the under 18-year-old population. MDHHS would anticipate that there would be corresponding losses for children as well, when their parents lose coverage. As many parents would not realize that their children could remain covered and/or many parents may not complete their renewals or other required paperwork. This would result in significant coverage losses in the under 18-year-old population that is not easily modeled and reflected in any of these tables.

[3] State Health & Value Strategies. Analyzing the Impact of Potential Medicaid Cuts: Overview of a Toolkit for States, April 25, 2025. Accessed on 29 April 2025 from https://www.shvs.org/analyzing-the-impact-of-potential-medicaid-cuts-overview-of-a-toolkit-for-states/#_ftn9.

Provider Updates: EVV, Time Studies, and Staff Access

Key Information from NCCMH Reimbursement Department

4/24/2025

NORTH COUNTRY
COMMUNITY MENTAL HEALTH

EVV Overview

What is EVV?

Electronic Visit Verification (EVV) is a system used to verify that in-home service visits occur as scheduled.

Current EVV-Required Codes:

- **H2015** – Community Living Supports (CLS)
- **T1005** – Respite Services

These codes **require EVV** for **in-home services only.**

EVV Compliance Requirements

- Claim **clock-in/out times must match** EVV system records.
- Ensures **claim accuracy** and reduces **denials**.
- Anticipating **future billing through a payer portal** that will be fully EVV-driven.

This helps avoid overlapping claims and reduces risk of denials.

Live-In Caregiver Exemption

In-home providers may be **exempt from EVV** if:

- They submit a **live-in caregiver attestation**, **AND**
- Provide **proof of address documentation.**

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Time Studies – Why They Matter

Purpose:

Time studies determine how the client's **per diem rate** is split between:

- **T1020** – Personal Care
- **H2016** – Community Living Supports (in licensed residential settings)

Required for:

- All new placements (within 30 days)
- Annually for each client

Time Study Requirements

- **One time study per client per year**
- Required **within 30 days** of any home change
- **Staff time** (not client time) is recorded
- Use **actual minutes**, not hours
- Covers a **full weekday and full weekend day**

Time Study Guidelines

- **Should not total 1440 minutes**
- Use **Personal Care & Community Support Log** for reference
- **No averaging** – log real-time data
- **Multiple events (e.g., toileting)**: Use 1–7 for repeat activities
- **Group activities**: Divide time by number of clients benefiting

NORTH COUNTRY
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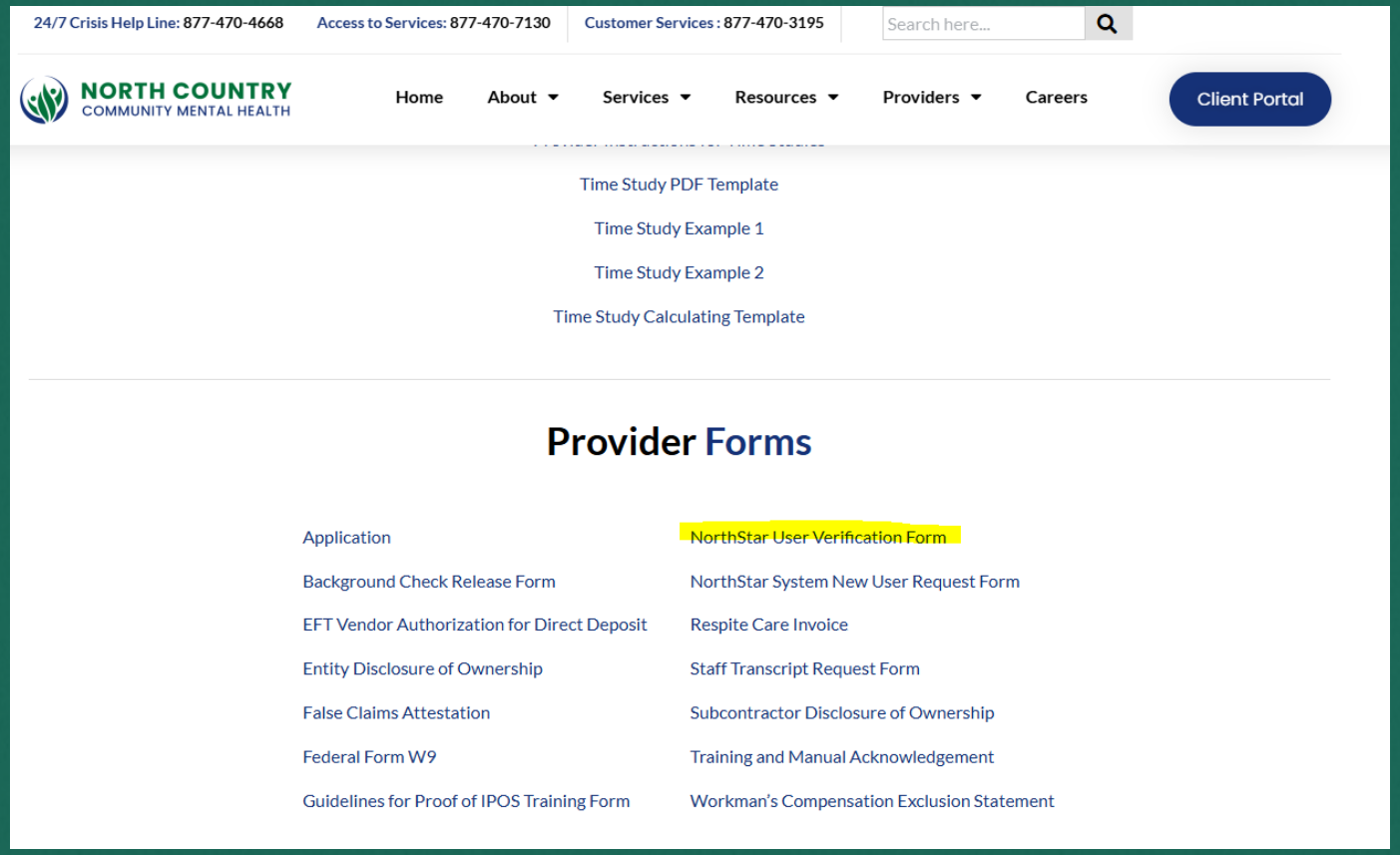
NorthStar Access Review

Please provide an **updated list of staff** who:

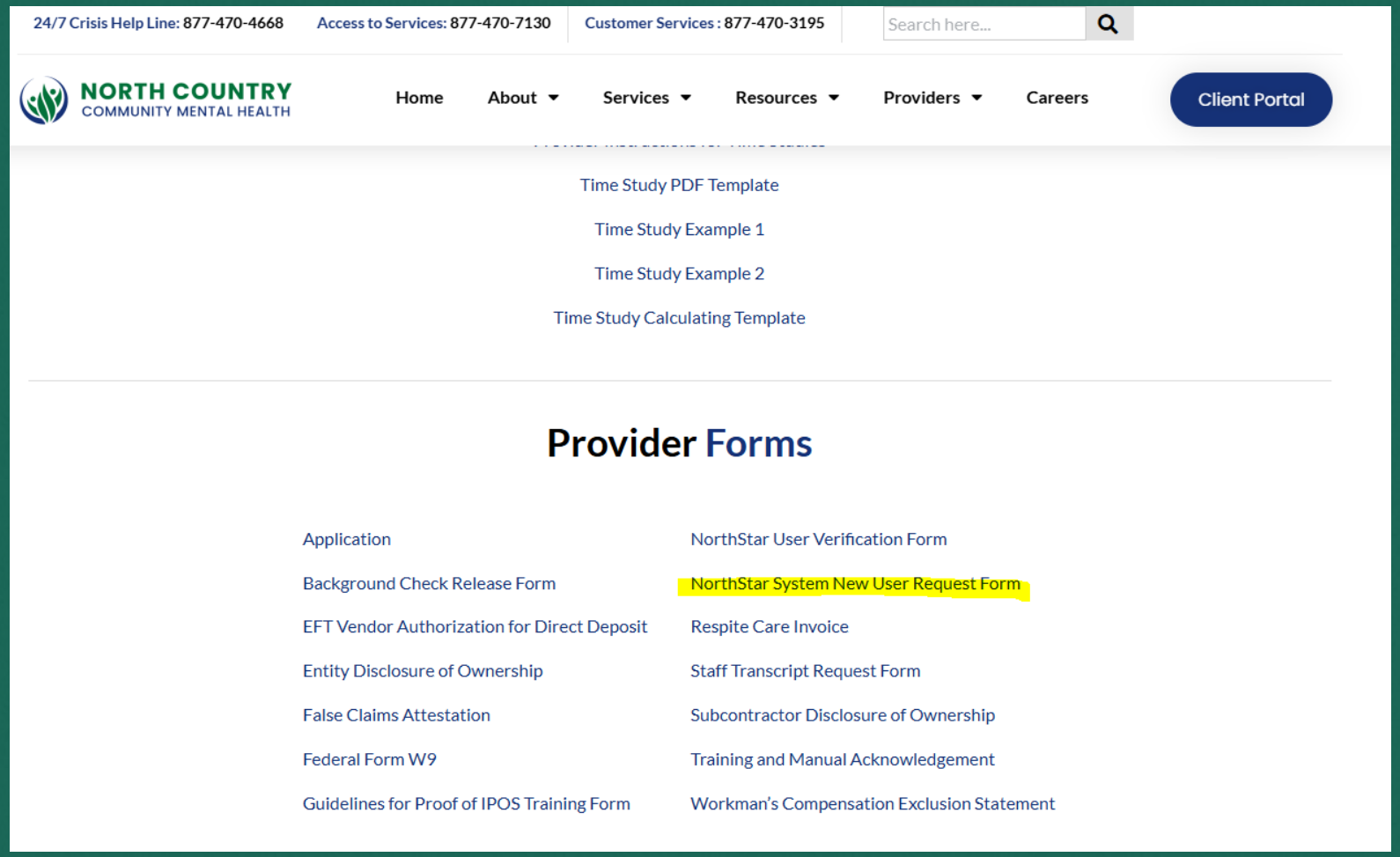
- Currently have access to **NorthStar**, and
- **Still require** access

We want to ensure **accurate user access** and remove any staff no longer active.



Access Request Form

- Updated **NorthStar Access User Request Form** is now available
- Find the forms on the provider website.



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Final Reminders & Questions

- Ensure **EVV compliance** for in-home services
- Complete **accurate time studies** within required timeframes
- Submit **updated staff access** list promptly

Questions?

We're here to help—thank you for your continued dedication!

Need Assistance? Contact Us

For any questions or support, please reach out to:

Phone: Dominique Cook 231-439-1233

Email: dcook@norcocmh.org

We're here to help and ensure everything runs smoothly!

NORTH COUNTRY
COMMUNITY MENTAL HEALTH

Compliance Training

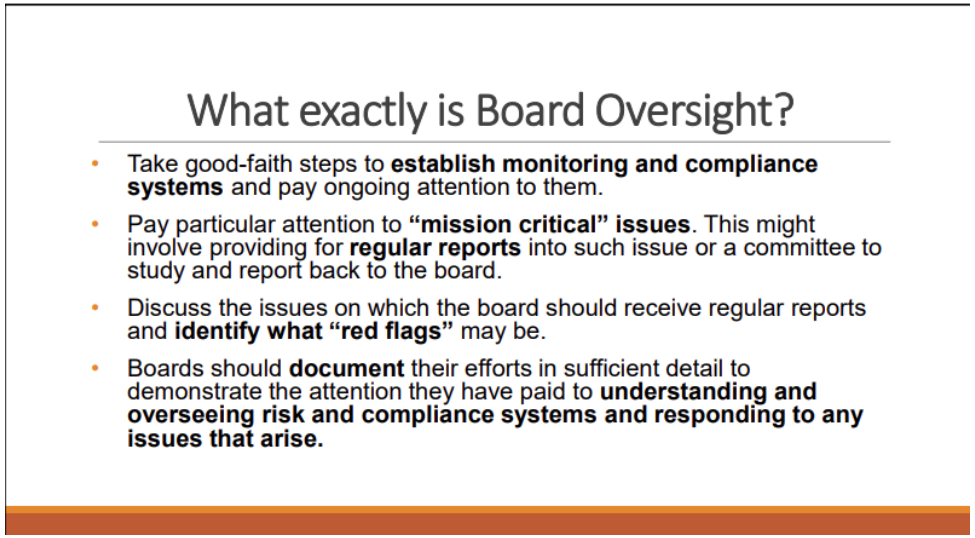
Provider Network Meeting

June 2025

OIG: 7 Elements of a Successful Compliance Program

1. Written Policies and Procedures 
2. Compliance Leadership and Oversight 
3. Training and Education 
4. Effective Lines of Communication with the Compliance Officer 
5. Enforcing Standards: Consequences and Incentives 
6. Risk Assessment, Auditing, and Monitoring 
7. Responding to Detected Offenses and Developing Corrective Action Initiatives 

COMPLIANCE LEADERSHIP AND OVERSIGHT



Slides from Susan Radwin's Board Governance Presentation, February 2025.

Board's "Duty of Care"

- **Oversight:** All audit, quality, risk, and other review activities and the associated outcomes are presented to the board.
- **Monitoring:** Ask questions, especially if information presented causes concern.
- **Assurance**: Verify that resources are available to fulfill compliance duties (funding, staff, tools, data, etc.)
- **Support:** Promote a culture of compliance

Written Policies and Procedures:
Board Conflict of Interest

1. Board members have a duty to subordinate personal interests to the welfare of NCCMH and those we serve. Conflicting interests can be financial, personal relationships, status, or power.
2. Board members are prohibited from receiving gifts, fees, loans, or favors from suppliers, contractors, consultants, or financial agencies, which obligate or induce the Board member to compromise responsibilities and are not in the best interests of NCCMH.
3. Board members will not use their board position to obtain employment in the organization for themselves, family members or close associates. Should a board member apply for employment, they must first resign from the board.
4. Board members will not obtain personal loans from the organization.

WRITTEN POLICIES AND PROCEDURES
Conflict of Interest Policy- Employees

Confidential Information –Can't use confidential info for personal financial gain or to benefit family members.

Business Transactions – Can't engage in financial deals that stem from official position and result in financial gain for self or family members.

Gifts & Influence – Can't accept gifts or favors that could influence decisions.

Fair Treatment – Must provide equal treatment and avoid giving special advantages to specific individuals.

Private Interests – Can't represent private interests in matters where the CMH Board has a direct stake.

Decision-Making Authority – Can't make regulatory, auditing, licensing, or purchasing decisions for entities in which they or their family have a financial interest.

Disclosure Requirements –Must promptly disclose any financial interests or outside employment that could create a conflict.

WRITTEN POLICIES AND PROCEDURES

Code of Conduct Policy

Staff SHALL NOT:

- Exploit one's position for personal gain or gratification
- Witness legal documents for a client (conflict of interest)

Examples of prohibited conduct:

- Unauthorized **solicitation**. Fundraising for personal business or for profit on NCCMH property is not allowed.
- Verbal or written **falsification** of any official report or document.
- **Misrepresenting** or **withholding** information on agency records
- **Unauthorized financial dealing with clients**. May not solicit, accept, or give to clients any gifts, money, or personal property

WRITTEN POLICIES AND PROCEDURES

Code of Ethics: Principals

- **Beneficence:** Promote good, do the right thing
- **Non-Malfeasance**: Avoid harm and exploiting one's position of power or influence
- **Fairness and Justice:** Equitably distribute resources, uphold civil and human rights
- **Veracity:** Provide accurate information, honor promises, and maintain integrity
- **Privacy and Confidentiality:** Adhere to the MHC and HIPAA privacy protections
- **Mandatory Reporting:** Comply with reporting statues and laws pertinent to client care
- **Honesty in Billing:** Bill services only if provided and disclose source of reimbursement
- **Trust in Marketing:** Strive for honesty and avoid deception in communication

TRAINING AND EDUCATION:

Deficit Reduction Act (DRA) of 2005: Requires Medicaid providers to implement training (like this one) as part of an effective compliance program.

FRAUD

Fraud is when someone knowingly deceives or misrepresents something to get an unfair advantage or benefit for themselves or others.

It includes any action that is considered fraud by federal or state law.

WASTE

Waste is over-utilization of services, or practices that result in unnecessary costs.

It's usually not because of illegal or extremely careless behavior; it's about misusing resources.

ABUSE

Abuse is when actions don't follow sound fiscal, business, or medical practices.

This results in unnecessary cost, or in reimbursement for services that are not medically necessary, or that fail to meet professional standards for health care.

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FRAUD: Examples

Upcoding – Charging for a more expensive procedure than what was actually performed.

Unbundling – Separating services that should be billed together to increase reimbursement.

Kickbacks – Accepting illegal payments in exchange for patient referrals

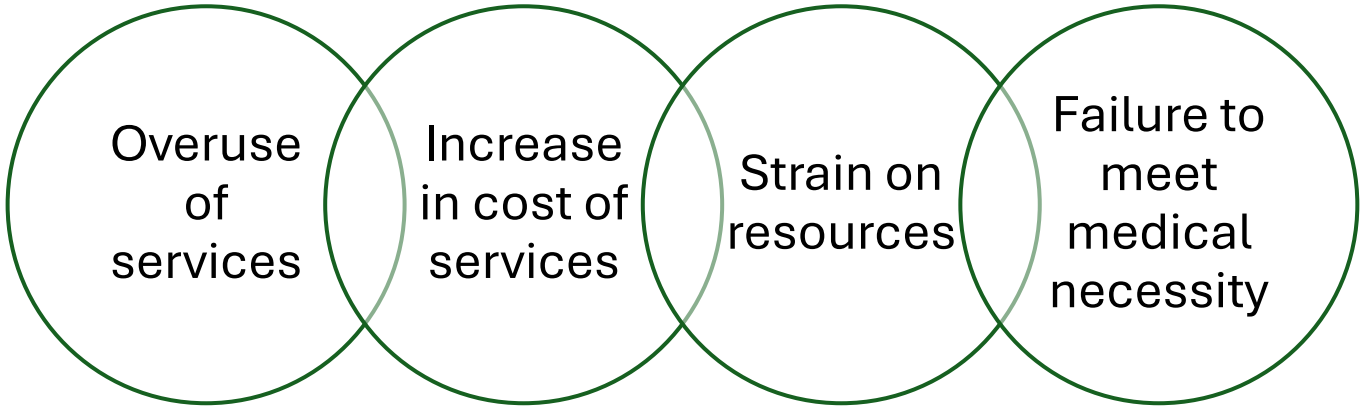
CASE: Acadia Healthcare, a company operating behavioral health facilities, was accused of submitting false claims to Medicare and Medicaid. Involved Harbor Oaks Hospital in New Baltimore, Michigan, among other facilities. Resulted in a $19.85 million settlement.

The allegations included:

- Admitting patients who did not qualify for inpatient treatment.
- Keeping patients longer than necessary to increase billing.
- Inadequate staffing and supervision, leading to patient harm.
- Failing to provide proper therapy and discharge planning.

TRAINING AND EDUCATION: Waste and Abuse

Unlike fraud, **waste** and **abuse** may not involve intentional deception, but they still harm the system by **misusing funds** and **reducing efficiency.** This results in:



Waste Example: Snail- mailing all client correspondence instead of using secure email or the client portal wastes money on postage, labor, and supplies.

Abuse Example: An outpatient clinic routinely orders extensive psychological evaluations for every new client, even when a brief assessment would be sufficient. This disregards medical necessity.

At NCCMH, Waste is often addressed with the use of Lean principals. Abuse is addressed through utilization management and auditing and monitoring.

TRAINING AND EDUCATION: Federal and State Requirements

Federal Affordable Care Act (ACA) and Michigan Medicaid Provider Statutes:

•Strengthens fraud prevention measures through enhanced screening and provider enrollment requirements. (background checks, licensure, disclosures, etc.)

•Prohibits Medicaid payments from being made to institutions beyond US borders

Federal Stark Law (Physician Self-Referral Law) and Michigan Self-Referral Law

- Prohibits physicians from referring Medicare/Medicaid patients to entities in which they or their family have a financial interest.
- Prevents conflicts of interest in healthcare referrals.
- Violations can result in financial penalties and exclusion from federal programs.

A doctor owns a partial stake in a behavioral health clinic that provides therapy and psychiatric services.

The Dr. refers Medicaid patients to this clinic for treatment without disclosing their own financial interest.

The clinic bills Medicaid for services provided to referred patients.

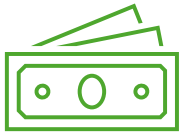
The Dr. profits from patient referrals, creating a conflict of interest.

TRAINING AND EDUCATION: Federal and State Requirements

Federal and State False Claims Acts:

- Prohibits knowingly submitting false claims for payment.
- Includes whistleblower (qui tam) provisions allowing individuals to report fraud.
- Violations can result in treble (triple the amount) of damages and civil penalties.

EXAMPLE: A provider in Maryland operated two behavioral health companies that submitted $3.6 million false claims for psychiatric rehabilitation services. She forged signatures and created fake patient records to bill Medicaid for services never provided. She stole identities of healthcare providers and Medicaid recipients to authorize fraudulent claims.



Federal Anti-Kickback Statute (AKS) and **Michigan Health Care False Claims Act**

- Criminal law prohibiting offering, paying, soliciting, or receiving remuneration in exchange for patient referrals or business involving federal healthcare programs.
- Includes penalties such as fines, imprisonment, and exclusion from Medicare/Medicaid.
- Covers financial incentives like cash payments, free rent, or compensation for referrals.

EXAMPLE: 15 Texas doctors agreed to pay over $2.8 million to settle allegations that they received illegal kickbacks in exchange for ordering laboratory tests. These doctors allegedly accepted payments from management service organizations in return for referring patients to specific labs, violating laws designed to prevent financial incentives from influencing medical decisions.

TRAINING AND EDUCATION:
Federal and State Requirements

Fed. Health Insurance Portability and Accountability Act (HIPAA) and MI Identity Theft Protection Act

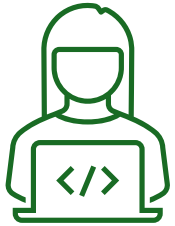
•Protects patient privacy and data security.

•Standardizes formats for claims, eligibility checks, and remittances.

Fed and State Whistle Blower Protections:

- **Employee Protections** – Laws safeguard individuals who report violations or take part in investigations.
- **No Retaliation** – Employers cannot fire, threaten, or discriminate against employees for reporting misconduct.
- **Qui Tam Lawsuits** – Individuals can file claims on behalf of the government and receive a share of recovered funds
- **Legal Remedies for Retaliation** –Employees can sue for job-related losses, reinstatement, and relief
- **Statute of Limitations** – Time limits vary based on the law under which a claim is filed.

Risk Assessment, Monitoring, Auditing



- NMRE Quality (and Compliance) Oversight Committee
- Risk Management program and committee
- Initial and ongoing screening for exclusions and sanctions (Valenz)
- Initial and ongoing disclosure reporting by controlling parties (DOO)
- Employee, Board, and provider attestations of compliance
- Adherence to procurement standards for purchases and contracts
- NMRE audits (i.e. Medicaid Encounter Verification)
- Quarterly reports of auditing and overpayment activities to NMRE/OIG
- Investigations initiated based on tips, grievances, or auditing/data mining.

Enforcing Standards: Consequences and Incentives

Consequences –

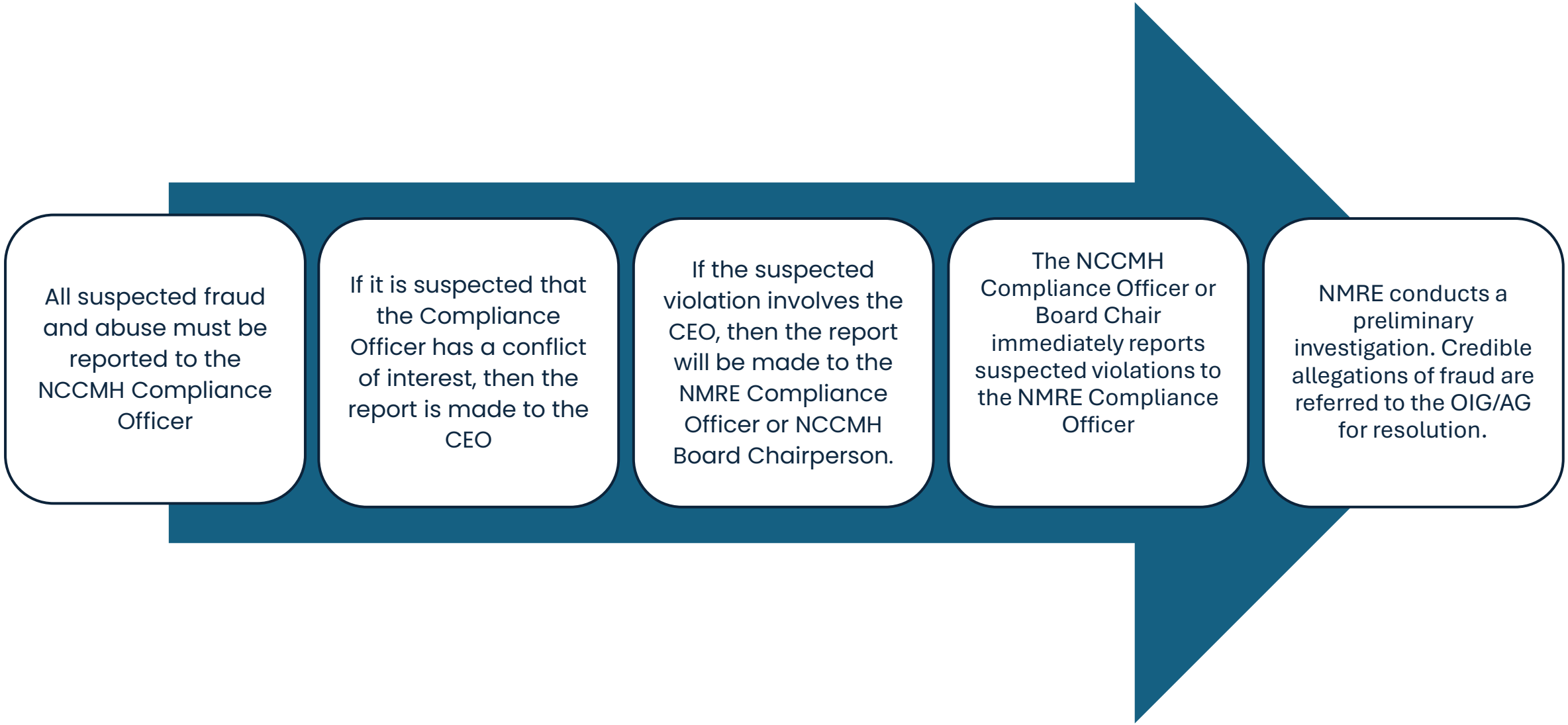
(Responding to Detected Offenses and Development of Corrective Action Initiatives)

- Employee accountability through training or disciplinary action
- Termination of employment/contract for deliberate or reckless noncompliance.
- Recoupment of overpayments (Provider) or imposition of monetary sanctions
- Systemic changes in process, policy, or procedure
- Criminal penalties, civil fines, loss of license, exclusion from Medicaid/Medicare

Incentives-

- Employee recognition, meaningful encouragement, compensation (performance reviews.)
- Enhanced workplace culture- trust, transparency, and accountability
- Whistleblower protections
- Federal self-disclosure programs and sentencing that considers the effectiveness of the compliance program.
- Per the OIG “Any other creative means of encouraging compliance and risk reduction.”

Effective Lines of Communication with the Compliance Officer



Effective Communication with Compliance Officer:

Where to Report Fraud or Abuse:

- **NCCMH Compliance Office**
  - Kim Rappleyea, Compliance Officer
  - Phone: 231.439.1240
  - Email: krappleyea@norcocmh.org
  - Mail: 1420 Plaza Drive, Petoskey, MI 49770

- **NMRE Compliance Office**
  - Hotline: 866.789.5774
  - Email: Compliancesupport@nmre.org
  - Mail: 1999 Walden Drive, Gaylord, MI, 49735
  - Website: https://www.nmre.org/fraud-prevention/


NORTH COUNTRY
COMMUNITY MENTAL HEALTH
THANK YOU

HCBS Provider/ Setting Training

MSU is working on a training – hoping to be ready in the Summer

Train-the-trainer

More info to come…

Survey Results

- MDHHS shared the results of the HCBS surveys from last summer.
- Currently planning to meet with CMH's to discuss next steps to get those settings HCBS compliant by September 30th.
- Settings will be reached out to shortly if there is anything that needs to be remediated.

Alarm/Delayed Egress

- Please note that the use of alarms/delayed egress can only be employed if there is *at least one person* in the setting who has an HBCS compliant restriction/modification in their IPOS. Otherwise, the systems must be removed. Giving everyone who lives in the setting the code will not suffice if no one in the setting has an HCBS complaint restriction. This could easily be reversed by simply changing the code and not providing it to all the residents again.
- If there is a delayed egress/alarm function in place, *it must be identified as a part of the restriction to freedom of movement* and can be titrated out consistent with the freedom of movement restriction.
- If a person has only the delayed egress function it should be addressed similar to if the doors were locked, and the person could not exit. CMS sees this as a setting wide restriction on freedom of movement and a restriction/intrusion on the right to privacy in the persons coming and going as they choose. The goal should not be to have the person restricted indefinitely and will need to write a titration consistent with the persons needs and abilities.

Effective September 30, 2025, all IPOS‘s of individuals who live in settings that employ alarms must include either an HCBS compliant modification or identify how the individual will be able to bypass the alarm easily.

LARA Resident Care Agreement

- CMS concern- House rules and resident funds
- House rules box shouldn't be checked
- Resident funds can't be held back
- MDHHS is working with LARA

Summary of Resident Rights

- Renew annually or anytime a new resident care agreement is required
- MUST be signed by resident
- On file at setting
- Suggests PIHP/CMHSP also keep a copy

HCBS Compliant Door Handles

- Per MDHHS: lever doorknobs are most easily accessible by all individuals.
- Lever door handles are the preferred type because a person does not have to grasp and twist the handle and can open by pushing down on the lever with a hand, arm etc. Knob handles can be much less accessible for those with physical impairments or the aged population.
- Should the setting choose the use the knob system they will have to change it if the person in the room cannot easily open/close/lock the door and it will be the regional leads responsibility to ensure that this occurs when new people move into the setting in order for the setting to be HCBS compliant

Restrictions within Settings

- No signs stating “no drugs or alcohol allowed on this property” “No firearms or weapons allowed on this property” in places residents/visitors can see. ONLY acceptable if in employee office or staff area.
- No signs stating Visitor policy- It is expected that in the event we see something like this posted we ask setting to remove it and not to put it back up and should speak with the house manager and if not available get their contact information. If the setting continues to be out of compliance a Corrective Action Plan (CAP) should be completed, if doesn’t participate in CAP then not eligible for Medicaid funding, implementing a transition to move individuals to compliant settings

Modifications/Restrictions

- Any modifications to the HCBS settings requirements needed by an individual must be supported by a specific assessed health and/or safety need and justified in the person-centered plan.
- There must be evidence in the record that the modification is required prior to the institution of the restriction.
- Settings may not request that restrictions be documented in the persons IPOS based upon the convenience or preferences of the setting.
- Settings may not institute setting wide restrictions for the benefit of one individual.
- For example, a setting may not restrict access to the kitchen or the kitchen cupboards for all residents because one person requires a modification in this area.
- The agreement of residents to any such restriction may not be requested by the setting in order to live within the setting and will not be considered justification of the restriction by MDHHS.
- A workaround must be developed and specified in the IPOS of any person receiving services in the setting who does not require the modification.

Modifications/Restrictions cont.

- The following must be documented in the plan:
  - Identify a specific and individualized assessed safety or health related need.
  - Positive interventions and supports used prior to modification.
  - Less intrusive methods tried.
  - Describe the restriction or modification that is directly proportionate to the specified need.
  - Develop a fade or titration plan to identify how the restriction will be eased over time based upon skill acquisition or reduced safety concerns.
  - The plan to ameliorate or eliminate the behavior must be reviewed and approved by the CMHSP or PIHP behavior review committee.
  - The plan must be reviewed regularly and no less than quarterly to determine if the modification is still needed.
  - Informed consent of the individual.
  - Assure interventions and supports will cause no harm.
  - Identify services and supports that will be utilized to support the person in the development of skills necessary to decrease the need for restrictive measures.

Contact Info:

Aaron Biery Waiver Coordinator/ HCBS Lead

abiery@nmre.org

P: 231.303.3061

Thank you!

SUMMARY OF RESIDENT RIGHTS: DISCHARGE AND COMPLAINTS

If you live in an Adult Foster Care home or Home for the Aged, you have certain rights as a resident of the home. These rights are protected under state licensing laws. Some of these rights help protect you against being wrongfully discharged from your home. This document provides an overview of some of your rights as a resident of an Adult Foster Care home or Home for the Aged. For this document, a licensee is another name for the property owner.

Disclaimer: You may have additional rights as a resident of a licensed setting. Your full rights are outlined in the state licensing rules, which can be reviewed at
http://www.michigan.gov/lara >> Community and Health Systems >> Covered
Providers >> Adult Foster Care >> Licensing Rules and Statutes

WRITTEN AGREEMENT

The licensee must sign a written agreement with you, which must include:

- A list of services that you will receive in the home
- A description of your rights and responsibilities as a resident
- A description of the process for being admitted and discharged from the home
- A description of the fees that you must pay as a resident of the home

The licensee must provide you with copies of the written agreement, and the "Admission and Discharge Policy" for the home.

DISCHARGE AND COMPLAINT PROCESS

The licensee can only discharge you from the home for certain reasons. The licensee must follow a specific process to discharge you. If you believe that the licensee wrongfully discharged you from the home, you may contact the Department of Licensing and Regulatory Affairs to file a complaint. The Department may be able to help you return to your home. **The discharge and complaint process is outlined on Page 2**

Proceed to Page 2

SUMMARY OF RESIDENT RIGHTS: DISCHARGE AND COMPLAINTS

TYPE OF HOME	ADULT FOSTER CARE FAMILY HOME	ADULT FOSTER CARE HOME	ADULT FOSTER CARE:CONGREGATE HOME	HOME FOR THE AGED
Regular discharge process	The licensee must notify you 30 days in advance of the discharge date. The notice must be written and include a reason for discharge. You must be given a copy of the notice.	The licensee must notify you 30 days in advance of the discharge date. The notice must be written and include a reason for discharge. You must be given a copy of the notice.	The licensee cannot discharge you without adequate preparation. The licensee must prove that discharging you is "in your best interest." This decision must take your expressed wishes into consideration. The licensee must provide you with a written notice with a reason for discharge. During discharge, your responsible agency or the Michigan Department of Health and Human Services must work with you to update your service plan.	The licensee must notify you 30 days in advance of the discharge date. The notice must be written and include a reason for discharge. You must be given a copy of the notice.
Emergency Process (When there is substantial risk to: (1) you; (2) other residents; (3) the provider; or (4) the property.)	The licensee must provide you with written notice at least 24 hours in advance. This notice must include an appropriate reason for emergency discharge. The licensee must receive written approval from you, your designated representative, or service agency before discharging you from your home.	The licensee must provide you with written notice at least 24 hours in advance. This notice must include an appropriate reason for emergency discharge. The licensee cannot discharge you without: (1) receiving approval from the responsible agency or Adult Protective Services; AND (2) finding another setting that can meet your needs.		The licensee must provide you with written notice at least 24 hours in advance. The licensee must also notify the Department of Licensing and Regulatory Affairs and Adult Protective Services before discharging you. The licensee cannot discharge you without finding another setting that can meet your nee

SIGNATURE

If the licensee provided you with a copy of this document, please sign below:

Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____