

Board of Directors Work Session Agenda
August 27, 2025, 11:00 AM
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440

1. Welcome and Opening Comments – Ms. Gardner
2. Public Comment
3. Corporate Compliance Training (Attachment) – Jack Calhoun
4. PIHP System Request for Proposal Discussion (Attachment) – Mary Marlatt-Dumas/Stephanie VanDerKooi



FY25 CORPORATE COMPLIANCE PLAN

October 2024

Prepared by LRE Compliance Officer: January 7, 2025

Reviewed by LRE Compliance ROAT: January 28, 2025

Reviewed by LRE Executive Team: January 23, 2025

Reviewed by LRE Operations Council: October XX, 2024

Reviewed and Approved by LRE Board of Directors: February 26, 2025

Distributed by LRE: February XX, 2025

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ORGANIZATIONAL STRUCTURE

The Lakeshore Regional Entity (LRE) serves as the Medicaid Prepaid Inpatient Health Plan (PIHP) for the following seven county region:

Allegan County: OnPoint (Allegan County Community Mental Health Services)

Kent County: Network 180 (Kent County CMH Authority)

Lake County: West Michigan Community Mental Health System

Mason County: West Michigan Community Mental Health System

Muskegon County: HealthWest

Oceana County: West Michigan Community Mental Health System

Ottawa County: Community Mental Health of Ottawa County

The Member Community Mental Health Service Programs (Member CMHSPs) have elected to configure LRE under the Michigan Mental Health Code Section 3301.1204b.

The Michigan Department of Health and Human Services (MDHHS) also refers to LRE as Region 3.

LRE as the PIHP

LRE serves as the Medicaid PIHP for the region with authority and accountability for operations and fulfillment of applicable federal and state statutory, regulatory, and contractual obligations related to the applicable waiver(s) and MDHHS contract(s). The role of LRE as the PIHP is defined in federal statute, specifically 42 CFR § 438 and the Fiscal Year 2025 (FY25) MDHHS/PIHP Contract.

LRE contracts with MDHHS for The Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915 (c)/(i) Waiver Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs

LRE: MISSION and VALUES

MISSION:

Through regional support and leadership for collaboration and innovation, LRE works to strengthen the public behavioral health system and ensure excellence in services.

VALUES:

- **Local Solutions – Value Local Differences:** We value locally unique service systems that are responsive to local needs, partnerships, and available resources.
- **Fiscal Responsibility – Accountable and Responsible with funds:** Transparent and accountable use of public funds. Maximize available resources.
- **Collaborative Relationships – Foster Effective Partnerships:** Nurture collaboration based on mutual trust and shared commitment to quality. Approach all interactions with respect, openness, and a commitment to proactively resolve conflict.
- **Innovation – Boldly Pursue Excellence:** Pursue audacious goals by challenging the status quo and trying new things. Actively work to identify and support opportunities for innovation.

OVERVIEW OF LRE's CORPORATE COMPLIANCE PLAN AND PROGRAM

SCOPE OF LRE CORPORATE COMPLIANCE PLAN

The LRE Corporate Compliance Plan is a high-level overview of the LRE Corporate Compliance Program that outlines LRE's commitment to ensuring compliance with the applicable federal and state statutory, regulatory, and contractual requirements.

All LRE staff, Member CMSHPs, and Network Providers are required to comply with all applicable federal and state statutory, regulatory, and contractual requirements including but not limited to those specifically addressed in the LRE Corporate Compliance Plan.

To the extent that the LRE Corporate Compliance Plan conflicts with, or misstates any applicable regulation, statutes or contractual requirements the regulation, statutes, and/or contractual requirements control(s).

PURPOSE OF LRE CORPORATE COMPLIANCE PROGRAM

The purpose of the LRE Corporate Compliance Program is to

1. Encourage the highest level of ethical and legal behavior from all LRE staff and Board of Directors.
2. Educate all LRE staff, LRE Board of Directors, and stakeholders on their responsibilities and obligations to comply with applicable federal, state, and local laws.
3. Communicate to all LRE staff, LRE Board of Directors, Member CMSHPs, and Network Providers, and stakeholders LRE's Corporate Compliance Program structure to promote understanding and encourage communication.
4. Minimize organizational risk and improve compliance with applicable federal and state statutory, regulatory, and contractual requirements; service provision; documentation standards; and Medicaid coding and billing requirements.
5. Maintain adequate internal controls throughout Region 3.
6. Provide oversight and monitor functions to reduce the possibility of misconduct, and violations through prevention and early detection and minimize exposure to civil and criminal sanctions as well as non-compliance with applicable federal and state statutory, regulatory, and contractual requirements; service provision; documentation standards; and Medicaid coding and billing requirements.
7. Promote a clear commitment to compliance by taking actions and showing good faith efforts to uphold applicable federal regulations, state statutes, and contractual requirements.

APPLICATION OF LRE CORPORATE COMPLIANCE PLAN

As a regional PIHP, the LRE Corporate Compliance Plan is intended to provide the framework for the LRE to comply with all applicable laws, regulations, contracts, and program requirements. It is the LRE's intent that all its compliance policies and procedures should promote integrity, support objectivity, and foster trust throughout the service region. The LRE Corporate Compliance Plan applies to all LRE day-to-day activities, including those activities that come within Federal and State oversight of PIHPs.

LRE staff are subject to the requirements of the LRE Corporate Compliance Plan as a condition of employment. All LRE staff are required to fulfill their duties in accordance with the LRE Corporate Compliance Plan, LRE policies, and LRE procedures to promote and protect the integrity of LRE. Failure to do so will result in disciplinary action, up to and including termination of employment depending on the egregiousness of the offense. Disciplinary action may also be taken against a supervisory staff member, who directs or approves a staff's improper conduct, is aware of the improper conduct, and does not act appropriately to correct it, or who fails to properly exercise appropriate supervision over a staff member.

LRE, directly and indirectly, through its Member CMHSPs, contracts services for adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders within its seven counties (Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa counties).

The LRE Corporate Compliance Plan applies to Member CMHSPs and Network Providers receiving payment through LRE and/or through the PIHP managed care functions. All Member CMHSPs and Network Providers, including their officers, employees, contractors, servants, and agents, are subject to the requirements of LRE Corporate Compliance Plan as applicable to them and as stated within the applicable contracts. Failure to follow the LRE Corporate Compliance Plan and cooperate with the LRE Corporate Compliance Program will result in corrective action plans, remediation, and contract action, if needed.

The LRE Corporate Compliance Plan, standards, policies and procedures included or referenced herein are not exhaustive or all inclusive. All LRE staff, Member CMHSPs, and Network Providers are required to comply with all applicable laws, rules and regulations including those that are not specifically addressed in the LRE Corporate Compliance Plan.

LRE CORPORATE COMPLIANCE PROGRAM ELEMENTS

LRE's Corporate Compliance Program is comprised of the eight elements as provided by the Office of Inspector General.¹

Element 1 - Written Policies, Procedures, and Codes of Conduct – The development, distribution, and enforcement of written policies, procedures, and codes of conduct that promote the LRE's commitment to full compliance with applicable federal and state statutory, regulatory, and contractual obligations that are accessible and applicable to all LRE Staff. These policies, procedures, and codes of conduct incorporate the culture of compliance into our day-to-day operations and address specific areas of potential fraud, waste, and abuse. LRE also maintains its policies, procedures, and codes of conduct through annual review.

See LRE Policies or Procedures:

[Policies and Procedures - Lakeshore Regional Entity \(lsre.org\)](#)

[1.1-Conflict-of-Interest-Dec2021.pdf \(lsre.org\)](#)

[1.1a-Conflict-of-Interest Procedure](#)

[1.3-Policy-Promulgation-Policy-Jan2023.pdf \(lsre.org\)](#)

[1.3a-Policy-Promulgation-Jan2023.pdf \(lsre.org\)](#)

[1.3b-Annual-Policy-Review.pdf \(lsre.org\)](#)

[8.01 Code of Ethics-Sept2018.pdf \(lsre.org\)](#)

LRE Policy 9.X – Code of Conduct

¹ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, General Compliance Program Guidance, November 2023, [HHS-OIG General Compliance Program Guidance | November 2023](#) (last visited April 9, 2024).

[10.5-Code-of-Conduct-Final-2021.pdf \(lsre.org\)](#)
[Code-of-Conduct-Distribution-and-Training-Procedure-Clean-20230721.pdf \(lsre.org\)](#)

Element 2 - Compliance Leadership and Oversight – The designation of a Compliance Officer and a Compliance Oversight Committee that is charged with the responsibility and authority of operating and monitoring the Corporate Compliance Program to make sure that it is implemented, monitored, and revised, as appropriate in an effective manner. (See “STRUCTURE OF LRE CORPORATE COMPLIANCE PROGRAM,” Sections LRE Compliance Officer and LRE Compliance Oversight Committee, pp. 9-11.)

See LRE Policies or Procedures: [9.1-CC-Plan-20230721.pdf \(lsre.org\)](#)
[Compliance-Auditing-and-Monitoring-Procedure-Clean-Reviewed-20230721.pdf \(lsre.org\)](#)
[Compliance-Oversight-Committee-Procedure-CLEAN-20230721.pdf \(lsre.org\)](#)

Element 3 - Compliance Training and Education – The development and implementation of appropriately tailored training programs and education for all LRE Staff and LRE Board of Directors. LRE ensures new LRE staff and LRE Board of Directors members receive LRE’s Corporate Compliance Program training at orientation or within thirty (30) days of employment or appointment, respectively. LRE ensures all LRE staff and the LRE Board of Directors receive annual compliance training and, as necessary, other periodic training. LRE also ensures LRE staff complete the required annual trainings in a timely manner as prescribed by LRE. Training is a condition of employment and failure to comply will result in appropriate disciplinary action.

LRE requires the following mandatory, minimum trainings for LRE staff, with the corresponding training timelines:

Training Name	Initial Training	Ongoing Training
Corporate Compliance	Within 30 days of Hire	Annually
Cultural Competence	Within 30 days of Hire	Annually
HIPAA	Within 30 days of Hire	Annually
Limited English Proficiency	Within 30 days of Hire	Annually
Recipient Rights	Within 30 days of Hire	Annually
LRE Enhanced Privacy Training	Within 30 days of Hire	Annually

Member CMHSPs and Network Providers are required to comply with the MDHHS training requirements. If you are a Network Provider, please review your contract or contact your contracting Member CMHSP(s) and inquire if any additional trainings are required based on service types rendered, etc.

See LRE Policies or Procedures: [8.08 Training Development-Sept2016.pdf \(lsre.org\)](#)
[Human Resources - Lakeshore Regional Entity \(lsre.org\)](#)

Element 4 - Effective Lines of Communication with Compliance Officer and Disclosure Programs

– The regular education of all LRE Staff, Member CMHSPs, and Network Providers of how to contact the LRE Compliance Officer. The development of writing policies and procedures regarding confidentiality (anonymity of complainants) and nonretaliation policies when reporting instances of noncompliance, including but not limited to fraud, waste, and abuse. The use of efficient and trusted mechanisms where all LRE Staff, Member CMHSPs, and Network Providers can contact the Compliance Officer through a hotline to receive complaints. LRE utilizes the following mechanism for receiving complaints:

1. LRE Telephone Hot Line – Suspected compliance violations or questions can be made to a toll-free hot line. The number is 1-800-420-3592 and includes confidential voice mail.
2. LRE Electronic Mail (E-Mail) – Suspected compliance violations or questions can be sent electronically via e-mail to the Compliance Officer at compliance@lsre.org.
3. Mail Delivery – Suspected compliance violations or questions can be mailed to:

LRE Compliance Officer
Lakeshore Regional Entity
5000 Hakes Drive
Suite 250
Norton Shores, Michigan 49441

4. In-Person - Suspected compliance violations or questions can be made in person to the LRE CO at the above address. Please contact the LRE CO to make an in-person appointment.
5. Virtual - Suspected compliance violations or questions can be made virtually via ZOOM or Microsoft® Teams upon request. Please contact the LRE CO to make a virtual appointment.

Non-Retaliation and Non-Intimidation of Person's Reporting Non-Compliance²

LRE Board of Directors Members, LRE staff members, Member CMHSPs and staff, and Network Providers and staff, who make good faith reports of violations of federal or state law, are protected by state and federal whistleblower statutes.

Under the Federal False Claims Act and the Michigan Medicaid False Claims Act, employees who report violations in good faith are entitled to protection from disciplinary actions taken by their employer.

² Also referred to as Whistleblower Protections.

1. The Federal False Claims Act, 31 USC §§3729 through 3731, provides for administrative remedies, encourages enactment of parallel State laws pertaining to civil and criminal penalties for false claims and statements, and provides “whistle-blower” protection for those making good faith reports of statutory violations.
2. Under the Michigan Medicaid False Claims Act, an employer shall not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee in the terms and conditions of employment because the employee initiates, assists in, or participates in a proceeding or court action under this act or because the employee cooperates with or assists in an investigation under this act. This prohibition does not apply to an employment action against an employee who the court finds: (i) brought a frivolous claim, as defined in section 2591 of the revised judicature act of 1961, 1961 PA236, MCL §600.2591; or (ii) planned, initiated, or participated in the conduct upon which the action is brought; or (iii) is convicted of criminal conduct arising from a violation of that act.

See LRE Policies or Procedures: [Compliance-Reporting-Responsibility-Procedure-Final-20230721.pdf \(lsre.org\)](#)

Element 5 - Enforcing Standards: Consequences, and Incentives – The development of appropriate consequences of instances of noncompliance, as well as incentives for compliance. The development of policies regarding conflict of interest; disclosure of ownership; sanctioned, excluded, debarred, etc. organizations and individuals; criminal background checks; etc.

Corrective Action Plans

If an internal investigation substantiates a reported violation, corrective action will be initiated including, as appropriate, which will include: 1) LRE issuing a non-compliance letter, 2) LRE requiring a Corrective Action Plan (CAP) from the agency found out of compliance, 3) Out of compliance agency developing a CAP inclusive of monitoring for adequate implementation and risk mitigation, and 4) Out of compliance agency implementing changes to prevent a similar violation from recurring in the future, is possible.

Elements of a Corrective Action Plan: As appropriate given the nature of the noncompliance, a corrective action plan submitted to LRE for approval shall, at a minimum, include:

1. Describe in sufficient detail the corrective action that will be taken to minimize or eliminate the risk from repeating in the future,
2. Names or Titles of those responsible for implementing the corrective action, and
3. An implementation date.

Depending on the seriousness of the offense, the resulting action for LRE staff could include additional training, written reprimand, suspension, or termination of employment. The resulting action for the Network Provider would also depend on the seriousness of the offense and could

include additional training, written reprimand, suspension, letter of contract non-compliance, and termination of contract.

See LRE Policies or Procedures:

[4.9-Corrective-Action-Plan-Performance-Improvement-Policy.pdf \(lsre.org\)](#)
[4.9a-Corrective-Action-Plan-Performance-Improvement-Procedure.pdf \(lsre.org\)](#)
[9.8-Compliance-Enforcement-20230721.pdf \(lsre.org\)](#)
[1.1-Conflict-of-Interest-Dec2021.pdf \(lsre.org\)](#)
[1.1a-Conflict-of-Interest-Procedure.pdf \(lsre.org\)](#)
[4.2-Contract-Management.pdf \(lsre.org\)](#)
[4.4-Credentialing-Recredentialing.pdf \(lsre.org\)](#)
[9.9-LRE-Exclusion-Screenings-Policy-20230721.pdf \(lsre.org\)](#)
[9.11-Criminal-History-Checks-20230721.pdf \(lsre.org\)](#)
[7.1-Quality-Management.pdf \(lsre.org\)](#)
[7.7-CMHSP-Member-Monitoring-2022.pdf \(lsre.org\)](#)
[7.8-Medicaid-Verification-2020.pdf \(lsre.org\)](#)

Element 6 – Risk Assessment, Auditing, and Monitoring – The use of audits or other risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas within delivered services, claims processing, and managed care functions.

The development of a Risk Assessment Work Plan that will be used to identify, analyze, and address the risks the organization faces and how well the current systems in place are able to prevent those risks.

The LRE Compliance Officer is also responsible for ensuring a risk assessment is performed annually with the results integrated into the daily operations of the organization.

See LRE Policies or Procedures:

[Compliance-Auditing-and-Monitoring-Procedure-Clean-Reviewed-20230721.pdf \(lsre.org\)](#)
[7.1-Quality-Management.pdf \(lsre.org\)](#)
[7.7-CMHSP-Member-Monitoring-2022.pdf \(lsre.org\)](#)
[7.8-Medicaid-Verification-2020.pdf \(lsre.org\)](#)
[9.1-CC-Plan-20230721.pdf \(lsre.org\)](#)

Element 7 - Responding to Detected Offenses and Developing Corrective Action Initiatives – The development of policies and procedures to respond to detected offenses, to initiate correction action initiatives to prevent future offenses, and to, when appropriate, report to governmental agencies.

See LRE Policies or Procedures:

[9.8-Compliance-Enforcement-20230721.pdf \(lsre.org\)](#)

[9.7-Compliance-Reviews-and-Investigations-20230721.pdf \(lsre.org\)](#)

LRE Policy 9.XX – FWA Investigations

LRE Compliance Procedure – FWA Investigations Step-by-Step Guide

STRUCTURE OF LRE CORPORATE COMPLIANCE PROGRAM

GENERAL STRUCTURE

LRE Board of Directors: LRE Board of Directors is responsible for the review and approval of the LRE Corporate Compliance Plan and review of matters related to the LRE Corporate Compliance Program.

LRE Compliance Officer: LRE designates a Compliance Officer, who

1. Is given sufficient authority and control to oversee and monitor the successful implementation and effectiveness of the LRE Corporate Compliance Plan, including all seven LRE Corporate Compliance Program Elements.
2. Has primary responsibility of advising LRE's Chief Executive Officer (CEO), Board of Directors, and Executive Team of compliance risks related to strategic and operational decisions and operation of the LRE Corporate Compliance Program.
3. Serves as the Chair of the Compliance Regional Operations Advisory Team (ROAT) and the LRE Compliance Oversight Committee (COC).
4. Reports status of implementation of the LRE Corporate Compliance Plan and its related compliance activities as well as any needs of the LRE Corporate Compliance Program to LRE CEO and/or Board of Directors.
5. Recommends revisions to the LRE Corporate Compliance Program and Plan, inclusive of all seven Corporate Compliance Program Elements, as well as the Compliance Policies and Procedures.
6. Provides consultative support to Member CMHSPs and Network Providers, as requested.
7. Is responsible for the day-to-day operations of the LRE Corporate Compliance Program.
8. Assures compliance training and education efforts for LRE staff and LRE Board of Directors are completed annually.
9. Assures PIHP is aware of evolving federal requirements and MDHHS contractual obligations and standards and ensuring compliance.
10. Coordinates and oversees investigations, audits, and monitoring activities.
11. Coordinates with LRE Operations, Human Resources, and other relevant departments regarding LRE Staff, Member CMHSPs, and Network Providers credentialing and recredentialing including but not limited to certifications, licensures, criminal background checks, sanctions checks, etc.

12. Independently investigate and act on matters related to compliance.
13. Draft and maintain reports including but not limited to annual Corporate Compliance Program Evaluation.

LRE Compliance Oversight Committee: LRE Compliance Oversight Committee (COC) that

1. Provides guidance, supervision, and coordination for the successful implementation and effectiveness of the LRE Corporate Compliance Program.
2. Reviews the effectiveness of the LRE Corporate Compliance Program and LRE Corporate Compliance Work Plan.
3. Reviews the Annual Corporate Compliance Risk Assessment.
4. Reviews recommendations from the Compliance Officer and Compliance ROAT that are related to the LRE Corporate Compliance Program, including all eight Corporate Compliance Program Elements.
5. Is comprised of the LRE Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Managed Care Officer, Compliance Officer, and Chief Information Officer. Legal Counsel will be an ad-hoc member of the COC. In addition, other members of the LRE not mentioned above may be asked to participate in the COC on a case-by-case basis to provide consultation on specific areas of expertise.
6. Meets quarterly and when otherwise needed to address specific impromptu matters.
7. Reviews all direct-to-consumer marketing activities in advance of launch if the activity involves giving anything of value directly to a consumer.

LRE Compliance Regional Operations Advisory Team: LRE Compliance ROAT advises on matters involving compliance and

1. Is comprised of LRE Compliance Officer and the compliance officer from each Member CMHSP in Region 3, which is appointed by the respective Member CMHSP.
2. Reviews the LRE Corporate Compliance Plan and related policies to ensure they adequately address legal requirements and identified risk areas.
3. Analyzes the regulatory environment and the legal requirements with which it must comply and specific risk areas.
4. Analyzes the effectiveness of the LRE Corporate Compliance Program and makes recommendations for improvements, where appropriate.
5. Assists the LRE Compliance Officer with developing policies and procedures to promote compliance with the LRE Corporate Compliance Program and the applicable federal and state statutory, regulatory, and contractual obligations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.
6. Assists the LRE Compliance Officer with identifying potential risk areas and violations.
7. Advises and assists the LRE Compliance Officer with compliance initiatives.
8. Works with appropriate departments, as well as Network Providers, to develop standards of conduct and policies and procedures that promote compliance to legal and ethical standards.

9. Recommends and monitors, in conjunction with the relevant functional area leaders, the development of internal and external systems and controls to carry out LRE's standards, policies and procedures as part of its daily operations.
10. Determines the appropriate strategy and approach to promote compliance with the LRE Corporate Compliance Program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms.
11. Develops a system to solicit, evaluate and respond to complaints and compliance issues.
12. Monitor internal and external audits and investigations for the purpose of identifying risk areas and implement corrective and preventative actions.
13. Assist in the development of program measurements to evaluate the corporate compliance program effectiveness.
14. Ensure compliance issues are appropriately communicated to the LRE CEO, Board of Directors, Executive Team, and Operations Council, and Network Providers, as appropriate.
15. Addresses other functions as requested by the LRE CEO, Board of Directors, Executive Team, and Operations Council.

LRE Operations Advisory Council: LRE Operations Advisory Council, with respect to the LRE Corporate Compliance Program,

1. As determined by the LRE CEO, LRE Operations Advisory Council reviews Compliance ROAT recommendations concerning compliance matters as identified by the Compliance ROAT and reported by the LRE CEO and chooses to support or not support the Compliance ROAT's recommendations.
2. Is comprised of the LRE CEO and the CEOs, or Executive Directors, of each Member CMHSP in Region 3.

CONFIDENTIALITY AND PRIVACY

All LRE staff, Board of Directors, Member CMSHPs, and Network Providers must conduct themselves in accord with the principle of maintaining the confidentiality of consumers' information in accordance with all applicable laws and regulations, including but not limited to the Michigan Mental Health Code and the Privacy and Security Regulations issued pursuant to HIPAA and recent updated HITECH revisions, and 42 CFR Part 2 as it relates to substance abuse records.

All LRE staff, Board of Directors, Member CMSHPs, and Network Providers will refrain from disclosing any personal or confidential information concerning members unless authorized by laws relating to confidentiality of records and protected health information.

If specific questions arise regarding the obligation to maintain the confidentiality of information or the appropriateness of releasing information, any LRE staff, Board of Directors, Member CMSHPs, and Network Providers should seek guidance from the LRE Compliance/Privacy Officer

or anonymously seek guidance through the LRE Corporate Compliance and Privacy hotline at 1-800-420-3592.

The relevant LRE policies regarding HIPAA security and privacy and breach notification policy and procedure can be found here:

See LRE Policies or Procedures: [3.2-HIPAA-Security-and-Privacy.pdf \(lsre.org\)](#)
[3.5-Breach-Notification.pdf \(lsre.org\)](#)
[3.5A-Breach-Notification.pdf \(lsre.org\)](#)

LEGAL AND REGULATORY STANDARDS

PRIMARY REGULATORY AND LEGAL STANDARDS

Numerous laws establish compliance requirements for the LRE, Member CMHSPs, and Network Providers. However, in formalizing LRE's Corporate Compliance Program, the legal basis of LRE'S Corporate Compliance Program centers around four primary legal and regulatory standards:

The Affordable Care Act (2010) – This Act requires the PIHP to have a written and operable compliance program capable of preventing, identifying, reporting, and ameliorating fraud, waste, and abuse across the PIHP's provider network. All programs funded by the PIHP including CMHSPs, sub- contract provider organizations and practitioners, board members and others involved in rendering PIHP covered services fall under the purview and scope of LRE's Corporate Compliance Program.

The Anti-Kickback Statute – This Act prohibits the offer, solicitation, payment, or receipt of remuneration, in cash or in kind, in return for or to induce a referral for any service paid for or supported by the Federal government or for any good or service paid for in connection with consumer service delivery.

The Federal False Claims Act – This Act applies when a company or person knowingly presents (or causes to be presented) to the Federal government (or any entity on its behalf) a false or fraudulent claim for payment; knowingly uses (or causes to be used) a false record or statement to get a claim paid; conspires with others to get a false or fraudulent claim paid; or knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal government (or its designated entity).

The Michigan False Claims Act – This Act prohibits fraud in the obtaining of benefits or payments in conjunction with the MI Medical assistance program; to prohibit kickbacks or bribes in connection with the program to prohibit conspiracies in obtaining benefits or payments; and to authorize the MI Attorney General to investigate alleged violations of this Act.

ADDITIONAL LEGAL AND REGULATORY STANDARDS

There are numerous other applicable federal and state statutory, regulatory, and contractual obligations that establish requirements for LRE's Corporate Compliance Program, include but are not limited to:

1. 42 CFR Part 2 Confidentiality of Alcohol and Drug Use Patient Records
2. American with Disabilities Act of 1990
3. Civil Monetary Penalty Law of 1981
4. Code of Federal Regulations
5. Deficit Reduction Act/Medicaid Integrity Program of 2005
6. Government Accounting Standards Board (GASB)Guide to Encounter Data Systems
7. Health Information Technology for Economic and Clinical Health Act (HITECH) Act
8. Home and Community Based Services Final Rule
9. Letters to State Medicaid Directors
10. Medical Services Administration (MSA) Policy Bulletins
11. Medicaid State Plan
12. Michigan Medicaid Provider Manual
13. Michigan Medical Records Act
14. Michigan Mental Health Code, Public Health Code and Administrative Rules
15. Michigan State Licensing requirements
16. Michigan Whistleblowers Act, Act 469 of 1980
17. Office of Inspector General Annual Work Plan
18. Office of Management and Budget (OMB) Circulars
19. Privacy and Security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
20. Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse
21. Quality Improvement Systems for Managed Care (QISMC)
22. Requirements as identified by the Office of Inspector General
23. Social Security Act of 1964 (Medicare and Medicaid)
24. Stark Law
25. State of Michigan MDHHS/PIHP contract provisions
26. State Operations Manual
27. Technical Assistance Advisories, as required
28. Technical Assistance Tools
29. The Balanced Budget Act of 1997
30. Waiver Applications

The LRE Corporate Compliance Plan is subject to the following conditions:

- A. The LRE Compliance Officer may recommend modifications, amendments, or alterations to the written LRE Corporate Compliance Plan as necessary and will communicate any changes promptly to all personnel and to the Board of Directors.
- B. This document is not intended to, nor should be construed as, a contract or agreement, and does not grant any individual or entity employment or contract rights.

DEFINITIONS AND TERMS

These terms have the following meaning throughout the LRE Corporate Compliance Plan.

- 1. **Abuse** means practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program. (42 CFR § 455.2)
- 2. **Compliance Inquiry** mean the initial step in the fraud, waste, and abuse (FWA) investigation process. A compliance inquiry begins when a Community Mental Health Service Provider (CMHSP) or other provider receives a complaint alleging FWA from any source exists, or the CMHSP or other providers identify questionable practices or irregularities that may indicate a potential credible allegation of fraud, or waste, or abuse, exists. The CMHSP or provider will conduct a basic fact gathering to see if there is sufficient evidence to refer the complaint to the Prepaid Inpatient Health Plan (PIHP) for a preliminary investigation.
- 3. **Corrective Action Plan** means a formal plan that identifies specific, actionable steps to improve an organization's processes or address deficiencies in performance when measured against established standards and contractual requirements.
- 4. **Credible Allegation of Fraud (CAF)** means an allegation, which has been verified by an agency or the State, from any source, including but not limited to the following:
 - (1) Fraud hotline tips verified by further evidence.
 - (2) Claims data mining.
 - (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. (42 CFR 455).
- 5. **Fraud (Federal False Claims Act)** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR §455.2).

6. **Full Investigation** means when the findings of a preliminary investigation give a PIHP reason to believe that PCAF has occurred, and the amount is \$5,000 or greater, the PIHP must refer the case to the Office of Inspector General (OIG) and Medicaid Fraud Control Unit, which will conduct an extensive and thorough investigation to determine if a credible allegation of fraud (CAF) exists. Also, if PCAF has occurred and the amount is less than \$5,000, the PIHP will conduct the full investigation to completion.
7. **Member CMSHPs** means the Member CMSHPs that hold a contract with LRE to provide supports and services to adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders to Medicaid enrollees and to perform various delegated managed care functions consistent with LRE policy. "Member CMSHPs" includes the agency itself as well as those acting on its behalf, regardless of employment or contractual relationship.
8. **Network Provider** means, according to the FY24 MDHHS-PIHP Contract, any provider, group of providers, or entity that has a provider agreement with PIHP or Member CMHSP, including a CMHSP, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result. A network provider is not a subcontractor by virtue of the network provider agreement, unless the network provider is responsible for services other than those that could be covered in a network provider agreement related to the delivery, ordering, or referring of covered services to a beneficiary.
9. **Preliminary Investigation** is the second step in the FWA investigation process. The PIHP analyzes the information contained within the CMHSP's FWA referral to the PIHP and determines whether more information is required to reach a particular conclusion. After determining whether the evidence is sufficient, the PIHP will analyze all of the information in its entirety, conduct interviews if required, and make a recommendation to the OIG and Attorney General (AG) that there is sufficient evidence to prove that a PCAF exists that is \$5,000 or more, and requires a full investigation. If a PCAF exists but the amount is less than \$5,000, a full investigation will still be required, but it will be the responsibility of the PIHP to conduct.
10. **Potential Credible Allegation of Fraud (PCAF)** is the belief that fraud has occurred, and the evidence is leading the examiner to this conclusion. The PIHP will determine if a PCAF exists.
11. **Resolution of Full Investigation** means when the full investigation is completed and legal action is initiated, or the case is dismissed due to insufficient evidence to support the allegations, or the matter is resolved between the PIHP, CMHSP, and the provider beneficiary.
12. **Waste** means overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

REFERENCES, HYPERLINKS, AND SUPPORTING DOCUMENTS

1. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
<http://www.cms.hhs.gov/deficitreductionact>
2. Anti-kickback Statute (section 1128B[b] of the Social Security Act)
http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm
<https://oig.hhs.gov/compliance/safe-harbor-regulations>
3. Code of Federal Regulations (Title 42, Part 2 and Title 45, Part 160 & 164)
<http://www.ecfr.gov/cgi-bin/ECFR?page=browse>
4. Department of Health and Human Services, Office of Inspector General
<https://oig.hhs.gov>
5. DOJ Compliance Guidance
<https://www.justice.gov/criminal-fraud/page/file/937501/download>
6. False Claims Act
<https://oig.hhs.gov/fraud>
<http://www.legislature.mi.gov>
7. Federal Sentencing Guidelines Section 8
<https://www.ussc.gov/guidelines/2021-guidelines-manual-annotated>
8. Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans, Medicaid Alliance for Program Safeguards, May 2002
<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf>
9. Managing Compliance Program Effectiveness: A Resource Guide
<https://oig.hhs.gov/documents/toolkits/928/HCCA-OIG-Resource-Guide.pdf>
10. Michigan Mental Health Code
[http://www.legislature.mi.gov/\(S\(ea1olrem4pvgdzylgs0hay4e\)\)/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974](http://www.legislature.mi.gov/(S(ea1olrem4pvgdzylgs0hay4e))/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974)
11. Michigan Public Health Code
<http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf>
12. United States Attorney Manual (USAM)
<https://www.justice.gov/jm/jm-9-28000-principles-federal-prosecution-business-organizations#9-28.800>
13. United States Department of Justice, Criminal Division, Evaluation of Corporate Compliance Program
<https://www.justice.gov/criminal-fraud/page/file/937501/download>

COMPLIANCE OFFICER CONTACT INFORMATION

LAKESHORE REGIONAL ENTITY

LRE Compliance Officer
Lakeshore Regional Entity
5000 Hakes Drive Suite 250
Norton Shores, Michigan 49441

Compliance Hotline: 1-800-420-3592
Compliance Fax: 231-769-2075
Compliance Officer: 231-769-2079
E-mail: Compliance@lsre.org

MEMBER CMHSPs

COUNTY(IES)	MEMBER CMHSP	COMPLIANCE OFFICER CONTACT INFORMATION
Allegan County	OnPoint (Allegan County Community Mental Health Services)	Diane Bennett - Compliance Officer Tel: 269-512-4737 Fax: 269-686-5201 E-mail: cofficer@onpointallegan.org
Kent County	Network 180 (Kent County CMH Authority)	Stacey O'Toole - Director of Quality, Data Analytics, and Compliance Tel: 616-825-5400 E-mail: stacey.otoole@network180.org
Lake County Mason County Oceana County	West Michigan Community Mental Health System	Devon Hernandez - Director of Corporate Compliance and Risk Management Tel: 231-845-6294 Fax: 231-845-7095 E-mail: devonh@WMCMHs.org
Muskegon County	HealthWest	Linda Closz - Director of Health Information Services Tel: 231-724-3631 Fax: 231-724-3659 E-mail: linda.closz@healthwest.net
Ottawa County	Community Mental Health of Ottawa County	Kristen Henninges - Compliance Program Coordinator Tel: 616-393-5685 Fax: 616-393-5687 E-mail: khenninges@miottawa.org

GOVERNMENTAL AGENCIES

To report suspected Fraud, Waste, or Abuse to the Office of Inspector General: MDHHS
Medicaid Fraud Hotline: 1-855-MI-FRAUD (1-855-643-7283) voicemail available after hours or
send a letter to:

Michigan Office of Inspector General
PO Box 30062
Lansing, MI 48909

Health and Human Services (HHS)/OIG Hotline: 1-800-HHS-TIPS (1-800-447-8477) or make an online report: [File Online Complaint](#)

ATTESTATIONS

ATTESTATION FOR LRE STAFF



LRE STAFF ANNUAL CORPORATE COMPLIANCE TRAINING CERTIFICATION FORM

1. I attended and completed the required annual corporate compliance training for LRE staff on _____:
(Month, Date, Year)
2. I have received, read, and understand the LRE Corporate Compliance Plan and all related policies and procedures.
3. I agree to act in compliance with and abide by the LRE Corporate Compliance Plan during the entire term of my employment or contract.
4. I acknowledge that I have a duty to report to the LRE Compliance Officer any suspected or actual violation of the LRE Corporate Compliance Plan, related laws, regulations, policies, and procedures by myself, another LRE staff, or any other person.
5. I will seek advice from the LRE Compliance Officer concerning appropriate actions that I may need to take to comply with the LRE Corporate Compliance Plan, related laws, regulations, policies, and procedures.
6. I agree to participate in any future compliance trainings as required and acknowledge my attendance at such trainings as a condition of my continued employment or contract.
7. I agree to disclose the existence and nature of any potential or actual conflict of interest to the LRE Compliance Officer. Further, I certify that I am not aware of any current conflicts of interest.
8. I understand that failure to comply with the LRE Corporate Compliance Plan or failure to report any potential or actual violation of the LRE Corporate Compliance Plan may result in disciplinary action up to and including termination of employment or contract.

LRE Staff Name (PRINT)

LRE Staff Signature

Date

ATTESTATION FOR BOARD OF DIRECTORS



LRE BOARD OF DIRECTORS ANNUAL CORPORATE COMPLIANCE TRAINING CERTIFICATION FORM

1. I attended and completed the "Annual Corporate Compliance Training" for the newly appointed LRE Board of Directors on _____.
(Month, Date, Year)
1. I have received, read, and understand the LRE Corporate Compliance Plan.
2. I agree to act in compliance with and abide by the LRE Corporate Compliance Plan during the entire term of my Board service.
3. I acknowledge that I have a duty to report to the LRE Compliance Officer any suspected or actual violation of the LRE Corporate Compliance Plan, related laws, regulations, policies, and procedures by myself, another Board Member, or any other person.
4. I will seek advice from the LRE Compliance Officer concerning appropriate actions that I may need to take to comply with the LRE Corporate Compliance Plan, related laws, regulations, policies, and procedures.
5. I agree to participate in future LRE Board of Directors compliance trainings, as required.
6. I agree to disclose the existence and nature of any potential or actual conflict of interest annually as required by the financial disclosure form and at any time when it arises thereafter to the LRE Board Chairperson and LRE Compliance Officer.
7. I understand that failure to comply with any part of the LRE Corporate Compliance Plan may result in my removal from the Board of Directors.

Board of Director Name (PRINT)

Board of Director Signature

Date



PIHP SYSTEM REQUEST FOR PROPOSAL (RFP)

PIHP procurement timeline and upcoming key dates



TIMELINE SUBJECT TO CHANGE





Overview of the PIHP RFP, which is comprised of multiple documents



- Proposal Instructions, Confidential Treatment Form, Vendor Questions worksheet.
- Hybrid Contract Terms and Federal Provisions Addendum.
- Schedule A: Statement of Work.
- Schedule B: Pricing.
- Schedule C: Insurance requirements.
- Schedule D: Data security requirements for hybrid purchases.
- Schedule E: Reporting.
- Schedule F: HIPAA Business Associate Agreement.
- Schedule G: Definition of Terms.
- Schedule H: Medicaid Mental Health and SUD Payment Responsibility Grid.
- Schedule I: Network Adequacy Procedure.
- Schedule J: Narrative questions.
- Appendix 1 - PIHP region map.
- Appendix 2 – Substance Use Disorder Grant Samples.



RFP Amendments

- Appendix 3 – Historical Cost and Utilization Data
- Appendix 4 – Major Service Category Mapping
- Appendix 5 – SFY 2023 Data Exhibits
- Appendix 6 – Projected CCBHC Funding



MDHHS Bidders Conference

Monday, August 11, 2025

There were between 10 and 12 Private Health Plans and Private Entities Present including:

- Carelon (formerly Beacon Health Options)
- Wayne State
- Michigan State University



Guidance for Q&A period and proposal submissions



Q&A period:

- Bidders may submit questions to solicitation manager in writing.
- All questions must be submitted in writing to solicitation manager by **August 20th 12 PM ET.**
- Answers to questions will be posted in SIGMA by the anticipated date of **August 29th.**

Proposal submissions:

- Follow the formatting and file structures as outlined in the RFP.
- If bidding on more than one region, only **one proposal** submission is needed.
 - Select Schedule J Narrative Questions require bidders to detail how their response varies by each region to which they are applying.
- All proposals must be submitted via SIGMA by **September 29th 11:50 AM ET.**

Recap: background on the PIHP procurement



MDHHS' vision is to improve access, quality of services and member choice for behavioral health (BH) and waiver services delivered by PIHPs for all ~300k beneficiaries served by Michigan's PIHPs.



Revisions to the PIHP structure are informed by public stakeholder feedback shared with MDHHS (February-March 2025 survey) and aim to address "pain points" identified by MDHHS and the community.



MDHHS aims for new PIHPs identified via the procurement to initiate services by October 1, 2026, and provide appropriate transition time.



MDHHS strategic pillars for PIHPs



Provide high quality, timely services

Ensure timely access to services through network adequacy and provider availability.

Deliver high-quality services that address the full continuum of care.

Improve choice & consistency across regions

Improve choice in access to services across regions.

Promote consistency across regions to ensure access to services regardless of where members reside.

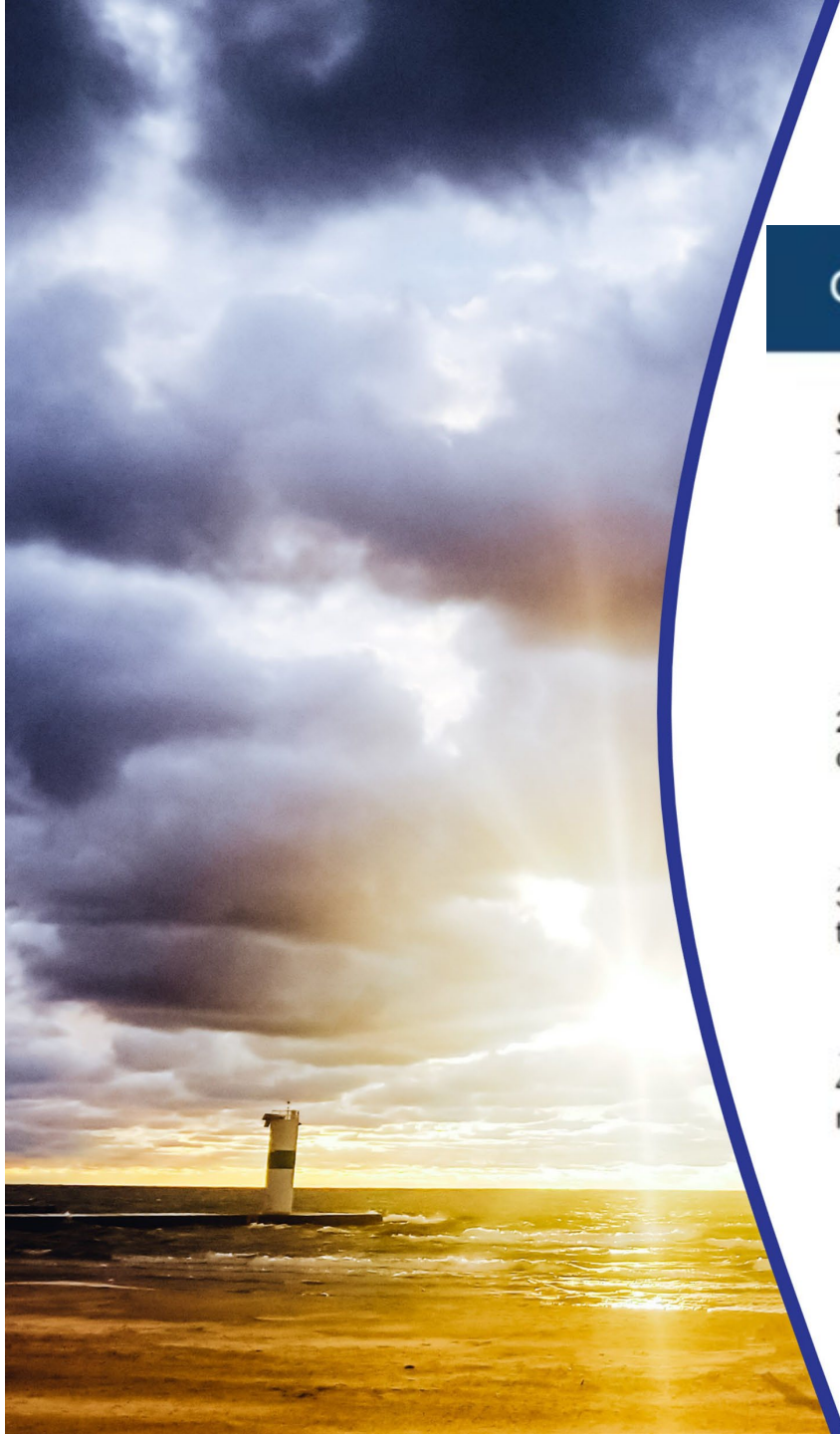
Ensure accountability & transparency

Increase accountability & transparency through enhanced oversight and outcomes-centered performance management.

Remove structural conflict of dual payor/provider responsibilities.

Simplify the system with reduced bureaucracy

Decrease bureaucracy and administrative burden, improving efficiency for providers as well as members accessing care.



Overview of select programmatic changes to PIHPs



Strategic Pillars

Example of select programmatic changes included in the RFP

1. Provide high quality & timely services

- **NCQA accreditation requirement** to ensure a nationalized metric of quality of care for each PIHP – *details to follow*.
- **Revised Network Adequacy standards**, with intention to further revise standards based on data collected to ensure robust provider networks.
- **Revised performance management structure** shifting from process metrics to outcome metrics, and an increased performance withhold percentage.

2. Improve choice & consistency across regions

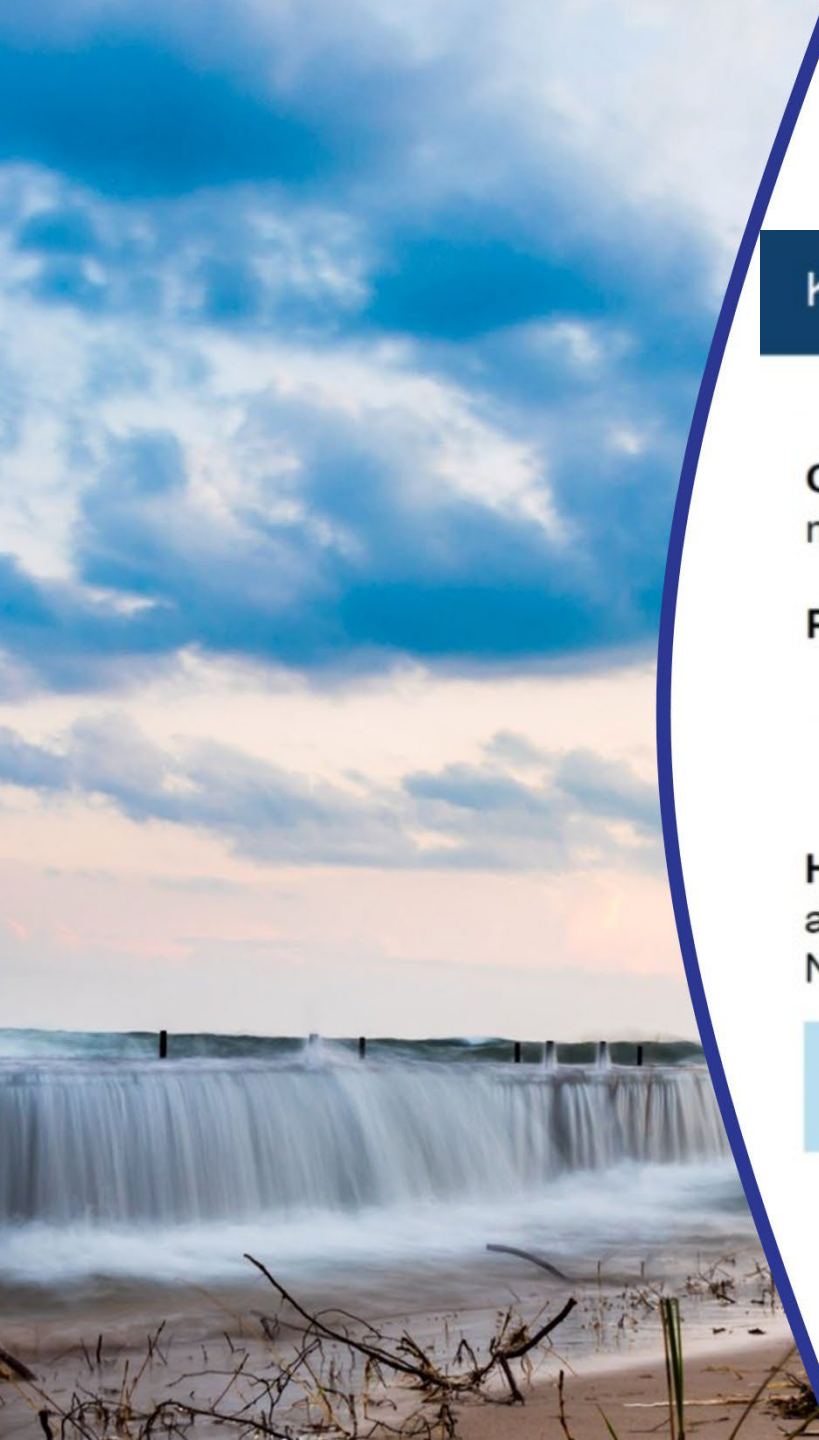
- **Consolidated regions** from 10 to 3 to increase consistency in enrollee experience and access to services across regions.
- **Potential for multiple PIHPs to operate in one region**, expanding choice for beneficiaries by providing enrollment options.

3. Ensure accountability & transparency

- **Board structure requirements** that minimize conflict of interest and introduce perspective of individuals with lived specialty BH experience.
- **Requirement to operate exclusively as a payor** entity independent from providers to reduce potential for conflicts of interest and increase transparency – *details to follow*.

4. Simplify system with reduced bureaucracy

- **Introduction of innovations to reduce administrative burdens** for providers to streamline operations.



Key program change details: organizational requirements for PIHPs



Operate exclusively as a payor entity, fully independent from providers: PIHPs must manage all payor functions may not delegate payor functions to other entities.

PIHP must be one of the following:

- Nonprofit Organization.
- Public body/governmental entity; or
- Public University.

Have National Committee for Quality Assurance (NCQA) accreditation: If PIHPs already have accreditation, proof must be provided. If PIHPs do not currently have NCQA accreditation, they must document a plan to get accreditation.

PIHPs may consider organizational restructuring in order to meet the RFP's eligibility requirements.



Expectations for transition period between current to new PIHPs



- PIHPs procured under this RFP are expected to cover all services within the remit of current PIHPs included, specialty behavioral health services, SUD services, block grant services, and HCBS Waiver services.
- Organizations procured through this RFP to serve as the new PIHPs are expected to work with the current PIHPs to facilitate a smooth transition.
- Providers will need to develop new contracts with the newly formed PIHPs.



Capital Reserve

- Restructuring Internal Service Fund (ISF) to Capital Reserve.
- Requirements based on type of entity.
- No upper limit for private nonprofit or public universities.
- Upper limits for public body or governmental entities.
- Financial reporting requirements.



Risk Corridor



- Shared risk arrangement.
- Applies to all contractors.
- Symmetric Risk Corridor based on performance.
- Overall the risk corridor is as follows:
 - +/- 2% contractor assumes full share of gains/losses.
 - +/- 2-7% contractor assumes 20% of gains/losses and MDHHS assumes 80% gains/losses.
 - Greater than +/- 7% MDHHS assumes all gains/losses.



Risk corridor and capital requirements

All entities



Symmetrical risk corridor with 3% total risk, both upside and downside

- 100% plan for first 2%
- 20% plan for next 5%
- 0% plan after 7%



The risk corridor will be based on a **Medical Loss Ratio (MLR)** that excludes general admin

$$MLR = \frac{\text{Health Care Claims} + \text{Quality Improvement Expenses}}{\text{Premium} - \text{Taxes, Licensng, and Regulatory Fees}}$$

Additional mechanisms for public bodies and/or governmental entities



Build-up mechanism. Public entities will be allowed a temporary upside-only risk corridor until they reach a certain capital threshold. The capital threshold will be based on risk-based capital principles and communicated separately by MDHHS.

(Unverified)



This presentation is intended to facilitate discussion related to behavioral health capitation rate development and is not complete without oral comment.



Capital requirements

Initial capital requirement

- Private nonprofit corporations and public universities must meet a capital reserve requirement at the start of the contract period.
 - The specific reserve level will be a percentage of annual revenue, based on risk-based capital principles in alignment with applicable financial risk assumptions and shall be communicated separately by MDHHS.
- Public bodies and governmental entities will receive funding from MDHHS to meet the minimum capital reserve requirement during an initial transition and ramp-up period.

Ongoing capital requirements – all entities

All contractors shall maintain the required minimum capital reserve throughout the duration of the contract period, in a manner consistent with sound actuarial and financial principles, and as determined by MDHHS.

Capital limits for public bodies and governmental entities

MDHHS may impose an upper limit on capital reserves, expressed as a percentage of annual revenue, to ensure appropriate stewardship of public funds. Capital limits will be based on risk-based capital principles and communicated separately by MDHHS.

Program overview – included services and key provider types

Overview of services and key providers



Michigan's Medicaid Provider Manual¹ and **Behavioral Health Code Sets, Charts, and Provider Qualifications document²** include coverage policies and provider requirements across all health insurance programs administered by MDHHS. This document is updated quarterly.

Several rules and requirements for delivering behavioral health services originate from **Michigan's Mental Health Code³**.



Carveouts for services delivered through Michigan's CCBHC Demonstration as well as services provided to individuals identified as mild-to-moderate who are enrolled with a Medicaid Health Plan as part of MDHHS' Mental Health Framework⁴.

- Note – Michigan's CCBHC Demonstration is scheduled to end at the end of SFY 2027, at which point MDHHS anticipates folding the CCBHC program back into managed care.



Key provider types for behavioral health services include:

- 46 Community Mental Health Services Programs (CMHSPs)
- 35 Certified Community Behavioral Health Clinics (CCBHCs)
- Community living support providers, including licensed facilities
- Inpatient psychiatric hospitals
- Other outpatient behavioral health and residential service providers
- Other home- and community-based services (HCBS) providers

1. <https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

2. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Reporting-Requirements/Q4_SF25_Behavioral_Health_Code_Charts_and_Provider_Qualifications.xlsx

3. <https://www.legislature.mi.gov/documents/mcl/pdf/mcl-chap330.pdf>

4. <https://www.michigan.gov/mdhhs/mihealthylife/mental-health-framework>



CMHA MULTI-PRONGED EFFORT

Strategy Component #1

Continue strong advocacy effort in opposition to the RFP being pursued (including political and media efforts) recognizing that the RFP can be withdrawn by MDHHS at any time.

- **CMHA is assembling the group (and growing) of organizations and statewide leaders** who oppose the privatization of the system, next week, to increase the intensity of the already robust political, media, and public sentiment advocacy pursued by CMHA, all of you, and our allies. Look for these actions, by CMHA, and for calls to action of you and our allies.
- **CMHA continues to urge its members and allies** to be strongly opposed to this procurement process.

CMHA MULTI-PRONGED EFFORT

Strategy Component #2

Legal action to halt or alter the RFP to ensure that Michigan's public system retains the sole or lion's share of the management of the state's mental health system.

- CMHA is working with its legal counsel to **develop and take pre-bid and post-bid legal action**. As part of this effort, CMHA and our legal counsel will be reaching out to several CMHA members, requesting that they agree to be plaintiffs in this legal action.
- CMHA is also **urging CMHA members organizations**, especially those who have contemplated legal action related to the procurement, to consult with their legal counsel relative to legal action spurred by the release of the RFP.
- CMHA will be issuing a **special assessment of its CMHSP and PIHP members (to build an advocacy war chest)** for use in covering the related legal costs incurred by CMHA and the CMHA members who agree to be plaintiffs in this case as well as other advocacy-related costs. **CMHA will also be contributing \$100,000** from its fund balance to this war chest. **CMH and PIHP CEOs will see a special assessment request in the coming days.**

A silhouette of a lighthouse on a rocky shore at sunset. The sky is a mix of orange, pink, and purple, and the ocean is dark. The lighthouse is a tall, dark structure with a small light on top. The foreground shows the dark silhouette of the rocks and the lighthouse's base.

CMHA MULTI-PRONGED EFFORT

Strategy Component #3

Development of innovative structural and financing models that retain the strength of the public system.

- CMHA will continue to urge its members, now with greater focus, to develop structural redesigns that can form the basis for a **in lieu of the RFP process, a robust system co-design effort by MDHHS, the leaders of the system, persons served, and other key stakeholders to the system** or, if the political, media, and legal advocacy outlined above is not successful in halting the RFP process, as **public-system centered bids in response to this RFP.**



URBAN COOPERATION ACT of 1967 (UCA)

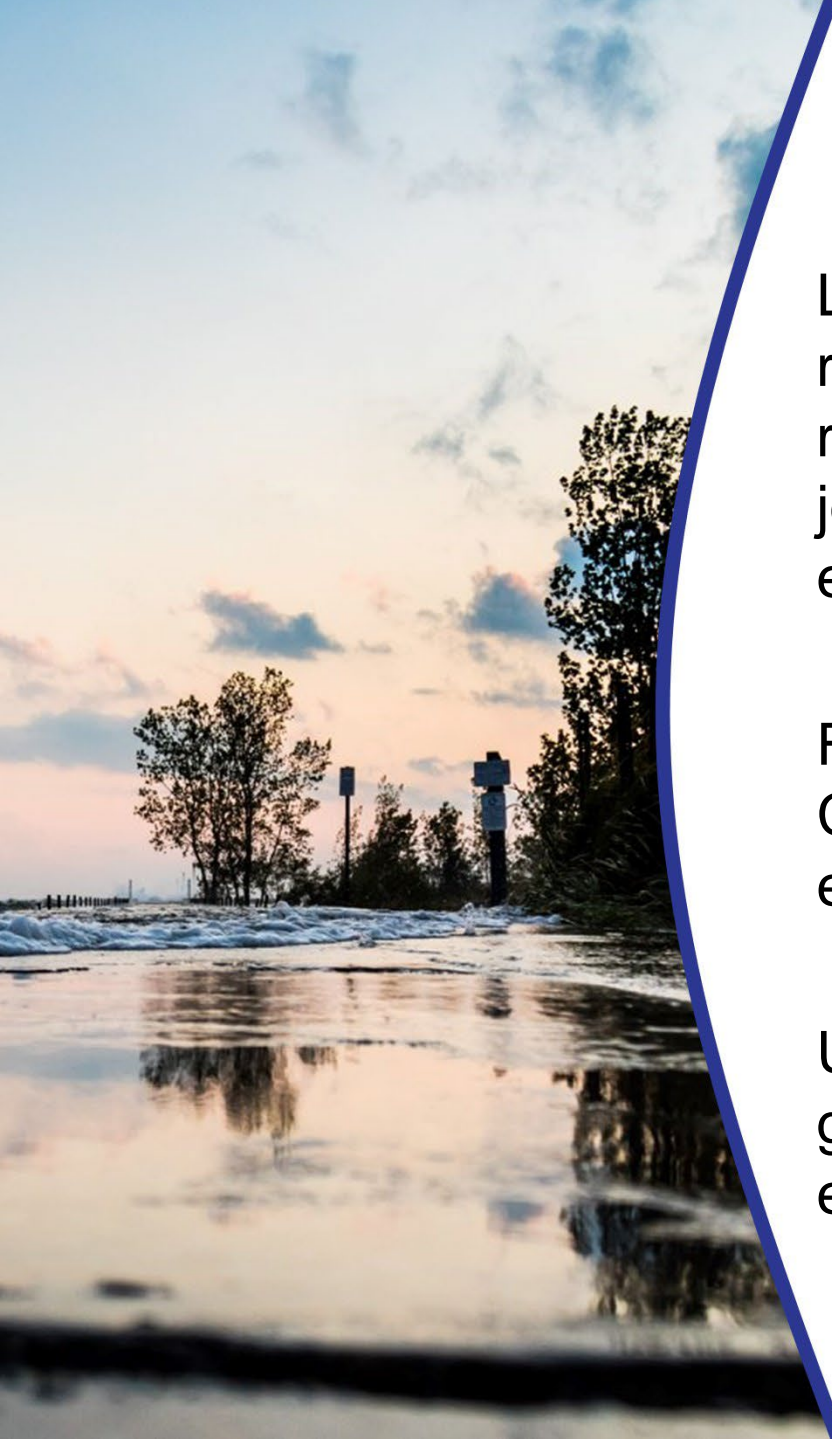
Under the UCA, the following entities may form a joint entity through an interlocal public agency agreement:

- PIHPS
- CMHSPS
- COUNTIES

“Central Region” Proposal

Recognizing the need for a bid-eligible entity, the five PIHPs from the new “Central Region” have developed an idea, acting through their respective boards, to enter into an interlocal agreement under the Urban Cooperation Act .(1967 PA 7; MCL 124.500) to form this entity.

Interlocal Agreements form the basis for the current SUD Oversight Policy Boards that are statutorily required.



“Central Region” Proposal

Legal advises that “a strong argument may be made that a regional entity may enter into an interlocal agreement with other regional entities and thereby create another legal entity that can jointly exercise the powers that each of the constituent [regional] entities possesses. (MCL 124.507)

Further, “[T]he definition of “public agency” under the Urban Cooperation Act [...] is sufficiently broad to encompass a regional entity established under [the Mental Health Code].

Under the Mental Health Code, a regional entity is a “public governmental entity separate from [...] organizations that establishes it.”

“Central Region” Proposal

UCA 504 states that “a public agency of this state may exercise jointly with any other public agency of this state...any power, privilege, or authority that the agencies share in common and that each might exercise separately.” One of the express powers of a regional entity (and a primary purpose) is “The power to contract with the state to serve as the Medicaid specialty service prepaid health plan for the designated service areas of the participating community mental health services programs.”

MCL 330.1204b(2)(b). UCA 505(1) requires a “joint exercise of power pursuant to this act shall be made by contract or contracts in the form of an interlocal agreement” and goes on to specify various elements of that interlocal agreement.

It should also be noted that the UCA permits, but does not require, the creation of a new separate legal entity to carry out the agreement and also permits but does not require one or more of the parties to the interlocal agreement to carry out the functions in the agreement on behalf of all parties.

LRE BYLAWS

CMHSP MEMBER RESERVED POWERS. Each **CMHSP Member** shall possess the powers and rights retained and reserved to the CMHSP Member under these Bylaws which shall include the power to approve through **UNANIMOUS VOTE** the following :

- All amendments, restatements or adoption of new bylaws;
- The Operating Agreement, any amendment thereto and its termination;
- Any proposal of the ENTITY related to merger, consolidation, joint venture or formation of a new organization;





DOCUMENTATION

[MDHHS PIHP PROCUREMENT RESOURCES PAGE](#)

[MDHHS RFP DOCUMENTS](#)

[LRE RFP QUESTIONS SUBMITTED TO MDHHS](#)

QUESTIONS



LAKESHORE
REGIONAL ENTITY