**NORTHERN MICHIGAN REGIONAL ENTITY**

**PROVIDER NETWORK MANAGERS MEETING**

**10:00AM – JULY 9, 2024**

**VIA TEAMS**

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| **AuSable Valley:** | [x]  Mary Martin | Contract and Compliance Specialist |
|  | [x]  Trish Otremba | Chief Quality Officer |
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| **Centra Wellness:** | [x]  Chip Johnston | Executive Director |
|  | [ ]  Kacey Kidder-Snyder | Provider Network Specialist |
|  | [x]  Pat Kozlowski | Access and Emergency Services Director |
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| **North Country:** | [x]  Angie Balberde | Provider Network Manager |
|  | [x]  Katie Lorence | Contract Manager |
|  | [x]  Kim Rappleyea | Chief Operating Officer |
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| **Northeast Michigan:** | [x]  Vicky DeRoven | Quality Improvement |
|  | [x]  Morgan Hale | Contract Manager |
|  | [ ]  Larry Patterson | Accounting Officer |
|  | [x]  Jen Walburn | Compliance Officer |
|  |
| **Northern Lakes:** | [x]  Kari Barker | Director of Quality Improvement and Compliance |
|  | [x]  Mark Crane | Contract and Procurement Manager |
|  | [x]  Tiffany Fewins | Administrative Assistant |
|  | [x]  Trapper Merz | Business Intelligence Specialist |
|  | [ ]  Jessica Williams | Performance Improvement Specialist |
|  |
| **NMRE:** | [x]  Carol Balousek | Executive Administrator |
|  | [x]  Eric Kurtz | Chief Executive Officer |
|  | [ ]  Heidi McClenaghan | Quality Manager |
|  | [ ]  Brandon Rhue | Chief Information Officer/Operations Director |
|  | [x]  Chris VanWagoner | Provider Network Manager |

INTRODUCTIONS

Chris welcomed committee members to the meeting and attendance was taken.

REVIEW AGENDA & ADDITIONS

No additions to the meeting agenda were requested.

APPROVAL OF PREVIOUS MEETING MINUTES

The June 11th minutes were included in the meeting materials and approved by consensus.

PRIOR ACTION ITEMS

**Non-Violent Intervention Training Requirements**

This topic was referred to the NMRE Quality and Compliance Oversight Committee (QOC), which meets on July 15th at 10:00AM.

REGION 2 CONTRACT BOILERPLATE REVIEW

**Introduction**

Eric spoke about the efficiency of having standard contracts throughout the region from a managed care compliance standpoint; early in the formation of the NMRE (Region 2 PIHP) in 2014, that wasn’t the case. Eric clarified that the PIHP is responsible for all the contract language in the managed care rules that tie to the PIHP Contract. Having one set of basic contract templates means that the NMRE doesn’t have to review all the CMHSPs contracts to ensure that they adhere to these same requirements. In FY19, the region began the process of developing standard templates for various types of contracts. Chris explained that enough time has passed to warrant an additional review of the templates, particularly considering recent staff turnover.

Chip explained that the first managed care programs were instituted in 1996 after Michigan received a Section 1915(b) waiver to adopt full risk capitated managed care for most Medicaid beneficiaries; contract templates were developed around the same time. Chip offered to visit the in-region CMHSPs to go through contracts (why to use, when to use, how to use) with staff.

Chip spoke about the history of the “Red Book,” which he created to map the path from the State Constitution through the development of the Community Mental Health system, to the federalization of the system when it moved from a fee-for-service to a capitated funding arrangement. The “Red Book” contains excerpts from the Michigan Constitution, the Mental Health Code, Administrative Rules, Attorney General and Legal Opinions, Court Decisions, History of Michigan’s Public Mental Health System, Procurement and Application for Participation (AFP) Processes, Medicaid Waivers, and more. Chris offered to send the electronic copy of the “Red Book” to committee members following the meeting. Chip noted that portions of the Medicaid Provider Manual do not align with State Medicaid Plans and/or the Mental Health Code.

**Specialized Residential**

Chip clarified that Type A Residential and Type B Residential are terms that date back 35 years. Before state hospitals for I/DD were closed, there were generally only Type A homes. Type A homes are owned by an individual who contracts with either the local DHHS or CMH.

Individuals were pulled out of the Mt. Pleasant Center (closed in 2009), and other residential facilities that served people with mental illness and developmental disabilities, into Type B homes.

* Type A Homes

Type A Homes are general residential foster care facilities licensed as such (I/DD, SMI, Geriatric). They are paid by their residents’ Social Security or family. The rules for Type A homes have been in place for 20+ years. Contracts should address staffing that is above what is required by licensing.

Type A homes receive a model payment “kicker” of $300 per month – now called an Adult Services Authorized Payment (ASAP), in addition to the Social Security payment. The ASAP is intended to augment Social Security rates because Social Security rates are far below those of private pay rates. CMHSPs were put in charge of authorizing ASAP payments.

For individuals who need “extra care” placed in Type A homes, the CMHSP must notify MDHHS to stop the ASAP payment; the CMHSP must then negotiate with the homeowner for a rate above what the individual receives for Personal Care from Social Security. In that scenario, the CMHSP should only be paying for Community Living Supports (CLS).

The CMHSP can only pay the home’s hourly rate plus administrative costs of not more than 9%; this is sometimes less than the home would have been paid from the ASAP payment. Additional funding that would have been provided by the ASAP payment can be built into the CLS rate.

Under 1915(b) and 1915(b)(3) services, the state must show cost neutrality, meaning the cost of the service (CLS) in the residential placement must be commensurate with the cost of the same service that would have been furnished in an institutional setting. To meet this, the Department created Personal Care (T1020) to lower the cost of CLS (mainly for Type B Homes). Personal Care, however, cannot be used in Type A settings. The Medicaid Provider Manual states that Personal Care cannot be paid with Medicaid when the individual’s Social Security is intended to cover these services. The only time Personal Care can be used in a Type A home is if the individual doesn’t have Social Security; the CMHSP must then work to get the individual on Social Security.

* Type B Homes

Type B homes are leased or owned by the CMHSP where the CMHSP controls the beds. The Contract is basically that of a Staffing Agency. The CMHSP collects all the revenue (Social Security, etc.) and pays it out based on a budget.

* Differences between Type A and Type B Boilerplate Language
* Section VIII(D) is only in the Type A boilerplate: “This Agreement shall terminate effective immediately if the Payor removes the Client from the Facility for any reason necessitating the Client’s placement in an inpatient facility or in some other setting, unless the Payor’s Chief Executive Officer (hereinafter referred to as the ‘Payor’s CEO’) notifies, in writing, the Provider that the Payor is not terminating its specialized program placement of the Client for supports/services at the Provider’s facility.”
* Differences in Section XI, Provider’s Supports/Services and Responsibilities:

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| --- | --- |
| Type A | Type B |
| 1. “The Provider shall perform supports/services for reimbursement by the Payor hereunder in the specialized residential setting as specified in the attached document labeled ‘Exhibit C’ (‘Scope of Independent Contractor/Supports/Services’), which is incorporated by reference into this agreement and made a part hereof.”
 | 1. “It is expressly understood and agreed by the parties hereto that the Provider shall operate the specialized program of the Paylor at the Facility and provide supports/services for up \_\_\_\_\_ (\_\_\_\_). Payor-authorized Clients placed there by the to reside concurrently therein and receive the support/services required from the Provider under this Agreement. It is also expressly understood and agreed by the parties hereto that the Clients to be served in the Provider’s supports/services at the Facility during the term of this Agreement shall be Clients placed there by the Payor only pursuant to the express written authorization of the Payor’s CEO or the CEO’s designated representative.”
 |
| 1. “The maximum number of Payor-authorized days of supports/services to be provided by the Provider to the Client under this Agreement shall not exceed \_\_\_\_\_ days.”
 | 1. “The Provider shall perform supports/services for reimbursement by the Payor hereunder in the specialized residential setting as specified in the attached document labeled ‘Exhibit C’ (‘Scope of Independent Contractor Supports/Services’), which is incorporated by reference into this Agreement and made a part hereof.”
 |
| 1. The language in paragraph 1 of Section C is the same, however, the Type A boilerplates adds:

“Changes made to said Individual Plan of Services of the Client hereunder through said person-centered planning process may result in changes in supports/services required hereunder and, thereby, may result in Amendment to or termination of this Agreement. |  |

Chip confirmed that these differences are correct, though some customization in these sections is allowed.

It was noted that the second sentence under (A) of the Type B boilerplate seems to be missing a word(s) and should be revised.

* The language in Section XII(F) differs slightly but the meaning is the same; this section could be changed to read the same if desired. It was suggested that the language included in Type B be copied over to the Type A boilerplate.
* Paragraph one of Section XIII(B), Service Access, Preauthorization, Delivery, and Utilization Management is the same, however the Type B boilerplate includes additional language:

“The Payor’s CEO or the CEO’s designated representative may, at any time, discharge any Client(s) from the Facility and Provider’s supports/services and/or transfer the Client(s) for any reason to placement(s) in another setting(s) during the term of this Agreement. The Payor’s CEO or the CEO’s designated representative also may elect at any time to place another Client in the Facility for Provider’s supports/services during the term of this Agreement as a subsequent replacement for the Payor discharge of, or transfer of, or death of any Client hereunder.”

“In the event that any vacancy occurs at the Facility during the term of the Agreement because the Payor does not elect to place another Client there as a subsequent replacement for Payor’s discharge of, or transfer of, or death of, any Client hereunder, either party hereto may seek a joint review of and executive discussions on the Provider’s year-to-date and projected revenue, costs, and expenditures and on whether it may be necessary to modify, through contractual amendment to this Agreement, the Payor’s reimbursement terms hereunder for actual supports/services to the other Clients of the Payor at the Facility, until or unless the Payor elects to fill said vacancy. Payor shall not pay Provider to maintain such a vacancy.”

Chip confirmed that this is correct, and the language included in the Type B boilerplate is important to include.

* Section XVI, Reporting Requirements, Accounting Procedures, and Internal Financial Controls of the Type B boilerplate includes the following language which is not included in the Type A boilerplate:

“For any fiscal year involving the contractual period covered under this Agreement, the Provider shall have a certified public auditing firm perform an annual independent audit of it, in substantial conformance with the American Institute of Certified Public Accountants Guide, to assess:”

1. “Compliance with the appropriate standard accounting practices and procedures required of the Provider.”
2. “The Provider’s operating results for the annual period, it’s financial position at the end of said period, and thereto, its status as to solvency ad to continuing operation as a going concern.”
3. “Compliance with the terms of this Agreement, as to the accuracy of the revenues, expenditures, allocated costs, financial position, and solvency/going concern status claimed by the Provider and reported to the Payor hereunder; and”
4. “Compliance with applicable federal and State laws governing its operations. The Provider shall submit a complete and accurate copy of such independent audit for each fiscal year no later than three (3) months after the close of any such fiscal year.”

Chip confirmed that this is correct due to the Provider’s scale/risk.

It was noted that both boilerplates include a provision (Section V) that the Provider will furnish the Payor with proof of financial solvency prior to the execution of a Contract. Chris asked if any of the CMHSPs collect this information. Mark responded that Northern Lakes collects an IRS 1040 Schedule C for every contracted provider. Financial audits are requested from larger, corporate providers. A different form is collected for professional practices. Non-profit 501(c)(3) providers are asked to furnish an IRS Form 990. New providers are asked to submit Business Plans as proof of fiscal solvency. Pat added that Centra Wellness collects financial audits as part of RFQ submissions.

* Exhibit B of the Type A boilerplate lists two questions: “1) The target service group for the supports/services under this Agreement is as follows:” and “2) The eligibility criteria for the supports/services under this Agreement are as follows:” The Type B boilerplate has the “Target Service Group and Eligibility Criteria for Services” spelled out. Chip confirmed that this is correct.
* Exhibit C of the Type A boilerplate lists one question: “1) It is expressly understood and agreed by the parties hereto that the Provider’s specialized program supports/services to be provide to the Payor’s Client, while place at the Facility, for subsequent reimbursement from the Payor per valid claims under this Agreement shall include the following:” Again, the Type B boilerplate has the “Scope of Independent Contractor Support/Services” spelled out (Personal Care and CLS). Chip confirmed that this is correct.

Approved contract boilerplates are housed in Teams 🡪 NMRE Regional Groups 🡪 Provider Network 🡪 Files 🡪 Annual Behavioral Health Boilerplates 🡪 FY2025 Region 2 Boilerplates. The PMN Guide is also located in the Teams files and contains useful information on a variety of PNM related topics.

Chris referenced a Contract Grid created by Chip in April 2021; this is attached to the meeting minutes.

Chip offered to provide access to his Teams folder titled, “Dave Short Project – Michigan” to any committee members who are interested. Those interested can email Chip at CJohnston@centrawellness.org to be included.

Kari acknowledged that the CMHSP should be monitoring staffing ratios. In a Type A home, the CMHSP should not be paying for the first level of staff that an AFC requires.

**Review Schedule**

A review schedule will be created so that all contract boilerplates will be reviewed throughout the coming year.

**Respite Rates**

During the June meeting, Kim asked the CMHSPs how they calculate the rate for respite providers. AuSable Valley, Centra Wellness, North Country and Northeast Michigan all use a flat rate; North Country will be moving in that same direction.

**Leases/Subleases with Clients**

In the interest of time, this topic was deferred to the August meeting.

REGIONAL DIRECTORIES

The NMRE will upload the completed tools and supporting documentation for HSAG Compliance Examination Standards I, III, IV, V, and VI on July 11, 2024. Any feedback or requests for corrective action regarding Provider Directories will be brought to the attention of this group.

HOSPITALS

**Helen DeVos**

An email from Jim McCormick at Lakeshore Regional Entity dated July 5th was shared with the committee. In the email, Jim stated that Lakeshore and its member CMHSPs have several outstanding questions and concerns with the pediatric med/psych unit. Of primary concern is that it is being labeled a med/psych unit, but they do not appear to be accepting admissions with a primary or acute medical diagnosis. An additional concern is that admissions are not occurring 24 hours per day/7 days per week. Currently, Lakeshore’s member CMHSPs are utilizing SCAs as needed.

**Munson ECT Update**

Munson intended to add an ECT program effective July 1st. The rate for the ECT services has not been negotiated to date.

**Kalamazoo NeuroPsychiatric Update**

The 64-bed facility has been licensed, however, accreditation, and CMS approval is pending. A July 1st opening was planned but it is unknown whether that occurred.

**Rates**

* FY2025

Chris has reached out to hospitals contacts to inquire about FY25 rate increases. The plan is to wrap up the process by the end of August.

* Tiered Update

MDHHS has developed a tiered rate structure for inpatient psychiatric services. The structure includes four tiers, each with a different staffing ratio, with a base rate of $800 per day:

* Tier 1: Baseline, with regular ward staffing
* Tier 2: Enhanced, with a 2:1 staffing ratio
* Tier 3: Enhanced, with a 1:1 staffing ratio
* Tier 4: 1:2 staffing ratio

The goal of the tiered rate structure is to improve outcomes for all populations and increase access to inpatient psychiatric services and address barriers to care for specific populations.

Instead of implementing tiered rates, the $8M allocated by the legislature will be used to uniformly increase the existing Hospital Rate Adjustment (HRA) for FY25. Despite this change, MDHHS expects efforts to report rate tiers on encounters to be maintained for FY25 implementation to establish a framework for potential future payment based on rate tiers.

Clarification was made that HRA Directives are sent to the NMRE quarterly. The NMRE makes the payments pursuant to the schedule provided by MDHHS at a rate of $600 per day.

It was noted that if hospitals base billing on tiered rates, CMHSPs will have to audit hospital records for validation, which would be administratively burdensome.

Staffing tiers were expected to be identified using code modifiers; ultimately, it was decided that modifiers can’t be used on revenue codes.

If the CMHSPs are contacted by hospitals with questions regarding tiered rates, they may be directed to Chris.

EVV UPDATE

Training continues to rollout for EVV prior to the scheduled implementation date of September 3, 2024. A subgroup of the regional Business Intelligence and Technology (BIT) Committee is forming to work out the EVV implementation process.

In a memorandum from Kristen Kordan to PIHP and CMHSP Executive Directors dated June 28, 2024, MDHHS removed claim submission from the HHAX to the payer system from the scope of the Behavioral Health implementation. Providers will still be required to use the HHAX pre-billing features to validate EVV Record errors. MDHHS will complete a post-payment verification of claims and encounters against HHAX EVV records; discrepancies will need to be addressed.

REGIONAL/STATEWIDE EVENTS, CONFERENCES, TRAININGS, NEWS

* **Rural Michigan Opioid & Substance Use Summit** – July 25th at Treetops.
* **CMHAM SUD and Co-occurring Annual Conference** – September 16th – 17th in Novi and virtual.
* **NMRE SUD Day of Education** – September 20th at Treetops Resort in Gaylord.
* **CMHAM Fall Conference** – October 21st – 22nd at Grand Traverse Resort in Traverse City.
* **CMHAM Improving Outcomes Conference** – December 5th – December 6th in Dearborn.

OPEN DISCUSSION

**Credentialing Report**

The next Credentialing Report is due to MDHHS on November 15th. Beginning October 1, 2024, recredentialing will be required every three years (vs. every two years).

Chris has received names of CMHSP staff to submit to MDHHS to receive training on the MiCAL Universal Credentialing platform.

**HCBS**

CMS is auditing the State of Michigan regarding the HCBS Final Rule. CMS has identified certain sites it will be visiting (Hope Network); CMHSPs were asked to provide names of Case Managers who can speak about HCBS. Chris agreed to seek additional information from NMRE Waiver Coordinator, Aaron Biery, and communicate it back to the Committee.

NEXT MEETING

The next meeting was scheduled for 10:00AM on August 13th via Teams.

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| **CONTENT TYPE** | **WHEN TYPICALLY USED** |
| Memorandum of Understanding (MOU) | 1. Other County Governmental Units such as sheriff, courts, health departments, county administration, etc... May or may not involve $$ (No limit on amount)
2. Other Governmental Units (other CMH’s, Health Departments, etc..) where no $ is involved and is typically used to define functions/tasks. To solidify/codify verbal agreements
 |
| Business Associates Agreement | An agreement with other entities (typically Health care or Health Care Vendors) that requires the exchange of Private Health Information. No $ is exchanged. |
| Purchase Orders | 1. 1x Pay-as-you-go. Usually for equipment, or administrative service. Usually, the item to be purchased is prior approved via an admin. process or Governing Board review. $ Amounts vary widely typically under $5,000
2. Risk exposure is weighed.
3. Recommend Business Associates Agreement and Confidentiality Statements are established if applicable
 |
| Letter of Agreement with HIPAA and Letter of Agreement Goods and Services (Without HIPAA)Administrative Services (i.e. Fix a door)  | 1. Other Governmental Units, outside our County, and Private Vendors when risk and dollar amount is small (typically under $5,000) and the service is time-limited, administrative or a very limited low risk clinical service.
2. With Non-Government less than $25,000 primarily due to Disclosure of ownership rules.
3. Recommend Business Associates Agreement and Confidentiality Statements are established if applicable or use Letter of Agreement with HIPAA contract template.
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| Administrative Services | 1. All ongoing typical CMH Administrative Services (Personnel – clerical, admin assistants, etc..)
2. Infrastructure – building maintenance, lawn, snow etc.
3. Involves 2CFR Part 200, Subpart E – Cost Principles, 200.436, 200.439, 42CFR 455.15 Disclosure of Ownership
4. Other State and Federal Regulations: solvency relationships to party etc.

Services that represent a higher risk ($$) to the CMH |
| Self-Determination Agreement | An agreement regarding the delivery of services and authorizations of same between an individual in a Self-Determined arrangement and a CMH. (Who does what). |
| Fiscal Intermediary | 1. Used in conjunction with Self-Determination arrangements.
2. Essentially an administrative services contract
3. Assures compliance with IRS regulations etc.
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| Respite Camp/Day Camps | 1. Private or Non-Profit Camps when client numbers are usually very small (1 or 2) and the risk exposure and dollar amount is small (typically under $5,000) and the service is time-limited (a day or weekend) and is a very limited/low risk clinical service.
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| Respite Only | 1. Used with a Respite Provider (including camps) providing on-going respites services multiple times throughout the year to one client; and/or
2. Used with a Respite Provider (including camps) who provides respite services only to multiple clients at multiple sites throughout the fiscal year; and/or
3. Used with a Respite Provider (including camps) who provides respite services only to multiple clients over a short duration.
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| CLS/Respite  | 1. Used when a Provider is authorized to move between Community Living Services (CLS) and Respite service throughout the course of a fiscal year with one client; and/or
2. Used with a Provider who provides CLS/Respite services to multiple clients at multiple site throughout the fiscal year; and/or
3. Used with a Provider who provides CLS/Respite services to multiple clients over a short duration; and/or
4. Provides any or all of the above and only CLS services
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| Drop-in  | 1. Straightforward contract for Drop-in SMI or SMI/IDD/SUD co-occurring services with a 501-c-3 client run center to focus on support and aftercare.
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| Children’s Therapeutic Foster Care & Other Children’s Community Settings | 1. Typically used for Individual foster care home placements (single child) where programing and skill building occurs.
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| Crisis Residential | A.) Used for Crisis Residential Facilities. Intended for diversions from inpatient hospitalization and the stay is anticipated to be “short-term” |
| Professional Individual | 1. Used with a single professional for services such as counseling, occupational therapy, etc.
2. Typically, a sole proprietor.
 |
| Professional Group or Clinic | 1. Used with group practices or clinics
2. Typically, Non-profits, Group LLC’s, or for profit companies.
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| Residential Type A Contract | 1. Used generally when the Home is owned and licensed by an independent provider. They are licensed as specializing in either Mental Illness or IDD.
2. The contract is for one of the beds in the facility and must address client needs over and above staffing levels and support provided for under typical licensing placements and staffing ratios as required by regulations and laws.
 |
| Residential Type B Contract | 1. Used when the home is either leased or owned by the CMH.
2. Licensed by the provider.
3. Bed access is controlled by the CMH
4. Is essentially a staffing contract and budget is facility based as opposed to client specific.
5. Net Cost contracting is often used for these arrangements in Exhibit F.
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| Supported Independent Residential Services | 1. Used for unlicensed settings.
2. Must be less than 4 individuals (per State law).
3. The Clients must hold the lease or own the home and expenses are paid by the clients or their guardians.
4. Payment is for staff to provide community living supports.
5. Home Help must be backed out of the overall staffing as determined by MDHHS evaluation and billed by the provider to the MDHHS separately.
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| **Special Topics Section of Contracts** |  |
| Indemnity | Three types:1. Protection of CMH
2. Two-way protections
3. Not addressed (each to their own)
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| Liability Insurance | More of an art form:1. Risk exposure to the CMH typically measured in human and financial terms.
2. There are guidelines from State Departments and Contracts

 **General Coverage is currently:** Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations  **Professional Liability (Errors and Omissions) Insurance**: Minimum Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate1. Michigan Municipal Risk has issued guidance on occasion.
2. There are 3 coverage levels for AFC homes:

General Liability – Covers the premises and individuals onsite. Professional Liability – Relates to the care provided to residents.Abuse and Molestation1. Factoring to rates are location, square footage, number of beds, and/or number of employees. Property coverage is also required (commercial policy above homeowner’s insurance). Current industry standards for coverage limits were provided as $1M per occurrence and $3M aggregate; umbrella policies may be purchased to increase coverage limits.
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| Use of Provider contract | Place holder Note conditions and what to look for |
| Earned Contract/They Pay Us | "Earned contracts", or "They pay us contracts" are where you would want the terms to be in your favor. Someone is buying a service from your CMH as opposed to you buying from them. So therefore, you are going to state the stuff that you feel minimally necessary to execute the contract for the services that they are paying you for. |
| Background Checks | Pursuant to Michigan law, all agencies subject to IRS Pub. 1075 are required to ask the Michigan State Police to perform fingerprint background checks on all employees, including Contractors and Subcontractor employees, who may have access to any database of information maintained by the federal government that contains confidential or personal information, including, but not limited to, federal tax information. Further, pursuant to Michigan law, any agency described above is prohibited from providing Contractors or Subcontractors with the result of such background check. For more information, please see Michigan P.A. 427 of 2018. Upon request, or as may be specified in Schedule A, Contractor must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks. |