Provider Network Management Agenda

Date: ***September 9, 2025***	***Location: TEAMS***

Time: 10AM – 12PM	***Dial-in Number:*** 1 (248) 333-6216 ***Conference ID:*** 952 875 519#

Participants

☐	**Wellvance** Teresa McGee Julie Streeter
☐	**Centra Wellness Network** Chip Johnston Pat Kozlowski Kacey Kidder

☐	**North Country CMH** Kim Rappleyea Katie Lorence Angie Balberde
☐	**Northern Lakes CMH** Hillary Rappuhn Mark Crane Kari Barker Jessica Williams

☐	**Northeast Michigan CMH** Connie Caderette Jennifer Walburn Vicky DeRoven Jen Wieczorkowski
☐	**NMRE** Eric Kurtz Chris VanWagoner Carol Balousek

1. Introductions
2. August 12, 2025 Meeting Minutes Approval
3. Prior Action Items
    a. Contact hospitals for FY2026, ensure contract boilerplate and rates on schedule (Chris)
    b. Update directory: NCCMH machine readability, NLCMH address independent facilitation, CW organize by county, all add telehealth
4. CMH Rate freeze discussion (region 4/Huron) (Angie Balberde)
5. Universal credentialing (standing item)
    a. FY2025 (full year) Credentialing Report
        i. MDHHS meeting (8/20/25)
6. Provider Directories (HSAG 2024)
    a. Telehealth
    b. Machine Readability (HSAG 2024 S1, E20)
    c. Organized by county, Elements provided compliant with 42 CFR 438 (HSAG 2024, S1, E18)
    d. Addresses Independent facilitation (via list, or link to webpage, etc)
    e. NAV and data integrity
7. Hospitals
    a. Status: Rate requests for FY2026
8. HCBS update
9. MDHHS PIHP RFP update
10. Conferences, trainings, and events
    a. CMHAM Recipient Rights Conference – September 17th – 19th in Kalamazoo.
    b. CMHAM Fall Conference – October 27th – 28th in Traverse City.
    c. Improving Outcomes, December 4th and 5th at Ann Arbor Marriot, Ypsilante
11. Ongoing Group TEAMS Posts
12. Open discussion

Next scheduled meeting October 14, 2025

NORTHERN MICHIGAN REGIONAL ENTITY
PROVIDER NETWORK MANAGERS MEETING
10:00AM – AUGUST 12, 2025
VIA TEAMS

Centra Wellness:	☐ Chip Johnston	Executive Director
	☒ Kacey Kidder-Snyder	Provider Network Specialist
	☒ Pat Kozlowski	Access and Emergency Service Director
North Country:	☒ Angie Balberde	Provider Network Manager
	☒ Katie Lorence	Contract Manager
	☒ Kim Rappleyea	Chief Operating Officer
Northeast Michigan:	☐ Connie Cadarette	Chief Financial Officer
	☒ Vicky DeRoven	Quality Improvement
	☒ Jen Walburn	Compliance Officer
	☒ Jennifer Wieczorkowski	Contract Manager
Northern Lakes:	☐ Kari Barker	Director of Quality Improvement & Compliance
	☒ Mark Crane	Contract and Procurement Manager
	☒ Carrie Hubbell	Administrative Assistant
	☒ Trapper Merz	Business Intelligence Specialist
	☐ Hillary Rappuhn	Project Coordinator
	☒ Jessica Williams	Performance Improvement Specialist
Wellvance:	☐ Teresa McGee	Chief Clinical Officer
	☒ Julie Streeter	Contracts Specialist
NMRE:	☒ Carol Balousek	Executive Administrator
	☐ Eric Kurtz	Chief Executive Officer
	☐ Heidi McClenaghan	Quality Manager
	☐ Brandon Rhue	Chief Information Officer/Operations Director
	☒ Chris VanWagoner	Contract and 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 July 11th minutes were included in the meeting materials and approved by consensus.

PRIOR ACTION ITEMS
Contact Hospitals for FY26, Ensure Contract Boilerplate and Rates are on Schedule
This topic will be discussed under the Hospital Status Update.

NORTH COUNTRY PROVIDER ORIENTATION DEMO

Kim led a demonstration of North Country's quarterly provider network meeting process. Informational bulletins are also furnished quarterly staggered in between meeting months. The August 2025 Provider Network meeting included a Provider Orientation presentation which can be found on North Country's website at: August-25-PNM-Meeting-Full-Packet.pdf.

UNIVERSAL CREDENTIALING

According to MDHHS, the Universal Credentialing CRM should be fully implemented for organizational providers. Despite some lingering bugs in the system, Chris urged the CMHSPs to move forward with implementation if they have not already done so.

Chris hosted a meeting on June 24th with CMHSPs and PIHPs across the state to discuss the implementation process; feedback from that meeting was sent to MDHHS. A PIHP Universal Credentialing Leads meeting is scheduled for August 20th.

Chris noted that the Universal Credentialing CRM was created in response to Public Act 282 of 2020 which mandated that MDHHS create a uniform credentialing process for providers/practitioners.

FY25 Credentialing Report

A FY25 Credentialing Report is due to MDHHS on November 15th.

- 180 Day Subscriptions
  Chris logged into the Universal Credentialing CRM and shared his screen. Chris showed that Primary Source Verification subscriptions (PSV) in the system expire after 180 days. Chris intends to ask MDHHS the reasoning behind the expiration date. Chris noted that the PSV will show as expired until all the required documentation has been updated.

- 2 Year GF/3 Year PIHP
  Chris shared an email dated August 7th from Sandra Gettel, Quality and Compliance Specialist with MDHHS, confirming that the CMHSPs' general funds contracts have been updated for FY26 to indicate that recredentialing is required every three years. Chris advised the CMHSPs to be prepared that any audits conducted for Medicaid should reflect recredentialing every three years and should reflect the time period stated in the contract for general funds, which prior to FY26, was every two years.

- PSV Should Automatically Update
  Chris explained that the license to provide services should be uploaded as part of the PMV; this would be the entity's license for a particular location, which may be found by visiting: Search - Verify A License. Licenses should be uploaded during credentialing/recredentialing. Chris agreed to consult with MDHHS about whether corporate licenses should also be uploaded.

PROVIDER DIRECTORIES (HSAG 2024)

Telehealth

An update has been added to 42 CFR 438.10(h)(1)(ix) that states that Provider Directories must include whether the provider offers covered services via telehealth. This will likely be added to the HSAG checklist for future audits.

Hours of Operation
During the June meeting, Kacey asked whether there is a standard that requires providers' hours of operation to be listed on the Provider Directory. Chris responded that hours of operation are not required based on the HSAG Compliance Review Provider Directory Checklist and 42 CRF 438.10(h)(1-2).

During the meeting on this date Kacey noted that a CAP from 2022 stated that Provider Directories will include: provider ID, name, NPI, address, contact information, parent vendor/affiliate, and may also include: whether the provider is accepting new patients, accessibility, and hours of operation.

Review of CMHSPs' Provider Directories
Chris reviewed the five CMHSPs' Provider Directories prior to the meeting. Chris reviewed the Provider Directories' compliance with the following categories:

	Machine Readability	Independent Facilitation	Organized by County	Telehealth
Centra Wellness	Yes	Yes	No	No
North Country	No	Yes	Yes	In Process
Northeast MI	Yes	Yes	Yes	No
Northern Lakes	Yes	No	Yes	No
Wellvance	Yes	Yes	Yes	No

Chris asked the CMHSPs to address any areas scored with a "No" above.

Chris demonstrated the NMRE's online Provider Directory, which was created by an outside vendor. Kacey requested the vendor information, which Chris agreed to provide.

Network Adequacy Validation (NAV) and Data Integrity
Chris explained that a new law at the federal level is in place for Medicaid Health Plans or Medicaid Provider Networks stating that MDHHS must conduct validation on the data that is submitted regarding network adequacy. As a PIHP, the NMRE is contractually bound to adhere to certain adequacy measurements established by MDHHS for its provider network. The NMRE is expected to ensure that the information contained in the CMHSPs' Provider Directories is accurate and matches other internal systems (PCE, brochures, website, etc.) This will likely be added to the NMRE's biennial monitoring process.

<u>HOSPITALS</u>
Status: Rate Requests for FY26
The following hospital rate requests for FY26 will be presented to the regional Operations Committee for approval on August 19th.

BCA StoneCrest

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$808.55	$825.00	2%
Enhanced Rate 1:1 Staffing	$1071.20	$1,093.00	2%

Bronson Behavioral Health

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	1,090.00	$1,123.00	3%

Harbor Oaks

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$824.00	$849.00	3%
Specialized Pediatric Unit (0100)	$1,400.00	$1,442.00	3%

Havenwyck

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult/Adolescent Psychiatric Inpatient (0100)	$999.01	$1,029.00	3%
Partial Hospitalization (0912)	$439.81	$453	

* Single Case Agreements (SCAs) may be used for Enhanced Staffing at a rate of $1,149.01.

Henry Ford Kingswood

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	—	$1,123.00	NA
Specialized Inpatient Pediatric Unit	—	$1,442.00	NA
ECT (0901)	—	$1,350.00	NA

McLaren Healthcare

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,037.21	$1,068.00	3%
Partial Hospitalization (0912)	$519.12	$535.00	3%

McLaren has requested a force majeure clause in its contract, excusing it from its contractual obligations if they become impossible or impracticable due to unforeseeable events outside its control, which Chris has denied.

Munson Medical Center

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,175.86	$1,193.50	1.2%
Partial Hospitalization (0912)	$471.19	$487.28	3.4%
ECT (0901)	$799.28	$811.27	1.5%

HealthSource Saginaw

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,081.50	$1,103.13	2%
Adolescent Psychiatric Inpatient (0100)	—	$1,113.95	NA
Geriatric Psychiatric Inpatient (0100)	—	$1,113.95	NA

* SCAs may be used for Enhanced Staffing at a rate of $1,500.00.

Once rates are approved by the Operations Committee, Chris will drop boilerplates into the Teams folders.

For hospitals that have not communicated a rate change with the NMRE, FY26 Contracts will be generated using FY25 rates.

HCBS UPDATE
No update was provided on this topic.

MDHHS PIHP BID OUT
The RFP to procure the state's PIHPs was issued on August 4th, with a submission due date of October 6th. The effective date for the newly selected PIHPs is October 1, 2026.

REGIOINAL/STATEWIDE EVENTS, CONFERENCES, TRAININGS, NEWS
- **CMHAM Recipient Rights Conference** – September 17th – 19th in Kalamazoo.
- **CMHAM Fall Conference** – October 27th – 28th in Traverse City.
- **Improving Outcomes** – December 4th – 5th in Ann Arbor

ONGOING GROUP TEAMS POSTS
Credentialing/Recredentialing
If a query of the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Databank (HIPDB) is not possible, then these alternatives must be verified instead:

1) Historical checks of criminal convictions
2) Historical checks of civil judgments
3) Disciplinary status with regulatory board or agency
4) Medicare/Medicaid sanctions and/or exclusions.

The CMHSPs currently check all but #2 above. The CMHSPs will likely have to: a) run organizations through the NPDB/HIPDB, or b) add historical checks of civil judgments. Kacey supplied the following links to the state and national court systems:
- Michigan: https://www.courts.michigan.gov/case-search/
- US: https://pacer.uscourts.gov/find-case/search-national-index

NEXT MEETING
The next meeting was scheduled for September 9th at 10:00AM.

UNIVERSAL CREDENTIALING LEADS MEETING - SUGGESTIONS FOR IMPROVMEMENTS

	Suggestions	Discussion/Notes	Status/Next Steps
1.	Future audits using the CRM and what will be required? Are these the only documents that will need to be presented during future audits? (Application, attestation, PSV)	It is expected that documents required for external audits (EQR0HSAG) will be available in the CRM.	Federal Compliance Team to utilize CRM UC for relevant documents, not all required evidence documents are in the CRM UC.
2.	Update on allowing users to have access to multiple agencies.	Currently available for those who have the appropriate access..	NA
3.	Is there any plan for agencies to upload documents that are locally required, but not state required. This would be very helpful and would prevent duplicative record keeping.	The option to upload additional documents is currently available. Keeping in mind this is a **uniform** system and all who subscribe to the profile/PSV will see the documents.	Complete assessment to determine what additional qualifications are required to provide services to CMHSP beneficiaries in Michigan. i.e require training and certifications prior to billing.
4.	Could the NPI field be a requirement for the practitioners to provide on their profile?	No, because atypical providers do not have an NPI number. It is required for those who do have an NPI number.	NA
5.	During the subscription steps there is a link to a Quality Checklist that seems like it might be an old version. Could the new one in Job Aids be linked instead?		Completed
6.	Can edits be made in the system when a mistake has been made.	Edits cannot be made once the subscription record has been completed, and an approval or denial letter has been sent. Contact CRM/UC Team for assistance.	Include in FAQ
7.	Why are CMHSP staff required to be included in the CRM.	This was a decision made based on the legislation. 2020-PA-0282, MCL 330 1206B	NA

8.	Seeking clarification of the type of organization and individuals per state guidelines.	The updated FAQ was shared in May. Residential providers are required to be included in the CRM. Providers/organizations that have limited access to internet or technology may be completed outside of the CRM at this time. Additional Guidance will be included in the revised policy.	This will be added to the FAQ and MDHHS Policy.
9.	Make training videos for both sides of the credentialing process. -Organization	Liz is reviewing training videos for improvements and any gaps. Some indicated the issues with volume etc.	CRM Team exploring videos to ensure this is available.
10.	Can the disclosures have a stop gap by forcing the applicant to explain why they may be saying yes (felony, drug use, etc.) like they do on a paper form?	This will be explored for future enhancement.	This will be explored for future enhancement.
11.	I have providers that I have sent letters to for the Universal Credentialing and still no response	Providers are unable to bill for services if they are not credentialed. Internal policies should be in place to address this issue.	Additional discussion. PIHPs should request a meeting if needed to talk about specific cases.
12.	What happens when the responsible party doesn't need to recredential a home for some time, yet my CMH does in order to stay compliant?	Re-Credentialing is required every 3 years for all organizations and practitioners. You can complete a PSV and subscribe to the current profile or request a change of the RCC so that you can complete the credentialing profile and then transfer after it has been completed.	NA

13.	The NPI isn't starred on the provider side as a required field. And it seems like it is mistakenly skipped over by some practitioners.	We can add a tool tip to remind them to include the NPI if applicable.	Tool Tip to be added
14.	We did not get clarification on if we could upload documents on behalf of providers. This would relieve so much pressure	Currently this is not an option, but we can discuss this as an update.	Evaluate fields that need to be changed for CMHSPs to upload documents in addition to providers.
15.	**The Universal Credentialing FAQs** list that NPDB is not appropriate to share, so that is understood. However, what should be shared for this? If nothing, confirm that we are to do individual NPDB checks and the attestation of the RCC and quality checklist is enough for compliance, or if we all need to complete these individually? Some agencies are uploading the receipt of the check. what documentation for the PSV should be shared for this (and NPDB)?	The NPDB is not able to be uploaded per NPDB. You can upload your signed off document in the documents tab or if this is a recredentialing, you can either use the available Quality checklist or one of your own and upload that, which will have a spot for signature signoff. (Audra email 12/10/2024)	Include in FAQ
16.	ICHAT, it was discussed that release of information is required for this, and not all agencies were sure if it was required to share that information by MDHHS. We generally agreed it was not appropriate though some agencies have already uploaded ICHATS while others are opposed. Can this be confirmed whether or not we are requested to provide ICHAT.	The ICHAT is public information and can be uploaded to the CRM. The document should only be viewed by those who have access to the system for the purposes of credentialing. This must not be shared with anyone else. Johanna Richardson – ICHAT Analyst Michigan State Police (Email dated 8/1/2023)	Include in FAQ

17.	**Difficulty changing the email address for individual Staff** - Some agencies disclosed that they do not enter an agency email for staff until the day they start work and are assigned their agency email as it is difficult to change personal emails, in addition to not wanting to share personal email addresses unnecessarily. It was noted that in one instance MDHHS did fix the email change for the RCC, but in other cases CMH's disclosed their requests had not yet received a response (with varying timelines).	CMHSP/PIHP IT System Administrators manage the CMHSP/PIHP staff contacts, so if changes to email addresses are needed, they can handle the change. Organizational or Practitioner Provider Contacts - these are added by the RCC admin users via the credentialing profile. If an email for a contact that has been added needs to be changed or updated, the RCC user should reach out to the MDHHS-BH-CRM@michigan.gov email address. *Any email change in the BH CRM for any user will require that they update their MiLogin account email to match what is in the BH CRM. If they do not match, they will not be able to access their account.	Include in FAQ
18.	**Individual Staff questioning the need:** Many employees of CMHSPs had provided feedback to their RCC that if they do not intend to work for another entity, they don't feel they should need to enter their information into a system for all system users to have access (despite efforts of the MDHHS and workgroup to avoid SS#, address disclosure). Name, attestation, education and certifications, work history data	Uniform credentialing system requires those who provide CMHSP services directly or indirectly to use the uniform credentialing system. 2020-PA-0282, MCL 330 1206B User access is limited to those who have administrator credentialing user access for that CMHSP and PIHP.	NA

	are still typically available to all users and there was general concern among CMHSP staff. •		
19.	**Populations for practitioners:** Some RCCs present at our meeting noted that a part of the credentialing they are responsible for is ensuring staff are qualified to provide services to specific populations. This is not present in the Medicaid credentialing policy via the PIHP contract, and thus not in the CRM, but is audited under credentialing for the MDHHS waiver audit. Staff at CMHSPs are hired to provide services to certain populations such as IDD, etc. The qualifications of staff as QIDP, QMHP, or CMHP have different requirements, and the staff may only be qualified to provide services to a certain population depending on whether the client is iSPA, HAB waiver, etc. In addition to the CRM, these RCCs must maintain a second system for tracking these qualifications, as they require supervisor credentials, experience levels, certain licensure or not, etc., to qualify them for services to the population. In some cases, case managers may attempt to assign a client to a population that the staff is not qualified to		Complete assessment to determine what additional qualifications are required to provide services to CMHSP beneficiaries in Michigan. i.e required training and certifications prior to billing.

	provide service for; the RCCs would not have knowledge if this was to occur and can lead to citations requiring CAPs as part of the MDHHS annual audit. It was discussed that this may or may not be an appropriate future addition to the CRM. As a note, some QIDP/QMHP staff such as Supports Coordinators are unlicensed but are still subject to audit by MDHHS under the credentialing standards. This is a consideration for future discussion. •		
20.	**RFP duplication:** It was noted during this discussion that for organizations, public proposals such as RFPs, RFIs, RFQs, etc., typically have an application required for submission acceptance. Once agency boards approve contracts, the provider would previously have been credentialed already. In this case, the providers would need to re-enter all of the application data in the CRM—a duplicative effort. They should not be entered during the RFP prior to board approval because we would not be credentialing organizations we would not contract with. While this may not have a one-size-fits-all solution, we wanted to bring this issue to the attention of MDHHS.		

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21.	**Clarification needed on what type of Provider should be using the CRM?** ○ AFC Providers confirmed on FAQ, including smaller 6 bed Mom/Pop AFC Providers, so we are good on these providers. ○ Personal Residential Homes (unlicensed)? ○ Organizations providing CLS, Respite, Supported Employment, Skill Building? ○ Crisis Residential? ○ Hospitals? ○ Pharmacies (T1999)? ○ ABA? ○ Fiscal Intermediary? ○ Individual Licensed Professionals not associated with an Organization (OT, Psychiatrist, etc.)? ○ Independent Facilitators? ○ PERS maintenance (S5160/S5161)?	Organizational Providers - Organizations/facilities that have a contract to provide services directly to members. Facilities that do not provider services directly to its members are not within the scope of the universal credentialing. Includes Inpatient Psychiatric , Residential, Addiction Disorder facilities, and Ambulatory facilities. More information will be provided in the FAQ and updated policy.	Include in FAQ/Policy

	○ Other Contracts not providing Direct Services… Pharmacy, Interpreters, Consultation, Supervision, Auto Repair, Answering Service (i.e. crisis lines)? * *At least one CMH noted they only enroll everyone that is licensed. Another CMH noted they decided to use the CRM for everyone that was up for contract renewal to have one method for everyone vs. having multiple systems to update.* •		
22.	**Discussion regarding the RCC's lead and what occurs when they go off on leave or retire**. Some CMH RCC's noted they were told one of the subscribers would have to take over as the RCC. Is there any guidance on how to determine which subscribers would take over for the provider record or is that being left up to the PIHPs/CMHSPs? •	CRM and UC Team are working on solutions built within the CRM-UC to assist in limited scenarios. Until this is completed, the PIHP/CMHSP in coordination with MDHHS reviews the profile and reaches out to those who have subscriptions. If there are no current subscriptions MDHHS will reach out to those who have an account affiliated with the provider. (It is important to keep the CRM updated for your CMHSP/PIHP)	CRM updates to address this issue coming.

23.	**Clarification needed if the RCC no longer contracts with the Provider.** Along similar lines as the prior bullet point, this was discussed; one attendee noted that it was her understanding that an RCC would still be considered the RCC and have to take the lead, however, a different attendee noted they were told one of the Subscribers would need to take over as the RCC. Can we get clarification on this? •	If a provider is no longer subscribed to the profile, another subscriber will need to take over. Please see above response.	CRM updates to address this issue coming.
24.	**Duplication/Committees:** There was discussion surrounding the need to maintain separate files due to local processes and policies, additional documentation requirements per CMH, items they attest to on the CMH application, miscellaneous documents, information that can't be uploaded like NPDB results or possibly ICHAT, etc. Also, regarding Individual Staff, a few CMH RCCs noted they are still having to do paper applications due to their committee procedure: practitioners don' t go into the CRM until they actually start their position and have their NPI. CMHSPs do realize that not having the application done in the CRM prior to them starting will probably be an issue for	Assess what files are being used and purpose of said files. See ///above	Review process and Barrier of access to the CRM prior to employment. Brainstorm solutions. Evaluate what is needed to include additional information regarding staff qualifications for CMHSP staff.

	MDHHS; the central issue is that many practitioner RCC's spoke up noting they have to maintain two systems despite the CRM. We can discuss more with MDHHS in the future as appropriate. •		
25.	**Clarification Still Needed on the 90-day completion time:** One RCC in our meeting had asked MDHHS when the 90-day time to complete the application begins. MDHHS staff had directed them to the profile history list to the far right of the Credentialing Profile, to the "Credentialing Profile History" list; when there is a "New Value" of "Complete", the 90-day clock starts ticking. It is possible, however, to discover that additional information needed after the application is completed and to require the profile to be re-opened for provider edits, such as for the provider to complete attestations. Confusion on whether it is when it notes "complete" or "submitted", and what if multiple revisions are needed? The below graphic has arrows that shows that there are two "Complete" status's, the initial at the bottom, and then after the record is opened for provider edits for the attestation, a second (and more accurate) Complete status at the	90 days from the date the application was approved/completed by the CMHSP/PIHP. Marking the application as complete indicates that all the required information is included. Once the application has been submitted the application status would indicate "Submitted". If the PIHPCMHSP requests revision it would indicate "Revisions Requested" or Pending Provider Edits" or "Edits Pending Approval".	NA

	top. Further clarification is requested on how this may affect future compliance or current operations. •		
26.	**Clarification needed on when previous credentialing dates should be entered:** Discussion surrounding previous credentialing dates occurred. The correct date for previous credentialing date is the date the previous notification was sent to provider, correct? Some CMHSPs have been entering in the last credentialing date based on their database they maintain. Others noted they don't have those dates (mostly being new to their positions and historic tracking problems). While these are probably available from previous credentialing reports submitted to their PIHP, in the event that this data is not available, it was suggested that we might potentially use the first date of the contract in these events, as while we may not be able to confirm the date of notification, we can truly confirm that the provider was credentialed prior to the contract. Are there any instances where previous credentialing dates should not be entered? •	Previous credentialing dates are required to determine the date the recredentialing is required to be completed by. This must not extend beyond 36 months. The provider and or HR should have a letter or meeting minutes to identify the date.	More information needed as to why the credentialing date would not be available.

27.	Worth noting to MDHHS is the PIHP/CMHSP system plans to continue our collaboration in efforts to make the CRM work as intended; this may or may not result in branching from one large group to a separate organizational group and a practitioner group. •	Thank you. The group can decide on what subgroups are needed.	Determine workgroups needed
28.	Adding Service Locations-Not all information is provided. Do the providers need to go out and come back in to edit or add information?	More info needed. Service locations are included in the CMHSP certification process as well.	If service locations need to be added or updated contact MDHHS BH CRM Team
29.	Accreditation Date Expiration-Can proof of expiration date (date field) be removed?		A work order has been completed to auto populate the Proof of expiration date field with the Accreditation Expiration Date.
30.	Providers have to upload the same liability certificate several times in the system because Workman's Comp, professionals are usually on the same certificate of insurance	Upload a face sheet if it applies to all employees. Have full document available upon request	Discussion needed
31.	When I am going through a submitted org provider application, I choose that I am not accredited, and it only makes me upload the sanction/exclusion checks, not the license PSV (if applicable). Is that by design?	If you are accredited you will need to complete the PSV.	Technical Guidance
32.	When I subscribe to a credentialing profile, it asks me if we are accredited. I always choose "none" but still have to upload PSV even if the PSV is not expired on the current application.		Schedule a TA call

33.	Can a site visit be created once the PSV has been created.	If the PSV has been completed "Complete Record", a site visit cannot be created. The site visit should be uploaded prior to the PSV being completed.	
34.	Notifications to providers to reach out to the PIHP/CMHSP to initiate the updates.(email)		
35.	Reminders: • After signing the attestations make sure the final steps of submission are completed. • Use @ when communicating in chatter to ensure a notification is sent to the recipient.		
36.	Add the following fields to the application: Race, Ethnicity and Language (a statement that the organization does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language, and that providing the information is optional.)		CRM team to include in future update.
37.	Review Home org Site PSV/Assessments process		
38.	Naming Convention and document management		Discuss internally for solutions and present next month

39.	If a CMH subscribes to an entity, do the PSV verifications need to be completed again if it's within the 180 days? It also appears to add multiple credentialing dates when people subscribe to the organization?	The PSV allows new subscriptions for 180 days but following the 180 days, a new PSV will need to be completed prior to any subscriptions being made	Add to FAQ
40.	Please clarify what PSV needs to be included. It is my understanding from the workgroup we do not upload NPDB or ICHAT documents but we do complete them and keep them in our records.		Please see above responses (15, 16)

FY2026 Inpatient Psych Unit Status September 6, 2025

BCA Stonecrest

FY2025 rates

Adult Psychiatric Inpatient (0100)	$808.55
Enhanced Rate 1:1 Staffing (0100)	$1071.20

FY2026 rates

Adult Psychiatric Inpatient (0100)	$825.00
Enhanced Rate 1:1 Staffing (0100)	$1093.00

Brightwell Behavioral Health Provider did not request higher rate. They may once contracts go out, as decided in July provider network meeting.

FY2025 rates

Adult Psychiatric Inpatient (0100)	$750.00

FY2026 rates

FY2026 Boilerplate has been sent for review with no rate request from provider received at this time

Bronson Behavioral Health

FY2025 rates

Adult Psychiatric Inpatient (0100)	$1,090.00

FY2026 rates

Adult Psychiatric Inpatient (0100)	$1,112.00

Cedar Creek- Steve Vernon has requested a 3% increase. Pending review at Operations on 9/16/25.

Adult/Child Psychiatric Inpatient (0100)	$1,107.25
Partial Hospitalization (0912)	$453.20

FY2026 rates (Pending Ops approval 9/16/25)

Adult/Child Psychiatric Inpatient (0100)	$1,140.00
Partial Hospitalization (0912)	$467.00

Forest View- Provider did not request higher rate. They may once contracts go out, as decided in July provider network meeting.

Adult and child/adolescent Psychiatric Inpatient (0100)	$1110.70
Partial Hospitalization (0912)	$495.71

FY2026 rates

FY2026 Boilerplate has been sent for review with no rate request from provider received at this time

Harbor Oaks

Adult Psychiatric Inpatient (0100)	$824.00

Specialized Pediatric Unit (0100)	$1400.00

FY2026 rates

Adult Psychiatric Inpatient (0100) 3% increase	$840.00
Specialized Pediatric Unit (0100) 3% increase	$1,431.00

Havenwyck

FY2025 rates

Adult/Adolescent Psychiatric Inpatient (0100)	$999.01
Partial Hospitalization (0912)	$439.81

FY2026 rates

Adult/Adolescent Psychiatric Inpatient (0100)	$1,019.00
Partial Hospitalization (0912)	$453.00
Enhanced Rate 1:1 Staffing (0100**)** **SCA ONLY**	$1,149.01

Henry Ford Kingswood

FY2026 rates

Adult Psychiatric Inpatient (0100)	$1,123.00
Specialized Inpatient Pediatric Unit (code?)	$1,442.00
ECT (0901)	$1,350.00

Healthsource

FY2025 rates

Adult/Adolescent/Child Psychiatric Inpatient (0100)	$1,081.50

FY2026 rates

Adult Psychiatric Inpatient (0100) (2% increase)	$1,103.13
Adolescent Psychiatric Inpatient (0100) (3% increase)	$1,113.95
Geriatric Psychiatric Inpatient (0100) (3% increase)	$1,113.95
Enhanced Rate 1:1 Staffing (0100**)** **SCA ONLY**	$1,500.00

Kalamazoo Behavioral Health Hospital (Potential NEW FY2026)

FY2026 rates

This is Neuropsychiatric Hospital (Indiana) owned. Justin Donato is contact; correspondence from FY2024 (last year) indicates a rate of $975 for adults and $1150 for adults with IDD. I have requested clarification on how they would be billed, with a modifier? No contracts were made for FY2025. For FY2026, NMRE was provided codes of 0124 and 0114 (semi private and private inpatient) at $1400, but nothing for our standard 0100 for all inclusive room and board. NMRE has requested clarification on if they would bill 0100, and if this rate would be similar to the rate provided last year, or if they do not plan to bill 0100 at all. More to come pending the hospital's response.

McLaren Healthcare

FY2025 rates

Adult Psychiatric Inpatient (0100)	$1037.21
Partial Hospitalization (0912)	$519.12

FY2026 rates

Adult Psychiatric Inpatient (0100) 3% increase	$1068.00
Partial Hospitalization (0912) 3% increase	$535.00

*Still working to remove force majeure

Munson Medical Center

FY2025 rates

Adult Psychiatric Inpatient (0100)	$1,175.86
Partial Hospitalization (0912)	$471.19
ECT (Pending final approval for addition)	*$799.28*

FY2026 rates

Adult Psychiatric Inpatient (0100) 1.5% increase	$1,193.50
Partial Hospitalization (0912) 1.5% increase	$487.28
ECT (Pending final approval for addition)	*$811.27*

MyMichigan

FY2025 rates

Adult Psychiatric Inpatient (0100)	$1,105.19
Partial Hospitalization (0912)	$632.42
Adolescent IOP (0905)	$450.00

FY2026 rates

Adult Psychiatric Inpatient (0100)	$1,138.35
Partial Hospitalization-Intensive (0913)	$632.42
Partial Hospitalization-Non-intensive (0912)	$459.42
Adolescent IOP (0905)	$450.00

Pine Rest

FY2025 rates

Adult Psychiatric Inpatient (0100)	$1,269.00
Child and Adolescent (0100)	$1,393.00
Older Adult Unit (0100)	$1,269.00
Partial Hospitalization for adults and children (0912)	$582.00
Partial for child with eating disorder (new) (0912)	$756.00
ECT Inpatient (0901,in addition to (0100)	$879.00
ECT Outpatient (0901)	$1,136.00

FY2026 rates

Adult Psychiatric Inpatient (0100)	$1,294.00
Child and Adolescent (0100)	$1,421.00
Older Adult Unit (0100)	$1,294.00
Partial Hospitalization for adults and children (0912)	$594.00
Partial for child with eating disorder (new) (0912)	$771.00
ECT Inpatient (0901,in addition to (0100)	$897.00
ECT Outpatient (0901)	$1,159.00

Southridge Behavioral Health Hospital (Potential NEW FY2026)

FY2026 rates

Adult Psychiatric Inpatient (0100)	$1,000.35

Trinity - Muskegon Provider did not request higher rate. They may once contracts go out, as decided in July provider network meeting.

FY2025 rates

Adult Psychiatric Inpatient (0100)	$1,082.00

FY2026 rates

FY2026 Boilerplate has been sent for review with no rate request from provider received at this time

Trinity – St. Mary's Provider did not request higher rate. They may once contracts go out, as decided in July provider network meeting. Adult Psychiatric Inpatient (0100) $1,236.00

Partial Hospitalization (0912)	$527.00
ECT (0901, while receiving 0100)	$871.00

FY2026 rates

FY2026 Boilerplate has been sent for review with no rate request from provider received at this time

UP Health – Marquette

SINGLE-CASE AGREEMENT BASIS ONLY FOR FY2025, CURRENTLY PLANNING THE SAME FOR FY2026. AS A NOTE: NORTHCARE WAS PAYING UP HEALTH-MARQUETTE $695 FOR MEDICAID AND $675 FOR ECT IN FY2025; I HAVE REQUESTED AN UPDATE FOR FY2026 FOR REGION 2 TO FOLLOW SUIT.

TO: REGION 4 PARTICIPANT CMHSP CEOS & SUD PROVIDERS
FROM: MILA C. TODD, CHIEF COMPLIANCE OFFICER & DIRECTOR OF PROVIDER NETWORK
SUBJECT: FISCAL YEAR 2026 PROVIDER RATES
DATE: JULY 10, 2025

As you are acutely aware, Michigan's public behavioral health system is facing a serious and escalating funding crisis driven by several factors including but not limited to a reduction and misclassification of Medicaid eligibles (upon which capitated funding is calculated), inflationary pressures, increased demand for services, and MDHHS repeatedly underspending appropriated specialty supports and services Medicaid funding. As a result of this prolonged systemic underfunding, the SWMBH region experienced a deficit in funding in Fiscal Year 2024 which resulted in entering the risk sharing arrangement with MDHHS, and essentially exhausting SWMBH's Internal Service Fund ("ISF"). Even with the recent FY25 rate adjustment, the SWMBH region continues to project a $7.3 million dollar deficit for Fiscal Year 2025.

SWMBH and its Participant CMHSPs have taken a number of steps to advocate for appropriate funding levels and educate MDHHS and its actuarial vendor, Milliman. Simultaneously, we have reduced expenditures where possible, recognizing that Medicaid specialty services are an entitlement benefit and cannot be denied, reduced, or delayed when medically necessary. As a result of the continued systemic underfunding, and in order to fulfill fiscal agent responsibilities to taxpayers and members served, SWMBH and Region 4 Participant CMHSPs will not increase provider contract rates for Fiscal Year 2026 at this time. We will monitor and evaluate the Fiscal Year 2026 ***actual*** financial experience and reconsider the possibility of upward rate adjustments at a later date. Please note that this Memo does not apply to CCBHC services. As per MDHHS, CCBHC services will be managed directly between MDHHS and the CCBHC beginning Fiscal Year 2026.

If additional information becomes available as MDHHS considers future capitation rates, that information and its impact on the provider network will be shared. Should you have any questions or concerns, please direct them to Mila Todd, SWMBH Chief Compliance Officer & Director of Provider Network at mila.todd@swmbh.org. Participant CMHSP network providers should direct their questions to the respective CMH contract manager.