BOARD OF DIRECTORS
REGULAR MEETING

Thursday, February 20, 2025 at 5:00 pm
Arenac Center, 1000 West Cedar Street, Standish, MI 48658

AGENDA

Page

1. CALL TO ORDER & ROLL CALL

2. PUBLIC INPUT (3 Minute Maximum Per Person)

3. RETIREMENT RESOLUTION FOR ELLEN LESNIAK

4 — 3.1 Res# 2502001: Approve the resolution recognizing Ellen Lesniak for 25 years of dedicated service and commitment – *See separate resolution on page 4*

4. COMMUNICATIONS

5 — 4.1 Commission on Accreditation of Rehabilitation Facilities (CARF) extension letter dated January 31, 2025 – *See page 5*

5. REGULAR BOARD MEETING, 01/16/2025 – Distributed
   5.1 Motion on minutes as distributed

6. CORPORATE COMPLIANCE COMMITTEE, 02/06/2025 – Distributed – Pawlak, Ch/Girard, V Ch

3 — 6.1 Res# 2501002: Approve the 2025 Corporate Compliance Plan – *See page 3 resolution sheet & plan attached to back of packet*

   6.2 Motion on minutes as distributed

7. RECIPIENT RIGHTS (RR) ADVISORY & APPEALS COMMITTEE, 02/10/2025 – Distributed – McFarland, Ch/ Mrozinski, V Ch
   There were no motions forwarded to the full Board
   7.1 Motion on minutes as distributed

8. FINANCE COMMITTEE, 02/12/2025 – Distributed – Banaszak, Ch/ Mrozinski, V Ch

6-7 — 8.1 Motion to accept investment earnings balances for period ending January 31, 2025 – *See pages 6-7*

3, 8 — 8.2 Res# 2502003: Approve the Finance February 2025 contract list – *See page 3 resolution sheet & page 8*

3, 9-22 — 8.3 Res# 2502004: Approve the Employee Handbook revisions related to the Earned Sick Time Act – *See page 3 resolution sheet & pages 9-22*

   8.4 Motion on minutes as distributed

BOARD OF DIRECTORS
REGULAR MEETING

Thursday, February 20, 2025 at 5:00 pm
Arenac Center, 1000 West Cedar Street, Standish, MI 48708

AGENDA

Page

9. PROGRAM COMMITTEE, 02/13/2025 – Distributed – Girard, Ch/Mrozinski, V Ch

3, 23-27 9.1 Res# 2502005: Approve the policies ending 30-day review – *See page 3 resolution sheet & pages 23-27*

3, 28-31 9.2 Res# 2502006: Approve the policies beginning 30-day review – *See page 3 resolution sheet & pages 28-31*

3 9.3 Res# 2502007: Approve the requests for clinical privileges – *See page 3 resolution sheet*

9.4 Motion on minutes as distributed

10. AUDIT COMMITTEE, 02/18/2025 – In packet – McFarland, Ch/ Pawlak, V Ch

3, 32-38 10.1 Res# 2502008: Accept financial statements – *See page 3 resolution sheet & pages 32-38*

3, 39-42 10.2 Res# 2502009: Accept electronic fund transfers – *See page 3 resolution sheet & pages 39-42*

3, 43 10.3 Res# 2502010: Approve disbursement & health care claims payments – *See page 3 resolution sheet & page 43*

44-45 10.4 Motion on minutes as presented – *See pages 44-45*

11. REPORT FROM ADMINISTRATION

46-58 11.1 Federal & State Health Policy Update – *See pages 46-58*

59-71 11.2 Bay & Arenac County Updates – *See pages 59-71*

12. UNFINISHED BUSINESS

12.1 None

13. NEW BUSINESS

13.1 Annual Recipient Rights (RR) Training

72 The annual RR training is due no later than March 31, 2025 – *See page 72*

73 13.2 Nomination Committee Meeting

The Nomination Committee has scheduled a meeting for 4:00 pm on Thursday, March 6, 2025 to review the applications to the BABH Board of Directors as a courtesy to the governing Boards of County Commissioners – *See page 73*

14. ADJOURNMENT

BOARD OF DIRECTORS
REGULAR MEETING

Thursday, February 20, 2025 at 5:00 pm
Arenac Center, 1000 West Cedar Street, Standish, MI 48658

RESOLUTIONS

Retirement Resolution, May 20, 2025

Res# 2502001: See separate resolution recognizing Ellen Lesniak on page 4.

Corporate Compliance Committee, February 6, 2025

Res# 2502002: Resolved by Bay Arenac Behavioral Health to approve the 2025 Corporate Compliance Plan.

Finance Committee, February 12, 2025

Res# 2502003: Resolved by Bay Arenac Behavioral Health to approve the Finance February 2025 contract list.

Res# 2502004: Resolved by Bay Arenac Behavioral Health to approve the Employee Handbook revisions regarding the Earned Sick Time Act (ESTA).

Program Committee, February 13, 2025

Res# 2502005: Resolved by Bay Arenac Behavioral Health to approve the following policies to end 30-day review:

a) Prescriber Practice Guidelines for Co-Occurring Mental Health & Substance Use Disorders, 04-24-04 (deletion)
b) Welcoming, 04-24-01 (deletion)

Res# 2502006: Resolved by Bay Arenac Behavioral Health to approve the following policies to begin 30-day review:

a) Cultural Competence & Limited English Proficiency, 07-03-05
b) Targeted Case Management/Support Coordination, 04-05-03 (deletion)

Res# 2502007: Resolved by Bay Arenac Behavioral Health to approve the request for clinical privileges for Ashley Badour, FNP-C, for a three-year term expiring February 28, 2028.

Audit Committee, February 18, 2025

Res# 2502008: Resolved by Bay Arenac Behavioral Health to approve the Financial Statements for period ending January 31, 2025.

Res# 2502009: Resolved by Bay Arenac Behavioral Health to approve the electronic fund transfer (EFTs) for period ending January 31, 2025.

Res# 2502010: Resolved by Bay Arenac Behavioral Health to approve the disbursements and health care payments from January 13, 2025 through February 14, 2025.

BEHAVIORAL HEALTH

RESOLUTION

Board of Directors
Regular Meeting of February 20, 2025

draft

WHEREAS, Ellen Lesniak was employed with Bay-Arenac Behavioral Health Authority's Managed Care Organization as a Finance Manager on December 14, 1998. Ellen Lesniak has served in this role and also as a Senior Financial Analyst until her retirement on September 9, 2024 after over 25 years of dedicated service; and

WHEREAS, the Board appreciates the expertise, dedication, and competence that Ellen Lesniak demonstrated to the agency as evidenced by her pivotal roles in ensuring accurate and timely state reporting, implementation of the organization's first electronic health record and claims processing systems, and in mentoring her staff by providing them the necessary tools and knowledge base to be most successful in their positions. Ellen was essential in ensuring compliance with timely and accurate claims processing, accounts receivables, and provider contract compliance for Bay-Arenac Behavioral Health Authority, including playing a significant role in the Provider Risk Assessment tool and obtaining Medicare incentive payments.

WHEREAS, the Board acknowledges Ellen Lesniak's unwavering commitment to the organization through her positive attitude, honesty, reliability, and most of all her willingness to go above and beyond without hesitation. Ellen has demonstrated exemplary expertise in financial reporting, service delivery, and medical billing requirements over the years and is highly respected by her peers and management of the organization. Ellen has been a leader in the Finance Department for several years and has enhanced processes and compliance that further supports the mission of Bay-Arenac Behavioral Health Authority

THEREFORE, BE IT RESOLVED that the Board of Directors of Bay-Arenac Behavioral Health Authority hereby presents this certificate in recognition of Ellen Lesniak for over 25 years of dedicated service and commitment.

Richard Byrne, Chair

Chris Girard, Secretary

Behavioral Health Center, 201 Mulholland, Bay City, MI 48708

carf INTERNATIONAL

January 31, 2025

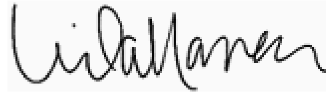
Sarah Holsinger, LMSW
Quality Manager
Bay-Arenac Behavioral Health Authority
201 Mulholland Street, 2nd Floor
Bay City, MI 48708

Dear Mrs. Holsinger:

This letter is to confirm the extension of accreditation for Bay-Arenac Behavioral Health Authority from January 31, 2025 to May 31, 2025 on survey 151303. The organization's survey will be scheduled between April 1, 2025 and May 31, 2025 and the current accreditation will remain in effect until the outcome of the survey is available. The organization should receive its accreditation report and the official level of accreditation award for this resurvey no later than July 31, 2025. Please be advised that this extension will be disregarded when issuing any new expiration date.

If more information is required, please contact me.

Sincerely,



Leila Nassar
Manager, Survey Services
888-281-6531, Extension 7150
lnassar@carf.org

Company 204731
Survey 189755

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

Bay-Arenac Behavioral Health Authority
Estimated Cash and Investment Balances January 31, 2025

Balance January 1, 2025	8,251,674.27
Balance January 31, 2025	6,245,818.15
Average Daily Balance	5,885,708.31
Estimated Actual/Accrued Interest January 2025	16,822.04
Effective Rate of Interest Earning January 2025	3.43%
Estimated Actual/Accrued Interest Fiscal Year to Date	72,844.41
Effective Rate of Interest Earning Fiscal Year to Date	3.58%

Note: The Cash and Investment Balances exclude Payroll and AP related Cash Accounts.

Cash Available - Operating Fund

		Rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Beg. Balance Operating Funds - Cash, Cash equivalents, Investments			7,733,635	3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099
Cash in			4,835,627	19,658,739	13,131,069	13,733,115	3,521,802	21,031,319	18,649,095	11,484,363	12,579,941	20,255,107	13,201,840	11,895,758
Cash out			(9,401,946)	(16,716,214)	(13,094,320)	(14,391,408)	(7,959,163)	(17,914,080)	(16,135,454)	(12,277,820)	(13,159,621)	(16,962,838)	(14,017,688)	(13,903,259)
Ending Balance Operating Fund			3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099	5,777,598
Investments														
Money Markets			3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099	5,777,598
	90.00													
	180.00													
	180.00													
	270.00													
	270.00													
Total Operating Cash, Cash equivalents, Invested			3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099	5,777,598
Average Rate of Return General Funds			4.05%	4.08%	4.08%	4.08%	4.08%	4.08%	4.08%	4.05%	3.70%	3.61%	3.57%	3.50%
			4.10%	4.24%	4.08%	4.05%	4.08%	4.05%	4.08%	3.72%	3.70%	3.52%	3.48%	3.30%
average			6,038,598	6,050,472	6,064,203	5,992,215	5,443,183	5,315,682	5,439,876	5,477,250	5,308,678	6,954,812	7,231,574	6,868,080

Cash Available - Other Restricted Funds

		Rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Beg. Balance-Other Restricted Funds - Cash, Cash equivalents, Investments			446,396	448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575
Cash in			1,773	1,903	1,850	1,919	1,865	1,935	1,943	1,828	1,803	1,675	1,684	1,645
Cash out														
Ending Balance Other Restricted Funds			448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575	468,220
Investments														
Money Market			448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575	468,220
	91.00	0.70%												
	91.00	1.10%												
	91.00	1.15%												
	91.00	1.35%												
	90.00	1.70%												
	91.00	2.05%												
	90.00	2.15%	-	-	-	-	-	-	-	-	-	-	-	-
	365.00	80.00%												
Total Other Restricted Funds			448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575	468,220
Average Rate of Return Other Restricted Funds			5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	4.99%	4.84%	4.84%	4.84%	4.84%
			5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	4.84%	4.84%	4.84%	4.84%	4.84%
average			444,504	445,432	446,359	447,294	448,229	449,170	450,117	451,058	463,216	464,054	464,894	465,725
Total - Bal excludes payroll related cash accounts			3,615,485	6,559,912	6,598,512	5,942,137	1,506,641	4,625,816	7,141,400	6,349,771	5,771,894	9,065,837	8,251,674	6,245,818
Total Average Rate of Return			4.17%	4.20%	4.19%	4.19%	4.18%	4.19%	4.19%	4.17%	3.84%	3.71%	3.63%	3.58%

Bay-Arenac Behavioral Health
Finance Council Board Meeting
Summary of Proposed Contracts
February 12, 2025

			Old Rate	New Rate	Term	Out Clause?	Performance Issues? (Y/N) Risk Assessment Rating (Poor/Fair/Good/Excellent)
SECTION I. SERVICES PROVIDED BY OUTSIDE AGENCIES							
Clinical Services							
1	ES	**DBT Institute of Michigan** Extension of the Single Case Agreement for one BABHA individual	$1,200/day	Same	1/20/25-1/22/25	Y	N
2	N	**7CLingo** ASL Interpretation Services	$0	$125/hour + flat mileage fees depending on the distance	2/21/25 - ongoing	Y	N
3	N	**Maxim Healthcare Services, Inc.** Staffing for PDN services for one BABHA individual	$0	RN - $72.32/hour LPN - $61.44/hour	2/21/25 - 2/21/26 (auto-renews)	Y	New Provider
4	N	**Mercy Plus Healthcare Services** Staffing for PDN services for one BABHA individual	$0	RN - $72.32/hour LPN - $61.44/hour	2/21/25 - 9/30/25	Y	N
5	M	**Bay Human Services, Inc.** Increase the FY24 CLS Contract Maximum	$782,000	$846,265	10/1/23 - 9/30/24	Y	N
6	M	**Rose Hill Center, Inc.** Second BABHA individual moving into Kelly Community Center	$718.28	Same	2/12/25 - 9/30/25	Y	N
SECTION II. SERVICES PROVIDED BY THE BOARD (REVENUE CONTRACTS)							
7	N	**Mid-State Health Network** MOU for Clubhouse Spenddown Project. Funds available to address consumers' spenddown obligations	$0	$20,000	10/1/24 - 9/30/25	Y	N
SECTION III. STATE OF MICHIGAN GRANT CONTRACTS							
SECTION IV. MISC PURCHASES REQUIRING BOARD APPROVAL							
8	S	**Calm, Inc.** Access to mental healht wellness/mindfulness website 175 users	$5,460/year $2.60/user/month	Same	3/3/25-3/2/27	N/A	N
9	D	**The Doctors Company** Professional liability insurance, Dr. Roderick Smith	$5,021	$4,322	2/1/25-2/1/26	N/A	N

R = Renewal with rate increase since previous contract
D = Renewal with rate decrease since previous contract
S = Renewal with same rate as previous contract
ES = Extension

M = Modification
N = New Contract/Provider
NC = New Consumer
T = Termination

Footnotes:

EARNED TIME OFF

22.1 Earned Time Off (ETO)

Earned Time Off (ETO) is provided to all eligible full-time employees of BABHA. ETO is a combined paid leave benefit to be utilized for vacation, ~~sick (including up to 40 cumulative hours for qualifying leave events under the Michigan Paid Medical Leave Act)~~ and personal leave. (Please refer to the Section 22.11 Earned Sick Time Act for paid sick time.) Planned use of ETO is encouraged to assist employees with balancing work and home life. ETO is to be pre-approved by the supervisor whenever possible. The excessive use of unplanned ETO may impact an employee's ability to schedule vacations or take other planned time off.

22.2 Rate of Accrual

Full-time employees currently accrue Earned Time Off (ETO) at the following rate, provided, however, the employee's combination of hours worked and used banked ETO result in at least all scheduled hours being covered. Regular full-time employees working less than forty-(40) hours per week accrue ETO on a pro-rated basis provided, the employee's combination of hours worked and used banked ETO result in at least a pro-rated amount of paid days similar to that of a 40 hour a week employee. Eligible employees who were previously, but no longer, subject to a negotiated CBA shall accrue ETO at the following rate effective January 1, 2020 based on eligible years of service with BABH, as approved by the BABH Board of Directors.

Employees may be eligible to accrue ETO as follows:

First Year	160 hours (20 days)
Years 2-9	232 hours (29 days)
10 or more Years	264 hours (33 days)

22.3 Accumulation of ETO

Accumulation of ETO is limited; that is, the amount carried forward may not exceed eight hundred forty (840) hours. Hours above this amount will be forfeited and are not compensable.

When an employee's continuous length of service reaches a point entitling him/her to the next higher rate of ETO accrual, earning at the new ETO rate will begin with the payroll period that includes his/her date of employment.

Employees shall receive ETO on the basis of their normal work week and at the rate of pay prevailing at the time the ETO is taken.

The amount of ETO available for use ~~will be reflected on the employee's most recent pay stub~~ is available to view in the time and attendance system.

22.4 Probationary Period

Probationary employees shall accrue ETO as outlined in "Rate of Accrual" above.

22.5 Temporary

Temporary employees shall not be entitled to ETO.

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22.6 Separation

Currently, upon retirement, death, layoff, or voluntary resignation, eligible employees shall be compensated for any accrued ETO hours at the rate prevailing on the employee's last working day. Effective October 1, 2018, eligible employees will receive payout of 50% of accrued ETO at voluntary separation (non-retirement) as long as 30 day written notice of resignation is received. Eligible employees retiring under the terms and conditions of Bay-Arenac Behavioral Health and the Bay County Employees' Retirement System, layoff or death will receive 100% payout of accrued ETO. Payment of ETO upon voluntary resignation or retirement is further contingent upon the employee's return of all agency property issued to, or in the possession of the employee, including, but not limited to, keys, ID badge, computer equipment, cell phone, etc. ETO is not authorized once notice of resignation is made unless pre-approved prior to notice of resignation and/or the employee provides verification of incapacity to perform work from a physician**.** Employees who are discharged are not eligible for payout of accrued ETO. Terminal ETO shall not be added to an employee's length of service.

Failure to return all agency issued property at the time of separation will be considered theft and will be reported to the local police department.

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22.7 Holiday

If an observed holiday falls within an employee's ETO, it shall not be counted as an ETO day unless the employee was scheduled to work on a holiday.

22.8 Leave of Absence

ETO shall not accrue during periods of leave of absence.

22.9 ETO Schedules

ETO schedules for employees shall be developed and approved by his/her Supervisor. Each supervisor shall schedule ETO over as wide a period as possible in order to maintain required services. Employees are to seek written pre-approval from their immediate supervisor prior to scheduling time off. ETO may be taken in increments of one-quarter (1/4) hour with advance approval of the supervisor. (Banked ETO must be utilized prior to requesting leave without pay.) ETO requests are not guaranteed and may be denied based on program need and/or outstanding work assignments.

Employees who request leave without pay must submit their request, including reasons for the request, through the chain of command to the Chief Executive Officer for approval. Denial of the request and/or the use of leave without pay due to poor attendance will subject the employee to disciplinary action as referenced within this handbook.

22.10 Verification of Illness

a) Eligible employees may ~~Utilization of~~ utilize ETO due to illness if the employee has exhausted ESTA hours or does not have accrued ESTA available ~~may require verification from a physician as determined by the Employer~~.

~~b) An employee who is unable to work more than five (5) consecutive scheduled workdays must present a physician's release to return to his/her regular job duties.~~

~~c)~~b) In the absence of available ESTA, ~~-~~ETO may be used for injury or illness of an employee or a member of his/her immediate family that necessitates his/her absence from work. Immediate family is defined in the ESTA and FMLA sections of the Employee Handbook. ~~as the employee's spouse, parents, children, or other current family members for whom the~~

~~employee is principally responsible for their financial/physical care.~~ ETO may also be utilized for appointments with doctors, dentists, or other recognized practitioners to the extent of time required to complete such appointments in the absence of available ESTA.

~~d)~~c) Employees returning to work from an illness or leave of absence of more than three (3) days may be required by his/her department head to submit a statement from his/her physician qualifying his/her ability to work or to verify the illness.

~~e) Personnel taking ETO on their last scheduled day of work before a holiday and/or ETO, on their first scheduled day after a holiday or ETO, may be required to submit a statement from their physician verifying the illness. It shall be the employee's responsibility to check with his/her department head when calling in to determine if the statement is necessary.~~

~~f)~~d) ~~In the event of a dispute involving an employee's physical or mental ability to perform his/her job or to return to work after a leave of absence of any kind and the Employer is not satisfied with the determination of the employee's doctor, the Employer may require a report from a medical doctor of the Employer's choosing at the Employer's expense if not covered by the employee's insurance. If the dispute still exists, the Employer's doctor and the employee's doctor shall agree on a third doctor to submit a report to the Employer and the employee. Any expense of the third doctor shall be borne equally by the Employer and the employee, if not covered by the employee's health insurance~~.

~~**22.11 Paid Medical Leave Act Leave**~~

~~Eligible Employees as defined under the Michigan Paid Medical Leave Act, 2018 PA 369 (the "MPML Act"), who are not eligible for ETO under this Policy may be eligible to receive paid medical leave as provided and required by the MPML Act. Posters from the Department of Licensing and Regulatory Affairs have been posted by the BABHA, setting forth the eligibility requirements, medical leave rights and remedies under the MPML Act. This may currently include certain regular part-time BABHA employees who work twenty-five (25) hours per week on average, but are who are not eligible for ETO as defined in this Policy. In addition, the following parameters apply to MPML Act paid medical leave:~~

~~a. MPML Act paid medical leave may only be taken by eligible employees for the reasons set forth in the MPML Act. BABHA employees eligible to participate in ETO are not eligible for additional MPML Act paid medical leave, even if ETO leave has been exhausted by the employee;~~

~~b. Eligible Employees shall accrue MPML Act paid medical leave at the rate of one (1) hour for every thirty-five (35) hours worked for a maximum cumulative accrual of one (1) hour per week and forty (40) hours during the benefit year. Accumulation of MPML Act paid medical leave is limited; that is, the amount carried forward may not exceed forty (40) hours. Hours above this amount will be forfeited and are not compensable. MPML Act paid medical leave is not compensable upon separation of employment;~~

~~c. Newly hired Eligible Employees may utilize accrued MPML Act paid medical leave as it is reflected on the employee's most recent pay stub.~~

~~d. MPML Act paid medical leave must be used in fifteen minute increments; and,~~

~~e. Eligible Employees who request MPML Act paid medical leave must submit a request to their immediate supervisor or designee, including reasons for the request.~~

DRAFT

~~Utilization of MPML Act paid medical leave due to qualifying illness may require verification from a physician as determined by BABHA and is subject to the provisions of Sections 22.10(a) (b), (d) and/or (e) of this Policy. Eligible Employees will be provided no less than three days to provide such documentation.~~

22.11 Earned Sick Time Act (ESTA)

Effective February 21, 2025 all employees, including full-time, part-time, seasonal, and temporary workers are eligible to accrue paid sick time. Employees will accrue one (1) hour of paid sick, time for every 30 hours worked. Current employees may begin using their accrued paid sick time as it accrues. Employees hired after February 21, 2025 may not begin using their accrued sick time until the ninetieth (90) calendar day after commencing their employment with BABH.

a. Employees who are exempt from the overtime pay requirements of the Fair Labor Standards Act, 29 USC 213(a)(1), are assumed to work forty (40) hours per week unless the employee's normal work week is less than forty (40) hours, in which case earned sick leave time accrues based upon that normal work week.

b. When requesting the use of sick time, employees should provide sufficient information for the employer to determine whether the leave meets the eligible uses of the ESTA.

c. Employees can use earned sick time for any of the following reasons:

1. The employee's mental or physical illness, injury or health condition; medical diagnosis, care or treatment of the employee's mental or physical illness, injury, or health condition; or preventative medical care for the employee.

2. For the employee's family member's mental or physical illness, injury, or health condition; medical diagnosis, care or treatment of the employee's family members' mental or physical illness, injury or health condition; or preventive medical care for a family member of the employee.

3. If the employee or the employee's family member is a victim of domestic violence or sexual assault, for medical care or psychological or other counseling for physical or psychological injury or disability; to obtain services from a victim services organization; to relocate due to domestic violence or sexual assault; to obtain legal services; or to participate in any civil or criminal proceedings related to or resulting from the domestic violence or sexual assault.

4. For meetings at a child's school or place of care related to the child's health or disability, or the effects of domestic violence or sexual assault on the child; or

5. For the closure of the employee's place of business by order of a public official due to a public health emergency; for an employee's need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency; or when it has been determined by the health authorities having jurisdiction or by a health care provider that the employee's or employee's family member's presence in the community would jeopardize the health of others because of the employee's or family member's exposure to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease.

DRAFT

d. For the purposes of this policy, "family member" includes all the following:

1. Biological, adopted or foster child, stepchild, or legal ward, a child of a domestic partner, or a child to whom the employee stands in loco parentis.

2. Biological parent, foster parent, stepparent, or adoptive parent or a legal guardian of an employee or an employee's spouse or domestic partner or a person who stood in loco parentis when the employee was a minor child.

3. A person to whom the employee is legally married under the laws of any state or a domestic partner.

4. A grand parent.

5. A grandchild.

6. A biological, foster or adopted sibling.

7. Any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

e. For earned sick leave of more than three consecutive days, the employer may require reasonable documentation that the earned sick leave has been used for a permissible purpose. Upon request, the employee must provide this documentation in a timely manner.

1. Employer required documentation should not include a description of the illness or details of the violence.

   a. Documentation signed by a health care professional indicating that earned sick time is necessary is reasonable documentation for purposes of this subsection. Documentation providing details of the nature of the illness is not required.

   b. In cases of domestic violence or sexual assault, one of the following types of documentation selected by the employee shall be considered reasonable documentation:

      i. a police report indicating that the employee or the employee's family member was a victim of domestic violence or sexual assault;

      ii. a signed statement from a victim and witness advocate affirming that the employee or employee's family member is receiving services from a victim services organization; or

      iii. a court document indicating that the employee or employee's family member is involved in legal action related to domestic violence or sexual assault.

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2. If the employer requires documentation, the employer is responsible for paying all out-of-pocket expenses the employee incurs in obtaining the documentation.

3. Commencement of use of sick time will not be delayed while awaiting documentation.

e. Unused, accrued paid sick time will be carried over into the next benefit year without a maximum. However, only a maximum of 72 hours of accrued sick time can be used in a calendar year (January 1st – December 31st). Sick time will be paid at the employee's regular rate of pay. If any employee is paid for sick leave which is subsequently denied, the overpayment may, as permitted by law, be deducted from the employee's next paycheck and/or future paychecks.

f. All unused, accrued sick time will be forfeited at the time of separation (unless the employee is reinstated within 6 months).

g. The use of paid sick leave must be approved by the employee's supervisor. Employees are asked to provide notice no more than 7 days in advance but no less than one hour before your scheduled start time, if they are aware of the need to use sick time if the absence is foreseeable. If the need for sick time is not foreseeable, notification should occur as soon as reasonably practicable. If the employee's absence due to illness or injury exceeds the amount of accrued paid sick leave, the employee must seek and obtain approval for other leave such as Family Medical Leave or ETO.

h. Employees will not be penalized or retaliated against in any way for requesting or using accrued paid sick time for the purposes designated above. Retaliatory actions against an employee for requesting or using paid sick leave time is prohibited. If an employee believes that the Employer has violated this Policy, that employee may bring a civil action or file a complaint with the Michigan Department of Licensing and Regulatory Affairs.

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Additional Sections requiring revision due to the Earned Sick Time Act:

CONTINUOUS LENGTH OF SERVICE

9.1 Definition

Continuous length of service for a Bay-Arenac Behavioral Health employee is that period of employment with the agency that is continuous and unbroken. However, length of service may be defined differently by action of the Board of Directors, or applicable benefit plan document, or as required or approved as to eligibility for wages or fringe benefit programs.

Continuous service is not recognized until the employee attains the status of a regular employee, at which time his/her length of service shall include the period of his/her probationary period.

Regular part-time employees are given half credit for continuous length of service if it immediately precedes regular full-time employment regardless of the number of hours actually worked. Regular full-time service is given full credit towards regular part-time service.

Time spent on approved paid leaves of absence shall be included in continuous length of service.

Continuous length of service for layoff purposes does not continue to accrue if the employee is on workers' compensation, Family and Medical Leave, disability leave [Short-Term Disability (STD) and Long-Term Disability (LTD)] or any unpaid leave. Earned Sick Time (ESTA) and Earned Time Off (ETO) will not accrue during such leaves.

9.2 Resignation

To be eligible for payment of accrued ETO, employees who intend to resign must provide their supervisor with at least thirty (30) calendar days written notice of their intention to resign. Resigning employees must provide the required thirty (30) calendar days written notice and must return all agency property issued to them or in their possession, including keys, ID badge, computer equipment, cell phone, etc., to be entitled to any payment of accrued ETO. Effective October 1, 2018, eligible employees voluntarily separating (non-retirement) will receive payment of 50% of accrued ETO as long as required thirty (30) calendar days written notice of resignation is received and all agency issued property is returned. ETO is not authorized once notice of resignation is made unless pre-approved prior to notice of resignation and/or the employee provides verification of incapacity to perform work from a physician**.** The Chief Executive Officer may waive the thirty (30) day notice requirement. All unused, accrued Earned Sick Time (ESTA) will not be paid out at the time of separation.

16.17 Overtime

Non-exempt employees of Bay-Arenac Behavioral Health that are subject to the overtime provisions of the Fair Labor Standards Act ("FLSA") shall be paid overtime compensation at the rate of time and one-half (1-1/2) of regular rate of pay for all hours actually worked in excess of forty (40) hours worked in a work week. (Workweek is defined as seven (7) consecutive twenty-four hour periods from Monday through Sunday). If ETO, ESTA, or paid holidays are included in the payroll week during which overtime is worked, ETO and/or ESTA will be adjusted and may be banked. Overtime pay is only authorized for hours **actually** worked in excess of forty (40) per week. Overtime work must receive prior authorization by the appropriate

supervisor/CEO. Employees that are exempt from the overtime provisions of the ("FLSA") are not eligible for, and will not receive, overtime pay as defined here.
All overtime work must receive prior authorization by the appropriate supervisor. All emergencies or unforeseen problems resulting in overtime must be reported to the appropriate supervisor and CEO for approval on the following workday.

Salary exempt employees are not entitled to overtime pay.

16.22 Agency Closure

In the event that BABH closes due to inclement weather or other unforeseen circumstances, employees who are actively working will be compensated through the end of their regularly scheduled shift. This time will be recorded as "weather" on the time sheet.

Employees in 24/7 operations who are required to work regardless of whether the agency closes will be compensated for actual hours worked. Such employees will bank earned time off (ETO) for the time worked through the duration of the weather closure.

Employees who are on approved ETO or ESTA on a day that the agency closes will be paid ETO or ESTA hours as scheduled.

If it is pre-announced that Bay-Arenac Behavioral Health is closed and staff are instructed not to report to work, employees will receive compensation for their full scheduled shift. This time is recorded under "weather" on the time sheet.

18.5 Time Worked

All agency personnel are required to begin work at their scheduled starting time and continue to their scheduled quitting time. For FLSA non-exempt employees, time late or the time involved in the case of early quit (except for sickness or other supervisor approved leave) shall not be paid as hours worked or by any other benefit. Tardiness or absenteeism will not be tolerated. The use of planned and unplanned leave will be monitored by the supervisor. Planned leave is defined as leave requested and approved with at least twenty-four (24) hours of advance notice. Excessive use of unplanned leave will result in disciplinary action, up to and including discharge from employment.

Employees classified as an exempt salaried employee will receive a salary which is intended to compensate the employee for all hours worked for BABH. This salary will be established at the time of hire or when the employee becomes classified as an exempt employee. While it may be subject to review and modification from time to time, such as during salary review times, the salary will be a predetermined amount that will not be subject to deductions based on the quantity or quality of the work performed.

Under federal and state law, an employee's salary is subject to certain deductions. Deductions may be taken from an exempt employee's salary as permitted or required by law. This would include, but is not limited to, the employee portion of health, vision, dental or life insurance premiums; state, federal or local taxes; social security; Bay County Employees' Retirement System; legal garnishments; and voluntary contributions to a retirement plan.

In addition, unless state law requires otherwise, an employee's salary can be reduced for the following reasons:

- When an exempt employee is absent from work for one or more full days for personal

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reasons other than sickness or disability;

- When an exempt employee is absent for one or more full days due to sickness or disability if the deduction is made in accordance with a bona fide plan, policy or practice of providing compensation for salary lost due to illness (ETO/ESTA);
- When an exempt employee does not perform any work during a workweek;
- For unpaid disciplinary suspensions of one or more full days imposed in good faith for workplace conduct rule infractions of major significance;
- For penalties imposed in good faith for infractions of safety rules of major significance;
- For weeks in which an exempt employee takes unpaid leave under the Family and Medical Leave Act; and
- An employer is not required to pay the full salary in the initial or terminal week of employment. In these circumstances, either partial day or full day deductions may be made.

If an exempt employee believes he/she has been subject to any improper deductions, he/she should immediately report the matter to Human Resources. Reports of improper deductions will be promptly investigated. If it is determined that an improper deduction has occurred, the employee will be promptly reimbursed for any improper deduction made.

20.9 Workers' Compensation

BABH provides workers' compensation coverage as provided by Michigan State statute. FMLA runs concurrently with an employee's Workers Compensation time off the job. The affected employee must report all on-the-job injuries on the appropriate form by the end of the workday of the alleged injury. Failure to properly report an injury may disqualify an employee for benefits. The injured employee's supervisor shall forward the accident report to the Human Resources Director with a copy to the respective designated manager or department head immediately upon receipt. The supervisor is responsible for assuring that all witnesses receive and complete the accident investigation report.

Examination: If the injured employee requires or requests medical attention, the supervisor shall contact Human Resources to make immediate arrangements for the employee to be evaluated and treated, if necessary, by the medical authority designated by the Board.

Pay Status: An employee who is injured during the course of his/her employment shall be paid for all hours scheduled to work on the date of the injury. If the employee is unable to work, workers' compensation shall begin on the eighth calendar day from the date of injury/illness. The first seven (7) calendar days, or five (5) workdays, subsequent to the date of the injury shall be subject to Earned Time Off or Earned Sick Time (ESTA), if requested by the employee.

If the injured employee is unable to work for fourteen (14) calendar days following his/her accident, workers' compensation shall be made retroactive to the first full day of absence. If such occurs and the employee received pay for any of the five (5) working days subsequent to the date of injury, his/her leave time will be reinstated to be utilized at a later date and his/her paycheck will be reduced accordingly.

The employee shall remain in communication with the employer concerning the nature of the disability and expected date of return. The employee will not be permitted to return to work without medical evidence of his/her ability to do so.

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Health insurance shall continue for one (1) year for non-probationary employees and three (3) months for probationary employees when they are receiving workers' compensation benefits. During this time, the Employer portion of premium may continue at agency expense. The employee continues to be responsible for their employee share of monthly premium. No other benefits, including ETO and ESTA, shall accrue or continue.

LEAVE OF ABSENCE

24.1 Procedure

All leaves of absence shall be without pay unless otherwise provided herein. Employees shall submit requests for leaves of absence to the department head who shall have disapproval authority. If the department head desires to secure approval of the request, it shall be forwarded to the Chief Executive Officer (CEO) for consideration.

24.2 Approval

All leaves of absence must be requested from and approved by the CEO.

24.3 Family and Medical Leave

It is intended that the Employer's policy concerning leaves of absence will comply with the Family and Medical Leave Act of 1993 (FMLA).

1. FMLA Leave. An eligible employee who has completed twelve (12) months of employment and worked at least 1250 hours in the past twelve (12) months may request an unpaid leave of absence for a period not to exceed twelve (12) weeks in any twelve (12) month period measured forward from the date the employee's first FMLA leave begins. The Employer reserves the right to place an employee on FMLA leave for absence related to the conditions set forth below. Unless leave is taken for the employee's own serious health condition, the total leave taken by spouses both employed by the Employer is limited to twelve (12) weeks. Employees are required to complete FMLA paperwork for any leave (paid or unpaid) related to the reasons below.

   The request must be in writing, must give the reason for the request and must give the expected duration of the leave. The leave may be taken for the following reasons:

   a. A serious health condition that makes the employee unable to perform the functions of his/her position;

   b. In order to care for the employee's spouse, child or parent if the person being cared for has a serious health condition;

   c. Because of the birth of a child of the employee and in order to care for the child within twelve (12) months of the child's birth;

   d. Because of the placement of a child with the employee for adoption or foster care and in order to care for the child within twelve (12) months of the child's placement;

   e. For any "qualifying exigency" (as defined by the Secretary of Labor)

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arising out of the fact that the spouse, son, daughter or parent of any employee is on active duty (or has been notified of an impending call order to active duty) in the Armed Forces in support of a contingency operation.

f. To care for a covered family member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grade, rank or rating.

2. Qualified employees may request a single leave of up to a total of 26 weeks of Family and Medical Leave for the following reason:

   If the employee is a spouse, son, daughter, parent or next of kin of a covered service member and requires leave to care for a "covered service member" who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

   a. A "covered service member" is a member of the Armed Forces, including the National Guard and Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for an injury or illness incurred by the member in the line of duty <u>on active duty</u> that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

   b. "Next of kin" is defined as the closest blood relative of the injured or recovering service member. "Next of kin" may include (1) un-remarried surviving spouses; (2) natural and adopted children; (3) parents; (4) remarried surviving spouses (except those who obtained a divorce from the service member or who remarried before a finding of death by the military); (5) blood or adoptive relatives who have been granted legal custody of the service member by court decree or statutory provisions; (6) brothers or sisters; (7) grandparents; (8) other relatives of legal age in order of relationship to the individual according to the civil laws; or (9) persons standing in loco parentis to the service member.

   c. The leave provided under this provision is combined with that set forth above, for a combined total of 26 weeks of FMLA leave during a single 12-month period. This means that if an employee also has some other FMLA-qualifying even in that 12-month period (for example, birth of a child, or the employee's own serious health condition), his or her total amount of FMLA leave during that 12-month period is still limited to 26 weeks. This also means that even if the service member's recovery lasts longer than the initial 12 months, the 26 weeks of service member FMLA cannot be "renewed", and the employee would not be eligible for an additional 26 weeks of service member FMLA in the following 12-month period.

   BABH may require a certification by the service member's health care provider.

3. Intermittent Leave. Unless the Employer agrees, leave for the birth or placement of the employee's child, or to care for the child within twelve (12) months of the child's birth or

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placement, may not be taken intermittently or on a reduced leave schedule. If medically necessary, leave for the employee's serious health condition or to care for a seriously ill spouse, child or parent may be taken intermittently or on a reduced leave schedule.

4. Substitution of Paid Leave. Prior to taking unpaid leave, employees must use Earned Sickt Time (ESTA) or Earned Time Off (ETO) for leave taken for the employee's serious health condition or to care for a seriously ill spouse, child or parent. Prior to taking unpaid leave, an employee must use ESTA or ETO for leave taken for the birth or placement of the employee's child, or to care for the child within twelve (12) months of the child's birth or placement. The use of paid leave will not extend an employee's FMLA entitlement. When an employee is eligible to and is approved to receive paid disability leave the employee may not be required to substitute paid leave in accordance with disability policy statements.

5. Scheduling and Notice by Employees. When leave is taken for the birth or placement of the employee's child or to care for the child within twelve (12) months of the child's birth or placement, and the leave is foreseeable based on the expected birth or placement, the employee must provide not less than thirty (30) days' notice before the date the leave is to begin. If the date of the birth or placement requires the leave to begin in less than thirty-(30) days, the employee must provide such notice as is practicable.

   When leave is taken for the employee's serious health condition, or to care for a seriously-ill spouse, child or parent, and the leave is foreseeable based on planned medical treatment, the employee must make a reasonable effort to schedule the treatment so as not to unduly disrupt the employer's operations. The employee must provide not less than thirty (30) days' notice before the date the leave is to begin. If the date of treatment requires leave to begin in less than thirty-(30) days, the employee must provide such notice as is practicable.

6. Medical Certification. When leave is taken for the employee's serious health condition, or to care for a seriously-ill spouse, child or parent, the Employer will require certification issued by the health care provider of the employee or of the spouse, child or parent of the employee, as appropriate. This certification must include the date the condition began, its probable duration, appropriate medical facts within the knowledge of the health care provider regarding the condition, and a statement that the employee is unable to perform his/her job function or is needed to care for a sick family member for a specified time.

   For leave taken intermittently or on a reduced leave schedule, further certification requirements are as follows:

   a. When there is planned medical treatment, the certification must include the dates on which treatment is expected and its duration.

   b. When leave is taken for the employee's serious health condition, the certification must include a statement of the medical treatment necessary for such leave and its expected duration.

   c. When leave is taken to care for a seriously ill family member, the certification must include a statement that such leave is necessary for the care of the family

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member who has a serious health condition or will assist in his/her recovery, and the expected duration and schedule of the leave.

7. Second and Third Opinions; Recertification. The Employer may require, at its own expense if not covered by insurance, a second medical opinion from a health care provider designated by the Employer, but not employed on a regular basis by the Employer. In the event of a dispute concerning the second certification, the Employer may require, at its own expense if not covered by insurance, a third opinion from a health care provider. The employee and Employer must agree on the selection of the third health care provider whose opinion is binding on both parties. The Employer may require that the employee obtain subsequent recertification on a reasonable basis.

8. Benefits During Leave. The Employer will continue to pay the Employer's portion of an employee's health insurance premiums for an eligible employee during the period the employee is on leave for any of the reasons under Subsections 1(a)-1(f) above. The employee shall be responsible to pay his/her portion, if applicable, of health insurance premiums during the period the employee is on leave for any of the reasons under FMLA Subsections a-f above. If an employee's health insurance premium payment is more than 30 days late, the Employer upon 15 days' notice to the employee may cease to continue the employee's health insurance coverage if the employee does not pay his/her portion of health insurance premium prior to the specific time. The employee will not accumulate ETO, nor be paid for holidays that may fall during the period of unpaid leave. If the employee fails to return after the leave has expired due to circumstances within the employee's control, the Employer may recover from the employee any premiums that the Employer paid to maintain medical coverage during the leave.

9. Return Rights. Upon return from a leave taken for a reason listed under Subsection 1(a)-1(e) above, the employee will be returned to his/her former position or to a position equivalent in pay, benefits, and other terms and conditions of employment. In all other circumstances, the employee is not guaranteed that he/she will be restored to his/her former position or to an equivalent position. The decision will be at the discretion of the Employer.

24.4 Military Leave

The agency shall observe the provisions of the federal and state law regarding re-employment rights and leaves of absence in accordance with federal and state statutes.

24.5 Bereavement Leave

In the event of a death in the employee's immediate family (spouse, significant other, child, step-child, parent, step-parent, parent-in-law, grandparent, grandchild, son-in-law, daughter-in-law, brother or sister) an employee shall be allowed three (3) days off, one of which should be the day of the service, if scheduled on a normal work day, without loss of pay.

The Chief Executive Officer may authorize up to two (2) additional days of leave with pay if circumstances such as extensive travel require the employee to be absent. Extensive travel is defined as any distance over 300 miles one-way.

Bereavement leave is authorized for full-time and part-time employees

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24.6 Jury/Witness Leave

A regular full-time and regular part-time employee who is summoned for jury duty, or who is subpoenaed as a witness to testify as to matters directly related to the employee's work for the agency, are eligible for jury/witness leave. Employees on jury/witness leave shall receive their regular scheduled pay and shall surrender the proceeds of their remuneration from the Court, except travel reimbursement, for those scheduled days of work.

To be eligible for jury/witness leave pay, the employee must give their supervisor, service director, and CEO advance written notice that he/she has been summoned or subpoenaed. After the trial, must provide the CEO with a written statement from the appropriate public official listing the dates the employee was required to serve on jury duty, or as a witness, and the amount of pay received for such service at those times. If a partial day is served, the employee must report to work for the remainder of the day.

24.7 Administrative Leave

An employee may be granted administrative leave not covered by the FMLA or other leave sections noted hereunder, at the Chief Executive Officer's sole discretion, for a period of up to one (1) year without pay and benefits (including health insurance). An eligible regular employee who has been granted a leave may not request a subsequent leave during the same calendar year and/or until 365 days after expiration of the expiration of the previously granted administrative leave.

All such leaves shall be specific in their duration and purpose.

Employees may not engage in gainful employment during an administrative leave, or any other authorized leave of absence granted by the agency, without prior written approval of the Chief Executive Officer.

Employees engaged in gainful employment during leaves of absence, without prior written approval of the Chief Executive Officer, will be considered voluntarily resigned.

24.8 Benefits

All personal leaves of absence shall be without pay and benefits. Employees may continue insurance coverage at their own expense during a personal leave of absence. An employee will not accumulate ETO, nor will be paid for holidays which may fall during the leave period.

24.9 Return from Leave of Absence

When granted a leave of absence, the employee commits himself/herself to returning to work immediately at the end of the leave. If an employee fails to return to work immediately at the expiration of a leave of absence or extension thereof, the failure to return shall be considered a resignation from agency employment.

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BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	Care and Treatment		
Section: 24	Co-Occurring Disorders		
Topic: 4	Prescriber Practice Guidelines for Co-Occurring Mental Health and Substance Use Disorders		
Page: 1 of 6	Supersedes Date: Pol: Proc:	Approval Date: Pol: 3-17-11 Proc: 3-17-11	______________________________B *oard Chairperson Signature* ______________________________ *Chief Executive Officer Signature*
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 1/8/2025. For controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to publish prescriber practice guidelines for the treatment of persons with co-occurring mental health and substance abuse disorders.

Purpose

This policy and procedure was developed to educate psychiatric providers including psychiatrists, physician assistants, nurse practitioners and nurses about agency endorsed prescriber practice guidelines concerning the treatment of persons with co-occurring mental health and substance use disorders.

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: Psychiatrists and Agency Nurses - Clinical
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Psychiatrists, Physician Assistants, Nurse Practitioners, and Clinical Nurses
☐ Policy Only ☒ Policy and Procedure
☐ Other:

Deletion

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment**		
Section: 24	**Co-Occurring Disorders**		
Topic: 4	**Prescriber Practice Guidelines for Co-Occurring Mental Health and Substance Use Disorders**		
Page: 2 of 6	**Supersedes Date:** **Pol:** **Proc:**	**Approval Date:** **Pol: 3-17-11** **Proc: 3-17-11**	______________________________***B*** ***oard Chairperson Signature*** ______________________________ ***Chief Executive Officer Signature***
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SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/COMMITTEE/ SUPERVISOR	APPROVAL /REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
M. Swank	CLT	01/10/11	New	
K. Withrow	M. Swank	07/01/13	Revision	Triennial review: Updated with Person First Language and deleted obsolete information
J. Hahn	J. Hahn	10/1/18	No changes	Triennial Review
J. Hahn	J. Hahn	10/10/2021	No Change	Triennial review
J. Hahn	J. Hahn	12/26/24	Deletion	No longer needed as co-occurring treatment has been embedded into behavioral health treatment philosophy and education for the past several years.

Deletion

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment**		
Section: 24	**Co-Occurring Disorders**		
Topic: 1	**Welcoming**		
Page: 1 of 2	**Supersedes Date:** **Pol: 2-15-07** **Proc: 10-12-10, 12-21-09, 10-20-09, 2-15-07**	**Approval Date:** **Pol: 10-17-13** **Proc: 8-15-13**	___________________ *Board Chairperson Signature* ___________________ *Chief Executive Officer Signature*
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DO NOT WRITE IN SHADED AREA ABOVE

Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to coordinate comprehensive, competent, seamless, ongoing, and recovery-oriented care for individuals with co-occurring disorders.

Purpose

This policy and procedure was developed to guide the provision of care for mental health and substance use disorders (SUD) to the residents of Bay and Arenac Counties.

Education Applies to

☒ All BABHA Staff
☐ Selected BABHA Staff as follows:
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contract Providers, as follows:
    ☐ Policy Only ☐ Policy and Procedures
☐ Other

Deletion

SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL /REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
M. Wolber	M. Swank	10/20/09	Revision	Updated to incorporate Kardex information on substance use, possession, selling, etc.
M. Wolber	CLT	12/21/09	Revision	Updated to include visitors
K. Withrow	CLT	10/12/10	Revision	Updated with People First language

Chapter: 4	Care and Treatment		
Section: 24	Co-Occurring Disorders		
Topic: 1	Welcoming		
Page: 2 of 2	Supersedes Date: Pol: 2-15-07 Proc: 10-12-10, 12-21-09, 10-20-09, 2-15-07	Approval Date: Pol: 10-17-13 Proc: 8-15-13	___________________ *Board Chairperson Signature* ___________________ *Chief Executive Officer Signature*
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K. Withrow	PNLT	08/15/13	Revision	Triennial Review: Updated with Person First Language and language promoting recovery.
J. Hahn	J. Hahn	10/1/18	No changes	Triennial review
J. Hahn	J. Hahn	10/10/21	No Change	Triennial review
J. Hahn	J. Hahn	12/26/24	Deletion	Incorporated into C04-S05-T06 Recovery Oriented System of Care

Deletion

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 7	**Human Resources**		
Section: 3	**Education**		
Topic: 5	**Cultural Competence and Limited English Proficiency**		
Page: 1 of 2	**Supersedes Date:** **Pol: 5-15-03, 6-20-00, 3-16-00,** **Proc: 5-31-16, 5-14-15, 6-24-09, 4 3-20-08,** **3-19-03, 6-20-02, 8-11-00** (previously C3-S9-T1)	**Approval Date:** **Pol: 3-20-08** **Proc: 10-21-19**	_______________ *Board Chairperson Signature* _______________ *Chief Executive Officer Signature*
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) that behavioral health services be available and provided to all persons living in Bay and Arenac Counties by staff who demonstrate cultural competence and recognize the need for accommodations when providing services to individuals. As part of this commitment BABHA recognizes the importance of addressing the implicit biases of the organization and its personnel, in order to continue to move the organization forward with recognizing and respecting diversity. All direct operated and contracted programs will abide by LEP guidelines and will provide an augmentative communication specialist, voice interpreter, and translation services whenever needed, at no cost to individuals (see BABHA Policy and Procedure C04-S07-T35 – Accommodations for Communication Services).

Purpose

This policy and procedure is established to ensure that staff have the understanding and skills to work effectively in cross-cultural situations and with individuals who have Limited English Proficiency (LEP).

Education Applies to

☒ All BABHA Staff
☐ Selected BABHA Staff, as follows:
☒ All Contracted Providers: ☒ Policy Only ☐ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure
☐ BABHA's Affiliates: ☐ Policy Only ☐ Policy and Procedure
☐ Other:

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 7	Human Resources		
Section: 3	Education		
Topic: 5	Cultural Competence and Limited English Proficiency		
Page: 2 of 2	Supersedes Date: Pol: 5-15-03, 6-20-00, 3-16-00, Proc: 5-31-16, 5-14-15, 6-24-09, 4 3-20-08, 3-19-03, 6-20-02, 8-11-00 (previously C3-S9-T1)	Approval Date: Pol: 3-20-08 Proc: 10-21-19	______________ *Board Chairperson Signature* ______________ *Chief Executive Officer Signature*
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SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL /REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
M. Wolber	J. Pinter	02/06/08	Revision	Removal of PIHP language and change from Braille to audio for visually impaired persons served.
M. Wolber	C. Pinter	04/27/09	Revision	Policy and procedure needs updating in regards to cultural competence and LEP
M. Wolber	J. Pinter	06/24/09	Revision	Procedure updated to reflect current practices and appointments to Board of Directors
Rebecca Smith	Rebecca Smith	05/31/13	No Changes	Triennial review
Kim Cereske	Melissa Prusi	05/14/15		
Kim Cereske	Melissa Prusi	05/31/16	No Changes	Triennial review
Rebecca Smith		10/21/19	Revision	Triennial review
T. Dilley	J. Lasceski	4/11/22	Revison	Triennial review; added implicit bias and updated to current practice.
B. Beck/J. Lasceski	J. Lasceski	1/21/2025	Revision	Added Implicit bias and updated to current practice. This P&P in error did not get sent to board for approval of updates in 2022. Sending to Feb. 2024 board mtg for approval

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	Care and Treatment Services		
Section: 5	Person Centered Planning		
Topic: 3	Targeted Case Management/Support Coordination		
Page: 1 of 2	Supersedes Date: Pol: 3-18-04 Proc: 8-20-18, 8-29-13, 5-20-11, 3-21-11, 2-15-10, 11-11-09, 4-16-09, 7/28/98	Approval Date: Pol: 5-20-11 Proc: 6-18-2021	____________________ *Board Chairperson Signature* ____________________ *Chief Executive Officer Signature*
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) that Client Service Specialists and Clinical Specialists assist recipients through the Person-Centered Planning process.

Purpose

This policy and procedure was developed to define Client Service Specialists (CSS) and Clinical Specialists (CS).

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: All Clinical and Clinical Provider Supervisors
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Primary Care/Outpatient
☐ Policy Only ☒ Policy and Procedure

☐ Other:

1.

Deletion

Chapter: 4	**Care and Treatment Services**
Section: 5	**Person Centered Planning**
Topic: 3	**Targeted Case Management/Support Coordination**

Page: 2 of 2	**Supersedes Date:** **Pol: 3-18-04** **Proc: 8-20-18, 8-29-13, 5-20-11, 3-21-11, 2-15-10, 11-11-09, 4-16-09, 7/28/98**	**Approval Date:** **Pol: 5-20-11** **Proc: 6-18-2021**	______________ ***Board Chairperson Signature*** ______________ ***Chief Executive Officer Signature***

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SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL /REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
M. Swank	G. Lesley	11/11/09	Revision	Updated P&P to give emphasis to the importance of recovery and wellness
M. Swank	CLT	02/15/10	Revision	Updated P&P to add assessment of medication adherence and side effects by Client services specialists and supports coordinators during all service contacts.
M. Swank	CLT	03/21/11	Revision	Updated P&P to change requirement for assessment of medication adherence. Reassessments will be completed at least monthly.
M. Swank	M. Swank	05/20/11	Revision	Revised P&P statements renaming CSMs and SCs as Client Services Specialists.
M. Swank E. Albrecht	PNLT	08/29/13	Revision	Added person first language as well as multiple references to recovery, wellness, quality of life,
K. Amon	SLT	06/30/15	Revision	Change MDCH and typographical error
K. Amon	SLT	8/20/18	Revision	Triennial Review
K. Amon	SLT	11/27/19	No changes	Policy and Triennial Review-Early to begin a new Review cycle.
K. Amon	SLT/Leadership C. Pinter	5/12/21 6/18/21	Revisions	Update to comply with Medicaid Provider Manual. Add clarification on the oversight and training of the IPOS
H. Beson/J. Hahn	H. Beson/J. Hahn	12/11/24	Revision	Combined Support Coordination and Targeted Case Management per Medicaid Provider Manual. Referred to comprehensive program plan.Archiving and Merging with C04-S27-T01

Deletion

Bay-Arenac Behavioral Health
Financial Statements
For Period Ending 01/31/2025

Certified for Accuracy

Accounting Manager

Chief Financial Officer

Bay-Arenac Behavioral Health Statement of Net Assets

Bay-Arenac Behavioral Health Consolidated Income Statement:

By Month to Date

By Year to Date

Bay-Arenac Behavioral Health Reconciliation of Fund Balance:

Bay-Arenac Behavioral Health Reconciliation of Unreserved Fund Balance:

Bay-Arenac Behavioral Health Fund Balance Summary:

Bay-Arenac Behavioral Health Cash Flow Statement

Bay-Arenac Behavioral Health Projected Cash Flows

Bay Arenac Behavioral Health
Statement of Net Assets

	Column Identifiers A	B	C	
1	**ASSETS**	**Jan 31, 2025**	**Sept 30, 2024**	
2	**Current Assets**			
3	Cash and cash equivalents	$4,852,321.09	$4,894,930.68	
4	Consumer and insurance receivables	261,977.08	192,843.18	
5	Due from other governmental units	5,981,407.07	7,094,667.58	
6	Contract and other receivables	257,062.79	288,615.57	
7	Interest receivable	0.00	0.00	
8	Prepaid items	614,600.65	444,849.69	
9	**Total Current Assets**	**11,967,368.68**	**12,915,906.70**	(3+4+5+6+7+8)
10	**Noncurrent Assets**			
11	**Cash and cash Equivalents - restricted**			
12	Restricted for compensated absences	1,521,583.13	1,514,776.32	
13	Restricted temporarily - other	107,604.17	111,510.10	
14	**Cash and Cash Equivalents - restricted**	**1,629,187.30**	**1,626,286.42**	(12+13)
15	**Capital Assets**			
16	Capital assets - land	424,500.00	424,500.00	
17	Capital assets - depreciable, net	6,368,374.54	6,368,374.54	
18	Capital assets - construction in progress	-	-	
19	GASB 87 Right to Use Bldg	2,272,819.47	2,272,819.47	
20	GASB 87 Accum Depr, Lease Amortization	(613,824.99)	(613,824.99)	
21	Accumulated depreciation	(4,164,796.72)	(4,103,871.94)	
22	**Capital Asset, net**	**4,287,072.30**	**4,347,997.08**	(16+17+18+19+20+21)
23	**Total Noncurrent Assets**	**5,916,259.60**	**5,974,283.50**	(14+22)
24	**TOTAL ASSETS**	**17,883,628.28**	**18,890,190.20**	(9+23)
25	**LIABILITIES**			
26	**Current Liabilities**			
27	Accounts payable	0.00	3,852,625.64	
28	Accrued wages and payroll related liabilities	0.00	275,406.50	
29	Other accrued liabilities	4,580,617.57	1,360,069.00	
30	Due to other governmental units	257,299.00	243,583.00	
31	Deferred Revenue	2,553.73	2,903.73	
32	Current portion of long term debt	16,738.31	16,738.31	
33	Other current liabilities	-	-	
34	**Total Current Liabilities**	**4,857,208.61**	**5,751,326.18**	(27+28+29+30+31+32+33)
35	**Noncurrent Liabilities**			
36	Long term debt, net of current portion	224,614.76	230,134.98	
37	GASB 87 Noncurrent Lease Liability	1,502,277.10	1,502,277.10	
38	Compensated absences	1,265,178.93	1,359,019.52	
39	**Total Noncurrent Liabilities**	**2,992,070.79**	**3,091,431.60**	(36+37+38)
40	**TOTAL LIABILITIES**	**7,849,279.40**	**8,842,757.78**	(34+39)
41	**NET ASSETS**			
42	**Fund Balance**			
43	Restricted for capital purposes	3,966,653.00	3,966,653.00	
44	Unrestricted fund balance - PBIP	2,827,136.47	2,827,136.47	
45	Unrestricted fund balance	3,240,559.41	3,253,642.95	
46	**Total Net Assets**	**$10,034,348.88**	**$10,047,432.42**	(43+44+45) and (24-40)

Bay Arenac Behavioral Health
For the Month Ending January 31, 2025
Summary of All Units

	A	B	C	D	E	F	G	
			Column Identifiers					
					(C-D)	(C / D)		
		January Actual	2025 YTD Actual	2025 YTD Budget	Variance	% to Budget	2025 Monthly Budget	
	Income Statement							
1	**REVENUE**							
2	**Risk Contract Revenue**							
3	Medicaid Specialty Supports & Services	5,938,995.23	19,612,009.28	20,987,120.67	(1,375,111.39)	93%	5,246,780.17	
4	Medicaid Autism	1,034,333.95	3,970,349.19	1,946,983.00	2,023,366.19	204%	486,745.75	
5	State Genl Fund Priority Population	135,504.00	542,018.00	542,017.67	0.33	100%	135,504.42	
6	GF Shared Savings Lapse	0.00	0.00	0.00	0.00	0%	0.00	
7	**Total Risk Contract Revenue**	**7,108,833.18**	**24,124,376.47**	**23,476,121.33**	**648,255.14**	**103%**	**5,869,030.33**	(3+4+5+6)
8	**Program Service Revenue**							
9	Medicaid, CWP FFS	0.00	0.00	0.00	0.00	0%	0.00	
10	Other Fee For Service	21,609.45	100,032.05	129,926.33	(29,894.28)	77%	32,481.58	
11	**Total Program Service Revenue**	**21,609.45**	**100,032.05**	**129,926.33**	**(29,894.28)**	**77%**	**32,481.58**	(9+10)
12	**Other Revenue**							
13	Grants and Earned Contracts	187,713.25	631,694.75	525,136.33	106,558.42	120%	131,284.08	
14	SSI Reimbursements, 1st/3rd Party	7,515.50	26,542.60	25,030.00	1,512.60	106%	6,257.50	
15	County Appropriation	65,587.83	262,351.32	262,351.50	(0.18)	100%	65,587.87	
16	Interest Income - Working Capital	17,081.36	74,040.00	105,525.83	(31,485.83)	70%	26,381.46	
17	Other Local Income	2,335.86	13,872.70	154,479.67	(140,606.97)	9%	38,619.92	
18	**Total Other Revenue**	**280,233.80**	**1,008,501.37**	**1,072,523.33**	**(64,021.96)**	**94%**	**268,130.83**	(13+14+15+16+17)
19	**TOTAL REVENUE**	**7,410,676.43**	**25,232,909.89**	**24,678,570.99**	**554,338.90**	**102%**	**6,169,642.75**	(7+11+18)
20	**EXPENSE**							
21	**SUPPORTS & SERVICES**							
22	**Provider Claims**							
23	State Facility - Local portion	11,021.20	43,915.48	58,453.00	14,537.52	75%	14,613.25	
24	Community Hospital	34,452.88	2,668,734.43	2,504,019.67	(164,714.76)	107%	626,004.92	
25	Residential Services	1,428,078.82	4,975,504.47	5,134,817.00	159,312.53	97%	1,283,704.25	
26	Community Supports	634,501.22	9,173,264.93	8,642,399.00	(530,865.93)	106%	2,160,599.75	
27	**Total Provider Claims**	**2,108,054.12**	**16,861,419.31**	**16,339,688.67**	**(521,730.64)**	**103%**	**4,084,922.17**	(23+24+25+26)
28	**Operating Expenses**							
29	Salaries	1,273,215.64	5,093,783.99	4,778,937.60	(314,846.39)	107%	1,194,734.40	
30	Fringe Benefits	383,111.85	1,556,874.50	1,593,293.69	36,419.19	98%	398,323.42	
31	Consumer Related	1,710.18	12,523.00	15,817.19	3,294.19	79%	3,954.30	
32	Program Operations	429,417.23	629,081.91	627,015.02	(2,066.89)	100%	156,753.75	
33	Facility Cost	61,988.82	207,982.35	233,673.33	25,690.98	89%	58,418.33	
34	Purchased Services	9,006.07	12,973.57	17,735.12	4,761.55	73%	4,433.78	
35	Other Operating Expense	122,708.53	736,198.40	708,627.70	(27,570.70)	104%	177,156.93	
36	Local Funds Contribution	17,906.00	71,624.00	71,624.00	0.00	100%	17,906.00	
37	Interest Expense	646.40	2,607.62	2,745.67	138.05	95%	686.42	
38	Depreciation	15,231.14	60,924.78	72,158.00	11,233.22	84%	18,039.50	
39	**Total Operating Expenses**	**2,314,941.86**	**8,384,574.12**	**8,121,627.33**	**(262,946.79)**	**103%**	**2,030,406.83**	(29+30+31+32+33+34+35+36+37+38)
40	**TOTAL EXPENSES**	**4,422,995.98**	**25,245,993.43**	**24,461,315.99**	**(784,677.44)**	**103%**	**6,115,329.00**	(27+39)
41	**NET SURPLUS/(DEFICIT)**	**2,987,680.45**	**(13,083.54)**	**217,255.00**	**(230,338.54)**	**-6%**	**54,313.75**	(19-40)

42 **Notes:**

43 Medicaid Revenue includes an accrual for **additional** funds if a **(shortage)** exists/**reduction** of funds if a **surplus** exists from/(to) Mid-State Health Network as follows:

BASED ON PEPM FUNDING:

44 Net Medicaid **(shortage)**: ($3,821,969)

45 Medicaid **(shortage)**: ($995,198)

46 Healthy Michigan **(shortage)**: ($1,202,206)

47 Autism **(shortage)**: ($1,624,565)

48 **BASED ON APPROVED BUDGET:**

49 Net Medicaid shortage: ($411,932)

50 Medicaid **surplus**: $48,312

51 Healthy Michigan **(shortage)**: ($303,086)

52 Autism **(shortage)**: ($157,158)

BAY-ARENAC BEHAVIORAL HEALTH
RECONCILIATION OF FUND BALANCE
AS OF JANUARY 31, 2025

	TOTALS
Fund Balance 09/30/2024	10,047,432.42
Net (loss)/income January 2025	(13,083.54)
Net Increase/(Decrease) Funds Restricted for Capital Purposes	-
Calculated Fund Balance 1/31/2025	10,034,348.88
Statement of Net Assets Fund Balance 1/31/2025	10,034,348.88
Difference	-

BAY-ARENAC BEHAVIORAL HEALTH
RECONCILIATION OF UNRESTRICTED FUND BALANCE
AS OF JANUARY 31, 2025

	TOTALS
Unrestricted Fund Balance 9/30/2024	6,080,779.42
Net (loss)/income January 2025	(13,083.54)
Increase/Decrease in net assets	-
Calculated Unrestricted Fund Balance 1/31/2025	6,067,695.88
Statement of Net Assets Unrestricted Fund Balance 1/31/2025	6,067,695.88
Difference	-

Bay-Arenac Behavioral Health
Fund Balance Summary

	Sept. 30, 2024 Unrestricted Fund Balance	Jan 31, 2025 Permanently Restricted	Jan 31, 2025 Temporarily Restricted	Jan 31, 2025 Unrestricted/ Reserved	Jan 31, 2025 Total Fund Balance
Unrestricted	3,253,643	-	-	3,240,559	3,240,559
Capital Purposes	844,325	-	-	844,325	844,325
Invested in Capital Assets	3,122,328	-	-	3,122,328	3,122,328
Performance Incentive Pool	2,827,136	-	-	2,827,136	2,827,136
Balances	10,047,432	-	-	10,034,349	10,034,349

BAY-ARENAC BEHAVIORAL HEALTH
Cash Flow

	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Estimated Funds:												
Beginning Inv. Balance	-	-	-	-	-	-	-	-	-	-	-	-
Investment	-	-	-	-	-	-	-	-	-	-	-	-
Additions/(Subtractions)	-	-	-	-	-	-	-	-	-	-	-	-
Month End Inv. Balance	-	-	-	-	-	-	-	-	-	-	-	-
Beginning Cash Balance	5,777,467	5,461,723	4,815,838	4,053,810	3,238,066	2,592,181	1,830,154	64,410	(581,476)	1,256,497	440,753	(205,132)
Total Medicaid	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583	4,876,583
Total General Fund	135,505	135,505	135,504	135,506	135,505	135,504	135,506	135,505	135,504	135,506	135,505	135,504
Estimated Misc. Receipts	89,759	205,900	89,759	89,759	205,900	89,759	89,759	205,900	89,759	89,759	205,900	244,614
Client Receipts	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000
Interest	15,178	15,178	15,178	15,178	15,178	15,178	15,178	15,178	15,178	15,178	15,178	15,178
Total Estimated Cash	**10,949,491**	**10,749,889**	**9,987,861**	**9,225,834**	**8,526,232**	**7,764,205**	**7,002,178**	**5,352,575**	**4,590,548**	**6,428,521**	**5,728,919**	**5,121,746**
Total Estimated Available Funds	**10,949,491**	**10,749,889**	**9,987,861**	**9,225,834**	**8,526,232**	**7,764,205**	**7,002,178**	**5,352,575**	**4,590,548**	**6,428,521**	**5,728,919**	**5,121,746**
Estimated Expenditures:												
1st Payroll	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000
Special Pay												
ETO Buyouts												
2nd Payroll	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000
Board Per Diem	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343
3rd Payroll							550,000					
1st Friday Claims	294,968	294,968	294,968	294,968	294,968	294,968	294,968	294,968	294,968	294,968	294,968	294,968
Mortgage Pmt	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032
2nd Friday Claims	1,005,077	1,505,077	1,505,077	1,505,077	1,505,077	1,505,077	1,505,077	1,505,077	1,505,077	1,505,077	1,505,077	1,505,077
Board Week Bay Batch	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989	1,144,989
Board Week Claims	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000
Credit Card	-	-	-	-	-	-	-	-	-	-	-	-
4th Friday Claims	908,641	908,641	908,641	908,641	908,641	908,641	908,641	908,641	908,641	908,641	908,641	908,641
5th Friday Claims							400,000		400,000			400,000
Local FFP payment to MSHN	53,717			53,717			53,717			53,717		
Transfer to State of MI												
Transfer from/(to) Reserve Account												
Settlement with MSHN												
Funds from MSHN									(3,000,000)			(1,500,000)
Transfer to (from) HRA												
Transfer to (from) Investment												
Transfer to (from) Capital Acct	-	-	-	-	-	-	-	-	-	-	-	-
Total Estimated Expenditures	**5,487,768**	**5,934,051**	**5,934,051**	**5,987,768**	**5,934,051**	**5,934,051**	**6,937,768**	**5,934,051**	**3,334,051**	**5,987,768**	**5,934,051**	**4,834,051**
Estimated Month End Cash Balance	**5,461,723**	**4,815,838**	**4,053,810**	**3,238,066**	**2,592,181**	**1,830,154**	**64,410**	**(581,476)**	**1,256,497**	**440,753**	**(205,132)**	**287,695**

Bay-Arenac Behavioral Health

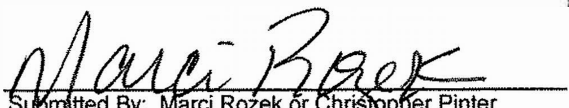
Cash Flow Forecasting
For the Month of February

		Bank Balance	Investment Balance
Estimated Cash Balance February 1, 2025		**5,777,467**	-
Investment Purchased/Interest		-	
Investments coming due during month		-	-
Estimated Cash Balance February 28, 2025		**5,777,467**	-
Estimated Cash Inflow:			
Medicaid Funds:		4,876,583	
General Fund Dollars:		135,505	
Board Receipts:		89,759	
Client Receipts:		55,000	
Funds from Investment:		-	
Interest:		15,178	
Total Estimated Cash Inflow:		**5,172,025**	
Estimated Cash Outflow:			
Payroll Dated:	**02/14/25**	(550,000)	
Payroll Dated:	**02/28/25**	(550,000)	
Board Per Diem Payroll:	**02/21/25**	(3,343)	
Payroll Dated:		-	
Claims Disbursements:	**02/07/25**	(294,968)	
Claims Disbursements:	**02/14/25**	(1,005,077)	
Claims Disbursements:	**02/21/25**	(975,000)	
A/P Disbursements:	**02/21/25**	(1,144,989)	
Mortgage Payment:	**02/24/25**	(2,032)	
Claims Disbursements:	**02/28/25**	(908,641)	
Claims Disbursements:		-	
Local FFP Payment:	**02/14/25**	(53,717)	
Transfer to Reserve Acct:		-	
HRA transfer:		-	
Transfer to(from) MSHN:		-	
Transfer to State of MI		-	
Purchased Investment		-	
Total Estimated Cash Outflow:		**(5,487,768)**	
Estimated Cash Balance on February 28, 2025		5,461,724	-
		(0)	-

Bay Arenac Behavioral Health
201 Mulholland, Bay City, MI 48708
Electronic Funds Transfers including Cash Transfers/Wires/ACHs
January 2025

Funds Paid from/ Transferred from:	Funds Paid to/ Transferred to:	Amount	Date of Payment	Description	Authorized By
Flagstar Bank	Huntington Nat'l Bank	3,500.00	1/2/2025	Transfer from General Account to Flex Spending Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	625,000.00	1/2/2025	Transfer from General Account to Payroll Account	Marci Rozek
Flagstar Bank	Flagstar Bank	303,443.04	1/2/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	545,000.00	1/3/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	8,936.84	1/6/2025	Credit Card Payment	Marci Rozek
Flagstar Bank	Flagstar Bank	65,000.00	1/6/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	140,000.00	1/7/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	1,337,714.30	1/9/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	575,000.00	1/15/2025	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	3,994.53	1/16/2025	Transfer from General Account to Flex Spending Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	5,000.00	1/16/2025	Transfer from General Account to HSA Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	570,612.23	1/16/2025	Transfer from General Account to Payroll Account	Marci Rozek
Flagstar Bank	Flagstar Bank	2,079,650.04	1/16/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	915,000.00	1/17/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	2,031.96	1/22/2025	Transfer from General Acct for Mortgage payment	Marci Rozek
Flagstar Bank	Flagstar Bank	971,281.81	1/23/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	145,000.00	1/24/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	15,000.00	1/29/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	560,000.00	1/29/2025	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	561,824.49	1/30/2025	Transfer from General Account to Payroll Account	Marci Rozek
Flagstar Bank	Flagstar Bank	925,953.97	1/30/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	3,994.53	1/31/2025	Transfer from General Account to Flex Spending Account	Marci Rozek
Flagstar Bank	Flagstar Bank	3,540,000.00	1/31/2025	Transfer from General Account to MMKT Account	Marci Rozek

Total Transfers: **13,902,937.74**



Submitted By: Marci Rozek or Christopher Pinter
Chief Financial Officer or Chief Executive Officer

Bay Arenac Behavioral Health
201 Mulholland, Bay City, MI 48708
Electronic Funds Transfers for Vendor ACH Payments
January 2025

Funds Paid from:	EFT #	Funds Paid to:	Amount	Date of Pmt	Authorized By
Flagstar Bank	E7084	Bay Human Services, Inc.	341.58	1/3/2025	Marci Rozek
Flagstar Bank	E7085	LIBERTY LIVING, INC.	32,338.63	1/3/2025	Marci Rozek
Flagstar Bank	E7086	HEALTHSOURCE	6,480.00	1/3/2025	Marci Rozek
Flagstar Bank	E7087	SAGINAW PSYCHOLOGICAL SERVICES	23,179.93	1/3/2025	Marci Rozek
Flagstar Bank	E7088	PARAMOUNT REHABILITATION	4,085.44	1/3/2025	Marci Rozek
Flagstar Bank	E7089	ARENAC OPPORTUNITIES, INC	14,079.63	1/3/2025	Marci Rozek
Flagstar Bank	E7090	DO-ALL, INC.	6,752.84	1/3/2025	Marci Rozek
Flagstar Bank	E7091	Winningham, Linda Jo	707.00	1/3/2025	Marci Rozek
Flagstar Bank	E7092	Nutrition for Wellness	490.70	1/3/2025	Marci Rozek
Flagstar Bank	E7093	WILSON, STUART T. CPA, P.C.	69,886.19	1/3/2025	Marci Rozek
Flagstar Bank	E7094	CAREBUILDERS AT HOME, LLC	14,812.25	1/3/2025	Marci Rozek
Flagstar Bank	E7095	Flourish Services, LLL	27,402.69	1/3/2025	Marci Rozek
Flagstar Bank	E7096	GAME CHANGER PEDIATRIC THERAPY	56,633.31	1/3/2025	Marci Rozek
Flagstar Bank	E7097	Spectrum Autism Center	15,313.37	1/3/2025	Marci Rozek
Flagstar Bank	E7098	ENCOMPASS THERAPY CENTER LLC	16,558.77	1/3/2025	Marci Rozek
Flagstar Bank	E7099	J.E.JOHNSON CONTRACTING, INC.	520.00	1/3/2025	Marci Rozek
Flagstar Bank	E7100	Moduform, Inc.	1,498.49	1/3/2025	Marci Rozek
Flagstar Bank	E7101	AUGRES CARE CENTER, INC	3,842.14	1/10/2025	Marci Rozek
Flagstar Bank	E7102	HAVENWYCK HOSPITAL	34,787.77	1/10/2025	Marci Rozek
Flagstar Bank	E7103	BEACON SPECIALIZED LIVING SVS	20,801.00	1/10/2025	Marci Rozek
Flagstar Bank	E7104	Fitzhugh House, LLC	11,864.40	1/10/2025	Marci Rozek
Flagstar Bank	E7105	Bay Human Services, Inc.	170,944.72	1/10/2025	Marci Rozek
Flagstar Bank	E7106	MICHIGAN COMMUNITY SERVICES IN	30,557.80	1/10/2025	Marci Rozek
Flagstar Bank	E7107	CENTRAL STATE COMM. SERVICES	35,064.74	1/10/2025	Marci Rozek
Flagstar Bank	E7108	LIBERTY LIVING, INC.	31,498.18	1/10/2025	Marci Rozek
Flagstar Bank	E7109	SUPERIOR CARE OF MICHIGAN LLC	8,574.60	1/10/2025	Marci Rozek
Flagstar Bank	E7110	Closer to Home, LLC	19,315.48	1/10/2025	Marci Rozek
Flagstar Bank	E7111	HEALTHSOURCE	54,000.00	1/10/2025	Marci Rozek
Flagstar Bank	E7112	MPA GROUP NFP, Ltd.	19,887.54	1/10/2025	Marci Rozek
Flagstar Bank	E7113	SAGINAW PSYCHOLOGICAL SERVICES	12,460.07	1/10/2025	Marci Rozek
Flagstar Bank	E7114	PARAMOUNT REHABILITATION	13,669.66	1/10/2025	Marci Rozek
Flagstar Bank	E7115	ARENAC OPPORTUNITIES, INC	29,846.98	1/10/2025	Marci Rozek
Flagstar Bank	E7116	DO-ALL, INC.	2,796.13	1/10/2025	Marci Rozek
Flagstar Bank	E7117	TOUCHSTONE SERVICES, INC	18,753.92	1/10/2025	Marci Rozek
Flagstar Bank	E7118	Winningham, Linda Jo	85.00	1/10/2025	Marci Rozek
Flagstar Bank	E7119	Nutrition for Wellness	887.20	1/10/2025	Marci Rozek
Flagstar Bank	E7120	WILSON, STUART T. CPA, P.C.	83,115.67	1/10/2025	Marci Rozek
Flagstar Bank	E7121	CAREBUILDERS AT HOME, LLC	32,291.43	1/10/2025	Marci Rozek
Flagstar Bank	E7122	CENTRIA HEALTHCARE LLC	88,134.91	1/10/2025	Marci Rozek
Flagstar Bank	E7123	PERSONAL ASSISTANCE OPTIONS INC	26.08	1/10/2025	Marci Rozek
Flagstar Bank	E7124	GAME CHANGER PEDIATRIC THERAPY	23,666.69	1/10/2025	Marci Rozek
Flagstar Bank	E7125	Spectrum Autism Center	11,821.22	1/10/2025	Marci Rozek
Flagstar Bank	E7126	ENCOMPASS THERAPY CENTER LLC	53,895.50	1/10/2025	Marci Rozek
Flagstar Bank	E7127	MERCY PLUS HEALTHCARE SERVICES LLC	80,506.25	1/10/2025	Marci Rozek
Flagstar Bank	E7128	Positive Behavior Supports Corporation	7,550.60	1/10/2025	Marci Rozek
Flagstar Bank	E7129	DBT Institute of Michigan	27,600.00	1/10/2025	Marci Rozek
Flagstar Bank	E7130	BAY CITY CRU	295,374.00	1/10/2025	Marci Rozek
Flagstar Bank	E7131	McCoy Heating and Cooling	932.50	1/10/2025	Marci Rozek
Flagstar Bank	E7132	TELNET WORLDWIDE, INC.	1,536.42	1/10/2025	Marci Rozek
Flagstar Bank	E7133	HAVENWYCK HOSPITAL	15,983.57	1/17/2025	Marci Rozek
Flagstar Bank	E7134	HOPE NETWORK BEHAVIORAL HEALTH	70,349.26	1/17/2025	Marci Rozek
Flagstar Bank	E7135	Hope Network Southeast	132,154.06	1/17/2025	Marci Rozek
Flagstar Bank	E7136	Bay Human Services, Inc.	213,415.53	1/17/2025	Marci Rozek
Flagstar Bank	E7137	MICHIGAN COMMUNITY SERVICES IN	224,643.81	1/17/2025	Marci Rozek
Flagstar Bank	E7138	VALLEY RESIDENTIAL SERVICES	89,932.79	1/17/2025	Marci Rozek
Flagstar Bank	E7139	LIBERTY LIVING, INC.	33,163.71	1/17/2025	Marci Rozek
Flagstar Bank	E7140	DISABILITY NETWORK	11,425.45	1/17/2025	Marci Rozek
Flagstar Bank	E7141	HEALTHSOURCE	48,600.00	1/17/2025	Marci Rozek
Flagstar Bank	E7142	FOREST VIEW HOSPITAL	22,000.00	1/17/2025	Marci Rozek
Flagstar Bank	E7143	CEDAR CREEK HOSPITAL	7,903.00	1/17/2025	Marci Rozek
Flagstar Bank	E7144	MPA GROUP NFP, Ltd.	62,162.88	1/17/2025	Marci Rozek
Flagstar Bank	E7145	LIST PSYCHOLOGICAL SERVICES	2,802.78	1/17/2025	Marci Rozek
Flagstar Bank	E7146	SAGINAW PSYCHOLOGICAL SERVICES	8,632.61	1/17/2025	Marci Rozek
Flagstar Bank	E7147	PARAMOUNT REHABILITATION	2,603.84	1/17/2025	Marci Rozek
Flagstar Bank	E7148	ARENAC OPPORTUNITIES, INC	5,400.77	1/17/2025	Marci Rozek
Flagstar Bank	E7149	DO-ALL, INC.	4,176.94	1/17/2025	Marci Rozek

Flagstar Bank	E7150	New Dimensions	14,740.86	1/17/2025	Marci Rozek
Flagstar Bank	E7151	TOUCHSTONE SERVICES, INC	3,132.48	1/17/2025	Marci Rozek
Flagstar Bank	E7152	Winningham, Linda Jo	692.00	1/17/2025	Marci Rozek
Flagstar Bank	E7153	Nutrition for Wellness	1,556.60	1/17/2025	Marci Rozek
Flagstar Bank	E7154	WILSON, STUART T. CPA, P.C.	88,194.57	1/17/2025	Marci Rozek
Flagstar Bank	E7155	CAREBUILDERS AT HOME, LLC	16,106.10	1/17/2025	Marci Rozek
Flagstar Bank	E7156	AUTISM SYSTEMS LLC	13,709.50	1/17/2025	Marci Rozek
Flagstar Bank	E7157	CENTRIA HEALTHCARE LLC	31,513.29	1/17/2025	Marci Rozek
Flagstar Bank	E7158	PERSONAL ASSISTANCE OPTIONS INC	76,424.23	1/17/2025	Marci Rozek
Flagstar Bank	E7159	Flourish Services, LLL	34,378.64	1/17/2025	Marci Rozek
Flagstar Bank	E7160	GAME CHANGER PEDIATRIC THERAPY	36,623.76	1/17/2025	Marci Rozek
Flagstar Bank	E7161	Spectrum Autism Center	12,278.91	1/17/2025	Marci Rozek
Flagstar Bank	E7162	ENCOMPASS THERAPY CENTER LLC	47,529.28	1/17/2025	Marci Rozek
Flagstar Bank	E7163	Acorn Health of Michigan	70.00	1/17/2025	Marci Rozek
Flagstar Bank	E7164	Positive Behavior Supports Corporation	2,157.65	1/17/2025	Marci Rozek
Flagstar Bank	E7165	BAY CITY CRU	0.58	1/17/2025	Marci Rozek
Flagstar Bank	E7166	BICKEL, MEREDITH	72.56	1/17/2025	Marci Rozek
Flagstar Bank	E7167	BINKLEY, CASEY	440.99	1/17/2025	Marci Rozek
Flagstar Bank	E7168	Bryan, Kelly	571.51	1/17/2025	Marci Rozek
Flagstar Bank	E7169	BYRNE, RICHARD	257.95	1/17/2025	Marci Rozek
Flagstar Bank	E7170	CERESKE, KIM	30.78	1/17/2025	Marci Rozek
Flagstar Bank	E7171	Cook, Jordyn	73.03	1/17/2025	Marci Rozek
Flagstar Bank	E7172	Deshano, Jennifer	154.10	1/17/2025	Marci Rozek
Flagstar Bank	E7173	FRIEBE, HEATHER	137.35	1/17/2025	Marci Rozek
Flagstar Bank	E7174	HECHT, KERENSA	60.97	1/17/2025	Marci Rozek
Flagstar Bank	E7175	HEWTTY, MARIA	308.00	1/17/2025	Marci Rozek
Flagstar Bank	E7176	JINKS, KIM	661.29	1/17/2025	Marci Rozek
Flagstar Bank	E7177	Kohn, Jessica	210.38	1/17/2025	Marci Rozek
Flagstar Bank	E7178	KOIN, STACEY E.	134.67	1/17/2025	Marci Rozek
Flagstar Bank	E7179	Lemiesz, Rachel	282.74	1/17/2025	Marci Rozek
Flagstar Bank	E7180	McClure, Laurel	191.29	1/17/2025	Marci Rozek
Flagstar Bank	E7181	Niemiec, Kathleen	90.45	1/17/2025	Marci Rozek
Flagstar Bank	E7182	NIX, HEATHER	30.15	1/17/2025	Marci Rozek
Flagstar Bank	E7183	Nixon, Heidi	151.55	1/17/2025	Marci Rozek
Flagstar Bank	E7184	O'BRIEN, CAROLE	84.42	1/17/2025	Marci Rozek
Flagstar Bank	E7185	Rooker, Stephani	79.40	1/17/2025	Marci Rozek
Flagstar Bank	E7186	ROSE, KEVIN	66.33	1/17/2025	Marci Rozek
Flagstar Bank	E7187	Schneider, Maryssa	168.57	1/17/2025	Marci Rozek
Flagstar Bank	E7188	Schumacher, Pamela	49.31	1/17/2025	Marci Rozek
Flagstar Bank	E7189	VanWert, Laurie	50.36	1/17/2025	Marci Rozek
Flagstar Bank	E7190	VASCONCELOS, FLAVIA	436.85	1/17/2025	Marci Rozek
Flagstar Bank	E7191	VOGEL, HOLLI	159.13	1/17/2025	Marci Rozek
Flagstar Bank	E7192	SAGINAW PSYCHOLOGICAL SERVICES	671.00	1/17/2025	Marci Rozek
Flagstar Bank	E7193	A2Z CLEANING & RESTORATION INC.	5,331.00	1/17/2025	Marci Rozek
Flagstar Bank	E7194	FLEX ADMINISTRATORS INC	1,550.45	1/17/2025	Marci Rozek
Flagstar Bank	E7195	HAMPTON AUTO REPAIR	566.18	1/17/2025	Marci Rozek
Flagstar Bank	E7196	Iris Telehealth Medical Group, PA	40,965.00	1/17/2025	Marci Rozek
Flagstar Bank	E7197	McCoy Heating and Cooling	532.50	1/17/2025	Marci Rozek
Flagstar Bank	E7198	MOVVA, USHA	14,650.00	1/17/2025	Marci Rozek
Flagstar Bank	E7199	NETSOURCE ONE, INC.	36,365.87	1/17/2025	Marci Rozek
Flagstar Bank	E7200	New Dimensions, Inc.	700.00	1/17/2025	Marci Rozek
Flagstar Bank	E7201	PRO-SCAPE, INC.	870.00	1/17/2025	Marci Rozek
Flagstar Bank	E7202	KOKALY, KAITLYN	70.00	1/17/2025	Marci Rozek
Flagstar Bank	E7203	Smith, Bridget M	5,900.00	1/17/2025	Marci Rozek
Flagstar Bank	E7204	Staples	4,864.97	1/17/2025	Marci Rozek
Flagstar Bank	E7205	UNITED WAY OF BAY COUNTY/RENT	2,125.00	1/17/2025	Marci Rozek
Flagstar Bank	E7206	VANWORMER, PAMELA	100.00	1/17/2025	Marci Rozek
Flagstar Bank	E7207	Yeo & Yeo Technology	472.50	1/17/2025	Marci Rozek
Flagstar Bank	E7208	Hope Network Southeast	128,631.75	1/24/2025	Marci Rozek
Flagstar Bank	E7209	Fitzhugh House, LLC	11,148.74	1/24/2025	Marci Rozek
Flagstar Bank	E7210	Bay Human Services, Inc.	57,454.03	1/24/2025	Marci Rozek
Flagstar Bank	E7211	MICHIGAN COMMUNITY SERVICES IN	103,709.89	1/24/2025	Marci Rozek
Flagstar Bank	E7212	CENTRAL STATE COMM. SERVICES	40.90	1/24/2025	Marci Rozek
Flagstar Bank	E7213	LIBERTY LIVING, INC.	32,811.45	1/24/2025	Marci Rozek
Flagstar Bank	E7214	HEALTHSOURCE	19,440.00	1/24/2025	Marci Rozek
Flagstar Bank	E7215	CEDAR CREEK HOSPITAL	18,064.00	1/24/2025	Marci Rozek
Flagstar Bank	E7216	PHC OF MICHIGAN - HARBOR OAKS	7,650.00	1/24/2025	Marci Rozek
Flagstar Bank	E7217	MPA GROUP NFP, Ltd.	31,458.72	1/24/2025	Marci Rozek
Flagstar Bank	E7218	LIST PSYCHOLOGICAL SERVICES	5,288.03	1/24/2025	Marci Rozek
Flagstar Bank	E7219	SAGINAW PSYCHOLOGICAL SERVICES	28,548.47	1/24/2025	Marci Rozek
Flagstar Bank	E7220	PARAMOUNT REHABILITATION	16,327.34	1/24/2025	Marci Rozek
Flagstar Bank	E7221	ARENAC OPPORTUNITIES, INC	5,005.21	1/24/2025	Marci Rozek
Flagstar Bank	E7222	DO-ALL, INC.	5,701.79	1/24/2025	Marci Rozek
Flagstar Bank	E7223	New Dimensions	9,321.34	1/24/2025	Marci Rozek
Flagstar Bank	E7224	TOUCHSTONE SERVICES, INC	13,110.24	1/24/2025	Marci Rozek

Flagstar Bank	E7225	Nutrition for Wellness	541.40	1/24/2025	Marci Rozek
Flagstar Bank	E7226	WILSON, STUART T. CPA, P.C.	83,810.71	1/24/2025	Marci Rozek
Flagstar Bank	E7227	AUTISM SYSTEMS LLC	8,676.26	1/24/2025	Marci Rozek
Flagstar Bank	E7228	CENTRIA HEALTHCARE LLC	8,670.23	1/24/2025	Marci Rozek
Flagstar Bank	E7229	GAME CHANGER PEDIATRIC THERAPY	56,951.14	1/24/2025	Marci Rozek
Flagstar Bank	E7230	ENCOMPASS THERAPY CENTER LLC	58,913.44	1/24/2025	Marci Rozek
Flagstar Bank	E7231	MERCY PLUS HEALTHCARE SERVICES LLC	15,159.84	1/24/2025	Marci Rozek
Flagstar Bank	E7232	HEALING WITH HEART	200.00	1/24/2025	Marci Rozek
Flagstar Bank	E7233	STATE OF MICHIGAN DEPT OF COMM HEALTH A	10,101.20	1/24/2025	Marci Rozek
Flagstar Bank	E7234	MICHIGAN COMMUNITY SERVICES IN	90.00	1/24/2025	Marci Rozek
Flagstar Bank	E7235	VALLEY RESIDENTIAL SERVICES	5,542.74	1/24/2025	Marci Rozek
Flagstar Bank	E7236	Bromberg & Associates, LLC	125.00	1/24/2025	Marci Rozek
Flagstar Bank	E7237	FLEX ADMINISTRATORS INC	500.00	1/24/2025	Marci Rozek
Flagstar Bank	E7238	J.E.JOHNSON CONTRACTING, INC.	385.50	1/24/2025	Marci Rozek
Flagstar Bank	E7239	KING COMMUNICATIONS	149.70	1/24/2025	Marci Rozek
Flagstar Bank	E7240	PETER CHANG ENTERPRISES, INC.	23,298.50	1/24/2025	Marci Rozek
Flagstar Bank	E7241	TELNET WORLDWIDE, INC.	1,512.12	1/24/2025	Marci Rozek
Flagstar Bank	E7242	HAVENWYCK HOSPITAL	8,461.89	1/31/2025	Marci Rozek
Flagstar Bank	E7243	VALLEY RESIDENTIAL SERVICES	2,735.37	1/31/2025	Marci Rozek
Flagstar Bank	E7244	LIBERTY LIVING, INC.	32,811.51	1/31/2025	Marci Rozek
Flagstar Bank	E7245	DISABILITY NETWORK	14,900.23	1/31/2025	Marci Rozek
Flagstar Bank	E7246	HEALTHSOURCE	55,080.00	1/31/2025	Marci Rozek
Flagstar Bank	E7247	FOREST VIEW HOSPITAL	8,800.00	1/31/2025	Marci Rozek
Flagstar Bank	E7248	PHC OF MICHIGAN - HARBOR OAKS	1,937.00	1/31/2025	Marci Rozek
Flagstar Bank	E7249	MPA GROUP NFP, Ltd.	34,801.68	1/31/2025	Marci Rozek
Flagstar Bank	E7250	LIST PSYCHOLOGICAL SERVICES	2,430.46	1/31/2025	Marci Rozek
Flagstar Bank	E7251	SAGINAW PSYCHOLOGICAL SERVICES	29,421.14	1/31/2025	Marci Rozek
Flagstar Bank	E7252	PARAMOUNT REHABILITATION	14,504.07	1/31/2025	Marci Rozek
Flagstar Bank	E7253	ARENAC OPPORTUNITIES, INC	13,936.94	1/31/2025	Marci Rozek
Flagstar Bank	E7254	DO-ALL, INC.	16,440.62	1/31/2025	Marci Rozek
Flagstar Bank	E7255	New Dimensions	7,558.68	1/31/2025	Marci Rozek
Flagstar Bank	E7256	Winningham, Linda Jo	1,006.00	1/31/2025	Marci Rozek
Flagstar Bank	E7257	Nutrition for Wellness	62.50	1/31/2025	Marci Rozek
Flagstar Bank	E7258	WILSON, STUART T. CPA, P.C.	90,301.30	1/31/2025	Marci Rozek
Flagstar Bank	E7259	AUTISM SYSTEMS LLC	6,052.43	1/31/2025	Marci Rozek
Flagstar Bank	E7260	CENTRIA HEALTHCARE LLC	37,303.05	1/31/2025	Marci Rozek
Flagstar Bank	E7261	Flourish Services, LLL	43,211.78	1/31/2025	Marci Rozek
Flagstar Bank	E7262	GAME CHANGER PEDIATRIC THERAPY	55,460.19	1/31/2025	Marci Rozek
Flagstar Bank	E7263	Spectrum Autism Center	21,901.62	1/31/2025	Marci Rozek
Flagstar Bank	E7264	ENCOMPASS THERAPY CENTER LLC	62,989.82	1/31/2025	Marci Rozek
Flagstar Bank	E7265	Acorn Health of Michigan	137.92	1/31/2025	Marci Rozek
Flagstar Bank	E7266	MERCY PLUS HEALTHCARE SERVICES LLC	21,965.79	1/31/2025	Marci Rozek
Flagstar Bank	E7267	HAMPTON AUTO REPAIR	1,902.01	1/31/2025	Marci Rozek
Flagstar Bank	E7268	HOSPITAL PSYCHIATRY PLLC	42,000.00	1/31/2025	Marci Rozek
Flagstar Bank	E7269	SHRED EXPERTS LLC	651.00	1/31/2025	Marci Rozek
Flagstar Bank	E7270	Yeo & Yeo Technology	378.00	1/31/2025	Marci Rozek

Total Withdrawals: **4,369,800.15**

Submitted By: Marci Rozek or Christopher Pinter
Chief Financial Officer or Chief Executive Officer

BEHAVIORAL HEALTH

INTEROFFICE CORRESPONDENCE

February 18, 2025

To: Sara McRae, Executive Assistant to the CEO

From: Karl White, Accounting Manager
Michele Perry, Finance Manager

Re: Disbursement Audit Information for Audit Committee

The following is a summary of disbursements as presented

Administration and Services for Behavioral Health

02/21/25 Checks Sequence: #100754-100829, ACH E7166-E7207

Employee travel, conference	$ 6,621.77
Purchase Order Invoices	$ 4,864.97
Invoices for Routine Maintence, purchase requisitions, & recurring	$ 433,514.63
SUBTOTAL - Monthly Batch	**$ 445,001.37**

ITEMS FOR REVIEW:

EFT transfer - Credit Card 02/05/2025	**$ 18,959.40**

Weekly Special Checks:

01/24/2025 Checks 100834-100848, E7234-E7241	$ 62,640.36
01/31/2025 Checks 100853-100871, E7267-E7270	$ 99,847.18
02/07/2025 Checks 100881-100888, E7291-E7294	$ 29,499.42
02/14/2025 Checks 100897-100903, E7327-E7328	$ 7,254.83
SUBTOTAL - Special Checks	**$ 199,241.79**

Health Care payments

01/17/2025	Checks 100747-100753, ACH Pmts E7133-E7165	$ 1,630,815.38
01/24/2025	Checks 100830-100833, ACH Pmts E7208-E7233	$ 908,641.45
01/31/2025	Checks 100849-100852, ACH Pmts E7242-E7266	$ 717,203.23
02/07/2025	Checks 100872-100880, ACH Pmts E7271-E7290	$ 521,266.41
02/14/2025	Cks 100889-100896, ACH Pmts E7323-7326 E7295-7322	$ 1,919,331.75
	SUBTOTAL - Health Care Payments	**$ 5,697,258.22**
	TOTAL DISBURSEMENTS	**$ 6,360,460.78**

Prepared by: *Karl White*

Reviewed by: [signature]

MINUTES

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
AUDIT COMMITTEE MEETING

Tuesday, February 18, 2025 at 5:00 pm

Room 225, Behavioral Health Center, 201Mulholland Street, Bay City, MI 48708

Committee Members:	Present	Excused	Absent	Committee Members:	Present	Excused	Absent	Others Present:
Pat McFarland, Ex Off, Ch	X			Sally Mrozinski	X			BABH: Marci Rozek, Michele Perry, Eric Strode, and Sara McRae
Robert Pawlak, Ex Off, V Ch	X			Vacant				
Tim Banaszak	X			Richard Byrne, Ex Off	X			
Jerome Crete	X							Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call	Committee Chair, P. McFarland, called the meeting to order at 5:00 pm. All members were present.	
2.	Public Input (Maximum of 3 Minutes)	There were not any members of the public present.	
3.	Unfinished Business 3.1) 2024 Bridge Toll Fees	3.1) M. Rozek reported there was no update, however, the Committee requested the bridge toll fees remain on the agenda.	3.1) No action was necessary
4.	New Business 4.1) Selection of Disbursements & Health Care Claims from Summary Report 4.2) Financial Statements for Period Ending January 31, 2025	4.1) Administration found the source information for the claims selected for review. 4.2) M. Rozek reviewed the financial statements noting the unrestricted fund balance and the general fund (GF) deficit. M. Rozek also reported a workgroup was established to further evaluate GF costs, including at the individual consumer level and recommend GF cost containment strategies. There were discussions regarding the challenges with GF estimates because costs can drastically shift month to month based on a consumer's Medicaid eligibility status.	4.1) No action was necessary 4.2) On motion of T. Banaszak and support by R. Pawlak, the Financial Statements for period ending January 31, 2025 were referred to the full Board for approval. The motion was adopted unanimously.

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	4.3) Electronic Fund Transfers (EFTs) for Period Ending January 31, 2025	4.3) M. Rozek reviewed the EFTs with the Committee.	4.3) On motion of R. Pawlak and support of J. Crete, the EFTs for period ending January 31, 2025 were referred to the full Board for approval. The motion was adopted unanimously.
	4.4) Review of Selected Disbursements & Health Care Claims Chosen from Summary Report by CFO	4.4) Administration reviewed the disbursements and health care claim invoices selected for further review. These included 100795 Essexville Automotive Repair for vehicle repairs and maintenance; E07193 A to Z Cleaning for janitorial services at BABH facilities; E07196 Iris Telehealth Medical Group for third party medial services; E07235 Valley Residential, LLC for the Rose home transition; 100844 Pinnacle Designs for office relocations; 100857 Chartier Plumbing & Heating for repairs at various BABH sites; 100858 Dearborn Life Insurance Company for employee insurance premiums; 100881 Camp Fish Tales for consumer camp payments; E07249 for vendor 5602 MPA Group for outpatient services; E07164 for vendor 5771 Positive Behavioral Supports Coordination for supports coordination services; and E07285 for vendor 5755 Game Changer Pediatric Therapy Services for autism services. There were general discussions regarding payments to Pinnacle Design services, specific repairs performed by Chartier Plumbing & Heating; the yearly average cost of employee premiums for life insurance benefits, the life insurance benefit provided by BABH, the average salary cost of a BABH employee, and the specific activities provided at Camp Fish Tales.	4.4) No action was necessary
	4.5) Consideration of Approval of Disbursements & Health Care Claims Totals	4.5) M. Rozek reviewed the disbursement and health care claims totals.	4.5) On motion of J. Crete and support of T. Banaszak, the disbursements and health care payments from January 13, 2025 through February 14, 2025 were referred to the full Board for approval. The motion was adopted unanimously.
5.	Adjournment	On motion of T. Banaszak and support of J. Crete, the meeting adjourned at 5:22 pm. The motion passed unanimously.	

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Pat McFarland, Committee Chair

KFF

Medicaid: What to Watch in 2025

Robin Rudowitz (https://www.kff.org/person/robin-rudowitz/),

Alice Burns (https://www.kff.org/person/alice-burns/),

Elizabeth Hinton (https://www.kff.org/person/elizabeth-hinton/), and

Jennifer Tolbert (https://www.kff.org/person/jennifer-tolbert/)

Published: Jan 23, 2025

At the start of 2025, many issues are at play that could affect Medicaid coverage, financing, and access to care. Medicaid is the primary program providing comprehensive health and long-term care to one in five (https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) people living in the U.S. While Medicaid (https://www.kff.org/from-drew-altman/again-no-medicaid/) was not discussed much on the campaign trail, there are expectations that big changes will likely be proposed through executive actions (https://www.kff.org/policy-watch/what-administrative-changes-can-trump-make-to-medicaid/) by the Trump administration and as part of a tax and spending debate in Congress. Even without Congressional action, the Trump administration can make significant programmatic changes through administrative action (including state demonstration waivers, regulations, and other guidance). Other areas to watch with Medicaid implications include state budgets and long-term care workforce challenges.

Federal Funding Cuts and Financing Reforms

The most significant changes to Medicaid in 2025 could include federal funding cuts and financing reforms. According to documents reported on by Politico (https://www.politico.com/news/2025/01/10/spending-cuts-house-gop-reconciliation-medicaid-00197541), House Republicans are considering $2.3 trillion in Medicaid cuts from policy changes that include: imposing a per capita cap on federal Medicaid spending, reducing the federal government's share of costs for the Affordable Care Act (https://www.kff.org/medicaid/issue-brief/medicaid-expansion-is-a-red-and-blue-state-issue/) (ACA)

expansion group, imposing Medicaid work requirements, reducing the minimum federal matching rate for Medicaid expenditures, changing the match rate for the District of Columbia, and repealing the incentive for states to newly adopt the Medicaid expansion that was passed in the American Rescue Plan Act. These policy changes would fundamentally alter how Medicaid financing works and federal spending reductions of this magnitude would put states at significant financial risk, likely forcing them to cut the number of people covered, cover fewer benefits, and cut payment rates for physicians, hospitals, and nursing homes. If the House and Senate pass a budget resolution with a $2.3 trillion target for Medicaid, Congress will need to come up with detailed legislative policy proposals to hit that target through the budget reconciliation process.

Under current law states are guaranteed federal matching dollars (https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/) without a cap for qualified services provided to eligible enrollees. The match rate (https://www.kff.org/policy-watch/follow-the-money-how-medicaid-financing-works-and-what-that-means-for-proposals-to-change-it/) (the share that the federal government pays, known as the federal medical assistance percentage or "FMAP (https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)") varies across states based on per capita income. States receive a higher match rate for some services and populations, most notably, the 90% enhanced match for the ACA expansion population, and sometimes, Congress adjusts (https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-spending-growth-amid-the-unwinding-of-the-continuous-enrollment-provision-fy-2023-2024/) the match rate upwards during economic downturns.

Work Requirements

With a second Trump administration and Republican control of Congress, work requirements (https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-current-waiver-and-legislative-activity/) are likely to be back on the agenda—through federal legislation or state Medicaid waivers. During the first Trump administration, 13 states received 1115 waiver approval to condition Medicaid coverage on meeting work and reporting requirements. Only Arkansas implemented work and reporting requirements with consequences for noncompliance; however, the waiver ended in 2019 when a federal court found the work requirement approval unlawful. 18,000 people lost coverage in Arkansas, primarily due to failure to regularly report the fact that they were working or document eligibility for an exemption. These approvals were either rescinded by the Biden administration or withdrawn by states, and Georgia is the only state with a work requirement waiver in place (following litigation over the Biden Administration's attempt to stop it). Several states have continued to pursue work requirement waivers despite data showing that most Medicaid adults are working (https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/) or face barriers to work. Among adults with Medicaid who are under age 65 and do not have Medicare or Supplemental Security Income (SSI), 91% are working, or are not working due to an illness, caregiving responsibilities, or school attendance.

A Congressional Budget Office (https://www.cbo.gov/publication/59109#:~:text=2811%2C%20the%20Limit%2C%20Save%2C%20Grow%20Act%20of%202023.,and%20state%20costs%20would%20increase.) analysis of a recent work requirement proposal shows that the policy would reduce federal spending due to reductions in enrollment and increase the number of people without health insurance but would not increase employment.

Other Waivers and Administrative Changes

Beyond work requirements, the previous Trump administration's Section 1115 waiver policy (https://www.kff.org/medicaid/issue-brief/medicaid-waiver-priorities-under-the-trump-and-biden-harris-administrations/) emphasized eligibility restrictions and capped financing. Eligibility restrictions included permitting states to charge premiums and lock out enrollees who are disenrolled for unpaid premiums. Waiver priorities shift across presidential administrations and the new Trump administration's waiver priorities will likely differ significantly from those of the Biden administration; however, it is unclear how the Trump administration will treat certain waivers promoted and approved by the Biden administration, such as those focused on addressing health-related social needs, multi-year continuous eligibility primarily for children, and leveraging Medicaid to help individuals leaving incarceration transition to the community. The Trump administration could choose not to approve waivers that remain pending, rescind existing waiver guidance, and withdraw approved waivers, although some of these waivers, particularly those that are using Medicaid to assist with reentry from incarceration, have been pursued by both Republican and Democratic governors.

Trump administration could delay implementation (https://www.kff.org/policy-watch/what-administrative-changes-can-trump-make-to-medicaid/) of new regulations or issue new rules or guidance related to access, managed care, and enrollment processes. The Biden administration finalized a number of major Medicaid regulations designed to promote quality of care and advance access to care (https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-final-rule-cms-2442-f) for Medicaid enrollees as well as to streamline eligibility and enrollment (https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health) processes in Medicaid and the Children's Health Insurance Program (CHIP). These rules are complex and are set to be implemented over several years. Congress may consider legislation to overturn these rules, without legislation, the Trump administration could delay implementation of certain provisions or could issue new regulations that would undo these final rules. (Rules related to long-term care are discussed below). Finally, the Trump administration could issue guidance and implement policy to make it more difficult for people to obtain and maintain coverage, which would reduce enrollment and spending. Previously, the Trump administration sought to reduce Medicaid enrollment by encouraging states to conduct eligibility verification processes in between annual renewal periods.

State Budget Constraints and Priorities

State fiscal conditions remained [stable](https://budgetblog.nasbo.org/budgetblogs/blogs/brian-sigritz/2024/06/28/states-finalize-fiscal-2025-budgets) (https://budgetblog.nasbo.org/budgetblogs/blogs/brian-sigritz/2024/06/28/states-finalize-fiscal-2025-budgets) at the beginning of state FY 2025 (https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2024-2025/), but the longer term fiscal outlook is less certain. Heading into FY 2025, revenue collections had begun to stabilize (https://budgetblog.nasbo.org/blogs/brian-sigritz/2024/05/23/few-april-surprises-as-revenues-stabilize) and states were returning to more "normal (https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Fiscal%20Survey/NASBO_Spring_2024_Fiscal_Survey_of_States_S.pdf)" state budget environments, following multiple years of high revenue and spending growth as well as pandemic-related volatility and unpredictability (https://www.taxpolicycenter.org/publications/beyond-crystal-ball-state-revenue-forecasts-during-and-after-covid-19-pandemic). States appeared (https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Issue%20Briefs%20/Summaries_of_Governors_Enacted_Budgets_2025.pdf) to be in a stable fiscal position, though there is variation (https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Fiscal%20Survey/NASBO_Spring_2024_Fiscal_Survey_of_States_S.pdf) across states. According to FY 2025 enacted budgets, most states anticipated (https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Issue%20Briefs%20/Summaries_of_Governors_Enacted_Budgets_2025.pdf) revenue growth would continue to flatten and state general fund spending growth would slow. While states have made a number of Medicaid investments in recent years, including to expand access to behavioral health services, improve Medicaid reimbursement rates (particularly for long-term care), and to use Medicaid to help address social determinants of health, and reduce health disparities, expectations of reduced revenue collections beyond 2025 may dampen (https://www.ncsl.org/state-legislatures-news/details/states-rethink-ambitious-projects-as-tax-revenues-shrink-and-pandemic-aid-ends?utm_source=national+conference+of+state+legislatures&utm_term=0_-318011a32a-%5blist_email_id%5d&utm_campaign=318011a32a-today_sept_13&utm_medium=email) enthusiasm for further investments in Medicaid and could even prompt spending reductions. Reduced state revenues may be tied to implementation of state tax cuts, the expiration of pandemic-era federal funding, and other macroeconomic uncertainties (https://www.taxpolicycenter.org/publications/state-revenues-show-sluggish-growth-through-first-six-months-2024) Any reductions in federal Medicaid spending would put further pressure on state budgets and lead to program cuts.

The Long-Term Care Workforce

It is unknown whether new administrative actions will undermine efforts to bolster the long-term care workforce. There are also longstanding challenges finding enough workers to provide long-term care for people who need such services, and the COVID-19 pandemic

exacerbated those issues considerably. As of February 2024 (https://www.healthsystemtracker.org/chart-collection/what-are-the-recent-trends-health-sector-employment/), employment levels in most long-term care settings remained below pre-pandemic levels. The Biden Administration finalized two rules intended to address those challenges and increase access to services. The Administration finalized a rule (https://www.federalregister.gov/documents/2024/05/10/2024-08273/medicare-and-medicaid-programs-minimum-staffing-standards-for-long-term-care-facilities-and-medicaid) that would create new staffing requirements (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-final-nursing-facility-rule-and-which-facilities-might-meet-new-staffing-requirements/) in nursing facilities, require state Medicaid agencies to report on the percent of Medicaid payments for institutional long-term care that are spent on compensation for direct care workers and support staff, and provide funding for individuals to enter careers in nursing facilities. The rule will increase the number of staff in many nursing facilities, but also increase Medicaid spending. The Administration also finalized a rule (https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services) aimed at ensuring access to Medicaid services, which included several provisions aimed specifically at home care, which is long-term care provided in home and community environments. The "access" rule requires states to spend least 80% of total payments for certain home care services on compensation for direct care workers. It's unknown whether the Trump Administration will implement those rules or revise them, and it is possible Congress will overturn them.

Cuts to Medicaid and changes in immigration policy may exacerbate workforce challenges, reduce payment rates for long-term care workers, and erode supports to family caregivers. In response to workforce challenges, many states have adopted (https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-provider-rates-and-taxes/) payment rate increases for nursing facilities and home care providers with the goal of boosting staffing levels. All states have also created supports for family caregivers, (https://www.kff.org/medicaid/issue-brief/how-do-medicaid-home-care-programs-support-family-caregivers/) recognizing that caregiving can be very demanding, particularly when there are shortages of paid caregivers. Those initiatives may be impossible to sustain if federal support for Medicaid is reduced by one third (https://www.kff.org/quick-take/house-gop-eyeing-cuts-of-nearly-one-third-in-projected-medicaid-spending/). Beyond reducing Medicaid resources, President Trump's planned crackdown on immigration may further strain the long-term care (https://rollcall.com/2025/01/09/trumps-immigration-plans-could-imperil-long-term-care-workforce/) workforce, which relies heavily on foreign-born workers.

What to Watch

The issues identified in this policy watch could have major implications for Medicaid coverage, financing, and access to care. As these issues play out, the following key questions will be at the forefront:

- ***Federal funding cuts and financing reforms:*** Will Congress enact major cuts to federal Medicaid funding and changes to how the Medicaid program is financed? What will federal cuts in Medicaid mean for people enrolled in the program, states, and providers? How will the impact of any federal policy and funding changes vary across states?
- ***Work requirements:*** Will Congress pass legislation to allow or require work and reporting requirements in Medicaid? If Congress does not include work requirements in legislation, which states will pursue work and reporting requirement waivers under a second Trump administration? How will such policies affect coverage?
- ***Other waivers and administrative changes:*** Beyond work requirements, what waivers will be encouraged and approved under the second Trump administration? Will the administration withdraw any approved waivers or rescind Biden administration waiver guidance? What will happen with major access and eligibility / enrollment regulations finalized under the Biden administration? How will other administrative guidance affect coverage?
- ***State budget constraints and priorities:*** What are current projections for state revenue growth? How will changes in state fiscal conditions affect states' ability to continue to pursue and maintain recent investments in Medicaid for behavioral health, long-term care, reimbursement rates, social determinants of health, and efforts to reduce disparities? How will federal Medicaid policy changes affect state budgets?
- ***The long-term care workforce:*** Will Congress or the new Trump administration overturn final rules that would bolster nursing facility staffing, wages for long-term care workers, and payment transparency? How will broader changes in Medicaid affect states' ability to retain higher payment rates for long-term care workers and supports for family caregivers? How will changes in immigration policies affect the direct care workforce?

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Sara McRae

Subject: FW: FY26 Executive Budget Proposal

From: Monique Francis <MFrancis@cmham.org>
Sent: Thursday, February 6, 2025 1:49 PM
To: Monique Francis <MFrancis@cmham.org>
Cc: Robert Sheehan <RSheehan@cmham.org>; Alan Bolter <ABolter@cmham.org>
Subject: FY26 Executive Budget Proposal

WARNING: This message has originated from an **External Source**, please use caution when opening attachments or clicking links.

From: Alan Bolter <ABolter@cmham.org>
Sent: Thursday, February 6, 2025 1:35 PM
To: CMHA Board of Directors, CMH & PIHP Directors, Provider Alliance, SUD Directors, and Legislation & Policy Committee
Cc: Robert Sheehan <RSheehan@cmham.org>
Subject: FY26 Executive Budget Proposal

All,

Yesterday, Governor Gretchen Whitmer and Michigan State Budget Director Jen Flood and Deputy Director Kyle Guerrant presented Governor Whitmer's Fiscal Year (FY) 2025 - 2026 Executive Budget Recommendations before a joint meeting of the Michigan Senate and House Appropriations Committees. This presentation jumpstarts what is known as budget season in Lansing, where both the House and Senate use the Governor's recommendation as a guide to negotiate their respective budget proposals and ultimately present a unified budget to the Governor before the statutory deadline of July 1st.

It is important to note that this budget recommendation serves as a jumping off point to get the negotiations with the House and Senate started. Many priorities the Governor announced will be replaced with those of legislative leaders. More likely than not, we expect negotiations to continue throughout the summer, past the July 1st statutory deadline into September, with a final FY 26 budget being presented to the Governor days before the October 1st fiscal year start date.

The much-anticipated budget recommendation, which amounts to the largest state budget in Michigan history, was released amidst the January Consensus Revenue Estimating Conference report that indicated the state's general fund was $1.2 billion higher than expected.

This year's presentation offers a $83.5 billion budget recommendation that includes a general fund total of $15.3 billion and a School Aid Fund total of $21.2 billion. The Governor highlighted the following priorities for strategic investment:

- Lowering costs for Michiganders

- Creating Jobs
- Getting Smart on Education
- Supporting Seniors
- Protecting and Defending Michiganders
- Making Government Work Better

More specifically, here are the items of significance to the public mental health system (I am in the process of reviewing of boilerplate sections and will send out an updated document once I have completed that review):

Links to budget documents Executive Budget and Associated Documents
Links to budget bill (DHHS begins on page 114): FY26-General-Omnibus.pdf

Specific Mental Health/Substance Abuse Services Line items

	FY'24 (Final)	FY'25 (Final)	FY'26(Exec Rec)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$3,160,958,400	$3,387,066,600	$3,422,415,900
-Medicaid Substance Abuse services	$95,264,000	$95,650,100	$98,752,100
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,599,700	$79,626,200	$80,207,900
-Health Homes Program	$53,400,100	$53,418,500	$53,239,800
-Autism services	$279,257,100	$329,620,000	$458,715,500
-Healthy MI Plan (Behavioral health)	$590,860,800	$527,784,600	$535,508,300
-CCBHC	$386,381,700	$525,913,900	$916,062,700
-Total Local Dollars	$10,190,500	$10,190,500	$9,943,600

Other Highlights of the FY26 Executive Budget:

Proposed FY26 Investments The FY26 Executive Budget provides $62 million ($15.2 million general fund) in new supports to address the opioid epidemic and provide behavioral health services for those in need. Proposed funding includes:

- $15.2 million to begin operating the new state psychiatric hospital in Northville, bringing 264 new beds online and increasing capacity by 54 beds (32 adult beds and 22 pediatric beds). This investment includes operational support and hiring staff to provide services at the new facility.

- $46.8 million of Michigan Opioid Healing and Recovery Fund dollars for prevention, treatment, harm reduction, recovery, and data collection for those affected by the opioid epidemic. This additional allocation will expand services to reduce the number of opioid users and overdoses.

    - $15 million one-time to invest in new programs to reduce opioid usage and overdoses.
    - $31.8 million ongoing to continue existing, successful programs, including efforts to address the racial disparities in overdose deaths statewide. This brings the total annual ongoing funding to $55 million per year, supported by incoming settlement dollars.
    - The department's three-year plan will drive the use of these resources. The plan represents a comprehensive, multifaceted, data-driven approach intended to strategically leverage available resources and take full advantage of this generational opportunity in the most impactful yet sustainable way possible. The plan includes:
        - Increasing the age of first opioid use though new and expanded programs. The department will partner with nonprofits, youth engagement organizations, and existing partners to expand prevention programing in schools. They will also conduct public awareness campaigns.
        - Reducing overdose deaths and addressing racial and geographical disparities. Those disparities are demonstrated in the chart below. DHHS will use resources to award multi-year grants to organizations working in underserved or under resourced communities. DHHS will also provide annual grants or contracts with organizations addressing racial disparities in opioid deaths and continue distributing naloxone in areas that need it most.
        - Growing the behavioral health workforce through scholarships to prospective students, paid internships, and loan repayment.
        - Prioritizing work to increase recovery beds and access to affordable housing. This will include reimbursing the cost of stay of residents and expansion of recovery housing. It also includes permanent affordable housing and investing in wraparound support programs like transportation and employment that enable people to stay in stable housing.
        - Investing in administrative infrastructure to gather data to track success and provide technical assistance to local governments. This ensures these funds are being utilized for maximum impact and allows the department to partner with local governments to collaborate on ways to address opioid usage

- $96.4 million to expand Medicaid eligibility ($33.1 million general fund) with a new income disregard that will allow more people to gain access to coverage.
    - Currently Medicaid requires elderly and disabled enrollees with income above 100% of federal poverty limits (FPL) to spend the majority of their income on health care costs each month – until their remaining income is less than 40% FPL – to access Medicaid. This proposal would shift this level to 100% FPL, broadening access to Medicaid supports and preventing excessive spend down to help keep more seniors in their homes and prevent individuals from spending down into poverty.

- $400,000 to explore the feasibility of expanding Medicaid eligibility for children aged 0 - 6 years ($200,000 general fund).
    - This will allow DHHS to prepare a feasibility study to determine long-term costs, benefits, potential barriers and any associated nuances of implementing continuous eligibility for Medicaid beneficiaries aged 0-6.
- $40 million for the community reentry of incarcerated individuals ($20 million general fund) to provide coverage starting 90 days before an individual's scheduled release.
    - This will allow for health screenings and other services prior to reentry to identify key health needs and social determinants to facilitate a successful transition. Investing in these transition services will help improve health outcomes and access to community services, all of which will reduce recidivism.

- $2.5 million for access to mental health services (general fund, one-time) to support behavioral health resources for first responders and public safety staff.

- $258 million to support the mental and emotional wellbeing of 1.4 million students through continuation of mental health and safety grants to school districts.

- $5 million to support the MiABLE program expansion.

Alan Bolter
Associate Director
Community Mental Health Association of Michigan
507 S. Grand Ave, Lansing MI 48933
(517) 374-6848 Main
(616) 340-7711 Cell

Sara McRae

Subject: FW: non value items

Importance: High

From: Chris Pinter
Sent: Friday, February 7, 2025 10:32 AM
To: Richard Byrne (redhorse2121@yahoo.com) <redhorse2121@yahoo.com>; Robert Pawlak (bopav@aol.com) <bopav@aol.com>; Patrick McFarland <pjmcfarland52@gmail.com>; Christopher Girard <cgirard1@msn.com>; Sally Mrozinski <smrozinski@arenaccountymi.gov>; Tim Banaszak Secondary (banaszakt@baycountymi.gov) <banaszakt@baycountymi.gov>; niemieck@baycounty.net; Jerome Crete <jtcrete@yahoo.com>; conleypat@gmail.com; CAROLE OBRIEN <caroleo3@sbcglobal.net>; pschumacher82@gmail.com
Cc: Marci A. Rozek <mrozek@babha.org>; Sara McRae <smcrae@babha.org>
Subject: FW: non value items
Importance: High

BABHA Board of Directors,

FYI...the Community Mental Health Association asked for a summary of issues that CMHSPs have had with the MI Department of Health and Human Services.

I suspect these issues will also be shared with the incoming legislators in the State House.

Chris

From: Chris Pinter
Sent: Monday, February 3, 2025 4:11 PM
To: Alan Bolter <ABolter@cmham.org>
Cc: Robert Sheehan <rsheehan@cmham.org>
Subject: RE: non value items

There are so many non-value added items that have been added to the PIHP/CMHSP contracts in the last several years.

I recommend focusing on the specific ones that **only increase administrative expense but fail to increase access to care or health outcomes** for our citizens:

1. **Conflict-free Access & Planning**
    a. CMHSPs are already prohibited by State law from making service decisions based on ability to pay or insurance (chapter 8 of the MHC)
    b. The capitation model and rate setting process financially disincentivizes CMHSPs from direct service provision if a lower cost provider is available
    c. Any largess a CMHSP may earn from "pecuniary" based service provision retains its public identity and is subject to audit, claw back and settlement with MDHHS...just ask the former Summit Point management team.
    d. The definition of rural and urban from the 422.116 Network Adequacy Standards (developed specifically for specialty and facility based providers under managed care) does not include any comparable 1915i Home and Community based services. This results in 49/83 counties in

Michigan being considered non-rural. If MDHHS just used the 2020 US census data indicating the % of county population residing in “rural” blocks (i.e. 50%+1), it would reduce the number of counties impacted to 27/83 and be more reflective of our state.

2. **Standard Cost Allocation Methodology/Medical Loss Ratio (MLR) requirements 42 CFR § 438**
    a. MDHHS and their actuary spent several years developing a standard cost allocation method for MLR reporting to monitor *comprehensive risk contracts*
    b. CMHSP recommendations were routinely discarded even after we could demonstrate contradictions with 2 CFR Part 200 requirements that are standard for nearly all governmental agencies
    c. Michigan has essentially a non-risk agreement between the State, Counties, and CMHSPs/PIHPs as local governmental entities. The contracts are cost settled each year, there are restrictions on the use of surplus and/or Internal Service Funds (ISF) and unspent funds are returned to the State.
    d. As a result, funds paid to CMHSPs/PIHPs do NOT lose their Medicaid identity as in a *comprehensive risk contract* with a private interest, governmental entities are not subject to the solvency requirements in 42 CFR § 438.116 and non-risk contracts defined at 42 CFR § 438.2 are not required to have an MLR calculation
    e. Unfortunately, the PIHPs are required to report the MLR despite its limited applicability to non-risk contracts.

3. **Inpatient Tiered Payment rates**
    a. MDHHS convened a Stakeholder Group to operationalize Section 1815 of the 2024 Appropriation Act to *increase Medicaid inpatient psychiatric rates.* The end result was far beyond the original guidance from the legislature and mandated a permanent *tiered minimum rate payment methodology to incentivize provision of inpatient psychiatric care.*
    b. Unfortunately, the establishment of a “minimum” rate for each tier will not increase access to inpatient services. Many CMHSPs already reimbursed hospitals far above the proposed minimums discussed by the workgroup and hospitals still have the negotiating leverage of supply and demand.
    c. inpatient psychiatric hospitals do not have the same inherent public safety obligations as a CMHSP under the law and may always default to the fact that it may actually be more financially advantageous for the hospital to leave the bed open or accept someone with lesser needs than admitting a challenging public patient.
    d. This is likely to increase existing CMHSP expenses for higher acuity cases without actually improving access to inpatient care.

4. **Waskul Settlement**
    a. MDHHS has settled a lawsuit filed several years ago concerning the knowingly underfunding of community living support services (CLS) for persons on the habilitation support waiver (HSW). The settlement will require a 50% increase in hourly staff wages from $20 to $32 per hour to settle this litigation.
    b. Unfortunately, although the settlement is state-wide, it excludes similar CLS services provided to other Medicaid beneficiaries in the public mental health system and will significantly exacerbate the pay differentials between professional staff with similar credentials performing comparable work under federal and state labor laws. This will only create further challenges in staff recruitment and retention.
    c. The legislature will have to appropriate the funds necessary for the settlement and as a result, existing CLS service expenses will increase significantly without any increase in the number of persons accessing care.

5. **Mandatory Rate increase for Autism services as noted in Medicaid Policy Bulletin 24-51**

a. MDHHS is mandating an increase in rates paid for Behavioral Health Treatment (BHT)-Applied Behavioral Analysis (ABA) services for persons with autism to $66 per hour even though the general rule under 438.6(c)(1) for State Directed Payments under PIHPs actually discourages States from directing expenditures under the PIHP contracts
b. As a matter of policy, MDHHS has tended to avoid implementation of requirements that fundamentally alter the nature of the PIHP contracts by establishing fixed payment rates. For example, the direct care wage mandates during COVID-19 provided for a uniform dollar increase for certain procedure codes but did not essentially establish a new wage scale. It is the responsibility of the PIHP and CMHSPs to establish fair market rates.
c. MDHHS did NOT take this increase into consideration in the development of the Fiscal Year 2025 Medicaid rates. This will add nearly $1,000,000 in expense just to BABHA without actually increasing the number of persons accessing services and directly contradicts existing boilerplate in section 960 indicating intent "To restrain cost increases in the autism services line item..."

There are others but these are the most challenging in recent years, particularly in the way that they purposely mischaracterize the relationship between the state and the counties, implies a commercial motive to governmental services and arbitrarily chooses winners and losers in the Medicaid program.

From: Alan Bolter <ABolter@cmham.org>
Sent: Wednesday, January 29, 2025 12:29 PM
To: Chris Pinter <cpinter@babha.org>
Subject: non value items

WARNING: This message has originated from an **External Source**, please use caution when opening attachments or clicking links.

Would you send me a list off the top of your head of non-value added items (I want to have a quick reference list for legislators when I meet with them)

Things like – CFAP & CANS (still having to do CFAS and PCFAS) etc

Alan Bolter
Associate Director
Community Mental Health Association of Michigan
507 S. Grand Ave, Lansing MI 48933
(517) 374-6848 Main
(616) 340-7711 Cell

‘A broken system.’ Mental health patient complaints go nowhere in Michigan

Getting a complaint to stick in Michigan’s mental health system isn’t easy, an MLive investigation revealed.

In 2023, 73% of complaints were found to be unsubstantiated and never investigated any further – usually by the same provider or hospital the complaint was lodged against.

Attempts to change the system over the last 20 years have not gained any traction. It’s left people already struggling to access mental health care for themselves and loved ones hopeless and demoralized.

Take Sue Stuever, who filed a complaint claiming she couldn’t get mental health services for her two adopted sons born with fetal alcohol syndrome and on the autism spectrum. She says one of the boys can become violent without proper treatment.

Her complaint was not substantiated.

“What was so silly about it is … they investigated themselves, which I find to be problematic,” Stuever said.

Sue Stuever, 50, sits with her sons Elias Stuever Battel, 14 at left, and Asher Stuever Battel, 16, on Thursday, Jan. 23, 2025 at the Stuever residence in Capac.Jake May | MLive.com

Another mother compared the process to a rigged chess game.

The state's patient complaint process, named the recipient rights system by the Michigan Department of Health and Human Services (MDHHS), is intended to protect vulnerable mental health patients. But an MLive investigation shows that people filing complaints rarely win. MLive reviewed complaints, inspections, police reports, state data and conducted several interviews with patients, guardians, mental health advocates and former mental health directors. A few key findings from the investigation include:

- The complaint process is tainted by conflicts of interest since providers investigate wrongdoing by their own employees or contractors. Appeals are also heard by a committee appointed by county mental health providers.
- The most serious allegations are found to be unsubstantiated. Among 17,084 complaints logged in fiscal year 2023, only 27% were substantiated; however, the rate dips dramatically for the most serious assault and sex abuse cases, which were substantiated 13% and 7% of the time, respectively.
- Some psychiatric hospitals aren't following the rules established by MDHHS to guide how complaints are received, investigated and resolved. In 2023, MDHHS assessments found 82% of hospitals had recipient rights processes deemed to be flawed. That's worse than 2022, when the number was 63%.

"A lot of times ... you sort of give up," said Marianne Huff, Allegan County mental health director from 2010 to 2017. "It's a very frustrating system for people."

'DANGEROUS FOR MY FAMILY'

When Stuever moved from Tuscola County to St. Clair County's Capac in 2022, she called ahead to transfer mental health services, hoping for a seamless transition for her sons, one of whom requires two-on-one supervision due to behavioral issues and occasional violence.

She said a nightmare began.

Chris Page, a registered behavioral technician, works on math and writing skills with Elias Stuever Battel on Thursday, Jan. 23, 2025 at the Stuever residence in Capac.Jake May | MLive.com

“They refused to even take down my name,” Stuever said, since she wasn’t yet living in the county.

After moving in June 2022, it took the mental health agency nearly five months to place her eldest son and a year to find consistent therapy for her youngest, according to the complaint she filed with the state’s Office of Recipient Rights.

The state office, which had 23 employees and a $3.2 million budget in 2023, oversees decentralized recipient rights offices in four state-run psychiatric hospitals with greater than 700 beds, nearly 55 licensed psychiatric hospitals with more than 2,500 beds and 46 county mental health providers that service more than 200,000 patients per year.

When Stuever tried to hold the system accountable for perceived missteps, she said she was led down a path of red tape and frustration. While complaints are usually private, Stuever shared her records with MLive.

“Mom expressed dissatisfaction with the amount of time it has taken to get services in place since her move to our County,” read notes in Stuever’s file that were included in the complaint investigation. “This is the second time mom has expressed her dissatisfaction.”

Asher Stuever Battel, 16, smiles from cheek to cheek while staring out his mother's phone while his favorite song and artist — Taylor Swift's "Speak Now" — plays aloud while he enjoys a sliced apple snack on Thursday, Jan. 23, 2025 at the Stuever residence in Capac.Jake May | MLive.com

"It was really awful and dangerous for my family," Stuever told MLive.

Initially, Stuever was told no one received her complaint, even though she printed verification of the email. Stuever said she felt investigators spent more time blaming her than evaluating possible mistakes.

Notes in the complaint summary accuse Stuever of not returning calls at times and failing to complete parental training classes she agreed to take.

The mental health agency in question told Stuever that at the time they didn't have contactors available to provide the services she was requesting, according to file notes included in the complaint investigation.

Elias Stuever Battel, 14, holds one of their pets on Thursday, Jan. 23, 2025 at the Stuever residence in Capac. Elias has been diagnosed with level three severe autism, a milder case of intellectual impairment than Asher, fetal alcohol syndrome and disruptive mood disregulation disorder. Jake May | MLive.com

Stuever's dissatisfaction with the system is common, according to advocates.

Michelle Barnes, the Jackson County cofounder of Advocacy for Mental Health MI Youth, works with nearly 900 parents like Stuever and navigated the mental health system with her own child. She said the system rarely substantiates allegations. According to 2023 data, nearly 75% of complaints were denied.

Because of this, she said parents tend to "give up."

"It's like you're drowning and you're waiting for someone to toss you a life preserver," Barnes said. "Instead, they're throwing you rocks."

'IT' S JUST TOO INCESTUOUS'

One reason claims are rarely substantiated, advocates argue, is because the state's 46 community mental health providers and 50-plus hospitals that offer psychiatric care hire their own recipient rights officers.

"That can raise some questions, if your own employees are investigating their coworkers and essentially their employer," said Simon Zagata with Disability Rights Michigan, a group that helps patients file complaints. "Is there the right level of independence there and the right amount of length from the system to ensure a good investigation and accurate outcome?"

Barnes said there is a chilling effect – parents are simply afraid to speak up.

"I don't know any parents that are getting all of the services that they're eligible for," she said.

Marianne Huff saw the process firsthand as Allegan County mental health director from 2010 to 2017. When rights violations were proven, she determined the punishment for her employees and contractors.

"I don't believe that rights officers should report directly to the CEO (or director)," Huff said. "There should be a state rights office, meaning ... that all rights officers should work for the state, because otherwise you have this conflict of interest."

James Haveman, Michigan's director of community health from 1996 to 2003 and 2012 to 2014, also thinks there should be a separate agency that investigates the complaints.

"I've always felt (recipient rights) should be from the outside looking in," he said. "When the fox is watching the henhouse – like the community health board, who employs the recipient rights person and reports to the director – that to me was always an uncomfortable situation ... It's just too incestuous."

Raymie Postema, director of the state Office of Recipient Rights, declined to comment on perceived conflicts of interest.

"I can't speak to the internal versus external rights systems," Postema said. "There's been a lot of back and forth, in general, for many, many years on that."

When asked to comment on MLive's investigative findings, MDHHS officials didn't respond directly, but spokesperson Lynn Sutfin issued a statement that said: "MDHHS is committed to ensuring Michigan residents seeking behavioral health services can exercise their rights and that rights complaints are addressed."

'HAMSTER WHEEL'

Appeals are possible, but not likely to get results.

Of 59 appeals accepted in 2023 – .08% of all complaints – 48 initial findings were upheld, seven were turned back for further investigation or action and no outcome was listed for the remainder.

Appeals are handled by a seven-member committee appointed by the same mental health authority or hospital under investigation, and in certain situations by a state-level appeals committee.

Patients can file a second appeal with the state Office of Recipient Rights appeals committee, but it's extremely rare to get results.

There were four state-level appeals heard in 2023 and seven in 2022. They're mostly sent back to the local recipient rights office for further investigation.

Barnes said it feels like a never-ending "hamster wheel."

A 'DEFICIENT' PROCESS

When hospitals and other facilities are assessed by MDHHS, statistics show many aren't doing an adequate job – 82 percent were not in compliance in 2023.

A 2020 assessment of Copper Country Mental Health Services in Houghton deemed its recipient rights system to be in "less than substantial" compliance. The next visit in 2023 led to the same conclusion.

During an MDHHS inspection completed at Garden City Hospital in December 2021, the hospital's recipient rights office didn't provide information on filing appeals or have an appeals committee in place. There was no distinct complaint log, investigative files were missing findings and complaints were categorized incorrectly, among numerous other problems.

The hospital repeatedly failed to provide adequate evidence that it corrected the issues, and in August MDHHS sent a letter indicating it asked Licensing and Regulatory Affairs (LARA) to file sanctions. It's unclear if sanctions were ever issued, but another MDHHS assessment conducted in October found the complaint process issues had been resolved.

Despite possible penalties, problems often don't get corrected.

Since 2022, 75% of psychiatric hospitals had "numerous areas of deficiency" in their complaint handling systems and needed "significant corrections," according to the Office of Recipient Rights.

County mental health providers performed better. Since 2020, about 20% were found by MDHHS to have "numerous areas of deficiency" in need of corrections.

CHALLENGING CASES

Mental health workers say the cases they deal with are difficult because the people seeking help can be afflicted in ways that disrupt their sense of reality.

Stepanie VanSlyke, the recipient rights officer for Munson Medical Center's in-patient psychiatric hospital, said deciphering statements that are true versus the byproduct of mental illness is "probably the most challenging part of the job."

"When we're talking about patients who are sick enough that they require an in-patient hospitalization, you've got to be pretty sick," VanSlyke said. "With mental illness there is a component of either paranoia or delusion -- or whatever their underlying mental illness is -- and trying to work through and balance all of that is really intense."

But the patient always gets the benefit of the doubt.

"Even if a patient is delusional, I have to believe what they're saying, unless I can prove otherwise," Van Slyke said.

That is of little comfort for Chelsea Benham, the 31-year-old mother of an autistic boy, who has felt these doubts first-hand in two separate cases.

When Benham's 11-year-old son claimed he was sexually assaulted at a hospital during a stay when he was nine, police investigated, but the inquiry was quickly closed, according to the report. Benham said she was told her son wasn't a "reliable witness" and the detective wasn't going "on a wild goose chase."

A year after that complaint, the boy was involved in another assault case – this time at his Ann Arbor-area house. Benham called 911 one day because her son was having a hard time. The licensed mental health worker who responded was accused of assaulting him. Once again, the boy's reliability was questioned. A police and internal investigation followed, but the boy was never interviewed because, in part, he "is not always a reliable reporter due to his disability," according to the recipient rights complaint findings.

Both were discouraging experiences for Benham and her son.

Chelsea Benham poses in her Pittsfield Township home on Thursday, Oct. 24 2024. Benham filed multiple complaints with the Michigan Department of Health & Human Services after negative experiences with social workers treating her 11-year-old son.Jacob Hamilton | MLive.com

Even though he couldn't be interviewed in the second case, Washtenaw County prosecutors charged the worker with assault and battery, but a judge found the worker not guilty at a bench trial.

The recipient rights investigation, however, substantiated various MDHHS rules violations, finding that the worker smacked Benham's son, made threatening remarks, used unreasonable force and deprived the family of their right to dignity and respect, according to the report, which also indicated the mental health worker was terminated and the findings added to her personnel file.

Benham was pleased the employee could no longer respond to crisis situations, but said the outcome felt inadequate since there was no broader examination into policies, training or procedures that led to the behavior.

Overall, the most severe assault and sexual abuse cases rarely result in any action. In 2023, there were just eight substantiated sex abuse cases out of 112 complaints in Michigan's entire mental health system that serves more than 200,000, according to state statistics. Serious assault and sex abuse cases were only substantiated 13% of the time in 2022 and 7% in 2023.

HISTORY OF REFORM EFFORTS

Problems in the recipient rights system have been acknowledged for decades.

Twenty years ago, then-Gov. Jennifer Granholm appointed a Michigan Mental Health Commission that raised serious concerns about the program.

The commission's report said mental health providers employed the investigators and determined the punishment, which presented a concerning "conflict of interest."

"The public mental health system is not sufficiently accountable to consumers and families," the commission's final report in 2004 said. "Recipient rights are one area where this is most evident."

The commission called for the system to be "redesigned."

And in 2007, Disability Rights Michigan attempted to bring the problem to public light when it published a 33-page report recounting the circuitous odyssey of one complaint that endured 14 investigations, appeals or administrative court hearings over more than two years before reaching a dead end.

The complaint accused Pathways, the Marquette County mental health authority, of failing to properly treat a mentally ill jail inmate who later committed suicide in custody.

"The well-documented allegation in this complaint, the response of the Recipient Rights Office in addressing the complaint, and the ensuing attempts to hold the system accountable to correct the violation, all serve to illustrate the inherent flaws in the Michigan's Department of Community Health's current Recipient Rights system," said the report.

Nothing came of it.

Two decades later, little has changed.

In 2021, among other changes to the mental health system, Republicans proposed a privatization law that would have stripped county mental health providers of their complaint investigation function and transferred it to a nongovernmental third party.

It was rejected in a vote the following year.

'IT'S AN AMAZING SYSTEM'

The largest organization opposing changes is the Community Mental Health Association (CMHA) of Michigan, a trade organization that brought in $10 million in 2023 and employs its own lobbyists representing the mental health providers.

Efforts to change the system "come up every five to 10 years," said Robert Sheehan, the trade group's CEO for the past 25 years. Sheehan said if complaints were handled by a third-party, it would create a "punitive environment," and the number of complaints would drop dramatically.

"It's an amazing system," he said, "because it's based on quality improvement, not based on (someone) being blamed for something."

But advocates and lawmakers are still crusading for change.

The most vocal legislator is state Sen. Michael Webber, R-Rochester Hills, who requested an audit of the Office of Recipient Rights by the state Auditor General in 2023. That audit is underway and expected to be completed by mid-2025. It's unclear if it will focus solely on state-run hospitals or the much larger recipient rights system.

The last Office of Recipient Rights audit occurred in 2014 and was limited to state-run psychiatric hospitals.

But Haveman, the former head of Michigan's mental health system, said overall there's little political will to improve the system.

"We could never get the votes to change it," he said.

Meanwhile, mothers like Denise Meitz struggle to get the services they believe their children need.

Meitz, whose 25-year-old cognitively impaired son requires around-the-clock assistance, has filed numerous complaints related to services she believes her provider improperly denied.

None were substantiated, despite appeals and administrative court hearings.

Meitz doesn't think the mental health gatekeepers truly understand the struggles of patients and their families.

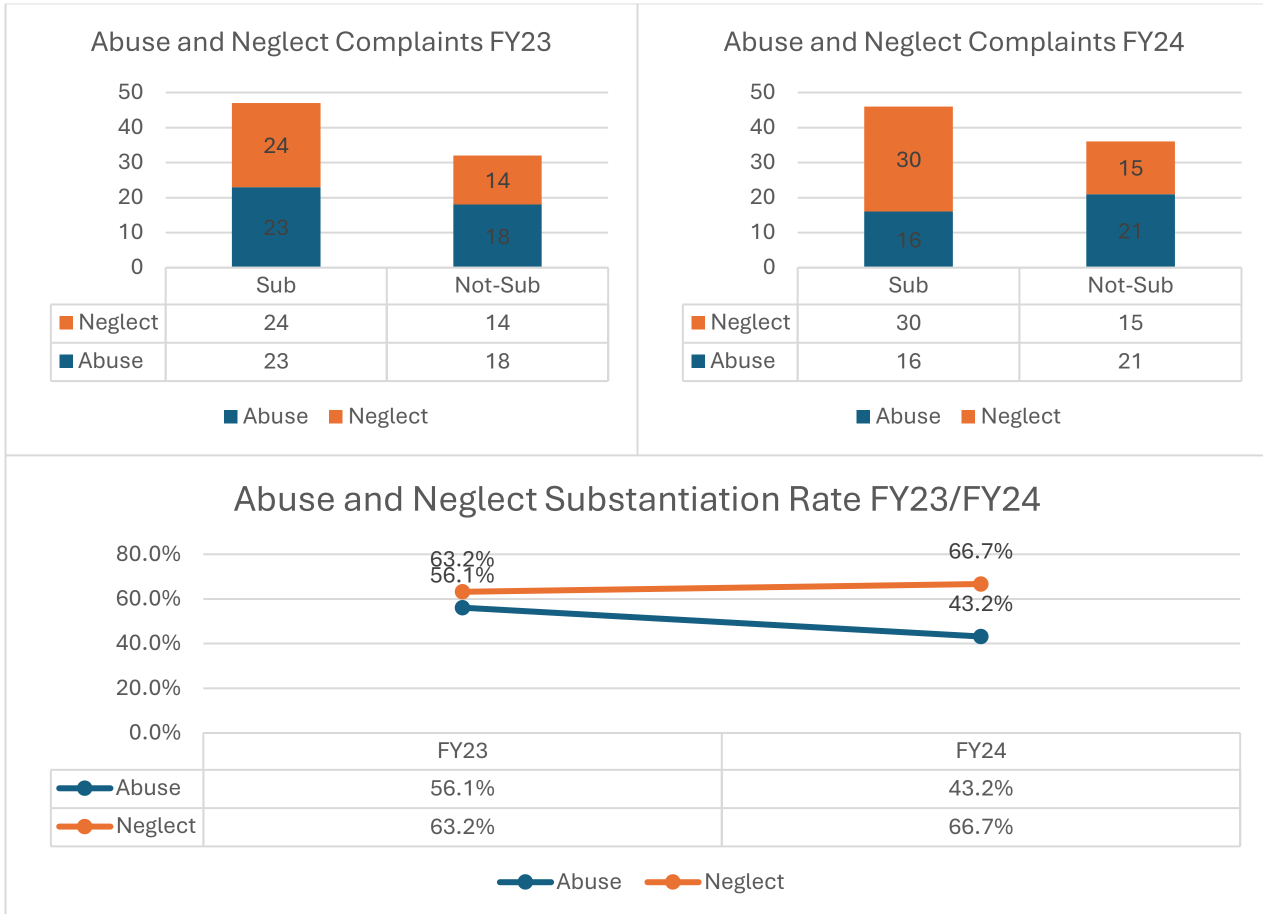
"You've got to understand that most of these mothers, they're just trying to keep up with meds and changing (diapers) -- just trying to survive," she said. "They don't even have time to pick up a pen and do a recipient rights complaint.

"And why would they, after what I've been through. It's a broken system."

If you've have an experience with Michigan's mental health complaint system that you'd like to share, please contact reporter Gus Burns, fburns@mlive.com.

BABHA ORR Response to "'A Broken System.' Mental health patient complaints go nowhere in Michigan" article by Gus Burns | MLive.com

RRAC Meeting February 10, 2025



The BABHA ORR received 190 complaints for FY23 with 41 allegations of Abuse and 38 allegations of Neglect. The substantiation rate for Abuse allegations was 56.1% and Neglect allegations was 63.2%. [More recent information for FY24 is that the BABHA ORR received 177 complaints, with 37 allegations of Abuse and 45 allegations of Neglect. The substantiation rate for Abuse allegations was 43.2% and Neglect allegations was 66.7%.]

BABHA's ORR data paints a different picture when comparing it to the article data which noted, "In 2023, 73% of complaints were found to be unsubstantiated and never investigated any further –usually by the same provider or hospital the complaint was lodged against." And "The most serious allegations are found to be unsubstantiated. Among 17,084 complaints logged in fiscal year 2023, only 27% were substantiated; however, the rate dips dramatically for the most serious assault and sex abuse cases, which were substantiated13% and 7% of the time, respectively."

Sara McRae

Subject: FW: Bay-Arenac Behavioral Health Announcements - Director of Integrated Care Selections

From: Chris Pinter
Sent: Friday, February 14, 2025 12:41 PM
To: Richard Byrne (redhorse2121@yahoo.com) <redhorse2121@yahoo.com>; Robert Pawlak (bopav@aol.com) <bopav@aol.com>; Patrick McFarland <pjmcfarland52@gmail.com>; Christopher Girard <cgirard1@msn.com>; Sally Mrozinski <smrozinski@arenaccountymi.gov>; Tim Banaszak Secondary (banaszakt@baycountymi.gov) <banaszakt@baycountymi.gov>; Jerome Crete <jtcrete@yahoo.com>; niemieck@baycounty.net; conleypat@gmail.com; CAROLE OBRIEN <caroleo3@sbcglobal.net>; pschumacher82@gmail.com
Subject: Bay-Arenac Behavioral Health Announcements - Director of Integrated Care Selections

BABHA Board of Directors,

We are pleased to report that Karen Amon will be returning to her previous position of Director of Integrated Services for Long term Care and that Nicole Sweet is being promoted to Director of Integrated Services for Acute Care.

Karen will have all of the supports coordination, community living supports (including North Bay and Horizon Home) , residential, vocational and self-determination services under her supervision.

Nicole will be responsible for emergency/access services (including mobile crisis), assertive community treatment, Bay County case management, Bay County outpatient, and psychiatrist/prescriber services. We will also be considering potential economies of scale within these service lines.

Joelin will continue overseeing all services to children and families including outpatient, case management, home based/infant mental health and autism services.

We will keep you posted as we move into the next stage of recruitment for the now vacant Director of Health Care Accountability and Clinical Program Manager CLS positions. We intend to continue to promote from within the organization as much as possible.

Chris

From: SharePoint Online <no-reply@sharepointonline.com>
Sent: Friday, February 14, 2025 9:07 AM
To: *BABH-Group <BABHAGroup@babha.org>
Subject: Announcements - Director of Integrated Care Selections

Director of Integrated Care Selections has been added

Jennifer Lasceski
2/14/2025 9:05 AM

Title: Director of Integrated Care Selections

Body: As previously announced to all staff, BABH was recruiting internally for two Director of Integrated Care positions. One position was to replace the Director of Integrated Care – Long Term Care position vacated by Heather Beson. The second position was for a Director of Integrated Care - Acute care services that currently is managed by Joelin Hahn. Joelin Hahn will continue to serve as the Director of Integrated Care with Children and Family Services.

As a result, Bay-Arenac Behavioral Health (BABH) has been in the process of internally recruiting and interviewing potential candidates for the Director of Integrated Care positions to take over these responsibilities. After a thoughtful and comprehensive process, the BABH Strategic Leadership team is pleased to announce that Karen Amon, Director of Health Care Accountability, has been selected as our next Director of Integrated Care Services - Long-Term Care services and Nicole Sweet, Clinical Services Program Manager – CLS has been selected as the Director of Integrated Care Services – Acute Care.

Karen has been an integral member of the Strategic Leadership team at BABH for the past 10 years. Prior to becoming the Director of Health Care Accountability, Karen served as the Director Integrated Health Services from 2014 until 2022, Karen served in both management and direct service roles within BABH and other behavioral health organizations in the Bay County area. Karen also served as a CARF surveyor for four years. She brings a comprehensive knowledge base of clinical services for all populations. Congratulations Karen!

Nicole has been a valued member to the BABH Leadership team serving as the Clinical Services Program Manager – CLS for the past 4 years. Nicole began employment with BABH in 2014 as an Emergency Services Specialist. She then transferred to the Arenac Center where she served as Intake/Emergent Services Clinical Specialist and then the Clinical Team Lead. In 2017, Nicole left full-time employment with BABH, working as a Program Therapist with Ascension Standish Hospital. In this role she provided therapy, case management services, and collaborated with Psychiatrist to develop treatment plans. During this time, she also continued to work casually with BABH's Emergency Services Department. Nicole returned full-time with BABH in January 2021 in her current position. She also brings a vast clinical knowledge base of clinical services for all populations. Congratulations Nicole!

The transition will begin soon as BABH begins the recruitment and selection process to find a replacement for Karen as the Director of Health Care Accountability and Nicole as the Clinical Services Program Manager - CLS. If you have any questions regarding this information, please feel free to contact your SLT member.

Expires: 3/7/2025

Modify my alert settings | View Announcements

2025 Annual Recipient Rights Training

It is that time of year again for the annual Recipient Rights Training. The training is on-line only this year and is required for all Board and Recipient Rights Advisory & Appeals Committee members. The training consists of three courses in Relias: Part I, Part II and Part III. All three training modules will need to be completed no later than March 31, 2025. All Board and Committee members should have received an email containing the link to Relias and sign-on information. If you have trouble accessing the training or have questions contact Sara McRae at smcrae@babha.org or 989-895-2348.

March 2025 BABH Board of Directors

March 2025

Su	Mo	Tu	We	Th	Fr	Sa
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9	10	11	12	13	14	15
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30	31					

April 2025

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SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Feb 23	24	25	26	27	28	Mar 1
2	3	4	5	6 4:00pm Nomination Committee 5:00pm Facilities & Safety Committee	7	8
9	10 5:00pm Recipient Rights Advisory & Appeals Committee	11	12 5:00pm Finance Committee	13 5:00pm Program Committee	14	15
16	17 Saint Patrick's Day 5:00pm Audit Committee	18	19	20 5:00pm REGULAR BOARD MEETING	21	22
23	24	25	26	27	28	29
30	31	Apr 1	2	3	4	5

1/15/2025 3:56 PM

Corporate Compliance Plan

~~2024~~2025

APPROVALS

Corporate Compliance Committee:
Strategic Leadership Team:
Corporate Compliance Committee: ________
Full Board Approval Date:

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Statement of Purpose

It is the policy of the Bay Arenac Behavioral Health Authority (BABHA) Board of Directors to have a Corporate Compliance (CC) Plan in effect, as stated in BABHA policy and procedure C13-S02-T18 Corporate Compliance Plan. The CC Plan is in place to guard against fraud and abuse, and to ensure that appropriate ethical and legal business standards and practices are maintained and enforced throughout BABHA[1].

The BABHA Corporate Compliance Plan ensures the integrity of the system in which BABHA operates and the culture in which it is served is maintained at the highest standards of excellence, with a focus on business and professional standards of conduct compliant with federal, state and local laws, including confidentiality, compliance with reporting obligations to the federal and state government, and promotion of good corporate citizenship, prevention and early detection of misconduct.[2]

The BABHA Corporate Compliance Plan is reviewed and updated annually.

Definitions

Abuse: Practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or failure to meet professionally recognized standards for healthcare.

Contracted Service Provider means an individual who has a contractual agreement with BABHA to provide behavioral health clinical or administrative goods or services to BABHA or its consumers, or an organization with such a contract.

CEO means Chief Executive Officer of Bay-Arenac Behavioral Health Authority.

CC is an abbreviation for Corporate Compliance.

CCO or CC Officer means Corporate Compliance Officer.

Fraud: An intentional deception or misrepresentation by a person that could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State laws.

Individual Practitioner means a licensed professional engaged with BABHA through either an employment contract or as a Contracted Service Provider, providing health care services for consumers consistent with their licensure.

Privacy Officer means the individual assigned the responsibility for overseeing the ongoing development of privacy related operations.

PHI is an abbreviation for Protected Health Information, which is comprised of several types of confidential consumer treatment information which is defined as protected under the Healthcare Improvement Portability and Accountability Act.

Security Officer means the individual assigned the responsibility for overseeing the ongoing development and management of security related technological operations.

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[1] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)
[2] CARF Standards: Section 1 Aspire to Excellence: E Legal Requirements: Standard 1

Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, considered not caused by criminally negligent actions, but rather the misuse of resources.

Policies, Procedures, Standards of Conduct

BABHA has established written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with applicable Federal and State standards, including but not limited to the False Claims Act (31 USC 3729-3733, the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005), the Michigan Whistleblowers Protection Act (PA 469 of 1980) and the federal Whistleblower Protection Act of 1989, 5 U.S.C. 2302(b)(8)-(9).[3]

The policies have been approved by the BABHA Board of Directors in accord with Federal Program Integrity requirements, the MI Dep't of Health and Human Services Medicaid Manual and the Medicaid Managed Specialty Supports and Services Contract.

Regulatory Compliance

BABHA maintains a list of Federal and State laws and regulations, and contractual requirements with which the organization must comply (see attachments). The list is maintained on the BABHA group drive by the CCO. The BABHA Corporate Compliance Committee has a regular monitoring process for review and disposition of new and changing regulatory requirements. The membership of the BABH Corporate Compliance Committee facilitates communications and preparations for compliance with new and revised regulatory and contractual requirements. The Director or Health Care Accountability attends the CMHA Legislative and Regulatory Meeting and updates the Corporate Compliance Committee on legislative proposals that may impact service delivery and operations.

~~In 2023, the Corporate Compliance Committee identified a weakness in BABHA's regulatory compliance process regarding confirming changes in policies and procedures that are made to comply with regulatory changes are fully actualized. The Committee worked with agency leadership to add post-implementation evaluations to ensure full vertical integration of policy and procedure changes. The Committee also determined improvements in the applicability section of the policy and procedure template are needed to provide more clarity regarding who needs to be educated regarding the document.~~ Agenda items on the Leadership Meeting have been added to include regulatory items to ensure that the full integration of changes are consistently being adopted. Policy and Procedure changes are presented to the staff through Relias and for Providers they are posted on the website. At the Provider Network and Quality Management Committee (PNOQMC) a reminder of the policies that have been updated is included ~~will be included~~ on the Agenda.

Medical Records

BABHA maintains an electronic record keeping system to ensure documentation of services delivered is maintained in a manner that is consistent with the provisions of the Michigan Medical Services Administration Policy Bulletins and the Michigan Medicaid Manual, and appropriate state and federal statutes. BABHA requires clinical service delivery records to document the quantity, quality, appropriateness and timeliness of services provided. Clinical contracted service providers (including Individual Practitioners) are required to either utilize

[3] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(i)

the BABHA electronic medical record keeping system or establish and maintain a separate comprehensive individual service record system. At a minimum clinical contracted service providers are required to scan key documents into the BABHA electronic health record (EHR).

BABHA policy and procedure C04:S10:T01 Clinical Documentation, C13-S01-T20 Designated Record Set, and C04:S10: T02 Signatures outlines specific BABHA record keeping standards. BABHA policy and procedure C13-S02-T03: Document Retention and Disposal outlines BABHA's strategies to comply with retention schedules in place by the State of Michigan.

Prohibited Affiliations[4]

BABHA has an active program to protect the organization from knowingly having a relationship with individuals debarred, suspended or otherwise excluded from participation in Federal procurement activities and healthcare programs such as Medicare.[4] The program also ensures BABHA does not knowingly have relationships with individuals excluded from participation in Medicaid, or any other state healthcare program.

BABHA policy and procedure C13-S02-T11 Prohibited Affiliations and Backgrounds outlines BABHA's monitoring and response program. The program covers BABHA's Board of Directors, CEO and employees, as well as contracted service providers (including Individual Practitioners), as well as selected vendors and suppliers.

Federal exclusion/ debarment registries are checked monthly for BABHA Board of Directors, Officers (i.e., senior managers), employees, individual professionals and clinical contracted service provider organizations, CEO's and key prescribers. BABHA also checks selected non-clinical vendors with significant transactions with BABHA and declared co-owners of contracted service provider organizations as appropriate.

BABHA contracts with a vendor to facilitate reviews of the registries monthly. BABHA requires providers to declare ownership and control interests and monitors these individuals concurrently with the providers and BABHA personnel.

Members of the BABHA Board of Directors, the BABHA CEO and new employees sign attestations of their compliance with these requirements and commit to notifying BABHA of any changes in status including criminal convictions. BABHA also requires employees to complete an annual attestation which confirms they have not acquired a criminal conviction during their employment that has not been reported to Human Resources.

Clinical contracted service provider organizations are required to perform initial and monthly checks for exclusion/debarment and criminal convictions for their employees and relevant subcontractors, if any. BABHA confirms these practices are in place during site reviews of contracted clinical service providers.

Criminal background checks are completed for BABHA employees upon hire and every two years thereafter. Abuse registry checks are completed for BABHA employees serving children. Contracted service providers are required to comply with the criminal background checks and abuse registry checks for providers that serve children. Specialized residential providers are further required to obtain fingerprint-based background checks.

Privacy and Security

BABHA has policies and procedures in place to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) for confidentiality of health care records, as well as 42 CFR PART 2 for confidentiality of any substance abuse treatment program records maintained by BABHA, and state laws governing the confidentiality of mental health and substance use disorder (SUD) treatment records and HIV/AIDS information. The policies and procedures cover protected health information (PHI) and substance use disorder treatment

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[4] Managed Care Rules: 438.610 Prohibited Affiliations

information generated, received, maintained, used, disclosed or transmitted by BABHA and selected contracted service providers (including Individual Practitioners).

BABHA's Agency Manual Chapter 9, Information Management, contains the organization's HIPAA Security, Transaction and Code Set Rule compliance strategies. Privacy and confidentiality strategies are addressed in Chapter 13, Corporate Compliance, Section 1.

BABHA's policy and procedure C13-S01-T18 Business Associates outlines which types of service providers, including health care service providers, and non-health care vendors and suppliers, who meet the definition of a Business Associate (BA) of BABHA. The BABHA Contract Manager and Finance Assistant work with the Privacy Officer to ensure BA Agreements are in place where required.

Standards of Conduct[5]/ Operating Philosophy and Ethical Guidelines

BABHA has written Standards of Conduct and Operating Philosophies/Ethical Guidelines for employees and Individual Practitioners to clearly delineate BABHA's institutional philosophy and values concerning compliance with the law, government guidelines and ethical standards applicable to the delivery of behavioral health care.

The BABHA Director of Human Resources prepares and reviews/ revises the Standards of Conduct/ Operating Philosophy and Ethical Guidelines, as appropriate. The Standards of Conduct/Operating Philosophy and Ethical Guidelines are submitted to the Strategic Leadership Team, CEO and BABHA Board for consideration and approval.

A copy of the Standards of Conduct/Operating Philosophy and Ethical Guidelines is distributed to all employees as part of the new employee orientation process and is also available to staff on the BABHA intranet site. It is posted for contracted service providers through the provider section of the BABHA website. Changes to the Standards are communicated to all staff via the policy/ procedure/ plan educational system.

Ethics Committee

BABHA operates an Ethics Committee chaired by the Recipient Rights/Customer Service Manager, which is a sub-committee of the BABHA Corporate Compliance Committee. The Ethics Committee is responsible for serving as a forum for the review and analysis of ethical dilemmas. The Committee also oversees BABHA standards for ethical conduct, including establishing policies and procedures to enhance the organization's responsiveness to internal and external customers with respect to the ethical dimensions of managing, coordinating, and providing community-based behavioral health services. The Ethics Committee is responsible for promoting staff understanding of ethical concerns in contemporary behavioral health care, including ongoing education.

The Ethics Committee is comprised of representatives from the major departments and programs of BABHA, as well as subject matter experts, internal and external to the organization. The Ethics Committee reports through the Corporate Compliance Committee. The Recipient Rights/Customer Service Manager has direct access to the CEO to address issues that overlap with personnel management and the Corporate Compliance Officer in the event of ethics issues that coincide with corporate compliance concerns.

The Ethics Committee meets twice per year, with additional meetings called on an ad hoc basis as needed for case review. Employees can submit an ethical question for consideration by the Committee. An Ethicist from a local university is on contract for consultation with the Committee as needed.

Duties of the Committee include but are not limited to:

[5] Managed Care Rules: 438.608 (a)(1)(i) Program Integrity Requirements

- Assisting with annual updates of the BABHA Standards of Conduct/Operation Philosophy and Ethical Guidelines as appropriate.
- Concerns raised by staff and leadership of BABHA that are not determined to involve regulatory compliance will typically involve a conflict of interest or ethical dilemma. The Ethics Committee is responsible for serving as a forum for review and analysis of ethical dilemmas. The Committee analyzes ethical dilemmas, consults with an Ethicist as necessary, and provides feedback/ recommendations to the individual who submitted the issue for consideration.
- Assisting the Director of Human Resources with overseeing BABHA standards for ethical conduct, including establishing policies and procedures to enhance the organization's responsiveness to internal and external customers with respect to the ethical dimensions of managing, coordinating, and providing community-based behavioral health services.
- The Ethics Committee is responsible for promoting staff understanding of ethical concerns in contemporary behavioral health care, including ongoing education.

Program Integrity Requirements for Clinical Contracted Service Provider Organizations

BABHA requires clinical contracted service providers to adhere to Federal and State requirements regarding guarding against fraud and abuse, and complying with applicable regulatory requirements and standards, as outlined in BABHA policy and procedure C13-S02-T16 False Claims.

Clinical contracted service provider organizations are required to implement and maintain written policies, procedures and standards of conduct, appropriate to the type and scale of the Provider agency, that articulate the organization's commitment to comply with federal and state program integrity requirements, including provisions for monitoring for exclusion and debarment from participation in state and federal health care programs.[6]

The required program integrity elements are communicated to the providers through contractual requirements. Compliance by contracted service providers is monitored by BABHA during site reviews.

Compliance Officer and Compliance Committees

The BABHA CEO has designated a Compliance Officer[7]. The BABHA Board of Directors has established a regulatory Compliance Committee and the CEO has a regulatory Compliance Committee at the senior management level.[8]

Corporate Compliance Officer

The CEO appoints the Corporate Compliance Officer. The CC Officer has the authority to address compliance concerns directly with the Chair of the BABHA Board of Directors, and the Health Care Improvement and Compliance Committee of the Board of Directors. The CC Officer has direct access to the BABHA Chief Financial Officer for consultation, as well as to specialized legal counsel of BABHA.

The CC Officer is responsible for the following:

- Developing and operating the CC Program; reviewing/ revising the CC Plan annually as necessary to meet changes in the regulatory and business environment;

[6] Managed Care Rules: 438.608(a)(6)
[7] Managed Care Rules: 438.608(a)(1)(ii)
[8] Managed Care Rules: 438.608(a)(1)(iii)

- Reviewing and revising as necessary BABHA policies, procedures and practices governing corporate compliance, privacy and confidentiality; and ensuring the Security Officer reviews and revises as necessary BABHA policies and procedures governing security;
- Chairing the CC Committee or appointing a designee; and maintaining meeting records;
- In consultation with the CC Committees as needed, preparing and implementing an education plan, to include Board members, senior management, all other employees and contracted service providers (including Individual Practitioners), as appropriate; including performance of new employee orientation;
- Identifying new Federal and State Acts, Regulations or Advisories relative to corporate compliance, fraud and abuse prevention, privacy, security and identity theft for which BABHA must comply; monitoring the environment to identify other regulatory requirements that may impact BABHA; reviewing, analyzing and assisting with the development of strategies to comply.
- Maintaining effective lines of communication, including monitoring and responding to calls received on the Corporate Compliance Hot-Line or via other methods of communication;
- In conjunction with the CC Committee, establishing a system and schedule of routine monitoring activities (see Attachments for Monitoring Plan) and ensuring follow-up activities are completed;
- In conjunction with the CC Committee, ensuring HIPAA Security and Fraud/ Abuse compliance risk assessments are conducted in accord with the monitoring plan and findings are addressed;
- In conjunction with the CC Committee, complete an evaluation of the effectiveness of the compliance program;
- Promptly investigating potential compliance and privacy issues discovered through monitoring/auditing activities and disclosures by employees and contracted service providers (including Individual Practitioners); includes mitigation and remediation; maintaining investigative files; in conjunction with the Corporate Compliance Committee, determining if root causes analyses are warranted; ensuring the Security Officer promptly investigates, mitigates, remediates and reports as required any security incidents;
- Working with the CFO to ensure prompt repayment of any overpayments identified through the corporate compliance program, including suspension of payments;
- Communicating reportable fraud/ abuse issues to payers, and federal and state authorities prior to investigation as required; act as liaison to payers and state authorities for compliance and privacy issues, and oversee the activities of the Security Officer in doing the same for security issues;
- Maintaining a log of compliance issues, whether substantiated, and remedial actions;
- Maintaining breach logs and reporting to HHS and regional/state payers as required on an annual basis;
- Working with legal advisers as necessary to develop and issue HIPAA Privacy Notices for use by BABHA Clinical programs and contractors;
- Working with legal advisers (as necessary) and BABHA contract management to develop and issue Business Associate Agreements;
- Ensuring disclosures of protected health information are logged by Medical Records staff as required by HIPAA; and
- Prepare and complete reports to the CEO, BABHA Board of Directors, Mid-State Health Network, and Corporate Compliance Committee on the activities of the CC Program.

Corporate Compliance Committees[9]

The BABHA Board of Directors Corporate Compliance Committee (BCCC) ~~Health Care Improvement and Compliance Committee (HCICC)~~ is the compliance committee of the Board. BCCC's~~HCICC's~~ duties include overseeing the BABHA Corporate Compliance Program by reviewing and approving the BABHA Corporate Compliance Plan and receiving regular reports of organizational activities to guard against fraud and abuse. The Corporate Compliance Officer formally reports on Corporate Compliance Program activities to the BABHA Board of Directors at least once per year with quarterly~~monthly~~ updates provided at each meeting.

The BABHA Board of Directors also has an Audit Committee, which helps ensure the fiscal integrity of the organization through internal controls and practice up to and including inspection of disbursements, paid health care claims and financial statements. The Committee also arranges for an independent audit, review the Financial Statement and Compliance Audits and recommend appropriate actions.

In addition to the Board Committees and the Ethics Committee, BABHA operates an internal Corporate Compliance Committee (CCC) comprised of members of senior management and key subject matter experts. The Committee is chaired by the Corporate Compliance Officer. The BABHA Finance Manager backs up the CC Officer as Chair of the CCC if needed. The Corporate Compliance Committee is responsible for all matters related to the legal and regulatory requirements of BABHA operations as it relates to contractual compliance, HIPAA privacy and security, and guarding against fraud and abuse of state and federal healthcare funds.

Duties of the Committee include but are not limited to the following:

- Assist the CC Officer in the ongoing development and operation of the CC Program,
- Perform fraud and abuse risk assessments and compliance program evaluations, identify focus areas, conduct any necessary audits and self-review, and develop compliance program improvement priorities,
- Assess existing policies and procedures in the identified risk areas for incorporation into the CC Program and develop new policies and procedures as needed,
- Assist the CC Officer with systems level remediation and mitigation of substantiated compliance issues, where appropriate, including performing informal root cause analyses where warranted,
- Assist in the monitoring of new laws and regulations and the development of strategies to comply,
- Assist with the review of internal and external monitoring and auditing activities to ensure that efforts are appropriate to provide assurance of compliance,
- Ensure routine monitoring occurs as scheduled and findings are responded to, as assigned to the Committee via the Corporate Compliance Plan.

Committee membership is comprised of the following staff roles within the organization:

- HIPAA: Security and Privacy Officers
- Finance (including Claims) Management: Chief Financial Officer, and Finance Manager (who also acts as the back-up the CCC Chair)
- Regulatory Compliance and Accreditation: Corporate Compliance Officer, Quality Manager, Medical Records Associate(s) (ad-hoc member(s)), Quality/Compliance Coordinator(s) (ad-hoc member(s)) and Secretary (Committee Recorder)
- Contracting: Contract Manager
- Clinical Practices: Directors of Integrated Care, Clinical Practice Manager (ad-hoc member)
- Ethics and Personnel: Director of Human Resources

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[9] Managed Care Rules: 438.608(a)(1)(iii)

- Recipient Rights: Customer Service/ Recipient Rights Manager

The Committee reports through the BABHA Corporate Compliance Officer to the Medical Director and CEO. The CC Committee meets 10-12 times per year. Meeting records are maintained by the Secretary member of the Committee.

Training and Education

BABHA has established an effective training and education program for its Board of Directors, senior managers, Compliance and HIPAA officers, employees, and clinical contracted service providers (including Individual Practitioners)[10]. All training is documented via employee training records, various meeting records and Corporate Compliance Activity Reports. The current BABHA Corporate Compliance Education Plan is attached to this document. The Corporate Compliance Officer maintains a Corporate Compliance Education Log, which is also attached.

Training of personnel and contracted service providers is required under the Deficit Reduction Act of 2005 Section 6032: Employee Education About False Claims Recovery. BABHA is required to attest to the State each year that training has been completed.

Board of Directors

The Board of Directors receives education on corporate compliance requirements annually, including information about fraud and abuse, conflict of interest, and how to report compliance concerns. The Board of Directors does review and approves the Corporate Compliance Plan each year. Contemporary compliance issues, such as new Medicaid and Medicare regulations, Office of Inspector General work plans, and federal/state compliance program standards are included on the Board of Directors Corporate ~~Health Care Improvement and~~ Compliance Committee agendas as warranted to keep the members abreast of changes in the compliance environment.

Employees[11]

New employees are oriented to the compliance program and privacy/ confidentiality requirements within 30 days of hire. All employees receive an annual corporate compliance and privacy/ confidentiality training update. Training content includes Standards of Conduct/Operating Philosophy and Ethical Guidelines and appropriate reporting mechanisms (e.g., the Corporate Compliance "Hot-line", etc.). Employee orientation and training updates also cover the False Claims Act (31 USC 3729-3733), the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; and the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005), the federal False Claims Act (31 U.S.C. §§ 3729–3733) and the Michigan Whistleblowers Protection Act (PA 469 of 1980). Training content is updated regularly to reflect relevant content from the BABHA Corporate Compliance Plan, and any systems issues identified during fraud, abuse and privacy investigations.[12] The Security Office likewise incorporates security related findings into the annual BABHA Information Management Strategic and Operational Plan.

As compliance or privacy/ confidentiality concerns arise throughout the year or as they are identified as through priorities defined in the BABHA CC Plan, educational communications are issued to employees. This includes

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[10] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(iv)

[11] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7

[12] CARF Section1: Aspire to Excellence; Section A Leadership; Standard 7 (requires training of personnel on the corporate compliance plan)

intranet site announcements, and discussion of topics at Strategic Leadership Team meetings, or Agency Leadership Meetings.

Supervisors

BABHA has determined the compliance program would be strengthened by providing specialized program integrity training for supervisors and managers. This training ~~is in~~is in addition to the standard employee orientation and training. ~~This training has been developed and implemented in 2023-2024.~~ New Supervisiors are trained by the Director of Health Care Accountability to outline their role in compliance. In addition, periodic training for supervisors has been sent out via email throughout the year and the CC Officer has met in person with new Supervisors when they are hired. The training focus is on what supervisors should be watching for as indicators of the presence of potential fraud or abuse, and the importance of monitoring processes for regulatory compliance.

Regulatory compliance has also been added to BABHA Leadership meeting agendas to ensure supervisors and managers are kept up to date on compliance issues and regulatory changes.

Contracted Service Providers[13]

Individuals (including Individual Practitioners) who are contracted with BABHA to provide clinical services receive an orientation to the BABHA Compliance Program and the Operating Philosophy and Ethical Guidelines. They sign an attestation to the completion of the orientation.

Clinical contracted service provider organizations are kept abreast of relevant current risk areas and trends as necessary via email communications and discussion during periodic primary, Community Living Support (CLS)/residential, autism provider, and vocational provider meetings. An annual training is completed by the BABHA Corporate Compliance Officer for primary clinical contractors, vocational, autism and CLS/residential service providers.

The following training and resource materials on Corporate Compliance, Privacy/Security and other topics, as well relevant BABHA policies and procedures are posted to the BABHA website in a Provider section for access by contracted service providers:

- Corporate Compliance Plan
- Compliance Hotline Poster for Providers
- Operating Philosophy and Ethical Guidelines
- Corporate Compliance, Privacy and Security Policies and Procedures
- Provider Training on Corporate Compliance for Subcontracted Mental Health Service Providers
- Provider Training on Privacy and Security for Subcontracted Mental Health Service Providers
- Documentation Requirements Guide

Corporate Compliance Officer, Security Officer, Privacy Officer, CC Committee

The Corporate Compliance Officer, HIPAA Officers and various other senior managers and key staff of BABHA subscribe to Federal and State list-serves which provide alerts regarding emerging regulatory requirements. BABHA also takes advantage of available governmental guidance and technical websites for the operation of Medicaid and Medicare program integrity programs and maintenance of HIPAA regulatory compliance.

BABHA contracts with legal counsel with extensive healthcare experience and seeks opinions and other educational guidance regarding general compliance and privacy issues.

[13] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 6

BABHA is a member of the Health Care Compliance Association and receives the newsletters and magazine. The Officers attend conferences and webinars on compliance, security, and privacy concerns as available and if cost effective. BABHA has identified the following training opportunities:

- US Dep't of Health and Human Services Office of Inspector General Compliance Resource Portal Provider Compliance Resources and Training materials
- Health Care Compliance Association web and regional conferences
- The Community Mental Health Association of MI, Improving Outcomes Conference sessions

BABHA is a member of the Regional Compliance Officers group for MSHN which offers a venue for communication of MI Office of Health Services Inspector General guidance regarding preventing and detecting fraud and abuse.

The Corporate Compliance Committee stays informed by reviewing changes to program integrity regulations for Medicaid, Medicare and other state health care programs, federal Office of Inspector General's Compliance Work Plans and federal program integrity guidance materials.

Lines of Communication

Effective lines of communication are in place between the compliance officer and the organization's employees[14]. BABHA operates a hot-line for consumer, employee, provider and contracted service provider reporting of compliance and privacy/ security concerns. BABHA's policy and procedure C13-S02-T01 Internal Reporting (Hot-LINE) describes the purpose and procedure for the hot-line and other reporting provisions.

The main BABHA Corporate Compliance Hot-Line Poster is attached to this plan. A customizable version is available for contracted service providers. The poster includes Mid-State Health Network and state MDHHS Office of Inspector General (MIOHSIG) contact information as required. The poster is displayed in all BABHA waiting, conference and break rooms

Employees and contracted service providers (including Individual Practitioners) have direct access to the BABHA Corporate Compliance Officer via phone, email and in person, both for consultation regarding compliance strategies and for reporting of suspected fraud and abuse, or privacy and security concerns.

In 2020, BABHA added an annual employee attestation, where they indicate whether or not they are aware of potential fraud or abuse, and whether they had any criminal convictions. Employees are further asked if they have reported these issues in accordance with BABHA policies. This includes Individual Practitioners.

Compliance activity is reported to the BABHA Board of Directors, as well as the Corporate Compliance Committee, which includes representatives from senior management, finance, contracts, medical records, quality, information management, human resources, and clinical programs. The BABHA Corporate Compliance Officer attends Agency Leadership and contracted service provider meetings (vocational, residential/CLS, primary, and Autism providers) to receive and respond to compliance related issues.

Information regarding the Corporate Compliance Hot-Line and how to contact the BABHA Privacy Officer, MSHN Privacy Officer and MIOHSIG are included in the handbook provided to individuals receiving BABHA services. An interpreter is made available to individuals with limited English proficiency as requested.

BABHA policy and procedure C13-S02-T02 Non-Retaliation reflects BABHA's commitment to ensuring individuals reporting fraud/abuse or privacy/ security concerns are not subject to retaliation or retribution.

[14] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(v)

Disciplinary Guidelines

BABHA's corporate compliance related standards are communicated to staff and clinical contracted service providers (including Individual Practitioners) through the Corporate Compliance education program outlined in this plan, including disciplinary guidelines and provisions for adverse contract action[15].

Employees

In addition to the corporate compliance and privacy/ confidentiality education afforded new and existing employees, employees are informed of expectations for their compliance with regulatory requirements and standards via document-specific education on new and revised BABHA plans, policies, and procedures. This includes education on the Corporate Compliance Plan, corporate compliance policies and procedures, and privacy and security policies and procedures.

Employees are educated at least annually regarding BABHA compliance, privacy and security related requirements, which include the obligation to report suspected fraud, waste, abuse and privacy/security violations, to report criminal convictions, as well as the protections available to individuals who are whistleblowers.

Employees directly responsible for fraud, abuse, and privacy/security violations, as well as those who assisted, facilitated or ignored a violation, are subject to disciplinary action. Disciplinary action is commensurate with the severity of the offense and occurs at the discretion of the CEO in consultation with the Director of Human Resources and the involved supervisor. All disciplinary action is applied in accordance w/ BABHA human resources policies/ procedures.

The following are examples of the types of potential disciplinary action, which are communicated to staff:

- Employees may be suspended with or without pay during an investigation
- For minor violations employees may be subject to verbal/written warnings
- For more severe violations employees may be subject to significant disciplinary action including suspension and/or termination of employment
- Considerations may include:
  - Inaccurate or incomplete documentation
  - Unsigned or missing documentation
  - Deliberately fraudulent service documentation
  - Failure to maintain continuous licensure, registration, or certification
  - Falsification of licensure or certification
  - Failure to adhere to BABH policies and procedures
  - Intent to defraud
- Discipline may also be applied to employees who assisted, facilitated, or ignored a fraud and abuse, including supervisory and management staff

Provisions for disciplinary action are outlined in the BABHA Agency Manual and the BABHA Employee Handbook. Each employee receives a copy of the Employee Handbook at the time of hire. The handbook and all agency policies, procedures and plans are posted on the agency intranet site, accessible by all employees. Standards

[15] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(vi)

of conduct and disciplinary guidelines are covered in employee compliance and privacy/security related trainings.

See the section on External Reporting for discussion of potential additional adverse action against licensed and registered professionals.

Contracted Service Providers

The contract boilerplate language outlines contract remedies for failure to comply with the terms of the contract, such as substantiated privacy/confidentiality or security violations, and fraud or abuse involving state or federal healthcare funds, as follows:

- Require a plan of correction together with status reports and/or additional oversight by BABHA;
- Recoupment of payments;
- Suspension or reduction of payments;[16] or
- Termination of the contractual agreement.

Provider trainings on these topics address adverse contract action that may be taken. Individual Practitioner and Organizational Provider re-credentialing includes consideration of past fraud, abuse, privacy and security related investigations.

For purposes of example only, the following is a non-exhaustive list of compliance or performance issues for which BABHA may take remedial action to address repeated or substantial breaches, or patterns of non-compliance or substantial poor performance:

- Reporting timeliness, quality and accuracy;
- Performance indicator standards;
- Repeated site review non-compliance (repeated failure on same item);
- Failure to complete or achieve contractual performance objectives;
- Substantial inappropriate denial of services or substantial services not corresponding to condition. Substantial can be a pattern, large volume or small volume, but severe impact;
- Repeated failure to honor appeals/grievance assurances;
- Substantial or repeated health and/or safety violations;
- Failure to adhere to training requirements and timelines for completion;
- Failure to complete required documentation for each service provided; and/or
- Failure to comply with prohibitions regarding exclusion, suspension or debarment from state and/or federal health care programs.

Adverse contract action is documented in contract files for each provider by the Finance Department. See the section on External Reporting for discussion of potential additional adverse action against contracted licensed and registered professionals and organizations, including reporting to Medicaid payers and the MI Dep't of Licensing and Regulatory Affairs (LARA).

Monitoring and Auditing[17]

BABHA has an active internal prevention, monitoring and auditing program[18]. The Attachments to this Plan include the current BABHA Compliance Committee Data Monitoring Plan, which define monitoring BABHA's

[16] Managed Care Rules: 438.608(a)(8)
[17] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7
[18] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(vii)

activities. The Monitoring Plan changes frequently based upon reporting timelines, results of ongoing environmental assessment activity and periodic risk assessments, and the availability of information.

BABHA's monitoring program includes methods to verify, by sampling or other methods, whether services that have been represented to have been delivered were received by the individuals whom BABHA intends to serve.[19] BABHA applies the verification process on a regular basis (see BABHA policy and procedure C13:A02:T20 Service Event Verification and Restitution) and participates in twice yearly verification activities by its regional payer. Monitoring activities include but are not limited to:

1. Privacy and Security
    a. Electronic Health Record monitoring for use of "break the glass" feature in the role-based security system
    b. Security risk assessment (annual)
    c. Scan of shared/ group network drives for exposure of PHI
    d. Monitoring for security breaches
    e. Email phishing drills
2. Fraud and Abuse
    a. Fraud and abuse risk assessment (Triennial)
    b. Annual financial compliance audits
    c. Retrospective record reviews to verify Medicaid service claims, concurrent checks of high risk services, (specifically self-determined community living support services), and continuing stay reviews of psychiatric inpatient bed days.
    d. Checks for sanctioned, excluded, or debarred employees, directors/ officers, contracted service provider CEO's or their owners, and selected vendors
    e. Verification of specialized residential provider Adult Foster Care Licensure
3. General Compliance
    a. On-site reviews of organizational contracted service providers against contract requirements per a defined annual schedule, including record reviews (see BABHA policy and procedure C04-S12-T35 Site Reviews.)
    b. Quality Record reviews for direct operated programs, including verification of:
        i. Documentation of medical necessity including diagnostics and clinical assessments;
        ii. Completion of annual ability to pay assessments;
        iii. Proper qualification of clinical staff for services rendered; and
        iv. The presence of physician orders for Medicaid services for which orders are required.

BABHA compliance staff run routine compliance monitoring reports for clinical supervisors and team leader self-review. (See the attached Data Monitoring Plan and Supplemental Compliance Reports). Record reviews and corrections to documentation are completed as needed. Supervisors also receive a list of the service encounters generated by their program each month. Supervisors are required to attest that the encounters have face validity, and they refer suspicious encounters to compliance staff for review. System barriers to compliance identified are addressed by quality and compliance staff in conjunction with clinical leadership. If compliance errors (not due to system errors) are not resolved within a reasonable timeframe, the Supervisor develops a corrective action plan.

Fraud/abuse risk areas for routine monitoring are identified by the Corporate Compliance Officer in collaboration with the BABHA Corporate Compliance Committee based on previous compliance concerns, state

[19] Managed Care Rules: 438.608(a)(5)

and federal priorities and identified risk areas. Monitoring reports are received by the CC Committee and corrective action taken, as necessary.

BABHA limits the service codes which can be used by employees and contracted service providers (including Individual Practitioners) to those which are relevant to their scope of work and credentials, as applicable. The electronic health record and its billing engine include extensive business rules which work to preclude as many billing errors as possible. Service authorization parameters and packages or bundles are employed to minimize the risk of abuse as much as feasible without adversely impacting person-centered planning by consumers served. Further information regarding BABHA claims management controls is outlined in the C08 Fiscal Management, Section 7 – Claims, of the BABHA policy and procedure manual.

Environmental and Risk Assessments[20]

The CC Officer, with assistance of the CC Committee, reviews the risk or focus areas identified in the Office of Inspector General (OIG) for the United States Department of Health and Human Services Work Plan, the Michigan Office of Health Services Inspector General (MIOHSIG) Recovery Audit Contractor Approved Scenarios, if any, as well as any other priority compliance or risk areas communicated by the Michigan Office of Health Services Inspector General or the Mid-State Health Network.

In addition, BABHA identifies themes in the results of its data/monitoring activities for reimbursement trends, prior audit findings, and internal record reviews to identify other areas of potential risk.

A security risk assessment is completed which reviews existing BABHA technological, administrative, and other safeguards to ensure compliance with HIPAA requirements.

In 2019 BABHA adopted the US Dep't of Justice Corporate Compliance Program Evaluation as a program evaluation tool. The evaluation is used by US attorneys when investigating Medicare fraud and abuse to determine the effectiveness of compliance programs. The presence of an effective program is a consideration when the DOJ assesses intent and determines fines/penalties. Findings being actioned are included in the list of areas warranting attention below. The evaluation is completed every three years, alternating with the BABHA Fraud/Abuse Risk Assessment.

The BABHA fraud and abuse Risk Assessment is also completed by the Corporate Compliance Committee every three years, and involves tracing BABHA's workflows for generation of service claims from contact with the person served to the submission of claims file to payers to assess and mitigate weaknesses in fraud/abuse protections. The Risk Assessment evaluates the likelihood of fraud and abuse occurring and potential impact on the organization should it occur. Workflows for both direct operated and contracted services are evaluated.

These activities result in corrective action planning to reduce risk and response to changing expectations in the external compliance environment. The BABHA Fraud and Abuse Risk Assessment template is attached to this plan.

The results of such reviews, on-site audits and CC data/monitoring activities are incorporated into BABHA policies, procedures and practices as necessary, and/or added to the CC data/ monitoring schedule for further oversight by the CC Committee. Findings from the compliance program evaluation and risk assessments are also included in the Corporate Compliance Plan evaluation of plan effectiveness and priorities.

[20] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7

Response and Corrective Action

BABHA has policies and procedures which provide for prompt response to compliance issues, including investigation of potential compliance problems as identified during self-evaluation and audits, correction of such problems promptly and thoroughly (including any required coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence and ongoing compliance with requirements.[21]

Investigations

BABHA policy and procedure C13-S02-T22 Complaint Investigations provides detail regarding BABHA investigation strategies. Both the BABHA Corporate Compliance Fraud/Abuse Record and Privacy/Security Record templates are attached to this plan.

In general terms, the CC Officer oversees the prompt and thorough investigation of any report of potential fraud or abuse, in coordination with the HR Department and/or management structure as appropriate. Similarly, the Privacy Officer conducts investigations of HIPAA privacy violations and breaches.

Record reviews are performed by the Quality and Compliance Coordinator under the oversight of the CC Officer. Suspected fraud and abuse of Medicaid funds is reported prior to investigation to the Mid-State Health Network, Michigan Department of Community Health, and the Michigan Office of Health Services Inspector General per contract requirements.

Each investigation includes the gathering and preservation of relevant documents and identification and interviewing of employees, recipients of services and/or contracted service providers (including Individual Practitioners) who may be able to provide pertinent information, as warranted. However, any investigation which overlaps with potential Recipient Rights violations, particularly confidentiality investigations, are coordinated with the relevant officials within BABHA. The BABHA CC Officer may use reports and interviews from those functions as a basis for determination of whether a privacy/ security concern will be substantiated, to minimize the impact of investigations on the involved parties.

Payments to contracted service providers may be suspended during investigations in accordance with BABHA policies. New referrals may also be suspended.

The BABHA CC Officer maintains a compliance log (and documentation files where warranted) of CC related issues and their disposition, including privacy, security, fraud, and abuse concerns.

BABHA and the provider network will cooperate fully with investigations or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Cooperation must include providing upon request, information, access to records, and access to interview employees and consultants including but not limited to those with expertise in administration of the program and/or in any matter related to an investigation or prosecution.

Corrective Action

Each investigation is documented, including information about the issue or incident, conclusions reached and the recommended corrective action, where such action is necessary. The CC Officer, Privacy Officer, or appropriate management personnel responds to the reporting party, as appropriate and to the extent reasonably possible, regarding the status of the investigation and any corrective action taken.

Corrective actions are geared to mitigate the impact of the issue or incident, remediate the error(s), and prevent future occurrence if possible. Steps taken range from employee education or training, consultation with

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[21] Managed Care Rules: 438.608(b)(7) Program Integrity Requirements

contracted service providers, revision of policies, procedures, or contract boilerplate, revision of electronic health record functionality, service claim recall, reporting and reporting recoupment of over-payments, disciplinary action against employees and adverse contract action against contracted service providers (including Individual Practitioners), as previously described in this Plan. Training programs are also updated frequently to address current patterns of fraud/abuse or privacy violations.

BABHA has added to it's investigative process a checkpoint to determine whether a root cause analysis is warranted to identify the variables that contributed to the occurrence and possible remediation.

Claims/Over-Payment Recoupment and Voiding of Encounters

BABHA's policy and procedure C08:S03:T13 Third Party Revenue Collection and Repayments outlines steps for prompt reporting and recoupment of all Medicaid and Medicare overpayments identified. Finance policies and procedures also address suspension of payments as necessary.

Recoupment of Medicaid, Medicare and other state/federal healthcare related over-payments for fraudulent or erroneous service claims from contracted service providers (including Licensed Independent Practitioners) are handled by the BABHA Finance Manager. This includes the voiding of encounters and any cost write-off or repayment that may be required for substantiated fraud or abuse by BABHA employees which may have resulted in an excessive or erroneous service claim. Recoupments are tracked on the BABHA Corporate Compliance Log by the CC Officer.

Providers are required to agree to a repayment strategy for larger recoupments, to the satisfaction of the CFO. The CFO, in consultation with the CEO as necessary, determines whether contracted service providers (including Individual Practitioners) will be subject to additional action, such as being turned over to collection agencies, if they fail to meet repayment obligations.

Other Corrective Action and Enforcement

BABHA works with the Michigan Office of Health Services Inspector General, and other governmental entities at the state and federal level which hold civil and criminal enforcement authority under Medicaid, Medicare, and other state/federal healthcare program integrity related statutes. Corrective action plans are also coordinated with the Michigan Department of Health and Human Services, the Michigan Department of Licensing and Regulatory Affairs, and Mid-State Health Network in accord with contract requirements.

Compliance Reporting

BABHA requires employees and providers to report to the CC Program and the CC Program must submit required information to its payers. The CC Program endeavors to be accessible and consultative to stakeholders.

Employee/ Contracted Service Provider Guidance and Reporting[22]

BABHA employees are required to report to the CC Officer and their Supervisor any suspected fraud/ abuse or privacy/security violation, and any criminal conviction that may result in their exclusion/debarment from Medicaid/Medicare programs. BABHA policy and procedure C13-S02-T01 Internal Reporting (Hotline) provides more information about such provisions. New employees are advised of this requirement during their orientation and other employees are reminded during annual training updates. Reporting obligations are cited in the contract boilerplate for contracted service providers (including Individual Practitioners).

[22] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7

Board members sign an attestation indicating they agree to report any criminal charge or conviction related to Medicaid, Medicare and any other Federal/State Healthcare Program, as well any other crime involving the delivery of a healthcare item or service. Employees sign a similar attestation annually.

Through the contractual agreement, provider agencies and Individual Practitioners agree to report to BABHA any suspicion or knowledge of fraud or abuse and to fully cooperate with investigations. Providers are required to immediately report to BABHA any invalid claims and/or overpayments for correction. Also, providers agree to immediately notify BABHA with respect to any inquiry, investigation, sanction or otherwise from the Office of Inspector General (OIG), as well as criminal convictions that may result in their exclusion or debarment from participation in Federal and State health care programs.

Employees and contracted service providers (including Individual Practitioners) are encouraged to utilize the CC Program as a source of consultation and guidance regarding compliance related questions. Technical assistance is offered by the CC, Privacy and Security Officers to the maximum extent possible as questions arise and when investigations occur. The CC Officer meets face-to-face with each new employee during new employee orientation and participates in face-to-face meetings with key contracted service providers.

CC and other agency policies, procedures and documents are designed to encourage and facilitate regulatory compliance. As an example, the business rules embedded in the electronic health record are narrow, limiting an employee's ability to make wrong choices. BABHA has dedicated staff to verify service claims and communicates regularly with contracted service providers (including Individual Practitioners) regarding questionable or erroneous claims.

External Reporting

BABHA is required to report potential fraud and abuse occurrences which warrant investigation to Mid-State Health Network, and ultimately to the Michigan Department of Community Health and the Michigan Office of Health Services Inspector General.[23]

BABHA submits a quarterly report to the MI Office of Health Services Inspector General (MIOHSIG) through MSHN regarding the number of complaints of fraud and abuse that warranted preliminary investigation throughout the year. Annually a summary is also provided directly to MDHHS by BABHA. Additional requirements for reporting of contracted service provider information were added by MIOHSIG, including new and terminated providers.

BABHA is also required under state law to report licensed or registered professionals and organizations to the Michigan Department of Licensing and Regulatory Affairs (LARA) for potential investigation and possible adverse action.

As a covered entity under HIPAA, BABHA must also report security breaches to the Federal government on an annual basis. BABHA also has mandatory State reporting obligations as an employer.

Reporting of Overpayments[24]

BABHA reports overpayments to regional and state payers, and federal and state offices of inspector generals as required by law and contractual obligations. In accord with regulatory requirements, BABHA specifies the reason for overpayments, including if due to potential fraud.[25]

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[23] Managed Care Rules: 438.608(a)(7)

[24] 42 CFR 401Reporting and Returning of Overpayments (for Medicare) and Section 1128J(d) of the Affordable Care Act for Medicaid overpayments

[25] Managed Care Rules: 438.608(a)(2)

Medicaid Eligibility

If BABHA becomes aware of changes in a Medicaid enrollee's circumstances that, to the best of its knowledge, may affect the enrollee's eligibility for Medicaid, BABHA notifies a representative of the local office of the Michigan Department of Human Services, which is responsible for managing Medicaid eligibility determinations. As a Community Mental Health Services Program, BABHA is also responsible for reporting to the State of Michigan the death of an individual receiving services. [26]

Provider Disenrollment

BABHA notifies regional and state payers when information is received about changes in a contracted service provider's circumstances that, to the best of BABHA's knowledge, may affect the provider's eligibility to participate in a managed care program as a Medicaid provider. [27]

Contracted service providers who leave or who are removed from the BABHA provider network are reported to MIOHSIG, MDHHS and MSHN for purposes of MDHHS monitoring of Medicaid provider enrollment.

Evaluation of Program Effectiveness and Program Priorities

The BABHA Corporate Compliance Program remains largely effective. The program's quality and effectiveness is evaluated every three years by the Corporate Compliance Committee, Corporate Compliance Officer and the Chief Executive Officer. BABHA created an evaluation tool using the U.S. Department of Justice Criminal Division, Evaluation of Corporate Compliance Programs template (see attachments). The lowest scoring items are actioned.

Throughout the course of the past year and/or through the DOJ evaluation process, the following areas were identified for improvement:

Planned Improvement	Target Date	Actions Taken	**Status** New; Continue; Discontinue; Completed
1) The Privacy Notice revisions to address changes in access to Medicaid claims data for coordination of care	3/1/25~~9/30/24~~	Still in process; regulations have continued to change. The Privacy Policy and Procedure needs to be updated and the Privacy Notice needs to reflect new requirements.	Continue
2) Add: Develop a system to track education of Fraud, Abuse, waste and compliance to Consumers and begin reporting quarterly to MIOHSIG/MSHN.	3/1/25~~7/1/24~~ and ongoing	The MSHN quarterly report has been modified to include consumer education. The identified population are those individuals in Self D and those that are sent the EOB's annually.	Continue~~New~~

[26] Managed Care Rules: 438.608(a)(3)
[27] Managed Care Rules: 438.608(a)(4)

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3) Continue to expand supervisor skills relative to program integrity and corporate compliance, beyond the traditional audit compliance.	4/1/2025	Have completed a training for supervisors and have sent out emails and intranet postings on topical items related to Fraud, Abuse, waste and compliance.	Continue
4) Increase follow-through with line staff regarding how policy/procedure changes should impact their day-to-day work.	4/1/25		Continue
5) Add: Provide education when appropriate for Fraud, Abuse and waste substantiations and record on the Fraud and Abuse log. This will be reported quarterly to MSHN and MIOHSIG.	4/1/2025		Continue New
6) Add: Review, educate staff and revise policies and procedures as needed to comply with the revisions to 42 CFR, part 2.	4/1/25		ContinueNew

Attachments: Law-Regulation Log/Compliance Education Log
Corporate Compliance Education Schedule

Compliance Committee Data Monitoring Plan

Data Monitoring Plan: Supplemental Compliance Reports
Corporate Compliance Log
BABHA Fraud and Abuse Risk Assessment with Action Plan
Evaluation of Compliance Report
Corporate Compliance Fraud/Abuse Record
Corporate Compliance Privacy/Breach Record
Hotline Poster