AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
PROGRAM COMMITTEE MEETING

Thursday, April 10, 2025 at 5:00 pm

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

	Committee Members:	**Present**	**Excused**	**Absent**		**Present**	**Excused**	**Absent**	Others Present:
	Christopher Girard, Ch				Pam Schumacher				BABH: Chris Pinter, Joelin Hahn, Sarah Holsinger, and Sara McRae
	Sally Mrozinski, V Ch				Robert Pawlak, Ex Off				
	Jerome Crete				Richard Byrne, Ex Off				
	Vacant								Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Policies Ending 30-Day Review: a) Medical Procedures & Treatment Completed by BABHA Staff at BABHA Sites, 04-09-23 (new) 4.2) Policies Beginning 30-Day Review: a) Basis of Accounting, 08-01-01 4.3) Requests for Clinical Privileges: a) Preston Joiner, PA-C – Renewal privileges for a three-year term expiring April 30, 2028		4.1) Consideration of motion to refer the policy, Medical Procedures & Treatment Completed by BABHA Staff, 04-09-23, to end 30-day review to the full board for approval 4.2) Consideration of motion to refer the policies to begin 30-day review to the full board for approval 4.3) No action necessary

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	4.4) Primary Network Operations and Quality Management Committee Meeting Notes from February 13, 2025, S. Holsinger		4.4) No action necessary
	4.5) Community Mental Health Service Program Advocacy Update		4.5) No action necessary
	4.6) Rural Mental Health & First Responder Leaders		4.6) No action necessary
	4.7) Possible Intervention Models for Transient Homelessness		4.7) No action necessary
	4.8) Strategic Initiatives & Dashboard Reports		4.8) No action necessary
5.	Adjournment	M - S - pm	MA

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment Services**		
Section: 9	**Health Care Management**		
Topic: 23	**Medical Procedures and Treatment Completed by BABH Staff and at BABH Sites**		
Page: 1 of 2	**Supersedes Date:** **Pol:** **Proc:**	**Approval Date:** **Pol:** **Proc:**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/5/2025. 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) etc. to ensure that individuals residing in our Specialized Residential AFC live in a safe environment and that all staff working with these individuals are trained to perform all care that a resident may require. Additionally, BABH ensures that Direct Care staff are not performing skilled nursing procedures or other procedures that are outside of their job description or scope of practice.

Purpose

The purpose of this procedure is to provide guidance to staff working in BABHA operated and contract licensed foster homes, community living supports (CLS) sites, day programs, and all other facilities in which BABHA staff or contractors are providing care regarding which medical procedures are allowed or not allowed at sites and/or can or cannot be performed by non-medical staff.

Education Applies to:

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: Horizon Home DCW, North Bay CLS
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Specialized Residential Providers and CLS providers
☐ Policy Only ☐ Policy and Procedure
☐ Other:

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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**
S. VanParis	HPC	6/15/2022	NEW	NEW

BAY-ARENAC BEHAVIORAL HEALTH
POLICIES AND PROCEDURES MANUAL

Chapter: 8	**Fiscal Management**		
Section: 1	**Accounting**		
Topic: 1	**Basis of Accounting**		
Page: 1 of 2	**Supersedes Date:** **Pol: 12-17-15, 3-18-04, 5-20-99** **Proc:**	**Approval Date:** **Pol: 11-18-21** **Proc:**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to maintain a modified accrual basis of financial accounting as required by the Department of Treasury. In addition, BABHA is obligated to issue financial statements and reports in accordance with guidelines from the Governmental Finance Officer's Association (GFOA), including Governmental Accounting Standards Board (GASB) 34, which requires financial statement presentation on a full accrual basis, GASB 68, accounting and financial reporting for pensions, ~~and~~ GASB 75, accounting and financial reporting for postemployment benefits other than pensions, GASB 87, accounting for Leases, and GASB 96, accounting for Subscription-Based Information Technology Arrangements~~.~~

It is the policy of BABHA to adhere to the following accounting and auditing standards, principles and procedures that are cited in The Michigan Department of Health and Human Services (MDHHS)/Pre-Prepaid Inpatient Health Plan (PIHP) Medicaid Managed Specialty Supports and Service Concurrent 1915(b)/(c) Waiver Program (Medicaid Contract) and the MDHHHS/Community Mental Health Services Program (CMHSP) Managed Mental Health Supports and Services Contract (General Fund Contract):

a. Generally Accepted Accounting Principles (GAAP) for Governmental Units.
b. Generally Accepted Auditing Standards (GAAS)
c. Audits of State and Local Governmental Units issued by the American Institute of Certified Public Accountants (current edition)
d. 2 CFR 200 Subpart E Cost Principles (supersedes Office of Management and Budget Circular A-87). (Except for the conditions described in 6.6.1 of the General Fund Contract)

Purpose

This policy is to establish an accrual method of accounting.

Applicability

☐ All BABH Staff
☒ Selected BABH Staff, as follows: Financial Services Staff

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

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. Wolbert	J. Wesolowski	11/25/2009	Revision	Format changes only
M. Rozek	C. Pinter	09/28/2015	Revision	PS format changes. Indicate 2 CFR 200 Subpart E Cost Principles supersedes OMB A-87. Also added GAAS to policy statement.
M. Rozek	C. Pinter	6/28/17	Revision	Format changes and added references/legal authority
M. Rozek	C. Pinter	9/1/18	No changes	Triennial review-no changes
M. Rozek	C. Pinter	8/20/21	Revisions	Triennial review, added reference to GASBs 68 and 75
K. White	M. Rozek	09/26/24	Revisions	Triennial review, added reference to GASBs 87 and 96

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, February 13, 2025

1:30 p.m. - 3:30 p.m.

Teams Conference Call

MEMBERS	Present	MEMBERS	Present	AD-HOC MEMBERS	Present
Allison Gruehn, BABH ACT/CSM/Sr. Outreach Prog. Mgr.	X	Karen Amon, BABH Healthcare Accountability Director/CCC	X	Amanda Johnson, BABH ABA/Wraparound Team Leader	
Amy Folsom, BABH Psych/OPT Svcs. Program Manager	X	Kelli Wilkinson, BABH Children's IMH/HB Supervisor		Jacquelyn List, List Psychological COO	
Anne Sous, BABH EAS Supervisor		Laura Sandy, MPA Clinical Director & CSM Supervisor	X	Kathy Jonhson, Consumer Council Rep (J/A/J/O)	
Barb Goss, Saginaw Psychological COO		Lynn Blohm, BABH North Bay CLS Team Supervisor	X	Lynn Meads, BABH Medical Records Associate	
Chelsea Hewitt, Saginaw Psychological Asst. Supervisor	X	Megan Smith, List Psychological Site Supervisor		Michele Perry, BABH Finance Manager	
Courtney Clark, Saginaw Psychological OPT Supervisor	X	Melanie Corrion, BABH Adult ID/DD Manager	X	Nathalie Menendes, Saginaw Psychological COO	
Emily Gerhardt, BABH Children Services Team Leader	X	Melissa Deuel, BABH Quality & Compliance Coordinator	X	Nicole Sweet, BABH Clinical Services Manager	X
Emily Simbeck, MPA Adult OPT Supervisor	X	Melissa Prusi, BABH RR/Customer Services Manager	X	Sarah Van Paris, BABH Nursing Manager	
xxx, BABH Integrated Care Director		Moregan LaMarr, Saginaw Psychological Clinical Director		Stephanie Gunsell, BABH Contracts Manager	
Heather Friebe, BABH Arenac Program Manager	X	Pam VanWormer, BABH Arenac Clinical Supervisor	X	Taylor Keyes, Adult MI Team Leader	
Jaclynn Nolan, Saginaw Psychological OPT Supervisor		Sarah Holsinger (Chair), BABH Quality Manager	X	**GUESTS**	**Present**
James Spegel, BABH EAS Mobile Response Team Supervisor	X	Stacy Krasinski, BABH EAS Program Manager	X	Taylor Forwerck, Saginaw Psychological OPT Supervisor	X
Joelin Hahn (Chair), BABH Integrated Care Director	X	Stephani Rooker, BABH ID/DD Team Leader			
Joelle Sporman (Recorder), BABH BI Secretary III	X	Tracy Hagar, MPA Child OPT Supervisor	X		

Topic	Key Discussion Points	Action Steps/Responsibility
1. **a. Review of, and Additions to Agenda** **b. Presentation: None this month** **c. Approval of Meeting Notes: 01/09/25** **d. Program/Provider Updates and Concerns**	a. There was an addition to the agenda; 4p. ATP's b. No presentations this month. c. The January meeting notes were approved as written with explanation of the action step items. d. **Program/Provider Updates and Concerns:** Bay-Arenac Behavioral Health: - ABA/Wraparound – No updates to report this month. - ACT/Adult MI – The ACT Team is down a clinical specialist and an ACT Nurse. The MI Team will be down 2 case managers as of March 5th and the team is in the process of distributing cases and moving around caseloads. Some consumers could be stepped down to Contract Providers; MPA and Saginaw Psychological there may be some referrals coming your way of those that can be stepped down for a lower level of Case Management. - Arenac Center – We are still down one case manager.	c. 01/09/25 Meeting Notes Action Steps to follow-up on: - 1.e. IPOS Training Form P/P – Sarah will address the discussion of the IPOS Training Form at the next provider meeting, but a meeting hasn't been scheduled yet.

Topic	Key Discussion Points	Action Steps/Responsibility
	- Children's Services – Stacey Koin is retiring the end of March. Lori LaGalo will be replacing Stacey, so Lori's position will be posted for Family Support. - CLS/North Bay – Bay Human Services has had some turnover in their leadership and reassigning patients overseeing CLS. BHS has capped their referrals, so if requesting CLS services, that may not be possible. Any referrals for MRS, we need a release of information on file. - Contracts – No updates to report this month. - Corporate Compliance – No updates to report this month. - EAS (Emergency Access Services)/Mobile Response – The Mobile Response Team is back down to part time on second shift. Monday thru Friday is 8:50-4:30 but Tuesdays are only till 9:00 not till the night. - Finance – No updates to report this month. - ID/DD – There are two Case Management positions open. - IMH/HB – No updates to report this month. - Integrated Care – BABH is in the process of reorganization and will be adding on another Clinical Director position, splitting Joelin's position in two since Joelin will be retiring in a few years. Joelin will be taking over as the children's clinical director, still the Director Integrated Care - Children's Services. BABH is in the process of hiring someone to be the Director Integrated Care - Acute Care, which is all services for adults including ACT, ES, Provider Network, etc. Changes will be coming over the next few months. - Madison Clinic – No updates to report this month. - Medical Records – No updates to report this month. - Quality – We are getting ready for the MSHN MEV reviews coming up in a week. We will start prepping for the MDHHS Waiver Audit which happens annually vs. every two years. We may be reaching out to staff for help. - Recipient Rights/Customer Services – Working with MDHHS and the PIHP for information regarding citations for ABD's. Citations are pretty broad,	

	Topic	Key Discussion Points	Action Steps/Responsibility
		but we need to narrow the language down. Working on information for appeals where we provide information from the case file. A workgroup will be set up on that. More information to come. - Self Determination – No updates to report this month. List Psychological: - IDD – We are down two case managers for the IDD Program. We are still looking for applicants. MPA: - CSM – No updates to report this month. - OPT-A – Two therapists left. Working on distributing Lauren's caseload. Morgan's have already been distributed. Saginaw Psychological: - CSM – No updates to report this month. - OPT – A new child therapist started last week. Another therapist is starting the middle of March. We are down a case manager.	
2.	**Plans & System Assessments/Evaluations** a. QAPIP Annual Plan (Sept) b. Organizational Trauma Assessment Update	a. QAPIP Annual Plan – Nothing to report this month. b. Organizational Trauma Assessment – Nothing to report this month.	
3.	**Reports** **a. QAPIP Quarterly Report (Feb, May, Aug, Nov)** b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports i. MSHN Priority Measures Report (Jan, Apr, Jul, Oct) ii. Recipient Rights Report (Jan, Apr, Jul, Oct)	a. **QAPIP Quarterly Report** – Count of Reportable and Non-Reportable Adverse Events Per 1,000 Persons Served by BABH: There were six types of adverse events reported during FY25Q1. There were 11 non-suicide deaths for FY25Q1 which was less than the previous quarter. There were two emergency medical treatments due to harm from another which is not a typical trend; one was reportable, and one was not reportable. These were for two separate individuals. There was a significant decrease in adverse events for FY25Q1 compared to previous quarters. There does not appear to be any other type of trend among these incidences, therefore, no specific actions are identified at this time. Reportable Behavior Treatment Events:	b. iv. MHSIP/YSS – Address this in a few months to see if staff have done anything to make improvements to the process.

Topic	Key Discussion Points	Action Steps/Responsibility
iii. Recovery Assessment Scale (RAS) Report (Mar, Jun, Sep, Dec) **iv. Consumer Satisfaction Report (MHSIP/YSS)** v. Provider Satisfaction Survey (Sept) c. Access to Care & Service Utilization Reports **i. MMBPIS Report (Jan, Apr, Jul, Oct)** ii. LOCUS (Mar, Jun, Sep, Dec) iii. Leadership Dashboard - UM Indicators (Jan, Apr, Jul, Oct) iv. Customer Service Report (Jan, Apr, Jul, Oct) v. Employment Data (Dec, Mar, Jun, Sept) d. Regulatory and Contractual Compliance Reports **i. Internal Performance Improvement Report (Feb, May, Aug, Nov)** ii. Internal MEV Report iii. MSHN MEV Audit Report (Apr) iv. MSHN DMC Audit Report (Sept) v. MDHHS Waiver Audit Report (Oct when applicable e. Ability to Pay Report f. Review of Referral Status Report	The number of emergency physical interventions decreased significantly for FY25Q1, and the overall number of interventions continues on a downward trend. There were 12 consumers that led to the 30 emergency physical interventions with one individual accounting for 13. The treatment team has been working together to explore changes to support improvement for this individual. This was a significant decrease from last quarter when this individual had 49 interventions. There were six 911 calls made for behavioral assistance for FY25Q1 which is an increase from previous quarters, however, the overall trend continues to be flat. Risk Events: Risk events are identified as 'harm to self, harm to others, police calls for behavioral assistance, emergency physical interventions, and two or more hospitalizations.' The number of risk events decreased during FY25Q1, but the trend continues to steadily increase. Consumers Diagnosed with Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Diabetes: BABH had an increase in consumers receiving the appropriate labs for this measure during FY25Q1. BABH will continue to action these alerts monthly to improve compliance. Staff recently made an adjustment to how these are being actioned, so compliance is expected to improve. Consumers Diagnosed with Schizophrenia and Diabetes Who Received Lab Work to Monitor Diabetes: BABH had an increase in consumers receiving the appropriate labs for this measure during FY25Q1. BABH will continue to action these alerts monthly to improve compliance. Staff recently made an adjustment to how these are being actioned, so compliance is expected to improve. Consumers Diagnosed with Schizophrenia and Cardiovascular Disease Who Received an LDL-C Lab: There were recent changes to the specifications for this measure so there are only two quarters of data at the time of this report. BABH has now begun actioning this measure. It takes a few quarters for these efforts to take effect. Evidence of Primary Care Coordination: All providers scored below 90% for primary care coordination. One provider had a significant improvement which was due to providing documentation in a timely manner. Reviews show that the coordination of care letter is either expired	

Topic	Key Discussion Points	Action Steps/Responsibility
	or was not completed. Corrective action plans have been completed to help improve compliance. Audited Services with Proper Documentation for Encounters Billed: The overall total compliance for all primary, secondary, and tertiary services reviewed during FY24Q3 and FY24Q4 was above the 95% standard and increased from the previous two quarters. These reviews included applied behavioral analysis, specialized residential, dietary, primary providers, BABH direct services, and community living support providers. There was a total of 11,621 claims reviewed with only 99 errors resulting in a 99% compliance rate. The most common finding was that the documentation was not completed, or the number of units billed did not match the documentation. Copy of Plan of Service Offered Within 15 Days of Planning Meeting: Overall, the percentage of compliance for offering the plan of service within 15 days was consistent for FY24Q3 compared to FY24Q4. It was determined that staff are not always using the electronic health record completely so there is missing data and blanks. Quality Staff are working with providers to remind staff to complete all data elements related to the plan of service. One provider has not been using the data field correctly which resulted in a 100% compliance rate due to having only one record reviewed. Corrective action plans have been implemented. Michigan Mission Based Performance Indicator System (MMBPIS): Indicator 1 (The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours.): BABH demonstrated 100% compliance for Indicator 1 for both children and adult populations during FY24Q4. This was a higher rate of compliance than MDHHS and MSHN. MMBPIS: Indicator 2 (The percent of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergent request for services.): BABH has higher compliance rates for all populations compared to Michigan Department of Health and Human Services (MDHHS). MSHN data has not been received. BABH saw an increase in all populations except IDD-Children. MMBPIS: Indicator 3 (The percent of Medicaid beneficiaries starting any needed ongoing service within 14 days of	

Topic	Key Discussion Points	Action Steps/Responsibility
	a non-emergency assessment with a professional.): For FY4Q4, BABH had lower compliance rates when compared with MDHHS for all populations except IDD-Children, which has had a steady increase for the past several quarters. MSHN data was not available. The highest contributing factor to lower compliance rates are no-show appointments. MMBPIS: Indicator 4 (The percent of discharges from a psychiatric inpatient unit who are seen for follow-up within seven days.): The BABH child and adult populations met the 95% compliance standard for FY24Q4. This is above or consistent with MDHHS. MSHN data was not available. MMBPIS: Indicator 10 (The percent of beneficiaries readmitted to an inpatient psychiatric unit within 30 days of discharge.): BABH met the compliance rate for the child and adult populations for FY24Q4 (both populations below 15%). Reduction of Inpatient Hospitalization Days (community inpatient and state facilities) for FY24: BABH had 10,0031 inpatient hospitalization days during FY23 and 9,652 days in FY24. This was a decrease of 379 inpatient hospitalization days during FY24 which met the goal of an overall reduction. Further analysis determined that over the past couple of months consumers have been staying significantly longer than the 5–7-day average. The Emergency Access Service department is looking into specific individuals to determine other trends and factors. b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports i. MSHN Priority Measures Report: Nothing to report this month. ii. Recipient Rights: Nothing to report this month. iii. RAS: Nothing to report this month. iv. **MHSIP/YSS**: This was brought to the meeting last month and was taken to the Consumer Council. There was a lot of feedback from the Consumer Council. BABH gives away a $50 gift card to one individual, but the council changed that to giving out 5 - $10 gift cards. They talked about hand delivering the surveys instead of mailing them. They suggested including an option for consumers to complete the	

Topic	Key Discussion Points	Action Steps/Responsibility
	survey with staff if they need assistance. Reduce the number of questions on the survey. Email or send text reminders to complete the survey to those that have opted in. Have a contest for consumers to share their success stories. Determine how it could be shared, via the intranet, website, Facebook. Update the graphs on the report to be easier to read. Change the timeframe of when surveys are distributed to avoid summer vacations. BABH is bound to a certain timeframe because of the region but Sarah will address it with the region. Update the Recovery Training video link for staff so that the training is more meaningful. This year the survey involved IDD consumers as well. When the MI/DD populations are combined, the percentages are still less in agreeance than there was previously, so adding in the IDD population didn't make a change. Melissa Prusi is wondering if we can look into changes around some questions that scored lower. We will address this in a few months if changes have been made related to staff meeting changes, etc., to see if we are making intentional efforts to fix this. v. Provider Satisfaction Report: Nothing to report this month. c. <u>Access to Care & Service Utilization Reports</u> i. MMBPIS Report: Nothing to report this month. ii. LOCUS: Nothing to report this month. iii. Leadership Dashboard: Nothing to report this month. iv. Customer Service Report: Nothing to report this month. v. Employment Data: Nothing to report this month. d. <u>Regulatory and Contractual Compliance Reports</u> i. **PI Report**: <u>Plan of Service within 15 Days</u> – MPA scored an 84% which is a 5% decrease from FY24Q3. Bay Direct scored an 87%, which is a 3% increase from FY24Q3. Saginaw Psychological scored 98% which is a 1% increase from FY24Q3. List scored 100%, but this was a result of	

Topic	Key Discussion Points	Action Steps/Responsibility
	one consumer record. Bay Direct and MPA had a significant number of plans of service that left the date blank in the 'Update Sent Link.' These blanks are not included in the overall percentage of compliance, but supervisors should be addressing this with staff and monitoring. Completion of Crisis Plan – BABH QI staff are reviewing all the crisis plans present for each quarter. The goal is to see the overall number of crisis plans increase for each population type which is a change from the standard previously reviewed (95% of consumers being offered a crisis plan). Completed Crisis Plans have increased since FY24Q2 for the MI-SMI and the number of completed Crisis Plans have also increased since FY24Q2 for the MI-SED populations. Evidence of Primary Care Coordination – Bay Direct, List, Saginaw Psychological and MPA all scored below the 95% standard. Bay Direct scored 86%, which is an 7% decrease from FY24Q3. Saginaw Psychological had a 4% decrease from FY24Q3. List increased 39% from FY24Q3 (List had a notable decrease in FY24Q3 due to sending over documentation after the review was finalized; it is likely the compliance level is higher than indicated in this graph). MPA scored 87% which is a 4% decrease from FY24Q3. There is no explanation of why the Pre-Plan and Plan of Service were completed on the same day or if the Plan of Service was completed on a different date than what was requested. The "My objective will be completed through.." does not include the scope/frequency/duration. Plan of Service- Risk Factors/Barriers section is blank. Pre-Plan Waiver Service Array checkboxes are blank. Back-to-back Interim Plans. Unsigned or expired documents. ii. Internal MEV Report: Nothing to report this month. iii. MSHN MEV Audit Report: Nothing to report this month. iv. MSHN DMC Audit Report: Nothing to report this month. v. MDHHS Waiver Audit Report: Nothing to report.	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, February 13, 2025

1:30 p.m. - 3:30 p.m.

Teams Conference Call

	Topic	Key Discussion Points	Action Steps/Responsibility
		e. Ability to Pay Report – Nothing to report this month. f. Review of the Referral Status Report – Nothing to report this month.	
4.	**Discussions/Population Committees/ Work Groups** a. Harm Reduction, Clinical Outcomes and Stakeholder Perceptions i. Consumer Council Recommendations (as warranted) b. Access to Care and Service Utilization i. Services Provided during a Gap in IPOS ii. Repeated Use of Interim Plans c. Regulatory Compliance & Electronic Health Record i. 1915 iSPA Benefit Enrollment Form ii. Management of Diagnostics **d. BABH - Policy/Procedure Updates** **e. Clinical Capacity Issues Status** **i. Review of Referral Status Report** **ii. OPT Group Therapy** **iii. Capacity Issue Discussion** **f. Medicaid/Medicare Updates** **i. Medicare Open Enrollment: Verify Insurance**	a. Harm Reduction, Clinical Outcomes and Stakeholder Perceptions i. Consumer Council Recommendations: Nothing to report this month. b. Access to Care and Service Utilization i. Services Provided during a Gap in IPOS: Nothing to report this month. ii. Repeated Use of Interim Plans: Nothing to report this month. c. Regulatory Compliance & Electronic Health Record i. 1915 iSPA Benefit Enrollment Form: Nothing to report this month. ii. Management of Diagnostics: Nothing to report this month. d. **BABH - Policy/Procedure Updates**: There are quite a few p/p's that went out in January and have been updated. They are on the BABHA website under the Provider tab, Policies/Procedures, and you can click on them and review them. **e. Clinical Capacity Issues Status** i. Referral Status Report: Things are looking better with the status report. ii. OPT Group Therapy: We will take more referrals. Group will continue for another 9-week session. iii. Capacity Issue Discussion: Things are stabilizing throughout the network. Referrals have been extremely slow. Staff continue to request securing therapy services specific to the Adult IDD population. f. **Medicaid/Medicare Updates** i. Medicare Open Enrollment: Due to Medicare Open Enrollment, remind staff to verify Medicare Insurance at appointments. If a consumer has changed their Medicare plan, staff need to verify that the doctor is credentialed with the new Medicare plan.	g. General Fund – Bring GF and Loss of Insurance Reports to next month's meeting so staff are aware of what action steps to take. o. Periodic Review Updates - Sarah will work with Karen and the EHR Committee to mockup the radio/text button.

Topic	Key Discussion Points	Action Steps/Responsibility
ii. Medicaid Reenrollment: Encourage /assist as needed with process **g. General Fund for FY2025** h. Conflict Free Case Management **i. MSHN Care Coordination - Line Staff Expectation** **j. Stage of Change in Assessment** k. GF Exceptions **l. HCBS New Expectations** **m. OPT Referral Criteria** **n. LOCUS Competency Monitoring** **o. Periodic Review Updates** **p. ATP's**	ii. Medicaid Reenrollment: Staff Reminder: Please help your consumers reapply for Medicaid. Emails are going out from Finance verifying who does/doesn't have Medicaid and letting case managers know to follow up if need be. g. **General Fund for FY2025**: Current projections indicated BABH will be is to be close to $1.5 million over budget in General Fund for FY25. The reenrollment process started for Medicaid this past year (around June 2024). Medicaid "Re-Enrollment" was halted during the COVID pandemic. Since the Medicaid re-enrollment start back up, there are quite a few individuals that no longer meet criteria for Medicaid and have lost their benefits. There are also cases that were flipped from Medicaid to a Medicaid spend down. Staff Reminder: Make sure to verifying consumer's insurance, addresses, and all their information, so it is updated in our system. Our DHHS partners indicate the primary issue with individuals being denied is due to having a wrong address in the MDHSS system. Address Changes: Consumer's need to update their address in the MI Bridges system. Loss of Medicaid Benefits: When someone loses their Medicaid, they have Appeals rights that are similar to when you send them the ABD. Please educating individuals and guardians on their right to appeal these decisions when they lose their Medicaid. We will go over the General Fund and Loss of Insurance Reports next month. h. Conflict Free Case Management: Nothing to report this month. **i. MSHN Care Coordination - Line Staff Expectation:** Line staff might get a message that one of their cases has been chosen for enhanced care coordination. This means that the Medicaid health plan has contacted MSHN, typically due to the individual being a high utilizer of emergency room and or health care services. The MSHN rep may contact you and request information or update on the individual. Please respond to any emails or voicemails that you receive from MSHN. **j. Stage of Change in Assessment:** Stages of Change section is not expected to be completed for individuals with IDD. Recommendation to add a check box to indicate "N/A" similar to other sections of the assessment. Checking the	

Topic	Key Discussion Points	Action Steps/Responsibility
	box to indicate "N/A" would collapse the section. Get feedback from staff. Karen will bring the recommendations to the committee and then take to the EHR Committee. **k.** GF Exceptions: Nothing to report this month. **l.** **HCBS New Expectations:** MDHHS has mandated that all case managers be trained if anyone on their caseload is living in a provider owned controlled setting or receiving adult waiver services. The next step is that all case managers will be trained in time. You might want to send as many case managers as possible to the trainings now. The target date for MDHHS is April 11th. BABH is looking at March 12th in the afternoon for a 4-hour training, and March 18th in the morning for a 4-hour training. The training is focused on RR, Person Centered Planning, review of Home and Community Based Services. MSHN is doing the training. We would like both trainings to be virtual. If staff doesn't participate, they will have to be part of another county training at a later date. MSHN has their waivers approved by CMS. MDHHS are working on enhancing their policy language in their PCP policy. Their target date is in April. The changes are to better guide individuals having choices in their living arrangements. In the Plan of Service, we have to be clear that the person was engaged in deciding where to live with staff. There will be further discussion coming on this topic. **m.** **OPT Referral Criteria:** Discussion about individuals receiving specialty MH services who choose to receive psychiatric medication services outside of the CMH system. If a consumer is getting psychotropic medications through a provider that is not a part of the specialty mental health system, and getting specialty mental health services through BABH, it could be considered a duplication of services. If someone is going to be receiving specialty mental health services, they must meet clinical criteria and all the documentation as to why they need specialty MH services. If someone does not meet criteria for specialty service level of care, they should be referred and warm	

	Topic	Key Discussion Points	Action Steps/Responsibility
		transferred to a Medicaid Health Plan provider. If they do not meet specialty MH service criteria during the initial Access Screening, they will receive an ABD from the Access Center and the letter will include a list of local resources. If someone has private insurance or Medicare in addition to Medicaid, they can go see a prescriber using their other insurance. Educate staff on taking good notes as to where the person is receiving services. **n. LOCUS Competency Monitoring:** Joelin emailed the LOCUS policy/procedure so please review those. It is in the LOCUS policy to monitor interrater reliability with LOCUS by having staff score a LOCUS scenario during staff meetings. Review the scores the provide education as needed. Note in staff meeting minutes the LOCUS interrater reliability monitoring and training conducted during the staff meetings. **o. Periodic Review Updates:** One of the corrective action items was we need to tighten up on monitoring of over/under utilization of services. We put in corrective action that we would look at updating the periodic review. Discussion about adding a radio button that says 'was there over/under utilization of services' and then a box to identify what was going on. We could put a request into the EHR Committee to add the radio button. **p. ATP's:** Staff Reminder: ATPs obtained by staff must be sent to Nicole Konwinski in the BABH Finance Department. ATPs are being overlooked as they are scanned into Phoenix and Finance staff are not made aware of it. If/when the ATP is scanned/saved in Phoenix, please email Nicole letting her know that it's scanned in, but preferably send it to her. Discussed why to create automated messages in Phoenix when an ATP is added to the scanned documents. Karen will look into this.	
5.	**Announcements**	No announcements to report this month.	
6.	**Parking Lot** a. Periodic Reviews – Including Options for Blending with Plan of Services Addendums	a. NA	
7.	**Adjournment/Next Meeting**	The meeting adjourned at 3:30 pm. The next meeting is scheduled for March 13, 2025, 1:30-3:30, at the Lincoln Center in the East Conference Room.	

BAY ARENAC
BEHAVIORAL HEALTH

Christopher Pinter

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Board Administration
Behavioral Health Center
201 Mulholland
Bay City, MI 48708
800-448-5498 : AccessCenter
989-895-2300 Business

Arenac Center
PO Box 1188
1000 W. Cedar
Standish, MI 48658

North Bay
1961 E. Parish Road
Kawkawlin, MI 48631

William B. Cammin Clinic
1010 N. Madison
Bay City, MI 48708

www.babha.org

March 25, 2025

The Honorable Governor Gretchen Whitmer
P.O. Box 30013
Lansing, MI 48909

Sent via email

Dear Governor Whitmer:

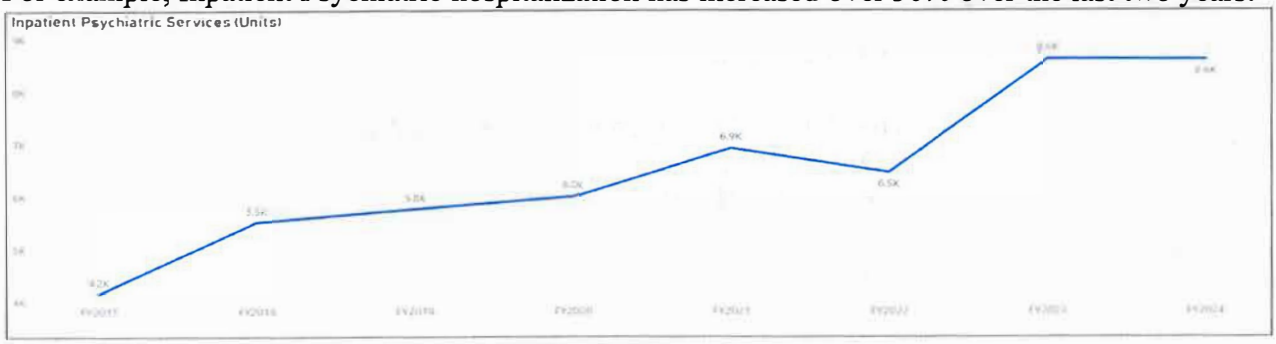
Bay-Arenac Behavioral Health Authority (BABHA) is the community mental health services program (CMHSP) for Bay and Arenac Counties. The priority populations for these services are persons with serious mental illness, intellectual/developmental disabilities (including autism), substance use disorders, and children with severe emotional disturbances. BABHA is part of the region comprising 12 CMHSPs and 21 counties. BABHA served over 5000 Michigan residents in fiscal year 2024.

The purpose of this correspondence is to request your assistance in resolving significant Medicaid revenue and expense gaps continuing into the current 2025 fiscal year that threaten to overwhelm many of the CMHSPs in the Mid State Health Network (MSHN) Pre-paid Inpatient Health Plan (PIHPs) region. The factors driving these revenue and expense issues include increased service demand, Medicaid enrollment issues, medical care price inflation, and Medicaid rate setting processes that understate projected service trends.

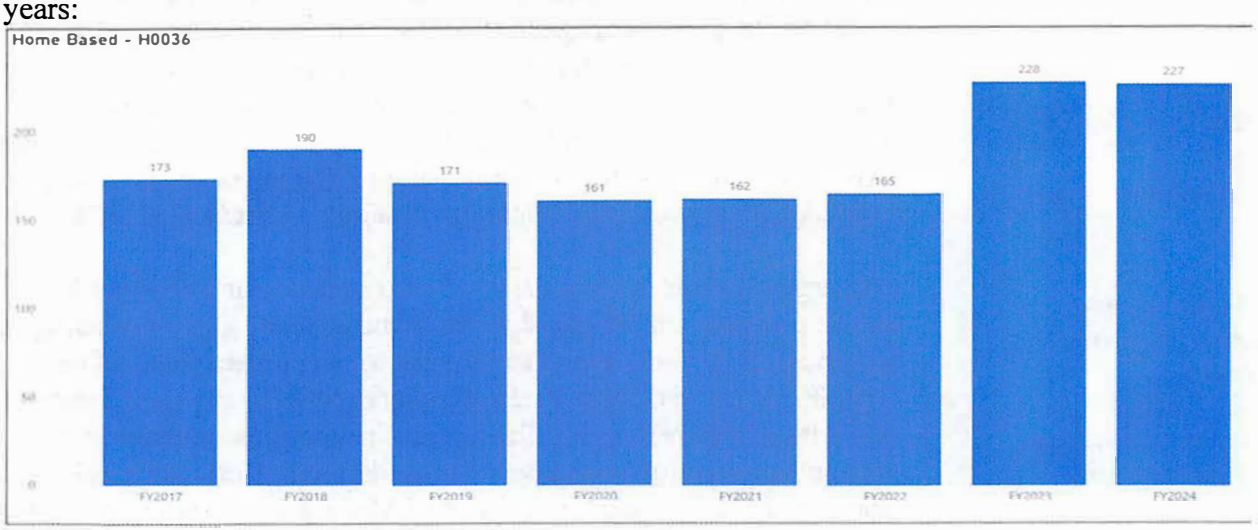
Service Demand
BABHA has experienced a significant increase in service demand since the end of the public health emergency in 2023[i]. This parallels the national trends that indicate the United States is enduring a significant mental health crisis, with nearly one in three adults experiencing anxiety and depression symptoms during 2023[ii]. This problem is particularly acute among children and youth to the degree that the American Academy of Pediatrics and others have declared a National emergency in child and adolescent mental health since 2021[iii] with suicide as the second leading cause of death among youth ages 10 to 24[iv].

The increases in service demand specific to BABHA are reflected in nearly all service categories but are particularly dramatic in the areas of inpatient psychiatric hospitalization, services to children and families, and services related to autism.

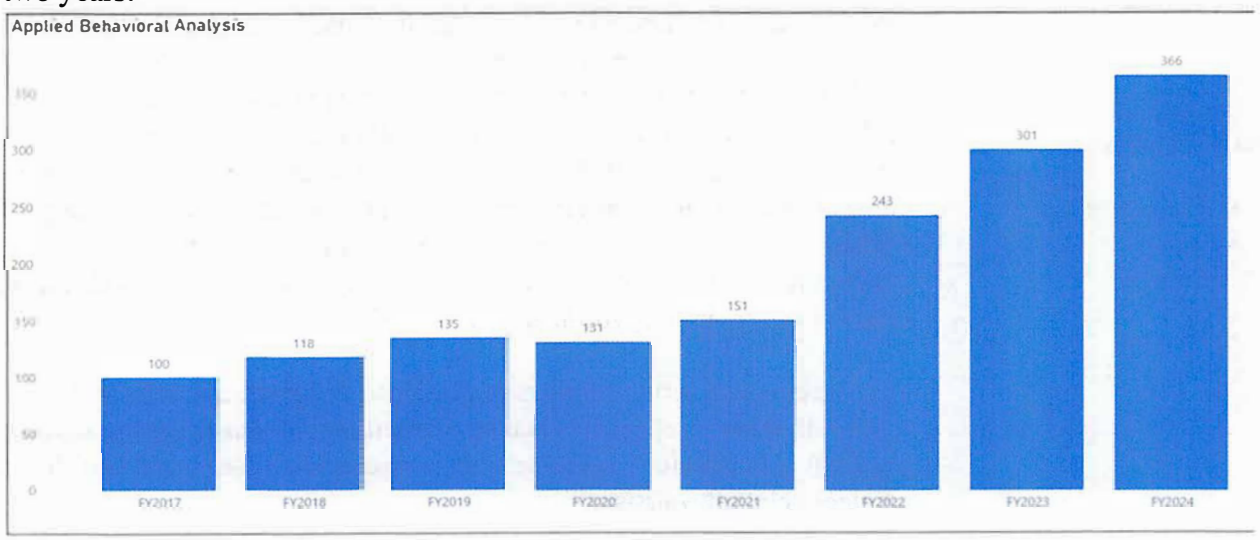
For example, Inpatient Psychiatric hospitalization has increased over 30% over the last two years:



Services to Children and Families in the Home Based Program have increased 38% in the last two years:



Autism-related Applied Behavioral Analysis (ABA) services have increased nearly 50% in the last two years:



This resulted in increases in Medicaid expenses between FY2022 and FY2024 for inpatient psychiatric hospitalization services of $4.8 Million to $7.2 Million (+53%); services to children and families of $3.2 Million to $3.7 Million (+17%); and autism-related ABA services of $8.0 Million to $11.6 Million (+45%). This increased service demand unfortunately has occurred during a period of significant other financial pressures on the CMHSP system as outlined below.

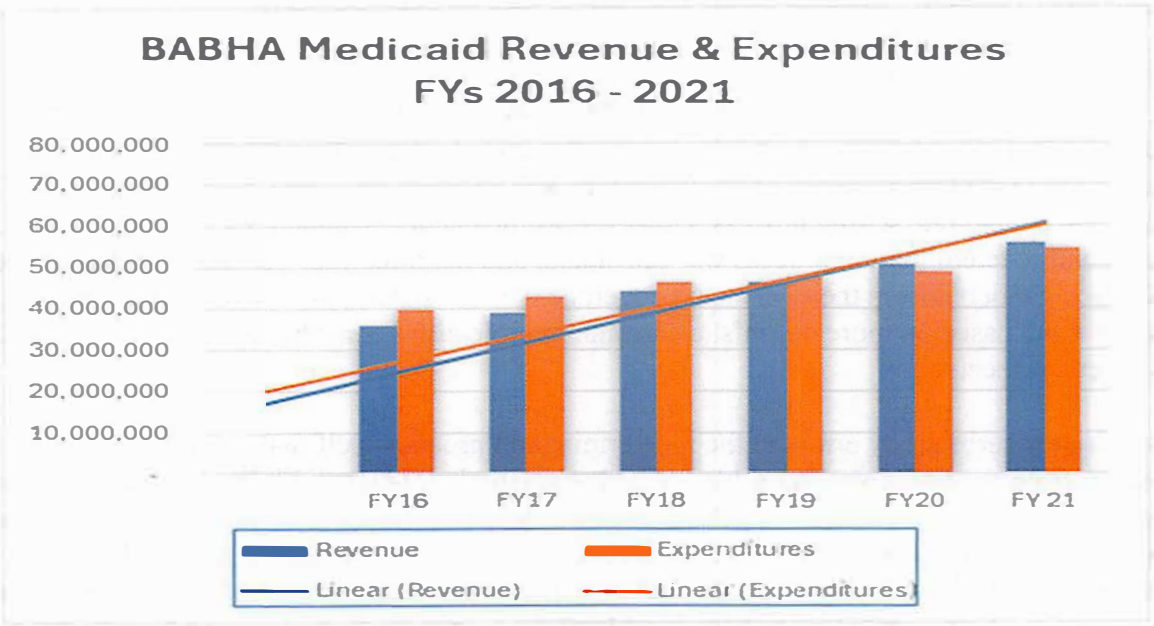
Medicaid Enrollment Changes
During the COVID-19 public health emergency, Medicaid reenrollment/redetermination within Michigan was frozen – resulting in an increase in Medicaid recipients throughout the state. This temporarily produced surplus funds at several PIHPs and gave a false impression of financial stability in the annual rate setting process. However, as the pandemic ended, the annual re-enrollment and redetermination process was reinstated, and the three year backlog resulted in over 700,000 Michiganders losing their Medicaid coverage. Unfortunately, the Medicaid rates have consistently been based on more optimistic enrollment projections contributing to the significant gaps in revenues received.

This was also exacerbated by errors in the redetermination process itself that transitioned some beneficiaries from the traditional "Disabled, Aged, and Blind" (DAB) eligibility to other population groups such as "Plan First", Temporary Assistance for Needy Families (TANF) or Healthy Michigan Plan (HMP) with significantly lesser associated revenue and covered benefits. Although these beneficiaries remained eligible for CMHSP services due to the severe and long term nature of their disabilities, even a temporary loss or change in Medicaid coverage can have a significant impact on revenues received by the PIHP. Some preliminary estimates have suggested a gross revenue loss across all of the state's PIHPs related to this issue of over $300 million just in 2024[v].

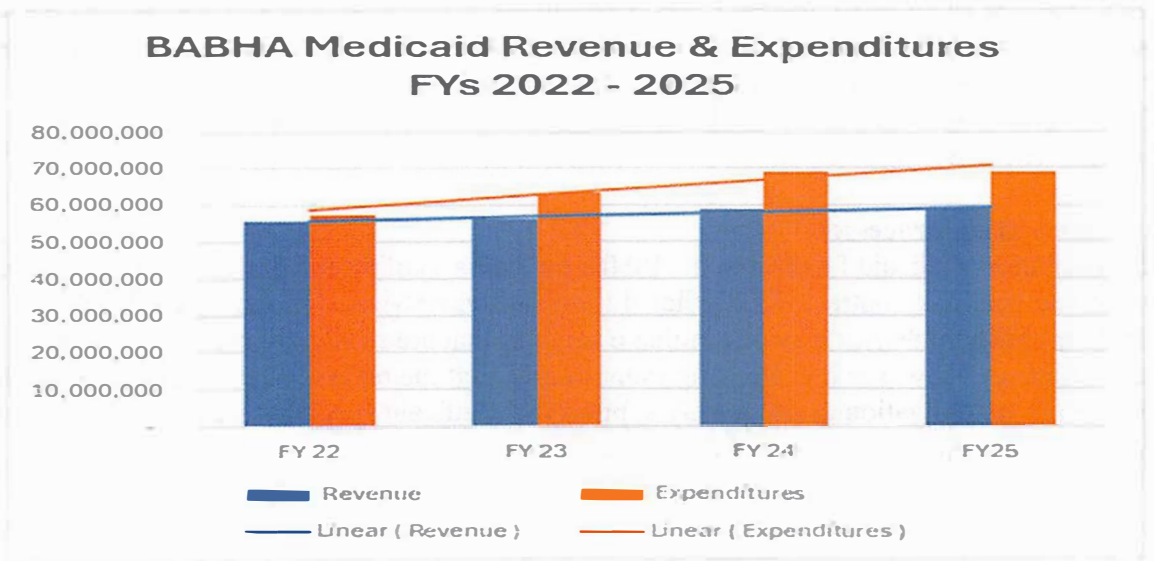
Medical care price inflation
The third factor impacting revenue and expenses has been the significant increase in the medical care price inflation index over the last 3 years. This has produced higher labor, supply chain and service expenses across the health care market. For example, BABHA Medicaid revenue between FY2021 and FY2025 increased approximately 6% (+$3.5 Million). However, the cumulative percent change in Consumer Price Index for All Urban Consumers (CPI-U) for medical care during the same period was approximately 16% according to the Peterson/Kaiser Family Foundation Health System Tracker [vi]. To put it another way, even if service demand had been held constant, the revenue increases during the last four years would still account for only about 40% of the medical care inflation experienced during this period.

Medicaid rate setting processes
MDHHS distributes Medicaid funding to the PIHPs on the basis of a capitated rate setting process and a shared regional risk contract. As Medicaid is an entitlement-based program, CMHSPs are limited in their ability to deny, delay or terminate services that are medically necessary for the individual consumer. However it is also important to note that the reverse of this equation is also true: the state has an obligation to adequately support the Medicaid specialty behavioral health program with funds appropriated from the legislature for that purpose.

For example, between FY2016 and FY2021, the cumulative increase in Medicaid revenue to BABHA was nearly 56% ($35.7 Million to $55.8 Million). This trend, also based on actuarial science, more than accounted for the 38% increase in service expenses ($39.6 Million to $54.6 Million) incurred during this same period.



Unfortunately, the Medicaid rate setting process between fiscal years 2022 and 2025 primarily relied on pandemic-compromised encounter data that understated post-COVID service trends.
For example, nearly all CMHSPs in the MSHN region received *a 5% rate reduction* in fiscal year 2023 based on atypical fiscal year 2021 utilization data suppressed by the first full year of COVID. This created a financial gap for BABHA that has yet to be closed and was compounded further by subsequent rate setting processes in FY2024 and 2025 that have failed to adequately account for the tremendous amount of post-COVID service rebound since the beginning of FY2023.



As a result, as revenues increased 6% ($55.8 Million to $59.2 Million) between 2021 and 2025, actual Medicaid expenses *increased approximately 26%* ($54.6 Million to $69 Million) during this same period due to expanding service demands and medical price inflation. This is a significant contrast to the revenue trends that occurred between FY2016 and FY2021 for essentially the same CMHSP provider system, same specialty care populations, and the same covered services. As a result, BABHA and several CMHSPs are struggling to meet the financial obligations of the Medicaid program at the same time unspent behavioral health funds are returned by MDHHS to the State Treasury[vii].

Recommendation

The continued uncertainty in Medicaid financing since FY2022 makes it very difficult for PIHPs and CMHSPs to adequately plan, evaluate and respond to emerging community demand. As the federal government focuses more on potentially reducing Medicaid spending, service demand continues to increase, and state actuarial processes continue to result in underfunding of the community mental health safety net, our communities become even more vulnerable to experiencing mental health crises and emergencies.

BABHA urges MDHHS to re-evaluate the FY2025 and FY2026 Medicaid rate setting process against the additional factors noted above and make the adjustments necessary to sustain the Medicaid specialty behavioral health program in Bay and Arenac Counties and similar areas of the state. The CMHSPs are just as dependent upon the State of Michigan as a good partner in this public endeavor as the State is on the Federal government for the Medicaid program.

The most important first step is to just push out the actual legislative appropriation for FY 2025. The current projection is that both Medicaid Mental Health and Healthy Michigan behavioral health will be underspent by a combined $280 million this year. These funds are needed to address the increasing expenses related to service demand, medical inflation, and legislative changes such as unemployment and earned sick time enacted in the last year.

Thank you for your attention regarding this important matter. If you have any questions regarding this correspondence, please feel free to contact me anytime at (989) 415-4422.

Sincerely,

Christopher Pinter
Chief Executive Officer

cc: Tricia Foster, Chief Operating Officer
JoAnne Huls, Chief of Staff

[i] The emerging BABHA inpatient, Home Based and Autism service activity for fiscal years 2021-2025 may be verified against sent encounters received by the MDHHS data warehouse.

[ii] N. Panchal, H. Saunders, R. Rudowitz, & C. Cox, "The Implications of COVID-19 for Mental Health and Substance Use" (Washington: KFF, March 20, 2023)

[iii] American Academy of Pediatrics, AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health, Statement (October 19, 2021)

[iv] L. Hua, J. Lee, M. Rahmandar, & E. Sigel, "Suicide and Suicide Risk in Adolescents," Pediatrics, 153, no. 1(2024): e2023064800

[v] Community Mental Health Association of Michigan, "Email to Governor Whitmer's Office", February 25, 2025

[vi] Petersen-Kaiser Family Foundation Health System Tracker, How Does Medical Inflation Compare to Inflation in the Rest of the Economy? August, 2024

[vii] Michigan House Fiscal Agency, "FY2023-24 Supplemental Appropriations Summary: House Passed, Article 7, House Bill 4161 (H-2), March 6, 2025.

MSHN
Mid-State Health Network

Community Mental Health Member Authorities

Bay-Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

The Right Door for Hope, Recovery & Wellness (Ionia County)

LifeWays

Montcalm Care Network

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health & Wellness

Tuscola Behavioral Health Systems

March 24, 2025

Contact: Edward Woods
public.mentalhealth2025@yahoo.com

FOR IMMEDIATE RELEASE

Michigan's Public Behavioral Health System Should Be Preserved – and Better Supported

Jackson, MI - Recently, some people within our state have suggested that Michigan should abandon its public specialty behavioral health managed care structure, led by regional entities known as "PIHPs" (Prepaid Inpatient Health Plans) and replace it with an Administrative Services Only (ASO) structure, as used in Connecticut.

In Michigan, PIHPs primarily ensure medically necessary services and supports are available and delivered to people with the most severe forms of mental illness, substance use disorders, and intellectual/developmental disabilities and are overwhelmingly financed by Medicaid. PIHPs do this through collaboration with Community Mental Health Services Programs and networks of providers across the regions they are responsible for. While not perfect, these organizations are lean, efficient, accountable, transparent, and effective. Hundreds of thousands of Michigan residents receive publicly managed, publicly funded, lifesaving, quality supports and services every single year.

The Connecticut ASO model does not come without complexities in terms of providing comprehensive care and bureaucratic hurdles for the agencies that interact with them. The experiences of Connecticut under their ASO model should make us slow down, take a breath, and analyze the comparative data of the two states before we make such a significant change in our state.

Connecticut's population is about 3.6 million and the geography is 5,000 square miles with 169 municipalities. In comparison, Michigan's population is a little over 10 million and large geographically as well as very diverse. Michigan has 96,713 square miles, 1,773 municipalities, and is the tenth largest state in population. I go into all these details because it is effective when figuring out a design for managing care across the state. So much of Michigan is very rural and what works in the UP is likely not going to work in Detroit or the other population centers. Even if the system in Connecticut works well for them, it does not mean it would work well in Michigan.

The Connecticut Department of Mental Health decided to create local mental health authorities (LMHA's) to manage a system of services in specific geographical areas. Half of the LMHAs were private non-profits and half were state operated.

Connecticut's journey through the tumultuous 1990s, marked by the transition to capitated contracts and the later carve-out for behavioral health, serves as a cautionary tale. While Connecticut's system has seen some positive transformations, it is far from a utopia and is slowly migrating towards the loss of local control. Local control is a key characteristic of PIHPs that were created by the Community Mental Health Services Programs here in Michigan.

A brief breakdown of the Connecticut experience shows that in the early to mid-1990's all of Medicaid services were put out to bid under capitated contracts. Capitated contracts are financing methods where the entity is paid a standard rate, usually in advance, and must cover all medically necessary services and supports for all eligible beneficiaries.

At the time, there were 11 companies that did business in Connecticut. Most, if not all of them, contracted out for behavioral health benefits management which was carved out of the general medical benefit.

The result in Connecticut was an unmitigated disaster for behavioral health outpatient, inpatient and child residential, which was mostly Medicaid reimbursed at the time. There were high levels of service authorization denials, delayed payments to providers, provider rate reductions, inadequate funding, and many quality concerns. It took a lawsuit to stop it.

From about 1991 - 2005 lots of new services for adults with mental health conditions were funded with Connecticut state grant resources, not Medicaid. This is important, because, unlike Michigan, Connecticut's system is still heavily supported by state funding, not Medicaid. Also, unlike Michigan, which has one of the best behavioral health service arrays in the country, Connecticut's service array was primarily focused on outpatient, psychiatric inpatient, a tiny amount of case management, and a handful of other services. Connecticut has never maximized Medicaid as a source of funding like Michigan has. The Connecticut LMHAs are still in existence today, although they have not been adequately funded for a long time.

The current PIHP boards in Michigan are mostly made up of persons served, or their family members, individuals with lived experiences of mental health, developmental disabilities, and addiction issues along with other stakeholders (such as County Commissioners). These volunteers prove the importance of keeping local control and community-based services and solutions accessible where they live and work.

As we navigate the future of Medicaid and public behavioral health services, it is crucial to learn from these examples and advocate for policies that prioritize the well-being of the residents of our state and their unique circumstances, needs, and communities. As the chairman of a PIHP Board, I am concerned when I hear PIHPs blamed for things that are beyond their control, are not their responsibility, or that may be required of them by state and federal policies. Let us have a conversation about what the PIHPs are and how to improve them.

The public behavioral health system in Michigan is not now, nor should it become some ubiquitous health care ASO. Michigan's public behavioral health system is governed by persons with lived experience, committed to local service, accountable to our community members who worship together, shop at the same places, and attend high school football games together. Every PIHP board member has a story of why they do this work and those that criticize PIHPs are welcome to get more directly involved to learn about its value to the beneficiaries that we are blessed to serve. I challenge all involved parties to engage in beneficiary focused improvements and to work together to develop plans that work best in Michigan.

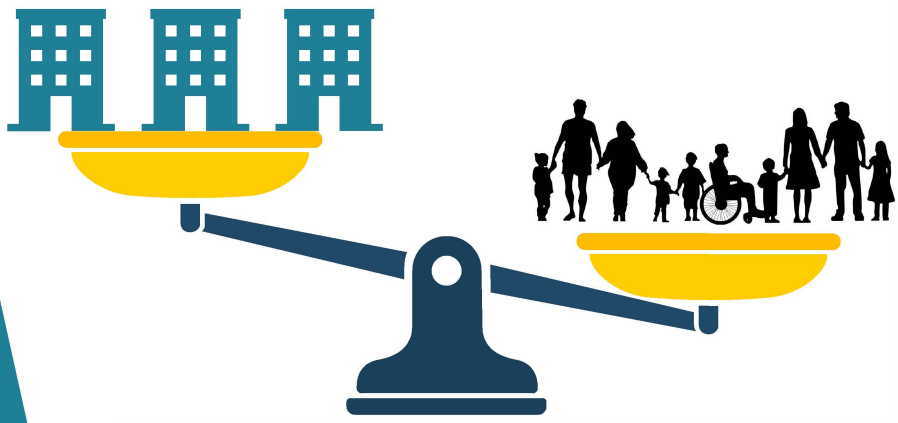
We are not conflicted in our interests! To the contrary – our highest priority interest is in ensuring that the best possible supports and services that the people in our communities need are available to them. Michigan's current PIHP boards are advocates for beneficiaries and we are committed to continuing this important work.

####

About Edward Woods:

Edward Woods is a retired steel company executive who is serving his fifth consecutive term as the Chair of the Mid-State Health Network Board of Directors. The board includes 24 members from across the 21-county region, which has about 400,000 Medicaid enrollees. He is also a member of the board of directors of LifeWays, a Community Mental Health Services Program serving Jackson and Hillsdale Counties, a position he has held since 1990. Since 2023, Mr. Woods has chaired the National Council for Mental Wellbeing Board. Under the board's guidance, the Council developed the Certified Behavioral Health Clinic (CCBHC) initiative, which gained bipartisan support in Congress and became a national model for mental health and addiction care. Mr. Woods has also served on a variety of local boards, including the Jackson County Chamber of Commerce, Jackson County Community Foundation, The Enterprise Group, Jackson Area Manufacturers Association, Jackson County Foster Care Review Board, National Association of Foster Care Reviewers, Allegiance Health Quality Council and Catholic Charities. Mr. Woods is also a past-president of the Community Mental Health Association in Michigan.

MICHIGAN'S MEDICAID SYSTEM:
PRIORITIZING CARE



Cut the Red Tape, Not the Care

MICHIGAN MEDICAID BEHAVIORAL HEALTH:
SHARED VALUES AND A PATH TO CHANGE

We represent the interests of Medicaid recipients who rely on Michigan's behavioral health system.

This overview outlines our **core values**, **concerns with the current system**, and **key reforms** needed to improve care.

Disability Rights Michigan

MI DDI Michigan Developmental Disabilities Institute

Michigan Disability Rights Coalition
With liberty and access for all.

MHA Mental Health Association in Michigan

1in6 Support

The Arc Bay County

AUTISM ALLIANCE OF MICHIGAN

DETROIT DISABILITY POWER

The Arc Michigan

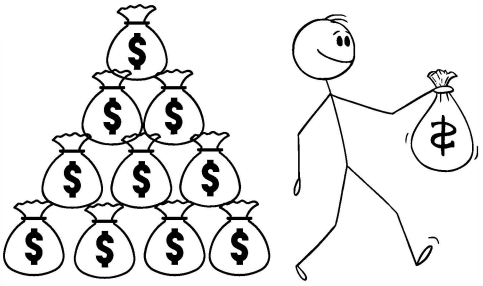
MSILC Michigan Statewide Independent Living Council

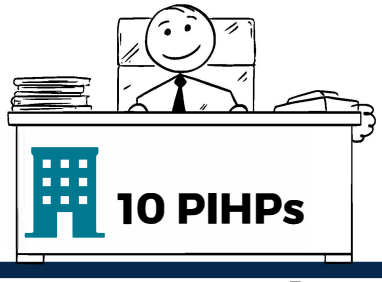
Administrative Layers

Michigan's Medicaid behavioral health system has **3 layers of administration** (excluding direct providers and the federal government) **before funds reach the people who need care.**

Paperwork over People

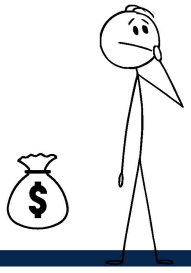
State of Michigan

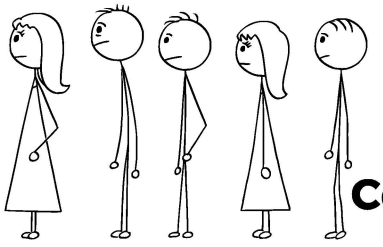




10 PIHPs

46 CMHs



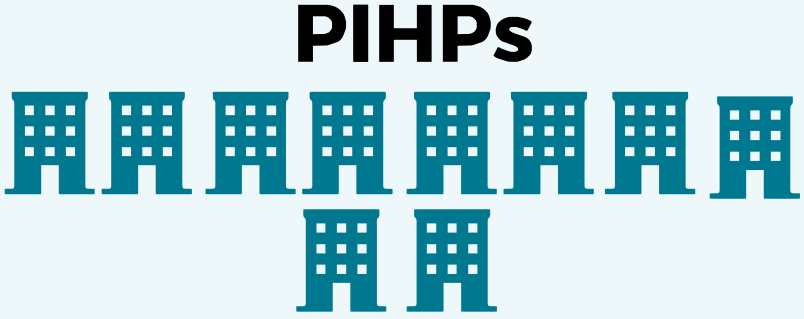


Consumers

Michigan must **prioritize care over bureaucracy**. It's time to put Medicaid dollars where they belong —**helping people**.

Put More Money Into Services, Not Administration

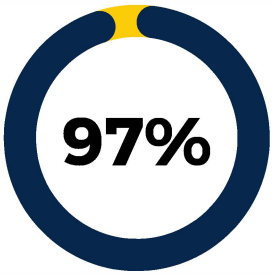
The PIHP layer is unnecessary and wasteful.



A Better System Exists

Replacing the **10 Prepaid Inpatient Health Plans (PIHPs)** with a **small number of Administrative Services Organizations (ASOs)** would cut unnecessary costs.

It Works Elsewhere



In Connecticut, switching to ASOs meant **97.5% of Medicaid dollars** went directly to services instead of administrative costs.

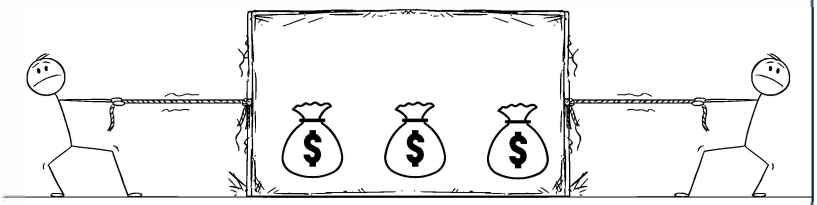
More funding for services = **Better care**

*Stronger provider networks mean **more choices, better access, and the ability for people to stay in their communities**.*

End the Conflict of Interest in Michigan's Medicaid System

The Problem

The same organizations that **authorize** Medicaid services are also responsible for **paying for them**—creating a built-in conflict of interest.



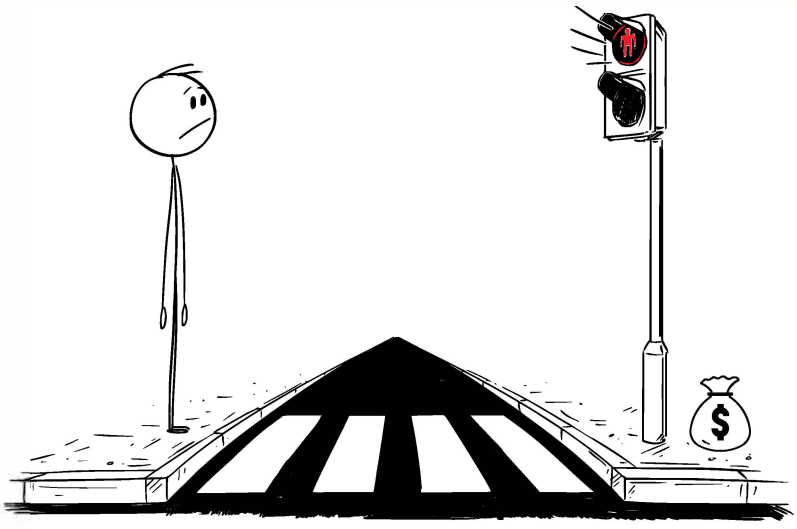
PIHPs **CMH**

Financial Incentives Over Care

PIHPs and CMHs decide what services to approve while trying to stay under budget.

This leads to:

- Unjustified service denials
- Waitlists due to low provider reimbursement
- Secretive decision-making about medical necessity



*It's time for a system that works for **Medicaid recipients and providers —not just administrators.***

The Model

Adopt a model like **Connecticut's**, where **Administrative Services Organizations (ASOs)** handle authorizations **without financial bias.**

Care over Cost-cutting

State of Michigan

Authorization Contract

ASO (s)

Why It Works:

- ASOs **have no financial reason** to deny services.
- Fee schedules ensure fair, **transparent** payment rates based on actual costs.
- **People get the care they need—without bureaucratic interference.**

46 CMHs AND Other Providers

Consumers

Why It Works:

- Providers **contract directly with Medicaid** and receive fair rates.
- CMHs return to their original role—**providing direct services, not managing care.**

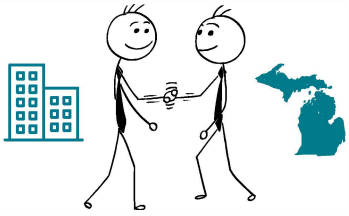
Michigan Medicaid Must Follow Federal Law

MDHHS is responsible for Michigan's Medicaid program. Federal law requires each state to have a **single state agency** in charge—MDHHS must fully oversee and enforce Medicaid policies.

The Current System is Broken

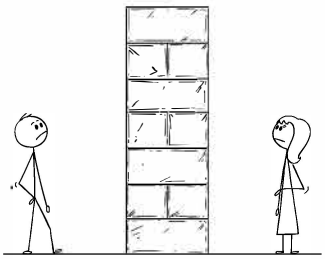
- **No real accountability:** MDHHS cannot hold PIHPs and CMHs accountable for non-compliance.
- **Medicaid recipients are left without options.** People shouldn't have to file lawsuits to get the care they're entitled to—most can't afford legal help.
- **CMHs and PIHPs fight back and resist efforts to fix problems.** MDHHS only contracts with PIHPs, but PIHPs don't enforce rules against CMHs—and MDHHS isn't enforcing rules against PIHPs.

The Solution:
A Direct, Enforceable System

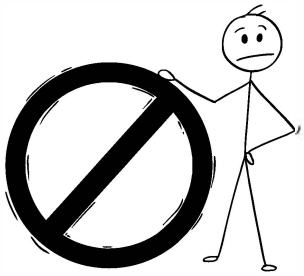


- MDHHS should **contract directly** with Administrative Service Organizations (ASOs) and providers. This ensures transparency and real accountability.

- Enforceable contracts mean better oversight. MDHHS must have the power to **replace contractors** if they fail to meet their obligations.



- **Clear separation of costs**. Dividing administration and service costs will bring full transparency to Medicaid spending.



- **The buck stops with MDHHS**. MDHHS must be directly responsible for ensuring Medicaid recipients receive the care they need.

*Michigan must fix its broken Medicaid system and **prioritize accountability, transparency, and access to care.***

RURAL MENTAL HEALTH AND FIRST RESPONDER LEADERS

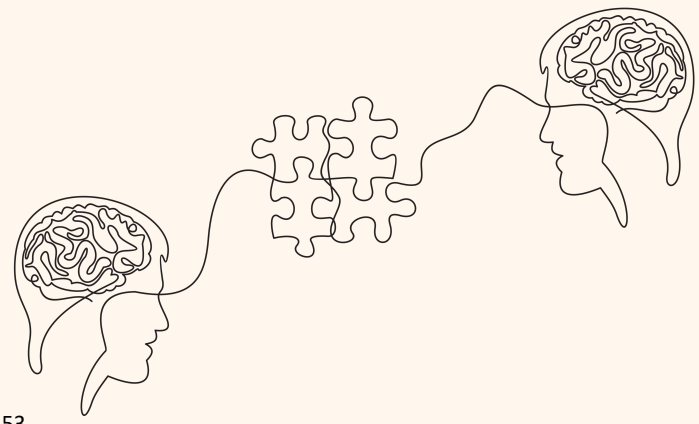
Join our bimonthly virtual roundtable events promoting community-based mental health and local first responder collaboration on relevant topics nominated by members and addressing barriers impacting rural communities in Michigan.

MiREMS Website

Our Focus

- Enhancing Interdisciplinary Communication
- Training Opportunities
- Exchanging Ideas
- Creative Problem-Solving with Limited Resources

Your participation is essential to enhance current systems that serve rural Michigan communities.



To request an invitation or more info please email: mhwest@mirems.org

April 3, 2025

Leslie Hall, Executive Director
Michigan Rural EMS Network
P.O. Box 265
Caro, MI 48723

Dear Ms. Hall,

Bay Arenac Behavioral Health is writing this letter regarding Michigan Rural EMS Network's Mental Health Awareness Training Grant Program, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). We look forward to collaborating on this project to help ensure access to needed mental health services. We understand first responders need up-to-date information that helps them respond more effectively to individuals diagnosed with serious mental illness (SMI) and/or serious emotional disturbances (SED). Our organization is committed to ongoing collaboration with local emergency services that improves coordination of care and the referral system. Bay Arenac Behavioral Health understands the importance of communicating with emergency services agencies by sharing information and ideas between organizations to facilitate care for individuals served in the emergency care system and to build awareness for community needs. Bay Arenac Behavioral Health recognizes the level of commitment is voluntary and does not require financial involvement or additional resources by the agency.

Since 1999, Bay Arenac Behavioral Health has provided mental health services in Bay and Arenac Counties. Our staff meets the requirements of a referral provider as outlined in the Funding Opportunity Announcement:

- **Bay Arenac Behavioral Health** has at least one experienced and licensed mental health provider to which the selected population of focus can be referred to;
- **Bay Arenac Behavioral Health** providers are experienced and licensed; many with at least two years of experience providing relevant services; and
- **Bay Arenac Behavioral Health** complies with all applicable local, county and state licensing, accreditation, and certification requirements.

Currently, our organization provides Outpatient therapy, Psychiatry, Case Management, Infant Mental Health, Home Based Services, Adult Foster Care, Crisis Services, and Mobile Response Services. I look forward to seeing the impact of this project. If you have any questions, please contact me at **989-497-1577**. James Spegel, BABH Mobile Response Team Supervisor, will be the main contact for this collaboration.

Sincerely,

Stacy Krasinski, MA LPC
Emergency and Access Services
BABH Clinical Program Manager
989-497-1577

Critical Time Intervention (CTI) Model:

Critical Time Intervention | CTI Model | Critical Time Intervention – this link has more about the background, evidence for effectiveness, HANDOUTS, and FAQs. The FAQ page gives a lot of info.

Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of *transition* (from institutions / inpatient / jail / etc.). It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods. CTI has been applied with veterans, people with mental illness, people who have been homeless or in prison, and many other groups. The model has been widely used on four continents.

Core Components

- Addresses a period of transition
- Time-limited
- Phased approach
- Focused
- Decreasing intensity over time
- Community-based
- No early discharge
- Small caseloads
- Harm reduction approach
- Weekly team supervision
- Regular full caseload review

There are 4 Phases in the Model. (They consider Pre-CTI a phase.)

Pre-CTI
Develop a trusting relationship with client.
Phase 1: Transition
Provide support and begin to connect client to people and agencies that will assume the primary role of support.

- Make home visits
- Engage in collaborative assessments
- Meet with existing supports
- Introduce client to new supports
- Give support and advice to client and caregivers

Phase 2: Try-Out
Monitor and strengthen support network and client's skills.

- Observe operation of support network
- Mediate conflicts between client and caregivers
- Help modify network as necessary
- Encourage client to take more responsibility

Phase 3: Transfer of Care
Terminate CTI services with support network safely in place.

- Step back to ensure that supports can function independently
- Develop and begin to set in motion plan for long-term goals
- Hold meeting with client and supports to mark final transfer of care
- Meet with client for last time to review progress made

Housing First Model:

These websites have a fact sheet, checklist, and toolkit available.

Housing First - National Alliance to End Homelessness

Organizational Change: Adopting a Housing First Approach - National Alliance to End Homelessness

Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation | United States Interagency Council on Homelessness

Housing First is a homeless assistance approach that

- prioritizes providing permanent housing to people experiencing homelessness
- is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues
- is based on the understanding that client choice is valuable in housing selection and supportive service participation
- believes exercising that choice is likely to make a client more successful in remaining housed and improving their life.

Housing First *does not require* people experiencing homelessness to address all of their problems including behavioral health problems, or to graduate through a series of services programs before they can access housing. The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter. Supportive services are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage.

Housing First works with both families and individuals.

Elements:

- Housing First programs often provide rental assistance that varies in duration depending on the household's needs.
- Consumers sign a standard lease and are able to access supports as necessary to help them do so.
- A variety of voluntary services may be used to promote housing stability and well-being during and following housing placement.

Two common models followed:

1. **Permanent supportive housing (PSH) is targeted to individuals and families with *chronic illnesses, disabilities, mental health issues, or substance use disorders* who have experienced long-term or repeated homelessness**. It provides long-term rental assistance and supportive services.
2. A second model, rapid re-housing, is employed for a wide variety of individuals and families. It provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self-sufficiency, and remain housed. The Core Components of rapid re-housing—housing identification, rent and move-in assistance, and case management and services—operationalize Housing First principals.

Microsoft | Power BI

Leadership Dashboard

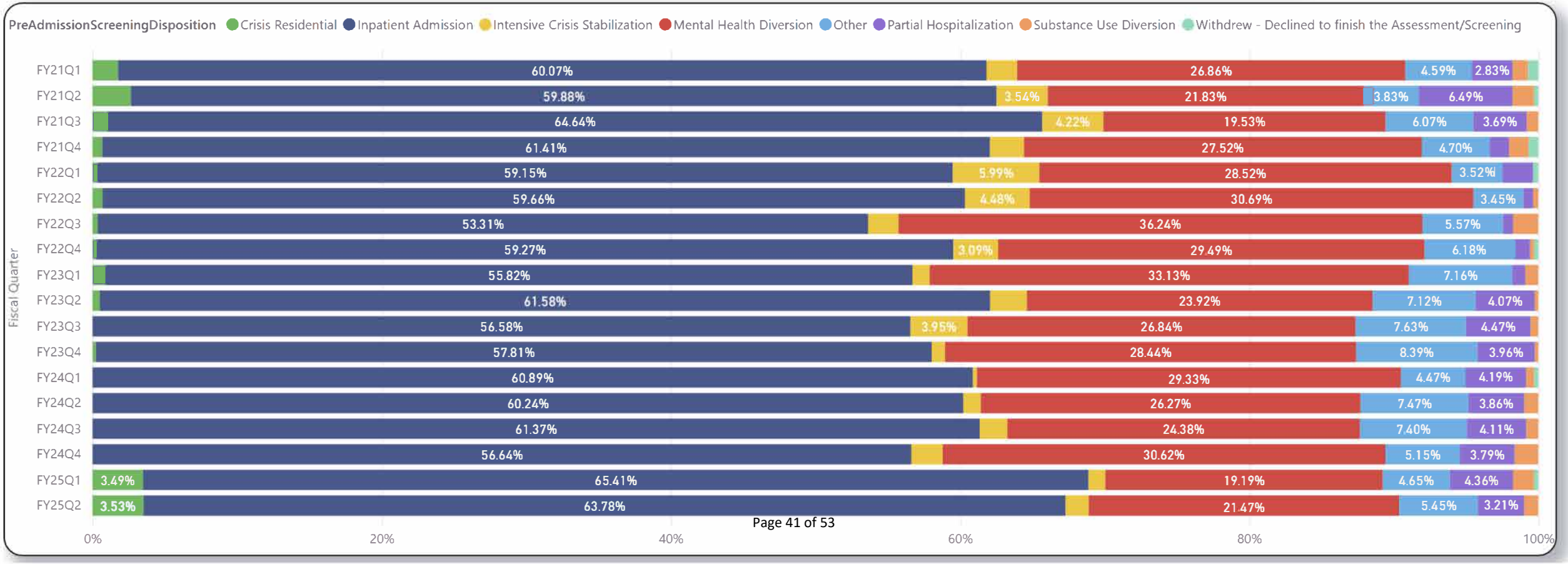
View in Power BI

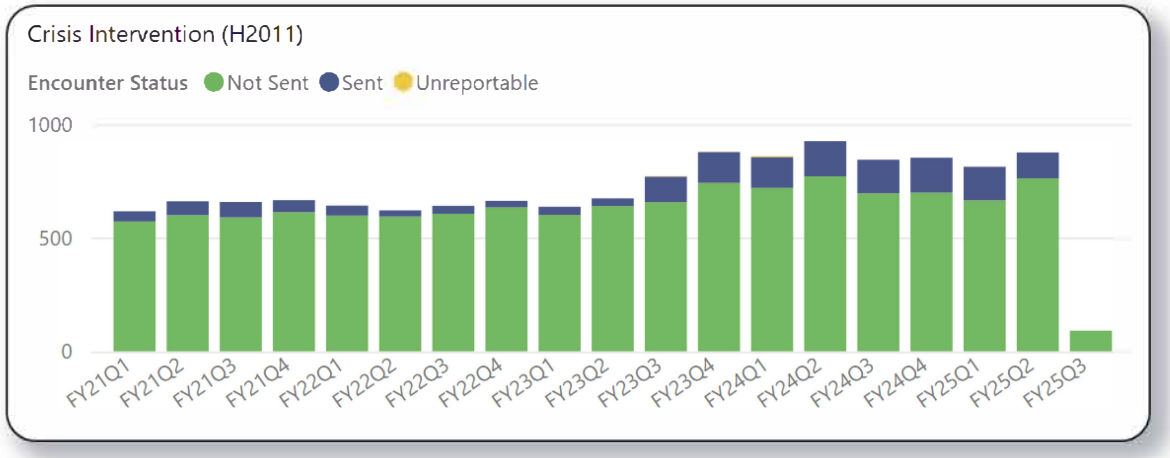
Last data refresh:
4/7/2025 11:47:54 AM UTC

Downloaded at:
4/7/2025 4:02:16 PM UTC

Adult or Child	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY22Q1	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3	FY23Q4	FY24Q1	FY24Q2	FY24Q3	FY24Q4	FY25Q1
Adult (18+)																	
Crisis Residential	5	9	4	2	1	1	1	1	3	2		1					12
Inpatient Admission	154	177	223	157	137	151	131	196	159	194	182	222	183	211	197	188	188
Intensive Crisis Stabilization			1		2				1							2	
Mental Health Diversion	55	48	54	58	56	62	71	84	74	52	72	83	81	79	59	87	54
Other	11	8	20	10	6	5	5	14	17	16	21	29	13	24	19	15	15
Partial Hospitalization	8	22	14	4	6	2	2	4	3	16	17	17	15	16	15	14	15
Substance Use Diversion	3	5	3	4		1	4	1	3	1	2	1	2	4	3	6	5
Withdrew - Declined to finish the Assessment/Screening	2			2	1			1					1				1
Child (0 -17)																	
Crisis Residential						1											
Inpatient Admission	16	26	22	26	31	22	22	15	28	48	33	26	35	39	27	21	37

Procedure Code	Value to Count
H0039	141
H2011	25
T1023	6050
Total	**6216**

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Encounter Status
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Sent
Unreportable
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500
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FY21Q1
FY21Q2
FY21Q3
FY21Q4
FY22Q1
FY22Q2
FY22Q3
FY22Q4
FY23Q1
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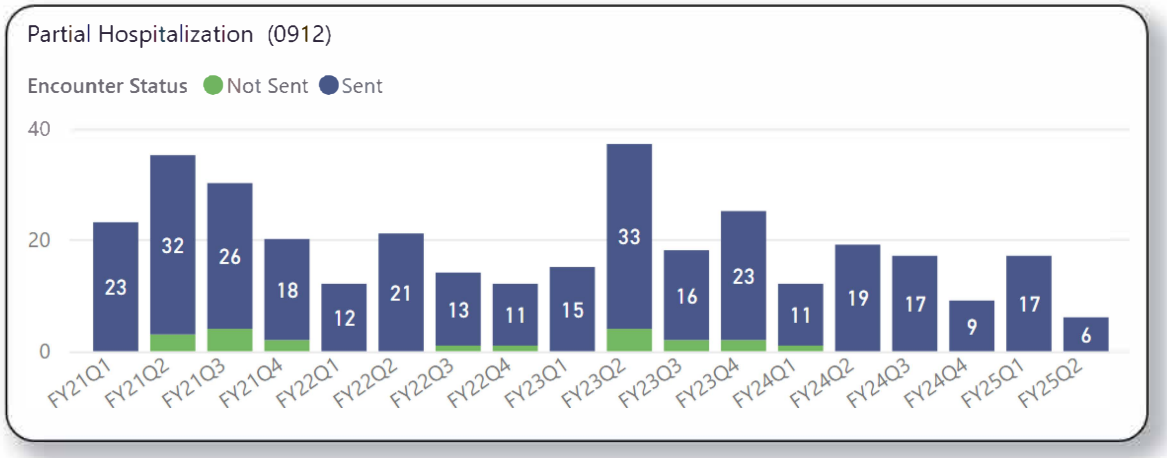
FY24Q4
FY25Q1
FY25Q2
FY25Q3


Partial Hospitalization (0912)
Encounter Status
Not Sent
Sent
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20
0
23
32
26
18
12
21
13
11
15
33
16
23
11
19
17
9
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6
FY21Q1
FY21Q2
FY21Q3
FY21Q4
FY22Q1
FY22Q2
FY22Q3
FY22Q4
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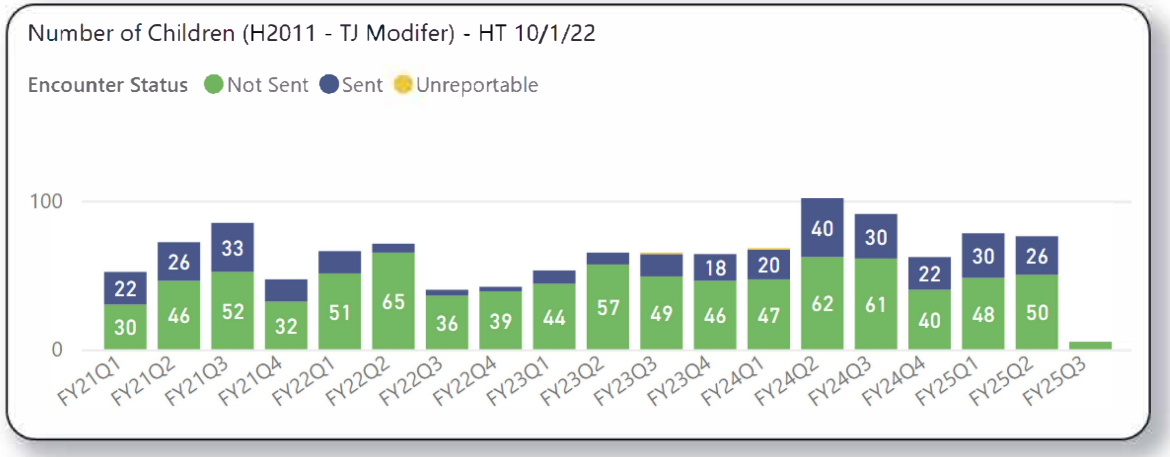
Number of Children (H2011 - TJ Modifer) - HT 10/1/22
Encounter Status
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Unreportable
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FY21Q1
FY21Q2
FY21Q3
FY21Q4
FY22Q1
FY22Q2
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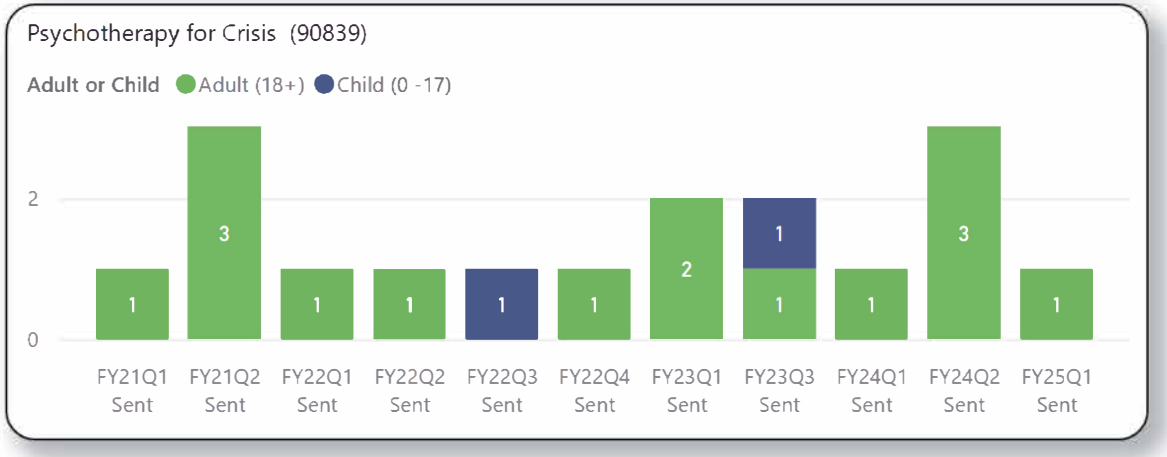
FY25Q1
FY25Q2
FY25Q3


Psychotherapy for Crisis (90839)
Adult or Child
Adult (18+)
Child (0 -17)
2
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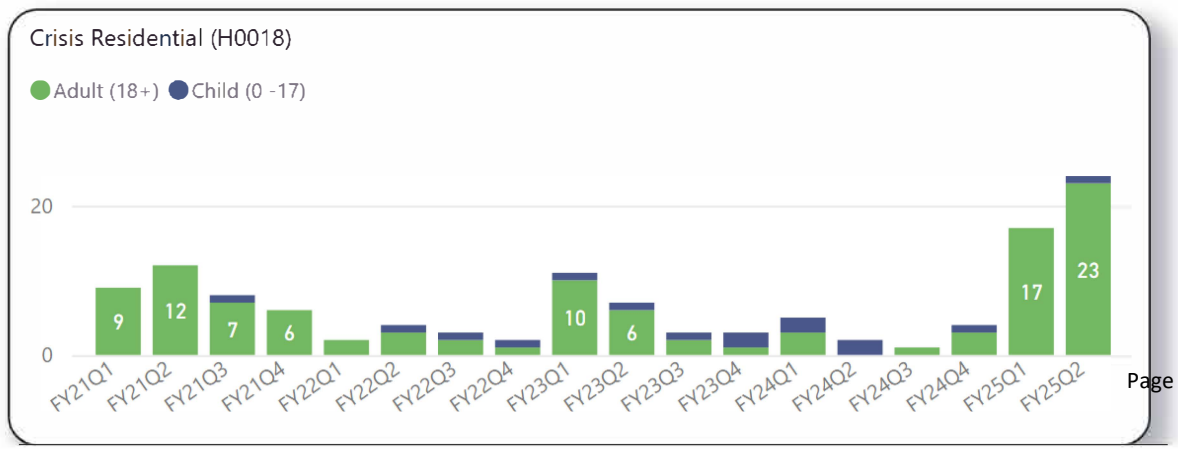
3
1
FY21Q1 Sent
FY21Q2 Sent
FY22Q1 Sent
FY22Q2 Sent
FY22Q3 Sent
FY22Q4 Sent
FY23Q1 Sent
FY23Q3 Sent
FY24Q1 Sent
FY24Q2 Sent
FY25Q1 Sent


Crisis Residential (H0018)
Adult (18+)
Child (0 -17)
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FY21Q4
FY22Q1
FY22Q2
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FY22Q4
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FY24Q3
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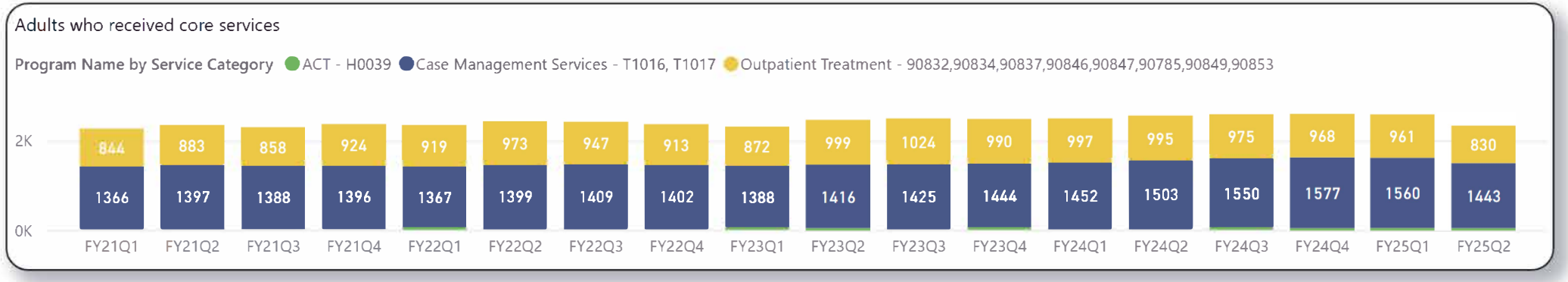
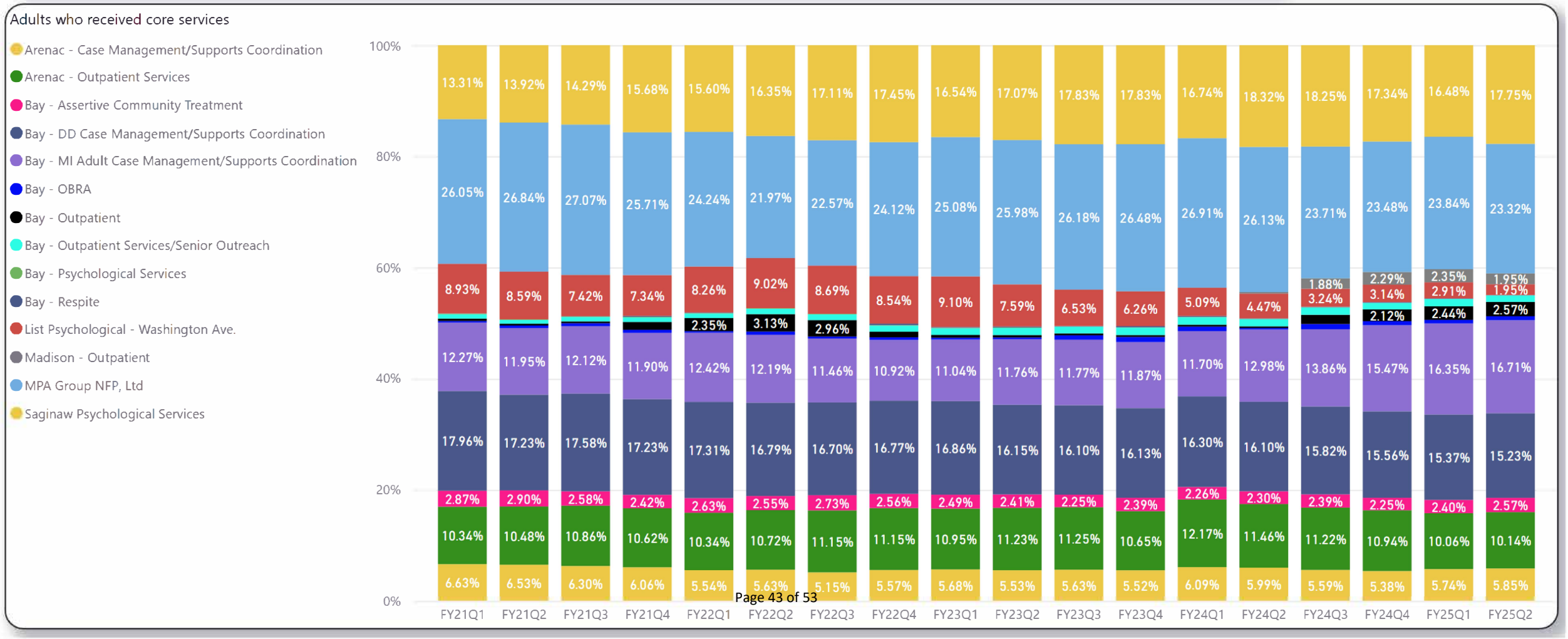
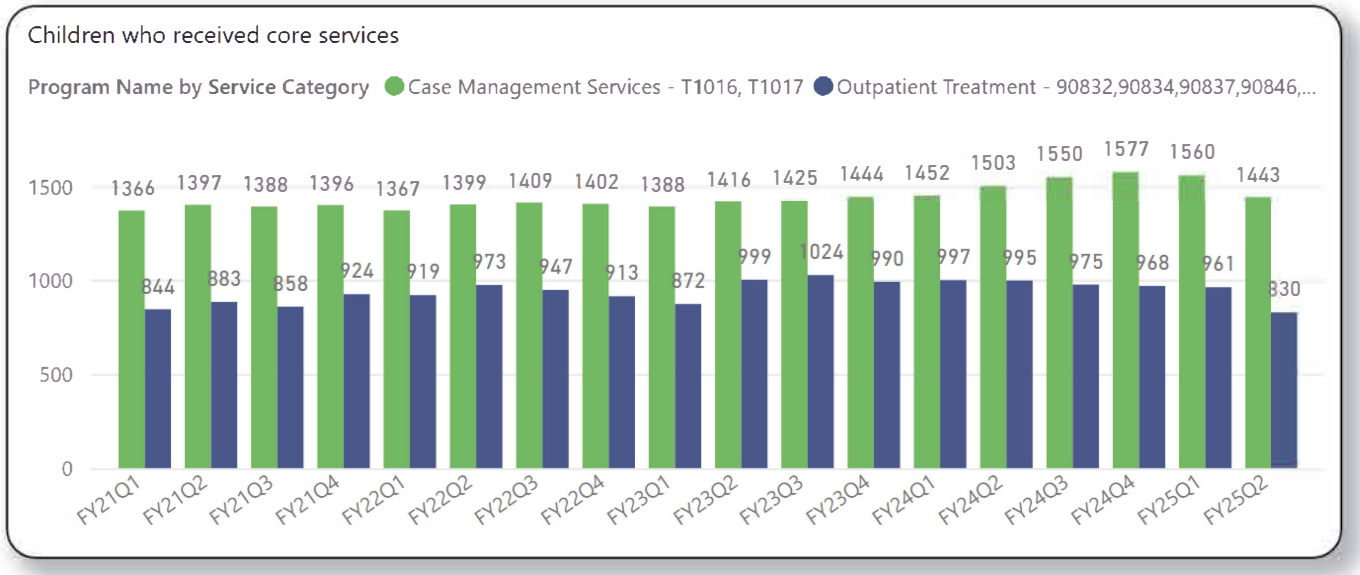
FY25Q2

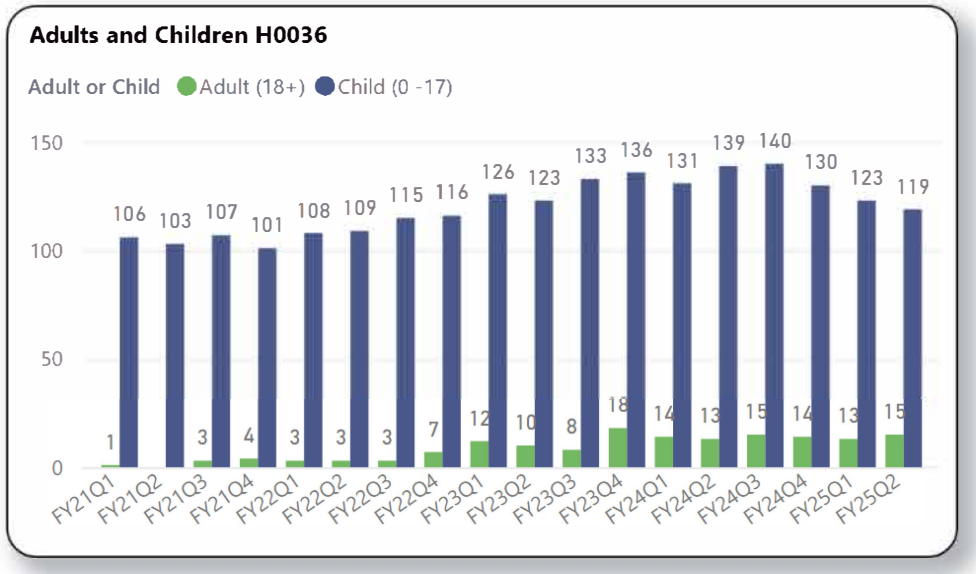


6945

Distinct Consumer Count




Children who received core services
Program Name by Service Category
Case Management Services - T1016, T1017
Outpatient Treatment - 90832,90834,90837,90846,...
1500
1000
500
0
1366 1397 1388 1396 1367 1399 1409 1402 1388 1416 1425 1444 1452 1503 1550 1577 1560 1443
844 883 858 924 919 973 947 913 872 999 1024 990 997 995 975 968 961 830
FY21Q1 FY21Q2 FY21Q3 FY21Q4 FY22Q1 FY22Q2 FY22Q3 FY22Q4 FY23Q1 FY23Q2 FY23Q3 FY23Q4 FY24Q1 FY24Q2 FY24Q3 FY24Q4 FY25Q1 FY25Q2


Adults and Children H0036
Adult or Child
Adult (18+)
Child (0 -17)
150
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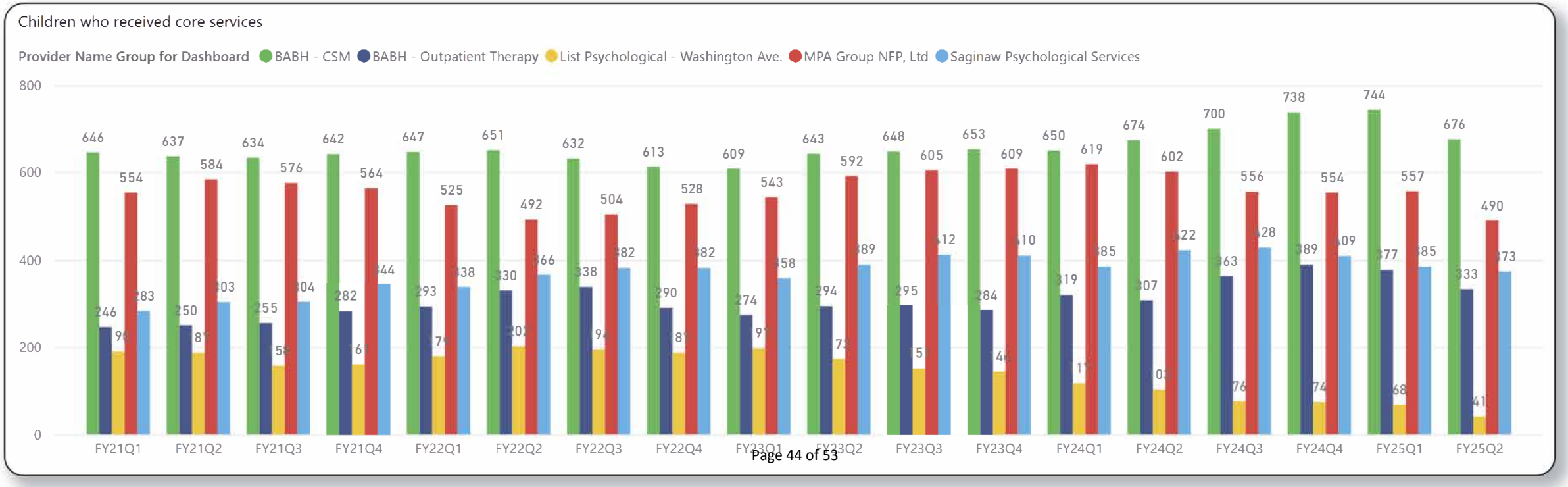
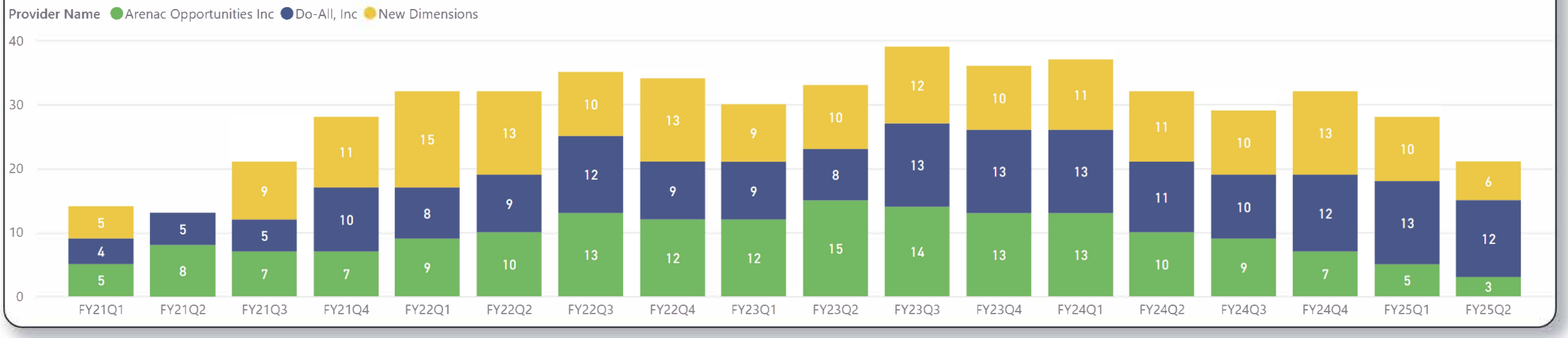
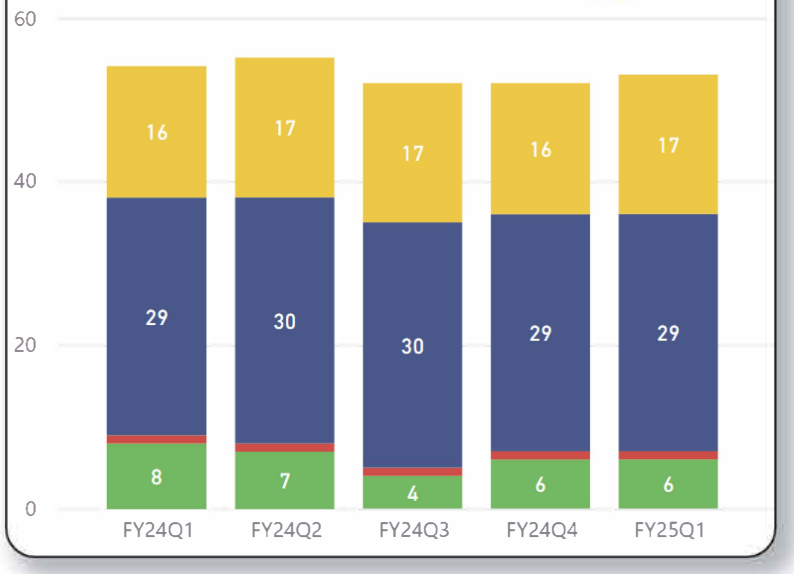
1 106 3 103 4 107 3 101 3 108 3 109 3 115 7 116 12 126 10 123 8 133 18 136 14 131 13 139 15 140 14 130 13 123 15 119
FY21Q1 FY21Q2 FY21Q3 FY21Q4 FY22Q1 FY22Q2 FY22Q3 FY22Q4 FY23Q1 FY23Q2 FY23Q3 FY23Q4 FY24Q1 FY24Q2 FY24Q3 FY24Q4 FY25Q1 FY25Q2


Children who received core services
Provider Name Group for Dashboard
BABH - CSM
BABH - Outpatient Therapy
List Psychological - Washington Ave.
MPA Group NFP, Ltd
Saginaw Psychological Services
800
600
400
200
0
646 246 554 283
637 250 584 303
634 255 576 304
642 282 564 344
647 293 525 338
651 330 492 366
632 338 504 382
613 290 528 382
609 274 543 358
643 294 592 389
648 295 605 412
653 284 609 410
650 319 619 385
674 307 602 422
700 363 556 428
738 389 554 409
744 377 557 385
676 333 490 373
FY21Q1 FY21Q2 FY21Q3 FY21Q4 FY22Q1 FY22Q2 FY22Q3 FY22Q4 FY23Q1 FY23Q2 FY23Q3 FY23Q4 FY24Q1 FY24Q2 FY24Q3 FY24Q4 FY25Q1 FY25Q2

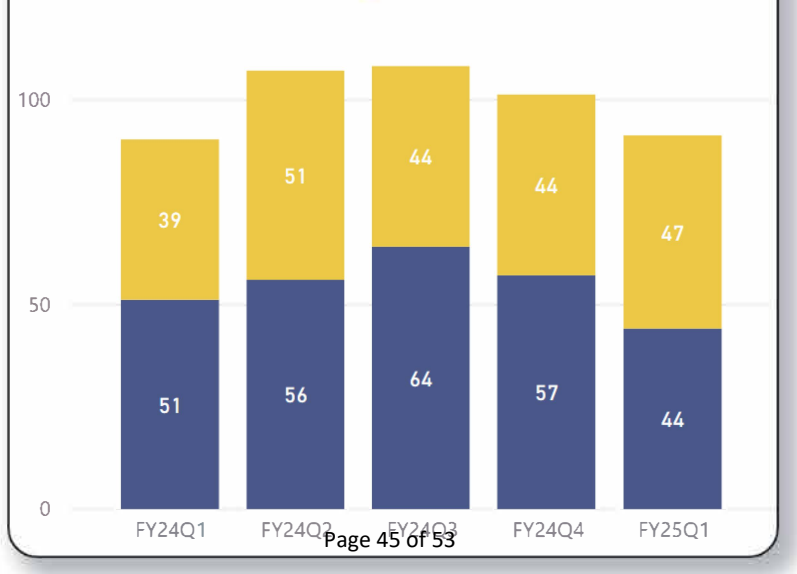
Skill building (H2014)



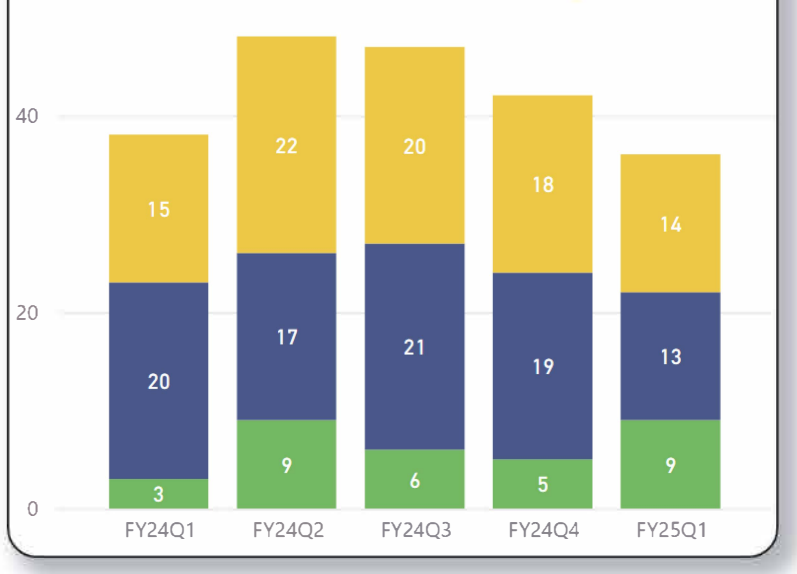
Job Coaching (H2025)



IPS (H2023 Y5)



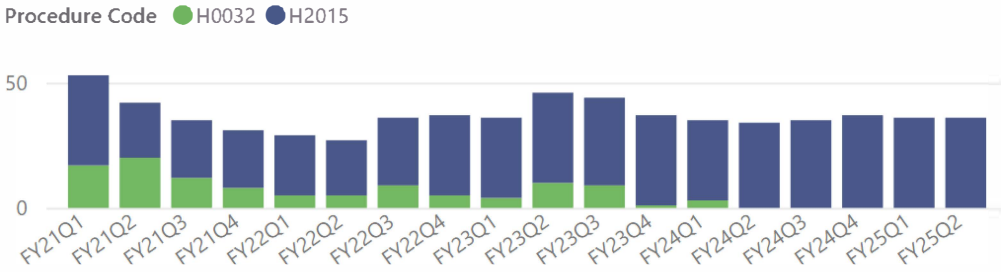
Supported Employment (H2023 2Y & 3Y)



North Bay CLS

Provider Name	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY22Q1	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2
North Bay										
H0032	17	20	12	8	5	5	9	5	4	10
H2015	36	22	23	23	24	22	27	32	32	36

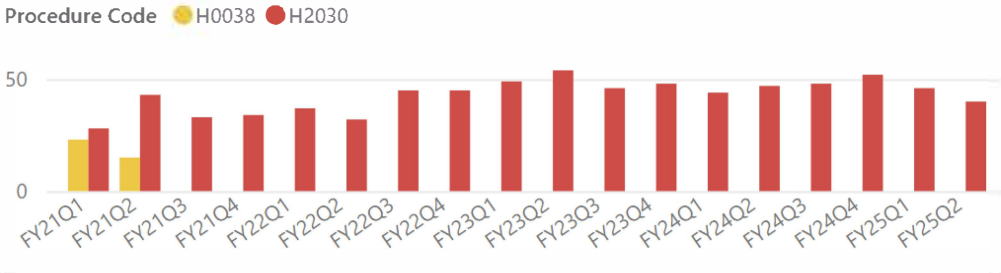
North Bay CLS



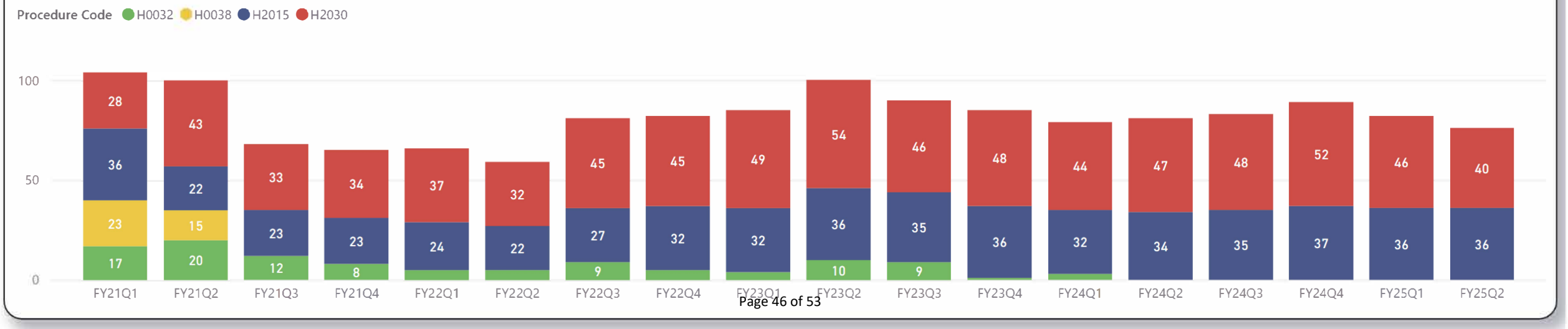
Touchstone

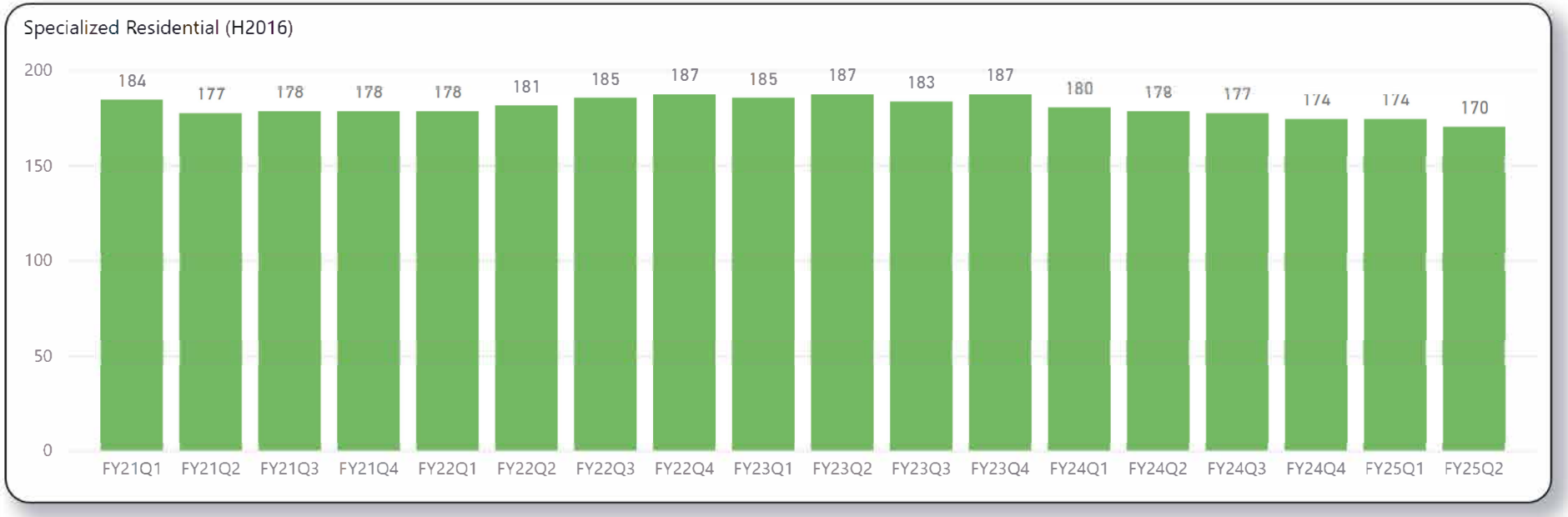
Procedure Code	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY22Q1	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2
H0038	23	15								
H2030	28	43	33	34	37	32	45	45	49	54

Touchstone



North Bay CLS

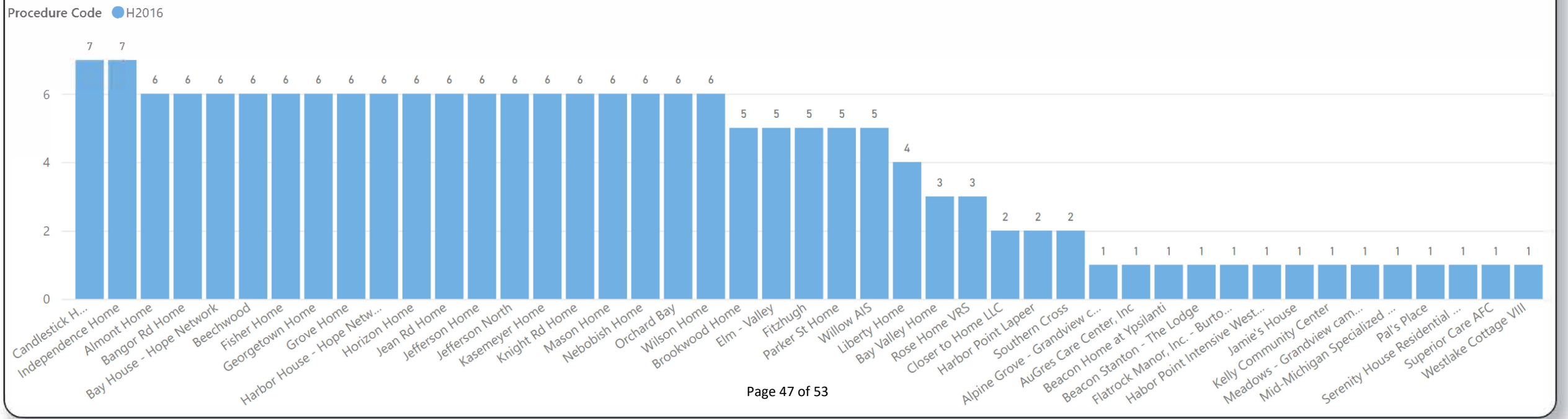




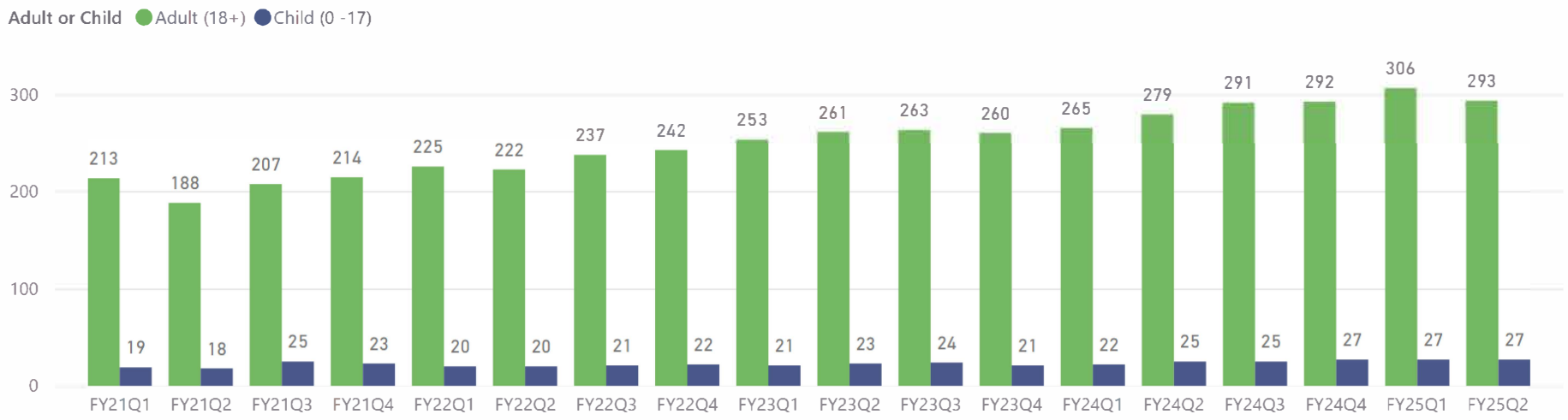
FY25Q1

Provider Name	H2016
Candlestick Home	7
Independence Home	7
Almont Home	6
Bangor Rd Home	6
Bay House - Hope Network	6
Beechwood	6
Fisher Home	6
Georgetown Home	6
Grove Home	6
Harbor House - Hope Network	6
Horizon Home	6
Jean Rd Home	6
Jefferson Home	6
Jefferson North	6

FY25Q1



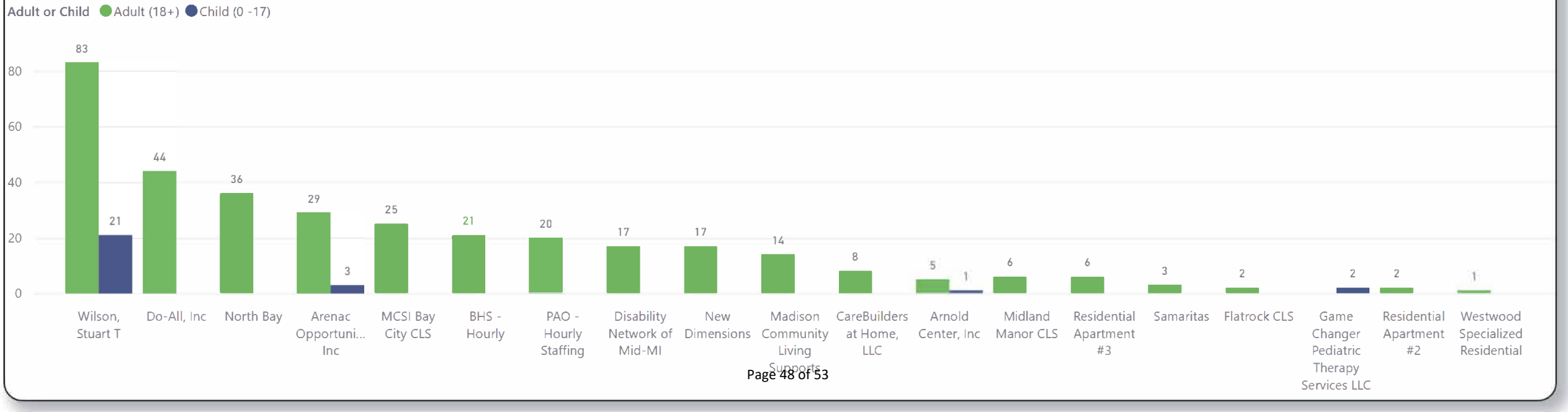
H2015

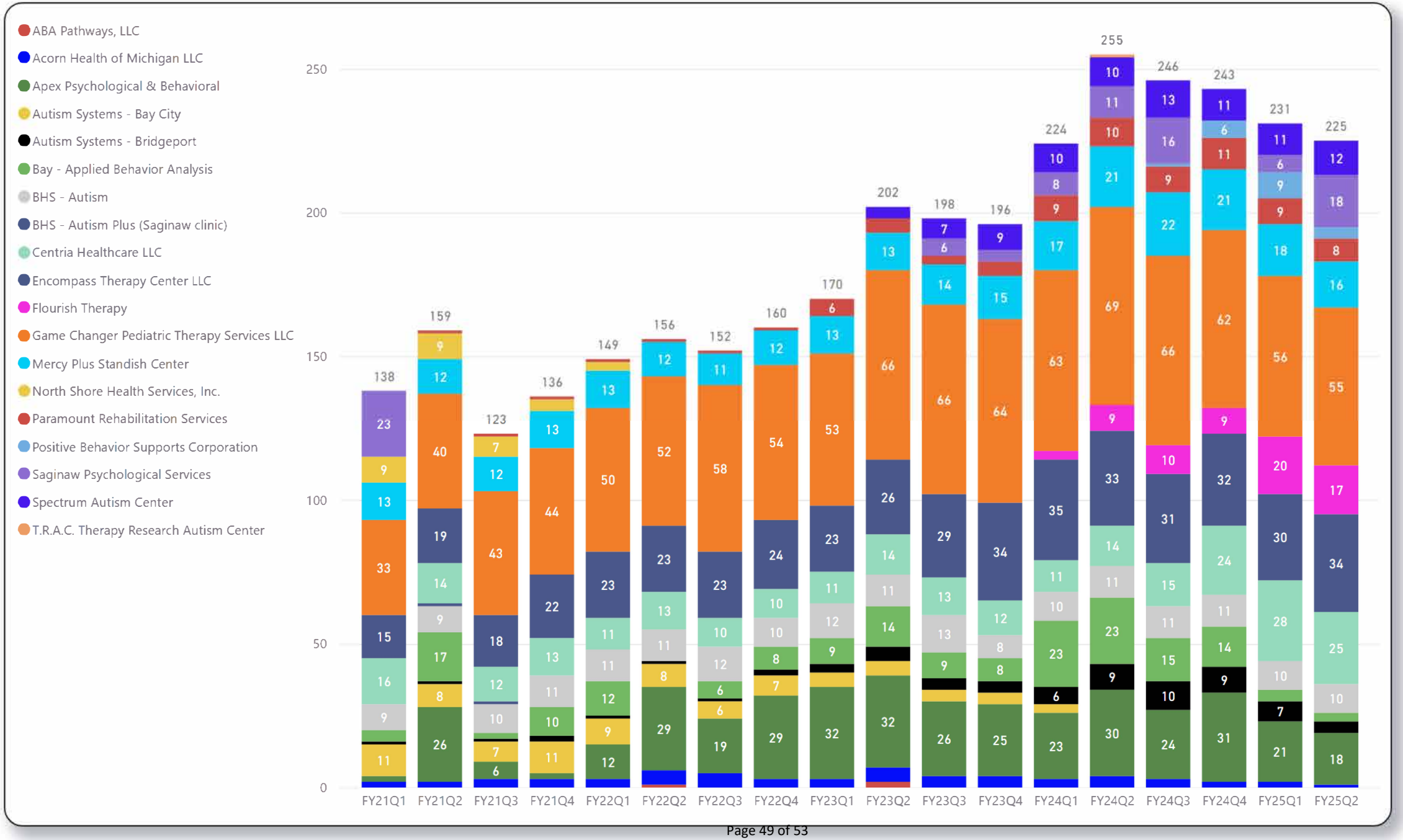


FY25Q1

Provider Name	H2015
Wilson, Stuart T	103
Do-All, Inc	44
North Bay	36
Arenac Opportunities Inc	31
MCSI Bay City CLS	25
BHS - Hourly	21
PAO - Hourly Staffing	20
Disability Network of Mid-MI	17
New Dimensions	17
Madison Community Living Supports	14
CareBuilders at Home, LLC	8
Arnold Center, Inc	6
Midland Manor CLS	6
Residential Apartment #3	6

FY25Q1




ABA Pathways, LLC
Acorn Health of Michigan LLC
Apex Psychological & Behavioral
Autism Systems - Bay City
Autism Systems - Bridgeport
Bay - Applied Behavior Analysis
BHS - Autism
BHS - Autism Plus (Saginaw clinic)
Centria Healthcare LLC
Encompass Therapy Center LLC
Flourish Therapy
Game Changer Pediatric Therapy Services LLC
Mercy Plus Standish Center
North Shore Health Services, Inc.
Paramount Rehabilitation Services
Positive Behavior Supports Corporation
Saginaw Psychological Services
Spectrum Autism Center
T.R.A.C. Therapy Research Autism Center
250
200
150
100
50
0
FY21Q1
FY21Q2
FY21Q3
FY21Q4
FY22Q1
FY22Q2
FY22Q3
FY22Q4
FY23Q1
FY23Q2
FY23Q3
FY23Q4
FY24Q1
FY24Q2
FY24Q3
FY24Q4
FY25Q1
FY25Q2
138
159
123
136
149
156
152
160
170
202
198
196
224
255
246
243
231
225
Procedure ...
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0373T
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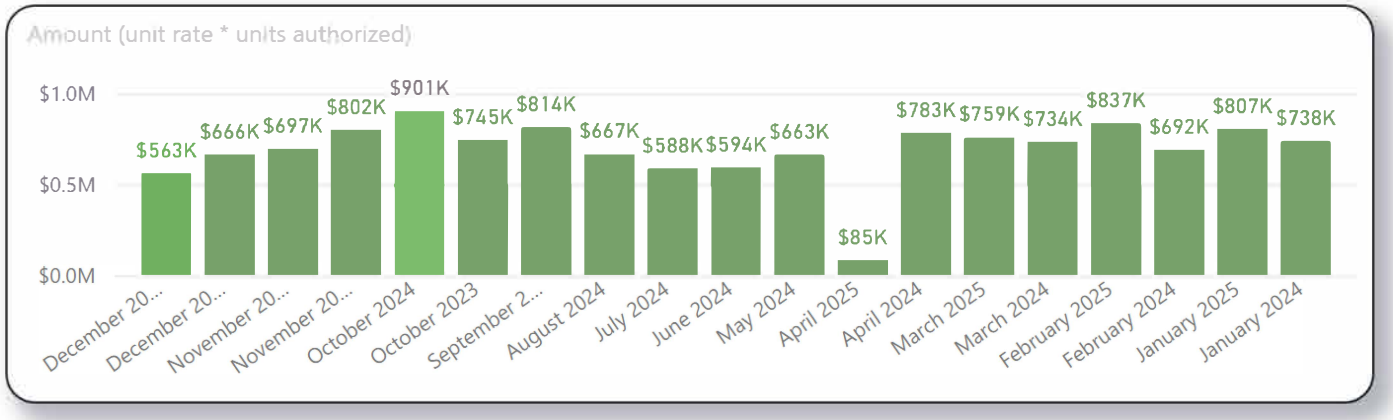
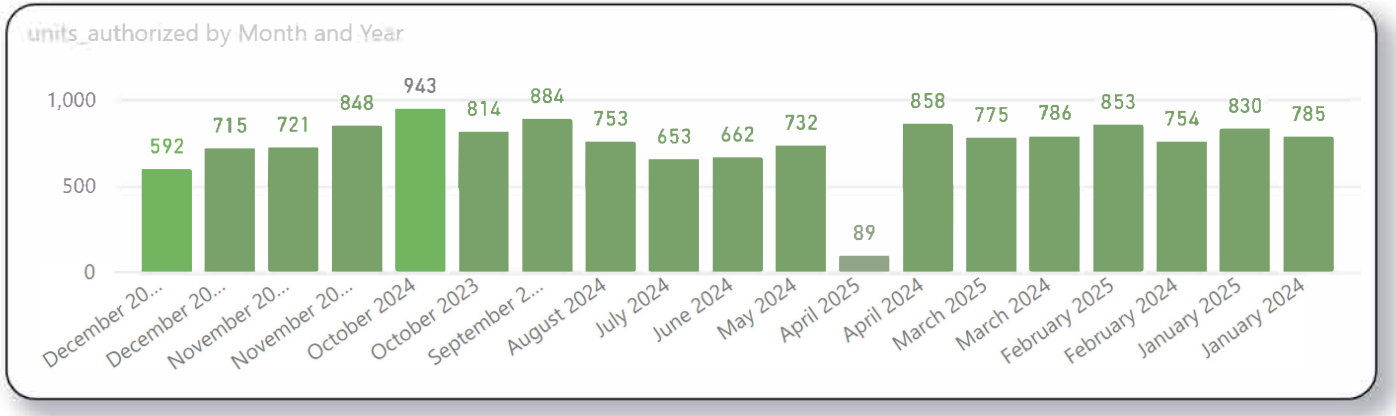
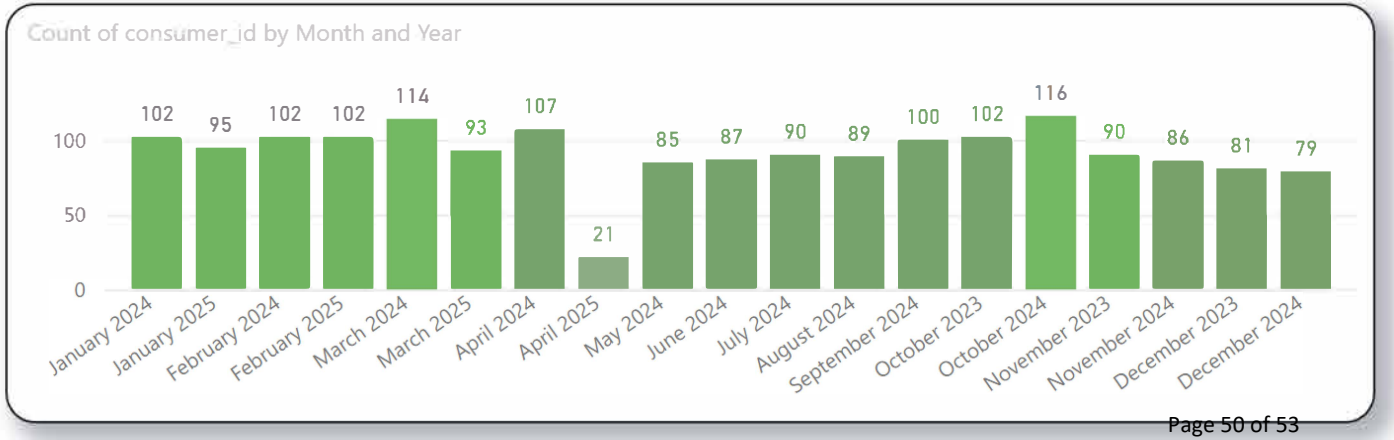
97157
H0031







Year	2023		2024		2
Month	units_authorized	Amount	units_authorized	Amount	u
January			785	$738,018	
February			754	$691,556	
March			786	$734,063	
April			858	$783,329	
May			732	$662,664	
June			662	$593,768	
July			653	$588,142	
August			753	$667,035	
September			884	$814,035	
October	814	$744,861	943	$900,595	
November	848	$802,376	721	$697,147	
December	715	$666,342	592	$563,071	

$13,135,0...
Amount

$2,849
Average of Amount

14,047
units_authorized

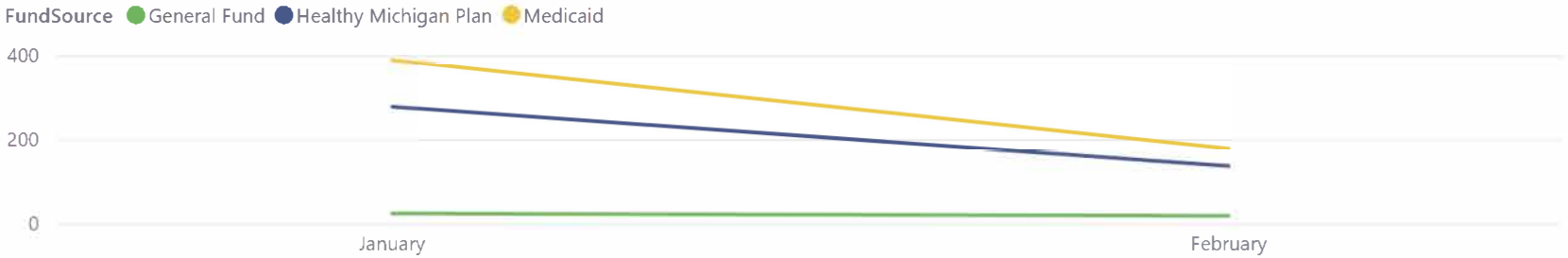
3
Average of units_auth...

31
Count of units_author...

Community Inpatient Days

FundSource	January	February
General Fund	23	17
Healthy Michigan Plan	277	136
Medicaid	388	177

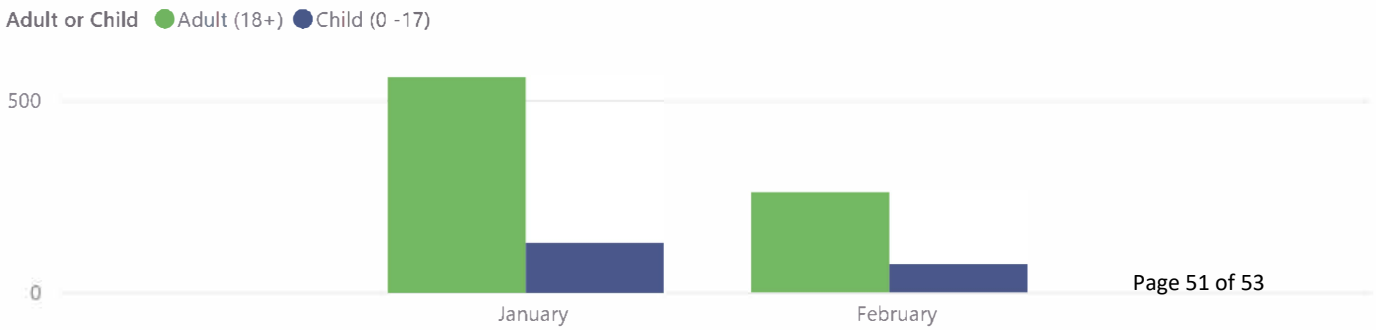
Community Inpatient Days



Community Inpatient Days By Fund Source

Adult or Child	January	February
Adult (18+)		
General Fund	23	6
Healthy Michigan Plan	277	136
Medicaid	259	116
Child (0 -17)		
General Fund		11
Medicaid	129	61

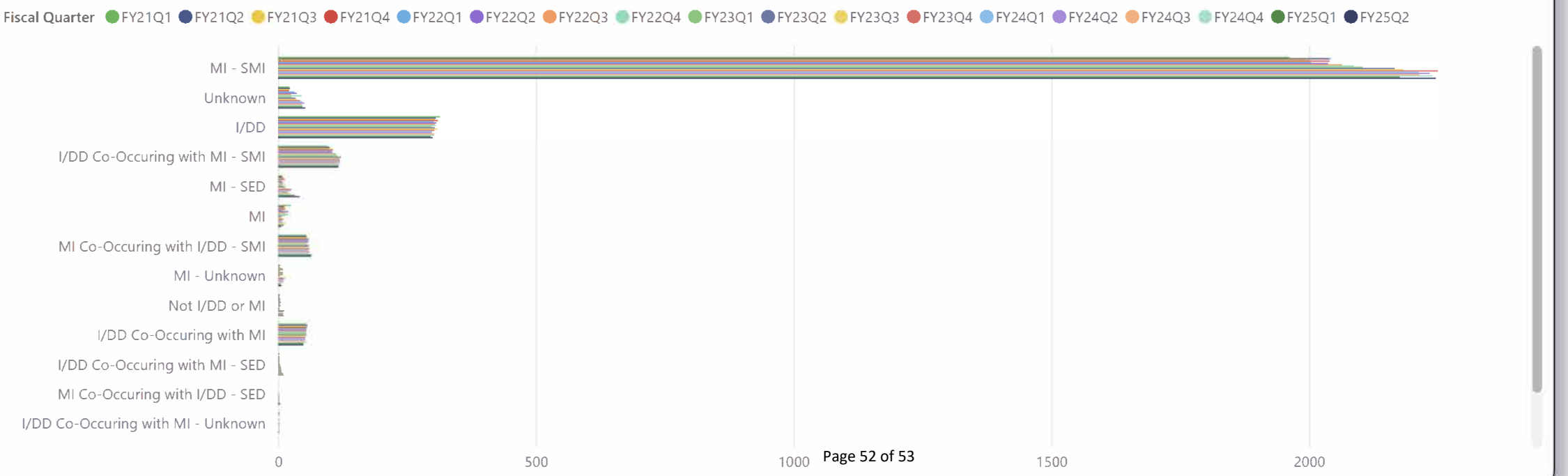
Community Inpatient Days By Fund Source



Adult - Distinct Count by Disability Designation

Disability_Designation	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY22Q1	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3	FY23Q4	FY24Q1	FY24Q2	FY24Q3	FY24Q4	FY25Q1	FY25Q2
I/DD	314	306	304	310	302	307	304	306	298	304	309	303	299	298	303	303	296	300
I/DD Co-Occuring with MI	55	57	57	55	55	55	54	55	55	55	52	52	53	52	54	55	49	49
I/DD Co-Occuring with MI - SED	1		1	1	1	1	1	1	1	4	5	5	5	6	7	7	9	10
I/DD Co-Occuring with MI - SMI	97	100	105	106	104	105	112	113	115	122	119	119	120	120	118	118	118	117
I/DD Co-Occuring with MI - Unknown		1	1				1			2	1		1	1	1		1	
MI	24	12	14	14	9	20	13	19	15	6	8	10	9	7	15	10	11	6
MI - SED	8	9	12	13	6	9	10	15	8	13	16	26	25	18	22	24	32	42
MI - SMI	1962	2041	2001	2040	2004	2037	2064	2087	2104	2166	2183	2250	2213	2234	2214	2239	2176	2246
MI - Unknown	6	1	6	9	9	3	10	10	9	3	7	13	11	10	11	8	5	7
MI Co-Occuring with I/DD	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
MI Co-Occuring with I/DD - SED										1	1	2	2	3	2	3	2	4
MI Co-Occuring with I/DD - SMI	55	55	56	60	58	59	57	57	61	59	58	61	59	60	63	59	65	64
Not I/DD or MI	4	2	2	4	4	3	6	5	3	5	3	2	3	12	10	11	9	10
Not I/DD or MI - Unknown		1		1	1							1						3
Unknown	22	23	22	21	32	36	25	46	26	34	36	43	47	51	46	48	47	53

Adult - Distinct Count by Disability Designation



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FY21Q1
FY21Q2
FY21Q3
FY21Q4
FY22Q1
FY22Q2
FY22Q3
FY22Q4
FY23Q1
FY23Q2
FY23Q3
FY23Q4
FY24Q1
FY24Q2
FY24Q3
FY24Q4
FY25Q1
FY25Q2
FY25Q3

Child - Distinct Count by Disability Designation

Disability_Designation	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY22Q1	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3	FY23Q4	FY24Q1	FY24Q2	FY24Q3	FY24Q4	FY25Q1	FY25Q2
I/DD	114	123	138	144	145	152	163	175	174	189	217	219	232	248	254	253	259	284
I/DD Co-Occuring with MI	4	4	5	5	5	6	4	4	5	4	4	3	3	4	4	3	3	4
I/DD Co-Occuring with MI - SED	69	73	68	69	77	77	79	78	76	73	71	67	65	65	72	71	66	58
I/DD Co-Occuring with MI - SMI	14	12	10	8	9	9	9	9	6	5	2	2	1					
MI	7	9	10	9	8	6	4	2	7	2	4	4	3	4	2	2	3	5
MI - SED	511	563	578	601	611	650	663	615	660	707	729	714	685	732	727	717	715	714
MI - SMI	113	110	102	90	81	77	70	55	51	49	40	37	35	26	20	9	7	4
MI - Unknown			1	1				1			1				1	1		
MI Co-Occuring with I/DD - SED	20	18	20	17	18	19	21	22	26	28	26	32	30	29	28	28	25	24
MI Co-Occuring with I/DD - SMI	10	8	9	8	5	4	4	4	2	1	1	1						
Not I/DD or MI	4	5	5	8	7	4	11	15	15	9	5	8	7	10	5	11	14	11
Unknown	11	9	3	7	4	10	7	16	9	2	8	11	10	10	6	11	11	15

Child - Distinct Count by Disability Designation