AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
PROGRAM COMMITTEE MEETING

Thursday, May 8, 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, Ex Off, Ch				Pam Schumacher				BABH: Chris Pinter, Joelin Hahn, Karen Heinrich, Sarah Van Paris, and Sara McRae
	Sally Mrozinski, V Ch				Robert Pawlak, Ex Off				
	Jerome Crete				Richard Byrne, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
	Shelley King								

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Nomination & Elections 3.1) Committee Chair 3.2) Committee Vice Chair		3.1) Consideration of nomination to elect _____ as Committee Chair 3.2) Consideration of nomination to elect _____ as Committee Vice Chair
4.	Unfinished Business 4.1) None		
5.	New Business 5.1) Clinical Program Review: Assertive Community Treatment (ACT), K. Heinrich 5.2) Policies Ending 30-Day Review: a) Basis of Accounting, 08-01-01		5.1) No action necessary 5.2) Consideration of motion to refer the policy, Basis of Accounting, 08-01-01, to end 30-day review to the full board for approval

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	5.3) Policies Beginning 30-Day Review: a) Photographing, Video Recording, Audio Taping, Fingerprinting Recipients, 03-03-06		5.3) Consideration of motion to refer the policy, Photographing, Video Recording, Audio Taping, Fingerprinting Recipients, 03-03-06, to begin 30-day review to the full board for approval
	5.4) Primary Network Operations and Quality Management Committee Meeting Notes from March 13, 2025		5.4) No action necessary
	5.5) 2025 Medical Staff Plan		5.5) Consideration of motion to refer the 2025 Medical Staff Plan to the full board for approval
	5.6) Federal Medicaid Update		5.6) No action necessary
	5.7) Michigan Department of Health & Human Services (MDHHS) Pre-paid Inpatient Health Plan (PIHP) Procurement Update		5.7) No action necessary
	5.8) Strategic Leadership Team (SLT) Transition Update		5.8) No action necessary
6.	Adjournment	M - S - pm MA	

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***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 4/1/2025. 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 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

BAY-ARENAC BEHAVIORAL HEALTH
POLICIES AND PROCEDURES MANUAL

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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 AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 6	**Photographing, Video Recording, Audio Taping, Fingerprinting Recipients**		
Page: 1 of 2	**Supersedes Date:** **Pol: 6-3-02, 7-15-99** **Proc: 6-3-02, 7-28-98**	**Approval Date:** **Pol: 6-21-12** **Proc: 5-8-12**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority that:

1. Fingerprints, photographs, video recordings or audiotapes may be taken and used, and one-way glass may be used: in order to provide services, including research, to a recipient; for educational or training purposes; or to determine the name of a recipient, when informed consent has been obtained from the recipient or applicable parent or guardian. Video surveillance is prohibited.

2. Photographs of a recipient may be taken for purely personal or social purposes and shall be maintained as the recipient's personal property, including digital images. A photograph of a recipient shall not be taken or used under this subsection if the recipient has indicated his or her objection.~~Photographs may be taken for purely personal or social purposes unless the recipient or applicable parent or guardian has indicated an objection, either verbally or in writing.~~ However, these photographs, videos, audio-recordings taken for personal or social purposes may not be put on social media of any kind without specific written consent of the legally responsible party.

Purpose

This policy and procedure are established to ensure that recipients are protected in the areas of photographing, video recording, audio taping and fingerprinting.

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

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

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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**
Marlene Wolber	Linda Maze	11/10/09	Revision	Triennial Review-format and language updated
Pepa Carlson Tina Dilley	Linda Maze	5/8/12	Revision	Revised to include video recordings and added related form: consent for Use of Photographs and/or Video Recordings
Melissa Prusi	Christopher Pinter	6/27/16	No changes	Triennial Review-no changes
Melissa Prusi	Christopher Pinter	06/20/2019	Revision	Triennial and annual review – minor changes
Melissa Prusi	Christopher Pinter	01/06/2021	Revision	Annual review
Melissa Prusi	Christopher Pinter	01/25/2021	Revision	Revised to reflect updated MDHHS ORR standards re: video surveillance.
Melissa Prusi	Christopher Pinter	06/23/2021	No changes	Triennial Review
Melissa Prusi	Christopher Pinter	12/12/2024	Revision	Updates to videotaping language
Melissa Prusi	B. Pinter	2/5/2025	Revision	More updates to Policy statement

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, March 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.		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	X	Jacquelyn List, List Psychological COO	
Anne Sous, BABH EAS Supervisor		Laura Sandy, MPA Clinical Director & CSM Supervisor	X	x, 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		Megan Smith, List Psychological Site Supervisor		Michele Perry, BABH Finance Manager	X
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		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		Taylor Keyes, Adult MI Team Leader	X
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		Nicole Konwinski, BABH Senior Reimbursement Admin.	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: 02/13/25** **d. Program/Provider Updates and Concerns**	a. There were additions made to the agenda for next meeting's discussion. Under 4, n. Transition of Care and Coordination Technical Requirement, o. Assessments, p. Authorizations, q. Outpatient Only Services, r. Opportunity Center, s. PNOQMC Note Review with Department Staff. b. No presentations this month. c. The February meeting notes were approved as written. d. **Program/Provider Updates and Concerns:** Bay-Arenac Behavioral Health: - ABA/Wraparound – No updates to report this month. - ACT/Adult MI – Adult MI 2 case managers short and case loads are high. - Arenac Center – No updates to report this month. - Children's Services – No updates to report this month. - CLS/North Bay – CLS providers have been doing really well. There was a leadership change at one of the providers and things are going great. - Corporate Compliance – We are seeing trends across the board with expired assessments/plans of service and copy and forward and copy	d. **Corporate Compliance Program Updates** - Staff to send examples of authorization issues to Karen so she can look into it.

Topic	Key Discussion Points	Action Steps/Responsibility
	and pasting notes mainly with progress notes. The assessment has to be done and through the assessment it determines medical necessity. The plan of service identifies the service needs and authorizes the service so Medicaid should not be charged for any services if they are expired. Interim Plans are being billed and should not be with expired assessments and the plans of service. Kelli raised a question where her Homebased staff are not able to enter an auth, they have to go to her for approval. This is also happening with other departments. Karen asked staff to send her examples so she can look into it. The copy and pasting has the same signatures pasted over, same misspellings, and this is not acceptable. - EAS (Emergency Access Services)/Mobile Response – Mobile Response is Monday thru Friday 8:30-4:30 and Tuesdays and Wednesdays till 9:00. - ID/DD – A case manager accepted a position this week. We hope to have that position filled by next meeting. - IMH/HB – We are down a Family Support Case Manager. - Integrated Care – BABH is adding another Clinical Director position and Nicole Sweet will be the new Clinical Director. We are close to filling Nicole's job and then she will have to train her replacement before taking over as the Acute Care Clinical Director for Adult Services. Joelin will be the Clinical Director for Childrens Services and Autism, and Karen will be the Clinical Director of Long-Term Care for IDD. - Madison Clinic – No updates to report this month. - Medical Records – No updates to report this month. - Quality – Wrapping up the MSHN MEV so corrective action will be coming out soon. CARF will be here April 14-16. - Recipient Rights/Customer Services – The site review process is under way. During the HSAG reviews for the PHP, there are changes for Customer Services. The customer handbook will have changes so there is a delay in getting these out as the handbooks have not gone to the printer yet. There will be changes in PCE for the ABD's. We are working	

	Topic	Key Discussion Points	Action Steps/Responsibility
		on the citations because instead of doing the broad 42CFR language, we need to be specific where we are pulling the citations from. - Self Determination – No updates to report this month. List Psychological: - IDD – No updates to report this month. MPA: - CSM – No updates to report this month. - OPT-A – No updates to report this month. Saginaw Psychological: - CSM – A new therapist is starting next week. We may possibly have another therapist starting in April. We are down a case manager, and one is a LMSW intern so when she graduates in May, we will be down two case managers. We are closed to CSM Medicare referrals. - OPT – No updates to report this month.	
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 – Nothing to report this month. 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** – Defer iv. MHSIP/YSS – Nothing to report this month. v. Provider Satisfaction Report – Nothing to report this month. c. Access to Care & Service Utilization Reports i. MMBPIS Report – Nothing to report this month.	b. iii. **RAS** - Deferred

	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	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** – The Employment Steering Committee meets quarterly. We encourage every agency to send someone, it doesn't have to be a manager, to share resources. Contract Providers have the bulk of referral sources so we would like to help out to get referrals sent over. With IPS services, it is zero exclusion. d. Regulatory and Contractual Compliance Reports i. PI Report – Nothing to report this month. 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. 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 – Nothing to report this month.	l. **ATP Notification Process** – Karen will put in a request with Dmitriy for

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, March 13, 2025

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

Teams Conference Call

Topic	Key Discussion Points	Action Steps/Responsibility
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 ii. Medicaid Reenrollment: Encourage /assist as needed with process **g. General Fund for FY2025** - **General Fund/Loss of Insurance Reports**	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 were 3 policies that were pushed through in February: Reasonable Safeguards, Site Reviews and Reporting and Investigation of Adverse Events. You can find all the policies on the BABH Website under the Provider tab. e. Clinical Capacity Issues Status i. Referral Status Report – Nothing to report this month. ii. **OPT Group Therapy** – OPT Group Therapy is still taking place. We are getting to the end of one series, but patients can join in from 3:00-4:30. iii. **Capacity Issue Discussion** – Capacity is starting to stabilize. Some providers state they think referrals have decreased. f. Medicaid/Medicare Updates i. Medicare Open Enrollment – Nothing to report this month. ii. Medicaid Reenrollment – Nothing to report this month. g. **General Fund for FY2025** – Joelin occasionally sends out the GF/Loss of Insurance Report. We are working on the report to be more useful, so when changes have been made, it will be sent out to the committee. h. Conflict Free Case Management – Nothing to report this month.	a client alert. Joelin will get with the Primary Providers for an updated staff/supervisor list. m. **AOT 30-Day IPOS Addendum** – James to get with Stacy on the discussion from today's meeting. r. **Opportunity Center** – Joelin will email the committee the referral process instructions.

Commented [JH1]: Please include the PP numbers. Karen should have them.

Topic	Key Discussion Points	Action Steps/Responsibility
h. Conflict Free Case Management i. LOCUS Competency Monitoring **j. Periodic Review Updates** **k. Date on Discharge Summary** **l. ATP Notification Process** **m. AOT 30-Day IPOS Addendum** **n. Transition of Care and Coordination TR** **o. Assessments** **p. Authorizations** **q. Outpatient Only Services** **r. Opportunity Center** **s. PNOQMC Note Review with Department Staff**	i. LOCUS Competency Monitoring – Nothing to report this month. j. **Periodic Review Updates** – We had confirmation from MSHN that they are not allowing us to do ranges anymore. If we continue to use ranges, we will be sanctioned. There is an internal workgroup next week to start talking about ranges. Will we have authorizations that are monthly, quarterly, etc. Do we want to take it out of the authorization so it doesn't give the option of ranges. To eliminate the range, other CMHs authorize 3 to 3 CM visits vs 3 to 5. PCE said we can get rid of the 'from' box so there will only be one box to choose. We need to address this with PCE and figure out what education we need to provide to staff so we know what our expectations are for the authorizations. We submitted corrective action to the state regarding this and are waiting to hear from them. Revisions to the Periodic Review are on hold. Proposed to add a section at the bottom under the authorizations that they could address over/under utilization. When they were reviewed, there are numerous auths for some departments, so we are concerned an open text box may not be enough. k. **Date on Discharge Summary** – The last visit date needs to be the last date the person received services. It's not necessarily the last service provided by the case manager, as they could have had a med review or therapy appointment. Click on the Service Activity Logs (SALS) to identify the last date of service for the discharge summary. **Reminder** that staff need to use the "Send Copy To" to notify all providers on the ABD. Suggestion for BABH to work with the Help Desk to create a "Discharge Instructions" for Help tab in Phoenix. Amy made revisions to the meds only instructions, so this was added to the Phoenix Help tab.	

Commented [JH2]: Sarah - can you add clarity to this section?

Topic	Key Discussion Points	Action Steps/Responsibility
	l. **ATP Notification Process** – Michele Perry and Nicole Konwinski with the BABH Finance Department gave an update on the ATP notification process since issues were addressed. ATPs need to be on file as a requirement from the state. Joelle S. has been assigned to work with the Finance department on the Medicaid and ATP issues. When consumers do not have an ATP on file and/or their Medicaid isn't current, Joelle will be emailing staff/supervisors and copying Finance staff since they all work on the same process. Finance would like a list of staff and supervisors from each provider. MPA would like to have a spreadsheet of all consumers that need an ATP and/or Medicaid sent to the supervisor not to the staff and supervisor. After discussion as to how the process runs and why it's being done, Finance will continue with the same process unless we hear otherwise. **Medicaid Application** – The asset limit increases starting 04/01/25 so please encourage your consumers who have lost or were denied Medicaid to reapply. BABH recommends the use of a paper-based Medicaid application. Finance had a meeting with Jodi Surbrook of MDHHS and she prefers people to fill out the paper-based form because MIBridges doesn't always work the way it should. Applications can be faxed to MDHHS, dropped off at the local DHS Office, or emailed. A 'Medicaid Redetermination Dates Report' was created in Phoenix. Dmitriy can create a 'client alert' and there was consensus among the committee members. This would alert that the redetermination date is coming up. Karen to follow-up on this. m. **AOT 30-Day IPOS Addendum** – The Michigan Health code updated the requirements for hospitalization for adults under court order. Whether it's a deferment or court order, an objective or intervention should be added to the IPOS. This will likely be accomplished by creating an addendum to the plan that it signed by the consumer. The AOT coordinator needs to submit	

Commented [JH3]: Sorry Joelle. I don't know how I messed up the numbering system.

Topic	Key Discussion Points	Action Steps/Responsibility
	the plan to the judge within 30 days. As this is a new process and primary care staff internal and external need to be educated, the AOT coordinator will contact program/provider leadership to schedule time at their staff meetings. In the interim, if the addendum is needed by the AOT coordinator, she should contact the program/provider leadership to make this request. Once all programs/providers have been trained, the communication process may be streamlined directly to staff. n. **Transition of Care and Coordination TR** – MDHHS added language to a technical requirement for Transition of Care and Coordination. These changes may impact how the process for case closures. We will discuss further at the next meeting. o. **Assessments** – The details in the assessments are used to substantiate the medical necessity criteria for Specialty Mental Health services, especially for Medicaid. The "Service Eligibility Criteria" section of the assessment contains the States criteria for each population (SMI, IDD, SED). There is a check box for **each** element of the medical necessity criteria. By checking a box, the clinician is attesting that there is adequate evidence in the details of the assessment to support that the individual meets the specific element of medical necessity criteria. Program/provider leadership reviewing the assessment should be able identify the evidence of that as they go through the sections. Joelin offered to provide staff education on medical necessities and training on how the assessment is used as evidence to support the need for Specialty Mental Health services. p. **Authorizations** – Authorization request need to be timely. There should not be a lapse in authorized units. In general, BABH will not support a request for retro dated units.	

	Topic	Key Discussion Points	Action Steps/Responsibility
		q. **Outpatient Only Services** – It is very rare for an individual who meets medical necessity criteria for Specialty Mental Health services, to only be receiving OPT services (it can happen, but it is very rare). BABH will be revising the authorization procedure to include that authorization requests for OPT only services will require reviewed for approval by a clinical director. r. **Opportunity Center** – BABH has been approved for a grant through MSHN which will pay for someone on a spenddown to go to the OC. Joelin will email the committee as a reminder of what the referral process is. s. **PNOQMC Notes: Review with Department Staff** – Please make sure to go through the PNOQMC meeting notes with your staff so they are aware of what is going on with BABH and the providers. FYI – there is a Recovery House in the process of being created in Bay City. It is not Medicaid approved as of yet. It will start off with male beds and possibly expand to female beds.	
5.	**Adjournment/Next Meeting**	The meeting adjourned at 3:30 pm. The next meeting is scheduled for April 10, 2025, 1:30-3:30, at the Lincoln Center in the East Conference Room.	

Bay-Arenac Behavioral Health Authority
Medical Staff Plan
2023-2024

Board Adoption: 11/16/2023

ARTICLE I: PURPOSE

The Medical Staff of Bay-Arenac Behavioral Health Authority, (BABHA) is composed of licensed independent or supervised practitioners who provide medical care to the agency's consumers either under employment or contractual arrangements.

The Medical Director, under the authority of the Chief Executive Officer (CEO) and Board, is responsible for establishing and monitoring standards of care, resolving disputes over clinical matters, providing supervision to all medical and nursing staff and promoting quality and performance improvement initiatives.

ARTICLE II: MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the BABHA medical staff is a privilege, which shall be extended only to professionally competent prescribing professionals who continuously meet the qualifications, standards and requirements set forth in this Medical Staff Plan.

Section 2. Qualifications for Membership

A. Only a prescribing professional holding an unlimited license to practice in the State of Michigan, who can produce evidence of his or her background, experience, training, judgment, individual character, and demonstrated competence, physical and mental capabilities (referring to any potential impairment), adherence to the ethics of his/her profession to assure the Medical Director, and/or the CEO that any patient treated by him/her will be given a high quality of medical care, shall be qualified to apply for membership, and

B. Primary Source verification of successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency for the Psychiatrist is required. National board certification in specialty is preferred. National certification from the American Nurses Credentialing Center (ANCC) or the American Association of Nurse Practitioners (AANP) for Nurse Practitioners or National Commission on Certification of Physician Assistants (NCCPA) for Physician Assistants is required at hire or contract.

Section 3. Nondiscrimination

No aspect of Medical Staff membership or clinical privileges shall be denied on the basis of gender, race, religion, age, creed, color, national origin or any other basis prohibited by law.

Section 4. Conditions and Duration of Privileges

A. The CEO shall review all initial privileges and renewal of privileges to the Medical Staff, upon recommendation by the Medical Director. The Medical Director will seek input from the Healthcare Practices Committee (HPC) when formulating his/her recommendation(s). The Medical Director will then make recommendations to the CEO. If the CEO concurs with the Medical Director's recommendation(s), the privileging request is forwarded to the appropriate committee of the BABH Board for action. The Board shall act on privileges and renewal of privileges, denials or revocations of privileges and reinstatements, and

B. Renewal of privileges to the Medical Staff shall be for no more that 24 calendar months. Initial privileges are Provisional and are for 12 calendar months.

Section 5. Ethics

A person who accepts membership on the Medical Staff agrees to act in an ethical, professional, and courteous manner, in accordance with the mission and philosophy of BABHA.

Section 6. Responsibilities of Membership

A. Each Medical Staff member must abide by the Medical Staff Plan,

B. And BABHA policies and procedures and recommendations made by the (HPC), when applicable.

C. Each Medical Staff member shall, upon request, provide documented evidence of current and continuous professional license, Federal and State controlled substance licenses, recent MAPS report card if applicable, and professional liability insurance in accordance with BABHA policy.

D. Each Medical Staff member shall submit a complete application for renewal of privileges prior to the end of the current privileging time frame, as directed by the credential verification organization. Failure of the Member to submit such an application in a timely manner shall be construed as a voluntary resignation from the Medical Staff.

D. Each Medical Staff member shall notify the Medical Director or CEO in writing within 15 calendar days or receipt of written or oral notice of any investigation or adverse action affecting Medical Staff membership or privileges at any hospital or health care entity, the commencement of an investigation or pending action regarding his/her license to practice

in the State of Michigan or in any other state, the loss of professional liability insurance, the filing of criminal charges, or any change in physical or mental health status which may interfere with the competent practice of his/her profession and performance of duties. Failure to notify may result in immediate suspension of privileges. The Medical Director or CEO is required to report any receipt of written or oral notice of any of the above action to the Department of Licensing and Regulatory Affairs (LARA).

Section 7. Medical Staff Member Rights

A. Each member of the Medical Staff has the right to meet with the Medical Director or the CEO.

B. Each member of the Medical Staff has the right to fully participate in the meeting of the Medical Staff.

Section 8. Temporary Privileges and Provisional Privileges

A. Temporary Privileges

The Healthcare Practices Committee will review credentials prior to making a recommendation for temporary privileges to the CEO. Temporary privileges may be granted for up to 120 days during the Credentialing Process. to the

B. Provisional Privileges

Each applicant approved for initial privileges will be granted Provisional Privileges for a period of one calendar year. At the end of the one-year provisional period, an evaluation of performance**,** to include input from the HPC, will be conducted. The individual will be eligible for full privileges if all requirements have been fulfilled and an acceptable standard of care and conduct have been rendered.

ARTICLE III: MEDICAL STAFF MEETINGS

Section 1. Meetings of Medical Staff

A. Meetings of the Medical Staff shall be held and chaired by the Medical Director. Written notice of the meeting will be sent to all members of the medical staff. The agenda of the meeting may include reports on quality indicators, pertinent clinical topics or case studies and performance measures. In addition, goals for the following year will be discussed and established.

B. Written minutes of all meetings shall be recorded and approved.

C. Additional communications during the year may occur by mail (e.g., newsletters, etc.) and email.

D. All nursing staff from the clinic sites will be periodically invited to attend the regularly scheduled Medical Staff meetings.

ARTICLE IV: PROFESSIONAL REVIEW ACTIONS

Section 1. Automatic Revocation (Voluntary Resignation), Suspension, Restriction, Limitation

A. State License: Whenever a medical staff member's license to practice in the state of Michigan (and in the state which they are physically located while practicing tele-psych) is revoked, suspended, or in any way limited or restricted, his/her privileges to practice under contract with BABHA will also be revoked, suspended, limited, or restricted to the same degree. Revocation shall result in immediate and automatic revocation of Medical Staff membership and all clinical privileges. Any suspension, limitation or restriction will be effective upon and for at least the term of the imposed suspension, limitation, or restriction. The Medical Director, under the authority of the CEO, will implement the appropriate restriction. If BABHA takes any action against any medical staff member for a quality concern, the Medical Director and/or CEO are required to report this to the State of Michigan Health Professional Licensing Bureau (LARA).

B. Drug Enforcement Agency (DEA) and State of Michigan Controlled Substance License: If a medical staff member's right to prescribe controlled substances is revoked, restricted, suspended, or placed on probation by a proper licensing authority, his or her privileges to prescribe such substances under contract with BABHA will also be revoked, restricted, suspended or placed on probation. The Medical Director, under the authority of the CEO, will implement the appropriate restriction.

C. Professional Liability Insurance: Evidence of professional liability insurance coverage, as defined by BABHA policy and/or clinical service contracts, shall be submitted upon request and in no event more than thirty calendar days after the effective date of the policy or renewal of the policy. Failure to maintain a minimum amount of professional liability insurance or to provide evidence thereof shall be construed as a voluntary resignation from the member's medical staff clinical privileges.

Any Member of the Medical Staff whose membership and clinical privileges have been automatically revoked under Section 1 above shall not have the right to a hearing under the Board's Grievance Procedure.

ARTICLE V: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application or reapplication for membership and clinical privileges with the BABHA Medical Staff.

Section 1. Privileged Communications

Any act, communication, report, recommendation, or disclosure regarding any practitioner**,** performed or made in good faith and without malice and at the request of an authorized representation of this or any other healthcare entity, for the purpose of achieving and maintaining quality patient care in this or any other healthcare entity, shall be privileged from disclosure to the fullest extent provided by law.

Section 2. Immunity and Release from Liability

No person furnishing information, data, reports, and records to any supervisor, Medical Director, or CEO regarding any member of the medical staff shall, by reason of furnishing such information, be liable in damages to any person. Employees of BABHA will not be liable in damages to any person for any actions taken or recommendation made within the scope of his/her employment if such an employee acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to him/her. Each member and applicant agree to release, indemnify, and hold harmless BABHA and all third parties from liability for any and all such statements or actions.

Section 3. Release of Information

BABHA representatives who may provide information to any other hospital or entity to which a Member or past Member may apply for membership and/or clinical privileges shall, by reason of furnishing such information, not be held liable in damages to any person, provided such release of information is made within the scope of the duties of such representative and is made in good faith and without malice.

ARTICLE VI: HEALTHCARE PRACTICE COMMITTEE (HPC)

Section I. Medical Director Responsibilities

A. The Medical Director of BABHA will provide oversight of the Medical Staff Psychiatric Services and Health Care Practices.

B. The oversight and peer review processes will be completed through the HPC activities, as outlined in the HPC criteria for review.

C. These processes will be for educational purposes and monitoring for quality trends and compliance with agency policy and procedures for the licensed professionals providing services in the Medical Practices.

D. The Medical Director will consult with the CEO regarding the Medical Staff Practices, as deemed necessary.

Section 2. Meeting Activities

A. The HPC will meet on a monthly basis, or sooner if needed, to review established criteria, as outlined in the HPC.

B. The HPC will review all medically related policies, procedures, and plans.

C. The HPC will provide peer review information and other pertinent information to the Medical Director during the privileging process.

D. Nursing Self-Assessment Skills Checklist will be completed annually by each nurse and reported to HCP, as necessary.

ARTICLE VII: MANAGEMENT OF PRESCRIBING PRACTICES

Section I. Electronic Software

A. All BABHA sites will use an electronic software system to ensure a prescribing data base is in place.

C. This database will be used to review prescribing practices and feedback will be provided to the HPC as appropriate.

Section II. Practitioner Responsibilities

A. All BABHA prescriber and nursing staff both direct operated and contracted are strongly encouraged to acquaint themselves with the general principles and clinical practice guidelines of the psychopharmacologic treatment strategies specific to the treatment of individuals with psychiatric and/or substance use disorders. General strategies for managing interactive effects of substance use on psychiatric symptoms and interventions, mechanisms for physician-to-physician coordination of care and treatment of individuals with chronic pain should be part of regular practice.

B. In keeping with improvements in best practices related to psychopharmacologic prescribing practices and interventions for individuals with psychiatric and/or substance use disorders, all network prescriber staff are encouraged to remain current on best practices related to care and treatment of individuals with co-occurring substance use disorders.

   a. Access to contracted Addictionologist for case review or second opinion recommendations
   b. Pharmaceutical Representative educational opportunities
   c. Project ECHO available to all staff
   d. Peer Chart Review process for prescriber-to-prescriber monitoring and support
   e. Collaborative agreements for mid-level providers with physicians for case review/consultation or second opinion recommendations
   f. Benzodiazepines Protocol and information sheet and Treatment for Stimulant Use Disorders guidelines, agency monitoring of controlled substance prescriptions and treatment through Power BI report, Marijuana policy, Drug Screening and Testing C04-S24-T05,

ARTICLE VIII. ATTACHMENTS

HPC Committee – Statement of Purpose and Membership

Attachments to HPC:

- Medical Record Peer Review Guidelines
- Medical Record Peer Review Tool

Nursing Self-Assessment Skills Checklist

Medicaid Reform Proposals: The Impact of Changes to FMAP and States' Use of Provider Taxes

Among proposals lawmakers are considering that would make changes to Medicaid are policies to lower the enhanced Federal Medical Assistance Program (FMAP) rate for expansion states, decrease the FMAP floor, reduce the FMAP rate for Washington, D.C., and restrict states' use of provider taxes to finance Medicaid. Some of these proposals were listed in the House Budget Committee's "menu" of reconciliation options disseminated last month. The following describes these proposals and what they could mean for states.

Lower Enhanced FMAP for Expansion States: The Affordable Care Act (ACA) expanded access to health insurance by allowing states to extend Medicaid coverage to individuals with incomes up to 138% of the Federal Poverty Level (FPL)—$15,060 annually for a single person in 2024—who were previously ineligible based on categorical requirements. This group, known as the "expansion population," qualifies for Medicaid solely based on income. In contrast, other Medicaid populations must meet additional eligibility criteria, which can vary by state. The expansion population benefits from an enhanced FMAP, of which the federal government currently covers 90% of costs, whereas FMAP for other populations ranges between 50–80%. Proposals to limit this enhanced rate would set federally matched dollars at a state's traditional FMAP rate (57% on average; see p. 20 of the House Budget Menu).

This would shift significant costs of expansion to states and could ultimately lead to beneficiaries who are covered by expansion losing coverage. 12 states—Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia—also have "poison pill" laws in place that will terminate Medicaid expansion in the state if the federal match declines. Additionally, the remaining states that have yet to expand their programs will likely be deterred from doing so.

Significantly reduced federal funding, without programmatic changes, will lead to substantial gaps in state budgets, which most states will not be able to fill on their own. Given the potential savings generated by reducing the FMAP for the ACA expansion population, it is very likely that this policy in particular could be used as a pay-for in the Republican reconciliation package.

Reducing the FMAP Floor: Currently, a state's standard FMAP rate is determined by a formula that considers the state's per capita income relative to the national average. However, no state's FMAP can fall below the minimum threshold of 50%. The House Budget Menu (p. 19) suggests lowering that minimum rate, though it does not specify the new threshold. Similar to the effect of lowering the expansion FMAP, reducing the overall minimum FMAP would decrease federal Medicaid funding and likely shift significant costs to ten states—California, Colorado, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Washington, and Wyoming—that currently receive the 50% minimum rate. As a result, these states would likely face significant Medicaid funding decreases.

Lowering the DC FMAP: Washington, D.C.'s FMAP is not determined by the standard formula; instead, it has been statutorily set at 70% since 1998 (p. 6). Congress may seek to remove that statutory designation and lower DC's FMAP in line with proposed reductions to the FMAP floor.

The House Budget Menu (p. 19) specifically suggests basing D.C.'s FMAP on the standard formula, which the document suggests would lower the rate to 50%. This reduction would result in substantial funding shortfalls for D.C.'s Medicaid program. Medicaid and federal grants are estimated to comprise roughly 25% of the District's revenue, and this proposal could sharply reduce overall funding.

Provider Taxes: Under current law, states have flexibility in financing their share of Medicaid costs and are allowed to levy taxes on health care providers to help fund the program. All states (with the exception of Alaska) rely on provider taxes for this purpose, and 39 states (including D.C.) have at least three provider taxes. The House Budget Menu (p. 20) includes a proposal to lower the Medicaid provider tax safe harbor from 6% under current law to 4% from 2026 to 2027 and 3% in 2028 and after. The most recent available data shows that provider taxes accounted for roughly 17% of the state share of the cost of Medicaid (this is an average, and many states have considerably greater risk).

If legislation were to restrict states' ability to use these taxes, they would struggle to replace the lost revenue, likely leading to a reduction in FMAP. In the first Trump administration, some changes to the federal rules governing provider taxes under the Medicaid Fiscal Accountability Rule (MFAR) were proposed, but they generated considerable opposition and were not ultimately adopted.

Statement from Protect MI Care Coalition on Medicaid Threats and Ongoing Organizing Across Michigan

LANSING, Mich. – As threats to Medicaid loom closer at the federal level, the Protect MI Care Coalition—a growing alliance of healthcare providers, advocates, and community organizations—is sounding the alarm and mobilizing swiftly to defend access to care for millions of Michiganders. The following statement can be attributed to Monique Stanton, president and CEO of the Michigan League for Public Policy:

"The Protect MI Care Coalition is being created to ensure that the voices of patients, caregivers, providers, and local communities are heard loud and clear in the fight to protect Medicaid. More than 2.6 million Michiganders rely on this essential program, including over 1 million children, seniors in long-term care, people with disabilities, veterans, and working families. Medicaid is not just a lifeline for individuals—it's the backbone of Michigan's healthcare system and a key driver of our state's economy.

"Proposals in Congress that would cut or cap Medicaid funding, including those outlined in the House Budget Resolution, would have catastrophic consequences for Michigan. In 2026 alone, our state could lose $2.2 billion in federal funding, experience a $4.9 billion drop in economic output, and see our state GDP fall by $2.9 billion. These cuts would trigger the closure of hospitals, birthing centers, behavioral health clinics, and nursing homes—particularly in rural and underserved communities—leaving entire regions without access to essential care.

"We're talking about more than just numbers or hypotheticals. These are our neighbors, co-workers, patients, and loved ones. Medicaid supports cancer patients receiving life-saving treatment, moms delivering babies in rural hospitals, people with disabilities receiving critical and cost-effective assistance at home, and kids receiving preventive care to grow up healthy and strong. In some rural counties, Medicaid covers the majority of births and provides the only path to behavioral health care.

"We are actively working with organizations across the state to finalize the full coalition membership as momentum builds. Our statewide network is growing quickly, and we are united by a shared mission: to stop these devastating Medicaid cuts and protect the health, dignity, and futures of Michigan families.

"To members of Michigan's congressional delegation: The stakes could not be higher. We urge you to stand with the growing list of community organizations across the state, your constituents, that are pleading with you to protect our care by protecting Medicaid. Vote no on any federal budget or legislation that includes cuts or caps to Medicaid. "

The Protect MI Care coalition steering committee includes:

- Center for Civil Justice

- Community Mental Health Association of Michigan
- Michigan Primary Care Association
- Michigan League for Public Policy
- Michigan Health & Hospital Association
- Michigan Elder Justice Initiative
- Michigan Council for Maternal and Child Health
- Michigan Association of Health Plans

Protecting People Over Profit

Public Management of Michigan's Behavioral Health System

Community Mental Health Association of Michigan

On February 28, 2025 the Michigan Department of Health and Human Services (MDHHS) announced that they are seeking public input through an online survey as the department moves to a competitive procurement process for the state's Pre-Paid Inpatient Health Plan (PIHP) contracts. **Our concern is that such bid-out plans, in the past, have opened the door to the privatization of Michigan's public mental health system.**

Unmandated Competitive Procurement: A Risky Proposal That Adds Chaos to Care

Potential funding cuts on the horizon

Disrupts care and creates confusion for those relying on critical services

Procurement process is NOT being driven by Federal rules or requirements

Rather Than a Chaotic Competitive Procurement Process, Take Real Steps to Collectively Solving Core Issues

HOW BEST TO IMPROVE ACCESS TO CARE & SERVICES FOR PEOPLE IN NEED

Sufficient Funding + **Ensure & Enhance Local Voice** + **Reduce Administrative Overhead** + **Increase Workforce & Network Capacity**

- **Sufficient Funding**
  Funding for the core mental health and I/DD services has remained FLAT over the past 5 fiscal years (including $0 general fund increase) while medical inflation has increased by over 10%* and Medicaid expenses have increased by nearly 25%. **Inadequate funding leads to shortages in available services, long wait times, and a lack of quality mental health providers.**
- **Ensure & Enhance Local Voice**
  Only a publicly managed system protects local input. **Privatization removes people's power, shifting care decisions to out-of-state boards with no direct ties to Michigan communities.**
- **Reduce Administrative Overhead**
  Collectively PIHPs have a MLR (Medical Loss Ratio) of 96.3%. The ONLY way to reduce layers and ensure more money goes directly into services is by reducing administrative overhead, which has dramatically increased over the past 5 years. **More bureaucracy means longer wait times, more hoops to jump through, and fewer resources for essential care.**
- **Increase Workforce & Network Capacity**
  3/4 of Michigan's public mental health organizations are experiencing workforce gaps despite salary increases or retention bonuses. Top reasons people leave the public mental health field: (1) too much paperwork / administrative hoops to jump through, and (2) better pay and work life balance. **A shortage of mental health workers means longer wait times, fewer available services—leaving Michigan's most vulnerable without the support they need.**

*According to the U.S. Bureau of Labor Statistics

BAY ARENAC
BEHAVIORAL HEALTH

May 1, 2025

Elizabeth Hertel, Director
Michigan Department of Health and Human Services (MDHHS)
P.O. Box 30195
Lansing, MI 48909

RE: MDHHS procurement process for Pre-Paid Inpatient Health Plan (PIHP) contracts

Dear Director Hertel:

The purpose of this correspondence is to commend MDHHS for encouraging recommendations from the public regarding the intended procurement process for the PIHP specialty behavioral health system announced on February 28th. This feedback will be important in meeting the stated objectives of increasing consumer choice and access to services while preserving the county Community Mental Health Services Programs (CMHSPs).

As you are aware, the Michigan Mental Health Code (MHC), Public Act 258 of 1974, includes the following MI Complied laws (MCL) governing the state and county relationship for public behavioral health services:

- MCL 330.1116 requires the state "...to promote and maintain an adequate and appropriate system of CMHSPs" and "shift primary responsibility for the direct delivery of public mental health services from the state to CMHSPs".

- MCL 330.1202 requires the state to "financially support, in accordance with chapter 3, CMHSPs that have been established and that are administered according to the provisions of this chapter."

- MCL 330.1206 and 1208 requires CMHSPs to "provide a 24/7 comprehensive array of services and supports" to residents of the counties with the "most severe forms of mental illness, intellectual/developmental disabilities, and serious emotional disturbances".

- MCL 330.1240 stipulates that "All expenditures by a CMHSP necessary to execute the program shall be eligible for state financial support", that by definition would include both Medicaid and general funds received either directly or indirectly from MDHHS.

- MCL 330.1308 requires the State to "pay 90% of the annual net cost of a CMHSP" that is established and administered in accordance with the MHC.

In recognition of the non-discretionary statutory obligations of MDHHS in the operation of the public behavioral health system and the fact that only the counties are permitted to create a CMHSP eligible for the support noted above, it is clear that the 83 county governments are one of the most important stakeholders in this procurement dialogue.

We strongly encourage MDHHS to initiate specific outreach directly to the counties in this process prior to any final procurement decisions. As the locally elected representatives with the most direct accountability and responsibility to their constituents for CMHSP services, this will ensure that the needs of the larger community are reflected in any final procurement outcomes.

Thank you for your consideration in this matter. If you have any questions, please feel free to contact me at (989) 895-2348.

Sincerely,

Christopher Pinter
Chief Executive Officer

cc: Bay County Board of Commissioners
Arenac County Board of Commissioners
Michigan Association of Counties (MAC)
Community Mental Health Asosociation of Michigan (CMHA)